

1987 WORKSHOP PLANNING NEEDS OF PRIVATE VOLUNTARY ORGANIZATIONS IN AFRICA

Agency for International Development
FVA/PVC

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Resources for Child Health Project

REACH



John Snow, Inc.
1100 Wilson Boulevard, 9th Floor
Arlington, VA
22209 USA
Telex: 272896 JSIW UR
Telephone: (703) 528-7474

PN-ABC-533

1987 WORKSHOP PLANNING NEEDS OF AFRICA PRIVATE VOLUNTARY ORGANIZATIONS

**I. 1987 ACTIVITIES AND GUIDELINES FOR PRIVATE VOLUNTARY ORGANIZATIONS
REGIONAL AND COUNTRY WORKSHOPS**

Mary Carnell, MD, MPH
Consultant

Dory Storms, ScD, MPH
Private Voluntary Organizations
Child Survival Support Program
Johns Hopkins University

II. REVIEW OF TECHNICAL NEEDS FOR 1987 AFRICA CHILD SURVIVAL WORKSHOPS

Mary Carnell, MD, MPH
Consultant

The Resources for Child Health Project
1100 Wilson Boulevard
Ninth Floor
Arlington, VA 22209

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FOREWORD

At the request of the Bureau of Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation (FVA/PVC), the Resources for Child Health Project provided consultant Mary Carnell, PhD, health planning specialist, to assist with addressing workshop planning and implementation needs of Private Voluntary Organizations in Africa. This activity was performed in two parts: (1) development of a 1987 workshop schedule, and planning guidelines for regional and country workshops; and (2) assessment of technical needs for 1987 Africa Child Survival workshops. The following pages include the two components outlined above.

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Mary A. Carnell, MD, MPH

Consultant
Resources for Child Health Project
John Snow, Inc.
Arlington, Virginia

Dory Storms, ScD, MPH

Private Voluntary Organizations
Child Survival Support Program
Institute for International Programs
Johns Hopkins University School of Hygiene and Public Health

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1987 ACTIVITIES AND GUIDELINES
FOR
PRIVATE VOLUNTARY ORGANIZATIONS
CHILD SURVIVAL REGIONAL AND COUNTRY WORKSHOPS

INTRODUCTION

This document is directed to an audience with a variety of perspectives as concerns the upcoming workshops. It introduces the program of activities as currently scheduled for 1987. It defines who will be participating in each event, and discusses the roles of various participants. It captures some lessons learned from last year's Meals for Millions Workshop in Sierra Leone in April, 1986. The guidelines should be helpful to PVOs who will be planning PVC funded regional or country workshops in the coming year. As more experience is gained with future workshops, the strategies and guidelines will evolve to reflect the experiences of other PVOs hosting workshops. In this way, the overall approach to workshops will be strengthened.

REGIONAL AND COUNTRY WORKSHOPS SCHEDULED FOR 1987

- IIP
AID/Indonesia Indonesia - 2 day country seminar, overlap with Storms visit in Feb 87; focus on training and evaluation issues (per AID Mission CS coordinator); discussions with FKMI (Ascobat Gani); Field visits to CARE, HKI, PCI, SCF (FY85), and mission funded CRS
- PVO/IIP
JHU/PRITECH Bolivia - 5 day country workshop, late Spring 1987, planned by JHU/PRITECH and hosted by field project; focus on procurement and logistics of ORT, nutrition, evaluation and health information systems; involve G. Smith; 12 participants: PCI, SCF, CARE (FY85); ESP, PCI, PLAN (FY86)
- PVO/IIP
REACH Rwanda - 7 day regional workshop, July 1987; hosted by ADRA/Rwanda; focus on immunization, nutrition, ORT for first year implementation; involve REACH, CDC. 14-15 participants from francophone Africa: ADRA/Rwanda (FY85); CARE/Mali, CRS/Senegal, PLAN/Mali, SCF/Cameroon, WVRO/Senegal, and HKI/Reg. Africa (FY86)
- PVO/IIP
REACH/PRITECH Zimbabwe - Two 7-day regional workshops. The first workshop to be hosted by WVRO, June 1987; focus on immunization, nutrition and ORT; 16-18 participants from FY 86 projects in English-speaking Africa: AMREF/Kenya, CARE/Sudan, SCF/Malawi, SCF/Sudan, WVRO/Sudan, HKI/Reg. Africa, AFRICARE/Nigeria and late-starting FY85 project CARE/Uganda
- PVO/IIP The second hosted by SCF, October 87; focus on village level health information systems; 12-14 participants from FY85 projects in English-speaking Africa: ADRA/Malawi, IEF/Malawi, MIHV/Uganda, SAWSO/Kenya, SCF/Zimbabwe, WVRO/Zimbabwe (FY85)
- USA WORKSHOPS**
- IIP Baltimore - 1½ day meeting at Hopkins, Dec. 1986, with PVO Headquarters technical staff.

GOALS for Workshops in 1987

The goal of FVA/PVC's technical support activities for PVO Child Survival(CS) programs is to improve infant and child potential for survival in developing countries. Country and regional workshops are an important component of AID's technical assistance strategy. Through workshops, PVOs enhance their roles in the child survival initiative and improve their strategic competence as related to Child Survival projects.

Some objectives of PVO child survival workshops in 1987 are to:

1. Promote collaboration and information sharing among PVOs who have FVA/PVC funded child survival grants
2. Facilitate the exchange of ideas and experiences among field personnel of PVOs working in child survival
3. Improve the delivery, use and effectiveness of child survival technologies by the PVOs, including immunization, oral rehydration, growth monitoring and breast feeding
4. Improve management information systems, including monitoring, baseline surveys, evaluation, and the establishment of program indicators
5. Provide PVO field staff with practical training in key child survival interventions
6. Familiarize the PVO field staff with AID reporting requirements
7. Identify ways to improve the in-country coordination and communication of PVO child survival activities between host country governments, bilateral, international and other non-governmental organizations working in health
8. Promote networking among PVOs in the region and/or country working on child survival in a way which builds on the network begun during the Sierra Leone Workshop in April, 1986.

STRATEGIES for PVO Child Survival Workshops in 1987

Workshops will be based on a needs assessment that corresponds to the needs identified in the field. To meet the proposed goals and objectives, the strategies for PVO Child Survival workshops include:

1. An opportunity to use PVO expertise and PVO field sites in a collaborative effort between PVOs and AID as part of the technical assistance strategy
2. Workshops for projects in their first year of implementation (projects funded in FY86) will focus on the key interventions of immunization, oral rehydration and nutrition.
3. Workshops for projects in their second year of implementation (projects funded in FY85) will focus on information systems and issues of sustainability.
4. Regional workshops to be divided according to primary language as workshops will be conducted in only one language. For example, francophone and anglophone workshops will be held separately in Africa.
5. Country workshops will incorporate all AID centrally funded child survival projects in the country (regardless of year of funding) and will be held in the main language used in that country (French, English or Spanish).
Because no country workshops have yet been conducted, these workshop guidelines may need revision subsequent to the upcoming Bolivia workshop.

STRATEGIES for PVO Child Survival Workshops in 1987 (cont.)

6. Field-based country or regional workshop
7. Small group format using a participant-observation methodology to maximize networking and interaction among participants
8. Regional workshops will emphasize project cohorts who began their Child Survival grants in the same funding year.

		Dates of Funding				
		85/86	86/87	87/88	88/89	89/90
FY85	CSI	1	2	3		
FY86	CSII		1	2	3	
FY87	CSIII			1	2	3

PEOPLE to be involved in the Workshops in 1987

1. Workshop Staff
 - a. Host PVO Workshop Coordinator - chosen by host PVO headquarters
 - b. Workshop Facilitator - hired by host PVO through their workshop budget
 - c. AID Workshop Technical Liaison - selected and funded by PVO Child Survival Support Program, Institute for International Programs, Johns Hopkins University School of Hygiene and Public Health, under the Cooperative Agreement with FVA/PVC
 - d. Technical Consultants - chosen after technical needs for workshop identified; funded by FVA/PVC
 - e. Local Resource Persons - identified by host country PVO and funded through workshop budget

2. PVO Participants
 - a. For purposes of sustainability, recommend that participants be local PVO staff who are actually responsible for delivery of services or direct supervision of service delivery; more senior PVO staff (Regional Director, etc.) may attend on a case-by-case basis.
 - b. Small group to optimize exchange and provision of technical assistance to each individual project.
 - c. Overall workshop size should be limited to maximize learning and minimize logistical problems such as transportation to communities, etc. No more than one to two persons from each PVO will be able to attend. Experience from the Meals for Millions Sierra Leone Workshop showed that 12-15 participants and 5-7 staff was the maximum that could be well managed with their format.

3. AID Participant(s)

- a. Because these workshops represent a unique learning opportunity for AID as well as PVO staff, AID will, in most cases, send at least one representative to the workshop as a participant/observer.
- b. The AID representative may serve as a resource to clarify any question which arise regarding AID policy and procedures with respect to Child Survival.
- c. Through understanding the realities that PVO projects face in the field, the AID representative will provide feedback to AID about lessons learned from the workshop, in order to improve AID's support to Child Survival projects in the future.

4. PVO Workshop Training Organizer

- a. Chief person relating to AID regarding workshop activities
- b. To be selected by host PVO from their headquarter's or regional staff
- c. Needs to be allotted considerable time for workshop planning

5. Facilitator

A facilitator is a key element for a successful workshop. He/she can help:

- a. provide structure for workshop planning and implementation, focussing on the process of the workshop
- b. provide a focus for workshop leadership, freeing other team members to concentrate on technical and organizational matters
- c. develop a cohesive workshop team

5. Facilitator (cont.)

- d. clarify participants' expectations of the workshop and help them form an effective working group seeking common objectives
- e. monitor participant interest and involvement, the appropriateness and timing of activities and group cohesiveness
- f. establish a climate in which all participants are considered as resource persons - an environment of equality, sharing and active involvement

6. AID Workshop Technical Liaison

Representing the PVO Child Survival Technical Support Program, Institute for International Programs, Johns Hopkins University School of Hygiene and Public Health, this person will assist workshop planning by fulfilling the following tasks:

- a. Act as direct liaison to AID to develop the workshop in conjunction with FVA/PVC Child Survival Coordinator
- b. Review AID's recommendations in response to required reports of all PVO projects participating in the workshop - specifically, technical recommendations to Detailed Implementation Plan for projects in Year 1 of implementation and First Annual Report for projects in Year 2 of implementation (This specific activity will be conducted under funding from the Resources for Child Health).
- c. In conjunction with AID's FVA/PVC Child Survival Coordinator, will insure plans for workshop reflect lessons learned from previous workshops
- d. Communicate with PVOs who have held Child Survival workshops to incorporate their suggestions in planning and conducting workshops
- e. Meet with host PVO workshop training organizer to integrate the identified technical components into the workshop format - identify and synthesize select priority messages to be transmitted during the workshop
- f. Work with workshop training organizer in obtaining necessary technical resource materials for participants and the resource center which will be set up for participants during the workshop

PEOPLE to be involved in the Workshops in 1987 (cont.)

7. Local Resource Persons

- a. Identified by local host PVO
- b. Their participation can provide a valuable link between international expertise and field operations issues
- c. Promotes local interest and "ownership" in workshop activities and priority messages

PRACTICAL GUIDELINES FOR PVO CS WORKSHOPS in 1987

The following components are necessary for planning a workshop:

1. Plan, Plan, Plan - Role of Host Headquarter's PVO
 - a. Define objectives, clarify expectations and set practical and measurable desired outcomes based on articulated needs of participating PVO field staff.
 - b. PVO needs to be prepared to contribute significant amount of staff time to this substantive planning endeavor. Meals for Millions contributed 75% of one person's staff time over a 3 month period.
 - c. Host country program director should be involved from the beginning and throughout the workshop planning process.
 - d. Develop lesson plans and make contingency plans in case problems arise with transportation, supplies, housing, weather, etc.

2. Resource Persons

- a. Resource persons should be identified to fill roles of facilitator, training organizer, technical consultants and local resource persons.
- b. Interpersonal skills which allow them to work as part of a team effort are essential.

3. Date

Mutually convenient time for AID and host PVO to allow for adequate planning and local participation and coordination with AID FVA/PVC Child Survival Program and technical consultants.

PRACTICAL GUIDELINES FOR PVO CS WORKSHOPS in 1987 (cont.)

4. Training Design

- a. Detailed daily lesson plans must be developed.
(See attached sample lesson plan, following page)
- b. Plan unstructured, quiet time into program for personal work.
- c. Do not overplan the time available - avoid evening sessions as lack of electricity and participant fatigue cautions against this.
- d. Daily assessment by participants and staff to keep a perspective on where they are vis-a-vis objectives of workshop. This allows adjustments to be made in the process so that individuals' expectations can be met while also satisfying workshop goals.
- e. Community visits scheduled daily, if possible, to provide "hands-on" learning and concrete examples for further discussion
- f. Additional time must be allowed for transport if community sites and/or workshop classroom is not at the same location as lodging for participants

5. Content based upon needs assessment.

In order to design a workshop which will address the technical development needs of PVO field staff to strengthen their skills in the field, those planning a workshop need to research their varying needs by:

- a. A letter of invitation from the host PVO to participating PVOs headquarters requesting their perceived needs and strengths of field project staff and their recommendations as to participants who would benefit most from the proposed workshop.
- b. Review by AID Workshop Technical Liaison of the recommendations from consultants who have given technical assistance to participating projects outlining various needs they identified

PRACTICAL GUIDELINES FOR PVO CS WORKSHOPS in 1987 (cont.)

5. Content based upon needs assessment. (cont.)

- c. For workshops for projects in their first year of implementation, preparation should include a review by AID Workshop Technical Liaison of AID's technical review panel of the detailed implementation plans of participating PVO projects.
- d. For workshops for projects in their second year of implementation, preparation should include a review by AID Workshop Technical Liaison of recommendations from the First Annual Project Reports of participating PVO projects.

6. Participant-Observer Learning Format

- a. Small group discussions to encourage a high level of participant involvement
- b. Combined field visit/discussion format to reinforce learning and demonstrate practical applications for new concepts
- c. Supplement discussions with short technical presentations on key child survival interventions

7. Location

- a. Environment conducive to learning and sharing with other PVO field staff
- b. Workshop location should reflect the workshop objectives. For example, if the purpose of the workshop is to reinforce child survival interventions for the rural communities, then workshop location in a rural setting would be most appropriate.

- c. Modest rural setting close to project activities allows:

-discussion of project realities with community members and field workers

-valuable transfer of learning theory into actual practice

-few distractions for participants; social time together provides in depth learning about each other's programs and experiences and contributes to valuable networking among projects

PRACTICAL GUIDELINES FOR PVO CS WORKSHOPS in 1987 (cont.)

8. Resource Materials

- a. A packet will be provided for each participant which covers all major technical aspects of child survival.
- b. To include essential information that cannot be covered during a short workshop
- c. Can be used to reinforce learning activities
- d. Can serve as valuable information for future reference

9. Resource Center

- a. To be developed at workshop site
- b. Allow participants exposure to other materials which cannot be provided individually because they are either too expensive, too bulky or only relevant to specific projects
- c. A place to share materials which others bring from their projects/countries on health education, health intervention, etc.
- d. Allows space for participants to spend their quiet and/or personal work time during the workshop

10. Budget

- a. Approximately \$40,000 has been provided by FVA/PVC to each of the host PVOs to carry out the three African regional workshops. These funds are intended to cover the following local workshop expenses: housing, food, materials, local transport and all participants' airfare/travel from home country to and from workshop site; salary per diem and travel for workshop facilitator.
- b. Usually these funds will not be adequate to cover host PVO headquarter staff's travel to attend and/or plan the workshop.
- c. AID provides technical assistance for workshop as regards planning and implementation of the workshop, including salary, travel and per diem for technical consultants.

II. REVIEW OF TECHNICAL NEEDS FOR 1987 AFRICA SURVIVAL WORKSHOPS

Review of the Technical Needs
for
1987 Africa Child Survival Workshops

Mary A. Carnell, MD, MPH
Consultant

Submitted to the:

Office of Private and Voluntary Cooperation
Bureau of Food for Peace and Voluntary Assistance
United States Agency for International Development/Washington

The Resources for Child Health Project
1100 Wilson Boulevard
Ninth Floor
Arlington, Virginia 22209

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1.0 Introduction

Three regional workshops are planned for Africa in 1987 as part of the technical assistance strategy for Private Voluntary Organizations (PVO) who have received AID Child Survival (CS) Grants. Currently, 11 PVOs with a total of 19 projects in 10 countries are operating in Africa. An understanding of the technical aspects requiring emphasis during these workshops is necessary for workshop planning. Towards this objective, a review of all project files, to date, was done. This included project proposals, issue papers, notes from the technical review panel, AID correspondence to PVOs, and trip reports by technical consultants. Detailed Implementation Plans (DIP) with technical reviews and Annual Reports with AID comments were present only for the projects funded in FY 85.

The PVOs have made considerable progress in the technical aspects of project planning and implementation. This report will trace this progress and then attempt to identify the areas which demand further strengthening. Detailed Implementation Plans for 12 of the 19 projects will be reviewed in April 1987. An update to this report will be made after this time, when considerable technical detail lacking in initial proposals will be presented.

This paper is written with a variety of readers in mind. The PVOs hosting the workshops need input on the strengths and weaknesses of the participating projects. This should enable them to focus their planning to better utilize the important experience/training of attending participants, as well as design the workshop to address the most urgent technical needs of the group. For AID and those groups supplying technical assistance to these workshops and projects, this report should clarify the needs of the PVOs with CS grants and help them better orient their assistance.

It is important to note that this paper will not define the technical needs of each individual project. The details of the review process, project by project, are too lengthy to be included, and remain incomplete until 12 of the 19 projects submit Detailed Implementation Plans. A summary of the strengths and needs for the group will be presented by technical subject area.

2.0 Background

2.1 1987 Regional Workshop Strategy for African CS projects

In-country workshops have been selected as a strategy to strengthen PVO field staff in the effective delivery and evaluation of priority child survival interventions. Hosted by PVOs, using a participant-observer methodology, these workshops should achieve a variety of objectives:

- 2.1.1 promote collaborative networking of PVO field staff within the African region

- 2.1.2 provide a good learning environment for PVO field staff, offering an opportunity to share experiences and learn from each other.
- 2.1.3. promote the technical development of the sponsoring PVO through the process of workshop planning and by the field-based review of their project by others in CS
- 2.1.4 allow AID a better understanding of field conditions and facilitate a two-way transfer of information
- 2.1.5 provide technical training at a lower cost than by individual field visits to all projects

2.2 Categories of PVO Projects

John Grant, FVA/PVC Child Survival Coordinator, developed a model to categorize PVO projects into 3 groups in terms of their program approach and their relationship to host country government health services. This was presented in a paper entitled, "US PVO and Congressional CS Initiative", November, 1985. It is a useful tool to understand the organizational orientation of PVOs in CS and the implications this has for technical strengths and weaknesses in their projects. It is helpful to generalize when looking for patterns in formulating a group strategy, such as planning a workshop for several PVOs. The three categories are summarized here, with full recognition that there are always exceptions and projects could fit into either of two categories. PVOs are listed according to their activities in the 19 FVA/PVC funded CS projects in Africa.

- 2.2.1 Projects which strengthen the Primary Health Care (PHC) component of rural development programs:
 - emphasis on promotional and educational efforts to improve community health practices and community access to government health services.
 - wide range of development activities at community level.
 - PHC as one component of a broader effort to improve living conditions of the local population.
 - extensive networks of community organizations.
 - potential to promote effective linkage between community groups and government health services, particularly EPI and referrals.
 - Examples: SCF, CARE, SAWSO, PLAN, CRS, WVRO, AFRICARE

These projects with a strong community base and community development orientation may have difficulties prioritizing CS activities. They often attempt to be responsive to community "felt" needs, but personnel may lack significant health experience. However, they know the communities well and have the potential to reach community organizations and members to ensure the children at risk in their target populations have access to basic health interventions.

2.2.2 Outreach programs from established PVO hospitals and clinics:

- provide health service delivery, immunization, treat dehydration, and malnutrition, etc.
- provide health education and health promotion
- train village health workers (VHW) who are supervised and supported by PVO health professionals in clinics/hospitals
- Examples: ADRA, MIHV, AMREF, SCF (Malawi)

Projects in this group employ medical personnel, often filling a government niche where they have few, if any, services. An emphasis on clinical work with a lack of public health orientation, outreach strategies and community program management skills can pose problems to implementing CS strategies which require targeting certain subsets of the population. Often the clinic approach is passive, serving those who appear, rather than seeking out the "high risk" population and/or drop-outs. These projects have the potential to do the technical aspects of child survival very well, for example, vaccine delivery.

2.2.3 Projects directed primarily towards the strengthening of host country government health services, frequently at the central level.

- employ qualified health professionals who direct their efforts toward strengthening the government health system, particularly PHC outreach service
- assist MOH with the development of PHC systems and appropriate monitoring and support systems
- provide technical assistance in training government PHC personnel
- Examples: HKI (Regional Technical Assistance), IEF

These projects, positioned in the Ministry of Health, attempt to facilitate change within the system. Well equipped to do health training, they may have more difficulty in planning service delivery for rural populations and the mobilization of communities to participate in their programs.

2.3 PVOs Grouped by Workshop

The purpose for this review is to assess the technical needs for the three regional Africa workshops. Therefore, it is important to conceptualize the mix of PVOs who will send field staff to each of the workshops. Using the categories just described, one can begin to identify potential strengths and weaknesses in the PVOs. This should assist the workshop strategy agenda planners to utilize participants as resource persons and in their selection of the technical areas to emphasize.

2.3.1 Francophone FY 86 Projects Rwanda

ADRA - 85 Rwanda - Host
CARE 86 Mali
CRS 86 Senegal
PLAN 86 Mali
SLF 86 Cameroon
WVRO 86 Senegal
HKI 86 Africa Region

2.3.2 Anglophone FY 86 Projects - Zimbabwe

WVRO 85 Zimbabwe - Host
AFRICARE 86 Nigeria
AMREF 86 Kenya
CARE 86 Sudan
SCF 86 Malawi
SCF 86 Sudan
WVRO 86 Sudan
CARE late 85 Uganda
HKI 86 Africa Region

2.3.3 Anglophone FY 85 - Host and Location to be decided

ADRA 85 Malawi
IEF 85 Malawi
MIHV 85 Uganda
SAWSO 85 Kenya
SCF 85 Zimbabwe
WVRO 85 Zimbabwe

Francophone 86 - Since there is considerable representation of PVOs with a strong community based focus, one could anticipate they would have much to share in their strategies for outreach, community mobilization, and local participation in decision making. However, their technical needs for designing and implementing the actual delivery of services (EPI, ORT programs), doing baseline data collection, and program monitoring may be major areas for concentration at the workshop.

Anglophone 86 - There is a fair mix of groups strong in service delivery and training as well as community participation, thereby offering considerable resources within the group for learning from each other. Technical assistance to the workshop will need to be more specifically focused on technical aspects of CS which will not be well understood by those attending the workshop.

Anglophone 85 - This group contains considerable breadth of PVO expertise, as well as two years of experience in their CS projects. They will require more time than the FY 86 workshops to share their "successes" and "lessons learned" with others doing similar work. Workshop activities will need to focus on helpful strategies to

resolve details of monitoring their projects, planning for sustainability after funding ends, and the evaluation of project progress.

3.0 Technical Aspects of Child Survival

The list and discussion of technical concerns which this section addresses is by no means definitive. It represents the author's effort to summarize the important technical needs for achieving further success in CS interventions. There is difficulty in attempting to break all the technical needs into component parts. Although it facilitates discussion and allows more precise comments on each subject, many of the areas are closely interwoven and depend upon one another to achieve a particular outcome. The topic of sustainability of effective activities is a case in point, and will be addressed separately in the next section. A demographic orientation is required when approaching all the technical areas and will be discussed first.

3.1 Demographics

A demographic perspective can be thought of as the matrix into which the CS activities must be woven. It is necessary to think in demographic terms, rather than purely geographic ones when designing program strategies. Particularly for PVOs whose staff have a clinic base and/or medical/nursing training, the concept of defining how to target a specific subset of the population for intervention often proves difficult. To choose an appropriate strategy, one needs to know the magnitude of the problem. It is not enough to know the total population of a project area or even the 0-5 years population if you wish to concentrate efforts on the 0-1 year age group (EPI) or the 0-2 years age group (ORT, nutrition). Even if the MOH includes broader age limits to their interventions, PVOs should still be able to focus on these subgroups and track their progress.

Targeting goes hand-in-hand with an 'at risk' concept. Those mothers and children at particularly high risk for illness and/or death in the community need and deserve more attention than the average. This approach requires first a simple list of criteria for 'high risk' and then, more importantly, a method to track these individuals. Typically, a pregnant woman who is diabetic or hypertensive raises a red flag when she visits the clinic; likewise, should a child less than one year in the community who is not immunized against measles. Enlarging the medical/clinic model of health care to a public health one requires a tremendous leap - one which requires training, program design, attention to monitoring and evaluation of coverage.

3.2 Baseline Surveys and Management Information Systems (MIS)

Creating, administering, and analyzing appropriate baseline surveys posed considerable problems for FY 85 projects and continues to challenge FY 86 projects. There is a very real, and frequently expressed, concern that the surveys and information systems being created are too complicated, and too time consuming, greatly impeding service implementation. In

addition, they are often considered too cumbersome and costly to be maintained by the central Ministry of Health or at the local level after project funding terminates.

One of the opportunities cited for PVOs, in obtaining increased funding through AID CS grants, was to allow them to improve their MIS. This would allow for the collection of relevant data towards the objective of documenting their work. They could also demonstrate their capabilities and comparative advantages in PHC (as compared with bilateral or multilateral projects).

Clearly, a compromise must be reached among the various participants. AID has a three tier system of reporting requirements. Data provided allow for the tracking of health indicators, as well as financial accounting. Documentation in these areas has not been a particularly strong point for many PVO projects. Hopefully, once the benefits of being able to document what one is doing, for whom, and at what cost are experienced, PVOs will be interested to continue. However, are all the data requirements necessary? Useful? For whom? At what cost in time, money, and trade-off from the demand for service delivery? The Ministry of Health, central and/or local, is another important participant in this decision. Frequently, their agenda includes the desire for a more complete data base. The use of PVO money and personnel to achieve this goal is often welcomed and encouraged. Similar questions regarding data usefulness and their ability to maintain such a MIS or administer similar cross sectional surveys without CS monies and PVO management needs to be addressed. The PVO is pivotal in the decision of what will actually be done, for it will be they who are in the field using their staff time and project monies to carry out the work. If it is not clear to the people on the ground what needs to be done, how to do it and why it is necessary, the likelihood of success is markedly diminished. Is this not a critical factor behind the frequent lament concerning poor quality of field data?

One recommendation is that "bench mark" surveys, rather than elaborate baseline surveys, may prove more appropriate and be adequate for PVOs to be able to demonstrate the impact of CS interventions over three years. Then, they could focus on simple monitoring systems to track a limited number of indicators (vital statistics, for example). These could be built upon once proficiency in data collection, simple tallying and analysis are demonstrated by workers at all levels.

Family registration and other population based systems (such as "mother-child home based cards" to track a mother and child from pregnancy through 3 years of life) show completeness and creativity. They do demand considerable time from headquarters and/or external technical assistance to initiate. It will be some time before their feasibility, data adequacy and accuracy, and long term usefulness can be evaluated. However, given that they are often being attempted in countries with a virtual void of denominator based data on rural populations (except clinic/hospital data and/or infrequent cross sectional surveys) these efforts deserve attention. Considerable thought into simplicity in their design is suggested.

3.3 Expanded Program of Immunization (EPI)

Few of the proposals or detailed implementation plans have dealt with the complexity of an effective EPI program in sufficient detail. They express a general understanding of the need for community organization and community mobilization but the practical details of implementation, the priorities and messages are not clear. There is concern that if an appreciation and understanding of this complexity is not clear to those writing the proposals and plans, that it will not become more clear as it is passed down the line. One reason for this may well be the role many of the PVOs play when there is an EPI government program. Frequently, only government medical personnel are allowed to administer vaccines. Therefore, the bulk of a PVO's staff may be village based health workers who will serve the essential function of mobilizing the community to participate in EPI activities, publicize the schedule, etc.

However, maintenance of the cold chain is technically the most critical and difficult aspect to an effective EPI campaign. The loss cannot even be measured when lack of attention at any point along the line leads to impotent vaccine. There is the financial loss from wasted vehicles, refrigerators, fuel and vaccines; the loss of time - all the workers involved in the campaign/program, all the families who take off work to be present, all the training in technique for administration of vaccine, the filling out of registers and vaccine cards; the loss of human life - the needless illness and death which affect the lives of children who succumb to preventable diseases after they were immunized ineffectively; the implication on future programs -- the loss of faith in good vaccines possesses tremendous problems for continuing EPI and achieving high coverage rates year after year.

The role that PVOs could play in monitoring the cold chain is potentially one of the most critical in EPI. Frequently, MOH do not have the money or personnel who are sufficiently trained to adequately monitor the cold chain from central levels out to the periphery. This is often a politically sensitive area. PVOs with long presence in a country and a history of collaboration with MOH over time are in a good position to assist the MOH in this difficult process. Therefore, PVO staff who interact at a local, regional and/or central level must be thoroughly versed with the complexities of the cold chain to be capable of offering the needed assistance.

Frequently, countries without widespread immunization programs, prior to managing an EPI, target a wider age range than currently recommended by WHO. Most PVOs align themselves with the MOH in following their schedule for EPI, and rightly so. However, PVOs could attempt to focus on the WHO target groups while not ignoring MOH demands.

3.4 Oral Rehydration Therapy (ORT)

Basically, PVOs follow country MOH guidelines by promoting either home mix sugar-salt solution (SSS) and/or packaged ORT. Too frequently, the objectives and goals are not clearly stated. Recent findings indicate that

it may take numerous teaching sessions (as many as 5-6) before a mother can effectively prepare and administer ORT. This suggests that simply describing and demonstrating ORT preparation and the indications for its use to groups of mothers may be grossly insufficient.

More thought needs to be focused on the type and content of training village-based workers are given in ORT. Phasing-in project implementation permits one to alter the system by eliminating errors and resolving problems before they become deeply ingrained and institutionalized.

Too little mention of the importance of continued breast and other feeding during and after diarrhea is made in project proposals and implementation plans. These important messages are central to maintaining normal growth patterns and need to be well integrated into ORT programs.

5 Nutrition and Vitamin A

The nutrition components of projects are generally weak. This may be a reflection on WHO and MOH policies, as much as it is on PVO programs. Following UNICEF's model for child survival (GOBI - growth monitoring, oral rehydration, breastfeeding and immunizations) many programs proposed doing growth monitoring (GM) at some point in their project. Yet, it is not clear for exactly what purpose GM is being done. Is it to follow the individual or for community monitoring? Is there a nutrition program once a high risk (malnourished) child is identified? Is there enough malnutrition in the project area (from the baseline survey) to justify the time to be spent by mothers and workers versus the anticipated outcome? If adequate food is not available and/or affordable in the project area will nutrition education make any difference? What is the cost/benefit of doing this activity in preference to other CS interventions? Clearly, these questions must be addressed project by project as the needs and the capacity to respond vary tremendously between and within countries.

Vitamin A may be a need, perhaps still unidentified, in some areas where PVO CS projects are currently working in Africa. Helen Keller International is providing regional technical assistance to PVO CS projects. They will be sponsoring a workshop for headquarters' staff of African PVOs to whom they give assistance on April 3, 1987, in New York City. The purpose of this workshop is to provide relevant information on Vitamin A to PVOs. Subsequent to this workshop, PVOs should be better positioned to plan what strategies are necessary in their project areas to determine if Vitamin A intervention needs to be implemented.

3.6 Family Planning

The thrust for family planning that AID - Washington wants emphasized in CS projects is in the process of being defined. In Africa, the area of family planning is frequently not well addressed by host governments or ministries of health. Often, prolonged breastfeeding and child spacing are promoted, but no concrete contraceptive technology is widely employed. If child survival interventions and economic improvements prove to rural populations that their children (and "social security") are safe, their

demands for effective contraception will increase. Hopefully, AID and the CS projects will be at a stage where they can respond to those real and felt needs.

3.7 Supervision

The importance of supervision, both in quantity and quality, cannot be overstated. Most projects address this crucial area in their proposals and plans of action. Although frequently discussed in terms of the chain of command and the frequency for supervision, there is too little attention to content. A few of the projects used a monthly reporting system for each supervisor of community health workers (CHW) to list how many were visited, problems encountered, etc. The common reality is that many of the supervisors of village health workers, whether PVO or MOH staff, are trained in clinical medicine. Unless given specific tasks to perform during supervisory visits, their supervision quickly turns into clinical case referral for complaints to which the VHW was not prepared to respond. Although a mechanism to respond to individual complaints needs to be established, it should not distract from addressing the public health needs of the larger community.

After sufficient training in how to effectively conduct supervision, a simple checklist can facilitate remembering which topics need to be covered at each level. Supervision becomes a sharing, with both parties clear as to what areas will be addressed and can prepare accordingly.

3.8 Logistics

PVOs frequently find themselves at the periphery, in areas the most difficult to access, particularly in certain seasons. Their experience in overcoming the tremendous obstacles to effective logistics are precious assets for child survival strategies. It is not uncommon, however, that PVOs work somewhat alone in these areas and do not have the habit to organize their trips; for example, trips from central to regional to local levels could be planned in conjunction with other groups (PVOs, MOH) having workers who would benefit from regularly scheduled transportation. It is often administratively easier and/or more expedient to work independently. But, if MOH are ever going to be able to meet the demands of supplying of commodities and doing supervision within their budgets, it will require close scrutiny of all elements in their logistics.

Many PVO projects are well integrated into the MOH and, therefore, rely heavily on MOH for their vaccines (and cold chain) and CRT supplies. Any ways that they can help MOH at local, regional and/or national levels to improve their management capacity to orchestrate these tasks helps insure not only the success and sustainability of their individual program activities, but also the future of the country's EPI, ORT or other programs.

3.9 Training

Many of the projects involve training village or community level health workers. Some involve training local MOH personnel and PVO mid-level project staff. A few PVOs are involved in more specialized MOH training. Although some PVOs outlined the details of training content, this was not generally true. Training content mentioned technical aspects of EPI, ORT, and growth monitoring. Although the need for knowledge of supervision, program design, planning, financial accountability, and other aspects of program management was often expressed, seldom was training in these areas planned. One PVO is conducting 6-week regional workshops for regional and field staff in international health and community development management. Certainly this is an impressive step towards an important goal.

Depending often on illiterate or semi-literate CHW, adult education methods for illiterate workers are seen as important tools for successful training programs. A few of the PVOs have hired full time or long term consultants specialized in this area to plan and conduct their training sessions. If these trainers are paired with local PVO or MOH counterparts, much progress towards institutionalizing these valuable skills could occur.

3.10 Staff

When requirements for the first CS proposals were made in 1985, AID expected health projects to have health personnel. This was not always the case, with projects often staffed by those more specialized in community development and/or administration. Then, in 1986, AID required that there be a full time person with medical credentials in the field for projects to be awarded CS monies. As programs have evolved, the importance of having good technical backstopping capabilities at PVO headquarters was noted. Therefore, 1987 proposals are required to show that their CS projects will have medical expertise, both in the field and at headquarters.

The critical need for PVO technical competence at the field level to help actualize CS interventions, such as EPI, has been stated earlier. Often it is necessary that the project has someone on staff who is not only technically competent, but also at a high enough level to deal effectively with MOH.

MOH staff and funding vary significantly from country to country and, regionally, within countries. Also, there is considerable variance in project field and country staff regarding their technical capacity to support and administer a given project. AID is encouraging each PVO to inventory their strengths and weaknesses of each particular project and at headquarters as to their technical capabilities. It is often difficult for those at the end of a process to precisely identify their strengths and weaknesses. Headquarters and regional PVO personnel are particularly well situated to aid in this identification. It requires that they have sufficient knowledge and familiarity of a project, together with their technical training and experience, to clearly articulate project resources and needs. Only then can requests for technical assistance be precisely

formulated when either the time and/or technical expertise at headquarters or in the region is unable to meet the needs identified.

3.11 Technical Assistance

Several PVOs are developing their own pool of technical assistants as well as upgrading the technical capacity of headquarters and/or regional staff. Both approaches allow the technical assistance to be tailored to the individual PVO's philosophy of development. In this way, they can help retain the individuality of a PVO's work without compromising CS technical aspects of implementation.

It is important to link outside technical assistance with visits from PVO headquarters' personnel. Not only does this aid continuity, communication and acceptance with field staff, but provides potential spin-off to other CS and health programs the PVO is engaged in.

3.12 Community Participation and Mobilization

Many of the African CS PVO projects are extremely well versed in this essential area. They are building their CS activities onto an extensive community based presence. For example, Title II programs have created a visible presence in certain countries hardest hit by drought and famine in recent years. Interfacing ongoing programs (food distribution, relief) with new CS initiatives needs detailed thought for effective implementation.

For those PVOs whose primary focus has been a clinic/hospital base, they have much to learn about community interaction from those PVOs whose operating base is at the village level. Particularly, the details of doing community outreach, involving the community in decisionmaking, acquiring their "ownership" of project goals and winning their moral and financial backing for VHWs need to be studied. Few interventions in CS, or more generally in PHC, can survive without intermediate and central logistical and supervisory capabilities. But, none will succeed without community participation. More often than not, if the time (and thought) is taken to bring an unsolvable logistical problem occurring at the periphery to villagers, they will find a solution if they are convinced of the need.

3.13 Financial Accounting

The benefits to PVOs from increased funding for their CS activities have been many. It has permitted considerable expansion of their health activities, requiring new staff to be integrated and training to be upgraded. But, AID funding is for only three years. The initiation of dramatic expansion in PHC activities must be planned for its ongoing support. Unless projects are able to adequately track resource inputs in terms of the cost of personnel salaries, training supplies, equipment, vehicles, maintenance, etc., it will be impossible to accurately predict what will be needed to sustain certain activities.

For many of the PVOs, this attention to monitoring costs with their linkage to program effectiveness is a new dimension in project management. It requires skills and an orientation that few organizations are fully equipped to manage. It may well be an area where technical assistance from health administrators at PVO headquarters or external to the PVO are needed. In tracking costs and effectiveness, PVOs must pay particular attention to maintaining low costs per beneficiary if there is going to be any hope to sustain or replicate program activities. And, finally, the creation of cost recovery mechanisms to cover recurrent costs needs considerable thought and creativity if financial self-sufficiency is to be developed.

3.14 Collaboration

Close collaboration between PVOs and host governments, bilateral and multi-lateral organizations, and other PVOs is needed to maximize the benefits derived from CS project activities. Many efforts are complementary and demand that PVOs aid in the development of more effective mechanisms for coordination. For example, many PVOs are well known and positioned in the communities where they offer access to community groups and can be instrumental in local mobilization. The host government, by contrast, offers direct health services and supplies, but may have a low profile at the periphery. Together, their skills and resources can complement each other, to contribute to a more effective program if their efforts are well coordinated. In addition, close collaboration is necessary if host governments are to adopt and replicate innovative approaches developed by PVOs.

PVOs often work with small populations. Collaboration with indigenous and other foreign PVOs working in the same area can maximize their impact through their combined efforts. Indigenous PVOs can be strengthened through training and sharing in project activities.

Collaboration among US PVOs working in the same country or region permits sharing the costs of training field staff and external technical assistance. However, success in this area will depend on bridging some differences between many PVOs' highly individualized approaches.

Good coordination and support between PVOs and these other groups, particularly the MOH, will determine if any success or progress that is made will be wholly or partially institutionalized. To address this need for improved communication and collaboration, the scheduling of regular meetings (at local, regional and national levels) between MOH and other groups involved in CS activities can be a major achievement. PVOs, with their established in-country presence, are well positioned to be the catalysts for the initiation of this important step.

4.0 Sustainability

Sustainability is quickly becoming the latest catchword in CS activities. Although it means many things to different people, this discussion will focus on the sustainability of effective activities --

activities which result in demonstrable changes in health - and not the continuation of specific programs or projects. Communities evolve and their real and felt needs and priorities change. Therefore, it may be inappropriate for certain projects to continue as originally designed. However, it is hoped that the effective activities developed during a project can find a way to be sustained, even if their form may be unrecognizable from the original project.

PVOs are often cited for their capacity to be innovative. They do not operate under all the same constrictions as government programs and have the freedom to experiment. Implicit in this freedom and creativity is the hope that they will discover some approaches which work better than the status quo. These should be shared with the MOH and other groups for possible adoption and replication. The contrary is also anticipated; PVOs will experiment with ideas that do not prove suitable. These approaches need to be modified or eliminated and are certainly not activities that need to be sustained.

Essential to sustainability for most CS activities in Africa are: 1) strong community commitment, 2) a good relationship with the MOH, and 3) financing schemes which keep costs low and allow for recovery of recurrent costs. Achieving community and MOH "ownership" of project activities requires their involvement early on in the planning stages of the project. Their involvement in decisionmaking, planning budgets, and choosing objectives and goals is instrumental. They can aid in selecting which interventions to begin with and the details of how each can be implemented keeping a close eye on recurrent costs.

Sustainability is not merely a question of willingness to continue project activities. Closely linked is the ability to meet the cost, in financial and personnel terms; the quality of technical competence of staff, as well as their numbers, and the level of funding. All too often the local, regional or national MOH are not unwilling, but are unable to continue effective project activities, given their meager budgetary and staff allowances. They no longer have access to the vehicles and/or fuel to continue either supervision or village campaigns as previously scheduled. Little by little, the systems, whether elaborate or relatively simple, break down. Maintenance falls off on cold chain equipment; ORT supplies do not arrive at scheduled intervals; records stop being kept by village workers when there is no longer anyone collecting and interpreting their statistics; village health committees stop holding meetings as they lose faith in local health posts who no longer show up for scheduled vaccination days due to a break in their supply of vaccines from the region; village health workers drop their prevention/education programs and become village "pharmacists" selling ORT packets or simple drugs - an activity where they can retain community prestige and receive financial gain when no one comes to retrain or supervise them.

These very real scenarios, repeated over and over again in "successful" as well as "unsuccessful" projects, are the too frequent realities three to five years after project funding is gone. There are no easy answers or simple technical steps to assume fail safe design. Yet,



approaches to interventions that many of the PVO proposals contain show exciting promise. Central to their success is the mobilization and participation of the community. Taking sufficient time at the beginning to sensitize the community and get their active involvement and support is effort well invested. Communities must take on the 'ownership' of the activities and feel personally responsible to carry them through, even when the PVO staff are gone and the MOH may let them down. The approach, therefore, must be multifaceted, interacting on many levels simultaneously. It is not enough to have elaborate community participation, but do nothing to promote and support the MOH by contributing to their training, enabling them to supervise their activities, etc.

Finally, given the economic reality in Africa, an extra word of caution needs to be made. The worldwide economic recession is having a multiplier effect on the poorest countries, many of whom are located in the Sahelian belt of Africa. Their countries' balance of payments is such that there is no assurance their Ministries of Health will see improvements in their abilities to continue even the most effective project activities. The emphasis must be on low cost, practical activities that can be sustained on the least amount of economic support from the government. Again, local cost recovery schemes may become the bulk of financing for an activity once project funding is gone. Although AID funding is for only 3 years, many of the PVOs plan to continue beyond this time in their project areas. Several have already begun to plan their phasing out of involvement over a realistic time frame.

CONCLUSIONS

PVOs deserve recognition for the tremendous progress they have made in the short time since FVA/PVC began funding CS activities. By the longitudinal approach taken to do this review, it becomes obvious the PVOs have made great strides in their understanding of CS interventions, in project writing, in budget formulation, and in setting realistic objectives with measurable outcomes. This represents considerable time and effort on their parts to achieve this overall sophistication, and merits acclaim. AID, as well, has improved in clarifying requirements for project proposals, reporting demands, field staffing needs, and technical backstopping capabilities. CS has presented opportunities and challenges to both the PVOs and AID. Numerous "successes" and "lessons learned" have been chronicled, but will increase as the process evolves.

This report outlines the technical needs of the nineteen FVA/PVC funded CS Africa projects, based on a review of their project files, to date. The workshop for FY 85 projects (7) will need to focus primarily on management information systems (MIS), as they relate to monitoring and evaluation. The emphasis should be on simplicity, low cost and usefulness. Whether the PVO and/or the Ministry of Health can realistically take over the MIS developed deserves close scrutiny at each step. The technical needs for Anglophone and Francophone FY 86 projects will not be fully assessed until their Detailed Implementation Plans are reviewed in April, 1987. At this time, the technical needs for these workshops include attending to the practical details of the implementation of CS strategies.

Examples include administering a baseline survey, following the EPI cold chain, and outlining supervisory activities.

This outline of technical strengths and needs should aid those PVOs planning these three workshops. Together with their needs survey completed by participating PVO headquarters and the results of the review of the Detailed Implementation Plans for FY 86 projects, the needs analysis should be complete.