

The U.S. Private and Voluntary Organizations (PVOs)

and

the Congressional Child Survival Initiative

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## I. Introduction

Congress provided the Agency for International Development (A.I.D.) with \$85 million in supplemental funds in FY 85 to launch a new Child Survival and Expanded Primary Health Care Initiative through the delivery of low cost health interventions such as immunization, oral rehydration therapy (ORT), breast feeding, growth monitoring, child spacing and nutrition education. The legislation specified that the Private and Voluntary Organizations (PVOs) be included "wherever appropriate". In a major effort to be responsive to this mandate, A.I.D. established a new competitive grants program for U.S. PVOs, and has channeled increased health funds to the PVOs through its bilateral programs and a major grant to UNICEF for the support of indigenous PVOs. In total, more than \$30 million, or some 36% of the supplemental funds were allocated to the PVOs. Approximately two-thirds of these \$30 million have gone to U.S. PVOs (see Figure 1).

This is a major initiative by any standard, and it is likely to have a significant impact on the PVOs activities in the primary health care field, and on the collaborative relationship between A.I.D. and the U.S. PVOs in this important area. The allocation of substantial new funding to the PVOs for primary health care activities, and the strong Congressional interest in the PVO participation in this Initiative presents real opportunities and challenges to the PVOs and A.I.D.

In this paper I want to discuss A.I.D.'s efforts over the last year to launch this new Initiative with the PVOs, and to describe some of the PVO activities that have been funded. I will focus primarily on the centerpiece of A.I.D.'s effort to provide support to the U.S. PVOs for Child Survival activities, a new \$13.5 million competitive grants program that was established in the Office of Private and Voluntary Cooperation, in the Bureau of Food for Peace and Voluntary Assistance (FVA/PVC). Finally I will mention some of the opportunities and challenges this new Initiative presents for A.I.D. and the PVOs.

## II. The Legislation and Rationale for Including the PVOs

This Congressional Initiative was an outgrowth of increased international attention on simple, low cost health technologies that can have a major impact on reducing infant mortality rates. At the end of 1982 in its annual State of the World's Children, UNICEF proclaimed the possibility of a "Child Survival Revolution" which could cut worldwide infant mortality rates in half by the end of the century through the delivery of four basic health interventions: growth monitoring; oral rehydration therapy; breast feeding and immunization (GOBI). In the last several years the notion that a Child Survival revolution is possible with existing low cost health technologies has attracted increasing support from the international development community. In 1983, for example, A.I.D.'s Administrator, Peter McPherson, initiated a major drive to promote Oral Rehydration Therapy (ORT) in the Agency's programs.

By 1984 the stage was set for a new Congressional initiative in this area. Key senators and Congressmen had begun to take an interest in these low cost interventions and the opportunity for the United States to make a major contribution to this effort to promote Child Survival. The Select Committee on Hunger was established in the House of Representatives and heard testimony about the potential for these interventions to have a significant impact on infant mortality in the developing world. Various private groups lobbied for substantially increased funding for basic primary health care activities related to Child Survival and pressured to have this support channelled through the PVOs.

The total of \$85 million in supplemental funds appropriated by the Congress in the FY 85 Continuing Resolution for new health care initiatives was included in three separate provisions: a new \$25 million "Child Survival Fund"; \$50 million in supplemental Health funds; and \$10 million in nutrition funds. All three indicated that the funding be utilized for oral rehydration, immunization, and other primary health care interventions, and included provisions for the support of PVO activities. They also stipulated that these supplemental monies be used for new activities over and above the projects already proposed to Congress by A.I.D. for FY 85.

The Child Survival Fund was an Amendment to Section 104(c) of the Foreign Assistance Act, introduced in both Houses of Congress. This legislation directed that the Fund be used to "promote, encourage, and undertake activities designed to deal directly with the special health needs of children and mothers. Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrheal diseases, and education programs aimed at improving nutrition and sanitation and promoting child spacing". (H.R. 5119) The authorization indicated that in addition to the government to government programs, these funds should be used to support appropriate activities of the PVOs and international organizations.

The \$50 million in supplemental health funds and \$10 million in nutrition funds were authorized by the Kasten-Hatfield Amendment to the Continuing Resolution to provide "additional monies to combat hunger and malnutrition" (Senate Congressional Record, 10/02/84 S12730). The Amendment stipulated that these funds "be available only for the delivery of primary and related health care services, nutrition and basic health care education (primarily oral rehydration and immunization programs), with such assistance to be provided through private and voluntary organizations and international organizations whenever appropriate". (IBID, 10/02/84 S12729) In proposing the amendment, Senator Hatfield specifically noted his expectation that "PVOs will be directly involved in carrying out the purposes and projects encompassed by this amendment" (IBID, S12731).

There are several reasons why the PVOs figured prominently in this legislation. First, key proponents of the idea of a "Child Survival Revolution", such as UNICEF, maintained that what was necessary to bring about a dramatic reduction of infant mortality rates was a broad-based social mobilization of the different sectors of society including public and private organizations and local community members; PVOs were seen as one of the groups which could make a vital contribution to this mobilization. UNICEF also viewed the PVOs as an innovative group which would be quick to apply these low cost health techniques at the local level.

Second, the Congress indicated that the focus of this health initiative should be "toward small scale projects that directly help the poorest of the poor, rather than

large scale infrastructure projects far removed from benefitting these peoples" (Senate Congressional Record 10/02/84 S12731). The PVOs were perceived by a number of Congressmen as organizations which were effective at the grass roots level and could ensure that primary health care services reached underserved populations. Senator Melcher made this case strongly when he stated that it was important, "to deliver primary health care to our friends abroad through the private and voluntary organizations because they truly get the food and primary health care to the people in the best possible way without waste" (IBID, 10/03/84 S12828).

Finally, there was grass roots pressure applied by private groups for increased funding for PVO primary health care activities. The Kasten-Hatfield Amendment was proposed in large part as an alternative to another amendment in the House which had been actively promoted by these groups. This would have earmarked 5% (or \$150 million) of the Economic Support Funds for the delivery of primary health care services through PVOs and international organizations. In proposing their substitute amendment, which authorized supplemental funds rather than an earmark, Kasten and Hatfield decided to retain the provision pertaining to inclusion of funds for use by PVOs.

### III. Overview of A.I.D.'s Support to the PVOs for Child Survival Activities

Of the \$85 million in supplemental funds authorized by Congress, A.I.D. has provided more than \$30 million in support to the PVOs for Child Survival activities through three channels: grants to U.S. and indigenous PVOs by the USAID Missions as part of their bilateral programs; a major grant to UNICEF for the support of indigenous PVOs; and the newly established central grants program for U.S. PVOs (see Figures 2 and 3).

Through the first channel, the A.I.D. Missions have provided a total of more than \$7 million in grant support to five PVOs in six countries. The largest of these was the \$2.9 million grant to the Haitian-Arab Center for a nationwide "mobilizing mothers campaign" through the indigenous PVOs. Two Mission grants totalling almost \$2 million were also made to Catholic Relief Services in Ecuador and Indonesia to add ORT and other Child Survival components to their ongoing Title II food programs.

UNICEF, the second channel for PVO funding, received a \$7.5 million grant from A.I.D. to support Child Survival activities of indigenous PVOs and other private agencies in a limited number of countries including Indonesia, Turkey, Nigeria, Sudan, Djibouti and India. UNICEF also channeled some of these funds through the International Red Cross. These funds will be used to mobilize key elements of the private sector to address critical health needs of mothers and children.

Finally, the third and single largest source of A.I.D. support to the PVOs is the new competitive central grants program established in the Office of Private and Voluntary Cooperation in Washington. This has provided \$13.5 million to 13 U.S. PVOs to carry out 26 Child Survival projects in 12 priority countries. An additional \$2 million in supplemental funds was awarded separately to Meals for Millions to support Child Survival activities in six countries, bringing total central grant funding to \$15.5 million. The rest of this paper will focus on the new competitive grants program and the PVO activities it has funded.

#### IV. The Establishment of the Competitive Central Grants Program for U.S. PVOs

It became clear even before the legislation was passed in October, that if the U.S. PVOs were to be involved in a substantive way in implementing new projects under the Child Survival Initiative, a new grants program would have to be established immediately with guidelines that corresponded with the legislative criteria and Agency priorities. In order to obligate the supplemental funds by the end of FY 85, A.I.D. had less than 12 months to decide on its internal priorities for the use of the funds, develop a set of guidelines for a new grants program, solicit, review and approve proposals from the PVOs, and complete the documentation necessary to obligate the funds.

Because of the time constraint, and the need for a well coordinated effort, A.I.D. decided to establish its centrally funded grants program in the Office of Private and Voluntary Cooperation in the Bureau of Food for Peace and Voluntary Assistance (FVA/PVC). This is the central Bureau in A.I.D. responsible for administering the distribution of PL 480 foods through cooperating governments and the PVOs; the Office of Private and Voluntary Cooperation is the focal point for A.I.D.'s relations with the PVOs.

This office has an excellent overview of the PVO community because of its responsibility for registering the U.S. PVOs with A.I.D. Furthermore, FVA/PVC also manages a large Matching Grant program in support of PVO field activities overseas, and thus has an established working relationship with most of the health related U.S. PVOs capable of carrying out Child Survival activities. In conjunction with this program, FVA/PVC has conducted a series of health sector evaluations of the major PVOs, and therefore has knowledge of their track record in the health field. As a central office with global responsibility for PVO activities, FVA/PVC could also help to ensure that the PVO programs would be consistent with A.I.D.'s priorities from one country to another, and would receive the technical support necessary for successful project implementation.

The central PVO grants program was designed within an overall framework established for the Agency-wide effort. In order to maximize the Agency's efforts to reduce infant mortality, A.I.D. decided to utilize the \$85 million from the three different legislative sources for a coherent, coordinated "Child Survival Action Program". A.I.D. organized an internal Child Survival Task Force to consider the many alternative uses and competing demands for the supplemental funds within A.I.D.'s worldwide program, chiefly comprised of important government to government health programs, in addition to PVO channeled assistance. Within the general parameters established by the legislation, the Task Force had to establish priorities and make policy recommendations to the A.I.D. Administrator about a wide range of questions such as which interventions to highlight, which countries to target, how to allocate the funds among the different A.I.D. Bureaus and Missions, and what the relative roles of the PVOs and multilateral agencies should be within the overall program.

As the Child Survival Action Program was developed FVA/PVC conducted an intensive dialogue with the rest of the Agency about the most appropriate role for the PVOs. In December, FVA/PVC hired a public health specialist as a consultant to help develop the guidelines and review criteria for the new PVO grants program. In January the funding allocations were made, and the guidelines for the program were finalized. On January 25th the new program was formally launched with the mailing of the proposal solicitation letter to a select list of 22 health related PVOs with demonstrated track records in the health field. A week later A.I.D. invited the PVOs to a workshop to explain the new program. The PVOs were asked to submit their proposals by March 8.

## VI. The Program Guidelines

A major effort was made to ensure that the guidelines for the new Child Survival grants program be as consistent as possible with the legislation, and the Agency priorities set by the Administrator. The proposal solicitation requested that the PVOs submit projects with the principal objective of improving the health status of children in the 0-5 year age group, with particular emphasis on lowering mortality from diarrheal and communicable diseases.

The guidelines strongly emphasized service delivery; the chief focus was to be on the delivery of preventive and promotive health interventions to target groups at the community level, rather than on strengthening PVO infrastructure. The PVOs were directed to give priority emphasis to ORT and immunization, whenever appropriate. Other related, low cost interventions such as nutrition education, weaning foods, Vitamin A, breast feeding, child spacing, and malaria prophylaxis could also be included if they had a high potential for improving Child Survival prospects in the target area.

The PVOs were asked to design projects that were directly responsive to the health needs of the target population. The proposed projects were to aim for measurable impact in the short to medium term, and demonstrate a reasonable chance for sustainability after the Child Survival and health funds had been expended.

In order to help maximize impact and facilitate the management of the program, A.I.D. decided to concentrate the centrally funded PVO projects in ten countries:

Asia:	Bangladesh and Indonesia
Latin America:	Bolivia, Ecuador and Haiti
Africa:	Kenya, Malawi, Rwanda, Uganda and Zimbabwe

A variety of factors were considered in selecting these countries including: infant mortality rates; the presence of health-related U.S. PVOs in-country; and the program priorities/health strategies of the USAID Missions and host country governments. FVA/PVC indicated that exceptions to this list of countries would be considered in special cases where it could be shown that the proposed project offered an outstanding opportunity for sizeable

impact on local problems of infant and child mortality. PVO projects were eventually approved for two exception countries -- Guatemala and Pakistan -- bringing the total number of countries to twelve.

In order to help ensure that the projects could be successfully initiated by the end of 1985 the PVOs were required to have an established formal presence in all countries where they proposed to carry out Child Survival projects. Within the priority countries where they had established programs, the PVOs could request support for new projects in primary health care, the addition of relevant new components to existing programs, or the expansion of existing programs into nearby geographic areas. There was no stipulation as to the size of the projects, except that each project cover a sufficient proportion of the target population to have a significant impact on local health status. The PVOs were asked to ensure that their proposed projects did not conflict with the established health strategies of the host countries or the A.I.D. Missions.

The PVOs were directed to prepare proposals for projects with a maximum of a three year duration. Because the supplemental funding was only assured for one year, FVA/PVC decided to fully fund the entire projects in FY 85. The PVOs were also required to provide a minimum of 25% to 50% of the cash resources for the projects, in order to extend the impact of the limited A.I.D. resources, and to promote project sustainability.

FVA/PVC developed extensive criteria for the PVOs to follow in preparing their proposals. One of its most significant aspects was the provision that proposals had to be project specific. PVOs could submit proposals which included projects in several countries. But for each country project the PVOs were asked to provide detailed information about: the project purpose and location; the health problems and health resources in the target area; the target group and proposed health interventions; the plan of operation; the measures to ensure sustainability of the program; the plans for monitoring the use of resources and implementation of proposed health activities; and the project budget, including a breakdown by health intervention. These guidelines enhanced the quality of the proposals that were received, and greatly facilitated the project review and approval process.

## VII. The Proposal Review and Approval Process for the Child Survival Grants

FVA/PVC organized a thorough proposal review and process that was carried out as expeditiously as possible (see Table 1).

Seventeen PVOs submitted proposals in early March for a total of 44 country specific projects. As soon as they were received, the proposals were pouched to the A.I.D. Missions in the priority countries, along with guidelines for reviewing and ranking them. The proposals were distributed to the health officers in A.I.D.'s Regional Bureaus, the Bureau of Program Policy and Coordination (PPC), Offices of Health and Nutrition, and the FVA/PVC project officers for their review.

In mid-March FVA/PVC also organized a technical review of the proposals by an external panel of pediatricians, primary health care, and development specialists who assessed each of the country specific project proposals in terms of the published criteria and commented about the technical merits of each project. The A.I.D. Regional Health Officers ranked the project proposals for each of the priority countries in their region, in terms of feasibility and regional health priorities. The FVA/PVC project officers reviewed the proposed projects in the light of the PVOs performance on previous grants. The A.I.D. Missions provided a valuable assessment of the in-country feasibility of proposed PVO activities and their relation to host country government health strategies.

In mid-April all of these different perspectives were analyzed and compared by a formal review committee which voted on each of the country specific project proposals, and made decisions about any proposal revisions to be required. This committee was chaired by FVA/PVC; the Regional Health Officers and representatives from the Office of Health and PPC were also voting members.

FVA/PVC finalized its funding decisions by end of April, and in early May formal response letters were mailed to the PVOs indicating the country projects that had been approved, and the funding levels. These letters shared the general findings and recommendations of the review committee with the PVOs, and requested any revisions or budget clarifications necessary before final approval could be given. The PVOs provided most of the necessary clarifications by June, the internal paperwork was completed promptly, and the grants were awarded in August and September.

VIII. Summary/highlights of the Centrally Funded PVO  
Funded Child Survival Projects

FVA/PVC awarded Grants totalling some \$13.5 million to 13 U.S. PVOs to carry out 26 country specific projects in 12 countries (see Table 2). The large grant recipients like CARE, Save the Children, and the Salvation Army will carry out four to five country specific projects distributed across the different regions. Other PVOs like Minnesota International Health Volunteers, International Child Care and the International Eye Foundation received support to carry out Child Survival projects in a single country.

The projects are reasonably well distributed among the three geographic regions in which A.I.D. operates. Latin America has the highest concentration with eleven projects in four countries--Bolivia, Ecuador, Guatemala and Haiti. Haiti, with five centrally funded projects, is the country with the highest concentration of Child Survival activities. Eight projects are located in Asia in Indonesia, Bangladesh and Pakistan. Africa also has eight projects distributed among five countries -- Kenya, Malawi, Rwanda, Uganda and Zimbabwe.

It is difficult to generalize about these twenty-six projects; there is considerable diversity in keeping with the different characteristics of the PVOs, and the wide range of conditions in which they are working. For example, Helen Keller International (HKI) is seeking to reach millions of children in Bangladesh and Indonesia through massive Vitamin A distribution campaigns, while other PVO projects such as Minnesota International Health Volunteers (MIHV) in Uganda have target populations of less than 10,000. Some PVOs, such as HKI or International Child Care (ICC) in Haiti, focus primarily on one or two interventions like Vitamin A or immunization and oral rehydration therapy, whereas other PVOs like Save the Children Foundation (SCF), Salvation Army World Service Office (SAWSO), employ a wide range of interventions in a comprehensive approach to primary health care. Some PVOs are providing PHC outreach services from their own hospitals and clinics; others are focusing primarily on health education and promotion at the community level and seek to link community groups with government health services.

In spite of the great diversity, there are some generalizations that can be made about these projects, and ways they can be categorized.

Most of these projects are located in rural areas with high infant mortality rates (above 100 per 1,000) which are isolated and/or underserved by government health services. There are only three projects located in marginal urban areas (SCF/Quito and Jakarta and ADRA/Haiti).

In most cases the PVOs are building on their established programs in these countries, either by adding relevant new health components to their existing programs, or expanding these programs into nearby geographic areas. There are only five or six cases in which the PVOs are initiating completely new primary health care projects. One of the strongest characteristics of these projects is that they are mobilizing their existing program infrastructures and networks of community organizations to help ensure that the children at risk in their target populations have access to basic health interventions.

Most of the PVO projects have a strong community based orientation and place considerable emphasis upon training, health education, and promotion at the community level. The majority include the training of health promoters and village health workers in priority interventions. These include ORT and home management of diarrheal episodes, educating mothers about the value of breast feeding, child spacing, growth monitoring and early immunization of children under two. Many also seek to develop or strengthen community organizations to support and sustain improved health and nutrition practices. An important objective of many of these projects is to increase capability of mothers to meet the basic health needs of their children.

### Health Interventions

Virtually all the projects place a strong emphasis on oral rehydration therapy (ORT) and include immunization as one of their principal interventions. These and other interventions common to many of the Child Survival projects are summarized below (see also Table 3).

ORT: Training in the use of oral rehydration solutions is an educational component well suited to the PVOs with their community outreach and networks of village health workers. Many of the PVO projects promote the use of ORS packets, but an almost equal number train community members in the preparation of home solutions.

Immunization: The approaches to immunization vary. Several of the PVOs with their own hospitals and clinics such as Salvation Army (Bangladesh and Pakistan), Adventist Development and Relief Agency (Malawi, Rwanda, and Haiti), Minnesota International Health Volunteers (Uganda), and International Child Care (Haiti) will administer their own vaccination programs, often in collaboration with the government. The most ambitious PVO vaccination program will be carried out by International Child Care which plans to vaccinate a target population of some 500,000 in several extensive regions of Haiti, utilizing mobile vaccination teams in coordination with the government health posts. Most of the other PVOs will play a largely promotional role, encouraging widespread community participation in government immunization programs.

Health and Nutrition Education: As noted earlier, most of the projects also include significant health and nutrition education components. The topics covered and amount of emphasis given to these community education programs varies, but most projects include a growth monitoring component, and some education about breast feeding, nutrition, and basic maternal and child health care.

Child Spacing: More than half the projects include a child spacing component. For some, such as ADRA/Malawi and Rwanda, it is a major component, while others, it assumes less importance. Most of these projects focus on the educational aspect, however, some also provide contraceptives.

Food Supplements: Several PVO projects such as CARE/Haiti and ADRA/Rwanda include the distribution of PL 480 food stuffs. Other PVO projects such as those of SAWSO in Bangladesh and Pakistan and Foster Parents Plan in Haiti utilize food supplements obtained locally for nutritional rehabilitation and related purposes. Several PVOs such as Save the Children and Helen Keller International promote home vegetable gardens. Catholic Relief Services plans a pilot project in Ecuador to gradually substitute locally produced weaning foods for the Title II food commodities currently in use.

Vitamin A: Vitamin A is the principal intervention in three projects: HKI/Indonesia, HKI/Bangladesh and International Eye Foundation/Malawi. In Bangladesh and Malawi the projects will combine Vitamin A distribution with other Child Survival interventions to maximize the impact on infant mortality. Vitamin A capsule distribution is also a minor component of some of the other Child Survival projects such as SAWSO/Bangladesh and Pakistan.

Other: Several of the projects also include other interventions where appropriate such as: pre-natal and post-natal care; potable water, sanitation, and hygiene; and self-financing pharmaceutical supply systems.

#### Program Approaches

These PVO projects can be grouped into three general categories in terms of their program approaches and relationship to host country government health services (see Table 4).

- A. Projects which strengthen primary health care components of rural development programs, with an emphasis on promotional and educational efforts to improve community health practices and community access to government health services.

Most of the Child Survival projects are enabling PVOs with a wide range of development activities at the community level to strengthen the primary health care component of their programs. Many PVOs such as Save the Children, CARE, Salvation Army, Foster Parents Plan, Catholic Relief Services, and World Vision carry out diverse activities with extensive networks of community organizations, such as local committees, church groups and women's clubs. For these PVOs, primary health care has been only one component of a broader effort to improve the living conditions of the local population.

Many of the Child Survival projects are enabling these "multi-disciplinary" PVOs to utilize their social promoters and extensive networks of community organizations in innovative ways to improve primary health care for their target populations. Because most of this group of PVOs do not operate their own hospitals and clinics, and are not providers of vaccines, drugs and other health commodities, a key aspect of their strategy is to promote more effective linkage between community groups and government health services, particularly for immunizations, and referral of serious cases for treatment. Because of their intimate knowledge of local communities and the confidence which they enjoy, the PVOs are in an unusual position to facilitate this linkage.

A sample of the Child Survival projects in this category will illustrate the innovative ways that the PVOs are utilizing their program infrastructures, and mobilizing community organizations to improve primary health care and nutrition for children:

Catholic Relief Services/Ecuador: CRS is carrying out an innovative Child Survival project in Ecuador to help Mothers Clubs in 45 rural communities to improve the nutrition of 3,000 children aged 0 - 6 through the establishment of self-sustaining health and nutrition programs. The project consists of four basic components: training of mothers in health and nutrition, including growth monitoring; training of local "health and nutrition counselors" to be supported by the community; establishment of communally managed pharmacies; and the self-sustaining production of local weaning foods. A key objective of the project is to bring about a shift from the use of Title II commodities to locally produced weaning foods.

Foster Parents Plan/Haiti: PLAN will strengthen and expand the health services of its established integrated community development program in Jacmel, Haiti, to improve the health status of some 13,500 children up to five years of age. PLAN will provide health training to its 60 social workers, who make regular household visits to many of the families in the region. PLAN's 40 pre-school centers will be used as a focal point for the formation of mothers clubs as well as for education and training in growth monitoring, use of ORT and control of diarrheal diseases, family planning, nutrition, etc. The project will coordinate closely with the Government of Haiti health services and immunization campaigns.

World Vision Relief Organization (WVRO)/Zimbabwe: WVRO is carrying out a highly innovative project to mobilize church and community support for the Government of Zimbabwe's primary health care program, with primary emphasis on immunization and parental training in appropriate use of ORT. WVRO will work through established churches and their congregations in 10 districts to serve 22,500 pregnant women and 25,000 children under 2 years of age. The project will train health coordinators in each congregation to educate, mobilize, and follow up in their communities to ensure broad based participation in the Government's efforts to expand immunization coverage and promote use of ORT.

CARE/Indonesia: In Indonesia and Bolivia CARE will carry out projects to integrate primary health care activities with its extensive water and sanitation program. In Indonesia CARE will train between 750 to 900 community health workers (CHWs) from 48 target villages to promote immunization programs, train mothers to prepare oral rehydration solutions and facilitate primary health care services with local community health centers. This project emphasizes health promotion working through CARE's established water committees; the CHWs will also coordinate closely with the Government clinics for immunizations and other health services.

B. Outreach programs from established PVO hospitals and clinics which provide health service delivery as well health education and promotion.

In approximately a quarter of the cases the PVOs have established hospitals or clinics with qualified health professionals and medical supplies. The Child Survival projects are enabling them to initiate or expand PHC outreach programs to serve nearby populations. All these projects include the training of village health workers, who are supervised and supported by PVO health professionals in the clinics. In contrast to most of the projects in the previous category, these projects can deliver health services such as immunizations, and provide in patient care for life threatening cases of dehydration, malnutrition, etc. In some cases these PVO projects coordinate closely with government health services; however, dependence on the government health system is reduced.

There are seven PVO Child Survival projects which fall into this category: The Salvation Army programs in Bangladesh and Pakistan; the Adventist Development and Relief Agency (ADRA) programs in Rwanda, Malawi and Haiti; the Minnesota International Health Volunteer (MIHV) project with the Kasangati Health Center in Uganda; and the International Child Care (ICC) program in Haiti. Two examples will illustrate the projects in this category.

SAWSO/Pakistan: The Salvation Army will expand two of its established primary health care outreach programs in Pakistan, and initiate new PHC outreach programs in four of its curative clinics in Orangi, Saddar and Azzam town in the Sind, and Thal in the NWFP. The project will enable the Salvation Army to extend health services to an additional 26,700 people in 11 villages near its clinics. The Salvation Army nurses will train and supervise health workers in each of these villages. This is a comprehensive PHC project including a mix of preventive and appropriate curative services. Immunization and training in ORT comprise about 40% of the interventions. Also included are: child spacing; ante-natal and post-natal care; growth monitoring and health education; distribution of Vitamin A capsules; treatment of pulmonary tuberculosis; and other curative services.

ADRA/Rwanda: ADRA is using its eight Adventist health care facilities in Rwanda as a base from which to extend health education and mobile immunization services to 379,000 people, including 78,500 children under five years of age, in nine adjacent communes. Nurse supervisors are training vaccinators who will work out of each health facility, transport vaccines to the communities in cold boxes, and hold community vaccination clinics. The nurses and promoters will also educate the mothers about the use of oral rehydration therapy, breast feeding, and child spacing.

C. Projects directed primarily towards the strengthening of host country government health services.

Several of the PVOs with projects funded by the Child Survival Initiative work very closely with, and through, host country government health services. These include Helen Keller International (HKI), International Eye Foundation (IEF), and Project Concern International (PCI). They employ qualified health professionals who direct their efforts towards strengthening the government health system, particularly with respect to primary health care outreach services. Typically, these PVOs assist Ministries of

Health with the design of key components of their PHC systems, and with development of appropriate monitoring and support systems. They provide technical assistance in the training of government primary health care personnel and, often, in the selection, training, and supervision of village health workers. The Child Survival projects are enabling these PVOs to expand their collaboration with the government health services to improve delivery of key Child Survival interventions at the community level.

There are five Child Survival projects in this category: HKI's projects in Indonesia and Bangladesh; PCI's projects in Indonesia and Bolivia; and IEF's projects in Malawi. Two examples will illustrate how these projects will operate.

HKI/Indonesia: HKI has collaborated closely with the Indonesia Ministry of Health for a number of years in the design and implementation of its extensive Vitamin A capsule distribution program; HKI was also one of the major collaborators in the recent study linking Vitamin A deficiency with infant mortality. This project will enable HKI to work with the Government of Indonesia (GOI) to design a gradual expansion of Vitamin A capsule distribution program. This will focus on children under six and mothers immediately after giving birth in a total target population of more than 7 million. HKI will also coordinate with the GOI to experiment with several alternative ways to increase Vitamin A intake in the population. These include Vitamin A liquid; use of fortified MSG; alternative nutrition education media messages to encourage children to consume Vitamin A rich vegetables; and the promotion of home vegetable gardens.

PCI/Bolivia: This project will enable PCI to expand its collaboration with the Government of Bolivia (GOB) in PHC outreach programs to two new departments Cochabamba and Potosi. PCI will provide training to the GOB primary health care workers, and assist in the identification, training and supervision of village health workers. PCI will work closely with the Government to develop effective pharmaceutical drug supply systems, and to carry out a wide range of PHC activities at the community level.

IX. Current Status of the Program: The Pre-Implementation Phase

Most PVOs received their funding in September and October. Currently most PVOs are working on project implementation plans, monitoring and evaluation plans and preparing for baseline surveys. Most projects will initiate the actual delivery of health services early next calendar year.

A.I.D. has also taken a series of steps to facilitate the initiation of these programs. It was clear when A.I.D. reviewed the proposals in April that despite the short period of time allotted for proposal preparation the PVOs had complied with the basic criteria for Child Survival programs especially with respect to problem identification and potential interventions. However, even the strongest project proposals needed further elaboration as to how the interventions would be carried out. Therefore, A.I.D. requested that the PVO grantees work with their field staffs to prepare detailed implementation plans by December 31.

Similarly, many of the monitoring and evaluation plans were weak, and A.I.D. recognized that the Child Survival program would have special reporting requirements. Therefore A.I.D. also asked the PVOs to develop appropriate project monitoring and evaluation protocols by December 31.

In September, A.I.D. organized a four day workshop for all the participating PVOs at Airlie House, Virginia, to clarify the special reporting requirements of the Child Survival program and to discuss management information systems, evaluation, and state of the art techniques for the delivery of ORT, immunizations, and other key health interventions. The workshop was attended by more than fifty PVO headquarters and field staff, and was successful in providing information on the delivery of the key health interventions, creating a forum for the substantive discussion of the reporting requirements, and establishing a spirit of collaboration among the PVOs and A.I.D. for this initiative. The PVOs, with their extensive field experience, made a important contribution to the finalization of the Agency's reporting system for the Child Survival Action Program.

FVA/PVC has also taken steps to ensure that the PVOs have access to any external technical support necessary for the preparation of technically sound implementation plans, and the successful initiation of project activities. Last summer, A.I.D. hired a consultant to meet with PVO headquarters staff to identify any external technical assistance needs, and as well as the range of resources that could meet those needs.

In September, A.I.D. established a modest one year collaborative Child Survival project with the National Council for International Health (NCIH) to assist in facilitating technical support to the PVOs. Under this collaborative project, consultants are now visiting a number of the field projects to provide technical assistance for the completion of the detailed implementation plans and to assess the technical support needs of the field staff for the implementation of project activities. Finally, FVA/PVC will have access to a limited amount of technical assistance through consulting firms in order to assist the PVOs in meeting specialized technical assistance needs.

X. Opportunities and Challenges Presented to A.I.D. and the PVOs by the Child Survival Initiative

This Initiative presents tremendous opportunities and challenges to the PVOs and A.I.D. The opportunities stem in part from the great attention focussed on Child Survival right now, the considerable amount of funding available and the chance to significantly reduce preventable deaths among the world's children. The challenges arise in large part from the size and complexity of the effort, the mandate to launch these programs as quickly as possible, and the desire to show clear, demonstrable results. I will focus first on some of the opportunities and challenges presented to the PVOs.

A. Opportunities for the PVOs

1. First, and perhaps foremost for the PVOs, this Initiative has provided them with additional funding support to expand and replicate programs in an area which they are committed to and is central to their humanitarian focus. Health care for mothers and children has long been an area of key concern to the PVOs. Increased support for these proven, low cost health interventions should significantly increase the positive impact of the PVO programs in this area.

2. Second, it provides an opportunity for the PVOs to demonstrate their capabilities, and their comparative advantages in the primary health care field. Because of the Congressional sponsorship and high visibility of this Initiative, there will be tremendous interest in the performance of the PVOs and they will have a ready platform from which to demonstrate the results of their programs. The PVOs have sometimes been criticized for their failure to document and share information about their projects. This Initiative will make support available to document some of the PVO "Success Stories". Funding and technical assistance is being provided to help the PVOs strengthen their management information systems, and collect information relevant to the performance of their programs.

3. Third, this offers an opportunity for the PVOs to move more into the mainstream of the primary health care field. It gives the PVOs a chance to receive more of the attention normally accorded to the large multilateral and bilateral projects. The PVOs now have an opportunity to increase their in-house health expertise and to obtain more of the relatively high priced external technical assistance to further professionalize their programs. In a number of cases the PVOs have already taken advantage of the additional resources to add health staff to their field programs. They will also have the opportunity to draw on selective technical expertise of some of the large health consulting firms utilized by A.I.D. for its bilateral programs. The Initiative should also provide the PVOs with an opportunity to strengthen ties with the Universities, and attract more of the graduates of the Public Health and Community Medicine programs.

#### B. Challenges for the PVOs

1. First and foremost is the challenge of initiating these new Child Survival projects in the field as soon as possible, consistent with the guidelines established for the new grants program. The infusion of resources to the PVOs from the Child Survival Initiative represents a considerable expansion of their activities in the health sector. Many PVOs are bringing on new health staff and hiring new promoters who have to become familiar with the PVO and target communities, and program objectives. Virtually all the PVO field offices are now in the midst of preparing their project implementation plans, and in some cases making necessary modifications in the original

project design. Some PVOs still have to obtain the formal approval for their projects from the host country ministries of health. Baseline studies will have to be completed in the next several months. Most of these projects will not be fully operational until early next year.

2. This Initiative clearly has important organizational and managerial implications for the participating PVOs in the health sector. As the PVOs expand their primary health care activities and add new interventions, not only do new staff have to be integrated into their organizations, but training for field staff and community health workers in the technical aspects of these health interventions has to be improved and expanded; in some cases new curricula and educational materials need to be developed. In many projects much more will be required of the existing multipurpose community health workers who are the backbone of the system; great care will have to be taken to ensure that these vital workers are not overburdened as they take on new responsibilities.

Most PVOs will have to make the logistical arrangements to ensure an adequate supply of health commodities for their service populations (i.e. vaccines, ORS, etc). This is particularly important for the many PVO projects that will not procure their own medical commodities directly, but are dependent on host-country government distribution systems for these supplies. In these cases the PVOs must make agreements with the ministries of health and other appropriate government agencies. Clearly, those PVO projects focussing primarily on health education and nutrition and seeking to link local populations with government health centers can not be successful if the government does not deliver the expected commodities and services.

3. In order to maximize effectiveness and impact the PVOs must seek ways to increase their collaboration with host country government agencies and other private organizations. Many PVOs work with relatively small populations, and PVOs rarely represent more than a small fraction of the total health resources in a country. Therefore, in order to leverage additional resources and to replicate and eventually institutionalize their programs the PVOs need to link their efforts with those of the other agencies working in primary health care in these countries.

The strong complementarity between the government health programs at the national level and the PVO projects at the local level has already been noted. Host country government health programs can often benefit from the access to community groups and local mobilization the PVOs can provide, and many PVO projects require the direct health services, and commodities that Government programs can deliver. In order to ensure the best possible fit between these complementary efforts, PVOs and government agencies have to develop more effective mechanisms for coordinating in the planning and implementations stages.

Close collaboration with the host country government health services is also vital if they are to adopt and replicate innovative approaches developed by the PVOs. As noted earlier, several of the PVOs such as Helen Keller International, International Eye Foundation, and Project Concern International are already working directly with Government agencies in order to strengthen their health services. Other PVOs testing innovative approaches in their programs need to develop effective mechanisms to bring these to the attention of government health services and to promote their replication.

Some of the U.S. PVOs are already coordinating with indigenous PVOs and other private groups working in their service areas. These ties need to be expanded and strengthened because of the opportunities to maximize impact through complementary efforts. It is also important for U.S. PVOs to help strengthen indigenous PVOs through training and other activities, because they can be an instrumental factor in the long term institutionalization of these programs.

The different U.S. PVOs working with primary health care in each country should also improve collaboration among their own programs. A number of cases have already been identified in which a U.S. PVO has a specific set of skills or resources that could benefit other U.S. PVO programs in the country. There can also be significant cost and other advantages from close collaboration in the training of field staff and sharing of external technical assistance resources. In several countries such as Haiti, Bolivia, and Indonesia the U.S. PVOs have already initiated a process of formal collaboration through the establishment of Child Survival coordinating committees and working groups. The success of these efforts to collaborate will depend in large part on the ability of the PVOs to bridge some of the differences between their highly individual approaches.

4. With the tremendous interest in this Initiative and commitment of resources to the PVOs, there is also the pressure to show results; A.I.D. and the Congress will want to know how effective the Child Survival monies are in improving the health status of children. The new reporting system which has been designed for the Child Survival Action Program should permit a better assessment of the effectiveness of the PVO programs, across the board and within specific countries. In order to report the kind of information required many PVOs will have to conduct improved baseline studies and strengthen their management information systems. The challenge is to design efficient management information systems to collect and monitor a limited set of data which is useful for project management and evaluation.

5. The Child Survival Program places strong emphasis on the delivery of a specific set of health interventions and on short term impact on health status. Yet traditionally, many of the PVOs have taken a much longer term, integrated approach to meeting the health needs of the local population. The PVOs will have to make an effort to ensure that this new emphasis on short term health outputs does not lead them to reduce their efforts in other related sectors, or to lose their long term development perspective. It is particularly important that they not neglect areas such as community involvement and the strengthening of local organizations which are critical to the institutionalization and sustainability of these programs.

6. Cost effectiveness and long term sustainability are key factors for the PVO planners to consider. The PVOs are initiating a dramatic expansion of their primary health care activities with these supplemental funds. Yet these projects have been funded by A.I.D. for only three years; the possibilities of obtaining additional external resources to continue these projects beyond that period are unknown at this time. PVOs must begin planning now for the sustainability of these projects at the end of three years.

The sudden infusion of new Child Survival and health funds may tempt some PVOs to make relatively high program expenditures, and to provide health services at little or no cost to beneficiaries in order to produce quick results. The resulting high cost per beneficiary could seriously jeopardize the prospects for long term sustainability. PVOs must be vigilant in monitoring the costs as well as the effectiveness of their efforts, and carefully maintain low costs per beneficiary if these projects are to be sustainable and replicable.

In addition to keeping cost per beneficiary and recurrent costs to a reasonable level, the PVOs need to develop fee for service and other cost recovery mechanisms which will help their health programs attain a degree of financial self-sufficiency. This is a particularly challenging area not only because of the low incomes of the service populations, but also because of the nature of the preventive health interventions. One of the PVOs that recently added a preventive health outreach component to its curative clinics has discovered that as the health status of the population has improved, revenues from curative services have declined. Nevertheless, some PVOs are experimenting with fee for service and other measures to generate local financing. The testing of innovative approaches to cost recovery is an area particularly well suited to the PVOs.

Another vital and challenging area is the institutionalization of preventive health services at the community level. Many of the PVOs are working to strengthen community organizations which can help to sustain health services at the local level. However, more experimentation is needed with mechanisms for community financing of basic health services. One of the most interesting experiments in creating self-sustaining health services at the community level is the Catholic Relief Services Project in Ecuador.

#### C. Challenges/Issues for A.I.D. in Working with the PVOs

1. The first major challenge for A.I.D. was to design a grants program for the PVOs which was consistent with the legislation and Agency priorities, and to obligate the funds in less than a year. Although some of the timetables were extremely tight -- particularly for PVO proposal preparation -- AID/Washington was successful in establishing a carefully targetted grants program, and in organizing a thorough, professional proposal review process which helped to ensure that the PVO projects with the highest potential were approved. This process has included provision for the PVOs to finalize project design prior to implementation.

2. A major challenge now is how to provide the most appropriate technical assistance and support to the PVOs for the successful initiation of these projects. Key questions relate to the amounts and kinds of support A.I.D. should provide and the mechanisms to use to ensure that critical PVO technical assistance needs can be met. Although many of the PVOs have some demonstrated capability in the health field, under this Initiative they are expanding the health components of their programs considerably, within a specific set of interventions, in a very short period of time. Therefore, adequate technical assistance and training will be key to successful project implementation, particularly during the initial phases.

It became very clear at the proposal review stage that a number of the PVO projects would need some external assistance in order to complete their detailed project planning and initiate implementation as soon as possible. Also clear was the need to ensure that project managers had adequate knowledge of state of the art techniques in the delivery of these health interventions, and could develop the management information systems necessary to monitor progress and measure effectiveness.

The question of how to provide technical assistance that would be responsive to the PVOs needs is significant because most of A.I.D.'s technical assistance mechanisms are designed primarily for the large bilateral projects. A.I.D. is now exploring ways that these technical assistance projects can be tapped to meet PVO needs; for example, how assistance to the PVOs can be "piggy-backed" onto the assistance provided to the government health programs. A.I.D. is also experimenting with some innovative approaches such as a collaborative project with NCIH to assist the PVOs in identification of their specific technical assistance needs and in obtaining access to the appropriate kinds of technical support. This question of how A.I.D. can best provide technical support to ensure the success of the PVO projects as they develop, will undoubtedly be an important concern throughout the life of these projects.

3. Another key question for A.I.D. has been the design of an appropriate reporting and evaluation system which could be used for both the PVOs and the bilateral programs and could provide some measure of project effectiveness and impact. This has been challenging not only because of the need to identify a limited number of common indicators appropriate for the different kinds of

projects but also because of the need for a practical, cost-effective system which would permit most of the program resources to be used for service delivery. A.I.D. has made a serious effort to develop a streamlined, three-tiered reporting system which requires basic output data from all projects, and invests the additional resources necessary for serious impact evaluations in only a select few. Even so, in order to collect the kinds of information desired at the second or third tier levels A.I.D. will have to make a serious effort to help the PVOs to improve the quality of baseline studies, and to strengthen their management information systems.

4. A.I.D. needs to resolve important questions about the relative role of AID/Washington and the A. I. D. Missions in monitoring and backstopping the centrally funded PVO Child Survival Projects. AID/Washington designed and launched the program, has direct communication with the PVO headquarters, and had a global overview of the different Child Survival projects being carried out by each organization. AID/Washington has also taken the steps described to provide technical support to the PVO projects. At the same time, many of the A.I.D. Missions have also taken an active interest in the PVO Child Survival projects. Some Missions with a large number of centrally funded and bilateral Child Survival projects, like Haiti and Indonesia, have appointed a fulltime in-country Child Survival coordinator. The Missions have the advantage of being close to the PVO projects in the field, having regular access to the PVO field staff, and being knowledgeable about other resources in-country.

This presents the opportunity for very effective, complementary coordination between AID/Washington and the Missions; however there is also the potential for confusion unless the relative roles of the two are explicitly defined. Clarification of the roles of the Missions and Washington in monitoring and providing technical assistance is also important in order to ensure that the PVOs do not receive mixed signals from the different A.I.D. offices.

5. Finally, A.I.D. will have to make an effort to ensure appropriate coordination between the PVO activities and other A.I.D. funded bilateral Child Survival activities and national government health programs. As noted earlier, many of the PVO projects focus heavily on health education and promotion and seek to link their target populations with government health services; therefore the effective delivery of government services will be key to the success of their projects.

Because of A.I.D.'s relations with host country governments and the substantial funding it provides for health activities, the local A.I.D. Mission is often in a position to play a facilitating role to ensure that government supplies and services reach the PVO target areas. Similarly, A.I.D. can play a key role in providing encouragement and financing to host country government agencies to adopt and replicate successful approaches developed by the PVOs. One of the challenges A.I.D. faces is how to encourage consistency between the PVO projects and government health programs and policies without stifling the PVO independence and innovativeness which are among their greatest assets.

## XI. Conclusion

The Child Survival Initiative has intensified and expanded the relationship between A.I.D. and the U.S. PVOs in the primary health care field. In the last year A.I.D.'s funding to the PVOs for health activities has doubled. This infusion of resources to the U.S. PVOs provides an unprecedented opportunity for the PVOs to play a key role in the worldwide effort to reduce infant mortality.

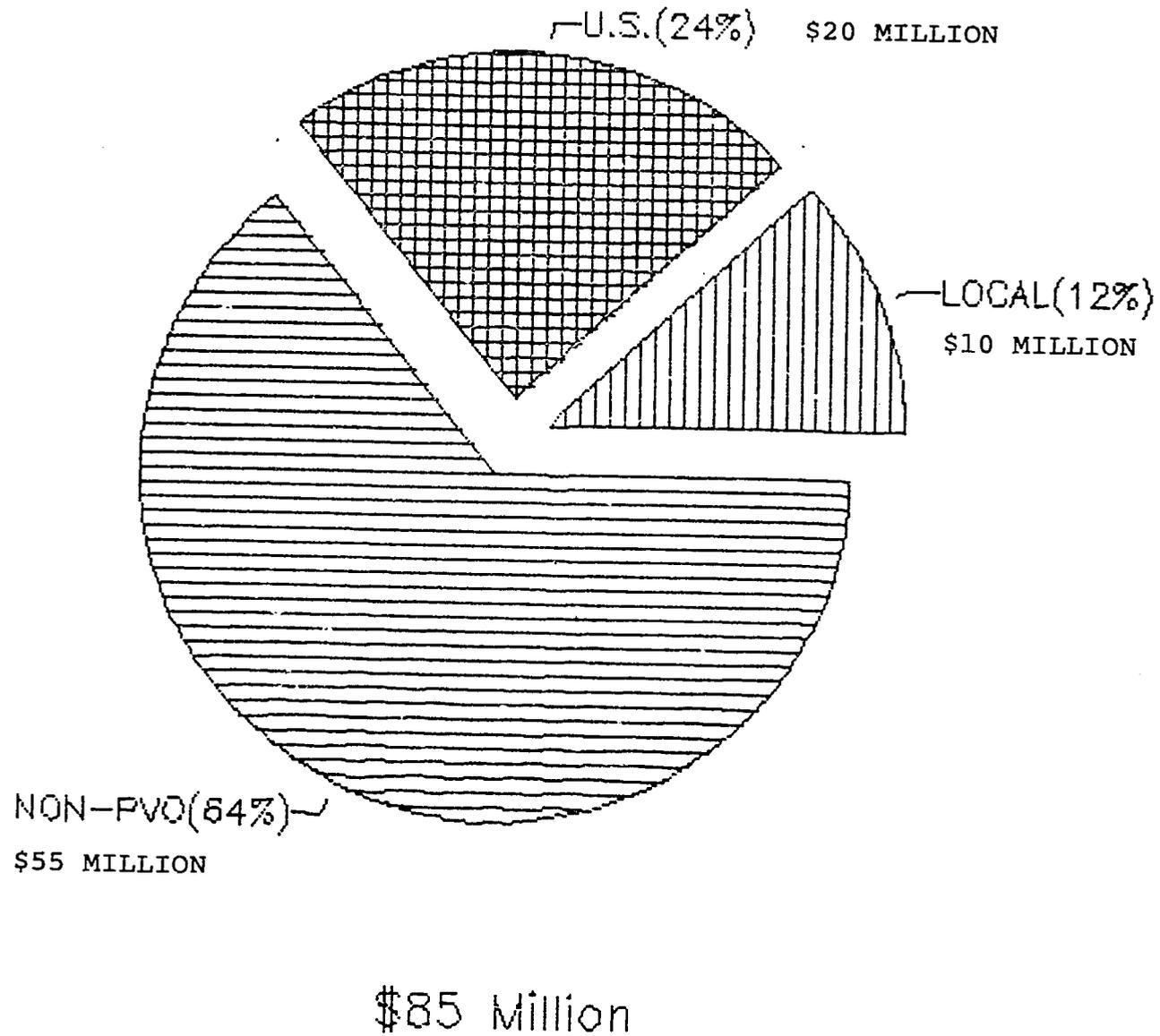
The success of the PVOs in this effort will depend in part on their ability to collaborate with host country government agencies and other organizations working to improve the health status of mothers and children; i.e. to become an integral part of the broader effort. It will also depend on their ability to avail themselves of the resources from A.I.D. and other donors to strengthen their primary health care programming and management, and to increase in-house technical expertise in the delivery of these interventions.

Finally, the ultimate measure of the PVOs success will be their ability to develop the methodologies and linkages necessary to institutionalize these health services at the local level, and to sustain this effort over the long term.

# PVO'S SHARE IN A.I.D.'S CHILD SURVIVAL ACTION PROGRAM

FIGURE 1

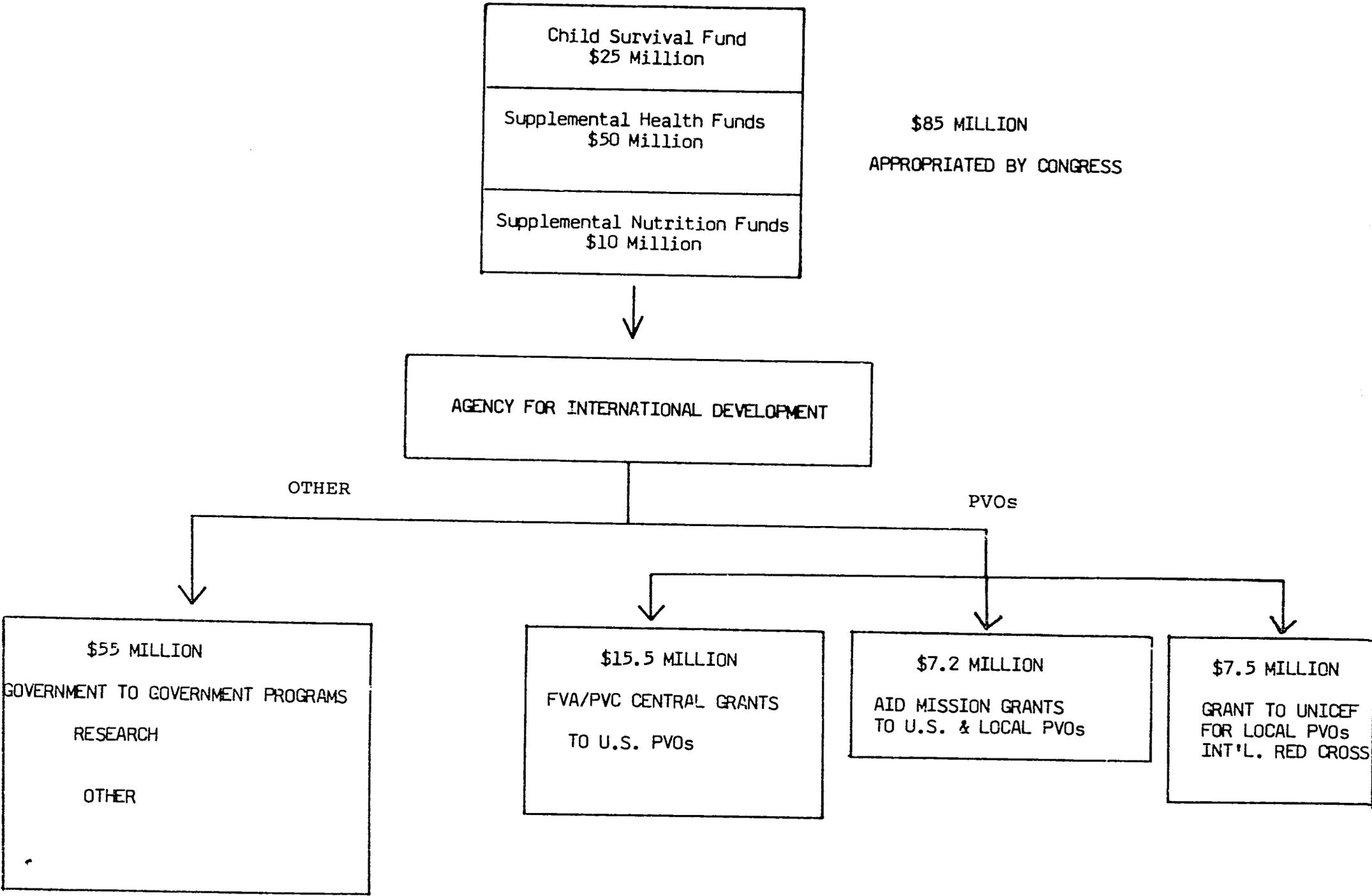
2



DISTRIBUTION OF SUPPLEMENTAL CHILD SURVIVAL HEALTH AND NUTRITION HEALTH FUNDS

FIGURE 2

29



# DISTRIBUTION OF PVO ACTIVITIES IN AID'S CHILD SURVIVAL ACTION PROGRAM

FIGURE 3

30

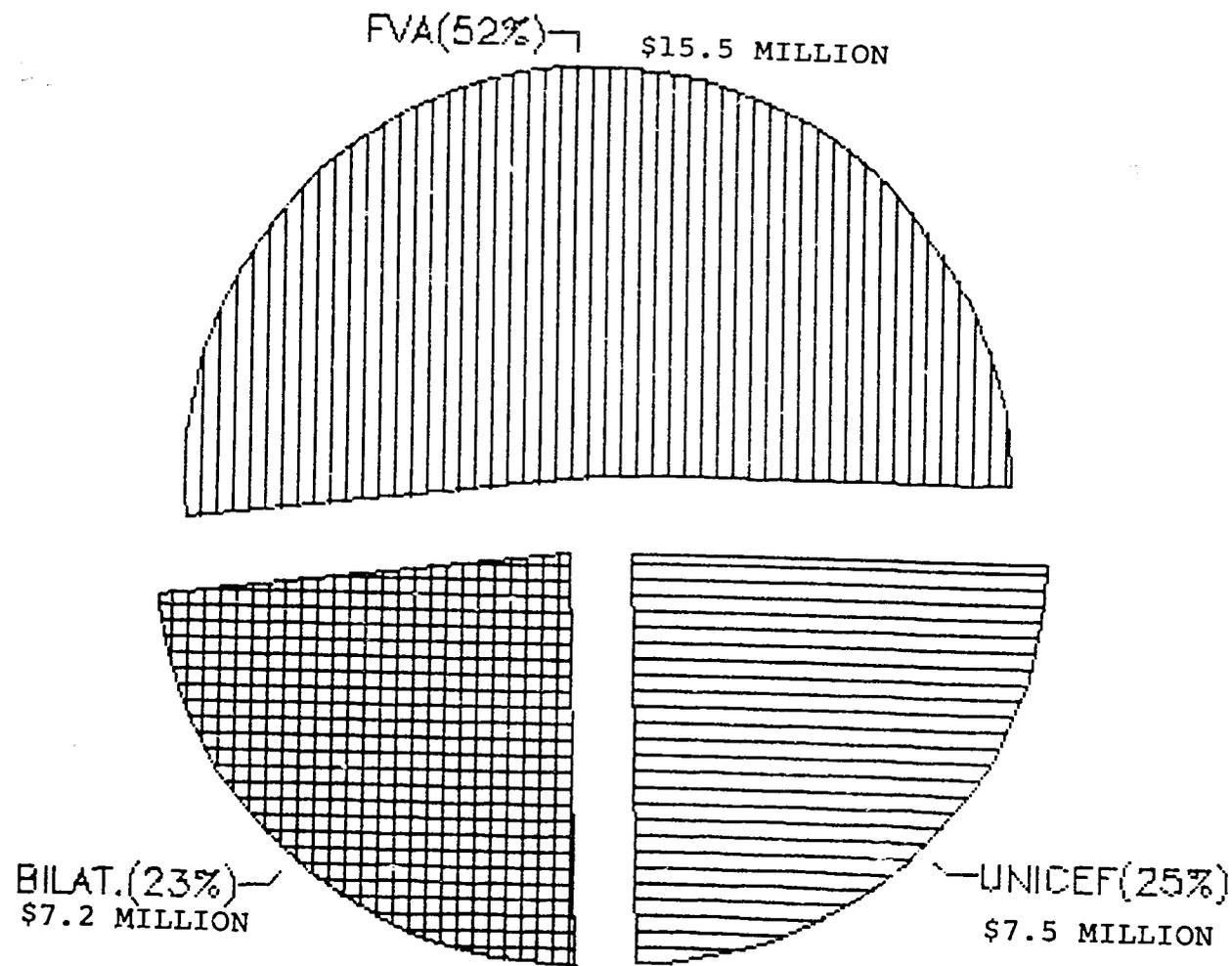


TABLE 1

PROPOSAL REVIEW AND APPROVAL PROCESS FOR FVA/PVC  
CENTRAL PVO CHILD SURVIVAL GRANTS PROGRAM

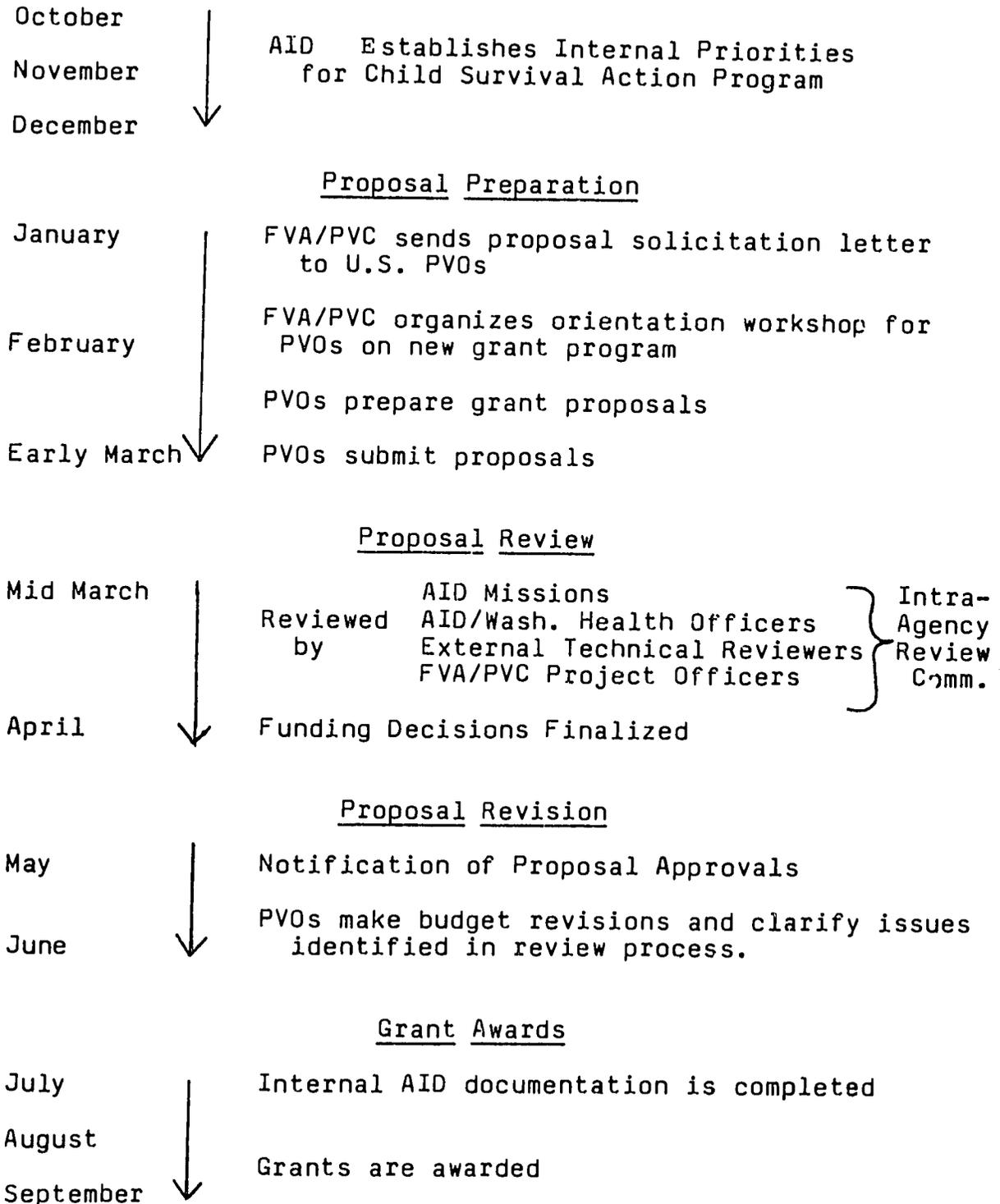


TABLE 2

DISTRIBUTION OF PVO CHILD SURVIVAL PROJECTS AND BUDGET ALLOCATIONS BY COUNTRY AND REGION (all figures in 000)											
AFRICA				LATIN AMERICA				ASIA			
COUNTRY	PVO NAME	NUMBER OF PROJECTS	BUDGET	COUNTRY	PVO NAME	NUMBER OF PROJECTS	BUDGET	COUNTRY	PVO NAME	NUMBER OF PROJECTS	BUDGET
Malawi	IEF ADRA	2	750	Ecuador	SCF CRS	2	1,091	Indonesia	HKI PCI SCF CARE	4	1,834
Kenya	SAWSO	1	149	Bolivia	CARE PCI SCF	3	1,819	Bangladesh	SCF SAWSO HKI	3	1,646
Uganda	CARE MIHV	2	856	Haiti	ICC PLAN CARE ADRA SAWSO	5	2,032	Pakistan	SAWSO	1	626
Zimbabwe	SCF WVRO	2	1,654	Guatemala	HOPE	1	700				
Rwanda	ADRA	1	270								
<u>TOTALS</u>		8	3,679 (27%)			11	5,642 (42%)			8	4,106 (31%)

TABLE 3

U.S. PVO HEALTH AND NUTRITION INTERVENTIONS

<u>INTERVENTIONS</u>	<u>APPROACH</u>
1. ORAL REHYDRATION THERAPY	<ul style="list-style-type: none"> <li>- ORS packets</li> <li>- Preparation of home solutions</li> </ul>
2. IMMUNIZATION	<ul style="list-style-type: none"> <li>- Direct administration of Vaccination programs</li> <li>- Promotion of community participation in Government Vaccination programs</li> </ul>
3. HEALTH and NUTRITION EDUCATION	<ul style="list-style-type: none"> <li>- Growth monitoring</li> <li>- Breast feeding</li> <li>- Child nutrition</li> <li>- Maternal and child health care</li> <li>- Hygiene</li> </ul>
4. CHILD SPACING	<ul style="list-style-type: none"> <li>- Education about birth spacing and family planning</li> <li>- Distribution of contraceptives</li> </ul>
5. FOOD SUPPLEMENTS	<ul style="list-style-type: none"> <li>- Distribution of Title II Foodstuffs</li> <li>- Supplemental feeding in nutritional rehabilitation centers</li> <li>- Home vegetable gardens</li> </ul>
6. VITAMIN A	<ul style="list-style-type: none"> <li>- Distribution of Vitamin A capsules</li> <li>- Experimentation w/Vitamin A liquids, fortified MSG and local production of Vitamin A rich foods</li> </ul>
7. OTHER:	
WATER and SANITATION	
PRENATAL and POSTNATAL CARE	
PHARMACEUTICAL SUPPLY SYSTEMS	
LIMITED CURATIVE SERVICES	

CATEGORIZATION OF PVO PROJECTS BY APPROACH / RELATIONSHIP TO GOVERNMENT HEALTH SERVICESI. PROJECTS WHICH STRENGTHEN PHC COMPONENTS OF RURAL DEVELOPMENT PROGRAMS AND PROMOTE LINKAGES WITH GOVERNMENT HEALTH SERVICES

1. CARE
2. Foster Parents Plan
3. World Vision Relief Organization
4. Catholic Relief Services
5. Salvation Army (Homeleagues)
6. Project Hope
7. Save the Children

II. EXPANSION OF PHC OUTREACH PROGRAMS FROM ESTABLISHED PVO HEALTH FACILITIES

1. Adventist Development and Relief Agency (ADRA)
2. Salvation Army (Pakistan and Bangladesh)
3. Minnesota International Health Volunteers
4. International Child Care

III. PROJECTS FOCUSED ON STRENGTHENING GOVERNMENT HEALTH SERVICES

1. Helen Keller International
2. International Eye Foundation
3. Project Concern International