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**AN
EVALUATION OF
Dialogue on
Diarrhoea**

The international newsletter on the control of diarrhoeal diseases

Prepared by:

Linda Sanei
Gayle Gibbons
David Sencer

The
Office of Health
Bureau for Research and Development
Agency for International Development

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THE PRAGMA
CORPORATION

116 EAST BROAD STREET
FALLS CHURCH, VA. 22046

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Prepared for:

The Office of Health
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Prepared by:

Project ASSIST
The Pragma Corporation
116 East Broad Street
Falls Church, Virginia 22046

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Authors:

Linda C. Sanei, Team Leader

Gayle Gibbons

David Sencer

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A multi-disciplinary team conducted the evaluation:

Ms. Gayle Gibbons	Project Director, Clearinghouse on Infant Feeding and Maternal Nutrition Editor, <i>Mothers and Children</i> , American Public Health Association
Ms. Linda Sanei	Program Manager/Analyst, Advisory Services Support for Infant Survival Technology (ASSIST) Project, The Pragma Corporation
Dr. David Sencer	Senior Fellow, Management Sciences for Health

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We would also like to convey AHRTAG's appreciation of A.I.D.'s financial support given them over the last seven years.

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EXECUTIVE SUMMARY

I. BACKGROUND

In 1980, the Diarrhoeal Disease Control Programme of the World Health Organization (WHO) made a request of Dr. Katherine Elliott¹ to produce a newsletter dealing with oral rehydration therapy (ORT) and other aspects of diarrheal disease control and prevention. With a grant of \$40,000 from WHO and the United Nations Development Programme (UNDP), *Diarrhoea Dialogue*² (DD) was born with a first print run of 2,500 copies. Following the First International Conference on Oral Rehydration Therapy (ICORT I) in 1983, the Appropriate Health Resources and Technologies Action Group, Ltd. (AHRTAG, publisher of *Dialogue on Diarrhoea*) submitted a proposal to A.I.D. outlining their objectives for the newsletter as well as their financial needs to expand production and distribution. Aware of the potential reach and impact that the newsletter could have, A.I.D. signed a two-year Cooperative Agreement (CA) with AHRTAG on August 10, 1984, to expand *Dialogue on Diarrhoea*'s circulation. Since then, resource inputs have amounted to an average of \$353,245 annually for seven years. Two evaluations have been held since the initial Cooperative Agreement was signed with AHRTAG and both have recommended continued A.I.D. support for the newsletter. The project authority under which the CA is funded, ORT-HELP (project number 936-5939), has a Project Assistance Completion Date of December 31, 1993. Funding for the CA under this project totals \$2,472,701, the last increment of which was provided in the amount of \$237,029 in May of this year.

Objectives of This Evaluation. This evaluation assesses the extent to which AHRTAG has achieved its implementation plans for fiscal years 1988 through 1991 and responded to the evaluation recommendations made in June of 1987. Further, the evaluation examines the validity and progress of the project in terms of its original goals, and discusses directions for the future. An A.I.D. drafted scope of work is the yardstick used by the team to measure AHRTAG's performance and progress and provides the framework for technical discussions.

¹Founder, *Diarrhoea Dialogue* and Scientific Editor of newsletter since its inception.

²*Diarrhoea Dialogue*, the official name of the newsletter when A.I.D. entered into the Cooperative Agreement with AHRTAG, was changed in 1985 to *Dialogue on Diarrhoea*.

Evaluation Methodology. Two methods of data collection are used for this evaluation: review of secondary data³ and interviews (see Annex A for a list of people interviewed). Interviews and document review were conducted in Washington, D.C. as well as at project headquarters in London, England. A field perspective was gained from individuals visiting the Washington area for the National Council for International Health Meeting, June 1991 and the MotherCare Project's Technical Advisory Group Meeting, also held June 1991.

II. GOALS/OBJECTIVES IN AGREEMENT

The stated goal of the original Cooperative Agreement was to:

expand the dissemination of information on all aspects of diarrheal diseases, with special emphasis on Oral Rehydration Therapy (ORT), to LDC leaders, health providers and international donors' staffs. In order to achieve this goal, this Agreement will provide funds 1) for the support and expansion of the English and French editions of the quarterly newsletter, *Diarrhoea Dialogue* and other technical material as requested by A.I.D.; 2) for the distribution of back copies of *Diarrhoea Dialogue*; and 3) for exploring and initial support of new translations of *Diarrhoea Dialogue*.

While the goal of the original Cooperative Agreement remains valid, the scope of AHRTAG's activities or project outputs has evolved. Amendments have not been used to articulate changes in AHRTAG's scope of work. Instead, AHRTAG's current scope is the result of: 1) various A.I.D. memoranda; 2) recommendations made during the 1985 and 1987 evaluations; and 3) annual implementation plans, the content of which has been largely driven by the 1985 and 1987 evaluation recommendations.

III. PROJECT ACCOMPLISHMENTS

Because of support from A.I.D. and other donors over the last seven years, 350,000 copies of *Dialogue on Diarrhoea* are circulated in ten languages worldwide; actual readership is estimated to be close to 2 million readers. Over the seven year period of A.I.D.'s funding, AHRTAG has achieved dynamic growth as an institution. Fundraising efforts have provided *Dialogue on*

³A number of project-related documents assisted the team in reaching its conclusions and recommendations. They include: 1) original Cooperative Agreement; 2) seven project amendments; 3) A.I.D. memoranda; 4) AHRTAG proposals, implementation plans, activity reports; 5) project evaluation reports; and 6) other miscellaneous material.

Diarrhoea with steadily increasing revenues from sources other than A.I.D. AHRTAG has reduced its dependency on A.I.D. by 39% for all language editions of *Dialogue on Diarrhoea* (see Table 1).

TABLE 1.
FUNDING FOR Dialogue on Diarrhoea FYs 1984-1991
(In 000's - Rounded)

Funding Source	YR 1 84-85	YR 2 85-86	YR 3 86-87	YR 4 87-88	YR 5 88-89	YR 6 89-90	YR 7 90-91
A.I.D.	413.0	295.0	367.7	410.0	400.0	350.0	237.0
Non-A.I.D.	73.4	52.0	160.0	189.6	198.0	233.5	277.5
% A.I.D. Contribution	85%	85%	70%	68%	66%	60%	46%
% Non-A.I.D. Contribution	15%	15%	30%	32%	34%	40%	54%

AHRTAG remains largely dependent on A.I.D. support for the English and French editions (see Table 2).

TABLE 2.
**A.I.D. SUPPORT FOR ENGLISH (LONDON), ENGLISH (INDIA),
FRENCH AND TAMIL EDITIONS OF Dialogue on Diarrhoea**
(Percentages)

	NO. OF COPIES	PERCENTAGE
English Edition DD (London)		
A.I.D. support	100,000 copies	87%
Other Donor Support	15,000 copies	13%
English Edition DD (India)		
A.I.D. support	30,000 copies	100%
Other Donor Support	0	0%
Tamil Edition DD		
A.I.D. support	25,000 copies	50%
Other Donor Support	25,000 copies	50%
French Edition DD		
A.I.D. support	15,000 copies	100%
Other Donor Support	0	0%

AHRTAG has achieved better funding diversification for its entire portfolio of projects and activities. Whereas *Dialogue on Diarrhoea* represented 60.9% of the organization's portfolio in 1986, it now represents only 28.7%.

Overall, AHRTAG has achieved a number of impressive accomplishments since 1987, including:

- Regular production of the A.I.D.-supported English, French and Tamil editions of *Dialogue on Diarrhoea*;
- Regular production and distribution of *Dialogue on Diarrhoea* in Portuguese, Chinese, Bangla;
- A new translated edition in Nepali initiated at the end of 1989 by the Health Learning Materials Programme in collaboration with the Ministry of Health, UNICEF, WHO, and Save the Children Fund;
- New funding commitment from the Dutch government, enabling regular production of *Dialogue on Diarrhoea* in Spanish;
- Funding commitment from USAID/Islamabad for English version of *Dialogue on Diarrhoea* specific to Pakistan and UNICEF/Islamabad funding commitment for Urdu inserts/supplements;
- Initiation of a subscription system for developed country readers, resulting in a steady annual income of approximately \$5,000;
- Maturation and growth of the Resource Center as an information support to all of the newsletters produced by AHRTAG.
- Management restructuring, resulting in improved staff morale, commitment and motivation;
- Adoption of new computer software for accounting, resulting in improved financial tracking and reporting.

IV. TECHNICAL CONTENT/EDITORIAL POLICY

CONCLUSIONS:

- AHRTAG has been responsive to the 1987 evaluation recommendations regarding technical content as well as to implementation plans.
- The technical content of *Dialogue on Diarrhoea* fills a niche that is important and unique, and that is not duplicated by other newsletters.
- The primary messages of *Dialogue on Diarrhoea* are still valid. The newsletter offers up-to-date, technically accurate, easily readable information.
- Current editorial practices provide an appropriate level of peer review.

RECOMMENDATIONS:

1. Newsletter content should be "reader" driven and not AHRTAG or donor driven.
2. AHRTAG could give consideration to the possibility of combining/integrating the contents of *Dialogue on Diarrhoea* and *ARI News* since readership is similar.
3. International Board membership should include more active developing country members to ensure attention to field perspective in the planning and editorial processes.

V. READERSHIP

CONCLUSIONS:

- Sufficient anecdotal information regarding the technical quality of *Dialogue on Diarrhoea* and its value to the field exists. However, good quantitative data is not available. This represents a significant gap area and an area of noncompliance with the 1987 evaluation recommendations.

RECOMMENDATIONS:

1. A.I.D. should add as a project objective: "AHRTAG shall design and implement a comprehensive evaluation strategy to provide information that will assist AHRTAG in their decisions about, and management of, future newsletter content."
2. To plan and execute a well-designed evaluation strategy, AHRTAG should involve Project Partners in this process.
3. We do believe that some of the following approaches could be considered by AHRTAG:
 - conducting Focus Group Discussions (FGDs) in selected countries/regions;
 - adding questions regarding *Dialogue on Diarrhoea* to existing surveys/evaluations in selected countries;
 - surveying organizations that distribute more than 100 copies of *Dialogue on Diarrhoea*;
 - conducting readership surveys in selected countries;
 - targeting questionnaires toward those individuals who have requested information from the AHRTAG Resource Center;
 - approaching USAID missions in countries where *Dialogue on Diarrhoea* distribution is high, soliciting their interest in funding an evaluation of the readership.
4. AHRTAG should be held responsible for providing evaluation results to A.I.D. and for incorporating results into the planning of future issue content.

VI. DISTRIBUTION

CONCLUSIONS:

- AHRTAG has in the last three years emphasized consolidation of the mailing list and updating its accuracy. Bulk mailings still comprise the major portion of the mailing list. Whether the institutions that are receiving the bulk mailings are the appropriate institutions and whether they are actually systematically ensuring the distribution of these copies is unknown.
- The system for mailing list maintenance and reporting has vastly improved.
- AHRTAG's subscription system for *Dialogue on Diarrhoea* has been largely successful and could be considered for implementation on a larger scale.

RECOMMENDATIONS:

1. A new cooperative agreement should ask that AHRTAG develop systems for ensuring the accuracy of the mailing list and effective targeting of the newsletter.
2. Establish effective procedures for tracking and crediting separately gift exchange subscribers from cash payment subscribers.
3. Investigate the cost and reader usefulness of merging mailing list upkeep processes used for ARI News and *Dialogue on Diarrhoea* and provide the findings to A.I.D.

VII. PRODUCTION MANAGEMENT

CONCLUSIONS:

- *Dialogue on Diarrhoea* is produced in a regular and timely fashion. The 1987 evaluation recommendations relating to production management have been implemented successfully.

RECOMMENDATIONS:

1. The costs associated with distribution will need to be examined as AHRTAG considers its overall decentralization strategy. Decentralization of production and distribution should seriously be considered on a case-by-case basis. However, institution building should not become a goal in and of itself if costs far exceed production and distribution from London.

VIII. LANGUAGE EDITIONS

CONCLUSIONS:

- The language editions that A.I.D. supports have been produced regularly.
- Emphasis has been placed by AHRTAG on building relationships with current Project Partners and not on the generation of new language editions.

RECOMMENDATIONS:

1. Institute new language editions only in the context of AHRTAG's general organizational strategy for decentralization.
2. As a first priority of AHRTAG's decentralization strategy, secure local funding for the language editions that A.I.D. currently supports.
3. Staff of *Dialogue on Diarrhoea* should continue project partner follow up and support. The South Asian Project Partners meeting held in January of this year serves as an excellent model.

IX. RESOURCE CENTER

CONCLUSIONS:

- Since 1987, the Resource Center has expanded its portfolio of projects and activities, while continuing to participate in and contribute to the planning and development of *Dialogue on Diarrhoea* content.
- The Resource Center has established an effective and relevant diarrheal disease database that does not overlap with other CDD databases.

RECOMMENDATIONS:

1. We do not suggest to A.I.D. that the Appropriate Technologies for Health (PRITECH) project's and AHRTAG's Information/Resource Centers be mandated by the Cooperative Agreement to share information. However, it is suggested that an effort be made to increase collaboration between the two project's centers, such as by exchanging computerized databases on diskette and hard copy.
2. As an objective of a new cooperative agreement, we suggest that a systematic approach be developed to analyze information requests, following up with originators of information requests and interviewing visitors to the Resource Center regarding their use of *Dialogue on Diarrhoea*.
3. The Resource Center could play a useful role in helping to identify potential Project Partners through their existing linkages.

X. MANAGEMENT

CONCLUSIONS:

- Great strides have been made since the 1987 evaluation in AHRTAG's management structure, overall financial management and policies. Great attention has been paid to the development of organizational procedures.
- The team concurs with AHRTAG's assessment that divisional responsibilities are currently unequal and endorses the organization's decision to undergo an external management review.

- AHRTAG has been quite successful in diversifying their funding base for *Dialogue on Diarrhoea* and other organizational projects and activities. The Scientific Editors have expressed a desire for technical assistance, however, in the area of fundraising and proposal development.
- *Dialogue on Diarrhoea* staff have collaborated quite successfully with some of A.I.D. Office of Health's centrally funded projects, although this is an area that could be strengthened.

RECOMMENDATIONS:

1. Resource Center linking with A.I.D.-funded project databases, or other databases, should be motivated purely by the need to identify/access technical articles for *Dialogue on Diarrhoea* content/article development, and not merely for the sake of collaboration.
2. AHRTAG should consider the financial feasibility of hiring an additional person with experience in non-profit fundraising to assist the Managing Editor in *Dialogue on Diarrhoea*'s fundraising efforts.
3. Scopes of work for the Scientific Editors should be rewritten to clearly reflect their current roles and responsibilities and level of effort.

XI. PROJECT VALIDITY

Is AHRTAG providing a service that fits within established A.I.D. policies and priorities?

Yes. Oral rehydration therapy (ORT) remains one of the twin engines of A.I.D.'s Child Survival Program and communication plays a critical role in this strategy. Moreover, A.I.D. has committed itself to working with the international community in achieving the goals adopted at the recent World Summit for Children: 50% reduction in child death due to diarrhea and a 25% reduction in the incidence of diarrhea between 1990 and the year 2000. We would argue that *Dialogue on Diarrhoea* is, in relation to other A.I.D.-funded CDD projects, a low-cost means of sustained communication that is not duplicated by other newsletters and is of critical import to the field.

Does AHRTAG have an established distribution network, committed staff and reputable advisors?

Yes. *Dialogue on Diarrhoea* is an established newsletter of international repute and *Dialogue on Diarrhoea* staff are highly committed. Every individual interviewed for this evaluation knew about *Dialogue on Diarrhoea* and regularly reads or scans it. The Scientific Editors and International Advisory Board members are recognized worldwide.

Does it continue to be more effective to direct support to an existing program than establishing a similar program in an American organization?

Yes. A.I.D. entered into a Cooperative Agreement with AHRTAG in 1984 precisely because AHRTAG was already producing a reputable newsletter on diarrheal diseases; *Dialogue on*

Diarrhoea was and is an AHRTAG conceived and owned product, not an A.I.D. conceived and designed activity. AHRTAG is known for its diarrheal disease expertise, having worked in this technical area for over ten years. Therefore, it is just as redundant today to consider establishing a diarrheal disease newsletter with an American organization as it was in 1984.

XII. THE FUTURE OF DIALOGUE ON DIARRHOEA

Decentralization has become a well articulated AHRTAG goal and has been a key objective of A.I.D.'s Cooperative Agreement with AHRTAG. To what extent, however, has AHRTAG focused its efforts on decentralization? In FY 1990, 29% percent of AHRTAG's expenditures provided support to partner organizations to produce and distribute *Dialogue on Diarrhoea*, as well as other newsletters, and to develop and provide continuing support for in-country resource centers (of which there are currently ten). This represents an approximate 4% increase over FY 1989.

Theoretically a well-executed decentralization strategy can lead to institution building. To date, however, AHRTAG's decentralization of the production and distribution of *Dialogue on Diarrhoea* to local institutions has led to, albeit stronger institutions, ones that are largely dependent on AHRTAG for funds.

So then, what can we likely expect from decentralization? We can expect at least a reduction in core expenditures by transferring to the field production work that would have been undertaken in London and we can expect to build the local capacity of the organization in newsletter translation, production and distribution. If the costs incurred in moving activities to the field are greater than the savings, institution building in and of itself does not make sense.

There are other issues that require examination before A.I.D. strongly endorses the total decentralization of the newsletter as a key objective of its Cooperative Agreement with AHRTAG:

- Decentralization requires time and continuing technical assistance. It is important that the time and money required to decentralize are not underestimated.
- Decentralization will not automatically lead to sustainability unless cost recovery schemes or other income generating activities are considered.
- Even with decentralization of production and distribution activities, local institutions will require continued funding to carry out these functions. AHRTAG will consequently have to help locate other donor funds for partner organizations that currently produce and disseminate *Dialogue on Diarrhoea* to continue their work.

- AHRTAG's core activities, i.e. article research and development and scientific quality control, will require continued funding from an outside donor unless AHRTAG takes on income generating activities or allows advertising in their newsletters. Neither cost recovery option is attractive to the team.
- Removing all production and distribution out of London to partner organizations may not be cost-effective. Thus, decentralization should be considered on a case-by-case basis only.
- With decentralization, quality of newsletter content may be more difficult to control and may in fact suffer depending on the degree to which activities are decentralized (see two decentralization scenarios presented below).

Possible Decentralization Scenarios. One decentralization scenario would see AHRTAG/London become the resource hub with its spokes operating in the field. They would supply partner organizations with camera-ready copy and/or negatives for their translation, production and distribution. A possible second scenario would have AHRTAG developing material on a range of primary health care topics and providing material to partner organizations who would then "pick and choose" AHRTAG articles for a publication uniquely their own.

XIII. OPTIONS FOR A.I.D. SUPPORT OF DIALOGUE OF DIARRHOEA

It is our collective recommendation that funding of *Dialogue on Diarrhoea* should be continued. In sum, a newsletter on diarrheal diseases does fit within A.I.D.'s current policies and priorities and is warranted from a programmatic point of view, particularly given A.I.D.'s leadership role in promoting and implementing CDD programs in developing countries, its commitment to goals articulated at the World Summit on Children, its increased awareness of and involvement in urban health care delivery, and its coordinated response to control cholera outbreaks in Latin America and Africa. From an economic standpoint, we believe that the contribution that A.I.D. has made in support of *Dialogue on Diarrhoea* is low compared with funding inputs for other major CDD projects.

The following are considered by the team to be viable funding options and their implications. (See pages 67 through 69 for more detail.)

Option 1: Continued funding at same level, adjusted for inflation.

Option 2: Emphasize accelerated decentralization, with phased reduction in funding.

I. BACKGROUND

In 1980, the Diarrhoeal Disease Control Programme of the World Health Organization (WHO) made a request of Dr. Katherine Elliott³ to produce a newsletter dealing with oral rehydration therapy (ORT) and other aspects of diarrheal disease control and prevention. With a grant of \$40,000 from WHO and the United Nations Development Programme (UNDP), *Diarrhoea Dialogue*⁴ (DD) was born with a first print run of 2,500 copies; by 1983 *Diarrhoea Dialogue*'s circulation increased to 20,000. Unless sufficient funding could be secured, expansion of the newsletter could not be considered. Fortunately, recognition of the need for a publication such as *Dialogue on Diarrhoea* was imminent. At the First International Conference on Oral Rehydration Therapy (ICORT I) in 1983, the role of communication in the promotion of ORT was stressed, underscoring the need for a regular publication on diarrheal diseases.

Following ICORT I, the Appropriate Health Resources and Technologies Action Group, Ltd. (publisher of *Dialogue on Diarrhoea*) submitted a proposal to A.I.D., outlining their objectives for the newsletter as well as their financial needs to expand production and distribution. Aware of the potential reach and impact that the newsletter could have, A.I.D. signed on August 10, 1984, a two-year Cooperative Agreement (CA) with AHRTAG to expand *Dialogue on Diarrhoea*'s circulation. Sole source justification for this decision was based upon the following factors:

- *Diarrhoea Dialogue* was a well-established publication.
- It was known for its clear presentation of the complex issues surrounding diarrheal diseases.
- It had a distribution network of over 95 countries worldwide.
- It was endorsed by the international donor community, i.e., WHO, UNICEF, UNDP, SIDA.
- *Dialogue on Diarrhoea*'s Editorial Advisory Board was comprised of internationally renowned diarrheal disease experts.
- The newsletter fit within A.I.D.'s programmatic priority, particularly in view of the 1983 launch of the Agency's expanded ORT initiative.
- It was considered by A.I.D. to be more cost-effective to fund an existing publication than to begin a new one.

³Founder, *Diarrhoea Dialogue* and Scientific Editor of newsletter since its inception.

⁴*Diarrhoea Dialogue*, the official name of the newsletter when A.I.D. entered into the Cooperative Agreement with AHRTAG, was changed in 1985 to *Dialogue on Diarrhoea*.

- A.I.D. believed that the newsletter could facilitate the Agency's and worldwide understanding of ORT and diarrheal diseases.

Two evaluations have been held since the initial Cooperative Agreement was signed with AHRTAG--one in July of 1985 and a second in June of 1987--both of which have recommended continued A.I.D. support for the newsletter. The Cooperative Agreement with AHRTAG has since been amended seven times. Amendment Four extended the Cooperative Agreement with AHRTAG through September 30, 1991, while other amendments provided incremental funding. The project authority under which the Cooperative Agreement is funded, ORT-HELP, Number 936-5939, has a Project Assistance Completion Date of December 31, 1993. Total funding for the Cooperative Agreement under this project totals \$2,472,701, the last increment of which was provided in the amount of \$237,029 in May 1991.

I.A. OBJECTIVES OF THIS EVALUATION

This evaluation assesses the extent to which AHRTAG has achieved its implementation plans for fiscal years 1988 through 1991 and responded to the evaluation recommendations made in June of 1987. Further, the evaluation examines the validity and progress of the project in terms of its goals, objectives, outputs and resource inputs,⁵ and discusses directions for the future. In the discussion of future directions, the team presents an analysis of whether funding should continue beyond the current Cooperative Agreement.

I.B. EVALUATION METHODOLOGY

Two methods of data collection are used for this evaluation:

- 1) review of secondary data;
- 2) interviews (see Annex A for a list of people interviewed).

⁵Given the way in which A.I.D. entered into its Cooperative Agreement with AHRTAG, i.e., buying into an existing product/activity, there is no separate logical framework or project paper design for this project, making evaluation in terms of goals, objectives, outputs and resource inputs more difficult. However, a number of project-related documents assisted the team in reaching its conclusions and recommendations. They include: 1) the original Cooperative Agreement; 2) seven project amendments; 3) A.I.D. memoranda; 4) AHRTAG proposals, implementation plans, activity reports; and 5) project evaluation reports.

A detailed scope of work, found as Annex A, was prepared by A.I.D. to assist the evaluation process, particularly to ensure appropriate depth, breadth and consistency of information sought. Interviews and a document review were conducted in Washington, D.C. as well as at project headquarters in London, England. The evaluation budget did not allow for field site visits. However, A.I.D. suggested interviewees with field experience as well as technical backgrounds. A fortuitous visit to London by one of AHRTAG's South Asian Project Partners, Ms. Indu Capoor, from the Centre for Health Education, Training and Nutrition Awareness (CHETNA) in India, gave the team an opportunity to probe for field information/feedback. In addition, field perspective was gained from individuals visiting the Washington area for the National Council for International Health Meeting, June 23-26, 1991, and the MotherCare Project's Technical Advisory Group Meeting, June 27-July 2, 1991.

While in Washington, D.C., the team received briefing books prepared by AHRTAG with background information. In London, the team received more documentation for review, selected pieces of which appear as Annexes.

I.C. ORGANIZATION OF THE REPORT

This report presents the results of the evaluation team's investigations. The report is divided into seven chapters.

- Chapter I: Background
- Chapter II: Project Goals and Objectives
- Chapter III: Project Accomplishments
- Chapter IV: A.I.D. Management of the Agreement
- Chapter V: AHRTAG Management and Performance
- Chapter VI: Future Directions

Chapters V and VI present the major findings of this evaluation and are responsive to the scope of work.

II. PROJECT GOALS AND OBJECTIVES

On August 10, 1984, AHRTAG entered into a Cooperative Agreement with A.I.D. The A.I.D. Office of Health, Health Services Division (R&D/H/HSD) within the Bureau for Research and Development, manages the Cooperative Agreement. Following is a discussion of project goals and objectives and the institutions' responsiveness to those mandates.

II.A. GOALS/OBJECTIVES IN AGREEMENT

The stated goal of the original Cooperative Agreement was to:

expand the dissemination of information on all aspects of diarrheal diseases, with special emphasis on Oral Rehydration Therapy (ORT), to LDC leaders, health providers and international donors' staffs. In order to achieve this goal, this Agreement will provide funds 1) for the support and expansion of the English and French editions of the quarterly newsletter, *Diarrhoea Dialogue* and other technical material as requested by A.I.D.; 2) for the distribution of back copies of *Diarrhoea Dialogue*; and 3) for exploring and initial support of new translations of *Diarrhoea Dialogue*.

What is missing from this goal statement are measures of goal achievement and targets. It is not clear from this statement what expansion means in number terms, nor how many translated versions of the newsletter were believed desirable/optimal. A memorandum (providing sole source justification for entering into the Cooperative Agreement with AHRTAG) from the Director of the Office of Health in 1984 to the A.I.D. contracts office provides some idea about A.I.D.'s circulation target for *Dialogue on Diarrhoea*, but the numbers mentioned were not incorporated into the Cooperative Agreement. To paraphrase this memorandum, with adequate resources *Dialogue on Diarrhoea's* audience could increase to over 500,000 by 1986, reaching well over a million via the multiplier effect. Yet, Amendment One of the Cooperative Agreement put a ceiling of 100,000 copies for the English edition and 15,000 copies for the French edition of *Dialogue on Diarrhoea*. According to AHRTAG, the ceiling established by A.I.D. for the English and French editions merely reflected the number of newsletters that A.I.D. was willing to support and did not prevent AHRTAG from increasing the print-run if other donor funds were secured.

Of seven amendments, only Amendment One (August 25, 1986) contained any language that modified AHRTAG's objectives and scope of work. It contained the following modifications: 1) A.I.D. attribution shall be prominently displayed on the newsletter; 2) no purchase of additional microcomputer hardware will be allowed in this amendment; 3) all materials

specifically ordered for *Dialogue on Diarrhoea* and purchased with A.I.D. funds must be identifiable; 4) visitors to the Resource Center who wish to use the *Dialogue on Diarrhoea* collection or have been referred to AHRTAG because of *Dialogue on Diarrhoea* should be recorded; 5) "major emphasis shall be given to increasing the level of support from other funders. AHRTAG shall develop and maintain a comprehensive strategy for donor funding. Numerous donors have indicated interest and/or intent of funding activities over the next two years. Both WHO and UNICEF are seen as key donors"; 6) Technical and Scientific Editors should be encouraged to pursue leads and generate interest among other donors; 7) continue to distribute existing back copies of *Dialogue on Diarrhoea* but no new printing shall be funded under this Agreement; and 8) explore and provide technical assistance for local translations of the newsletter. Amendment One also provided incremental funding in the amount of \$295,000 and revised the Cooperative Agreement expiration date to September 30, 1988. Both AHRTAG and A.I.D. clearly understood at the time of Amendment One, that A.I.D.'s contribution was subject to availability of funds.

Amendments Two through Six revised A.I.D.'s total contributions, provided for incremental funding or extended the Agreement end date. Amendment Four (August 30, 1988) extended the Agreement by an additional three years, from September 30, 1988, to its current end date of September 30, 1991. Resource inputs have amounted to, on average, \$353,243 annually for seven years.

In sum, while the goal of the original Cooperative Agreement remains valid, the scope of AHRTAG's activities or project outputs has evolved. Amendments have not been used to articulate changes in AHRTAG's scope of work. Instead, AHRTAG's current scope is the result of: 1) various A.I.D. memoranda; 2) recommendations made during the 1985 and 1987 evaluations; and 3) annual implementation plans, the content of which has been largely driven by the 1985 and 1987 evaluation recommendations.

Consequently, we will evaluate AHRTAG's performance toward the original project goal: "[to] expand the dissemination of information on all aspects of diarrheal diseases, with special emphasis on Oral Rehydration Therapy (ORT), to LDC leaders, health providers and international donors' staffs" by answering the questions posed in this evaluation's scope of work (see Annex A). The scope of work incorporates the 1987 evaluation recommendations as well as AHRTAG's implementation plans for fiscal years' 1988-1991. The scope of work thus becomes the yardstick by which to measure AHRTAG's performance and progress and provides the framework for discussions held throughout the remainder of the report.

II.B. SUMMARY OF 1987 EVALUATION RECOMMENDATIONS

In general, AHRTAG has been responsive to the 1987 evaluation recommendations. Any deviance from the proposed recommendations is due in large part to changing diarrheal disease technologies or to changes in the management structure of the organization. Two major areas of noncompliance relating to readership and distribution have been identified and will be further elaborated in Chapter V: AHRTAG Management and Performance. Table 1 summarizes the major recommendations made by the 1987 evaluation team; AHRTAG's performance is assessed by a column that designates whether the recommendation, in our estimation, has been fulfilled. This table provides the reader a quick overview of AHRTAG's performance and is helpful as a reference for discussions in Chapter V.⁴

⁴For the reader's review, an assessment of AHRTAG's implementation of the 1985 evaluation recommendations can be found as Annex B.

TABLE 1.

ASSESSMENT OF THE 1987 EVALUATION RECOMMENDATIONS

<u>RECOMMENDATION</u>	<u>IMPLEMENTATION STATUS</u>	<u>COMMENTS</u>
Technical content:		
Place more systematic emphasis on control and/or prevention of diarrheal diseases of different etiologies, including the prevention of dehydration and the reduction of mortality through ORT.	Yes	Over 20 articles related to prvn.
Basic messages should be examined every 2-3 yrs on a cyclical basis.	Yes	
Simple health info. system, including indicators of processes and outcomes of CDD programs, should appear in future issue.	No	WHO/Geneva was developing, not ready to publish
A large number of topic areas suggested for future newsletter inclusion.	Yes	Almost all topics mentioned have been included.
Scientific Editors & Editorial Advisory Board members should assess, when traveling overseas, the effective utilization of the newsletter according to an agreed upon format.	No	Due to insufficient travel
Target audience that Editors aim to reach should be reviewed and statement should be revised to reflect clearly who readers are.	No	Target audience assumed but not stated
Readership:		
Larger number of letters referring to experiences and significant questions be printed in each issue.	No	Approx. same # of letters included, perhaps less (due to space constraints)
No new survey be undertaken that follows the format of two previous surveys. New surveys should be based on specific questions dealing primarily with effective use of ORT and the impact of diarrheal disease control on morbidity and mortality rates. Samples should be selected based on quantitative methods to test significance.	No	Development of comprehensive eval. stat. was in process; 3rd survey undertaken to provide info. for this eval.
Distribution:		
Should consolidate its readership rather than attempt to promote distribution of additional copies from London; however, in future, staff should develop plan of action for expanding the mailing list based on specific audiences.	Yes	
Project Coordinator should detail all of info. required from mailing list and steps taken to examine existing computer system to determine what steps to take to speed up processing of mailing list.	Yes	New mailing list program initiated

<u>RECOMMENDATION</u>	<u>IMPLEMENTATION STATUS</u>	<u>COMMENTS</u>
3. Summary of subscription policy should appear in regular place in each issue of <i>Dialogue on Diarrhoea</i> . Prior to this, Editors should outline a standard policy for discounts on bulk subscriptions to institutions.	Yes	
4. Future mailings should include return addresses.	Yes	7,000 eliminated from mailing list
5. Reply cards should be inserted with mailings once annually inquiring whether subscribers wish to remain on mailing list, to verify address info. and no of copies; non-respondents should be deleted from mailing list.	No	Costs/benefits weighed; judged infeasible.
6. Verify conclusion reached by 1985 evaluation team recommending no reprinting of back copies; suggest that even photocopies of out-of-stock issues be done on occasional basis only.	Yes	
7. Contrary to advice of 1985 evaluation team, suggest that local printing of <i>Dialogue on Diarrhoea</i> is viable alternative to printing in and distribution from Britain; recommend pursuing decentralization strategy.	Yes	
Editorial and graphic content:		
1. Detailed editorial plan should be developed that will allow editorial staff more advance notice for developing issue contents.	Yes	
2. Balance of content and style be maintained.	Yes	
3. Visual content of newsletter should be addressed as thoughtfully as editorial content; graphic elements should be used more frequently; graphic materials and photo library should be beefed up.	Yes	
4. Editorial assistant should be recruited.	Yes	
5. Resource Center should take more active role in facilitating search for information to enable editorial staff to develop supplemental materials.	Yes	
Production management:		
1. Production cycle for each issue should be extended by two weeks.	Yes	
2. Production assistant should take on more responsibility for lay-out and paste-up of <i>Dialogue on Diarrhoea</i> ; should investigate possibility of using desk-top publishing.	Yes	
Fundraising strategy:		
1. Dollar expectation for outside funding support should be reduced to be maintained at approx. \$160,000 until such time further expansion of program is considered appropriate.	No	Additional funding has been secured; \$160,000 target exceeded.

RECOMMENDATION

IMPLEMENTATION STATUS COMMENTS

2. Rather than encouraging further outside funding for *Dialogue on Diarrhoea*, A.I.D. should encourage AHRTAG to seek funding to support other current and planned program areas both to reduce organization's dependence on one large donor (A.I.D.) and to better balance its current project portfolio.

Yes

3. AHRTAG should develop a more aggressive donor-oriented fundraising strategy, developing contacts with and knowledge of donors through the network of prestigious professionals attached to the organization (i.e., Scientific Editors, Council Members, Editorial Advisory Board members, Membership).

Somewhat

Language editions:

1. Staff should carefully identify organizations that will be responsible for translation, printing and distribution of *Dialogue on Diarrhoea* locally; local sources of funding to support these editions should be pursued.

Yes

2. A policy statement should be agreed upon and established relating to development of inserts/articles for language editions to avoid publication of articles contrary to *Dialogue on Diarrhoea*'s policy.

Yes

3. An in-country rep should be identified to supervise and provide technical assistance.

Yes, as necessary

4. Problems/issues related to local language editions should be examined in formal meetings among *Dialogue on Diarrhoea* staff, Scientific Editors and Advisory Board members.

Yes

Resource Center:

1. Resource Center should continue to be involved in all editorial meetings. *Dialogue on Diarrhoea* implementation plans should elaborate activities of Resource Center, both to outline editorial support needed for upcoming issues and to describe development of additional materials related to diarrheal diseases.

Yes

2. Care should be taken to ensure that as Resource Center develops its own base of activities/projects, *Dialogue on Diarrhoea* receives necessary and continuing support.

Yes

3. Should take advantage of existing computerized databases such as Medline and Medlars. A.I.D. should facilitate exchange of info. between Resource Center and related projects under A.I.D.'s aegis that maintain similar information centers.

Yes

4. Should develop some means of evaluating effectiveness of supplemental material developed for *Dialogue on Diarrhoea*.

No

Management:

1. A restructuring of staff relationships is suggested; project coordinator and office administrator positions should be made staff rather than line positions.

No

2. If AID's newsletter is added, recommend that a new editor be hired to manage this activity.

Yes

Management structure revised; project coord. position eliminated.

<u>RECOMMENDATION</u>	<u>IMPLEMENTATION STATUS</u>	<u>COMMENTS</u>
3. Scientific Editors, Managing Editor of <i>Dialogue on Diarrhoea</i> , Project Coordinator and Resource Center Director should meet regularly, perhaps twice monthly and Scientific Editors should be invited to contribute to other relevant meetings.	Yes	
General:		
1. There is a need to consolidate and strengthen present activities before further expansion; once consolidation process is complete, the team hopes that circulation will continue to expand in order to reach greater numbers of intended audience.	Yes	
4. Funds outside of A.I.D. should continue to be sought to assist in the translation and/or dissemination of current issues.	Yes	
5. There is an urgent need to have better functional system of information exchange between <i>Dialogue on Diarrhoea</i> and the series of A.I.D. Health/Nutrition projects involved in primary health care, especially CDD (e.g., HEALTHCOM, PRITECH, PRICOR, REACH, DMD, WASH, etc.).	Yes	
6. Have serious reservation about impact of new AIDs newsletter and Resource Center activities (development of four new resource centers) on production of <i>Dialogue on Diarrhoea</i> . Careful analysis should be made to decide best functional/organizational arrangement to satisfy <i>Dialogue on Diarrhoea</i> as well as general AHRTAG needs/goals.	Yes	
7. Suggest that if agreement is extended for 3-5 years, that next evaluation take place in three years in 1990.	Yes	

II.C. AHRTAG IMPLEMENTATION PLANS: FISCAL YEARS 1988-1991

As specified in the original Cooperative Agreement, AHRTAG is required to, and has complied with, the annual submission of an Implementation Plan.⁵ The Cooperative Agreement states that:

The Implementation Plan is a major planning tool for the project and should detail how the Recipient plans to achieve the activities described in the scope of work. It should cover such topics as the following: number of issues to be distributed, number of countries to be served, broad programmatic issues, topics for future issues, on-going evaluation work, relevant bench marks, ways to extend the *Diarrhoea Dialogue* network, and number and ways to expand back copies and translations. (*Source*: original Cooperative Agreement, pg. 4)

As mentioned, the content of these plans has been largely driven by: 1) A.I.D. priorities; and 2) evaluation recommendations. In our estimation, AHRTAG has fulfilled its Implementation Plans for FY's 1988-1991. Table 2 provides a quick overview of AHRTAG's plans and shows whether plans have been implemented.

⁵The only missing Implementation Plan is for FY 1989-1990. Plans were discussed and approved by the A.I.D. Cognizant Technical Officer, but no written plan was submitted.

TABLE 2.
ASSESSMENT OF DD IMPLEMENTATION PLANS FOR FY 88-91

<u>PLAN</u>	<u>IMPLEMENTATION STATUS</u>	<u>COMMENTS</u>
FY 88-89		
Production/distribution of 4 issues of English DD (100,000 copies with A.I.D. support)	Yes	
Translation, production, distribution of 4 issues of French DD	Yes	
Increase print-run for French edition from 12,000 to 15,000	Yes	
Production of supplements for English and French editions	Yes	
Translation, production, distribution of 4 issues of Tamil DD	Yes	
Increase print-run for Tamil edition from 10,000 to 25,000	Yes	Additional print-run 25,000 with UNICEF support (Total: 50,000)
Develop editorial committee in India for Tamil edition to provide technical support and deal with inquiries	Yes	
Production, distribution of 4 issues of English edition of DD/India	Yes	
Expand print-run for English/India edition from 20,000 to 35,000	No	Expanded to 30,000 with A.I.D. support
Best of 'Practical Advice' pages to be printed in India with UNICEF support	Yes	
Consolidation of activities before pursuing other language editions	Yes	
Consolidation and review of mailing list, development of computerized subscription system	Yes	
Continued development of additional editorial materials and promotional activities	Yes	
Increased collaboration with UNICEF-funded Project Partners	Yes	
Issue plans for DD Issues' 34 - 37	Yes	Virtually every topic planned for was included
Quarterly editorial meetings with Scientific Editors	Yes	
Editorial Advisory Board Meeting, December 88 (ICORT III)	Yes	
Winning entries and runners-up from Children's Poster Competition reproduced in special publication	Yes	
October 88 - exhibition of selection of posters at Commonwealth Institute in London	Yes	
'Questions & Answers' in collaboration with WHO/CDD will be finalized and produced as occasional inserts	Yes	

<u>AN</u> <u>88-89 (continued)</u>	<u>IMPLEMENTATION</u> <u>STATUS</u>	<u>COMMENTS</u>
alize DD CDD activities country profiles	No	Stopped, as WHO was developing
alize 'Readers Report' publication based on readers' experiences with CDD activities	Partially	Series of readers' questions compiled & submitted to WHO, never published
endance at ICORT III, Frankfurt Book Fair, XII Congress on Malaria and Tropical Diseases	Yes	
publicity and promotional materials developed including DD leaflets, posters, display panels, badges, etc.	Yes	
article about DD activities and achievements developed as part of general AHRTAG publicity strategy; press release system developed	Partially	Early stages of development
raise funds from additional donors, aiming to reach agreed target of \$200,000 set by USAID	Yes	Contributions equaled \$198,000
Source Center:		
compile insert for Issue 37: cereal/home-based remedies for diarrhea, including rice-ORS	Yes	Insert topic changed to breastfeeding; cereal ORS covered in later issue
exchange relevant information with organizations that have materials on diarrhea, like WASH, PRITECH	Yes	With exception of PRITECH's Info. Center
develop listing of new acquisitions to be distributed bi-weekly	Yes	
develop listing of retrospective and new holdings of AHRTAG database, to be distributed monthly	Yes	
develop database of individuals/organizations whose work is some way related to CDD or production of health ed. materials	Yes	
perform on-line search of commercial databases	Yes	
review DD classification system and keywords	Yes	
update Free International Newsletters resources list	Yes	
update Health Education Materials for Diarrhea resources list	Yes	
update French and Spanish Education Materials resources list	Yes	
Y 89-90 - None prepared per A.I.D. Directions		

<u>PLAN</u>	<u>IMPLEMENTATION</u>	<u>COMMENTS</u>
<u>FY 90-91</u>	<u>STATUS</u>	
Production/distribution of 4 issues of English DD (100,000 copies with A.I.D. support)	Yes	
Production of Health Basics inserts for English edition	Yes	
Translation, production, distribution of 4 issues of French DD, 15,000 copies	Yes	
Production of regional supplements for French edition	Yes	
Translation, production, distribution of 4 issues of Tamil DD (25,000 copies with A.I.D. support)	Yes	
Production, distribution of 4 issues of English edition of DD/India (30,000 copies with A.I.D. support)	Yes	
Indian primary health care supplement produced and mailed with each edition (FIONA Plus)	Yes	
Reprinting and distribution of 4 editions of English/Pakistan (25,000 copies with USAID support)	Yes, partially	4 editions not possible due to delayed AID finding
Consolidation of activities before pursuing other language editions	Yes	
Transfer mailing list to new, faster and more efficient computer	Yes	
Further collaboration with PRITECH (especially in Senegal and Pakistan) and other A.I.D.-funded projects	Yes	
Issue plans for DD Issues' 42 - 45	Partially	Issue plans revised from initial plans to adequately cover anti-diarrheals
Quarterly editorial meetings with Scientific Editors	Yes	
Editorial Advisory Board Meeting January 1991 (London-based editors only)	Yes	
Finalize DD CDD activities country profiles		Discontinued due to WHO's development of same
Produce mailing list statistics on quarterly basis	Yes	
Undertake collaborative readership survey with World Service of BBC	Partially	Trial run with AIDs newsletter; awaiting results
Decentralization:		
Focus on decentralizing printing and distribution of English DD from London reducing mailing list to 40,000	No	
Analyze mailing list for Africa	Yes	
Locate potential Project Partners in Africa (field visits)	Yes, partially	Preliminary field visits made
Hold Project Partners meeting for Asia region; use info. as framework for working with organizations in Africa Resource Center:	Yes	
Nothing articulated for Resource Center		

III. PROJECT ACCOMPLISHMENTS

Before the A.I.D. Cooperative Agreement was signed, AHRTAG was already publishing *Dialogue on Diarrhoea*, but with a limited circulation due to insufficient financial support. Because of A.I.D. and other donor financial support for *Dialogue on Diarrhoea* over the last seven years, *Dialogue on Diarrhoea* has grown to an official total circulation worldwide of 350,000 in ten languages; actual readership is estimated to be five or six times this number, or close to 2 million readers. Over the seven year period of A.I.D.'s funding, AHRTAG has achieved dynamic growth as an institution, strengthening its financial position as it has continued to expand operations. Fundraising efforts have provided *Dialogue on Diarrhoea* steadily increasing revenues from sources other than A.I.D., as shown below in Table 3.

TABLE 3.

FUNDING FOR *Dialogue on Diarrhoea* FYs 1984-1991
(In 000's - Rounded)

<u>Funding Source</u>	<u>YR 1 84-85</u>	<u>YR 2 85-86</u>	<u>YR 3 86-87</u>	<u>YR 4 87-88</u>	<u>YR 5 88-89</u>	<u>YR 6 89-90</u>	<u>YR 7 90-91</u>
A.I.D.	413.0	295.0	367.7	410.0	400.0	350.0	237.0
Non-A.I.D.	73.4	52.0	160.0	189.6	198.0	233.5	277.5
% A.I.D. Contribution	85%	85%	70%	68%	66%	60%	46%
% Non-A.I.D. Contribution	15%	15%	30%	32%	34%	40%	54%

This table suggests that AHRTAG has reduced its dependency on A.I.D. by 39 percent. This is true when the data are aggregated, i.e., total funding for language editions that A.I.D. supports as well as for language editions that A.I.D. does not support. Table 4 disaggregates the data over the same time period; here a very different picture emerges.

TABLE 4.

**A.I.D. SUPPORT FOR ENGLISH (LONDON), ENGLISH (INDIA),
FRENCH AND TAMIL EDITIONS OF *Dialogue on Diarrhoea***
(percentages)

	NO. OF COPIES	PERCENTAGE
<i>English Edition Dialogue on Diarrhoea</i> (London)		
A.I.D. support	100,000 copies	87%
Other Donor Support	15,000 copies	13%
<i>English Edition Dialogue on Diarrhoea</i> (India)		
A.I.D. support	30,000 copies	100%
Other Donor Support	0 copies	0%
<i>Tamil Edition Dialogue on Diarrhoea</i>		
A.I.D. support	25,000 copies ⁶	50%
Other Donor Support	25,000 copies	50%
<i>French Edition Dialogue on Diarrhoea</i>		
A.I.D. support	15,000 copies	100%
Other Donor Support	0 ⁷ copies	0%

Thus, although AHRTAG has reduced its dependency on A.I.D. for all language editions of *Dialogue on Diarrhoea*, it is largely dependent on A.I.D. for support of the editions that A.I.D. has provided funding for over the life of the Cooperative Agreement. It is not clear what is meant by A.I.D. in Amendment One of the Cooperative Agreement "to increase the level of support for *Dialogue on Diarrhoea* from other funders." Does this imply locating funds in addition to A.I.D.'s for the language editions that A.I.D. provides major support for, or locating funds to seed the growth of other language editions? AHRTAG has been operating on the latter premise. If A.I.D. intended the former, then A.I.D. should have made this clear and has had

⁶Up until 1991 A.I.D. had been providing 100 percent of funding for 25,000 copies of the Tamil edition. Only recently were funds secured from UNICEF/South India for the printing and distribution of the Tamil edition; however, rather than providing support toward the 25,000 copies, UNICEF is providing support for an additional print-run of 25,000, contributing to an overall circulation of 50,000. A.I.D. funding for the 25,000 still remains at 100 percent.

⁷Approximately \$34,000 of Britain's Overseas Development Administration (ODA) funds went toward the support of the French edition from March 1988 through March 1989. There has been no additional ODA support since March of 89.

sufficient time to do so. AHRTAG consequently cannot be faulted for operating on this assumption. Moreover, we agree with the 1987 evaluation team's recognition that the very size of A.I.D.'s grant to AHRTAG indicates to other donors that this is a program area that does not require their support. To quote from the 1987 evaluation, "The visibility of A.I.D. might cause other donors to prefer another program area. Donors sometimes prefer to have more significant control over a program they fund."

To AHRTAG's credit, a better balance has been achieved in the organization's overall project portfolio over the seven-year period. AHRTAG acknowledges the importance of the 1987 evaluation team's recognition of an imbalance and its suggestions for remedies to the success of its current diversification. Whereas *Dialogue on Diarrhoea* represented 60.9 percent of AHRTAG's financial portfolio in 1986, it now represents only 28.7 percent. (See Figures 1-3.)

Figure 1.
Dialogue on Diarrhoea Expenditures, 1984

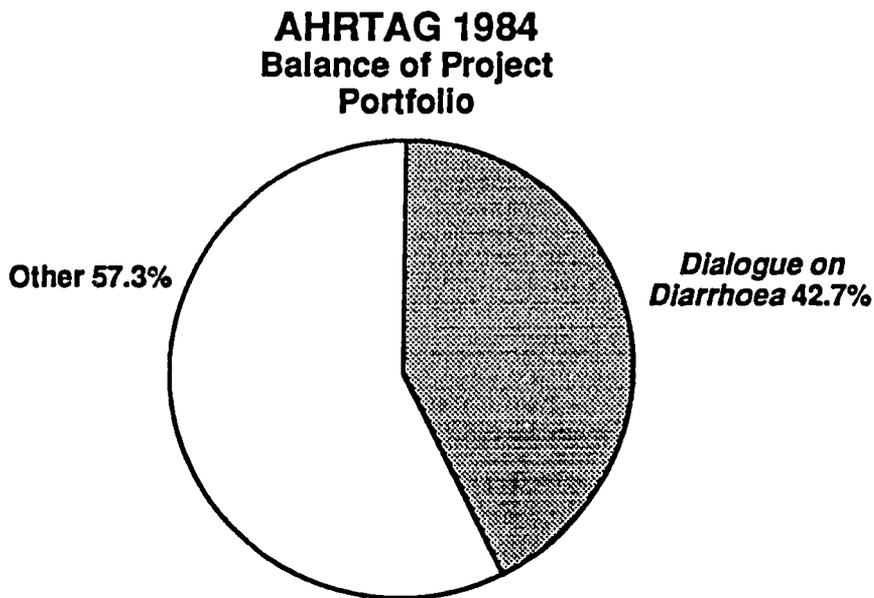


Figure 2.
Dialogue on Diarrhoea Expenditures, 1986

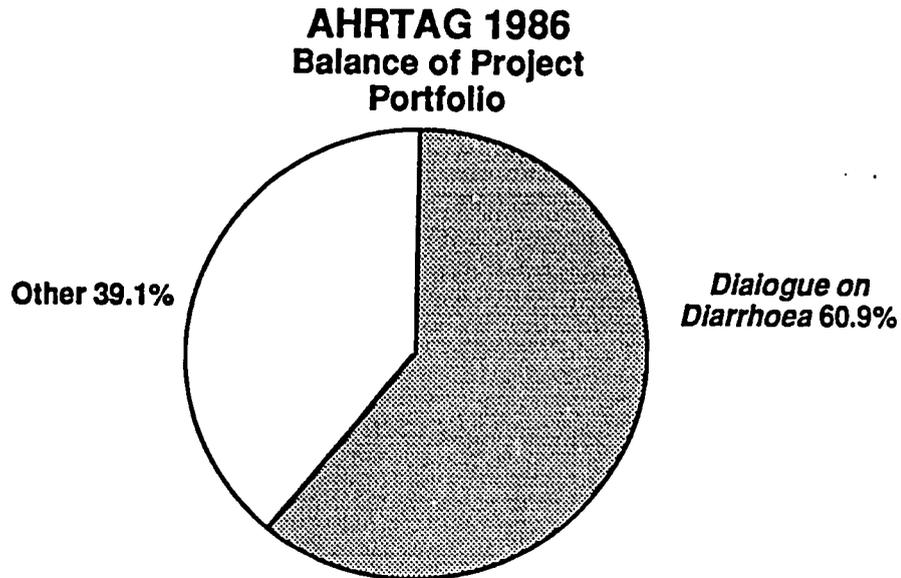
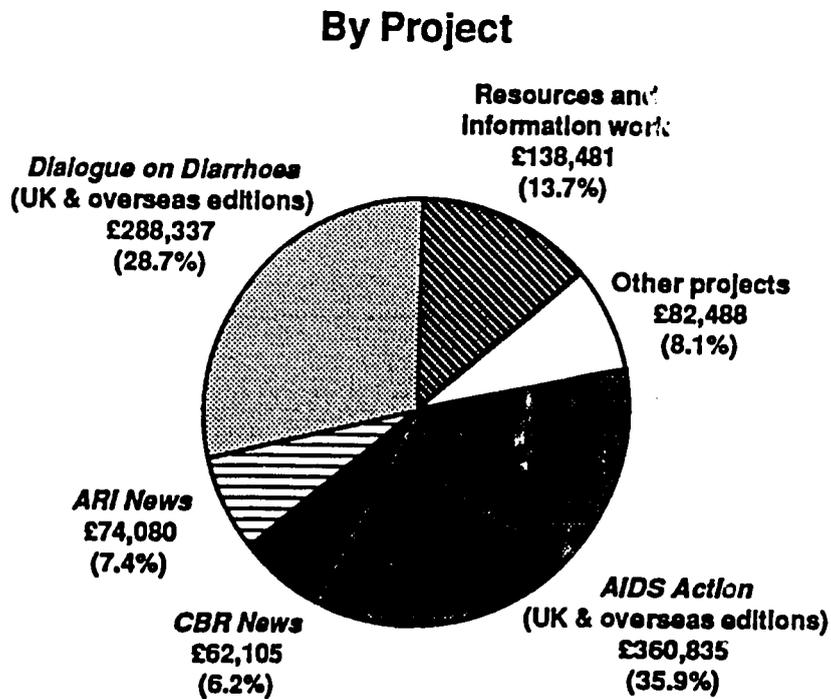


Figure 3.
Dialogue on Diarrhoea Expenditures, 1990



Overall, AHRTAG has achieved a number of impressive accomplishments. Highlights of AHRTAG's accomplishments since the 1987 evaluation (not strictly confined to activities supported by A.I.D.) include:

- Regular (quarterly basis) and timely production and distribution of the A.I.D.-supported English, French and Tamil editions of *Dialogue on Diarrhoea*.
- Regular and timely production and distribution of *Dialogue on Diarrhoea* in Portuguese, Chinese, Bangla.
- A new translated edition in Nepali initiated at the end of 1989 by the Health Learning Materials Programme in collaboration with the Ministry of Health, UNICEF, WHO, and Save the Children Fund.
- New funding commitment from the Dutch government, enabling regular production of *Dialogue on Diarrhoea* in Spanish to begin in 1990, the last issue having been produced in April 1988.
- Funding commitment from USAID/Islamabad for English version of *Dialogue on Diarrhoea* specific to Pakistan and UNICEF/Islamabad funding commitment for Urdu inserts/supplements.
- Regular inclusion of practical supplementary publications/inserts covering a wide range of subjects, such as breastfeeding; health education; immunization; practical hygiene; shigellosis (compiled by project staff of A.I.D.-supported Applied Diarrheal Diseases Research (ADDR) Project); water and sanitation; weaning; persistent diarrhoea; and refugees/displaced communities.
- Initiation of a subscription system for developed country readers, resulting in a steady annual income of approximately \$5,000.
- Initiation of a new system for production of newsletters using Ventura desk-top publishing software, enabling staff to produce final art work in-house.
- Inheritance of library of WHO photos, enhancing access to a wide range of depictions of primary health care topics.

- **Maturation and growth of the Resource Center as an information resources for all of the newsletters produced by AHRTAG, helping to generate new ideas as well as providing background information on specific subject areas to newsletter staff; and development of the Resource Center in its own right, providing information and documentation services, technical assistance and training to developing country individuals and institutions through its databases, on-line networking, in-house library, resource lists and directories, Resource Centre Training and Support Programme, and training courses. Through its Resource Centre and Training and Support Programme, the Center is working with Project Partners in the Israeli Occupied Territories and Egypt in the recently launched Middle East Health Resources and Information Network, linking health organizations and practitioners within the region; the Centre for Educational Development in Health, Arusha (CEDHA), assisting the Ministry of Health in Tanzania to establish resource centers within continuing education centers in six zones to provide access by zonal and district level workers to teaching and learning materials for continuing education; and establishing an extensive network of primary health care resource centers in Africa similar to the Middle East network.**
- **Management restructuring, resulting in improved staff morale, commitment and motivation**
- **Adoption of new computer software for accounting, resulting in improved financial tracking and reporting.**
- **Development and implementation of new organizational procedures and policies.**

IV. A.I.D. MANAGEMENT OF THE AGREEMENT

By its very definition, a cooperative agreement does not allow the same degree of "legally binding" management oversight that a contract does. It functions more like a grant, where monies are transferred to the recipient institution for use at their discretion. Given this, the degree of A.I.D. input to AHRTAG over the seven-year period of time has been impressive.

In fact, AHRTAG admitted that of the donors providing support to *Dialogue on Diarrhoea*, A.I.D. was the only one that had invested the time and money to evaluate the effectiveness of their investment. AHRTAG has found the A.I.D. evaluations extremely helpful in providing solid direction for their activities.

The evaluation team did discover two weaknesses in A.I.D.'s management of the Agreement that could be strengthened should a new Cooperative Agreement be initiated. One, there has been a degree of laxity in A.I.D.'s enforcement of the recipient's Agreement obligation to submit annual implementation plans and activity reports, and in A.I.D.'s review of these plans. For example, although the Fiscal Year 1989-1990 implementation plan was verbally agreed upon between A.I.D. and AHRTAG, a report was never demanded nor submitted. The practice of strict adherence to Agreement deliverable submission and review should be reinstated under a new Cooperative Agreement. Two, A.I.D. has not played a vigorous role in encouraging and structuring collaboration of AHRTAG's Resource Center with the information centers of other major centrally funded CDD projects, such as the Technologies for Appropriate Health Care Project (PRITECH). This facilitation role should be activated under a new Cooperative Agreement.

V. AHRTAG MANAGEMENT AND PERFORMANCE

This section assesses the technical content of the newsletter and examines all of the components that work in concert to produce the final product, *Dialogue on Diarrhoea*. Discussion of findings will be preceded by the relevant questions from the scope of work and followed by the team's conclusions and recommendations. As previously mentioned, the scope of work was developed by A.I.D. to provide assistance to the evaluation team in measuring AHRTAG's response to the 1987 evaluation recommendations and the implementation plans for FYs 1988-1991. The reader may find it helpful to refer back to Tables 1 and 2 for an overview of these recommendations/plans.

Readers will find the following format used throughout this chapter.

- Heading ...for each major area articulated in the scope of work
- Questions ...from scope of work
- Findings ...responding to scope of work questions
- Conclusions ...presented for each area rather than as a separate chapter
- Recommendations

V.A. TECHNICAL CONTENT/EDITORIAL POLICY

QUESTIONS:

- *Has there been a more systematic emphasis placed on the control and/or prevention of diarrheal diseases of different etiologies including the prevention of dehydration and reduction of mortality through ORT?*
- *Has the technical content of the newsletter covered a broad range of thematic topics related to diarrheal diseases control?*
- *Has Dialogue on Diarrhoea examined basic messages on a cyclical basis? Have issue plans included more validated scientific and research materials? Has this material been circulated in advance to editorial advisors and donor agencies? Has an additional scientific reviewer been added to the review process for each issue?*
- *Have the topics suggested by the evaluation team been covered in subsequent issues?*

- *Has Dialogue on Diarrhoea met the needs of its perceived readership? In terms of range of subjects covered? Approach and style? Illustrative material? Has a balance been maintained between practical and research-oriented material?*
- *Has Dialogue on Diarrhoea included a larger number of readers' letters, in particular, those referring to experiences and significant questions?*
- *Have supplements been produced as planned? Are these of technical merit?*
- *Have other editorial activities/planned supplementary materials been carried out and produced?*
- *Are the primary messages of Dialogue on Diarrhoea still valid? Have changes in content reflected the need to broaden approaches to diarrheal diseases control? Should the subjects covered in the newsletter continue to be largely the same or should the content of Dialogue on Diarrhoea broaden its focus to cover a wider range of subjects? If expansion of topics is desirable, what should that expansion look like? Should A.I.D. seriously consider merging the contents of Dialogue on Diarrhoea with AHRTAG's newsletter on acute respiratory infections, ARI News?*
- *How best can Dialogue on Diarrhoea continue to support efforts to prevent and control diarrheal diseases?*

FINDINGS:

The technical content of *Dialogue on Diarrhoea* fills an important and unique niche, one that is neither filled nor duplicated by other newsletters focusing on diarrheal diseases, such as PRITECH's Technical Literature Updates (TLU) or WHO's Annotated Bibliography. Its content is readable, appropriate, and current, containing research findings as well as a potpourri of practical advice articles and examples taken from field experience. Balance is sought between the practical and the scientific by extracting practical field applications from validated research articles. Balance is also sought in the selection of readers' letters; letters often reveal deeply rooted myths as well as interesting traditional approaches, some of which may have scientific validity, but have not undergone rigorous clinical trials. The use of inserts/supplements continues to be expanded and is an excellent method for providing current knowledge in greater depth. In all material considered for newsletter inclusion, editors strive for geographic balance to ensure universal relevancy and allow readers the opportunity to share experiences across countries. Reader inquiries and comments are encouraged. These aspects of content and style make *Dialogue on Diarrhoea* a unique publication, one that is true to its name -- a *DIALOGUE*.

The primary messages of *Dialogue on Diarrhoea* are still valid: as technology for the treatment of diarrhea has evolved over the years, *Dialogue on Diarrhoea's* editorial content has changed accordingly. The newsletter continues to cover the full range of diarrheal disease issues: prevention⁸; diagnosis; case management; and evaluation methodology. More emphasis is and should continue to be placed on the need for feeding and fluids during the diarrhea episode with ORS being used for actual dehydration. Likewise, there has been continued emphasis on breastfeeding as the single most important means of preventing diarrhea. Other topics that have received coverage include nutrition, weaning foods, water and sanitation, personal hygiene and Vitamin A. *Dialogue on Diarrhoea* has reviewed major areas of diarrheal disease on a cyclical basis, but without rigid adherence that might interfere with the inclusion of topics that are current and timely, such as cholera. Most of the topics that the evaluation team asked be considered for future issues have been incorporated during the last three years. (See Annex C for a complete index of articles and inserts, June 1987 through June 1991.)

A particularly valuable technical contribution was *Dialogue on Diarrhoea's* coverage of the new WHO papers on drugs used to treat diarrhea. Using *Dialogue on Diarrhoea* as a vehicle for this serial publication ensured widespread distribution of a valuable scientific contribution that would otherwise not have reached as far into the field. Another excellent technical contribution was the insert on shigellosis and invasive diarrheas, developed by the staff of the A.I.D.-funded Applied Diarrheal Diseases Research (ADDR) Project. This is an example of a successful collaborative effort with an A.I.D.-supported CDD project.

Quality control of *Dialogue on Diarrhoea* has been assured by the Scientific Editors, Drs. Katherine Elliott and William Cutting and members of the Editorial Advisory Board, as well as Dr. Nate Pierce of WHO and Ms. Kathleen Cravero of UNICEF. The Agency for International Development and its major centrally funded diarrheal disease projects have not been major contributors to technical content of the newsletter, aside from ADDR's contributions.

The Editorial Advisory Board, comprised of internationally recognized diarrheal disease experts, is intended to meet every 18 months to discuss key current issues in diarrhea, including technical advances and new research, to plan future newsletter content for one year's cycle, and to act as a sounding board for ideas established during the quarterly meetings of *Dialogue on Diarrhoea* staff. In practice, many of the members of the Editorial Advisory Board, especially who reside outside of the United Kingdom, do not meet every 18 months as intended. The last Editorial

⁸ The 1987 evaluation team recommended that a systematic emphasis be placed on prevention; in response, there have been over 20 articles related to the prevention of diarrhea.

Advisory Board meeting that included its international members was held at ICORT III in December of 1988 and before that ICORT II in December of 1985. Neither meeting had full attendance of all of the Board's membership. At the most recent Editorial Advisory Board meeting, held in January, 1991, only the U.K.-based members attended. International members are asked for their written comment to editorial plans, draft issues, etc., on a regular basis but only a few (three or four) have intermittently responded by mail. Occasional trips to the field by *Dialogue on Diarrhoea*'s Managing Editor, Scientific Editors, or U.K.-based Editorial Advisory Board members have, on occasion, offered the opportunity to visit with some of the international members.

Quarterly planning sessions for future *Dialogue on Diarrhoea* issues are held among the Managing, Assistant and Scientific Editors, U.K.-based Advisory Board members (if available) and Resource Center staff. At these meetings, ideas are generated, potential topics are discussed in great detail and suggestions are made of potential authors for commissioning of articles. For reasons of time and economy, then, most of *Dialogue on Diarrhoea*'s editorial advice derives from the U.K.-based Scientific Editors and Advisory Board members, in concert with other *Dialogue on Diarrhoea* staff, tapping into, on occasion, the ideas and advice of Dr. Nate Pierce of WHO and other technical experts as appropriate. This practice has provided an appropriate level of peer review. Contents of issues are technically accurate, relevant and timely. However, since field needs and views are critical to the relevancy of the newsletter and international Advisory Board members are intended to reflect the needs of the field in selecting/reviewing newsletter content, composition of the Editorial Advisory Board is an area worth redressing.

We were asked by A.I.D. to reflect on the future content of *Dialogue on Diarrhoea*. Should it remain focused on diarrheal diseases and other subjects as they relate to diarrheal disease prevention such as nutrition, breastfeeding, Vitamin A, hygiene, water and sanitation, or should it broaden its content focus to cover a wider range of subjects. It was generally agreed that newsletter content should broaden only in response to audience needs and desires and that its content not be donor- or U.K.-driven. However, for several reasons discussed below under Conclusions/Recommendations consideration could be given to combining the contents of *Dialogue on Diarrhoea* and *ARI News*. Whatever the future content focus, continued emphasis should be placed on the delivery of high quality, timely messages.

CONCLUSIONS:

- AHRTAG has been responsive to the 1987 evaluation recommendations regarding technical content as well as to implementation plans.
- The technical content of *Dialogue on Diarrhoea* fills a niche that is important and unique, one

that is neither filled nor duplicated by other newsletters focusing on diarrheal diseases.

- The primary messages of *Dialogue on Diarrhoea* are still valid. The newsletter offers up-to-date, technically accurate, easily readable information. The use of inserts/supplements continues to be expanded and is an excellent method for providing current knowledge about diarrheal diseases in greater depth.
- Current editorial practices provide an appropriate level of peer review.

RECOMMENDATIONS:

1. Newsletter content should broaden in response to audience needs and desires; its contents should be "reader" driven and not AHRTAG or donor driven.
2. AHRTAG could give consideration to the possibility of integrating the contents of *Dialogue on Diarrhoea* and *ARI News* because:
 - the audience is the same and the mailing lists for both newsletters are similar;
 - the case management technique is used for both conditions diarrheal disease and acute respiratory infections;
 - some of *Dialogue on Diarrhoea*'s other language editions have incorporated the information from both newsletters into one publication, indicating a possible field preference for this type of delivery.
3. Since field needs and views are critical to the relevancy of the newsletter, international Board membership should be reviewed in order to obtain a more active roster of developing country members and ensure attention to a field perspective in the planning and editorial processes. Consideration may be given to including some of AHRTAG's Project Partners as Advisory Board members, as suggested at the South Asian Project Partners meeting held in January, 1991.⁹

⁹All of AHRTAG's Project Partners have been incorporated into the pre-publication review process, not as official Editorial Advisory Board members, but as field reviewers of planned newsletter content to ensure field relevancy. Mailing to these partners commenced during the review for the September 1991 issue of *Dialogue on Diarrhoea*.

4. Since scopes of work for the Scientific Editors were drafted many years ago, it is suggested that new scopes of work be executed that accurately reflect the current relationship with AHRTAG, clearly spelling-out a Scientific Editor's role, responsibilities and level of effort. Any role that Scientific Editors are to play with respect to fundraising should be clearly articulated.

V.B. READERSHIP

QUESTIONS:¹⁰

- *Who is the target audience? Has the target audience changed? Does the readership reflect the target audience? Is it broader or narrower than envisaged?*
- *What efforts have been made to assess readers' information needs and identify additional information about the readership?*
- *Was it possible to base the most recent readership survey on scientific sampling methods (i.e., sample size carefully selected based on quantitative methods to test significance of results)?*
- *What level of feedback is received from readers? Has feedback from readers been considered in planning content? Have readers' needs been met and inquiries dealt with effectively and in a timely fashion?*
- *How is the newsletter actually used by those who receive it? Has there been a different usage between the most recent and last surveys?*
- *To what extent is the newsletter shared with others?*
- *Are there any lessons to be learned between the two readership surveys?*
- *Have the supplementary materials produced, such as resource lists, been useful to readers? Are there other types of information support that would be useful to readers?*

¹⁰Knowledge of readership composition is one of the major gap areas identified by the team. Consequently, not all of the questions in the scope of work could be adequately addressed.

FINDINGS:

Three readership surveys have been conducted since the inception of A.I.D.'s Cooperative Agreement with AHRTAG, none of which have used scientific sampling methods. The first survey, conducted in 1983 and prior to A.I.D. funding, was sent to 2,236 *Dialogue on Diarrhoea* readers. As an incentive to respond, readers were promised slides on diarrhea management. This first survey had a 40 percent response rate. The second survey, in 1986, in which no incentives were offered, had a 1 percent response.

One recommendation from the 1987 evaluation was that no future readership surveys of the two previous types be undertaken and that a better strategy for evaluating the newsletter's effectiveness be developed. The team asked that AHRTAG consider selecting readership samples based on quantitative methods in order to test the significance of results.

There has been a clear intent by *Dialogue on Diarrhoea* staff to fulfill this recommendation, i.e., they have given serious thought to methods for collecting readership information, such as using a Focus Group Discussion (FGD) format in selected countries or adding questions regarding *Dialogue on Diarrhoea* to existing British Broadcasting Corporation's (BBC) surveys in selected countries. However, reaching a final decision as to the method(s) to be used has not been made to date. Instead, a third readership survey was undertaken to provide information for this evaluation that utilized the same format as the previous two. In all fairness, the survey did incorporate lessons learned from the two previous surveys, such as recognizing the significant role that incentives play in encouraging response. However, even with incentives, the third survey yielded a less than 1 percent response, approximately half of which derived from Nigeria. (Two factors might increase this rate slightly: 1) survey forms continued to be received after the cut-off date; and 2) the actual number of addresses on mailing list are less than total number of copies distributed and it is unclear whether bulk copies mailed to institutions were sent out in time for respondents to return survey.) The survey, comprised of multiple, mostly open-ended, questions, was inserted into each copy of *Dialogue on Diarrhoea* distributed. This approach to evaluation represents a major area of noncompliance with the 1987 evaluation recommendations. And given the very poor response to this survey, we have not included its findings as an Annex nor are we incorporating its results into our findings.

Our identification of this gap is not without our understanding of the difficulty faced by AHRTAG in conducting a reader survey. It is worth noting that the 1987 recommendation may have been biased toward North American/European readership surveys in which individuals may be more likely to understand or read English, take the time to complete a survey, afford postage, and make the effort to actually purchase postage and mail the survey--all conditions that may not exist in the developing country readership. Because surveying readership in developing countries

is difficult, it may have been appropriate for A.I.D. to assist in the identification of a group with experience in survey design as well as implementation in the field to provide AHRTAG some assistance or feedback on survey design and distribution methodology.

Although the 1987 evaluation team indicated that physicians are the primary recipient group of the newsletter, we cannot validate this information because of the poor response to the last two surveys. It is our understanding from the Scientific Editors that the editorial policy has always been to direct messages to the primary health care team. In our review of past issues we can affirm this claim, endorse it and suggest that it continue.

Despite our not having good scientific evaluative information regarding *Dialogue on Diarrhoea's* effectiveness, there is an abundance of anecdotal evidence *Dialogue on Diarrhoea's* that should not be dismissed. Throughout our interviews, we received very positive feedback about *Dialogue on Diarrhoea*. One of the Editorial Advisory Board members recounted how during his travels he had seen many of the illustrations that appear in various issues of *Dialogue on Diarrhoea* hanging on walls in health centers throughout several countries. In Nigeria, this same individual came across a newsletter that was regularly quoting *Dialogue on Diarrhoea's* content, called *RurCon* of the A.I.D.-funded Agricultural Development Project. We were told by a staff member of USAID/Jakarta about how the Director of Indonesia's Diarrheal Information Center translates many of *Dialogue on Diarrhoea's* articles into Bahasa Indonesian. In addition, the Managing Editor of *Dialogue on Diarrhoea* provided the team with copies of other newsletters that have quoted from *Dialogue on Diarrhoea*, as well as copies of a number of readers' letters. These can be found as Annex D. In fact, AHRTAG receives a steady stream of approximately 35 letters a week or over 1800 letters a year asking for information or placement on the newsletter's mailing list.

Interviews with physicians from Guatemala and Bangladesh, and one of AHRTAG's Project Partners from India, all of whom shared positive anecdotal information regarding *Dialogue on Diarrhoea's* usefulness to the field, attests to the continuing importance and need for a publication like *Dialogue on Diarrhoea*. This anecdotal evidence is coupled with the team's collective intuition that the newsletter is a useful contribution to the field. Anyone who has worked in development quickly learns the value of information to people in the field, and becomes aware of the dearth of information available. This statement, however, does not excuse the need for AHRTAG to systematically collect evaluative information to really know and understand who the *Dialogue on Diarrhoea* audience is and how the audience's needs can be better served. It also does not address whether the newsletter is reaching the intended audience, to be discussed in the following section on distribution. In fact, some individuals interviewed have suggested that a newsletter is only as effective as its mailing list.

CONCLUSIONS:

- Sufficient anecdotal information regarding the technical quality of *Dialogue on Diarrhoea* and its value to the field exists. However, good quantitative data relating to who comprises the readership, exactly how the newsletter is used by those that read it, how the audience's needs may be better served in the future, and how information contained in the newsletter impacts behaviors (e.g., prescribing behaviors) is not available. This represents a significant gap area and an area of noncompliance with the 1987 evaluation recommendations.

RECOMMENDATIONS:

1. If a new Cooperative Agreement is entered into with AHRTAG, A.I.D. should add as a project objective: "AHRTAG shall design and implement a comprehensive evaluation strategy to provide information that will assist AHRTAG in their decisions about, and management of, future newsletter content."
2. To plan and execute a well-designed evaluation strategy, AHRTAG should involve Project Partners in this process (by meetings such as the South Asian Project Partners Meeting, January 1991, or by regular communication using E-mail). In addition, AHRTAG may want to consider employing an outside consultant/group with expertise in conducting international readership surveys. A.I.D. could provide direction to AHRTAG in this matter. Should AHRTAG employ the services of an outside consultant, technical expertise would need to be provided in the areas of survey design and sampling strategy, amounting to approximately one person-month of technical assistance.
3. Although we do not attempt here to predict what means to evaluate the newsletter might emanate from the evaluation design process, we do believe that some of the following approaches could be considered by AHRTAG:
 - conducting Focus Group Discussions in selected countries/regions designed expressly for *Dialogue on Diarrhoea* feedback (more expensive option), or piggy-backing onto other FGD's being done by projects such as PRITECH;
 - adding questions regarding *Dialogue on Diarrhoea* to existing surveys/evaluations in selected countries; exploring the possibility of piggy-backing questions related to *Dialogue on Diarrhoea* onto existing British Broadcasting Corporation surveys;
 - surveying organizations that distribute more than 100 copies of *Dialogue on Diarrhoea*;
 - conducting readership surveys in selected countries, arranging for surveys to be returned to a location in country such as the local British Broadcasting Corporation P.O. Box;

- targeting questionnaires toward those individuals who have requested information from the AHRTAG Resource Center;
 - approaching USAID missions in countries where *Dialogue on Diarrhoea* distribution is high, soliciting their interest in funding an evaluation of the readership. (We have reason to believe that USAID missions may be quite interested in obtaining evaluative information about who is reading *Dialogue on Diarrhoea*, how it's being used, and its impact on behaviors. In fact, the USAID/Haiti mission has expressed interest in funding a small evaluation of *Dialogue on Diarrhoea*'s readership.)
4. AHRTAG should be held responsible for providing evaluation results to A.I.D. and for incorporating results into the planning of future issue content.

V.C. DISTRIBUTION

QUESTIONS:

- *Has the mailing list been consolidated? Have efforts been made to target specific groups? Do mailings include return addresses? Have reply cards been inserted with mailings at least once on an annual basis to indicate whether subscribers wish to continue, and if so, if the number of copies included in the mailing are correct?*
- *Has the mailing list programme been revised and updated in order to provide better information and faster processing of data?*
- *Has a subscription system been introduced? To what extent has it been successful? Is considered cost-effective?*
- *Are there other distribution channels that should be more fully utilized? Should the distribution be increased or consolidated further?*
- *Has a mailing list analysis for Africa and Asia been undertaken as planned? If so, what are the outcomes of this analysis? Have Project Partners been identified for Africa?*

FINDINGS:

So that AHRTAG might meet the original mandate given it by A.I.D. in 1984 to increase the distribution of the English edition of *Dialogue on Diarrhoea*, a major emphasis has been placed over the years on expansion of the mailing list. However, in compliance with a 1987 evaluation recommendation, AHRTAG has in the last three years emphasized consolidation, working hard

to update the accuracy of the mailing list (a number of duplicate addresses were noted during the 1987 evaluation). By including a return address on the envelope in which *Dialogue on Diarrhoea* is mailed, "returns" have assisted in eliminating approximately 7,000 individuals/institutions from the mailing list.

An emphasis in the early years on increasing distribution resulted in an increase in the number of bulk copies provided to institutions. Although an efficient method to contain costs, it is not without attendant problems. The team's examination of the mailing list revealed that many institutions are receiving over 100 copies. For instance, in Nigeria, the total number of copies distributed is 22,265, only 1,780 of which are individual copies. The remaining 17,495 are distributed by 189 subscribers at the rate of 93 copies each, on average. This bulk mailing method is not necessarily inefficient as an option for distribution. However, whether the institutions that are receiving the bulk mailings are the appropriate institutions and whether they are actually regularly and methodically ensuring the distribution of these copies is unknown. Given A.I.D.'s interest in evaluative information and in ensuring appropriate targeting, analysis of the mailing list is warranted.

A computer analysis of the mailing lists for *ARI News* and *Dialogue on Diarrhoea* was completed during the team's visit. This analysis revealed that in the Africa region, of the 5,325 individuals that receive *ARI News*, roughly 50 percent also receive *Dialogue on Diarrhoea*. In this instance, mailing *ARI* and *Dialogue on Diarrhoea* together would be cost-effective. This would be obviated if a decision is reached to merge the technical contents of both newsletters. Nonetheless, further similar analysis of this type is believed warranted.

During the last evaluation, AHRTAG was experiencing difficulties with mailing list upkeep, i.e., slow processing of data (approximately 10 minutes per entry/deletion). Since that time their computer hardware and software have been upgraded resulting in faster, more efficient data processing (each entry/deletion now takes less than one minute). The new software program, CARDBOX, is able to generate reports, showing the number of copies distributed per country and breaking that distribution down into the number of individual copies as well as bulk copies. The new program also facilitates the management of AHRTAG's subscription system (tracking of paid subscribers and sending invoices) which has been in place since 1988. This system has not proven foolproof however with regards to projects/institutions that are not cash subscribers but receive *Dialogue on Diarrhoea* free on an exchange basis, such as the arrangement between PRITECH's Information Center and AHRTAG, exchanging TLU for *Dialogue on Diarrhoea*. Some of these institutions/projects that are on a gift exchange basis have received letters from AHRTAG suggesting that their nonpayment of fees will result in discontinuation of their subscription to *Dialogue on Diarrhoea*. Both the PRITECH Project and American Public Health

Association's Clearinghouse on Infant Feeding and Maternal Nutrition have received these letters. Since this does not foster good will, we suggest that AHRTAG explore ways to distinguish between gift exchange and cash payment subscribers.

Currently *Dialogue on Diarrhoea* has approximately 250 cash subscribers (from developed countries only) at \$20.00 per annual subscription. The cost per year of invoicing (including postage, envelopes, and printing) has been approximately \$1530, \$1360 and \$1054 respectively for years' 89-91. Staff time required to invoice has been estimated at about two weeks. Comparison of actual costs and annual income (approximately \$5000) make this a minimally cost-effective activity for AHRTAG. However, large-scale implementation may make this quite cost effective. It may be feasible to implement a subscription policy for developing country institutions that are receiving *Dialogue on Diarrhoea* in bulk. For this plan to be successful, however, it would need to become part of AHRTAG's overall decentralization effort, and piloted with one of AHRTAG's South Asian Project Partners. In our assessment it would not make sense for London to collect subscription fees, largely because most developing country institutions do not have access to foreign exchange and would have to pay fees in local currency, necessitating the exchange of this local currency into British pounds sterling. AHRTAG would not be able to manage the influx of a vast number of local currencies. Moreover, the resulting income, after currency exchange, would be minimal.

Increasingly, AHRTAG is working to decentralize both production and distribution of the newsletter with the goal of reducing the number of copies sent from England by increasing the number of copies produced and distributed directly from the field. Decentralization can potentially play a positive role in reducing core funding outlays for distribution without reducing the total number of copies distributed. However, decentralization should not be an goal in and of itself unless it is cost effective. For instance, moving production and distribution to Africa seems completely justified given the volume of copies that are sent to this region: of 108,000 copies of *Dialogue on Diarrhoea*, 80,000 are distributed in Africa. However, distribution problems (mail between countries of close proximity are often routed through Europe because no flight exists between some countries) may make decentralization to Africa cost prohibitive. Decentralization will need to be considered on a case-by-case basis.

CONCLUSIONS:

- AHRTAG has in the last three years emphasized consolidation of the mailing list and updating its accuracy. This has been achieved largely through return mail. No attempt has been made to better target mailings. Annual reply cards, suggested by the 1987 evaluation team to assist in better targeting, have not been used; although reply cards were seriously contemplated by AHRTAG, their use was judged infeasible due to several considerations, including a

perception that field subscribers would be unable to afford postage, resulting in a poor return rate. Bulk mailings still comprise the major portion of the mailing list. Whether the institutions that are receiving the bulk mailings are the appropriate institutions and whether they are actually systematically ensuring the distribution of these copies is unknown.

- The system for mailing list maintenance and reporting has vastly improved.
- AHRTAG's subscription system for *Dialogue on Diarrhoea* has been largely successful and could be considered for implementation on a larger scale.

RECOMMENDATIONS:

1. A new Cooperative Agreement should ask that AHRTAG develop systems for ensuring the following:
 - a) accuracy of the mailing list;
 - b) effective targeting of the newsletter.

Both should be added as objectives of a new Cooperative Agreement.

2. Suggested possible actions for achieving the first objective include:
 - using visits to the field by any AHRTAG staff member as an opportunity to check mailing list accuracy;
 - obtaining feedback from Project Partners on mailing list accuracy;
 - assigning a program person for technical oversight of mailing list maintenance;
 - inserting a reply card with *Dialogue on Diarrhoea* as suggested by the 1987 evaluation team.
3. Suggested possible actions for achieving the second objective include:
 - developing a follow-up questionnaire or reply card to be sent to institutions in five to ten countries with large bulk distribution, asking a number of questions to ensure relevancy of their institution as a distribution point, and whether numbers received are sufficient. This could also serve as an opportunity to identify potential Project Partners; writing HPN Officers of USAID missions to gain their insight regarding appropriate institutions for *Dialogue on Diarrhoea* targeting in country. Corresponding with USAID missions about the mailing list could also serve as an opportunity to inquire about the

possibility of USAID funding a local language edition of the newsletter, or an evaluation of the newsletter's effectiveness.

4. Establish effective procedures for tracking and crediting separately gift exchange subscribers from cash payment subscribers.
5. Investigate the cost and reader usefulness of merging mailing list upkeep processes used for *ARI News* and *Dialogue on Diarrhoea* and provide the findings to A.I.D.

V.D. PRODUCTION MANAGEMENT

QUESTIONS:

- *Has the production schedule been extended to give additional time for review, other staff input? Has planning allowed for input from a wide range of interests?*
- *Has the production assistant been encouraged to take more responsibility for lay-out and paste-up? Have staff investigated the possibility of using desk-top publishing?*
- *Has the illustrative materials included graphics, tables and line drawings in addition to photographs?*
- *Have issues been produced in a regular and timely fashion?*
- *What are the unit costs for producing *Dialogue on Diarrhoea*?*

FINDINGS:

Dialogue on Diarrhoea is produced in a regular and timely fashion. The production cycle for each issue begins three months prior to the time copies are available from the printer. This represents a one month extension of the production cycle as recommended by the 1987 evaluation team. The entire development process for each issue, from initial planning to commissioning of articles to review, production and printing, is on a six-month cycle. This publication time line allows sufficient time for review (See Annex E). Because AHRTAG produces three other international newsletters, production schedules are strictly adhered to.

The production of the newsletter has been streamlined since the last evaluation. All design, layout and typesetting are now done fully in-house, using Ventura software. One person is responsible for the "desktopting" of all AHRTAG's newsletters, although other staff members

have received training in desk top publishing so that skills are not institutionalized in just one person. As noted in Chapter III, AHRTAG has inherited a library of WHO photos, enhancing access to a wide range of depictions of primary health care topics; these are arranged by subject. In addition, AHRTAG maintains a graphics file from which clear black and white illustrations and line drawings can be obtained; these are also maintained by subject.

Production costs for *Dialogue on Diarrhoea* are relatively low for a number of reasons, the first of which relates to economies of scale, i.e., the cost per copy diminishes in direct proportion to the number of copies printed. Therefore, the cost per copy for a 100,000 print run is substantially lower than the cost per copy for a 5,000 print run. Secondly, *Dialogue on Diarrhoea* has benefitted from AHRTAG's investment in desk-top publishing software and additional staff to operate it, without having to absorb the financial burden of that investment, as costs have been shared among AHRTAG's four newsletters. Costs to produce *Dialogue on Diarrhoea* are also less because no one staff member bills 100 percent of his/here time to *Dialogue on Diarrhoea*, but instead to a number of projects/newsletters. Billable time is task-oriented rather than project-oriented, as recommended by the 1987 evaluation team.

An analysis of costs for producing and distributing *Dialogue on Diarrhoea* for the last three years is presented in Annex F. This analysis has taken into account direct as well as indirect costs. The unit cost for producing the English edition in 1987-1988 was \$.71 per copy while in 1990-1991 it was \$.68. Examining these unit costs vis-a-vis the costs of producing a similar publication in a U.S.-based institution is made difficult for a number of reasons, i.e., size of print run, pay scales, overhead and fee rates, and exchange rate. However, what comparisons can be made demonstrate that costs are competitive. We can say with confidence that it is not more expensive to produce the newsletter in London, particularly given the low distribution costs.

Distribution costs are kept low in part because of bulk mailing. It is also likely that it is actually less expensive to mail to certain regions of the world from London, than from a U.S.-based organization. In fact, many of the remail services used by groups in the U.S. have their hubs in Europe. Consequently, U.S.-based firms must mail first to Europe, whereupon mail is forwarded to Africa. Given that 80,000 copies of the 108,000 print run go to Africa, it may be more cost effective to mail directly from London than from an institution in Africa, as mentioned in the previous section. Mailing from London consequently results in financial as well as time savings. Overall, the cost of producing and disseminating *Dialogue on Diarrhoea* from London is at least the same if not less expensive than for a U.S.-based institution.

CONCLUSIONS:

- *Dialogue on Diarrhoea* is produced in a regular and timely fashion. The 1987 evaluation recommendations relating to production management have been implemented successfully.

RECOMMENDATIONS:

1. The costs associated with distribution will need to be examined as AHRTAG considers its overall decentralization strategy. If costs for distributing the newsletter from a particular point are less or at least competitive with those of London's, then decentralization of production and distribution should seriously be considered, particularly given the level of institution building that will occur by establishing a partnership with a local institution. However, if costs far exceed London's costs for distributing the newsletter, institution building should not become a goal in itself.

V.E. LANGUAGE EDITIONS

QUESTIONS:

- *To what extent has Dialogue on Diarrhoea identified local sources of funding? Consolidated existing language editions before pursuing further editions? Developed guidelines for working with local groups and selection of Project Partners? Identified, where possible and necessary, in-country representatives to monitor progress?*
- *Has evaluation of the Tamil and French editions justified their continued production?*
- *Have the language editions that A.I.D. provides support for been produced in a regular and timely fashion?*

FINDINGS:

Dialogue on Diarrhoea is currently produced in Bangla, Chinese, English, French, Nepali, Portuguese, Spanish, Tamil and Urdu. An Arabic version has been produced intermittently, but is currently without funding. A Turkish edition was produced with UNICEF funding, but AHRTAG is unaware if this has continued. In addition, anecdotal information has uncovered a number of translations in vernacular languages. The 1987 evaluation suggested that selected

articles had been reproduced in 56 different local languages. We were unable to confirm the validity of this information, which was derived from the 1986 readership survey, but such an estimate is probably accurate.

The 1987 evaluation examined all of *Dialogue on Diarrhoea's* language editions, going beyond those editions that A.I.D. funds, in response to the scope of work prepared by A.I.D. However, we believe that although interesting, assessing editions that A.I.D. does not support is beyond A.I.D.'s realm. Consequently our focus is on those editions that A.I.D. does support: English, French and Tamil.

The English edition of *Dialogue on Diarrhoea* is printed and distributed quarterly from three locations:

- 1) London 108,000 copies have been printed and distributed by AHRTAG (100,000 with A.I.D. support);
- 2) India 30,000 copies have been printed and distributed by The Christian Medical Association of India (CMAI), New Delhi; and
- 3) Pakistan 25,000 copies have been printed and distributed by Imajics Ltd., Karachi (although the Pakistan English edition is not paid for with A.I.D. central funds, it is supported by USAID/Islamabad, and therefore has been included).

The English edition of *Dialogue on Diarrhoea* has been produced in a regular and timely fashion, with the exception of the English Pakistan edition, where the production schedule was set back due to delayed A.I.D. funding. Total circulation for the English edition is 163,000 copies per issue.

Fifteen thousand copies of the French edition are printed and distributed quarterly by the Organisme de Recherches Sur L'Alimentation et la Nutrition Africaines (ORANA) in Dakar, Senegal. During FY 1990 ORANA only published three editions of *Dialogue on Diarrhoea* based on English issues 33, 34 and 35-36. The publication of a combined issue was suggested by *Dialogue on Diarrhoea's* Managing Editor as ORANA had been experiencing delays with production and printing. In addition, ORANA has had numerous problems with its mailing list which can only be resolved by the purchase of a new computer. In the early part of 1991, ORANA undertook an evaluation of its readership (by inserting a reply card in copies distributed)

and concluded that an additional 10-15,000 copies of the French edition is warranted above and beyond the current 15,000. It is the team's opinion that a close analysis of the mailing list should be undertaken before expansion is considered.

The Rural Unit for Health and Social Affairs (RUHSA) in Tamil Nadu, South India is the organization responsible for translating, printing and distributing 25,000 copies of a Tamil edition of *Dialogue on Diarrhoea*. Additional funding (matching A.I.D.'s contribution) from UNICEF/South India has enabled RUHSA to increase the print run for the Tamil edition from 25,000 to 50,000. RUHSA has published nine issues of *Dialogue on Diarrhoea* in Tamil and distributed these throughout South India. According to RUHSA, the Tamil edition receives excellent feedback with a large number of individuals asking to contribute articles to the newsletter. A recent evaluation of a sample of readers' letters by RUHSA revealed that: 50 percent request more information; 40 percent give appreciation and acknowledgement; 8 percent ask questions and reveal doubts; and 2 percent provide constructive criticism.

Obtaining good evaluative information, ensuring appropriate targeting, and solving distribution problems were key issues raised by Project Partners during the South Asia Project Partners' Meeting held in January of 1991 (see Annex G for full report of meeting). Quality control was not raised by Project Partners as a key issue. This is understandable given CMAI's and Imajics' role in only reprinting issues and articles produced in London. In the case of the English edition in Pakistan, any Pakistan-specific material produced is reviewed by an outside editorial committee; this ensures the quality of new articles. A team of grass roots health workers in South India has been established to review and adapt the material and language level for the Tamil newsletter and there is anecdotal evidence to support the Tamil edition's translation quality, although the team could not assess the accuracy of this claim.

The 1991 South Asia Project Partner's Meeting consolidated AHRTAG's relationship with its Asian Project Partners and serves as a model for future meetings of this type. It gave Partners the opportunity to discuss a number of important issues, including effective methods for evaluating readership. During this meeting it became apparent that the questions existing in London regarding *Dialogue on Diarrhoea*'s use and effectiveness also exists at the field level. All participants saw their relationship with AHRTAG as mutually beneficial: AHRTAG is providing credibility and support to the partner organization, and the organizations are providing a network of national non-government organization partners to AHRTAG. AHRTAG was perceived as an enabling agency, providing resources, technical support and important information, rather than as a donor agency.

Since the 1987 evaluation, AHRTAG has focused on building and consolidating its relationships with existing Project Partners and on locating funding for established language editions, such as

those in Spanish and Arabic. In fact, a funding commitment for a regular Spanish *Dialogue on Diarrhoea* was secured from the Dutch government in 1990. Unfortunately no funding source has been located for the regular production of an Arabic edition.¹¹ Little attention has been paid to identifying and seeding the growth of new language editions of the newsletter, as a *Dialogue on Diarrhoea* staff goal has been to consolidate and strengthen existing language editions before pursuing new language editions. Nonetheless, a Nepali edition was launched at the end of 1989 and some thought has been given to the possibility/need for a Kiswahili edition (Kiswahili is the dominant indigenous language in East Africa, particularly Kenya and Tanzania). As recommended by the 1987 evaluation team, guidelines for selecting Project Partners have been established (see Annex H).

CONCLUSIONS:

- The language editions that A.I.D. supports have been produced regularly.
- Emphasis has been placed by AHRTAG on building relationships with current Project Partners and not on the generation of new language editions.

RECOMMENDATIONS:

1. Institute new language editions only in the context of AHRTAG's general organizational strategy for decentralization.
2. As a first priority of AHRTAG's decentralization strategy, secure local funding for the language editions that A.I.D. currently supports.
3. Before expansion of the French edition is considered, undertake the following:
 - analyze and update for accuracy the current mailing list;
 - evaluate the readership by means other than a written survey, perhaps using a Focus Group Discussion format.

¹¹We have been informed of recent (Fall, 1991) confirmation of Norwegian Red Cross funding for information sheets in Arabic on aspects of diarrheal diseases taken from various issues of *Dialogue on Diarrhoea*. If successful, this could prove a springboard to a regular, expanded version of *Dialogue on Diarrhoea* in Arabic.

4. Staff of *Dialogue on Diarrhoea* should continue Project Partner follow up and support. The South Asian Project Partners meeting held in January of this year serves as an excellent model. In addition, E-mail could be used as a regular means for communication.

V.F. RESOURCE CENTER

QUESTIONS:

- *Have the Resource Center staff been involved in contributing material and information support to Dialogue on Diarrhoea as required? Have they regularly been included in editorial meetings?*
- *Has the Resource Center developed and maintained an effective and relevant diarrheal diseases information base?*
- *Has the development of an in-house computerized database assisted Dialogue on Diarrhoea project staff? Has the database been used for inquiries from Dialogue on Diarrhoea readers? What use has been made of the modem and the E-mail? Has E-mail been used to link with related projects under A.I.D.'s aegis, such as Quality Assurance, Applied Diarrheal Disease Research, Primary Health Care Technologies (PRITECH), Health Communication (HEALTHCOM), etc.? What use is made of other computerized databases (linking with Medline, Medlars, etc.)?*
- *What means were developed to evaluate the effectiveness of the supplemental material developed for Dialogue on Diarrhoea readers?*
- *Has technical assistance been provided to strengthen other resource centers in developing countries as had been envisioned? If so, did the provision of technical assistance greatly tax the Resource Center staff too greatly? To what extent is this kind of technical assistance planned for the future?*
- *Has the Resource Center budget been adequate? Are materials purchased with A.I.D. funding still identifiable? Has a system been implemented to assess how the resources are being used?*

FINDINGS:

Since the 1987 evaluation, the Resource Center has grown tremendously, expanding its portfolio of projects and activities (see Annex I: Activities Report/1990). It currently maintains a high profile within the organization, being recognized for the technical contributions it makes in

support of all AHRTAG activities. As a result, *Dialogue on Diarrhoea* has benefitted. Resource Center staff participate in *Dialogue on Diarrhoea* editorial meetings and play a key role in helping to generate ideas and in providing background documentation and references for articles to be developed. Resources cited in *Dialogue on Diarrhoea*'s special inserts are identified by Resource Center staff.

The Resource Center collection has been computerized using the computer software INMAGIC. All materials purchased with A.I.D. funds are specially coded and tracked. The Center has four computerized databases that are regularly updated. The bibliographic database is unique in comparison with on-line commercial databases for two reasons. First, its focus is on health--particularly community-based experiences--rather than on medical and scientific literature. Second, it focuses on collecting information from developing rather than developed countries. The serials database contains up-to-date information on publishers and subscription details for over 500 newsletters and periodicals, including the *British Medical Journal*, *The Lancet*, *Social Science and Medicine* and *AIDS Care*. The audiovisuals database contains information on a wide range of videos and slides, while the organizations/contacts database contains information on individuals and organizations working in primary health care worldwide. For the benefit of *Dialogue on Diarrhoea*, all databases can be searched using key words from the diarrheal disease thesaurus.

When technical articles are required for *Dialogue on Diarrhoea*, the Resource Center scans its own databases and, when necessary, links with other computerized databases most appropriate for the subject area such as MEDLARS system (NLM) and the Commonwealth Agricultural Bureau Abstracts (CAB). The Center also regularly links with the A.I.D.-supported Water and Sanitation for Health (WASH) and Vector Biology and Control (VBC) libraries, as well as the Clearinghouse on Infant Feeding and Maternal Nutrition.

The team discovered very little overlap between AHRTAG's Resource Center materials' collection and that of A.I.D.'s major centrally funded diarrheal disease project--PRITECH. While AHRTAG's Resource Center focuses on developing country programs, training manuals and educational materials, PRITECH's Information Center focuses on scientific and technical literature in CDD. Communication between the projects' centers has not been mandated by the Cooperative Agreement, but could prove useful in AHRTAG's accessing technical documents for planned articles. Approximately one year ago, staff of AHRTAG visiting Washington met with PRITECH Information Center staff and discussed future collaboration. As a result of this meeting, the centers have begun to exchange their acquisition lists. Both projects saw the mutual benefit of linking databases. However, PRITECH has been unable to identify a failure in their modem operation, making communication with AHRTAG's database impossible at the time this report was written.

The Resource Center budget as well as staff have steadily increased during the last five years (from 2.5 persons in 1985 to 6.5 in 1991). Financial support is derived from a number of different sources, of which approximately 30 percent is contributed by A.I.D. Approximately one-third of A.I.D. money is spent on acquisitions and the remaining two-thirds on salary, divided among four staff members. This support has enabled the Resource Center to improve the overall quality of information available and services it provides. For instance, the Resource Center staff's involvement in support of all AHRTAG activities allows them to share relevant information collected for the ARI or AIDs newsletters with *Dialogue on Diarrhoea* staff. In addition, the Resource Center produces and distributes free-of charge five resource lists on information materials, training courses, and international newsletters. One specifically relates to diarrheal diseases. Likewise, it produces a monthly update that lists recent acquisitions and is circulated to AHRTAG staff as well as to Project Partners in the field.

Resource Center staff regularly respond to information requests from the field. During a recent nine month period, 329 requests were received for diarrheal disease-related information, representing 23.4 percent of all requests received (this includes requests for the free publications mentioned above). The majority of these requests were from Africa. Information requests are maintained in a log book and visitors are requested to fill out a Visitor's Form. However, this information is not computerized nor is it analyzed in any systematic way. We believe that this represents an area for strengthening.

The Resource Center works with a number of partner organizations in Egypt, Gaza, India, Kenya, Tanzania, and the West Bank providing support and technical assistance for the development and/or strengthening of local information centers. Staff also are involved in AHRTAG's operational projects concerned with health education, appropriate technology and rehabilitation of the disabled. While these activities are not directly related to *Dialogue on Diarrhoea*, the relationships that have been established by the Resource Center through its Middle East Network and other projects can play a positive role in AHRTAG's decentralization efforts by identifying potential Project Partners for local production and distribution of *Dialogue on Diarrhoea*.

CONCLUSIONS:

- Since 1987, the Resource Center has grown considerably, expanding its portfolio of projects and activities. Expansion of activities has not taken away from staff members' abilities to actively participate and contribute to the planning and development of *Dialogue on Diarrhoea* content.

- The Resource Center has established an effective and relevant diarrheal disease database that does not overlap with other CDD databases.

RECOMMENDATIONS:

1. We do not suggest to A.I.D. that PRITECH's and AHRTAG's Information/Resource Centers be mandated by the Cooperative Agreement to share information. However, we do believe that communication links could prove mutually beneficial to both projects. Therefore, it is suggested that an effort be made to increase collaboration between the two project's centers, such as by exchanging computerized databases on diskette and hard copy.
2. Although there is a regular flow of information requests from the field and visitors to the Resource Center (who record their affiliation in log books), no attempt has been made to analyze written requests nor to speak further with Resource Center visitors to gain evaluative information. As an objective of a new Cooperative Agreement, we suggest that a systematic approach be developed to:
 - analyze the types of information requests received and what information is being disseminated;
 - follow up with originators of information requests, inquiring about how the information they requested is being used, and obtaining feedback on *Dialogue on Diarrhoea*;
 - develop a brief set of guidelines/questions to be used to interview individuals visiting the Resource Center, as a means to obtain evaluative information regarding *Dialogue on Diarrhoea*, such as: How do they use the newsletter?; What do they find most valuable?; What would they like to see incorporated in the future?
3. The Resource Center could play a useful role in helping to identify potential Project Partners through their existing linkages.

V.G.MANAGEMENT

QUESTIONS:

- *Has AHRTAG's staffing changed to meet new demands? Are staff able to devote enough time to the project? Has the relationship with the Scientific Editors continued to work well? How is staff morale? Is work divided among staff members efficiently, effectively?*

- *Given the new organizational structure, have project activities been well managed? Has the financial reporting and administration been well managed? Is team management working well? How has the absence of an Executive Director affected the organization?*
- *Has additional editorial staff been employed to assist the managing editor with *Dialogue on Diarrhoea*? If so, to what extent has additional staff helped reduce the burden on the Managing Editor? Has the Managing Editor taken on a larger management role that places her in a senior position over all other newsletter editors?*
- *Are annual performance reviews being conducted, using individual job descriptions for guidance?*
- *Who in the organization has taken on the role of developing AHRTAG's external relationships, i.e., securing funds from outside?*
- *Has AHRTAG developed other areas of program work and donor support for these to reduce its dependency on A.I.D. and reduce the imbalance in its project portfolio? Has AHRTAG developed a more donor-oriented fundraising strategy? Have the Scientific and Managing Editors taken a leadership role for *Dialogue on Diarrhoea* fundraising?*
- *Has the project developed closer links and information exchange with other A.I.D.-funded health/nutrition projects?*

FINDINGS:

The 1987 evaluation team completed a very thorough examination of AHRTAG's management structure, staffing patterns and financial systems. While in our opinion this examination went well beyond those aspects of management pertaining to *Dialogue on Diarrhoea* (the only AHRTAG activity supported by A.I.D.'s Cooperative Agreement), it was understandably deemed necessary at that time. To a great extent it was diagnosed as necessary due to implicit and explicit organizational dysfunction, having a direct bearing on *Dialogue on Diarrhoea* staff morale, productivity, effectiveness, etc. These problems having been corrected in the ensuing years, allows us to focus our evaluation on management only as it pertains to *Dialogue on Diarrhoea*.

V.G.1. STAFFING

Since 1987, the Executive Director and Project Coordinator positions have been eliminated. Currently there are three divisions, each of which has a director. This co-directorship, according to the Managing Editor of *Dialogue on Diarrhoea*, as well as the Scientific Editors, has produced very positive organizational results. (See organizational chart Figure 4.) Staff morale and commitment are high. Staff are dedicated to the task and work hard, believing that they can not only share their ideas, but that these ideas will be considered seriously by management. Individuals interviewed described the working environment as "participatory," "consensus building." There has been some noted inequality in divisional responsibilities. These and other issues will be addressed by an upcoming external management review.

In addition to the Managing Editor, a full-time Assistant Editor was hired in 1988 in compliance with the 1987 evaluation recommendation. Two individuals have held this position since 1988; the most recent Assistant Editor was hired in January of 1991. She has been able to take on many of the day-to-day tasks related to producing *Dialogue on Diarrhoea*, freeing the Managing Editor to spend more time managing the division, liaising with the Scientific Editors and AHRTAG Council, developing policies and procedures, and to a lesser extent, visiting Project Partners in the field and working on decentralization of the newsletter as well as fundraising.

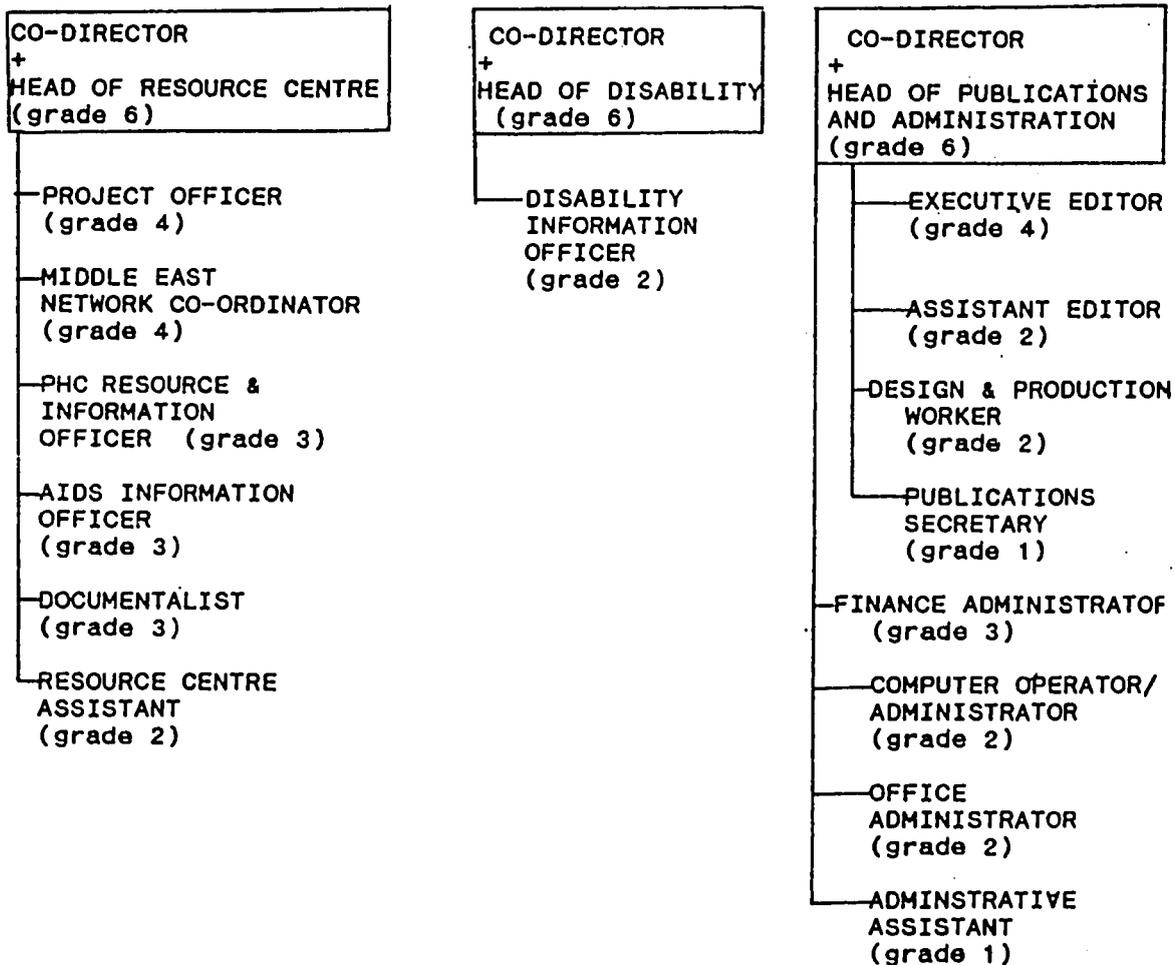
Currently, staff dedicated to *Dialogue on Diarrhoea* equal three full-time equivalents. This includes: Managing Editor, 38 percent; Assistant Editor, 50 percent; publications secretary, 35 percent; design and production worker, 33 percent; mailing list manager, 50 percent; office administrator, 15 percent; and Resource Center staff, 79 percent (split among four individuals).

The Scientific Editors expressed their satisfaction with the way AHRTAG is functioning and with their relationship with *Dialogue on Diarrhoea* staff as well as with AHRTAG Council members. They described working relationships as "happy" ones. When queried about whether the project could withstand the absence of the Managing Editor were she to terminate her employment, they answered that while it would not have been possible in 1987, were she to leave today, the remaining staff are believed to be strong enough to carry on very well.

The management team (three co-directors) meets every two weeks; meetings are held with the Scientific Editors quarterly. The 1987 recommendation regarding the institution of annual performance reviews has been implemented with success.

Figure 4.

AHRTAG ORGANIZATIONAL STRUCTURE



V.G.2. FINANCE/ACCOUNTING

The 1987 evaluation concluded that AHRTAG's accounting systems "seem to provide both basic control and good financial management information. Costs are collected in categories that provide relevant information, allow simple and equitable allocations, and comparative analysis. For a small, non-profit organization, the systems are unusually well designed and maintained." We as a team agree with this statement; our only comments are additive. Whereas in 1987 cash flow was a problem, it is no longer; 25 percent of AHRTAG's annual income is in the bank at any time. According to the Finance Administrator, accounting/tracking systems have vastly improved even since 1987. In his opinion everything during that time happened in a very "ad

hoc" way--for example, there was no annual budget schedule for disbursing funds to Project Partners and no systematic way of knowing when to report to different donors (different donors have different financial reporting schedules). With a new accounting software program, called Sun, these inadequacies have been corrected. The accounting program is now able to, according to the Finance Administrator, "track everything." It is able to analyze each transaction at five levels: 1) cost centers (breaking down A.I.D.-funded activities into five sub-areas relating to language editions and Resource Center activities); 2) grants; 3) donors; 4) publications; and 5) consultants.

Further improvements in financial systems have stemmed from Great Britain's enforcement of SORP, Statement of Recommended Practices for charity organizations, and auditor recommendations.

V.G.3. FUNDRAISING

With the absence of the Executive Director and Project Coordinator, fundraising efforts for AHRTAG have fallen to the three division heads. Fundraising for *Dialogue on Diarrhoea* has largely been taken over by the Managing Editor. However, both A.I.D. (as articulated in Amendment One of the Cooperative Agreement) and the 1987 evaluation team envisioned much greater fundraising roles for the Scientific Editors, particularly because of their prominence in the field of diarrheal diseases and their intimate knowledge and understanding of *Dialogue on Diarrhoea* and AHRTAG. While the Scientific Editors' continuing links and contacts have proved valuable in establishing/initiating new funding from international agencies, their direct involvement in field-level fundraising has been minimal, in large part due to infrequent travel. Thus, while the Scientific Editors may continue to play a key role in obtaining donor funds from international agencies, their role in identifying/establishing Project Partners in developing countries and in obtaining local funding may be diminished. Clearly this is an area for reexamination.

It is difficult to assess the degree to which AHRTAG has taken on a more aggressive donor-oriented fundraising strategy as an organization, as we have examined fundraising only related to *Dialogue on Diarrhoea*. However, if one takes into account the degree to which AHRTAG has diversified its funding base for language editions not supported by A.I.D., we can say with some assurance that they have been successful. The success of *Dialogue on Diarrhoea's* decentralization effort in the past and in the future has and will depend largely on *Dialogue on Diarrhoea's* Managing Editor, although this is an area requiring reexamination as well.

V.G.4. COLLABORATION

AHRTAG has successfully collaborated with A.I.D. Office of Health's Applied Diarrheal Diseases Research (ADDR) Project, wherein ADDR develops a research column for every issue of *Dialogue on Diarrhoea*, and contributes supplements on a twice yearly basis. In addition, the following collaborative activities have been undertaken:

- an article produced in conjunction with the Quality Assurance Project (formerly PRICOR);
- an announcement of the Vitamin A Field Support (VITAL) Project;
- an article by one of PRITECH's key private sector/commercialization of ORS experts;
- an article on methods for changing prescribing behaviors by the Drug Management Group of Management Sciences for Health; and
- the Resource Center's frequent computerized linking with the Water and Sanitation for Health (WASH) library, the Vector Biology Control (VBC) library and the Clearinghouse on Infant Feeding and Maternal Nutrition.

Although collaboration between *Dialogue on Diarrhoea* and the central office of PRITECH in Washington has not been extensive to date, there has been a great deal of collaboration with PRITECH at the field level in Senegal and Pakistan. Coordination at the central level had been envisioned by the former Technical Director of PRITECH, but there was no follow-up by PRITECH once the Technical Director vacated his position. There has been no collaboration between *Dialogue on Diarrhoea* and the centrally-funded A.I.D. Communication for Child Survival (HEALTHCOM) project. The HEALTHCOM Project Director did not fault AHRTAG with the lack of collaboration, as HEALTHCOM has made no effort in this regard either.

It is often assumed that projects will collaborate and share information for the sake of professional peer review. Yet it was pointed out by more than one individual interviewed that many projects and institutions are in competition with one another, which reduces their willingness to share information. As one director of a major A.I.D.-supported CDD project suggested, projects cannot be forced to collaborate when it is not seen as mutually beneficial--there must be a logical, rational fit between projects for collaboration to work. The collaboration between ADDR and *Dialogue on Diarrhoea* is an example of an appropriate fit: ADDR supports basic research; *Dialogue on Diarrhoea* is used as a vehicle to disseminate research findings.

CONCLUSIONS:

- Great strides have been made since the 1987 evaluation in AHRTAG's management structure, overall financial management and policies. Great attention has been paid to the development of organizational procedures.
- The team concurs with AHRTAG's assessment that divisional responsibilities are currently unequal and endorses the organization's decision to undergo an external management review.
- AHRTAG has been quite successful in diversifying their funding base for non-A.I.D. supported language editions of *Dialogue on Diarrhoea* and other organizational projects and activities. The Scientific Editors of *Dialogue on Diarrhoea* have expressed a desire for technical assistance, however, in the area of fundraising and proposal development, particularly in trying to solicit funding from USAID missions.
- *Dialogue on Diarrhoea* staff have collaborated successfully with some of the A.I.D. Office of Health's centrally funded projects, although this is an area that could be strengthened.

RECOMMENDATIONS:

1. Resource Center linking with A.I.D.-funded project databases, or other databases, should be motivated purely by the need to identify/access technical articles for *Dialogue on Diarrhoea* content and development, and not merely for the sake of collaboration. AHRTAG should be notified when PRITECH has solved its modem problem so that communication links may be established.
2. AHRTAG should consider the financial feasibility of hiring an additional person with experience in non-profit fundraising to assist the Managing Editor in *Dialogue on Diarrhoea's* fundraising efforts.
3. Scopes of work for the Scientific Editors should be rewritten to clearly reflect their current roles and responsibilities and level of effort. Special attention should be paid to the role, if any, that the Scientific Editors, will play in future field-level fundraising efforts.

VI. FUTURE DIRECTIONS

Are the purpose and assumptions of the project still valid and do they fit within A.I.D.'s policies and priorities? What should be the future direction of the project? Is decentralization of the newsletter a valid goal? Will decentralization bring sustainability? Should A.I.D. continue to play a role in support of *Dialogue on Diarrhoea*? If so, what form of the project should be supported and at what funding level? (Note: These key questions will be addressed in this chapter using a question and answer format.)

VI.A. PROJECT VALIDITY

Is the original project goal "[to] expand the dissemination of information on all aspects of diarrheal diseases, with special emphasis on Oral Rehydration Therapy (ORT), to LDC leaders, health providers and international donors' staffs" still valid today? To answer this question we must ask ourselves: Are diarrheal diseases still widely prevalent? Are millions of children still dying from dehydration associated with diarrheal disease? Is cholera an emerging problem in Latin America and Africa? Do rates of correct ORS use continue to flag in relation to awareness? The answer to all of these is a resounding "yes." The problem of diarrheal diseases has not gone away and new technologies and information are emerging that need dissemination.

At issue here is whether A.I.D., given the number of emerging health concerns, particularly as they relate to urban health care delivery, wishes to focus its scarce resources on a recurrent cost such as a newsletter, particularly one that has a single focus? In the 1987 Evaluation Report (pg. 30), A.I.D. chose to fund a recurrent cost such as *Dialogue on Diarrhoea* in the first place because:

- AHRTAG was providing a service that fit within established A.I.D. policy directives;
- *Dialogue on Diarrhoea* had an established distribution network;
- *Dialogue on Diarrhoea* had a committed staff and reputable advisors;
- Directing support to an existing program promised to be more effective than establishing a similar (presumably redundant) program in an American organization.

In our assessment these points remain valid today and are further elaborated below.

Is AHRTAG providing a service that fits within established A.I.D. policies and priorities?

Yes. Oral rehydration therapy (ORT) remains one of the twin engines of A.I.D.'s Child Survival Program. Since 1985, A.I.D. has made a significant contribution to diarrheal disease control efforts, allocating over \$228 million to assist national programs in at least 64 countries.

Moreover, A.I.D. has committed itself to working with the international community in achieving the goals adopted at the recent World Summit for Children: 50 percent reduction in child deaths due to diarrhea and a 25 percent reduction in the incidence of diarrhea between 1990 and the year 2000.

Communication plays a critical role in A.I.D.'s ORT strategy. Experience has taught the Agency that sustained communication, and not communication "blitzes" or "campaigns," is one of the keys to changing behavior. We would argue that *Dialogue on Diarrhoea* is a low-cost means of sustained communication that is not duplicated by other newsletters, and which offers up-to-date, simply and clearly presented, technically accurate information on a disease that continues to kill millions of children. As an information source, *Dialogue on Diarrhoea* complements and reinforces messages of countless donor-funded CDD programs and activities all over the world. For these reasons, we believe that support of *Dialogue on Diarrhoea* continues to fit within A.I.D.'s policies and priorities.

Does AHRTAG have an established distribution network, committed staff and reputable advisors?

Yes. *Dialogue on Diarrhoea* is an established newsletter of international repute that has conferred prestige to AHRTAG and has become the "flagship" of the organization. None of the other international newsletters that AHRTAG produces, including *ARI News*, *AIDs Action* or *Community Rehabilitation News*, has received the level of acclaim that *Dialogue on Diarrhoea* has, despite equally excellent quality. Every individual interviewed for this evaluation knew about *Dialogue on Diarrhoea*, and regularly reads or scans it. Comments about *Dialogue on Diarrhoea* ranged from "practical," "valuable," "motivational," "morale-building," "dynamic," "gets people excited" to, when queried about stopping or significantly reducing the number of copies distributed to the field, "it would be a terrible loss."

As described in section V.G. Management, *Dialogue on Diarrhoea* staff are highly committed. The Managing Editor of *Dialogue on Diarrhoea* has worked with the newsletter almost since its inception. The Scientific Editors are as committed today to the newsletter as when it was first conceived. One does not question the reputation of the advisors; however, as mentioned in Chapter V.A. the composition of this Board should be reexamined given the need to ensure that the field perspective is adequately represented.

Does it continue to be more effective to direct support to an existing program than establishing a similar program in an American organization?

Yes. A.I.D. entered into a Cooperative Agreement with AHRTAG in 1984 precisely because AHRTAG was already producing a reputable newsletter on diarrheal diseases; *Dialogue on*

Diarrhoea was and is an AHRTAG-conceived and owned product, not an A.I.D.-conceived and designed activity intended for outside competition. AHRTAG has established its excellent organizational reputation because of *Dialogue on Diarrhoea* and is known for its diarrheal disease expertise. Its staff, advisors and Resource Center have been working in this specialized area for over ten years. They have established good working relationships with international organizations, including WHO, the policy arm for international control of diarrheal diseases. These established relationships as well as *Dialogue on Diarrhoea's* staff expertise would be difficult to match anywhere. *Dialogue on Diarrhoea* remains uniquely AHRTAG's and is not subject to transference. Therefore, it is just as redundant today to consider establishing a diarrheal disease newsletter with an American organization as it was in 1984.

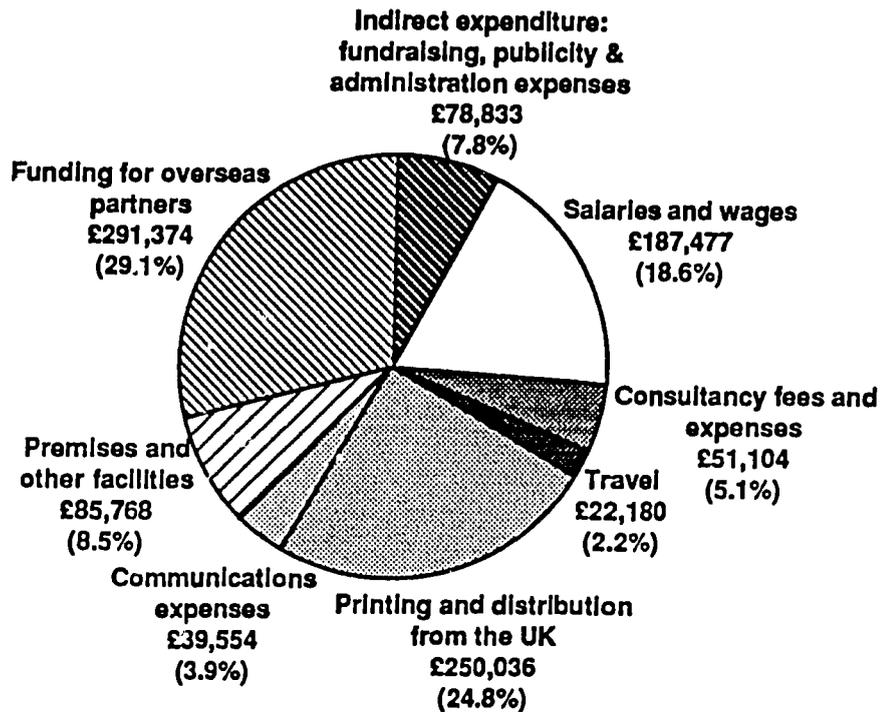
In sum, it is easy to rationalize why the project goal remains valid and fits within A.I.D.'s policies and priorities. But this rationalization does not get at the harder question of whether funding a recurrent cost is justified given the Agency's organizational goal of sustainable development. The next section, which addresses what the future of *Dialogue on Diarrhoea* might look like, discusses the more difficult issues surrounding sustainability and decentralization. For instance, does decentralization lead to sustainability?

VI.B. THE FUTURE OF *DIALOGUE ON DIARRHOEA*

Decentralization has become a well articulated AHRTAG goal and has been a key objective of A.I.D.'s Cooperative Agreement with AHRTAG. To what extent however has AHRTAG focused its efforts on decentralization? In FY 1990, 29 percent of AHRTAG's expenditures provided support to partner organizations (see Figure 5) to produce and distribute *Dialogue on Diarrhoea*, as well as other newsletters, and to develop and provide continuing support for in-country resource centers (of which there are currently ten). This represents an approximate 4 percent increase over FY 1989.

Theoretically a well-executed decentralization strategy can lead to institution building, particularly if the activity lends itself to becoming self-sustaining. For instance, AHRTAG's Resource Center has built a plan for sustainability into its support for the Centre for Educational Development in Health, Arusha (CEDHA) to establish resource centers in six zones throughout Tanzania. After the initial seed money is provided to establish book shops in the zonal resource centers, the aim is to make these self-sustaining by developing a revolving fund from the sale of books (in local currency). In this case, decentralization is working toward sustainable development.

Figure 5. AHRTAG Expenditures by Type



To date, however, AHRTAG's decentralization of the production and distribution of *Dialogue on Diarrhoea* to local institutions has led to, albeit stronger institutions, ones that are largely dependent on AHRTAG for funds. No provision has been made for sustaining newsletter production. Organizations are largely dependent on AHRTAG unless activities can be made self-sustaining. Yet the cost recovery options are not attractive: 1) charging subscription fees; and/or 2) allowing advertising. The former option has not been considered because AHRTAG has always provided its newsletters free-of-charge on the premise that primary health care workers in developing countries cannot afford to pay for a subscription. This policy fits with the philosophical underpinnings of the organization to support "health for all" by providing current, practical, and appropriate information free to those who need it most. The organizations with which AHRTAG has developed relationships, all NGOs, also support this policy. And A.I.D. has supported AHRTAG's policy insofar as it applies to developing country individuals/institutions. The latter option, whether or not to allow advertising, opens up a number of ethical concerns. The likely candidates for advertising would be large pharmaceutical firms and infant formula manufacturers, the very industries that produce anti-diarrheals and formula milks, the antithesis of *Dialogue on Diarrhoea's* purpose and messages.

If neither cost-recovery option is appropriate then what can we likely expect from a decentralization strategy? We can expect at least a reduction in core expenditures by transferring to the field production activities that have been undertaken at the central level (in this case London) and we can expect to build the local capacity of the organization in newsletter translation, production and distribution. If the savings realized are only marginal by moving production to the field, then the goal of building institutional capability becomes worthwhile. However, if the costs incurred in moving activities to the field are greater than the savings, institution building in and of itself does not make sense, particularly if one considers the amount of ongoing technical assistance that will be required of the central level to support field activities.

There are a number of issues that require examination before A.I.D. strongly endorses the total decentralization of the newsletter as a key objective of its Cooperative Agreement with AHRTAG. Consider the following:

- Decentralization requires time and continuing technical assistance. A *Dialogue on Diarrhoea*-sponsored meeting held with Asia Project Partners in January of this year underscored the issues common to organizations undertaking the production and distribution of a publication, and the level of support and technical assistance required from the parent organization (See Annex G). Project Partners suggested ways in which AHRTAG could be supportive, including on-site training and assistance in editing and writing, mailing list computerization, overall planning and management, resource center development, etc. It is important that the time and money required to decentralize are not underestimated.
- Quality of newsletter content may be more difficult to control, particularly if the goal is to build local institutional capacity which should mean eventual local autonomy.
- In addition to providing technical assistance to the partner organization, AHRTAG will have to help locate funds for the institution to carry out its production and distribution function unless fee recovery or advertisement schemes are initiated.
- Core activities will continue to need funding from an outside donor unless AHRTAG develops some income-generating activities to sustain newsletter development.
- Removing all production and distribution out of London to partner organizations may not be cost-effective. A recent trip to Africa to investigate the possibility of locating a partner organization in East Africa to produce and distribute *Dialogue on Diarrhoea* yielded some interesting information. Given the difficulty of traveling between various countries in Africa

and the frequency with which Europe is used to route mail even to countries with close proximity to one another, it may prove more expensive to decentralize *Dialogue on Diarrhoea* distribution to Africa than to retain it within London.

If A.I.D. were to support AHRTAG toward the goal of total decentralization of *Dialogue on Diarrhoea*, one scenario would see AHRTAG/London become the resource hub with its spokes operating in the field; that is, London would continue to meet with Advisory Board members, Scientific Editors and other technical experts, with WHO, UNICEF and A.I.D., if applicable, to develop issue content and to commission articles, and to design and lay out the newsletter. They would then supply partner organizations with camera-ready copy and/or negatives for their translation, production and distribution. *Dialogue on Diarrhoea* staff would provide technical assistance to Project Partners during start-up activities and act as a resource as necessary. Ultimately, with the exception of providing camera ready art and/or negatives, *Dialogue on Diarrhoea* staff would wean the Project Partners only after being confident that local funding is assured, materials are sensitively and accurately translated, printed in a quality fashion, distributed effectively, and evaluated appropriately.

A possible second scenario would have AHRTAG developing material on a range of primary health care topics, eliminating the need for specifically vertically focused newsletters, and providing material to partner organizations who would then "pick and choose" articles developed by AHRTAG for a publication uniquely their own. This publication would need to mention AHRTAG's contribution, but would have its own logo. Although partner organizations would not be able to alter the content of material received from AHRTAG, they would be able to choose which materials to be included in the newsletter, adding their own local articles to the core material. A couple of partner organizations in Asia at the January meeting pointed out their interest in creating a more locally applicable newsletter, pulling together a number of diarrhea, ARI, and other health related topics.

If A.I.D. is to support the goal of decentralization, expectations should be realistic. Total decentralization cannot be achieved in the span of two-three years. Decentralization of project activities should be considered on a case-by-case basis to determine cost-effectiveness. Decentralization will not logically lead to sustainability unless cost-recovery schemes or other income-generating activities are pursued. Project Partners will require continuing technical assistance from AHRTAG. The resources required for decentralization will be significant.

VI.C. OPTIONS for A.I.D. SUPPORT OF *DIALOGUE ON DIARRHOEA*

Although not articulated in any of the project documents, i.e., original Cooperative Agreement or amendments, there has been a mutual understanding between A.I.D. and AHRTAG that support was to be gradually reduced. Has this happened? Based on our analysis in Chapter III the answer is no. Although A.I.D. money has helped to stimulate the expansion of *Dialogue on Diarrhoea* and catalyze support for local language editions, it is still the primary donor for the English and French editions. As pointed out earlier, A.I.D.'s overwhelming funding presence for these editions has probably decreased the likelihood of AHRTAG's being able to attract other donor funding. Yet, is it in A.I.D.'s best interest to surrender its claim to *Dialogue on Diarrhoea* to another donor?

We have already established a rationale for continued funding of *Dialogue on Diarrhoea* discussed in section VI.A. Project Validity. In sum, a newsletter on diarrheal diseases does fit within A.I.D.'s current policies and priorities and is warranted from a programmatic point of view, particularly given A.I.D.'s leadership role in promoting and implementing CDD programs in developing countries, its commitment to goals articulated at the World Summit on Children, its increased awareness of and involvement in urban health care delivery, and A.I.D.'s coordinated response to control cholera outbreaks in Latin America and Africa. From an economic standpoint, we believe that the contribution that A.I.D. has made in support of *Dialogue on Diarrhoea* is relatively low as compared with funding inputs for other major CDD projects.

It is our collective recommendation that funding of *Dialogue on Diarrhoea* should be continued. The following are considered by the team to be viable funding options and their implications.

- Option 1: Continued funding at same level, adjusted for inflation.
- Option 2: Accelerated decentralization, with phased reduction in funding.

Either option is acceptable to the team. While Option 1 suggests that A.I.D. continue support for as long as a newsletter on diarrheal diseases remains within the Agency's funding policies and priorities, Option 2 supports a phase-out of support for the newsletter, with an emphasis on decentralization. More detailed discussion of the options follows.

OPTION 1: CONTINUE FUNDING AT SAME LEVEL.

Enter into a new Cooperative Agreement with AHRTAG for a two-year period of time either under current project authority (ORT-HELP) or under the PRITECH project authority. (Extensions optional.) Opt for assisting AHRTAG at roughly the current level of funding for

all years, adding for inflation and program activities as deemed appropriate. Address gap areas identified during this evaluation relating to readership and distribution. Decentralization of production and distribution of newsletter would only be considered on a case-by-case basis after assessing cost-effectiveness.

PROGRAMMATIC IMPLICATIONS:

FOR A.I.D.:

- Condition funding on a clear plan for evaluation and effective targeting (distribution-mailing list analysis).
- Provide direction/assistance to AHRTAG in their development of evaluation strategy, perhaps recommending group/individual consultant with expertise in this area.
- Ensure that project goals, objectives, outputs and resource inputs are clearly articulated in project documents, including benchmarks, deliverables, and the role that A.I.D. is expected to play with respect to technical and management input.

For AHRTAG:

- Develop evaluation and distribution (for effective targeting) strategies (may or may not require the services of outside group/individual consultant; approximately one person month).
- Make securing funding for the English edition/India, Tamil and French editions a first priority.
- Analyze the cost-effectiveness of establishing Project Partners in Africa and other locations.
- Implement evaluation and distribution strategies.

BUDGETARY

IMPLICATIONS: Average of \$300,000 per year.

OPTION 2: ACCELERATED DECENTRALIZATION; PHASED REDUCTION IN FUNDING OVER TWO-TO-THREE YEAR PERIOD OF TIME.

Enter into a new Cooperative Agreement with AHRTAG for a two-year period of time either under current project authority (ORT-HELP) or under the PRITECH project authority. (Year three funding optional.) Opt for assisting AHRTAG toward total decentralization of the newsletter with a phased reduction in funding over a two- to three-year period (realizing that total decentralization could not realistically occur in this time frame). Emphasis is on both decentralization and evaluation of the newsletter.

PROGRAMMATIC IMPLICATIONS:

FOR A.I.D.:

- Condition funding on AHRTAG's submission of a clear, step-wise action plan for decentralization, a comprehensive evaluation strategy, and a distribution strategy (for effective targeting).
- Provide direction/assistance in development of the decentralization plan, including the selection of priority regions/countries/institutions.
- Provide more funding in year one of the agreement to cover the following costs:
 - one additional full-time staff person to assist in identifying institutions, fundraising and technical assistance;
 - additional travel budget for core staff;
 - approximately one person month of technical assistance to AHRTAG to develop an evaluation strategy.
- Ensure that project goals, objectives, outputs and resource inputs are clearly articulated in project documents, including benchmarks, deliverables, and the role that A.I.D. is expected to play with respect to technical and management input.

FOR AHRTAG:

- Develop decentralization, evaluation and distribution strategies.
- Recruit for a full-time individual with experience in non-profit fundraising.
- Make securing funding for the English edition/India, Tamil and French editions a first priority.
- Analyze the cost-effectiveness of establishing Project Partners in Africa and other locations.
- Implement decentralization, evaluation and distribution strategies.

BUDGETARY IMPLICATIONS:

Year 1: \$600,000
Year 2: \$400,000
Year 3: \$250,000

**RESPONSIVENESS TO 1987 EVALUATION RECOMMENDATIONS,
IMPLEMENTATION PLANS, FY 1988-1991
FUTURE DIRECTIONS**

A. TECHNICAL CONTENT

1. Has there been a more systematic emphasis placed on the control and/or prevention of diarrhoeal diseases of different etiologies including the prevention of dehydration and reduction of mortality through ORT?
2. Has the technical content of the newsletter covered a broad range of thematic topics related to diarrheal diseases control?
3. Has DD examined basic messages on a cyclical basis; have issue plans included more scientific and research material and been circulated in advance to editorial advisors and donor agencies? Has an additional scientific reviewer been added to the review process for each issue?
4. Have the topics suggested by the evaluation team been covered in subsequent issues?
5. Has DD met the needs of its perceived readership? In terms of range of subjects covered; Approach and style; and Illustrative material? Has a balance been maintained between practical and research-oriented material?
6. Have supplements been produced as planned? Are these of technical merit?
7. Have other editorial activities/planned supplementary materials been carried out and produced?
8. Has DD included a larger number of readers' letters, in particular, those referring to experiences and significant questions?
9. Are the primary messages of DD still valid? Have changes in content reflected the need to broaden approaches to diarrheal disease control? Should the subjects covered in the newsletter continue to be largely the same or should the content of DD broaden its focus to cover a wider range of subjects? If expansion of topics is desirable, what should that expansion look like?
 - merging ARI and DD newsletters into one as has been done in some language editions?
 - integrating more fully into a broader approach to primary health care?

- focusing on the mother-child dyad and all diseases that affect the 0-5 age group, including: ARI; diarrheal disease; malaria (specific to some regions); nutrition, including maternal nutrition (its links to child health are so often neglected), etc.?
10. How best can DD continue to support efforts to prevent and control diarrheal diseases?

B. READERSHIP

1. Who is the target audience? Has the target audience changed? Does the readership reflect the target audience? Is broader or narrower than envisaged?
2. What efforts have been made to assess readers' information needs and identify additional information about the readership?
3. Was it possible to base the most recent readership survey on scientific sampling methods (i.e., sample size carefully selected based upon quantitative methods to test significance of results)?
4. What level of feedback is received from readers? Has feedback from readers been considered in planning content? Have readers needs been met and inquiries dealt with effectively and in a timely fashion?
5. How is the newsletter actually used by those who receive it? Has there been a difference in usage between the most recent and the last surveys?
6. To what extent is the newsletter shared with others?
7. Are there any lessons to be learned between the last two readership surveys?
8. Have the supplementary materials produced (such as resource lists) been useful? Are there other types of information support that would be useful to readers?

C. DISTRIBUTION

1. Has the mailing list been consolidated? Have efforts been made to target specific groups? Do mailings include return addresses? Have reply cards been inserted with mailings at least once on an annual basis to indicate whether subscribers wish to continue, and if so, if the number of copies included in the mailing are correct?
2. Has the mailing list programme been revised and updated in order to provide better information and faster processing of data?
3. Has a subscription system been introduced? Is this policy clearly mentioned in DD? To what extent has it been successful? Is it considered cost-effective?

4. Has a mailing list analysis for Africa and Asia been undertaken as planned? What are the outcomes of this analysis? Have project partners been identified for Africa?

D. PRODUCTION MANAGEMENT

1. Has the production schedule been extended to give additional time for review, other staff input? Has planning allowed for input from a wide range of interests?
2. Has the production assistant been encouraged to take more responsibility for layout and paste-up? Have staff investigated the possibility of using desktop publishing programs?
3. Has the illustrative material included graphics, tables and line drawings in addition to photographs?
4. Have issues been produced in a regular and timely fashion?
5. What are the current unit costs for producing DD?

E. LANGUAGE EDITIONS

1. To what extent has DD identified local sources of funding? Consolidated existing language editions before pursuing further editions? Developed guidelines for working with local groups and selection of project partners? Identified, where possible and necessary, in-country representatives to monitor progress?
2. Has evaluation of the Tamil and French editions justified their continued production?
3. Have the language editions that A.I.D. provides support for been produced in a regular and timely fashion?
4. Have the language editions that A.I.D. does not provide support for been produced in a regular and timely fashion?

F. RESOURCE CENTER

1. Have the Resource Center staff been involved in contributing material and information support to DD as required? Have they regularly been included in editorial meetings?
2. Has the Resource Center developed and maintained an effective and relevant diarrheal diseases information base?

3. Has the development of an in-house computerized database assisted DD project staff? Has the database been used for inquiries from DD readers? What use has been made of the modem and the E mail? Has E mail been used to link with related projects under A.I.D.'s aegis, such as Quality Assurance Project, ADDR, PRITECH, HEALTHCOM, REACH, WASH, etc. What use is made of other computerized databases (linking with Medline, Medlars, etc.)?
4. What means were developed to evaluate the effectiveness of the supplemental material developed for DD readers?
5. Has technical assistance been provided to strengthen other resource centers in developing countries as had been envisioned? If so, did the provision of technical assistance tax the Resource Center staff too greatly? To what extent is this kind of technical assistance planned for the future?
6. Has the Resource Centre budget been adequate? Are the materials purchased with AID funding still identifiable? Has a system been implemented to assess how resources are being used?

G. MANAGEMENT ISSUES

1. How has AHRTAG staffing changed to meet new demands? Are staff able to devote enough time to the project? Has the relationship with the Scientific Editors continued to work well? How is staff morale? Is work divided among staff members efficiently, effectively?
2. Given the new organizational structure, have project activities been well managed? Has the financial reporting and administration been well managed? Is team management working well? How has the absence of an Executive Director affected the organization?
3. Has additional editorial staff been employed to assist the managing editor with DD? If so, to what extent has additional staff helped reduce the burden on the Managing Editor? Has the Managing Editor taken on a larger management role that places her in a senior position over all other newsletter editors?
4. Are annual performance reviews being conducted, using individual job descriptions for guidance?
5. Who in the organization has taken on the role of developing AHRTAG's external relationships, i.e., securing funds from outside?
6. Has AHRTAG developed other areas of programme work and donor support for these to reduce the dependency on USAID and reduce the imbalance in its project portfolio? Has AHRTAG developed a more donor-oriented fundraising strategy? Have the Scientific and Managing Editors taken a leadership role for DD fundraising?

7. Has the project developed closer links and information exchange with other AID-funded health/nutrition projects?

H. FUTURE DIRECTIONS

1. Are the purpose and assumptions of the project still valid and do they fit within A.I.D.'s policies and priorities? What should be the future direction of the project?
2. Is decentralization of the newsletter a valid goal? Will decentralization bring sustainability?
3. What should be the strategy for decentralization? Issues to be considered include:
 - reduction of central costs of production and distribution
 - criteria for selection of project partners
 - criteria for selection of priority regions
 - the potential for local funding of publications activities
 - guidelines for collaborative working relationships with project partners
 - issues of quality control, planning and policy
 - the level and type of technical and administrative support required by project partners, to develop local capabilities for producing materials and project management
 - the affect decentralization would have on the roles and responsibilities of project staff and scientific editors
 - the extent of local partner autonomy
 - implementation including timescale
4. It has been the clear intention of A.I.D. to gradually reduce its support for DD? In light of this, does the evaluation team recommend continuation of funds beyond the current Cooperative Agreement? If so, what level of funding is recommended to ensure continued distribution of DD? If support were decreased by 50%, what would that mean to AHRTAG and DD? What form of the project should be supported by A.I.D.? How would a revised project, in terms of content and/or implementation fit into A.I.D. funding policy?

LIST OF PEOPLE INTERVIEWED

Annex A (continued)

A.I.D. Washington Staff

Tony Boni, Cooperative Agreement CTO, R&D/H/HSD
Robert Clay, Chief, R&D/H/HSD
Carol Dabbs, LAC/DR/HN
Lloyd Feinberg, Program Manager, R&D/H
Linda Lou Kelley, ENE/TR/HPN
Jerry Norris, Chief, ENE/TR
Tom Park, Chief, LAC/DR
Ann Van Dusen, Director, R&D/H

USAID Field Staff

Dave Eckerson, HPN Officer, USAID/Haiti
Charles Llewelyn, HPN Officer, USAID/Bolivia

AHRTAG Staff and Council

Lois Carter, Chair, AHRTAG Council
Barbara Bubb, Vice-Chair, AHRTAG Council
Simon Burne, Treasurer, AHRTAG Council
Mike Rowland, Editorial Advisory Board
Andrew Tomkins, Editorial Advisory Board
Sharon Huttley, Editorial Advisory Board
Katherine Elliott, Scientific Editor
William Cutting, Scientific Editor
Kathy Attawell, Managing Editor, DD, Head of Publications & Administration, & Co-Director
Nel Druce, Assistant Editor
Chris Wilde, Finance Administrator
Celia Till, Production/Design
Mary Helena, Publications Secretary
Suzanne Fustukian, Resources and Information Coordinator and Co-Director
Sara Hill, Primary Health Care Research and Information Officer
Sheila O'Sullivan, Documentalist

Appropriate Health Resources and Technologies Action Group Ltd. (AHRTAG)
1 London Bridge Street
London, SE1 9SG
United Kingdom

A.I.D. Centrally Funded Projects

Applied Diarrheal Disease Research (ADDR)

Jon Simon, Project Director

Harvard Institute for International Development (HIID)
1737 Cambridge Street
Cambridge, Massachusetts 02138

HEALTHCOM II

Mark Rasmuson, Project Director

Academy for Educational Development (AED)
1255 23rd Street, N.W.
Washington, D.C. 20037

MotherCare

Dr. Barbara Schieber, Principal Investigator
Quetzaltenango Project
INCAP
Apartado 1188
Guatemala City, Guatemala

Home Office of MotherCare Project:
John Snow, Inc.
1616 North Fort Meyer Drive, 11th Floor
Arlington, Virginia 22209

PRITECH

Glen Patterson, Project Director
Danielle Grant, Director of Management and Administration
Karen White, Director, Information Center

PRITECH Project, Management Sciences for Health (MSH)
1925 North Lynn Street, Suite 400
Arlington, Virginia 22209

Quality Assurance

Jeanne Newman, Deputy Director

Center for Human Services
7200 Wisconsin Avenue
Bethesda, Maryland 20814-4202

Other Organizations

Academy for Educational Development

Judy Brace, Vice-President and Director of Development Information Services
Academy for Educational Development (AED)
1255 23rd Street, N.W.
Washington, D.C. 20037

CHETNA (AHRTAG partner for *ARI News*)

Ms. Indu Capoor
Centre for Health Education Training and Nutrition Awareness (CHETNA)
Drive-In Cinema Building, 2nd Floor
Thaltej Road
Ahmedabad, Gujarat 380 053
India

Centers for Disease Control (CDC)

Dr. Mike Linnan
Centers for Disease Control
USAID/Jakarta, Box 4
c/o American Embassy
APO San Francisco, 96356-8200

Pan American Health Organization (PAHO)

Dr. Abraham Horwitz
Director Emeritus
PAHO/WHO
525 23rd Street, N.W.
Room 1012
Washington, D.C. 20037

Save the Children (USA)

**Dr. Amin, Public Health Officer
Save the Children (USA)
Bangladesh Field Office
House 33 A
Road 9A
Dhanmondi R.A.
Dhaka, Bangladesh**

ASSESSMENT OF THE 1985 EVALUATION RECOMMENDATIONS

<u>RECOMMENDATION</u>	<u>IMPLEMENTED</u>	<u>OBSERVATIONS</u>
1. No further promotional efforts be undertaken for the English language edition.	YES	Circulation has been increasing by 50 new subscribers monthly without any promotional efforts.
2. No reprinting of back copies.	YES	Back copies have been distributed. Additional copies needed are photocopied.
3. Decentralized production of the English edition by providing camera-ready copy not be pursued.	YES	It is now feasible to supply film for the local printing and distribution of DD.
4. DD continue to be targeted to a broad audience, to include those outside of the health system, e.g. teachers.	YES PARTIALLY	Readership has expanded within the health professions. Those outside are to be reached progressively through the training of trainers, translation of articles into local languages and implementation of Diarrheal Disease Control (DDC) programs.
5. A readership survey be taken in early 1986.	YES	See report and annex.
6. French language edition should receive high priority.	YES	Circulation has reached 12,000 copies. An evaluation has been recommended.
7. Tamil language edition will continue to be supported.	YES	A review has been suggested before proceeding.
8. Translation of DD into Indonesian be undertaken starting with Issue 19.	NO	Issue 19 was translated and distributed independently of AHRITAG. This edition included advertising from local pharmaceutical companies. The Evaluation Team recommends the source of this publication be identified
9. The need for DD in local languages be documented before being actively pursued.	YES	Local translation is being actively pursued after careful identification of local institutions.

<u>RECOMMENDATION</u>	<u>IMPLEMENTED</u>	<u>OBSERVATIONS</u>
10. Funding from UNICEF for the Arabic edition be pursued	YES	DD received \$15,000 for two years from UNICEF. DD was printed and distributed in Egypt by means of film sent from London.
11. Spanish language edition receive priority and a funding strategy be developed.	YES PARTIALLY	Composite editions have been produced, but a stable source of funding for the regular translation of DD into Spanish has not been found.
12. Activities planned and materials developed for the ICORT II Conference.	YES	These activities and materials increased dialogue with the field.
13. The role of the Resource Center be defined.	YES	The Evaluation Team strongly recommends the computerization of the Resource Center.
14. Resource Center materials purchased with A.I.D. funding be identifiable.	YES	A coding system has been developed.
15. Information requests relating to the DD project be tracked.	YES	Information is tracked.
16. Visitors using DD collection be recorded.	YES	Visitors are recorded.
17. Donor support outside of A.I.D. be sought for DD.	YES	See Annex E which provides a listing of non-A.I.D. donor support.
18. A financial expert familiar with the needs of A.I.D. be sent to AHRTAG.	YES	A method of financial management was recommended and implemented.
19. The Project Coordinator provide the A.I.D. Project Officer with financial reports.	YES	Quarterly financial reports are submitted to the A.I.D. Project Officer.
20. An organizational and staffing structure was recommended.	YES	The recommended staff positions were filled.
21. Appropriate working space for DD staff be found.	YES	DD inhabits the basement offices of the AHRTAG premises. AHRTAG will be moving at the end of 1987.

Dialogue on Diarrhoea: index of articles/inserts etc
June 1987 -- June 1991

Articles

Aetiology

- 32: Cholera update
- 45: Measures to control spread of cholera (forthcoming)
- 35: Diarrhoea and AIDS
- 35: Diarrhoea pathophysiology: mechanisms of diarrhoea, and why they matter
- 37: Feeding bottles: a source of faecal contamination
- 43: Worms and community health

Drug therapy

- 42: Antibiotic resistance
- 45: Changing prescribing practices (forthcoming)
- 42: Drugs and diarrhoea (neomycin, streptomycin and hydroxyquinolines)
- 43: Drugs and diarrhoea (antimotility drugs)
- 44: Drugs and diarrhoea (adsorbents, sulphonamides)
- 33: Iran: attitudes to treatment and use of antibiotics
- 42: Peru: co-ordinated national action against inappropriate drug use
- 43: Physicians' behaviour
- 45: When to use antibiotics (forthcoming)

Epidemiology

- 31: ARI and diarrhoea: a natural collaboration
- 34: CDD programmes: WHO, USAID, UNICEF
- 34: Child spacing: impact on health
- 32: Cholera update
- 31: Diarrhoea in urban slums: Bombay and Karachi
- 36: Food borne illness: a world overview
- 34: Viewpoint: Indonesia (CDD) study
- 34: Viewpoint: PNG (diarrhoea mortality and management)

Health education and training

Health education

- 29: Early learning about ORT: children can be teachers
- 29: Diarrhoea game
- 30: Hygiene education

Training

- 38: CDD training activities: step-by-step planning
- 38: Diarrhoea training unit
- 29: ORT: improving medical education
- 38: ORT in practice: training methods
- 29: Practical advice: evaluation of training
- 38: Practical advice: how to teach
- 29: The physician and ORT: recent initiatives

Laboratory services

- 38: Viewpoint: local laboratory skills

Nutrition

Breastfeeding

- 38: Breastfeeding promotion: the right start
- 39: Promoting breastfeeding in urban communities
- 34: Child spacing: impact on health

Nutrition and diarrhoea

- 41: Diarrhoea and potassium
- 41: How to feed a baby who cannot breastfeed
- 37: Lactose intolerance
- 33: Leaf concentrate consumption and diarrhoea
- 37: Persistent diarrhoea: appropriate dietary management
- 36: Preventing food borne infections
- 44: To feed or not to feed?
- 37: WHO meeting and guidelines on nutritional management of persistent diarrhoea

Vitamin A

- 33: Vitamin A and diarrhoea: reducing the risk?

Weaning

- 40: Fermented food: reducing contamination
- 40: Adapting food technologies: but what do mothers think?
- 40: Improved weaning foods: germinated flours
- 40: Improved weaning foods: sprouted grains, peas and beans
- 29: Weaning foods and diarrhoea
- 36: Weaning foods: breaking the chain of infection

Oral rehydration therapy

- 41: Cereal based ORT (reports on use)
- 35: Correct measures: home made ORS
- 44: Cost effectiveness of ORT units
- 41: Home guidelines: treatment, ORS, SSS
- 41: How to make rice based ORS
- 36: ICORT III: Third International Conference on ORT
- 34: Key issues in ORT
- 41: ORS for diabetics?
- 32: ORS: flavouring and colouring
- 33: ORS: flavouring and colouring follow up
- 42: Pakistan: should ORS be marketed like other drugs?
- 34: Rice based ORS
- 33: Using ORS packets to measure water volume?

Sanitation and hygiene

- 45: Animal and human health (forthcoming)
- 45: Chickens and childhood diarrhoea in Peru (forthcoming)
- 36: Environmental health in the Caribbean
- 36: Food borne illness: world overview
- 30: Hygiene education: Bangladesh
- 36: Hygiene, food safety and diarrhoea: case study, Leeds, UK
- 36: Improving environmental hygiene: how to plan a community based project
- 31: Poor urban neighbourhoods: water and sanitation 'do's and don'ts'
- 39: Why do mothers wash their hands?
- 30: Zimbabwe: encouraging families to build latrines

Survey and evaluation methods

- 39: Brazil: a RAP survey
- 29: Evaluation of training
- 39: Investigating beliefs: collecting information
- 39: Investigating beliefs: research methods
- 38: ORT in practice: training methods

Traditional remedies/local beliefs

- 39: Beliefs and behaviour: the Maasai in Kenya and Tanzania
- 39: Beliefs of rural mothers about diarrhoea in Orissa, India
- 39: Diarrhoea in Nicaragua: causes and local remedies
- 39: Uganda: newborns, 'false teeth' and diarrhoea

Urban health

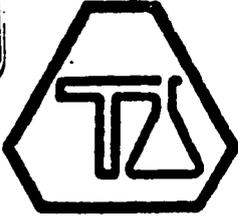
- 31: Diarrhoea in urban slums: Bombay
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ANONİM ŞİRKETİ**

Evrenozade Sokak 4 Bomonti - Şişli 80223 İSTANBUL - TURKEY
☎ : 147 00 40 - 43/146 10 56 - 57 Fax : 130 66 60 Tlx : 27729 Tila Tr.
P. O. B. 260 Şişli - İSTANBUL # : MÜDERRİSOĞLU ŞİŞLİ - İSTANBUL

Editor
Mrs/Miss Kathy Attawell
Dialogue on Diarrhoea
85 Marylebone High Street
London W 1m 3DE
ENGLAND

RECEIVED - 7 MAR 1988

Istanbul, 29.2.1988

Dear Kathy Attawell

Thank you for your letter dated 20 November regarding a copy of our bulletins. We used some items from Diarrhoea Dialogue and the pictures on page 2 in D.D. December 1986 issue 27. We are glad to send you the first 3 issues enclosed.

With best wishes
Yours sincerely

Pharm. Serap Dolgun
Product Manager



İLAÇ TEDAVİSİ

Tüm ishallerde hastalıklarda tedavinin temel amacı, hastalık sırasında sulu dışkı yoluyla kaybedilen sıvı ve elektrolitlerin yerine konmasıdır. Ancak bazı dizanterik hastalıklarda sıvı kaybı nisbeten azdır ve ateş, karın ağrısı ve toksisitenin temel klinik semptomları, bağırsak epitel hücrelerinin patojenik organizmalarla veya bunların toksinleriyle karşılaşmış zarar görmesinin bir sonucudur. Bu hastalıklarda antibiyotik tedavisi büyük önem taşır.

ANTİMİKROBİYAL İLAÇLAR

— Çoğu ishallerde hastalıkta antimikrobiyal ilaçların herhangi bir etkisi olduğu kanıtlanmamıştır, bu nedenle kullanılmamalıdır.

— Şiddetli ishal görülen bazı hastalıklarda, antimikrobiyal tedavi yaşamı kurtarabilir. Bunlar arasında Shigella'nın, özellikle S. dysenteriae l'in neden olduğu dizanteri ve bazı uzun süreli ishaller vardır. Neyse ki, bu vakalar, dünyanın bazı bölgelerinde hâlâ görülen S. dysenteriae l salgınları dışında nispeten az görülür. Bu hastalıkları en etkili biçimde tedavi edebilmek için, hem doğru bakteriyolojik tanıyı koymak, hem de hangi antibiyotiklerin en etkili olacağını belirlemek açısından laboratuvar araştırmaları çok büyük önem taşır.

— ORT ile beraber uygulandıklarında, antibiyotikler kolera tedavisinde yararlı olabilirler, çünkü hastalığın süresini kısaltır ve kaybedilen dışkı miktarını azaltırlar.

— Antibiyotikler, Shigella'ya bağlı dizanterinin daha hafif vakalarında, muhtemelen E. Coli'nin enteropatogenik serotiplerine bağlı ciddi ishallerde ve seyahat ishallerinde de değerlidir. Campylobacter jejuni'ye bağlı ishallerde antibiyotik tedavisi, yalnız hastalığın erken dönemlerinde uygulamaya başladığında yararlı olur. Ancak bu uygulama genellikle olası değildir. Çünkü organizmanın belirlenebilmesi için en az 2 günlük özel laboratuvar incelemesi gereklidir.

— Tifoid olmayan Salmonella'nın sistemik yayılım gösterdiği vakalar haricinde antibiyotikler kontredikedir. Çünkü klinik yararları yoktur ve bu organizmaların dışkı yoluyla atılması işlemini uzatırlar.

— Taze dışkı örneklerinin mikroskopik incelemesinde Entamoeba histolytica veya Giardia lamblia'nın trofozoitlerine rastlanan semptomatik vakalarda antiparazit ilaçlar değer kazanır.

MOTİLİTEYİ AZALTAN İLAÇLAR

Bunlar arasında loperamide ve diphenoxylate gibi sentetik opioidler ve paregoric gibi morfin türevleri vardır.

Çocuklarda görülen ishallerde ve seyahat ishallerinin dizanterik olmayan tiplerinde, motiliteyi azaltan ilaçlar çok az da olsa hastalığın süresini kısaltır ama sekresyonu azaltıcı olmadıklarından dışkı miktarını etkilemezler. Bu ilaçlar yetişkinlerde bir ölçüde semptomatik rahatlama yaratabilir ama 5 yaşından küçük çocuklarda kontredikedir. Çünkü solunum depresyonu ve bilinç kaybı gibi yan etkileri vardır. Dizanteri vakalarında motiliteyi azaltan ilaçlar gerçekten de hastalığın şiddetini artırabilir çünkü istilacı organizmaların Kolondan dışarı atılmasını geciktirebilir.

SEKRESYONU AZALTAN İLAÇLAR

İki ilaç, Chlorpromazine ve Berberi, antisekretuar etki gösterirler ama ikisi de rutin kullanımda pratik değildir.

— Chlorpromazine şiddetli kolera vakalarında dışkı miktarını azaltır ama rahat-

sızlığı şiddetli olmayan hastalarda pek etkili değildir. Bu nedenle ve ayrıca uyku verdiği için kullanımı tavsiye edilmez.

— Berberin, Asya'da geleneksel olarak kullanılan bir ishal ilacıdır. Hayvanlar üzerinde yapılan araştırmalarda V. Cholerae ve E. Coli enterotoksinlerinin neden olduğu dışkılamamın miktarını azalttığı görülmüştür. Ancak insanlar üzerindeki çalışmalarda sürekli ve kalıcı etki sağladığı görülmemiştir. Rutin ishal mücadelesinde tavsiye edilmez.

DİĞER İLAÇLAR

Bizmut subsalisilat, seyahat ishalleri olan hastalarda orta derecede etkilidir; ama gerekli olan doz çok yüksektir. Etki mekanizması bilinmemektedir. Cholestyramine, bazik anyon değişimi yapan emilmeyen bir reçinedir. Hem safra tuzlarını ayırır, hem de bakteriyel toksinleri bağlama yoluyla etki eder. Önceki denemelerde çocuk-

İSHAL'DE
AĞIZDAN SIVI TEDAVİSİ İÇİN
TUZ-ŞEKER KARIŞIMI

REHIDRATEK



REHIDRATEK İSHALDE HAYAT KURTARICIDIR.

İshalin neden olduğu su ve elektrolit kaybının giderilmesinde en etkili ve en kolay tedavi:

TUZ-ŞEKER ERİYİĞİ REHIDRATEK

Dünya Sağlık Teşkilatına (WHO) uygundur.

larda ishalin süresini azalttığı bulunmuştur, yeni çalışmalar yapılmaktadır. Belirli oral antibiyotiklerle (örneğin, Gentamicin ve Neomycin) beraber kullanıldığında sürekli ishal olan hastalarda, yani 14 günden uzun süren akut ishal vakalarında, etkili olmuştur. Yüksek dozaj asidozu uzatabilir, ilacın rutin kullanıma girmesini tavsiye edebilmek için yeterli kanıt yoktur.

Kaolin ve Pektin, veya başka birçok ilacın ki bunların arasında geleneksel ilaçlar ve Aspirin gibi antiinflamatuarlar vardır, yararı hiç bir şekilde kanıtlanmamıştır.

İLAÇ KULLANIM REHBERİ

Ishal tedavisinde ilaçların rolünü belir-

ten bilgilerin eksik olmasına ve laboratuvar onayı gerektirmesine karşın aşağıdaki bilgiler, özellikle yeterli laboratuvar kontrolü olmadığı zamanlarda yardımcı olabilirler: -Örneğin bir kolera salgını sırasında olduğu gibi, sulu ishal (kanlı değil) vakalarında koleradan şüphelenilmiyorsa antibiyotik verilmez. Epidemide Tetracycline veya V. cholerae'ya karşı etkili olan başka bir antibiyotik kullanılmalıdır.

— Dizanteri görülen hastalarda, özellikle ateşi (vücut ısısı 38, 5°C den fazla) ve çok hasta olan çocuklarda, Ampicillin veya Trimethoprim sulphamethoxazole (cotrimoxazole) gibi uygun antibiyotikler verilmelidir. Antibiyotik seçimi coğrafik bölgedeki Shigella cinsinin antibiyotige olan bilinen duyarlılığına dayandırılmalıdır.

— Özellikle 5 yaşından küçük çocuklar akut ishalin rutin tedavisinde herhangi "antidiyareyik ilaç" kullanmak için hiç mantıklı dayanak yoktur. Kaybedilen sıvı ve elektrolit miktarının geri konması (AST) tüm ishallerde öncelikle uygulanması gereken tedavi şeklidir.

REFERANS:

Dialogue on diarrhoea
sayı: 25 Haziran 1986

Prof. R. B. Sack, Baltimore Şehir Hastanesi, 4940 Eastern Avenue, Baltimore, Maryland 21224, USA.

PRATİK KULLANIMDA AST



Ishalin etkisi sonucunda dehidrate olmuş bir çocuk, yaşam kurtaran ağızdan şeker-tuz eriyiği (ASTE) ile tedavi ediliyor. Sabah 9.00'da, çocuğun, çökmüş bingıldığı dehidratasyonun açık bir belirtisidir. Saatler ilerledikçe çocuk tehlikeyi atlatıyor ve saat 13.15 sıralarında meme emebilmeye başlıyor.

Saat 9⁰⁰

Saat 9¹⁵



Saat 10⁰⁰

Saat 13¹⁵



REFERANS:

Dialogue on Diarrhoea
Sayı: 25 Haziran 1986
National Control of Diarrhoeal Diseases Project (NCDDP), 20 a Gamal el Din Abul Mahassen St, Garden City, Cairo, Egypt.



TEK İLÂÇ SANAYİİ
Anonim Şirketi



SIM CANADA
10 Huntingdale Blvd.
Scarborough, Ont. M1W 2S5

(416) 497-2424
FAX (416) 497-2444

*Unless publ.
(other pubrs)*

April 10, 1989.

AHRTAG,
1 London Bridge Street,
London, England,
SE1 9SG.

Dear Sirs:

For some time I have been receiving the ARI News and Dialogue on Diarrhoea and find both these Newsletters very informative.

In my role as Coordinator of Continuing Education for our missionary nurses of SIM International, I put out a xeroxed newsletter for the nurses a couple of times a year. I am wondering if I may use some of the material from your publications if I give recognition of such.

Thank you in advance for your prompt answer to this request.

Yours sincerely,

Patricia C. Styran

(Miss) Patricia C. Styran, M.Sc.N.
Coordinator Continuing Education
for Nurses.

RECEIVED 7 ...



SIM amalgamates Andes Evangelical Mission, International Christian Fellowship and Sudan Interior Mission

DIRECTIONS Evaluation: Results

An evaluation questionnaire was sent out earlier this year to all non-U.S. and some U.S. readers of DIRECTIONS. It was completed and returned by some 11% of those who received it. This report provides a brief background on the general objectives of DIRECTIONS, a summary of respondents' comments, and suggestions for those with specific interests outside the domain of DIRECTIONS.

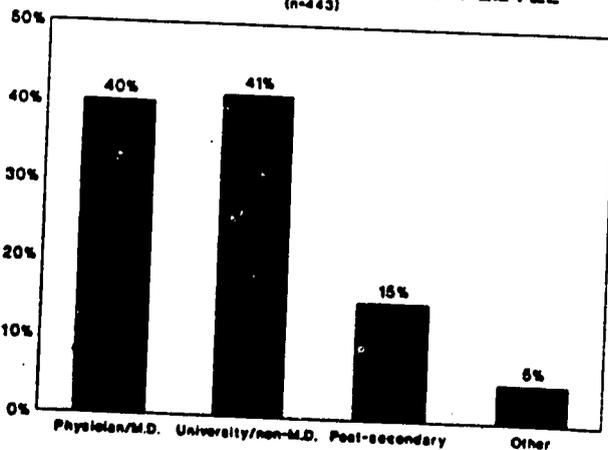
Background. DIRECTIONS information is focused on health program managers and aims to provide enough information about health technologies to enable them to make wise choices for their own programs. Topics are selected if they are important health concerns in every major region in the developing world, they are not covered by other publications, and specific relevant technologies exist that can be used at the primary care level.

Respondents' Characteristics. Figure 1 shows the distribution of respondents' occupations. The largest number indicated administrative/managerial duties as their main occupation. When secondary and primary occupations are considered together, nearly 65% of the respondents are involved in program management. Respondents are generally highly educated, as shown in Figure 2. More than 80% have a university degree. Figure 3 shows the geographic distribution of respondents was similar to that of readers in general. The majority are from Africa, which is probably due in part to the fact that countries where English is spoken are more heavily represented on the mailing list.

Respondents' Views. Generally, respondents are quite pleased with DIRECTIONS. Approximately 71% read each paper thoroughly, 65% share their copies, and 74% save each copy for later reference. Some 78% find the technical information to be about right; among managers this proportion was slightly higher (82%). The information is mostly or somewhat new to 90% of respondents. About 69% of respondents think DIRECTIONS contains enough examples; 30% feel it should contain more.

Each of the past eight issues of DIRECTIONS was ranked "useful" or "very useful" by more than 75% of respondents.

Figure 2: HIGHEST EDUCATION LEVEL (n=443)



Of the future topics ranked by their importance for respondents' work, immunization and malaria were rated "very important" by more than 50% of respondents. More than 70% considered water use, malaria, immunization, skin disease, and child-to-child health promotion to be important concerns. Topics suggested by respondents include AIDS, nutrition, diarrhea, and health education.

Other Comments

- 1) Other Languages Sought--We would like to offer translations of DIRECTIONS but do not have funds to do it. Any groups that may be able to undertake or help finance translation and printing should contact us at PATH.
- 2) Foreign Exchange for Materials--This is difficult to address. For some, UNESCO coupons may be a solution. For more information, write to UNESCO, 7 place de Fontenoy, 75700 Paris, France.
- 3) Issues on Diarrhea, Respiratory Disease, or AIDS--These topics are covered in substantial depth in other free publications. To receive Dialogue on Diarrhea, ARI News, or AIDS Action, write to AHRTAG, 1 London Bridge Street, London SE1 3SG, U.K.

We would like to extend sincere thanks to those who took the time to answer the survey and share their views and comments with us.

Figure 1: OCCUPATIONS (n=342)

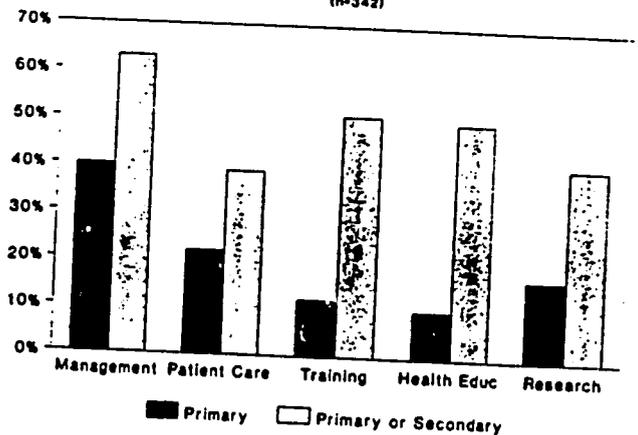
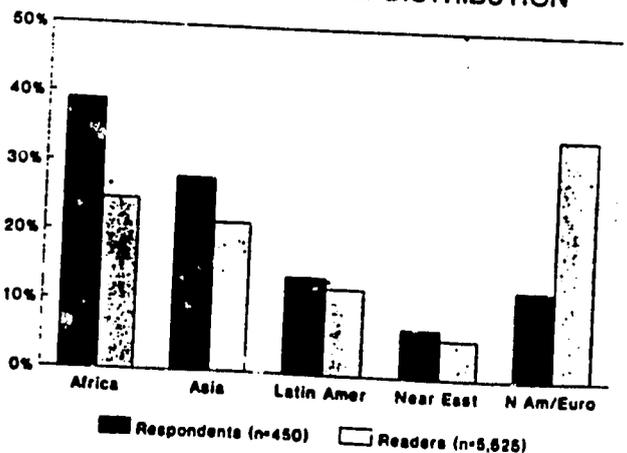


Figure 3: REGIONAL DISTRIBUTION



DD in other
publications

Soiled Saris

Saris, worn by most women in India, Pakistan and Bangladesh and fairly widely throughout the rest of Asia, are often used for many household tasks as well as for clothing. A study was carried out to see whether this behaviour was common and if it affected the rates of childhood diarrhoea.

Collecting data

Information was obtained from 247 families in Dhaka slum areas, about the sex and age of children under six, family income, maternal education and attitudes of mothers towards 'misuse' of saris. Mothers were observed at home to learn about their usual hygienic practices, including what they did with their saris. Information was also collected on the incidence of diarrhoea among their children.

Contamination of saris

There was no practice that all mothers believed to be a wrong use of the sari, including wiping a child's bottom after it had defecated. Very few suggested that a particular use 'can spread disease'.

Misuse of saris was seen as wrong for other reasons, such as 'it will make the sari wet'.

Observation of mothers showed that, in a third of homes, saris were used to wipe both clean and dirty children, to wipe eyes (even

where these were infected), and to blow noses, including their own. In over half the homes, mothers wiped dirty hands on their saris. Children whose mothers 'misused' their saris in these ways more frequently than the average, tended to have diarrhoea more often. The level of maternal education and family income did not appear to influence hygienic or unhygienic use of saris.

Altering behaviour

Discussions with mothers clearly showed that they were not aware they were contaminating their saris, or that the soiled saris could pass on diseases like diarrhoea to their children. It is important to convince them of this danger, because they can easily change their own behaviour and see results for themselves, unlike many other hygiene interventions. Success in preventing misuse of saris could serve as a good indicator to health workers of the effectiveness of an educational message in altering behaviour in a sanitation programme. Also, as general hygiene conditions improve, personal hygiene practices such as misuse of saris will become even more important.

— Bonita Stanton in *Dialogue on Diarrhoea* issue 26, September 1986.

water economics.

The concept of water economics in health education implies cultivating an awareness and innovative culture among people with regard to using scarce water, so that people look at water as a precious and limited supply to be used with judicious planning and selective distribution. The basic approach in such training would necessarily be the vital role that uncontaminated water supply plays in the survival of children and the family. This would call for planning the supply and the con-

sumption of water by the family on the basis of utility demand. *With the knowledge that the supply of water is not unlimited, be it in the city or the villages, inculcating a habit of planned water consumption is the moot education.*

Since the introduction of modern water supply, families have by and large abandoned the traditional practice of storing drinking water separately. Health education in water economics must revive the practice of storing a limited amount of drinking water after its purification, out of

reach from pollution. Once the water ration for drinking has been ensured, the consumption of unfiltered water for other purposes like bathing, washing, lavatory, gardening, etc. can be planned according to the availability or the severity of shortage. In recent years, there has been an increasing awareness among architects and urban planners for suitable designs to recycle unfiltered water after its primary consumption.

In villages or urban slums, the possibilities of sanitary planning, for recycling the unfiltered water, could undoubtedly be explored. It is indeed necessary to find ways and means of recycling water from the bathing taps to the community washing bay or to farming and gardening. Health education enjoys a major role in developing this innovative attitude and culture towards precious water supply. Besides planning in water consumption, another area of education is stopping people from polluting the sources of water in their own environment, be it a well, a pond, a lake, a canal or a river flowing past their village.

Once the conceptual areas have been identified, the planning of water economics as a part of wider health education would necessarily call for more detailed discussions and deliberations among the experts in the field. The objectives of holding such discussions would be to examine the feasibility, programming for experimental field trials and planning to receive the feedback. This would help the health educators to formulate broad recommendations in incorporating water economics as a component of community health education to deal with water scarcity. While the governments get busy with the formulations of water policy and water mapping, voluntary health education can prepare the nation to live healthy and happy lives within the constraints of water scarcity.

Weaning - FOR A HEALTHY BABY

Breastmilk is the best and safest food for young babies. Older babies need extra foods as well as breastmilk at the right age, and in sufficient amounts, to enable them to grow and stay healthy. The malnourished child will get sick more often and will be less able to fight off illnesses, such as diarrhoea.

Weaning foods can be very dangerous for babies. If they are not hygienically prepared, they can be a major source of infection.

Weaning means giving family foods in addition to breastmilk. Weaning is a gradual process by which the infant becomes accustomed to the adult diet.

Until the age of two years, babies can still receive an important amount of nourishment from breastmilk.

Weaning foods should be given at about four to six months. Start by giving one or two teaspoons a day of carefully mashed food, in addition to regular breastfeeds. Do not use a feeding bottle. Slowly increase the number of meals and the amount of food given.

By the age of eight months, most babies need four 'meals' a day, including a variety of foods, in addition to regular breastfeeding. At one year, a child should be able to be given all types of family foods, although the food may still need to be softened or mashed.

Feed babies using a clean cup and spoon. Do not add water to the weaning food, as it does not have enough nutritional value, and if the water is dirty or contaminated, the baby will probably get diarrhoea.

Good weaning foods

A thick, creamy porridge made from the basic food of the community is good. The basic food or staple is cheaper than most other foods and is

usually eaten by the family at most meals. Examples of basic foods include:

- * cereals: maize, wheat, sorghum, oats, barley, bread (soaked in gravy, milk or tea), rice;
- * roots: cassava, yam, cocoyam, potato, sweet potato;
- * starchy fruits: plantain, breadfruit, banana.

On their own, especially when cooked in water, most cereals, grains and roots are too low in energy. Some oil or fat (or sugar) should be added to the porridge to make it richer and easier to digest. Adding oil increases the energy value of the weaning porridge.

Give this porridge, in addition to breastmilk, for about two weeks. After this time, babies need other foods as well as breastmilk and porridge to provide enough energy and a balanced diet.



Baby, 4 months, is fed soft food, fruit or vegetables, AS WELL AS breast milk.

* fruits

Before being given to babies, they should be peeled carefully or washed in clean water, then mashed or the juice squeezed out. If water is added to the juice, it must be clean; otherwise babies may get diarrhoea. Examples include oranges, pumpkin, tomato, banana, papaya, mango, pineapple.

Acknowledgements:

Based on an article by Dr. Shanti Gosh and material from:

Learn More About Breast-feeding and Weaning. League of Red Cross and Red Crescent Societies 1987.

Primary Health Care Technologies at Family and Community Levels. Aga Khan Foundation, UNICEF, WHO 198

Feeding Mother and Child. The Caribbean Food and Nutrition Institute.

Prevention of Diarrhoea. Supervisory Skills, WHO 198

It appears in full in: Dialogue on Diarrhoea, AHRTAG, 1 London Bridge Street, London SE1 9SG.



Baby, 9 months, eats mashed food

CHANGE

20 Crown Street
London WC2N 5HT
England

Tel: 01-839 4985

EDITOR-IN-CHIEF:
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Editorial Assistant:

Dillys Baker

PUBLISHER:

Paul Cautley

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Views expressed in CHANGE are not necessarily those of the publishers.

Although we are satisfied with the authority of those who pro-

nique we present, CHANGE has not tested these out in practice. CHANGE, however, acknowledges that these are useful and practical techniques.

Contributions and letters for consideration are welcome and should be sent to CHANGE.

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NEWSLETTER

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COMMUNITY PAEDIATRICS AND PRIMARY CHILD HEALTH CARE

Number 6

Date: DECEMBER 1990



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Division of Community Paediatrics
Department of Paediatrics and Child Health



University of the Witwatersrand,
Johannesburg

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* see p4
→ 85



Collecting information

This article outlines a series of ways to collect information about beliefs and behaviour, known as RAP (rapid assessment procedures), applied to understanding of diarrhoeal diseases.

RAP can be used to replace surveys when resources are limited and only minimal information can be collected quickly before, during, or after programme development. RAP is preferably used to complement and enrich information obtained by a survey which assesses local conditions and needs; knowledge, attitude and practices; opportunities for intervention; and the activities and effects of different programmes. RAP is short for Rapid Assessment Procedures, but the name was also chosen for its ability to convey some of its characteristics. Research activities using RAP are rapid (two to four weeks of fieldwork), community based, focused, action oriented, and low cost.

Techniques

The techniques used in RAP are:

- Limited participant observation — observation of a community, household or programme to gain important insights into everyday life and activities.
- Observation — looking at and listening to events and behaviours of interest.
- Conversation — informal individual or small group conversations.
- In depth key informant interview — more detailed interviews with a selected group of individuals, asking open-ended questions and incorporating additional questions based on responses.
- Survey interviews — structured or close-ended questionnaire given to a selected group of respondents.
- Focus group — discussion in which a small group of participants (six to ten) guided by a facilitator, talk freely and spontaneously about topics considered important. Different community group meetings (church, women, school, co-operatives, committees, etc.), though not focus groups in a strict sense, can also be used to obtain information.

A more complete description of each technique is provided in the RAP field guide and other manuals. Data collection with each of these techniques is guided by checklists (for observation, for example), discussion guides (for focus groups), interview guides, etc.

We have used RAP to learn more about diarrhoeal disease in Central America and Panama in relation to the following:

- popular and health providers' perceptions, definitions and response to diarrhoea episodes in children
- infant and child feeding and care practices
- sanitary conditions in homes and surroundings
- existing distribution systems for medicines
- sources of information for mothers and health providers

The fieldwork activities were concentrated in three areas: in the community, the household and among health providers. Detailed guidelines with specific questions for data collection were developed; here we will only outline the main topics or sectors of information included within each area and illustrate some of the findings.

Community

Information about the community can be obtained from available data (census, reports, theses etc.). Other relevant and more specific information (for example, on traditional health providers) can be obtained during fieldwork through observation and interviews with key informants, such as community leaders and school teachers.

Household

A minimum of 15 households (for communities of 1,000 inhabitants) is selected. When random selection is not feasible, a range of households from different locations should be selected. Contrasting households (e.g. those with children who frequently have diarrhoea, and with children who seldom

have diarrhoea), can be selected to make the survey more representative. Mothers of selected households are interviewed as key informants using more structured questionnaires. Focus groups of mothers with children under five can also meet to discuss the topics.

Useful information can be obtained from these interviews and group discussions about: family composition; socio-economic conditions; characteristics and sanitary conditions of the home and surroundings; different types of diarrhoea — causes, symptoms, perceptions of severity, health care seeking and treatments; detailed description of the last episode of diarrhoea in the family and response to it; diet of healthy children and of children with diarrhoea; child care (especially food preparation, faeces disposal and hand-washing); remedies (home and commercial medicines, including ORS) used for diarrhoea in the home; knowledge and use of ORS; sources of information.

Different health care providers are key informants.

Their knowledge and practices can be assessed while their co-operation is sought.

Information obtained using RAP can be very valuable for programme planning, implementation and evaluation. Consideration of techniques for data recording and organisation, qualitative data analysis and report writing have not been dealt with here, but are crucial to produce useful information. These are discussed in detail in the RAP field guide.

Elena Hurtado, Division of Nutrition and Health, Institute of Nutrition of Central America and Panama (INCAP), Guatemala; and Susan Scrinshaw, School of Public Health, University of California, Los Angeles, CA, USA.

Encouraging breastfeeding instead of bottlefeeding can help prevent diarrhoea. Breastfeeding is vital both in the prevention of diarrhoea and for feeding of children during and after attacks.

Breastmilk, an effective and inexpensive drink suitable for use as ORT, is all too often disregarded. The reasons why breastfeeding offers protection against diarrhoea are thought to be:

- the immunological and antimicrobial properties of breastmilk;
- the gut bacteria of exclusively breastfed infants tend to inhibit the growth of diarrhoea-causing bacteria;
- bottle fed infants are at greater risk of illness due to bacterial contamination;
- breastfed infants may have a better nutritional status, and thus less risk of death from diarrhoea.

Hygiene can prevent diarrhoea

Young children and babies are at great risk of getting diarrhoea caused by germs contained in food or drink that has not been cleanly prepared.

It is especially important to keep dishes, cups, and spoons used for young children's food very clean.

Food must be protected from flies and other insects, domestic animals and rats and mice.

Foods are excellent places for breeding germs. Meat, fish and milk are the main sources of infection. Care should be taken to buy fresh food and not to store it for too long.

Water for drinking and cooking should be drawn from a tap or other protected source such as a spring or borehole. If this is not possible, drinking water should first be boiled. An easy time to boil water is after the evening meal. If boiling is not possible, storing it for at least twelve hours to allow the sediment to settle is better than nothing. Drinking water should be stored in a clean, covered container.

When a mother's baby over 6 months is hungry or thirsty, she should breastfeed it. This gives it a perfect food while allowing the mother to take the time she needs to prepare the baby's other food safely.

Prevent Dehydration and Weight Loss During Diarrhoea



BREASTFEEDING



Feeding bottles are a major cause of diarrhoea

So, it is important to know that:

- Babies who are exclusively breastfed are less likely to get diarrhoea, because breastmilk is free from germs and contains antibodies which protect a baby from infection
- Bottled babies are more likely to get diarrhoea. Feeding bottles are very difficult to keep clean, and dirty bottles are a major source of illness, especially diarrhoea; bottled babies are also at risk from contaminated water which may be used to mix up powdered milk
- If a baby has diarrhoea, always continue breastfeeding because a baby still needs food, and especially liquids, to replace what is lost during the diarrhoea. Breastfeeding will also reduce the stool volume and speed recovery
- When a baby has frequent diarrhoea, oral rehydration fluids may be needed as well. These should be given up cup and spoon. If the baby is too weak to suck at the breast, expressed breastmilk can also be given by cup.
- Cups used to feed a baby with expressed breastmilk should carefully washed with boiled water to remove germs.

*adapted from *Diarrhoea Dialogue and Improving young child growth in Kenya.*

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Reproduced from the *Breast is Best Newsletter*, Belize.

Do you like the cartoon? Can anyone translate the punch line? Perhaps we should be asking you to write it instead. Ideas on a postcard to . . .

The Compleat Mother, a Canadian newsletter, asks its readers to 'Stamp Out Bottle Feeding!' by urging Canada Post to commemorate breastfeeding on the next stamp by writing to the Stamp Advisory Committee. Should we be doing this? Would someone out there like to find out how we could get a stamp showing a breastfeeding mother?

The Nursing Mothers of Australia Association (NMAA) newsletter is full of articles and letters encouraging and supporting breastfeeding mothers. One issue has five pages of, for me, poignant letters from mothers saying what they miss about breastfeeding. NMAA has also introduced a new section in its newsletter — 'Mother to Mother' — which gives readers the opportunity to seek new suggestions to help with any mothering (but not necessarily breastfeeding) problem they may be having. It encourages readers to share with other mothers ideas that have worked for them.

The newsletter from the Breast is Best League, Belize, Central America, congratulates 24 breastfeeding counsellors who have now trained and been given their Leadership Training Certificate and badge. They were chosen by sister counsellors to represent each district and the objectives of the training were to:

- 1) develop contact persons in each district
- 2) develop leadership skills in order to enhance productivity

- 3) develop skills in motivation of volunteers
- 4) develop communication skills
- 5) learn to conduct meetings and record minutes
- 6) develop counselling skills
- 7) develop listening skills
- 8) be able to evaluate work done
- 9) learn adult education teaching skills
- 10) share and learn how to raise funds
- 11) be able to manage funds
- 12) enhance personal growth and development
- 13) be able to co-operate with others
- 14) form mother support groups

I have just received a copy of a fascinating booklet, *Highlights on Breastfeeding*, by the Egyptian Society of Breast Milk Friends. In particular, I was interested to read an article about 'Human Milk Banking' by Osman El Sayed Abdalla, written in 1987. The first part of the article was on the practicalities of milk banking but I quote from the rest of the article:

'As regards religious point of view of initiating such milk banks, we interviewed some of our eminent religious personnels, sheiks and professors in Al Azhar University and Cairo University.

'Few of them agreed about this if there is UNAVOIDABLE NECESSITY to have these banks on national basis. The majority disagreed and refused the whole idea. The main basic causes for their refusal was to avoid any future marriages of breast-milk-fed brothers and sisters, to avoid corruption, abuse of breast milk particularly if donor will be paid for donation.

'Apart from too many basis to prohibit such project is the least that we in this way will be surpassing one of the unbreakable limits ordered by Our Mighty God.

'So many miracles have been just realized behind the great unravelled statements in our Holy Quran 14 Centuries age while just recently this has been illustrated by scientists and so many other findings.

'These miracles compels us to think that the great order of condemning marriage of those who share breast milk feeds with others might be related to some disastrous immune dysfunction so results in similar disorders.

'Finally although Dar El Eftaa in Cairo has again proposed that it can be legal to carry on such project we are still convinced that this is by all means illegal and should be prohibited.'

The June issue of *Dialogue on Diarrhoea* is completely about breastfeeding and well worth reading. Lactase, the gut enzyme required to digest and absorb lactose, is easily damaged by infections and malnutrition. How important is lactose intolerance?

How is it diagnosed and managed? The articles say that for infants with acute diarrhoea and temporary lactose intolerance breastfeeding should be continued.

Finally, the Nursing Mothers of Australia Association is now running information days. They are available for anyone interested in NMAA and their purpose is to help members understand the activities of NMAA, what is expected in various roles, and an understanding of the Code of Ethics. Participants gain an overview of NMAA at Group level and beyond to regional, branch and national activities. Attendance at an information meeting is a pre-requisite for training for the positions of breastfeeding counsellor or community educator. It sounds similar to the Working Together Days the NCT is trying to set up.

Compiled by Shirleyanne Seel

Last October, Shirleyanne celebrated ten years as a tutor and she is still going strong! Congratulations, Shirleyanne.

Breastfeeding, mother nature's gift

Breast milk is no ordinary feed
It is a unique feed that only mum can give
me through her breast

It is a unique feed that only mother nature
can prepare

It is a feed meant just for me.

When mum has no milk she can never share
mine with visitors

When there is no food in the house, I know I
can never starve

When mum is too tired to cook, I know my
food is always ready

When mum has had a hard day I know she
will get rest just by breastfeeding me.

Mum's breast milk is no ordinary milk
It is specifically meant for me as a well
balanced diet

It is specifically meant for me because I
need to grow into a strong man of
tomorrow

It is the only feed that comes in such an
attractive container

Breast milk is complete, don't compete
Thank you mother nature for giving me
such an appropriate feed

Thank you mum for giving me my
appropriate feed

Thank you for giving me the best start in
life.

Dikoloti Virginia Morewane
Botswana

This poem also appeared in the *Breast is Best League, Belize, Newsletter*, Summer, 1989.

Introducing solid foods to baby

Breastmilk is the best and safest food for young babies. Older babies need extra foods as well as breastmilk. It is important that babies are given extra foods as well as breastmilk at the right age, and in sufficient amounts, to enable them to grow and stay healthy. Too little food, given too late, or inadequate food with too few nutrients may lead to poor growth and malnutrition. The malnourished child will get sick more often and will be less able to fight off illnesses such as diarrhoea. Weaning foods can, however, be very dangerous for babies. If they are not hygienically prepared they can be a major source of infection. This Health Basics insert describes good weaning practices to help families prevent diarrhoea in their children.

What is weaning?

Weaning means giving family foods in addition to breastmilk. Weaning is a gradual process by which the infant becomes accustomed to the adult diet.

It is not good for babies to stop giving breastmilk when new foods are first being given—weaning foods do not replace breastmilk, they complement it. As the baby gets older it needs more food to grow and stay healthy. The number of breastfeeds can be reduced slowly as the baby starts to eat more and more family foods. However, it is important to remember that until the age of about two years babies can still receive an important amount of nourishment from breastmilk.

When to start giving extra foods?

Weaning food should be given to the baby at about the age of four to six months. At four months most babies start to need extra food in addition to breastmilk because they are growing fast and breastmilk is no longer enough.

How should weaning foods be given, and how often?

Start by giving one or two teaspoons a day of carefully mashed food in addition to regular breastfeeds. Do not use a feeding bottle. Slowly increase the number of meals and the amount of food given. By the age of eight months most babies need four "meals" a day including a variety of foods, in addition to regular breastfeeding. At one year old a child should be able to be given all types of family foods, although the food may still need to be softened or mashed. At this age a child needs to eat about half the daily amount of food its mother eats.

Feed babies using a clean cup and spoon. Do not add water to the weaning food. Watered-down weaning food does not have enough nutritional value, and if the water is dirty or contaminated the baby will probably get diarrhoea. Patience is needed when babies are first starting to eat family foods—while they are learning to eat this way they may often spit out the food—this does not mean that they are not hungry. Let the baby get used to one food for a few days before introducing another.

Weaning foods should ideally be:

- high in energy;
- easy to digest;
- low in bulk and viscosity (not too thick);
- fresh and clean;
- inexpensive and easy to prepare;
- not too highly seasoned.

What are good weaning foods?

A thick creamy porridge made from the basic food of the community is a good weaning food for babies. The basic food or staple is cheaper than most other foods and is usually eaten by the family at most

meals	Examples of basic foods incl
• cereals	— maize
	— wheat
	— sorghum
	— oats
	— barley
	— bread (soaked in g milk, or tea)
	— rice
• roots	— cassava
	— yam
	— cocoyam
	— potato
	— sweet potato
• starchy fruits	— plantain
	— breadfruit
	— banana



On their own, especially if cooked in water, most cereals, grain roots are too low in energy. Some fat (or sugar) should be added to the porridge to make it richer and easier to swallow and digest. Adding oil increases the energy value of the weaning porridge.

Give this porridge in addition to breastmilk for about two weeks—this time babies need other foods as well as breastmilk and porridge to provide enough energy and a balanced diet. It is important that weaning foods contain some oils, fats or sugars; fruits; dark green vegetables or orange or yellow fruits; food from animals or fish or from pulses (for example lentils). These different types of food provide energy, vitamins, and proteins. The best weaning meals should contain some from all of these groups. Continue to breastfeed regularly between meals



Child-to-child, Mwanthia

95

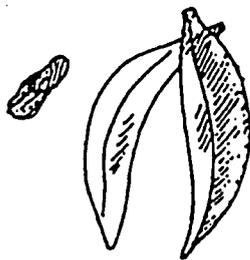
Examples of types of foods from these groups are:

• *Peas and beans*

These are as good as food from animals for providing protein but are cheaper. They need to be cooked thoroughly and mashed to make them easily digestible for babies. Examples include chickpeas, cowpeas, groundnuts, soya beans, split peas, lentils, blackeye beans, peanuts, red beans, navy beans.

• *Food from animals and fish*

These are good for babies but are usually more expensive than peas and beans. Examples include meat, fish, offal, eggs, milk, and food made from milk such as cheese and yoghurt, curd, cottage cheese.



• *dark green leafy vegetables, and orange and yellow vegetables and fruits*

Babies need these foods to prevent eye damage and possibly blindness from shortage of Vitamin A. Examples include: spinach, kale, tomatoes, carrots, amaranth, sweet cassava, pumpkin leaves, calalu, pumpkin and pawpaw.

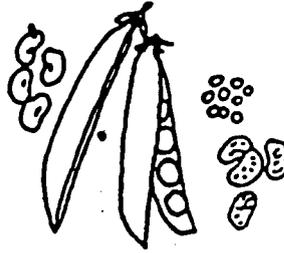
• *oils, fats or sugars*

These add extra energy to the weaning porridge or cereal dishes. Sugars are not as good as oils or fats and will also damage teeth. Examples include: corn, palm, groundnut, coconut and sunflower oils, ghee, butter, margarine, lard, any animal fat.

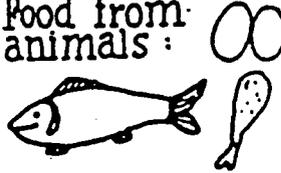
• *fruits*

Before giving these to babies they should be peeled carefully or washed in clean water, then mashed or the juice squeezed out. If water is added to the juice it must be clean; otherwise babies may get diarrhoea. Examples include: oranges, pumpkin, tomato, banana, papaya, mango, pineapple.

• *Peas and beans* :



• *Food from animals* :



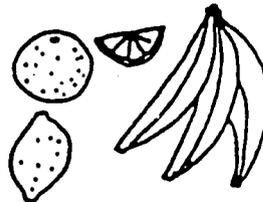
• *Dark green vegetables and orange and yellow fruits and vegetables* :



• *Oils and fats or sugars* :



• *Fruits* :



Acknowledgements

This Dialogue on Diarrhoea insert is based on an article by Dr Shanti Ghosh and material from:

- Learn More About Breastfeeding and Weaning. League of Red Cross and Red Crescent Societies 1987.
- Primary Health Care Technologies at Family and Community Levels. Aga Khan Foundation, UNICEF, WHO, 1986.
- Feeding Mother and Child. The Caribbean Food and Nutrition Institute.
- Prevention of Diarrhoea. Supervisory Skills. WHO, 1987.

The Economics of Breastfeeding

Many mothers appreciate the money saved by breastfeeding their babies, but consider how breastfeeding affects the broader economic picture. The National Committee on Improving Breastfeeding Promotion Strategies in the Women, Infants, and Children (WIC) Program, a project funded by the American Public Health Association, gives a hint of breastfeeding's economic impact in this statement:

It has been estimated that at least two and a half million dollars could be saved annually in formula costs if WIC mothers who do not breastfeed for just one month. (Extrapolated from the U.S. Department of Agriculture and State Agency Participation and Expenditure Summary Report—fiscal year 1987)

WIC is a supplementary feeding program created sixteen years ago to help reduce sickness and mortality among U.S. babies who fall into poverty. The United States Department of Agriculture gives WIC grants to states, which distribute vouchers for foods that help provide specific nutrients for pregnant women, nursing mothers, infants, and children up to age three. Infant formula is by far the most expensive item within the WIC food package—costs having risen over 100% during the last five years. WIC accounts for nearly 40% of infant formula purchased in the U.S. representing the single largest market for infant formula in the world.

In response to these figures, the American Academy of Pediatrics (AAP) issued a policy statement on the WIC program. The first of their eight points reads:

Breastfeeding should be aggressively promoted among WIC recipients because of its exceptional nutritional value and its savings to the program.

La Leche League joins the AAP in its aim and offers WIC its help through its peer educators and its Breastfeeding Peer Counselor Training Program, which began with a focus on minority women and offers nursing mothers classes on the basics of breastfeeding helping other mothers. WIC clinic personnel contribute to this program's effectiveness by referring experienced nursing mothers from minority communities for consideration as peer counselors. Once these mothers have completed their training, they then work with the WIC personnel to help increase the incidence and duration of breastfeeding in these communities. This mother-to-mother approach, which is funded by donations from foundations, grants and LLL members introduced a year ago in Chicago. It has since spread to Gary, Indiana, and four more programs are scheduled in Lansing, Michigan; Belleville, Illinois, and South Bend, Michigan City, Indiana.

La Leche League, Vol. 4

Readers letters

RECEIVED 10 MAY 1990

Sonnie Pharmacy And clinic
Njama - Kowq,
% The Catholic Mission,
Manso,
Sierra Leone.
18th March 1990.

Dear Sir,

I'm glad to inform you that Dialogue on Diarrhoea issue no. 38 of September 1989 that was posted to me was received on the 4th March 1990.

The introduction and use of oral rehydration solution and the methods as set out in the pamphlet posted to me by Professor Hong Hock Boon of Singapore in 1984 on rice water as rehydration fluid and means to control diarrhoea, I'm glad that the knowledge gained on oral rehydration solution and rice water as stated in the various Dialogue on Diarrhoea five to six years ago when I started getting this educative pamphlet while first in matters Jong via BO, has assisted me and the Community that I am now serving that deaths due to severe dehydration as before is difficult to see.

I being one of the many Druggists working in a small community village pharmacy and clinic in a rural area with no hospital facilities, can now hopefully manage and treat severe dehydrated patients.

with the use of locally made oral rehydration solution which is cheap and easy to afford rather paying attention as before to I.V. fluids that was thought by many people to be the only means to save life due to dehydration.

Please I wish to call your attention to sub no. 3934547 1 Patrick Johnny and sub no 3130030 Mr P. Johnny of Sonnie Pharmacy and clinic being the same person.

May I please conclude by extending my sincere thanks to members responsible for the production of this educative pamphlet (Dialogue on Diarrhoea)

Yours sincerely

Patrick Johnny (Druggist)

Readers

Diocesan Medical Board
PO Box 3044
Arusha Tanzania
18-4-90

RECEIVED 30 APR 1990

Dialogue on Diarrhoea
Ahrtag
1 London Bridge Street
LONDON SE 1 9SG UK

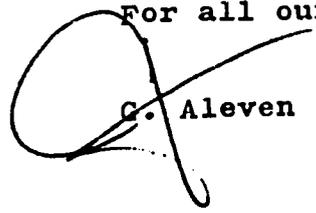
Re; Diarrhoea Dialogue

Regularly you are sending us copies 50 from your newsletter. They are sent to our health workers in the rural area's and the last 2 number~~s~~ we used at our workshop for health workers in March. I like to thank you for the lively way in which you are presenting the material, especailly knowledge about health education methods. It stimulates our staff.

This is just to tell you how we appreciate and make use of your newsletter

Thank you,

Sincerely
For all our health workers


G. Aleven

NTN/2.3/132/90

24 January 1990

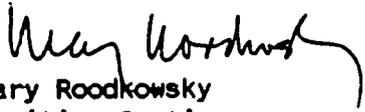
Dear Ms Attawell:

We received at UNICEF India Country Office, the June 1989 issue of "Dialogue on Diarrhoea" with the supplement "Health Basics; Breast Feeding". This supplement is quite impressive and we would like to order some extra copies which we could use in our work with the Voluntary Health Association of India, with the Bombay Municipal Corporation and other groups. Would it be possible for you to send me approximately 200 copies of this insert so that we could distribute it in that way.

Please let me know if there is any cost involved.

Many thanks.

Yours sincerely,


Mary Roodkowsky
Nutrition Section

Ms Kathy Attawell
Dialogue on Diarrhoea
AHRTAG
1 London Bridge Street
London SE1 9SG

MR:aj
letnut5
(103/166)

*MH -
plse
send
asap -
writing
letter*

*sent
3/10/90*

RECEIVED 31 JAN 1990

PC → (EE) 20/10/89

M/Engs.

Nabwalya Rural Health Centre
P/B NABWALYA
MPIKA.
ZAMBIA.

3rd OCTOBER, 1989.

RECEIVED 13 OCT 1989.

A. H. RTAG. LTD,
1 LONDON BRIDGE STREET
LONDON SE 1 9 SG

RECEIVED - 9 NOV 1989

Dear Sir,

I am glad to write to you on my intention to research on rural health especially here in this isolated area of Eastern Luangwa Valley.

As a holder of Certificate in Environmental Health and Hygiene, I have developed keen interest in their health and the things around which their health hangs:

Their nutritional status and the various factors affecting it. Their educational systems, Social and traditional systems, customs and all that come under it, and basically just now their health stands in their own environment bear essential dimensions.

This area (Luangwa Valley) is well known for its Wildlife species that it is for its inhabitants and there is more to it than people elsewhere look at.

I would like to be brought into contact with one who can help me to carry out a systematically sound research; this could be one at an institution of related field-studies. I have already started collecting useful data and information, which I strongly believe, should appear in book form so that many of my fellow health personnel and others outside of it should benefit from.

I await to here from you on the matter just presented.

Best regards.

Yours Sincerely



Andrew Tembo

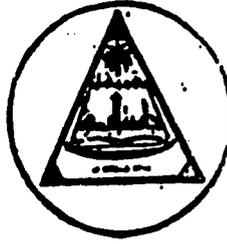
RECEIVED - 6 JUN 1990

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

BASRAH UNIVERSITY

College of Medicine

Department of Community Medicine



جامعة البصرة
عمادة كلية الطب
فرع طب المجتمع

No :

Date : 21st May 1990

الرقم :

التاريخ :

Dialogue on Diarrhoea

Appropriate Health Resources and Technologies Action Group "AHRTAG"

1 London Bridge Street

London SE19SG

U.K.

Dear sir

I am an assistant lecturer in the Department of Community Medicine in Basrah Medical College in Iraq . I was reading "Dialogue on Diarrhoea" issue 39, December 1989, page 3, when I came across an article outlines a series of ways to collect information about beliefs and behaviours , known as RAP "Rapid Assessment Procedures" applied to understanding of diarrhoeal diseases. In this article it was mentioned that there are different techniques for this "RAP" method" , and that the complete description of each technique is provided in the RAP field guide and other manuals .

I would be very grateful if you kindly provide me such guide and manuals to be used in my research and teaching activities in my department.

Thank you

Sincerely Yours

Ghada A.H.A. Al-Kadhimi

RECEIVED 25 MAR 1991

PELLA Family HEALTH CENT.

P. O. BOX 109, HONG

CONCORA STATE

NIGERIA

5/8/91

M. H. E. W. L.

The Editor

Dialogue on diarrhoea

AHRTAG

1 LONDON BRIDGE STREET

LONDON SE 1 9SG, UK

Dear Editor

WHAT IS THE BEST WAY TO PROMOTE THE USE OF O.R.T./SSC DURING DIARRHOEA?

In her effort to make health for all by the year 2000, the Nigeria government is trying her best to make O.R.T./SSC, despite all her efforts, of using Static Centres all over the dispensary/clinic which full O.R.T. trays, sugar, salt and sachet. Almost 2/3 of child health welfare clinic session (Health education) in a month is devoted to O.R.T./SSC through demonstration. Every time that comes to the dispensary, must be demonstrated how to prepare such substances and then explain the importance. The standard refer to measure of one level teaspoon of salt to four level teaspoon of sugar to boom of boil and cool water (clean) usually been used to. In beer bottle or 2 soft drinks bottles sachet is been given to them. It is usual to prepare such at home they usually want for home when directed by the physician or someone who is in consultation with to go to the O.R.T. unit. Mothers usually prefer anti diarrhoea drugs. About 80-90% of the mothers have the idea but still fear a great failure rate. The question put in mind is that what is salt/sugar water to do with diarrhoea, it is in regard of this only for mothers commented about it because they have said that child do not have the interest of taking it. It is very funny as our books they responded to wards it.

How can we make it then despite intensive mobilisation through media houses and other source of information

Best wishes
Mac. A. A. AMU HASSAN

Christian Reformed World Relief Committee

P.O. BOX 109
Ph: 04-2691

Corozal Town
Belize, C.A.

pc KBW

March 22, 1991

Ms. Kathy Attawell, editor
Dialogue on Diarrhoea
AHRTAG, 1 London Bridge Street
London SE1 9SG, UK

RECEIVED 12 APR 1991

Ms. Attawell,

I am writing in response to your "Discussion Point" article Worms and community health (Issue 43, December 1990). Unlike the group of health workers referred to in the article, if you ask our community health workers the causes of diarrhoea, they will almost certainly mention parasites.

Last year we learned that locally grown papaya can be used as an anthelmintic. We already had laboratory analysis to confirm that 70% of our population has parasites. So we decided to check out the effectiveness of the papaya.

In 3 villages we obtained stool for ova and parasites. The use of papaya was explained to those with positive stools. After treatment with papaya, repeat analysis for ova and parasites were obtained. The results (enclosed) showed a dramatic improvement. Furthermore, mothers need very little encouragement to use the papaya. As your article suggests, worms are a recognized problem in the communities. Villagers seem more ready to participate in other health education activities where this need is addressed.

If any more extensive studies have been done on the use of papaya as an anthelmintic we would certainly appreciate knowing about them. Also if you have any advice about frequency of treatment in the absence of laboratory analysis in children under age 6, that would be much appreciated.

Sincerely,

Debra Schout

Debra Schout
Health Educator

DS/lg

Comite De Desarrollo y Ayuda De La Iglesia Cristiana Reformada

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ORAL REHYDRATION UNIT
General Hospital
Port of Spain
Trinidad

November 19, 1990

Dear Sir,

At the above unit we are celebrating ten (10) years of controlling diarrhoeal disease by the use of Oral Rehydration Therapy. It is interesting to know that this coincides with the ten years of publication of Dialogue on Diarrhoea. We have benefited a great deal from information in various issues especially those that dealt with :-

- Diet during and after ORT - the fact that cultural aspects must be considered
- Breast feeding
- Solutions used in various countries
- Health Education Programmes
- Diarrhoea and Aids
- Vitamin A and Diarrhoea
- Making it work
- The Show and Tell Competition in which we participated

Most important to us was **HEALTH BASICS ORAL REHYDRATION THERAPY** - which helped us a lot in our teaching session to parents, student nurses and other health personnel.

We have felt the warmth that came as a result of a coming together of ideas and information, which manifested a caring and a sharing aimed at bringing about better health for the children of the universe. We have also sensed the great effort of the publishers to keep publications on stream and very informative and available to every health worker. We are satisfied.

At our Unit we have had our measure of success. When we started ten years ago we encountered similar problems to those experienced by other countries, especially getting parents and doctors to accept this type of treatment.

We have overcome all of our problems and we have a success rate of ninety-five percent (95%). Despite our economic problems and the exodus of health workers to greener pastures, we have been able to keep our mortality and morbidity rate way below that of periods before this type of treatment was introduced. We base our success on health education programmes carried out at the Unit, Health Centres and mass-media production. Fifty-nine per cent (59%) of our children had appropriate fluids at home before coming to the Unit for follow-up treatment.

Along with this letter we submit statistics on our mortality rate at our hospital's diarrhoeal ward in five-yearly periods. Also some statistics at our Oral Rehydration Unit.

I wish the publishers, participants and readers another successful decade.

Supis
.....

105

p/c RE/WC ✓

PPG /

reader's viewpoint ?

Neil - this was attached

to a questionnaire - but
may be of interest
to publish?

15 3 91

Dr. Neil Heard,
Box 23803
Claremont 7735
South Africa.

Dialogue on Diarrhoea.

Drugs and Childhood Diarrhoea (issue 42 DD)

The misuse of antibiotics in acute infantile diarrhoea is a problem. I am sure that most doctors know that 95% of acute infantile diarrhoea can be treated with ORT alone, yet in over 50% of cases they prescribe an antibiotic and/or adsorbents and anti-motility drugs. I would like to contribute my observation.

Many hospitals where doctors are trained, do not teach outpatient child care, and so medical students rarely see acute diarrhoea. There are several thousand admissions per month to oral rehydration units, but students cannot bank on teaching exposure even after admission, unless the disease becomes protracted. University teaching staff are giving students insight into academic ward paediatrics, of little relevance to their working lives, but not to day to day problems such as acute diarrhoea. This may be because of the way these teachers were trained as postgraduates. Drug industry advertisements for medicines such as loperamide, supported by local trials may confuse a coordinated strategy to promote the use of home based ORT.

Some oral rehydration units accepting up to 4000 patients per month give mothers a pink fluid, to feed their infants in hospital, and on discharge a silver packet of magic mystery powder to be mixed with a litre of clean water at home. Hospitals are teaching patients to expect proprietary treatment for acute infantile diarrhoea. Patient empowerment is not a priority in teaching hospitals even in Africa.

Thus doctors will not prescribe home based ORT alone and patients will not accept it. The State policy for privatisation of health services in South Africa, means that most of patients attend fast turnover practices or the deliberately inadequate state services. Antibiotics, adsorbents and antimotility drugs are an alternative to adequate care, by rushed staff, working with inadequate facilities which they cannot change, and who may lack a broad perspective on acute infantile diarrhoea because of the circumstances of their teaching. Changes needed to support a move away from this approach include a political lobby for a national health service, changes in medical school attitudes to outpatient child care, and programmes at all levels to empower patients. Mothers should be mixing their own ORT from salt and sugar in hospital and at home.

Neil Heard.

Neil Heard

Dialogue on Diarrhoea



DP45

JUNE 1991

AHRTAG

The Appropriate Health
Resources and
Technologies Action Group

WEEK	DATE	
-10	28/12/90	Articles commissioned (ME, SE, AE) Discuss plans & information requirements with RC
-4	8/2/91	Reminders for commissioned articles (if no reply received), and to RC (AE)
0	8/3/91	Deadline for submission of commissioned articles (and material from RC)
2	22/3/91	Draft copy ready (articles edited; news, letters, inserts, other in-house material prepared) and sent to SE, WHO, AID (DD only) for comment (AE&ME). Illustration needs discussed - AE & PD
4	5/4/91	Deadline for comments
5	12/4/91	All comments incorporated, text marked up by PD & available as galley proofs (either from BO, or DTP)
7	26/4/91	Proofs checked by SE, AE & ME; pictures gathered by KM & agreed by AE & ME; captions written by AE & agreed by ME; layout done by PD (to be sent to BO, or for DTP)
9	10/5/91	Page proofs, including all pictures, from printers & sent to SE (& Technical Editors if ARI) for OK
10	17/5/91	OK from SE; proofs checked by AE & ME
11	29/5/91	Any changes to page proofs incorporated by printers
12		Colour proofs to be received by AHRTAG & agreed by PD
13	7/6/91	Address labels printed at AHRTAG & sent to printers
14	14/6/91	Printing & delivery to AHRTAG.

ME - Managing Editor
 AE - Assistant Editor
 RC - AHRTAG Resource Centre Staff
 SE - Scientific Editors (KE & WC/DD) or Editor-in-Chief (FS/ARI)
 PD - Production & Design Worker
 PS - Publications Secretary

The international newsletter on the control of diarrhoeal diseases

Published by AHRTAG, 1 London Bridge Street, London SE1 9SG, U.K. Tel: 01-378 1403 Telex: 912881 TX G Fax: 01-403 6003

Comparative Costs of Publication and Distribution
of DD English, 1987-88, and 1990-91

1987-88

Issue Published	DD30 Sep 87	DD31 Dec 87	DD32 March 88	DD33 June 88
Direct Costs				

Printing	9880	9950	9877	12701
Distribution	16437	16162	16627	14993
Other	4163	3888	4930	6220
Sub Total	30480	30000	31434	33914
Salaries	9696	9143	9102	6424
Overheads	9214	9488	9130	7433
TOTAL	49390	48631	49666	47771
No of issues	115000	120000	115000	115000
Costs per issue (£)	0.43	0.41	0.43	0.42
Costs per issue (£) in 1990/91 prices	0.53	0.50	0.53	0.51

1990-91

Issue Published	DD41 June 90	DD42 Sep 90	DD43 Dec 90	DD44 March 91
Direct Costs				

Printing	15044	11601	8881	10828
Distribution	16969	11701	8921	10800
Other	4633	6089	4400	4350
Sub Total	36646	29391	22202	25978
Salaries	9035	9633	8917	8917
Overheads	8034	9934	6749	6749
TOTAL	53715	48958	37868	41644
No of issues	116000	114000	112500	108800
Costs per issue (£)	0.46	0.43	0.34	0.38

Notes

- In the period covered by DD42 £3371 extra was spent on laser printer
- The overheads cost for DD42 includes £2789 contribution to the new computer network

**REPORT OF MEETING WITH SOUTH ASIA
DIALOGUE ON DIARRHOEA
AND ARI NEWS
PROJECT PARTNERS**

January 7-9 1991

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1. AIMS AND OBJECTIVES

The meeting had four key aims:

1.1 To ascertain how AHRTAG can support decentralised production of newsletters and related health materials in future. For example:

- assisting with identifying funders and collaborating on approaches for longer term support
- training and technical support in publications and information activities
- provision of information updates on specific issues relating to a range of PHC issues

1.2 To encourage project partners to network with each other and explore mechanisms for achieving this; provide a forum for the exchange of information and experiences in the production of the Dialogue and other materials; and establish a network for exchange of information on regional issues and activities.

1.3 To look at key issues relating to the translation of, adaptation, production and distribution of newsletters, including technical, policy and planning issues, quality control, content, feedback and evaluation, distribution and monitoring.

1.4 To review the current materials produced by AHRTAG and reproduced or translated by project partners; and to discuss the future direction of these publications so that they best meet the needs of readers in South Asia.

2. PARTICIPANTS

The meeting was attended by representatives of:

- Bangla edition - Bangladesh Rural Advancement Committee (BRAC), Dhaka, Bangladesh
- Bangla edition - Child in Need Institute (CINI), Calcutta, West Bengal, India
- Nepali edition - Health Learning Materials Centre, Kathmandu, Nepal
- English edition - Christian Medical Association of India, (CMAI), New Delhi, India
- English edition - Imajics (Pvt) Ltd, Karachi, Pakistan
- Tamil edition - Rural Unit for Health and Social Affairs, (RUHSA), Vellore, India
- English edition (ARI News) - Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahmedabad, India

3. ORGANISATIONAL PROFILES: CURRENT ACTIVITIES AND FUTURE PRIORITIES

3.1 Bangladesh Rural Advancement Committee

BRAC was initiated in response to relief and emergency situations in Bangladesh. It has 4,500 registered staff (115 at head office) and 3,000 volunteers. It has since developed a programme of activities which aims to promote empowerment and self reliance. These programmes are: rural development, including income generation and credit; non-formal primary education, including literacy and numeracy for 8-10 year olds and 11-16 year olds and skills which can be applied in work in health programmes (mostly females); and women's health and development (building on the OTEP programme which began in 1980). BRAC works through men's and women's groups; mosques; village health committees; which are independent from BRAC, but which create demand for health services from government.

BRAC produces publications including an in-house newsletter in Bangla, a newsletter produced as reading material for schools, and occasional materials on health issues such as nutrition, EPI, vitamin A. The organisation has begun to focus more on publishing materials - early on the primary focus was on field work - as they have realised that there is little relevant training material available.

BRAC started to work with AHRTAG in 1988, producing occasional composite editions of a newsletter based on material selected for Bangladesh and West Bengal from DD and ARI News. It has not been possible to produce regular editions because there have been considerable difficulties in getting government registration for the publication. Without registration, postage costs are considerably higher. 40,000 copies of each issue have been produced, 10,000 of which have been distributed in West Bengal by the Child in Need Institute. In Bangladesh copies are distributed to primary schools, rural libraries, non government organisations, physicians, health centres and through the voluntary health services society of Bangladesh, an umbrella group.

Since DD/ARI News is the only practical health newsletter published in Bangla, BRAC would like to continue to publish and distribute it in whatever future form it takes. BRAC appreciates receiving material that is already prepared and reviewed and that it cannot produce the same calibre of material easily in-house. AHRTAG's newsletter(s) will continue to provide a useful source or base for a Bangla health publication.

3.2 Child in Need Institute

The Child in Need Institute was established in 1974, and began as a health organisation focusing on MCH issues in Calcutta. Now working in 50 villages, CINI has 200 staff, and has recently diversified its activities to include income generating activities with women and women's groups, as well as promoting

women's health and rights. CINI also carries out training activities including training health workers for government and voluntary agencies, and applied health research for CINI and outside agencies. More recently CINI has begun to work on urban health issues, including working with street children.

CINI supports its health activities through publications, largely training support materials, and a newsletter called 'Our Children' distributed throughout Bengal. A newsletter based on the experiences of women's groups in Bengal is due to be published in 1991.

CINI has been distributing the Bangla edition of the composite newsletters in West Bengal; it has a large network of government and non government organisations which makes this possible. In future they would like to collaborate more with BRAC in producing locally relevant materials to insert in the newsletter, to enhance feedback from West Bengal, and to ensure that the target audience in Bengal and Bangladesh is the same.

For the future, CINI is considering ways in which it can provide further support to health workers, through a more systematic approach to producing publications and the establishment of a resource centre. These would help to coordinate the technical and communications activities of CINI.

3.3 Health Learning Materials Centre

Dr Adikhari is based at the Institute of Medicine in the University, and at the training centre. The lack of basic books and materials for health workers led to an expressed need for a health learning materials programme in Nepal. The programme was established in 1984, and started by carrying out a needs and resources survey, including visits to health posts. Most of the posts had only one book 'Where there is no doctor'. This however was not used by the doctors who felt that it was below them, but not passed on to non-physician staff either. The programme started by producing basic printed materials; by 1989 the project had become the health learning materials centre, as part of the university, regularly producing materials. The centre collaborates with the health learning materials centres and programmes in Burma, Thailand, Sri Lanka and Indonesia.

The mandate of the centre is to produce materials for support of training of primary health care workers. The centre currently produces a HLM network newsletter, a PHC newsletter and a combined version of DD and ARI News. All are distributed free of charge.

The edition of DD/ARI News is funded through the CDD programme by UNICEF. Since the beginning of 1990 10,000 copies each of three issues have been produced, and distributed to health workers, primary school teachers, environmental workers, voluntary health agencies and the small farmers development programme. 5,000 copies are sent out through the Ministry of Education and Culture, 800 copies through the Ministry of Health to health post

workers, 800 directly to health workers.

A major problem is the lack of staff dedicated to publications; most HLMC staff are already working fulltime in other jobs. This creates problems, for example, there is no time to go into the field to properly assess the usage of publications, or to assess information needs or solicit contributions.

3.4 Christian Medical Association of India

The Christian Medical Association of India is 80 years old and was initially set up to assist hospitals. It has 350 institutional members which form a network, and provides a wide range of medical training, including training for paramedics and a well respected nursing diploma. CMAI also produces materials including textbooks on health care and books specifically for small hospitals. It has a publications section which produces and distributes its own materials as well as distributing AHRTAG publications.

CMAI prints and distributes 30,000 copies of Dialogue on Diarrhoea, plus its own insert focusing on various PHC issues. Copies are distributed to CMAI member institutions, through the Catholic Hospital Association of India (2,000), through the Voluntary Health Association of India (2,000), to 3,000 PHC centres, 350 schools of nursing, 300 medical colleges and the remainder to individuals. A key priority is to update the mailing list, followup feedback to the readership questionnaire, and improve the management, planning and organisation of the publications and distribution departments of CMAI.

CMAI is planning to increase its publishing activities, which already includes the Christian Medical Journal of India, the insert to DD on PHC and another newsletter, to include the regular publication in future of a newsletter on essential drugs for its hospital network, for which it has funding available. CMAI's preference would be to produce one PHC newsletter relevant to India, based on material from AHRTAG and including material from other sources about Indian issues, that is for doctors and other health professionals, in English which is practical, and written in accessible language.

3.5 Imajics (Pvt) Ltd

Given Pakistan's appalling health situation and poor health services infrastructure, Imajics was started to provide information about health development in a more imaginative and effective way than existing NGOs. Imajics produces the monthly magazine 'National Health', established in 1983, which has a commitment to raising awareness of the problems of the health system and to improving it. Initially intended to reach all literates in Pakistan it still largely reaches physicians and related professions, international agencies and NGOs. 5,000 copies are distributed every month.

The English version of DD, reprinted in Pakistan, has a mailing list of 25,000. 2,000 copies are sent to health related NGOs, 1,000 to donor agencies and the Ministry of Health, 2,000 to diarrhoea training units, 50 to PRITECH, the remainder to individual GPs, paediatricians, medical colleges, libraries, schools of nursing etc. There is an editorial board, which contributes to and comments on pages produced with a specific focus on Pakistan related issues.

A regular four page Urdu insert in DD, with UNICEF funding is planned from January 1991. There is also a need to review and improve the readership profile, including analysing the mailing list, finding out more about the needs of the current readers and assessing whether or not there is a need to produce material for and reach more community health workers, teachers etc.

Future priorities include changing National Health from a monthly magazine currently supported by advertisements, to a quarterly publication without ads, hopefully with Canadian support, focusing on PHC. This could use material from a new look DD. There is also a need to produce regular material on essential drugs to counteract the overprescribing in Pakistan and levels of self-medication. It is also planned that the work of Imajics will be used as a training centre for journalists as there is a lack of good journalistic training in Pakistan. Other possibilities being considered include establishing a family planning communications network as part of broader focus on women's health and family planning issues.

3.6 Rural Unit for Health and Social Affairs

RUHSA is part of the Christian Medical College in Vellore, which has an emphasis on training and manpower development; PHC and programme evaluation, as well as publications. RUHSA has more recently broadened its focus from scientific/research activities to include more work in health education. RUHSA runs a wide range of primary health care programmes and health services.

The Tamil edition was begun in 1986; 9 issues have been produced and the mailing list has increased to 50,000 from the original 10,000. Copies are well distributed and the channels include the library system which is well established in Tamil Nadu. Feedback is excellent and the Tamil edition is greatly appreciated. In terms of future work it might be useful to ask questions about the type of impact we can expect to achieve with a newsletter, and to review the key messages which we are trying to get across.

Possibilities for reaching new audiences with composite editions could also be considered.

3.7 Centre for Health Education, Training and Nutrition Awareness

CHETNA is now ten years old and has recently evaluated its activities. The organisation started as a support to nutrition programmes, with a primary focus

on training activities. It is now working in Rajasthan as well as in Gujarat, providing informal and participative training to TBAs, teachers as well as health workers, with the emphasis on communications skills rather than on basic health facts.

CHETNA also became aware of the lack of materials in local languages and started to produce materials in Gujarati and Hindi, as well as collecting materials on topics identified on the basis of requests from health workers. The needs of grass roots government and non-government health workers were assessed, the conclusion being that there was a need for simple material in local languages with appropriate illustrations to ensure that messages are understood. CHETNA also produces a newsletter in English about its activities, and translates and adapts VHAI's health workers newsletter into Gujarati (10,000 copies). Since VHAI is producing materials in Hindi, CHETNA is focusing on Gujarati. CHETNA also produces materials for other organisations.

CHETNA is also planning to develop a resource centre with a focus on children's and women's health.

More recently CHETNA has changed the focus of materials produced towards trainers rather than grass roots health workers. ARI News has therefore been a useful vehicle for CHETNA to establish links with doctors and other trainers of health workers, and has enhanced the work of CHETNA in educating doctors so that they do not undermine the community workers.

In 1989-1990 CHETNA produced 10,000 each of four issues of ARI News in English, and is under contract to UNICEF to produce four more issues. It has been a useful experience for CHETNA, enabling it to build up both its profile and mailing list among doctors; so far they have built up a mailing list of 7,000 and are approaching directorates of health for additional names and addresses - so far they have received 369 returns out of 3,000. The recently held Ahmedabad conference of physicians was also used to build up the mailing list. The audience for ARI News in English consist largely of physicians and postgraduates, or health workers with a high level of education.

In future CHETNA plans to focus on vernacular materials rather than English, and suggests that an AHRTAG newsletter on health issues in English should be managed by CMAI. CHETNA would be very interested in producing a vernacular, adapted version of a practical AHRTAG newsletter to meet the needs of community health workers.

4. PRACTICAL ISSUES AND PROBLEMS

4.1 Government

All project partners shared problems, to different degrees with government and bureaucracy. In Bangladesh there have been considerable holdups because of the time it has taken to register the publication. Government permission is often very slow in coming and this causes problems with obtaining paper for printing, cheaper postal rates etc. The Indian government has recently introduced new regulations preventing NGOs from accepting external funds for publications; this means that both CMAI and RUHSA will need to establish separate subsidiary publications organisations.

4.2 Distribution and mailing lists

Distribution, particularly methods of distribution and the actual mechanics of distributing such a large number of copies through the postal system and other channels, was also a common concern. Partners all gave examples of problems of getting such a large number of copies to post offices (hiring a van etc), making sure that they are stamped by the post office, the unreliability of return mail and of the postal services in general, the time which it takes for copies to be distributed through the postal system - in Nepal exacerbated by difficult terrain, since 35% of the country is under snow most of the time and 41% is extremely mountainous; many health posts in Nepal are 5-6 days walk away.

There was also concern about the length of time taken to distribute through other channels, and about the reliability of ministries and other agencies used for distribution. In Nepal it was discovered that the Ministry of Education was not distributing effectively; copies are now sent using a direct express service which is better but more expensive. RUHSA has been using local people to distribute some copies, to speed up distribution and as part of income generating activities.

These problems also raised concerns about whether the newsletters are reaching their intended audience, and methods which might be used to monitor this.

Various issues were raised relating to the mailing lists. These included the difficulty of maintaining and keeping up to date such large lists; rationalising the lists and when and how to take off those who no longer want or use the newsletters. CMAI, for example, has a mailing list of over 20,000 for DD in India. They have started to remove from the list those readers who did not reply to a recent readership survey.

4.3 Donors, cost recovery and sustainability

Partners expressed concern about longer term funding to sustain the publishing and distribution of free materials.

Most felt that funding from local or national donors might be possible, to help reduce dependence on AHRTAG, and CMAI, for example, has already set itself a target of raising 70% of funding overall from within India. Similarly RUHSA has obtained additional funding from UNICEF South India for 25,000 extra copies of the Tamil edition, and is confident that 100% of funding for DD could be secured within India, from DANIDA, TINP (World Bank) and UNICEF. CHETNA and HLMC currently receive funding for their AHRTAG activities from UNICEF in Delhi and Kathmandu respectively; there was some concern about the length of time for which donors would continue to commit themselves to support for the newsletters.

In Pakistan there have been considerable delays in obtaining commitment from both UNICEF and USAID to fund the Urdu/English edition of the Dialogue.

In general uncertainty about future donor priorities and delays in the administration of grants created difficulties for future planning. Unexpected or unanticipated increases in costs, of printing, distribution, paper also cause some difficulties.

There was some discussion about the issue of free material versus material which is paid for by recipients. Some felt that free material was less appreciated by readers; others that most of the readers would not be able to pay. It was generally felt that charging readers a subscription fee was not feasible for various reasons - most readers would not be able to afford the fee, or will not pay or will forget to pay, and the costs and time involved in administering such a system would make it not worthwhile, as well as placing a heavy burden on the organisations producing the newsletters.

The cost of sending out copies to individuals was also raised. Although this is more expensive than distribution in bulk through other channels, it was felt that it is often the most effective way of ensuring that copies reach the readers.

4.4 Target audience

Partners also raised issues relating to the audience for the newsletters, in particular how we can be sure about who they are, whether they really want and use the newsletters, how they use them and how we can measure their impact on the readers. It was agreed that it would be useful to try to develop guidelines for monitoring and keeping abreast of the information needs of the readership.

The target audience also varies from one country to another and depends on the language; for example in Pakistan the primary audience (for the English edition) is physicians, whereas for the Bangla edition it is primarily community health workers, primary school teachers etc.

4.5 Feedback

Feedback when it is received is good and positive. A major problem is encouraging feedback; it is difficult to get readers to write in with comments other than positive comments. It is also difficult to assess what is happening at the periphery. Most letters received by partners are mailing list requests. Similarly, it is difficult to get readers to respond to questionnaires. This again makes it hard to assess whether or not DD is read or used and how.

The Tamil edition receives the most feedback; many readers have written asking to contribute to the newsletter.

4.6 Lack of a reading culture

Although health workers express the need for information, CINI for example is unsure about whether they use it; CINI has tried to produce various newsletters but has been unable to sustain them. A need to develop better ways of measuring whether or not material is used has been identified; people rarely respond to written surveys. The lack of material in vernacular languages also creates problems in inculcating a reading culture.

In Nepal, even doctors will not always read material that is sent to them.

4.7 Adaptation, production and printing

There has been varying success with editorial committees, reading and review teams etc. Regular liaison with such groups has not proved to be easy and is very time-consuming. With the Tamil edition, for example, the reading team, which consists of a doctor, nurse, health educator, health aide and two community organisers who check the language level, has met regularly and successfully; the editorial committee has not yet met for various reasons.

In Pakistan there have also been difficulties in arranging meetings which all the editorial board members can attend. Feedback from editorial advisors is also not always forthcoming.

Most partners had experienced some difficulties with printers, including unreliability, unexpected increases in prices, errors or less than perfect work. Most have used different printers to try to improve the quality of the newsletters and service.

In some countries there is a problem with obtaining appropriate local illustrative materials, including drawings and photographs.

Some groups, such as RUHSA, are planning to move towards using DTP programmes to produce materials to save costs.

5. HEALTH INFORMATION NEEDS - ROLE OF THE DIALOGUE AND ARI NEWS

5.1 Lack of resources and information

There was agreed to be a general dearth of good, well researched, practical and accessible health information, in spite of the amount of material that is produced especially in India. There is also a serious lack of information available in the vernacular languages for community health workers who do not read English. CINI, for example, has a large library, but very little material is available in Bangla. They are currently considering the possibility of establishing a more relevant resource centre.

It was agreed that there is a need for more information on local issues, and more practically focused information for health workers at community or health post level.

5.2 Vernacular versus English material

This was a key issue during the discussion. It was generally agreed that material for community and health post workers needs to be available in the vernacular. Professionals already have access to a reasonable range of material in English. Health workers, for example, in West Bengal and Bangladesh require information in Bangla; those in Nepal in Nepali, and in India it was felt that outside the large metropolitan areas many PHC centre doctors did not always have a good understanding of English. It was suggested that material produced by AHRTAG in English should also be adapted and translated into for example Gujarati (CHETNA) and Hindi (VHAI).

In addition to translation, adaptation is also needed to ensure that the information is appropriate to the needs of community workers; a literal translation can cause difficulties. It was also felt that vernacular material can only be produced at the local level, and that only those working directly with communities and community health workers can assess their information needs.

Given the problem in many places of a lack of reading culture, it was agreed that it would be preferable for community workers to receive one publication in the local language, covering a range of issues, rather than several single focus subject focused publications - they would be unlikely to read more than one publication.

The English version of the newsletter was felt to be most appropriate for physicians, those working in training institutions, and others with a fairly high level of education. In some places doctors prefer material in English, if that is the language in which they have been trained. In addition, material in English that is international in focus plays an important role in preventing doctors from undermining community health workers, if it carries the same messages as CHW

material in the vernacular. It was also felt that publications like DD and ARI News play an important role in educating physicians in the sub-continent where there is not a culture of continuing education and doctors do not take the time to update themselves - many receive most of their information from drug company representatives, unless they are in a teaching or training environment.

Therefore the publication of material in English at one level and material in the vernacular at another is complementary. The balance between the two will vary, depending on the country and the level of health worker. In Tamil Nadu, for example, there is a much greater need for material in Tamil than in English at all levels.

5.3 The role of AHRTAG and AHRTAG's newsletters

Newsletters published by AHRTAG are important sources of information for a variety of reasons. They have credibility and authority because they have been through peer review; they have a particular style and approach; they are also often the only outside source of up to date information received by readers. They can counteract the information supplied by drug companies to physicians, and provide a useful basis for training. Although there is a limit to which lower level health workers can utilise the newsletters, written material that is internationally produced has greater credibility.

In addition, AHRTAG has access to wider sources of information and technical input than is possible for most organisations in developing countries, including those in the sub-continent.

It was universally agreed that there is a continuing need for material produced in English by AHRTAG on health issues; as a basis for local or regional English and/or vernacular editions. Problems such as diarrhoeal diseases and ARI are not going to disappear for a long time; the basic messages are still valid. AHRTAG's partners can assess what would be most appropriate to the local or national situation.

The question of possible overlap with other nationally produced publications and materials was discussed. There is, for example, a great deal of material on health produced in India. It was felt, however, that there is no overlap because it is mostly India focused, rather than international, and not always of good quality. There is far less material available in other countries in the region, so again there is no problem of duplication.

AHRTAG can also play a role in providing advice and technical support relating to project management; staffing; training; increasing organisational capacity; writing, editing and producing materials; assistance with fundraising.

5.4 Issues of adaptation

As previously agreed, if material is to be translated, it also needs to be adapted, to a greater or larger extent, depending on the article and subject matter. Some of the material contained in the newsletters is too complicated for community health personnel, and concepts need to be explained more simply. This, however, needs careful consideration, if the advantages of credibility, peer review and approach are not to be lost. It is important to maintain the message, authority and approach of DD and ARI News.

Participants felt that they should be allowed to take responsibility for adaptation, since they understand the needs of their audience and are aware of which issues are important. AHRTAG has chosen to work with groups with expertise in health issues and in education for this reason. Partner organisations are aware that they have a responsibility in this area, that they have to maintain certain standards and that they are accountable both to AHRTAG and to their readers. As partners they accept this responsibility and feel that the key issue in the relationship with AHRTAG is that of equal partnership.

Adaptation of illustrations; inclusion of local or national news items and articles; and local correspondence was agreed not to be a problem.

5.5 Content and subject focus

Addition of material on other subjects was believed to be important; the Bangla edition, for example, also contains other messages on other issues apart from diarrhoeal diseases and ARI necessary for health workers, such as breastfeeding, safe water etc.

Participants felt very strongly that vertical programmes have been extremely detrimental to health programmes and services; in south Asia the vast majority of health workers do not just work on one area. For doctors it is reasonable to receive several single subject publications; for other health workers one publication with a broader focus would be more appropriate.

The stated preference of all partners was that rather than producing Indian or Nepali versions of two or more AHRTAG newsletters, it would be more rational and more useful to produce a Dialogue that combines material on a range of issues. There was strong opposition to producing a newsletter on maternal and child health; women's health needs to be covered in its own right not in relation to children and childbirth. There was concern about the issue of funding and single focus publications: currently it may be easier to raise funds for a publication specifically about essential drugs, or safe motherhood, next year it may be something else.

Mostly, however, in spite of changing donor priorities, the fundamental health problems and issues remain the same, and there is a need to consistently promote messages about diarrhoea, breastfeeding and so on for a prolonged period of time.

One suggestion was to start by continuing the DD style of practical inserts, focusing on specific subjects, such as goitre, anaemia, women's health etc to raise readers' awareness of and introduce these issues, and to gradually incorporate a range of topics into the newsletter. In this way the credibility and recognition of AHRTAG's newsletters could be used to raise awareness of other health issues.

There was some debate about whether DD/ARI News need to contain basic messages. Some participants felt that they were able to produce simple messages themselves, and that experiential information would be more useful. However, it was agreed that for most readers who do not have regular access to medical information the basic messages are important, and many organisations do not have the capacity or access to researching and compiling basic information. There are also considerable advantages in repeating basic messages.

6. RECOMMENDATIONS AND CONCLUSIONS

6.1 Distribution and mailing lists

- There is a need to develop better systems for maintaining and updating mailing lists, including methods to assess whether or not copies are reaching their intended audience and whether or not they are being used. Regular insertion of reply cards, or readership surveys could be used. However, given the often poor response to written surveys, some face to face assessment would also be necessary.
- Analysis of mailing lists and better information about readership profile is also a priority area.
- Regular monitoring of the effectiveness of distribution through channels other than the postal system would also be useful.
- Exploration of other informal channels for distribution is also suggested, for example, in Bangladesh street hawkers are used for delivery in place of the postal system in some places.

6.2 Feedback and evaluation

- Local editions of AHRTAG publications need to try to increase feedback from readers in different ways. Increasing the coverage of local/national issues is one way to encourage greater feedback. The use of incentives, competitions etc could also be considered. Where possible, the most effective feedback is obtained from personal interaction. Ways should be found to encourage this and to enable partner organisations to meet readers, and carry out field visits more regularly. Developing guidelines for

feedback and evaluation would be helpful, including more specific requests to readers on particular issues or articles rather than general comments, for example.

- Innovative and different methods of carrying out surveys of readers needs are required; written questionnaires do not provide a good response.
- Evaluation also needs to involve more face to face discussions; but not until partner organisations have consolidated areas such as mailing lists, understanding of readership profiles, regular funding and publications schedules. Some have carried out readership surveys with mixed results; the response to the ARI News survey in India was 30% which is extremely high; RUHSA receives an increasing number of letters relating to the Tamil edition. A strategy for regular monitoring and evaluation of other language and English editions needs to be developed in future.
- It was agreed that measuring the impact of the newsletters is not possible, since they are one of several possible influences. It was recommended that realistic criteria and indicators be developed for measuring the impact of publications on practices; including establishing realistic goals in the first place.

6.3 Future direction of publications

- AHRTAG's role in producing health education materials is a valuable one; publications such as DD and ARI News have an important role in continuing education for health professionals and as a basis for vernacular newsletters which are more or less adapted, depending on the audience.
- AHRTAG material has credibility and authority, and the advantage of high level peer review; in addition AHRTAG is in a unique position to collect material and information through its international network and extensive links with sources of expertise.
- AHRTAG should continue to produce material on health issues using the same approach and style, which is authoritative and well-researched, but covering a wider range of subject matter than diarrhoeal diseases and acute respiratory infections, and which can be used by partner organisations, either reproducing in full, or adapting and translating, or incorporating into their own vernacular publications. It was stressed that DD/ARI News should not compromise their unique scientific/practical approach, but should use their credibility and authority to bring other health issues to the attention of readers.
- Partner organisations suggested that the international focus be truly international, and not focus only on issues relating to countries in the South - approaches to health should be universal.

6.4 Adaptation, production and printing

- Guidelines for adaptation should be clearly defined, if a local English version of the newsletter is produced, based mainly on an AHRTAG London produced newsletter.
- Guidelines for vernacular adapted versions of AHRTAG material should be more flexible, given the greater need to adapt language, layout and design to meet the needs of community health workers. Project partners are better able to assess the information needs of their constituents, and should have the flexibility to select material which is most appropriate for readers in Bangladesh, Nepal etc. Partners recognise that they have a responsibility to maintain high standards, and are accountable to AHRTAG and to their readers.
- If local or national material and information are added to the newsletter, it should be differentiated and the source should be clear, so that it is clear where the responsibility for a particular article lies, ie with the partner organisation or with AHRTAG.
- Consideration could be given by some partner organisations to greater use of DTP and other technologies to save time and reduce costs.

6.5 Collaboration with and support to project partners

All participants saw the relationship between AHRTAG and their organisations as mutually beneficial; providing credibility and support to the partner organisations and a network of national NGO partners to AHRTAG. AHRTAG is perceived as an enabling agency, providing resources, technical support and important information, rather than as a donor agency.

- Collaboration between AHRTAG and newsletter (and resource centre) project partners could be increased, including a more collaborative approach to planning future activities and issues.
- This was the first meeting between AHRTAG and its project partners in the region, and the first time that partner organisations had been given a formal opportunity to provide feedback. It was suggested that mechanisms be set up to allow for more regular communication and feedback in future, possibly including: future meetings, perhaps every two years; inclusion of partner organisations on the editorial board or on an occasional basis, to provide input into issue planning and material for inclusion in future issues; as well as once or twice yearly updates on specific areas such as resource materials, new developments in printing technologies.

- If AHRTAG changes the focus of the newsletter, more regular contact and dialogue with partner organisations is recommended, to ensure commonality of purpose and intent; and assist with maintaining technical quality and standard principles. Such involvement is important so that partners know what it is that they will be adapting or translating.
- AHRTAG can also help to provide a link between the project partners themselves. The establishment of a network was not felt to be necessary; most are already part of various networks nationally and regionally eg VHAI, SAARC, and are already finding it difficult to provide regular input into all the existing networks. The newsletter(s) could help to keep partner organisations informed about the activities of their counterparts in other parts of the region, as well as the activities of AHRTAG's project partners in other regions.
- Collaboration in funding was also recommended, between partner organisations themselves and between partners and AHRTAG. For example, information sharing on donors, joint approaches to donors. This should assist partner organisations to develop their own funding links and reduce dependency on AHRTAG. A future fundraising strategy for AHRTAG and project partners could be jointly developed. It was suggested that other partner organisations might set targets for raising funds nationally or regionally in a similar way to CMAI and RUHSA. It was agreed that collaboration with AHRTAG enhances the credibility of project partners, and the link increases their international reputation as well as developing experience in certain areas of work, all of which facilitate their development and ability to generate funds for their own areas of project work.
- Project partners also expressed a need for technical support, on-site training and assistance in a range of areas, such as editing and writing skills, planning, management and building up of publications activities, information support for publications and resource centres; assistance with identifying illustrative materials; with computerisation of mailing lists.

Summary of criteria for newsletter project partner selection

1. Perspective on health and development issues, and experience and type of work in health and development issues, including links with communities
2. Publishing and production experience and capabilities
3. Mailing lists, and capacity for developing and managing mailing lists
4. National and regional links and networks
5. Local printing capacity, costs and quality
6. National and regional distribution capacity, postal systems and inter-country communications
7. Staffing capacity, experience and potential for skills development
8. Working relationships with a range of other organisations, nationally and regionally
9. Relationships with government, non-government sector, donor agencies
10. Capacity for managing finances and administration, project management
11. Access to expertise and to resources and information
12. Extent of computerisation, computer links

AHRTAG
RC

Primary Health Care

RESOURCE CENTRE

Resource & Information Co-ordinator **SUZANNE FUSTUKIAN**
Information Officer **MIMI KHAN**
Documentalist **SHEILA O'SULLIVAN**
Middle East Network Co-ordinator **ALISON CONDIE**
Resource Centre Assistant **MARGARET ELSON**

AHRTAG Resource Centre Activities Report 1990

AHRTAG promotes primary health care (PHC) through its international publications and information clearinghouse, and facilitates the exchange of information and experience by networking with international, government and voluntary agencies working in health and development. Established in 1977 and based in London, AHRTAG is a registered non-governmental organisation. The organisation is managed by an elected Council of Management from a small but growing membership of people experienced in PHC in less developed countries.

This report covers the work of AHRTAG's Primary Health Care Resource Centre during the period January – December 1990. Information about the wider activities of AHRTAG is available in the annual report which covers the period October – September to coincide with AHRTAG's financial year.

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Introduction

Information for action

Information is often taken for granted by many of us in the North—since we are surrounded by it, its value to us often goes unnoticed. Easy access to documents, databases and other media puts us in a privileged position.

To our partners in the South, information is highly valued—partly because of its scarcity but also because of the clear perception of its importance. Information is the key to participation. It informs the daily practice of individual families and is the key to their participation in the life of their communities and countries. Information is also necessary for change and to challenge structures of injustice.

Access to information is a vital component in the implementation of equitable and sustainable development. Health services and organisations need information to formulate plans, to evaluate, analyse and refine their practices. However, information provision is not an end in itself. The context in which information is used is important, and to be relevant information needs to be practical, appropriate and based on sound research. To have effective long term impact, information needs to be part of an overall framework of action involving programmes of training and continuing education.

The provision of relevant information plays an essential role in the implementation of successful PHC programmes—in the initial training and reorientation of health workers from curative oriented, hospital based delivery systems of medical care to prevention oriented, community based health care; in communication and management skills; and in encouraging people to take an intersectoral approach to health by forging links with colleagues in related sectors.

AHRTAG newsletters

AHRTAG supports health workers in the South with practical and appropriate information. The best known elements of this work are the AHRTAG newsletters which have been very successful in reaching people with practical information; we are now publishing four newsletters and planning a fifth. The current titles are *Dialogue on Diarrhoea*, *ARI News*, *AIDS Action* and *CBR News*, reaching a worldwide audience of more than 350,000 in nine languages. AHRTAG's newsletters are translated, in collaboration with project partners, into French, Spanish, Arabic, Portuguese, Urdu, Bangla, Tamil and Chinese. The fifth newsletter will focus on organisation and management issues in PHC.

Primary health care resource centre

The PHC Resource Centre further extends AHRTAG's information service by operating a clearinghouse for information in response to the requests of health workers. We have developed major collections in the subject areas covered by the newsletters and provide information support to the newsletters' readers. The Resource Centre staff are in the process of building a comprehensive collection on PHC, including urban PHC and health services. AHRTAG's computerisation programme also allows for more efficient selection of materials when responding to enquiries from health workers overseas.

The Resource Centre also has a pro-active outreach programme, linking with PHC organisations in the South. A key development in this area, building on the experience of the RC, was a pilot project initiated in 1987 which offered training and support to organisations to set up or strengthen their own resource centres. The pilot project was developed by AHRTAG in response to the critical lack of information faced by health personnel in developing countries. The aim of the project was to improve the effectiveness of PHC programmes by making information on appropriate techniques and approaches more accessible to personnel working at district and community level in both rural and urban areas. Sharing practical experiences and

useful learning materials can be most effectively channelled through resource and training centres.

AHRTAG gained valuable experience during the pilot project. The Resource Centre Training and Support Programme is now working with project partners in the Israeli Occupied Territories and Egypt in the recently launched Middle East Health Resources & Information Network linking health organisations and practitioners within the region. And, in partnership with the Centre for Educational Development in Health, Arusha (CEDHA), AHRTAG is assisting the Ministry of Health in Tanzania to establish resource centres within continuing education centres in six zones to provide access by zonal and district level workers to teaching and learning materials for continuing education. The Resource Centre Training and Support Programme is also working toward the establishment of an extensive network of PHC resource centres in Africa similar to the Middle East network.

The vast majority of health workers, however, have no resource centres or access to current or available information. Every year, we receive an increasing number of enquiries from health workers in this situation. We are currently receiving an average of 900—1000 enquiries per year (without advertising!). This is one of the most underfunded parts of our programme—largely because we are dealing with the specific information needs of individual health workers.

We receive a great variety of requests, with the majority coming from African countries. We have analysed the types of enquiries received over the past few years and, in response, have developed a series of resource lists and directories to respond to the requests for information on training materials and health education.

While these publications deal successfully with a proportion of the requests, we still undertake research and photocopying of articles relevant for each request. For those requests that are outside our subject area or where we feel that expert advice is required, we refer the request to one of our contacts. When responding we also aim to locate a regional or national information centre with which the health worker can make links.

A few examples of the types of enquiries we receive:

— from Ilorin, Nigeria:

"My area of interest is in the application of goal programming to task allocation and supervision for community health workers in Nigeria. I was given your address as you might be in a position to assist with some relevant materials..."

— from Hopital Baptiste Biblique, Togo:

"I am a nurse interested to promote PHC within the health delivery system. Please give me more information and advice on the following topics: principles and methods of community development, working with groups, planning and administration, PHC concept, evaluation..."

— Rev Brother Sherrer, Nigeria

"We would be glad to know the title of a book on sand filtration systems as our school is installing a water supply in a very waterless region. If there is any alternative/non-chemical system, we would be very glad of this information..."

We hope that the developments briefly outlined here and the more detailed presentation which follows, give the reader a clear picture of the AHRTAG Resource Centre's current activities and future plans.

Suzanne Fustukian

January 1991

Information & documentation services

AHRTAG's Resource Centre (RC) has become well established as an international 'clearinghouse', supporting the work of health personnel and organisations in the South since 1977, by providing information on all aspects of PHC. During this period the RC has built up a unique collection of resource materials (many items of which originate in the South) not widely available elsewhere. The RC also has considerable experience in approaches to resource management, and has developed its own health-related classification system and in-house databases.

AHRTAG's RC collection of over 10,000 books, journals and unpublished materials covers subjects from water supply to weaning, and from international debt to disposable syringes. AHRTAG regularly receives complimentary copies of new publications, as well as conference and meeting reports. Many of the newsletters originating in the South are also important as sources for identifying newly published material.

Documentation and computerisation

AHRTAG's bibliographic database is unique in comparison with online commercial databases for two reasons. First, its focus is on health—particularly community-based experiences, rather than medical or scientific literature. Second, whereas many online databases focus on journals which are published in the North, many of the 500 newsletters and journals regularly scanned and indexed by AHRTAG's RC staff are published in the South. Such journals and newsletters are not indexed by these commercial databases.

AHRTAG's bibliographic database is one of several that have been developed in the RC using the computer software INMAGIC. Their record structures have been developed following internationally recognised standards, which will assist the future exchange of information. Searching AHRTAG's database is aided by an in-house thesaurus.

The classification system used in the RC was developed in 1978 specifically to meet AHRTAG's needs and cover the various aspects of PHC which were thought to be lacking in other schemes available at the time. The scheme is reviewed and updated periodically to take into account both AHRTAG's changing needs and those of the PHC approach. For example, sections on AIDS and Urban Health have recently been added. A number of organisations internationally have used and/or adapted the scheme.

AHRTAG CLASSIFICATION SCHEME

AA POLITICS, ECONOMICS & DEVELOPMENT

AD Culture and Society

AD Population

HA PRIMARY HEALTH CARE

HB Community Health Care

HC Diseases/Disease Control

HE Nutrition

HJ Medical Services

HK Medical Equipment & Facilities

HL Women's Health

HM Mother & Child Health

HN Family Planning

HP Traditional Health Care & Alternative Therapies

HQ Disability & Rehabilitation

HR Oral & Dental Health

HS Urban Health

HV Health Planning & Management

HX Health Personnel & Training

HY Health Education

HZ Health Services

TA COMMUNITY DEVELOPMENT

TB Energy

TC Environment

TG Water & Sanitation

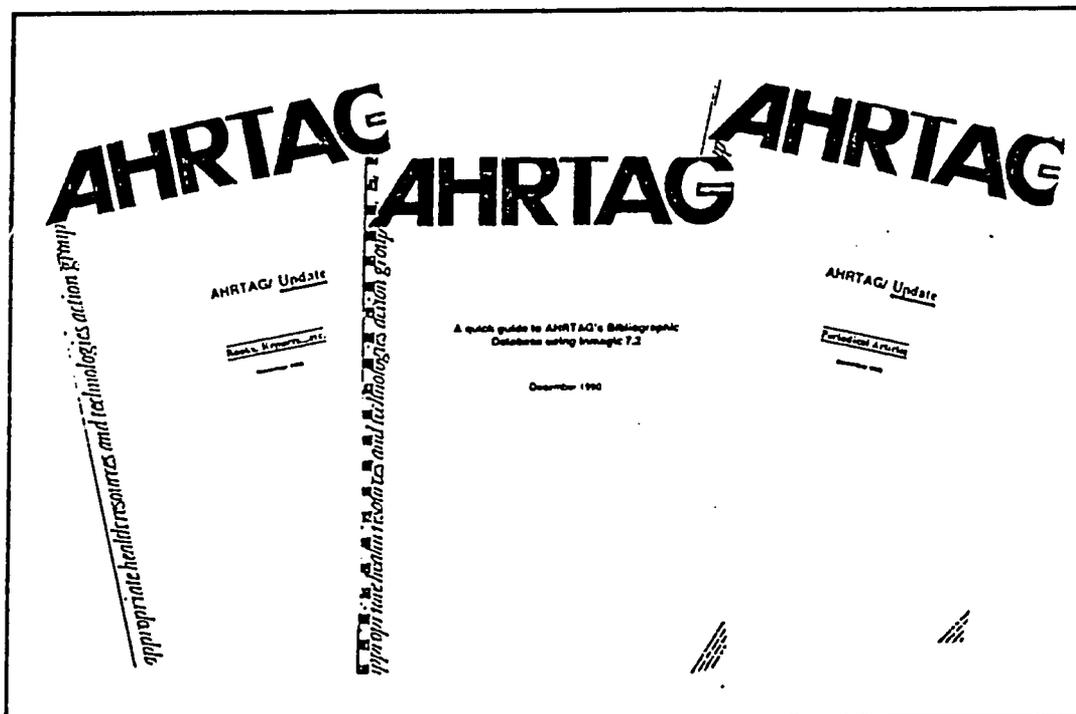
TH Food Production & Agriculture

TJ Women & Development

TK Appropriate Technology

At present there are four computerised databases regularly updated by the RC:

- **The AHRTAG Bibliographic Database** — AHRTAG's main database containing books, reports, conference proceedings, journal articles, and unpublished papers/documents. It was begun in 1988 and contains items received by AHRTAG since that date. Key items already held in the RC before that date are gradually being entered. The database is updated monthly and the AHRTAG UPDATE provides a current awareness service for staff. Plans are being developed to circulate these 'updates' more widely in 1991. This will involve providing individuals and organisations with a comprehensive information service which would include both the update and copies of selected material.



- **Serials Database** — AHRTAG currently receives over 500 newsletters and periodicals, including the British Medical Journal, The Lancet, Social Science and Medicine, and AIDS Care. This database contains up to date information on publishers together with subscription details. Also included are details of target audience and a description of content. Each item has been given appropriate keywords for the subject covered and can be searched in the same way as the other databases.
- **Audiovisuals Database** — contains information on the wide range of videos and slides held at AHRTAG. The information contained on this database includes details on: producer, distributor, format, length and price, together with a short abstract on the content and target audience.
- **Organisations/contacts Database** — currently holds information on individuals and organisations working in PHC worldwide, giving details of: areas of expertise, target groups, geographic location and type of activities.

Other Information resources

In addition to its databases, the RC has a collection of files on countries and national/regional organisations; equipment catalogues; health education materials including models, posters and flannelgraphs. It has also built up an extensive collection of catalogues and information on publishers and audiovisual distributors both in the UK and overseas. These prove useful not only for internal purposes but for project partners overseas.

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Enquiry services

The RC offers an information and enquiry service to health personnel overseas. During 1990 we responded to over 1,000 written and telephone enquiries. The Centre received 280 visitors during 1990, a 32% increase in the number of visitors over the previous year. They were seeking information on a wide range of subjects, from the role of the hospital in PHC to the production of health education materials. Other development organisations have also turned to AHRTAG for information support: for example, Save the Children Fund, Intermediate Technology Development Group and Christian Aid have requested help with information enquiries from developing countries.

		DATE.....29/11/90...
		NUMBER.....
AHRTAG RESOURCE CENTRE USER CARD		
Name:	TISSU SUJITHA WUTHITHANSUNG	Position: HEAD OF DEVELOPMENT SUPPORT SECTION
Address:	GPU BOX 2048 BANGKOK, 10501 THAILAND	Address of Organisation: THAI VOLUNTEER SERVICE GPU BOX 2440 BANGKOK THAILAND
Tel:	251 4411	Tel: Fax: EMail:
Subject, country & objective of research:		
AIDS		
Do you have any comments or suggestions to make about AHRTAG's services? Are there any books, periodicals, or other documents which you think AHRTAG should have in the library?		
PLEASE TURN OVER		

...for AHRTAG's newsletters

The RC plays a key role in the development of the AHRTAG newsletters, helping to generate new ideas as well as providing background information on specific subject areas to newsletter staff. The RC staff consult with newsletter staff on the content of future issues and compile the resource lists which frequently appear in the publications.

RC staff respond to frequent enquiries from newsletter readers for further information on specific issues, for example, the role of counselling in AIDS prevention work, and questions about the use of condoms. The RC staff also carry out specific research at the request of both newsletter staff and readers.

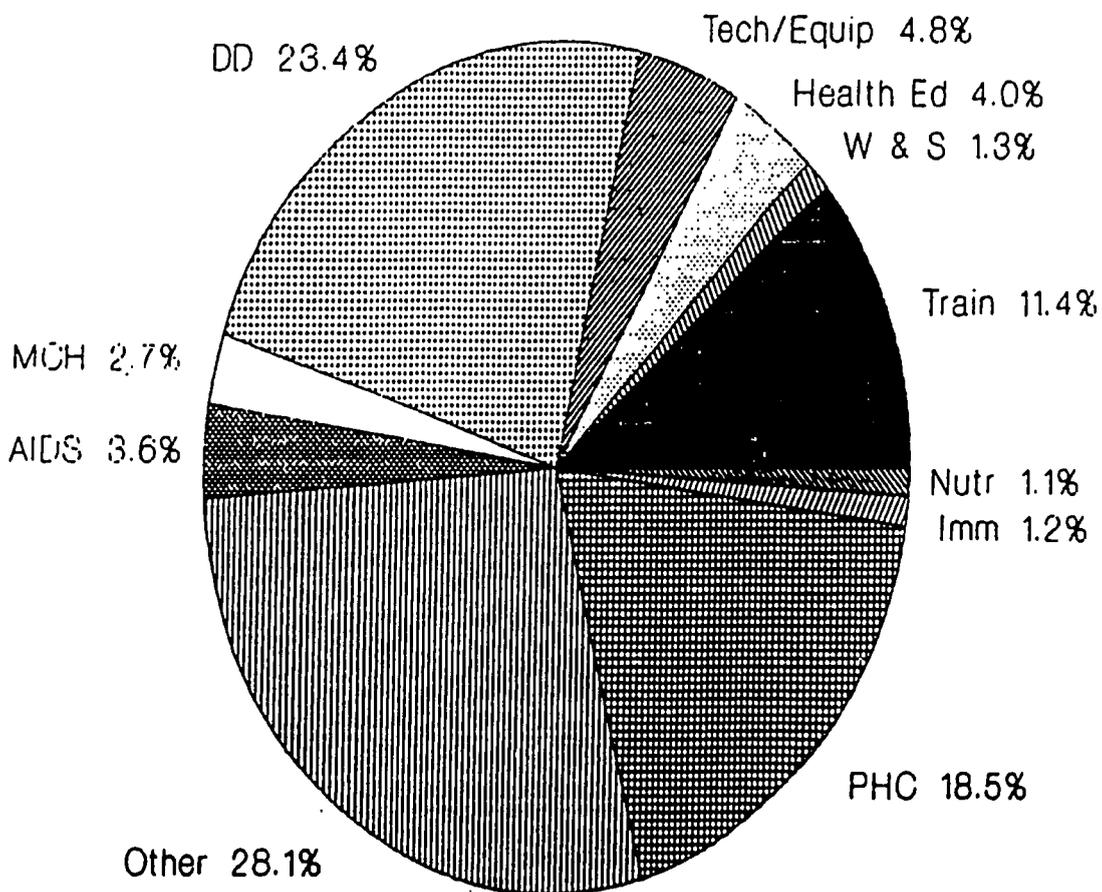
The RC's network of information resources and contacts also enables it to offer information services beyond the scope of its own extensive databases:

- to put individuals in touch with organisations in their own region or internationally
- to exploit appropriate international online databases
- to seek information from individual specialists and relevant non government organisations or research institutions internationally

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RESOURCE CENTRE

Enquiries - 1990 (%)



DD = Diarrhoeal Diseases W & S = Water & Sanitation Tech/Equip = Health Technologies and Equipment
Health Ed = Health Education MCH = Mother & Child Health Train = Training Nutr = Nutrition
Imm = Immunization

Information at work

Training

'Introducing Primary Health Care in Developing Countries : an Introductory course'

AHRTAG, in cooperation with the Bureau for Overseas Medical Service, has run this week-long course every six months since April 1988. It is designed for health workers from Europe who are intending to work in a developing country for the first time. The aim of the course is to enable health workers to:

- increase their awareness of health development issues
- reorientate to a low technology environment with few appropriate resources, and different working roles
- make informed judgements on where their skills will be most valuable
- allow participants - doctors, nurses, midwives and other medical personnel - to familiarise themselves with the relevant resources and organisations involved in primary health care

The course covers issues such as water and sanitation, essential drugs, immunisation, mother and child health, disability issues, health education, and the identification of sources of information. In the last two components the RC collection plays a crucial role. The course also encourages health workers to examine their own preconceptions carefully and to think about why they want to work in a developing country.

Group visits

A number of university based primary health care courses send student groups to the RC on an annual basis. Students are given an introduction to the work of AHRTAG and the RC together with a pack of information and resources. An RC staff member is then available to assist in the location of materials and to answer questions. (*A charge is made for this service.*) Return visits are welcomed and encouraged. Students from the following colleges and courses visited the RC during 1990:

- 'Community Eye Health', Institute of Ophthalmology, University of London
- Institute of Education, University of Copenhagen, Denmark
- 'Diploma in PHC Education and Development', Institute of Education, University of London
- 'Teaching PHC', Liverpool School of Tropical Medicine
- 'Master in Community Health', Liverpool School of Tropical Medicine
- 'Information Systems for PHC', Liverpool School of Tropical Medicine
- 'Diploma in PHC', Queen Margaret College, Edinburgh
- Royal College of Nursing, London
- The Missionary School of Medicine, London

Publications

The PHC Newsletter

Preparations were made during 1990 to launch a Primary Health Care Newsletter, with a pilot edition due to be published in Spring 1991. This newsletter will aim to meet the needs of people who implement PHC, such as health workers in leadership and management positions; those involved in planning and management, supervision and training, especially at district level; and those who provide support to district level workers, whether through government, non-government or multilateral agencies.

In the long term, it is intended that this newsletter will contribute to or provide the basis for national PHC newsletters and will become a valuable tool for training.

The PHC Newsletter will complement the specific focus of AHRTAG's other newsletters, highlighting the challenges facing PHC in the 1990s, particularly focusing on organisational and management issues, with suggestions and debate on how to make more rational use of existing resources, including personnel.

The pilot edition

The pilot edition of the PHC Newsletter, on the basis of which funds will be raised for its regular production, will give an idea of how future issues might be shaped. It will set out the aims of the newsletter and the prospects for PHC in the 1990s. The themes include: the impact on the implementation of PHC of international debt and structural adjustment programmes, national economic constraints, conflict, poverty and environmental degradation.

- the need for both longer term change and for the creative use of limited health resources, stressing an integrated, rather than a vertical approach to health planning, and cooperation with organisations outside the health sector.
- the continuing importance of PHC as the best way to achieve equity and the goal of health for all.
- the importance of local organisation and infrastructure as the crucial link between community needs and national resources, while giving communities the opportunity to participate in decision making.

Regular features

The newsletter aims to include the following:

- case studies of innovative ways to combat inequalities in health;
- updates on technical progress in the fields of health, nutrition and environmental issues;
- readers' contributions and networking, giving readers the chance to share their experiences and receive feedback through the newsletter;
- technical information and training skills;
- updates on new resources, including abstracts of books and key articles, audiovisuals and training materials.

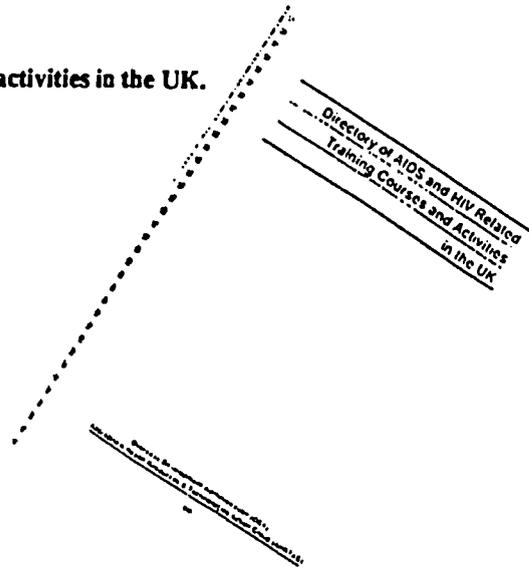
Resource lists and directories

To disseminate information on PHC, AHRTAG compiles and publishes resource lists on information materials and training courses.

Recent publications include:

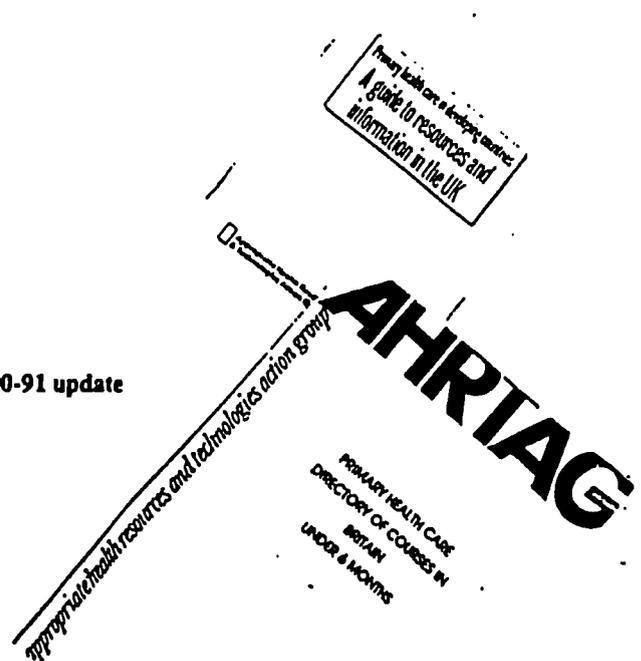
Directory of AIDS and HIV related training courses and activities in the UK.

This directory was commissioned by the Overseas Development Administration (ODA) Health and Population Division to provide information on training opportunities relating to AIDS and HIV for overseas students. It lists over 80 courses available in the UK, organised by subject area and institution. Subject areas include nursing, medical microbiology, health education, counselling, and clinical and community care. Entries for each course contain information on target groups, fees, course length, qualifications required and teaching methods used. The ODA has also provided support for free distribution of the directory to those responsible for planning and organising training and UK placements of overseas health personnel and postgraduate students.



Primary health care in developing countries: a guide to resources and information in the UK

In its second, updated edition, this booklet lists 137 organisations in the UK connected with primary health care in developing countries: charities, campaigning and solidarity groups, funding bodies, academic institutions, publishers of useful information and suppliers of appropriate equipment. Each entry includes an outline of the organisation's activities, and services offered. It is indexed by subject and country.

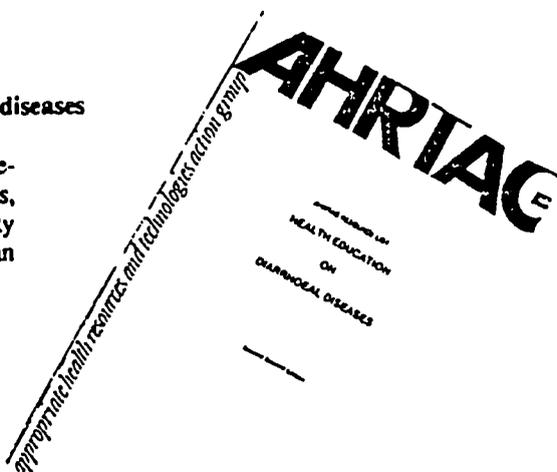


AHRTAG primary health care short course directory: 1990-91 update

This directory lists 68 short courses (less than six months in length) currently available in the UK. It covers a wide range of health related subjects as well as those directly related to PHC, including agriculture, community development, nutrition, planning and management, population, public health technology and refugee health. Information is also provided on course length, fees, content, and entry qualifications.

AHRTAG resource list: health education on diarrhoeal diseases

This list details resources to assist health workers and especially health educators. It includes manuals, bibliographies, journals, newsletters and teaching aids, both on community health in general, and specifically on diarrhoeal diseases, an area in which AHRTAG has particular expertise.



AHRTAG resource list: free international newsletters

This revised resource list (second edition) describes 84 free newsletters which discuss topics and issues related to primary health care. In countries where it is both expensive and difficult to obtain books and journals, free publications are particularly useful to health workers, whether they are involved in training, clinical or community work.

Visiting speakers

RC staff have been active in arranging visiting speakers to AHRTAG and during 1990 regular sessions were held with videos, slides and group discussion. Speakers included:

- Gaye Palmer — From the Baby Milk Action Campaign (BMAC)
- Vijay Mathur — Director of the Oral Health Self Care Project (OHSEC) in Delhi
- Sue Chowdhury — From Oxfam's Health Unit, and member of AHRTAG's management council
- Rosario Cardich — The Co-ordinator of Movimiento Manuela Ramos, Lima, Peru, an organisation which works with women and popular education, health issues, income generation and publishing
- Margaret Ince — From the Water, Engineering and Development Centre (WEDC), Loughborough University
- Rebecca McNair — speaking on her work with the Red Cross in Romania
- Jane Talbot — From the Development Education Section at Voluntary Service Overseas (VSO)
- Hala Salem — From the Community Health Department at Birzeit University, West Bank (project partners in the Middle East Network), on the role of resource centres and health information within the context of health care under military occupation

Working together : partnership with the south

During 1990, two projects involving information support and training in the running of resource/information projects were started in the Middle East and Tanzania. Both projects represent a further development of AHRTAG's pilot 'Primary Health Resource Centre Network' which operated from 1987-1990. Through the pilot programme, AHRTAG's RC established professional links with a number of organisations in the Middle East and East Africa which had set up PHC programmes.

The Middle East : health resources & information network

This year has seen the launch of a Middle East Health Resources and Information Network linking health organisations and practitioners within the region. AHRTAG has established this network in response to a growing demand from health workers in the Middle East for information on primary health care. It will make information and educational resources more accessible to health workers through the development of local health resource centres. AHRTAG is working initially with four partners in the Israeli-Occupied Territories and Egypt who are operating local primary health care programmes, carrying out research and training, and producing health education materials.

Health in the Middle East

The disease pattern in the Middle East reflects a mixture of diseases characteristic of both developing and highly industrialised countries. The largely preventable 'diseases of poverty' still remain, including agricultural, occupational and sanitation-related diseases in rural areas, i.e. parasitic, intestinal and respiratory tract infections, as well as malnutrition in both urban and rural areas. Young children are particularly vulnerable to these diseases. In Egypt, for example, the IMR in 1988 was said to be 83 deaths per 1,000 live births, and infant and child deaths were estimated to constitute about 50 per cent of total deaths. At the same time, hypertension, cardiovascular diseases, diabetes and diseases caused by smoking are on the increase. Other specific diseases include vector-borne diseases, for example, schistosomiasis, malaria, filariasis and rift valley fever.

In the West Bank and Gaza Strip, the health status of the community and the work of health service personnel has been affected by more than 20 years of Israeli occupation, since no committed national authority has existed to maintain and develop a health care programme. Health facilities are clearly inadequate to meet the needs of the population, as a result of long-term underfunding, underresourcing and maldistribution of facilities. This has had a detrimental effect on the health of the population, particularly that of women and children.

Health information needs

Although resources appropriate for use or adaptation in the Middle East are produced throughout the area and elsewhere, many organisations have difficulties in obtaining these materials for the following reasons:

- lack of direct lines of communication between countries—this is a particular difficulty for PHC projects in the Occupied Territories
- budget restrictions
- limited access to source materials publicising new and available health resources, in particular to Arabic materials

- a lack of networking facilities to link groups and organisations involved in similar work, or producing useful resources

The main objectives of the Network will be to support existing resource centres and help to develop new ones; to give technical assistance and support in the development of local PHC resources and materials; and to assist in strengthening networks, both between organisations in the Middle East, and with international PHC networks.

Project partners in the Middle East

The initial four partner organisations in the Middle East Health Resources and Information Network are:

- Community Health Department, Birzeit University, Birzeit, West Bank.
- Union of Palestinian Medical Relief Committees, West Bank and Gaza Strip.
- Association for Health and Environmental Development (AHED), Cairo, Egypt
- Health Unit, Centre for Development Services, Cairo, Egypt

WEST BANK AND GAZA STRIP

AHRTAG has been working since early 1987 with organisations which aim to address the long term health needs of Palestinians in the Occupied Territories. However, since the beginning of the uprising (intifadah) in December of that year, these organisations have also found it necessary to respond with emergency health campaigns to meet needs arising from the conflict.

Community Health Department (CHD), Birzeit University, Birzeit, West Bank

The CHD is a health and development research group within Birzeit University, with a focus on community and preventive health. It was established in the early 1980s in response to needs identified by a variety of community and health groups, women's organisations and academics for accurate baseline data on the health status of the Palestinian community in the West Bank and Gaza Strip and for the development of local and appropriate health information. The need for access to such resources is increased by the Occupied Territories' isolation from both international and Arab sources of information through travel restrictions and censorship imposed by the Israeli authorities.

The CHD has ongoing research projects on nutrition, intestinal parasites, demography, water and sanitation, health education and women, and development. It also provides technical consultations on request. Health

education has been a key focus and the CHD regularly produces pamphlets, leaflets and posters in Arabic on a variety of PHC issues. AHRTAG has already supported the CHD's research on water and sanitation, nutrition and community health by sharing information, ideas and materials through the RC. This experience has made an important contribution to the initiative to expand the Health Resources and Information Network.

Despite the military order which has forced the closure of Palestinian universities since the beginning of the uprising in 1987, teaching and research continues off campus. Staff and students run the daily risk of harassment for these activities. At the time of writing, two weeks into the Gulf War, health research activities have been stopped indefinitely as all communities have been put under strict 24-hour curfew, which has been lifted only every few days.





Union of Palestinian Medical Relief Committees (UPMRC), West Bank and Gaza Strip

The UPMRC is a voluntary grassroots organisation which promotes and practises PHC through a network of mobile and permanent health clinics, with related preventive health activities. Established in 1979, the UPMRC now has some 850 voluntary health workers, including doctors, nurses and other health professionals.

Its aim has been to provide PHC for those sections of the population who need it most, particularly women and children, and those who have least access to the established health system. Health education plays an important part in its work, with the aim of helping people to take more control of their own health, rather than simply seeking treatment for medical symptoms.

Village health worker training and continuing education of health practitioners are also a major part of the UPMRC's work. Other

activities include a community based rehabilitation programme, village medical laboratories, women's health projects and village health surveys.

In response to the uprising, emergency care through UPMRC mobile teams has become crucial throughout the Occupied Territories. Training villagers in first aid has been a priority, and a blood grouping project was started in 1988 to record the blood types of 40,000 potential donors.

Because information on PHC and community health resources is limited in the Occupied Territories, the AHRTAG Resource Centre's primary focus has been to assist UPMRC health professionals and community health workers in this area. AHRTAG is also supporting the production of health education materials in Arabic (*see below*).

EGYPT

Association for Health and Environmental Development (AHED), Cairo

AHED was established by a group of health professionals to promote awareness of primary health care issues among Egyptian health and community workers. It stresses the importance of recognising the wide range of social factors which affect health and health care.

Members of AHED have set up a primary health care programme of preventive and curative services in the Cairo area which are overseen by the Association, with a particular focus on training community health workers

to deliver adequate health education. It aims both to meet the needs of the community in which it works, and to serve as a model for other government and non government organisations establishing such PHC centres.

The development of a health resource centre has been identified as a fundamental need for health workers involved in the AHED programme. The resource centre will aim to strengthen the skills and abilities of workers in health and environmental services.

Health Unit, Centre for Development Services (CDS), Cairo

The Health Unit at CDS has recently been established to provide training programmes, health resources and support for non government community and primary health care initiatives in Egypt. The Unit will produce training materials, run courses and provide information about other relevant courses held both locally and abroad which are based on a participatory and 'popular' approach to education.

The Unit has established a resource centre to provide information and resources for health trainers, educators and practitioners. Through a series of workshops, the Unit aims to encourage active participation of health workers in local and international exchanges of resources and experience.

Production of health education materials

In a complementary project to the network, AHRTAG is assisting the UPMRC to produce locally developed and distributed health education materials. The UPMRC has long recognised the importance of health in preventive care and has been pioneering health education materials production in the area. The material is targeted at a wide range of people including trainers in the villages and refugee camps, the literate general public and students in primary and secondary schools.

Members of the network have a good basic knowledge of the major health problems in the area, and a working knowledge of the seasonal spread of epidemics. In order for health education messages to be effective production also involves a thorough understanding of culture and the way in which people perceive health and disease. Members meet regularly and identify the priority diseases at the specific time of production, for example, diarrhoea, mumps or brucellosis. The final production phase involves the field testing of materials in order to evaluate their impact. Successful materials are then produced in booklet, leaflet or poster form and distributed to over 120 local health institutions in the West Bank and Gaza Strip.

The subjects of recent published material have included disability, self catheterisation, and breastfeeding. Further materials on urinary tract infection, dehydration and rehydration and brucellosis are in production.

Recent developments

Middle East Network Project Coordinator, Alison Condie, was appointed in November 1990. While recent events in the region have necessitated some revision of workplans, a number of projects have already been initiated.

Using our contacts with several international organisations including WHO, UNICEF, and Oxfam as well as health research departments in British universities, we have fulfilled requests from our Network partners for information and resources in areas including:

- literature and resource searches on issues such as stigma and disability, essential drugs, sanitation programmes
- purchase of resource materials for resource centres
- information on health and development short courses in UK during 1991
- information on international conferences and workshops relevant to partners' needs
- visits to AHRTAG by partners from the Middle East

Tanzania : resource centres for continuing education

AHRTAG, in partnership with the Centre for Educational Development in Health, Arusha (CEDHA) is assisting the Ministry of Health Continuing Education Unit to establish resource centres in six zones throughout Tanzania. The aim of these resource centres is to facilitate access to teaching and learning materials for continuing education in health. The main beneficiaries will be staff and students at training schools, and health workers in rural areas.

The role of continuing education in Tanzania

Tanzania is one of the Least Developed Countries (LDCs) and suffers a variety of poverty related problems. Yet the strong political commitment of its government has meant that social indicators are better than those for other countries with similar economic status. Primary health care and basic education have been a priority, as have training and continuing education in health.

Current government policy has focused on strengthening district level health services, particularly in the area of management. This emphasises the development of action based management training in health information systems, health systems research, supervision and financial management, community participation and health education. The intention is to improve the quality of health staff rather than to drastically increase their numbers.

Continuing education is a vital factor in strengthening district level health services. Through continuing education of health workers, the quality of primary health care can be maintained and improved.

Seventy percent of the districts in Tanzania have a training institution which usually also have a library. Although these institutions are currently engaged in basic training, they are detached from health service delivery and have little input into continuing education. With the emphasis in Tanzania on strengthening district level health systems, it is envisaged that these school libraries could provide an entry point to increase the involvement of the training schools with district services and information needs, thus building on existing infrastructure. The goal would be for two way sharing, with the institutions' own training syllabus responding to service needs and the libraries responding to information requirements of the districts.

The continuing education strategy

The Continuing Education Programme of the Ministry of Health began in 1980. The current objectives of the Continuing Education programme are to develop greater integration between vertical and horizontal health programmes and approaches; decentralisation; greater integration of strategy between basic training and continuing education, including production of Health Learning Materials (HLM); the development of a distance learning strategy; and coordination of training in externally assisted programmes.

Broad 'action' plans are being formulated so that resource needs are identified and coordinated within regions; several regions are then grouped together to make up a 'zone'. Six key training institutions within each zone have been appointed 'zonal continuing education centres' whose role will be to support the other 92 training institutions in continuing education activities such as the training of trainers and supervisors in management, methodology and PHC.

CONTINUING EDUCATION STRUCTURE

NATIONAL:	Ministry of Health/Training Department: Continuing Education Unit (MOH) (Policy on coordination and identifying appropriate resources)
ZONAL:	Northern zone — CEDHA Southern Highlands zone — PHC Institute, Iringa Eastern zone — Public Health Nursing School, Morogoro Southern zone — Mtwara Western zone — Kigoma Medical Assistants' Training Centre Lake zone — Bugando Medical Centre districts
REGIONAL:	At regional level, the Regional Medical Officer will be responsible for programmes including PHC in the region; the regional team will provide continuing education to the districts
DISTRICT:	The District Medical Officer is responsible for continuing education, and with the district team will provide continuing education to health workers in the field

Resource Centres

AHRTAG's Resource Centre and CEDHA are collaborating on the development of zonal resource centres in the following phases:

- Initial assessment and planning, based on a survey of the six centres; and identification of basic resource material and furniture for each centre. While the centres will have basic core needs, specific requirements, based on the health status of the zonal population and information needs, will have to be identified.
- Provision of teaching/learning materials and ongoing information support. CEDHA and AHRTAG will advise the centres on selecting appropriate materials, and AHRTAG will assist with acquisitions and purchases for the centres over three years where these involve the use of foreign exchange. AHRTAG's resource lists of recommended PHC materials, the review bulletin and specific searches on AHRTAG's database and other relevant databases will be used to select materials.
- Technical assistance on organising the materials selected will be carried out centrally by CEDHA and at the zonal centres.
- Training workshops and seminars will be planned by CEDHA with AHRTAG and appropriate training materials will be produced covering assessment of information needs, documentation procedures, management and staffing needs. Emphasis will be placed on devising appropriate systems for organising and classifying resource materials.
- A zonal resource centre network will be established between the CEDHA resource centre and participating centres. This will enable resources to be shared.
- Establishing communications with relevant external institutions will be necessary. AHRTAG will provide assistance in developing international links.

Sustainability

The outlook for the sustainability of the project is promising, since it is building on existing infrastructure and aims for greater integration of vertical programmes. The Health Learning Materials Programme (see below) will be linked very strongly with the Continuing Education programme. The long term aim to make books more available to district health workers will require seed money initially to establish bookshops in the zonal resource centres, with the aim of developing a revolving fund from the sale of books (in local currency).

Project partner

Centre for Education Development in Health, Arusha (CEDHA)

CEDHA is a training institute established under the Division of Health Manpower Development and Training of the Ministry of Health. Its aim is to strengthen and support the health care system through improvements in the relevance and efficiency of health manpower training. CEDHA supports health service programmes and training schools run both by the government and voluntary agencies.

Since 1982 CEDHA has developed three integrated programmes:

- teacher training
- research and curriculum development
- involvement of health workers in continuing education

CEDHA's zonal activities include the creation of a strategy for district-based continuing education. This will establish an appropriate learning strategy for rural health workers through workshops and seminars run by the district teams, with technical support from CEDHA.

National level activities include:

- The Teacher Preparation Programme which offers a one year Diploma in Health Personnel Education designed to train managers of health service programmes and teachers of health workers.
- The Research and Curriculum Development Programme seeks to ensure that health systems research, operational research and curriculum development become an accepted part of all health service programmes and training activities with CEDHA as coordinating centre.
- The Health Learning Material Programme aims to supply adequate health learning materials, appropriate to the needs of Tanzania and to make them available to all categories of health workers.

Building links

An important part of the RC's work is to develop links both locally and internationally with other organisations concerned with health, development and information services. An international network of contacts exists which includes key research institutions in the UK and internationally, such as the Department of International Child Health (Institute of Child Health, University of London) and the London School of Hygiene & Tropical Medicine; specialist information agencies and clearinghouses; and multilateral, government and non-government health and development agencies. Close working relationships are maintained with other groups involved with information provision and services.

Networking on Information Services

SATIS : sharing information

SATIS is an international network of non government organisations working on appropriate technology in areas such as health, agriculture and water supply. They include NGOs working on sustainable development in more than 150 countries. SATIS supports its members by providing a package of services in information management, publishing, communications and technology replication. AHRTAG has been a member since 1985 and for the past two years, AHRTAG's documentalist, Sheila O'Sullivan, has been one of two co-ordinators of the SATIS North Documentalists' Group.

Interdoc : Information for change

Interdoc is an international group of non government organisations working with information on social and development issues. In May 1990, Sheila O'Sullivan attended the Interdoc meeting, 'Information for social change' in the Netherlands. As a result of this, several information workers from overseas have visited AHRTAG, and AHRTAG's library classification scheme is being considered as a tool for organising the collection of materials on health in the Ecumenical Centre in Durban, South Africa, a centre which plays an important role in the democratic movement in South Africa.

Enquiry services : working together

In May, AHRTAG participated in a two-day meeting of twenty four organisations organised by Intermediate Technology Development Group (ITDG), providing enquiry services worldwide on appropriate technology. Costing, funding, when to charge for information, evaluation and ways of working more with local information centres, were all shared concerns. By developing links through meetings like this one, and working more collaboratively, the efficiency of each individual organisation's inquiry service is greatly increased.

Conferences and meetings

During the year RC staff members or consultants attended the following conferences.:

On AIDS

- Southern African Network of AIDS Service Organisations, Harare, Zimbabwe, May 1990
- Second International Symposium on AIDS Information and Education, Yaounde, Cameroon, October 1990
- 'Policies for Solidarity' Conference, Paris, November 1990
- 'Women and AIDS' Conference, NGO AIDS Consortium, London, November 1990 (as workshop facilitator)

With the aim of strengthening existing international contacts, an RC staff member on a visit to the United States met with the Boston Women's Health Book Collective and with the Fund for Free South Africa (FREESA) to discuss planned AIDS-related work in South Africa.

On PHC

- 'Primary Health Care at the Grassroots; experiences from the Third World', CIIR Overseas Programme Conference, October 1990 (as workshop facilitator)

AHRTAG also participates in regular meetings of the following groups

- Teaching Aids at Low Cost (TALC) Council
- UK NGO AIDS Consortium
- NGO PHC Group (Geneva)
- Action on International Medicine (AIM)
- London Hazards Centre Council
- Working Group on Information and Documentation, European Association of Development Institutes (EADI)
- SATIS North Documentalists' Group
- Computers for Development (UK)
- UK Library Association
- Trainers in Health Development Support Group (UK)

Among the visitors AHRTAG received from other organisations were:

- David Hilton, Deputy Director, Christian Medical Commission
- David Membrey, Ranfurly Library
- Chandra Kannapiran, Information Officer, Voluntary Health Association of India
- Dr David Nyamwaya, Director, Health Education Network, Kenya
- Irene Bertrand, WHO Office of Library and Health Services

Resource Centre details

Staff

- Alison Condie: Middle East Resource Centre Coordinator (from November 1990)
- Margaret Elson: Resource Centre Assistant
- Suzanne Fustukian (Co-director): Resources and Information Coordinator
- Mimi Khan: Resource Officer (until August 1990)
- Sheila O'Sullivan: Documentalist

Consultants

- Nancy Coulson
- Richard Walker

Finances

Income	£	
Christian Aid	7,000.00	
ODA	46,461.00	
USAID	34,109.88	
Miserior	22,371.00	
DIFAM	325.72	
Sales	1,075.42	
Services	2,010.24	
		£113,353.26
Expenditure	£	
General	11,616.98	
Networks:		
Pilot Project	17,928.68	
Middle East	16,953.16	
Information work:		
diarrhoeal diseases	30,030.67	
AIDS	38,586.82	
ARI	2,949.47	
Production of health education materials	13,894.65	
RC Continuing Education Project, Tanzania	6,102.54	
		£138,062.97

Summary statement

Income received during period	£113,353.00
Total expenditure during period	£138,063.00
Excess expenditure	£24,710.00
recoverable from donors	£17,320.00
met by AHRTAG core funds	£7,390.00