



PVO RESOURCES FOR CHILD SURVIVAL: *Improving Quality*

January 23-26, 1990
Aliso Creek Inn, Suite 100, Laguna, California

The 4th annual workshop for U.S.-based PVO staff who back up Child Survival projects in Africa, Asia-Pacific, Latin America and the Caribbean

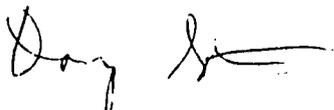
What do we know about quality of care? We know that good managers can make a difference. A good manager is found in the field, gaining a better understanding of the actual process of service delivery. The manager monitors quality of care by asking a simple question: "How are we doing the job?" If the performance seems below standard, the manager must take some action to correct the situation, then observe to verify that improvement does occur.

You who are responsible for technical or administrative oversight of the Child Survival projects must ask the following of your projects: How much time does the project manager spend in the impact areas of the community? Does the manager have sufficient knowledge of assessment techniques and of quality-assurance methodologies? Does the project have published, and widely understood, performance standards? Are they standards for what is really necessary? Do project training programs conduct competency testing of health workers and volunteers? When was the last time the project's continuing-education sessions focused on quality of care?

Quality is too important to be left to chance. The costs of quality improvement are small compared to the costs of an incompletely immunized child, or the costs of poor counseling of the mother whose child's growth is faltering. There is a paperback, published by Mentor, entitled *Quality is Free*. Although written primarily for business, the author, Philip Crosby, outlines steps in a quality-improvement program that are also applicable to the Child Survival projects:

1. Make it clear where management stands on quality—set a quality policy, and publicize it throughout the organization.
2. Designate the quality-improvement team that will have the responsibility to create and to implement the improvement program in the various departments or services.
3. Obtain and report information on problems of service delivery; chart and post trends of performance data for all to see.
4. Investigate the cost of quality. Compare that to the costs of failing to perform to requirements.
5. Raise quality awareness in project staff by regular meetings to discuss performance problems and to decide on steps to remedy defects. Tackle the biggest and most important problems first.
6. Train supervisors to carry out their job in quality improvement. (Role play is a useful assessment tool.)

The Aliso Creek workshop showed that PVOs have a commitment to quality. Now is the time for action. Best wishes,



Dory Storms
August 1990

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Workshop Planning and Preparation

“PVOs freely shared successes and failures and exchanged ideas with each other, thanks in part to the informal atmosphere. I came away with new ideas, insights, and enthusiasm for my work.”

—PVO representative

Background

The Agency for International Development, Bureau for Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation (AID/FVA/PVC) currently funds twenty-three U.S.-based private voluntary organizations (PVOs) to carry out Child Survival projects in twenty-two countries in Africa, Asia/Pacific, Latin America, and the Caribbean. Since 1985 the PVO staff who backstop the field projects have participated in an annual PVO Resources for Child Survival workshop. PVOs have found that these workshops—funded by AID/FVA/PVC as part of its Child Survival technical support strategy—offer an important forum to network, share, and consult with other Child Survival PVOs.

The annual PVO Child Survival workshops are designed and conducted by staff and consultants of the PVO Child Survival Support Program, under a Cooperative Agreement between AID/FVA/PVC and the Institute for International Programs of The Johns Hopkins University School of Hygiene and Public Health. The PVO Child Survival Support Program directs a number of activities designed to strengthen the capacity of PVOs to plan and carry out effective Child Survival projects.

Organization

The Aliso Creek Workshop built on the experience of the three previous annual workshops, held in Baltimore, Maryland (1986), Lake Havasu, Arizona (1988), and Lake Junaluska, North Carolina (1989). This fourth annual workshop was held in Aliso Creek, California, on January 23-26, 1990. The thirty-six participants included technical staff from twenty-one PVOs who are responsible for the design, implementation, and evaluation of eighty-one Child Survival projects.

The team that organized the workshop consisted of a facilitator (Mr. Dale Flowers), a workshop coordinator

(Ms. Cynthia Carter), a logistics assistant (Ms. Eve Berry), and the coordinator for the PVO Child Survival Support Program (Dr. Dory Storms). Dr. Donglu Zeng, a staff member of the PVO Child Survival Support Program, assisted in planning and implementing the workshop.

Needs Assessment

Planning for the 1990 workshop began with an assessment of PVO needs. The organizing team asked PVO staff who backstop Child Survival country projects to recommend topics that would benefit their daily work.

As in past years, PVO staff felt that project sustainability was an important issue that warranted further discussion. A majority expressed concerns about weaknesses in health information systems (HIS); several also wanted to pursue last year's introduction to the most effective kinds of computers and computer software for PVO field

projects. Several PVO staff who attended the "Lessons Learned from Midterm Evaluations" session at the Lake Junaluska workshop requested a follow-up, particularly feedback from annual reports and final evaluations. Finally, a number of veteran and new PVO staff were curious to discuss other PVOs' views on the advantages and disadvantages of investing in impact analysis.

Evaluations of the 1989 workshop encouraged reviewing one or two technical issues in greater detail: for example, malaria and acute respiratory infection (ARI) are new A.I.D. initiatives, and many projects are considering or are already incorporating these activities into their Child Survival programs. With 46 percent of the participants new to Child Survival, sessions regarding use of the FVA/PVC technical assistance mechanism and a review of the A.I.D. reporting system became important topics to review.

Based on these needs, the organizing team chose the focus "PVO Resources for Child Survival: Improving Quality."



Cynthia Carter, PVO Child Survival Support Program, preparing workshop agenda

Debra Curbeam

Workshop Goals

The following workshop goals emerged from the needs assessment and from experience gleaned at earlier workshops:

1. Provide feedback on achievements and accomplishments of PVO Child Survival projects, as well as lessons learned.
2. Share experiences and materials related to technical backstopping of PVO Child Survival projects.
3. Examine with A.I.D. the direction of PVO Child Survival health information systems in 1990.
4. Raise awareness of issues affecting quality of Child Survival implementation.
5. Identify specific steps necessary to sustain high-quality technical support to PVO Child Survival field projects.

Dates and Location

As in previous years, workshop planners scheduled the annual workshop between the Child Survival proposal and the detailed implementation plan deadlines—this year, January 23, 24, 25, and 26. In past years, workshops were scheduled for three days; a significant percentage of participants, however, left on the third day before the workshop covered its agenda. Thus the organizing team scheduled a four-day workshop for Aliso Creek to encourage a full three to three-and-one-half days to meet other PVO staff, to share lessons learned, to examine next steps, and to update technical information.

Workshop sites have alternated between the East and West coasts; thus the 1990 workshop headed west. California was chosen as a logical site because of its three centrally funded Child Survival PVOs, with another in nearby Arizona. Staff from the three California PVOs (Project Concern International, World Vision Relief & Development, Inc., and Freedom from



Cynthia A. Carrer

Hunger Foundation) agreed in the fall of 1989 to co-host the workshop and to organize the opening reception, with the Pacific Ocean providing the now-traditional "water theme."

A book of bed-and-breakfasts and out-of-the-way places in California introduced the Aliso Creek Inn, set deep in a canyon just south of Laguna Beach. Scouts from the PVO Child Survival Support program reported comfortable housing, a variety of meeting rooms, a private setting, and convenience to the airport.

Participants

PVO Child Survival grantees received a letter of invitation to the workshop in November 1989, requesting the attendance of one or two home-office staff who were responsible for technical backstopping of Child Survival country projects. The final roster of participants consisted of thirty-five home-office staff from twenty-one PVOs, one representative from the World Vision International

Asia regional office, and another from the International Science and Technology Institute, which works very closely with the PVOs. Forty-six percent of the participants were new to the Child Survival Program, having assumed their positions within the previous year. They represented a variety of administrative and technical positions, ranging from medical directors to budget officers. A list of workshop participants can be found on pages 49-50.

A number of resource people took a role in organizing particular technical sessions. Mary Harvey, of JSI/REACH and the FVA/PVC technical adviser for EPI in Africa & Haiti, reviewed Child Survival project reports and reported on the PVOs' progress in EPI. Donglu Zeng, of PVO Child Survival Support Program and former health officer for UNICEF/China, presented health information systems findings from a review of 1988 annual reports. Sally Stansfield, medical epidemiologist, presented a consultant's view of HIS from the field perspective. Nils Daulaire of JSI/New Initiatives conducted small group discussions of how to incorporate ARI/pneumonia prevention and treatment activities into Child Survival programs. Larry Cowper, former USAID project officer, reviewed issues and steps to implement malaria prevention programs. Marilyn Christensen of Save the Children Federation presented an overview of SCF's computerized health information system. A computer expert herself, Ms. Christensen also organized a computer software session and a demonstration of electronic bulletin boards. In addition, Stewart Blumenfeld of PRICOR spoke about his organization's operations research activities in which they address issues of quality control in primary health care programs.

PVO feedback from 1989 workshop evaluations and 1990 workshop needs assessments highlighted the importance of A.I.D. representation at the workshop. AID/FVA/PVC was able to send two representatives again this year: John McEnaney, the newly appointed chief of



Dory Storms

Participant Karen LeBan, SCF

the Child Survival and Health Division, and Sallie Jones, newly arrived from S&T/Health Office of Nutrition. Mr. McEnaney and Ms. Jones participated throughout the week and led sessions regarding new A.I.D. initiatives and the use of technical assistance.

Three staff members from the PVO Child Survival Support Program, of The Johns Hopkins University, attended: Dory Storms, program coordinator; Cynthia Carter, technical support specialist and workshop coordinator; and Donglu Zeng, technical support specialist and workshop resource person. The PVO Child Survival Support Program contracted the workshop facilitator, Dale Flowers, and the logistics assistant Eve Berry.

Theme

The theme of the workshop focused on the need to give attention to the quality of the Child Survival implementation process. In past years, PVOs met to review and share lessons learned, to make recommendations for improvement, and to formulate new strategies that would lead to stronger field projects. Such interaction heralded the next step: taking

a stronger, more effective Child Survival strategy into the twenty-first century. Qualitative evaluation of training programs, EPI program pitfalls, budgetary issues, use of HIS data in management, and institutional memory were but some of the issues tackled in the 1990 workshop.

Process and Content

Principles of adult education structured the workshop process, stressing both communication between participants and unique contributions of each individual: all participants are resource persons for each other. The workshop emphasized small group sessions to facilitate exchange; formal sessions were often panel discussions and fishbowl exercises led by PVO staff, providing the rest of the group the opportunity to benefit from the experience of its members.



Dory Storms

A sunny January day at Aliso Creek Inn

Agenda

Workshop organizers have learned through regional and headquarters workshops that often the most valuable and productive experiences arise from informal networking. A "buddy system" to help veteran and new participants share insights and support was one such valuable innovation—a product of the near fifty-fifty split between returning and first-time members and of the reality of high staff turnover. For three sunny

afternoon hours of unstructured time each day, buddy pairs, PVC discussion groups, and special-interest sessions mingled in the Aliso Creek gardens.

Workshop organizers varied the pace and type of formal sessions to minimize participant fatigue. The schedule included plenary sessions, split group/concurrent sessions, and small group activities for groups of six to eight persons. Participants also carried out a debate on the pros and cons of impact analysis, discussed institutionalization in

a fishbowl exercise, drew colorful pictures of sustainability, and experienced hands-on learning in a computer software lab.

Each morning, a community meeting was held to orient the group to the day's activities, make announcements, and receive feedback. At the end of the day, participants who were scheduled to take an active role in the next day's sessions met with resource persons and the workshop facilitator.

PVO Resources for Child Survival: Improving Quality, January 23–26, 1990
ALISO CREEK INN, SOUTH LAGUNA, CALIFORNIA

	Tuesday 1/23	Wednesday 1/24	Thursday 1/25	Friday 1/26
8:00 am	Opening Session	Community Meeting	Community Meeting	Community Meeting
8:15 am		A Consultant's View of CS Project HIS	New A.I.D. Initiatives	What Sustainability Means to Me
9:30 am	Progress in PVO Child Survival <ul style="list-style-type: none"> • Introduction • Achievements in Training • Achievements in EPI 		Improving Quality <ul style="list-style-type: none"> • Problems of Quality • Operations Research • Role of HQ & Field Staff in Improving Services 	
10:00 am		HIS: Why are we doing so badly and what can we do about it?		Sustainability Case Studies
11:00 am		Concurrent Sessions: Part I <ul style="list-style-type: none"> • Computer Software—Group A • Project Reporting—Group B 		
11:30 am	What Child Survival Means to Me		Resource Room	Report on Regional Workshops
12:00 pm	Unstructured Time	Unstructured Time	Unstructured Time	Resource Room: Computer Lab
2:00 pm		Concurrent Sessions: Part II <ul style="list-style-type: none"> • Project Reporting—Group A • Computer Software—Group B 	Concurrent Sessions: Discussion & Practicum—Part I <ul style="list-style-type: none"> • ARI • Malaria • Technical Assistance 	Unstructured Time
3:00 pm	Pros & Cons of Impact Analysis	Development and Computerization of HIS		Institutionalization of Lessons Learned
3:30 pm			Concurrent Sessions: Discussion & Practicum—Part II <ul style="list-style-type: none"> • ARI • Malaria • Technical Assistance 	
4:00 pm	Study of Project Costs	Next Steps <ul style="list-style-type: none"> • PVO Action 		
5:00 pm				Closing Session
6:30 pm				MEXICAN FIESTA!
7:00 pm	Review of Health Information Systems, 1987-1988		CHINESE NEW YEAR!	

Materials Displayed at the Aliso Creek Workshop Resource Center

AFRICARE:

Final Evaluation Report (Nigeria)
Jumoke Description
"Health for the African Family"
"For All African Children"

African Medical & Research Foundation (AMREF):

1988 Annual Report, "AMREF in Action"
Facts About AMREF & The Flying Doctors
"Starting where the people are — The African Medical & Research Foundation," *Carnegie Quarterly*, Spring 1987
"Go an Extra Mile: Adventures & Reflections of a Flying Doctor"

Andean Rural Health Care (ARHC):

Brochure: Andean Rural Health Care Optimum Reporting Criteria for Field Work Activities, Jan. 1989
Census-Based, Impact-Oriented Approaches to Andean Rural Health Information Package
—Andean description
—Updated information
—Comments from a medical viewpoint
—Board of directors
—List of available resources
—Grassroots newspaper
—Contribution card

CARE:

1989 CS Annual Report (CARE/NY—Primary Health Care Unit)
Final Evaluation (Bolivia)
CARE's projects in Bolivia, Oct. 1989
Immunization Survey, July 1989
Factors Affecting the Use of Infant

Mortality Rate as an Indicator for CARE projects, Nov. 1989
Growth Monitoring & Promotion: Guidelines for Design & Implementation, Apr. 1989

ESPERANCA:

Management Information Systems Description
Census forms (Spanish)
Survey forms (Spanish)
Calendars

Helen Keller International (HKI):

Facts about HKI
VITAP — Vitamin A Child Survival
VITAP materials order form
VITAP Vitamin A Orientation Workshops
Vitamin A brochures (multiple languages)
Vitamin A display card
Vitamin A deficiency and xerophthalmia training aids and slides
Poster: Vitamin A: How to Keep Eyes Healthy
Vitamin A buttons
Vitamin A: Key words for the library
Guidelines for the Prevention of Blindness Due to Vitamin A Deficiency
Vitamin A news notes
Vitamin A resources; organizations
Vitamin A RE/10 conversion formula
Vitamin A supplements
Vitamin A deficiency countries
Vitamin A deficiency
Vitamin A content of tropical foods
Assignments children: Vitamin A deficiency & xerophthalmia
U.N. Statement: Vitamin A and Mortality
Joint WHO/UNICEF Statement: Vitamin A for Measles

"Saving a Child from Xerophthalmia: A Disease of Darkness" (English and French)

"Effects of Sun and Shade Drying on Vitamin A Content"

"Increased Risk of Respiratory Disease & Diarrhea in Children with Preexisting Mild Vitamin A Deficiency"

"Vitamin A Status in Children Who Are Prone to Respiratory Tract Infection"

"Field Guide to Detection and Control of Xerophthalmia"

Video: ABC TV News 20/20 — A Gift of Sight, A Gift of Light

Project Hope (HOPE):

Multi language: Vaccination Where is Infecciones Respiratorias Agudas para personal Voluntarios de Salud
Control de Enfermedades Diarreicas
Programa Ampliado de Inmunizaciones

LaLeche League (LLL):

Description of LaLeche League
Summary Report: LLL Groups and Leaders
Annual Report (Honduras)
Annual Report (Guatemala)
The Leaders Handbook
New Beginnings — LaLeche League's Breastfeeding Journal
"Womanly Art of Breastfeeding" (English and Spanish)
"How Leaders Can Help with Newborn Jaundice," Leaven
Manual: PFS: First Choice
Paquete Documentos Liga De La Leche Guatemala, July 1989
Spanish Language Breastfeeding Overview
Breastfeeding Abstracts: Kangaroo Care & Breastfeeding for Preterm Infants
Pamphlets: Breastfeeding Resources (multiple languages)

- French and Spanish bulletins on breastfeeding
- LaLeche Certificates
1st BA Refresher Course
- Center for Breastfeeding information order form
- Translations list and order form
- Minnesota International Health Volunteers (MIHV):**
- Detailed Implementation Plan (Kenya)
- Final Evaluation (Uganda)
- Report of Survey Results (Kenya, 1989)
- Budget revision letter to A.I.D., 11-17-89
- Project Concern International (PCI):**
- "A Manual for Planning Management of the Integrated Service Post (Posyandu) in Southwest Sulawesi"
Dept. of Health, Republic of Indonesia; Kendari, 1989.
- Rotary Polio Plus (ROTARY):**
- Annual Report (Nigeria)
- Annual Report (India)
- Project Update Oct-Dec 1988
- Reports: Polio Plus Nigeria Sponsored Workshops, 1988
- Report: In-House Polio Plus Project Review Meeting on Nigeria, June 1989
- Volunteer Care for Immunization Task Force
- Volunteer Resolution/Commitment
- India's Polio Plus Immunization Task Force Volunteer Members' Reference Manual & Service Record
- India Polio Plus Immunization Task Force
- Towards the Strengthening of LGA level EPI in Nigeria
- Towards the acceleration of Nigeria EPI coverage — Handbook for the LGA coordinator
- Newsletter: Polio Plus Task Force for India, Sri Lanka & Nepal (2 issues)
- Video: "Together We Can Do It"
- Sample Information Packet
- Operation India Description
- Target Year 2000-Polio Free World
- Polio Plus Reporter
- World Update
- Map of World Operations
- 1988-89 Report on Operations
- Save the Children Federation (SCF):**
- SAVE's strategy for health
- Summary of Major Grants since 1985
- Field Projects' Major Achievements
- "The Hidden Force: Field Workers in People Centered Development," David L. Guyer
- "Learning to Teach: Training of Trainers for Community Development" Jose Vella
- "Already I Feel the Change, Women's Voices in Four Countries," Lessons from the Field; Vol. 1
- Bridging the Gap: A Participatory Approach to Health & Nutrition Education
- Reaching the Unreached in an Urban Area through M.I.S. for Third International Symposium on Public Health in Asia and the Pacific Region.
- Recording Instruments: Their use by Resident Home Visitors
- Measuring Health—A Practical Guide to a Community Health Information System
- Draft: A Child Survival HIS
- Training Workbook: Detailed Implementation Plan; A Step-by-Step Guide for Developing a DIP, 1-90
- Vital Event Reporting
- HIS Information Summary
- Supervisors Roster
- Village Worker Roster
- Measuring Health
- Facts on Child Survival
- Brochure: Ten Steps to Five
- Tech Notes: Mother Too
- Family Planning Chart
- Nutrition Checklist (Zimbabwe)
- Video: Indonesian HIS
- Video: Empowerment of Women
- Video : Ten Steps to Five
- World Vision Relief and Development (WVRD):**
- WVRD Headquarters Program Proposal, 1990
- Midterm Evaluation (Mauritania)
- Zimbabwe Child Survival Summary Report, Aug. 16-22, 1987
- Report on the Primary Health Care & Child Survival Workshop for WVRD Management Team
- Baseline Survey Report on Immunization, ORT, Nutrition, Family Planning and Socioeconomic Status in Ward No. 51 of Dhaka Metropolitan City
- Together*: A publication of World Vision
- AIDS Prevention & Control—A Guide for Health Workers, Educators & Community Leaders
- Selected publications for community health care
- "A Special Drink to Treat Diarrhea"
- Health/Nutrition Brochure: How to Have a Healthy Family
- How to Have a Healthy Family (English and Spanish)
- CS Project Mohammadpur Calendar Poster
- World Relief Corporation (WRC) :**
- Midterm Evaluation (Haiti)
- Midterm Evaluation (Bangladesh)
- MEBSH/Haiti Child Survival Project Consultation on Training & Supervision Activities
- Training for Transformation: A Handbook for Community Workers Vol. 1 & 2
- Navamaga: Training activities for

group building, health and income generation

International Science and Technology Institute (ISTI):

Introduction: Providing Data and Analysis in Support of USAID Health & CS Projects Worldwide

1989 USAID Health & Child Survival Project Questionnaires with New AIDS/HIV Activities Reporting Schedule

Standard Reports Produced for USAID HIS by ISTI.

REACH:

EPI Essentials: A Guide for Program Officers

EPI/CDD/WHO/G Training Course Revised WHO Coverage Survey

Stages Européens de Formation Pratique en Santé Internationale (Training Course for French Speakers)

Facilitator Guidelines for Coverage Survey

Guidelines for Conducting Missed Opportunities Survey for Immunization

Guidelines for Incorporating EPI into Primary School Education

Costing Guidelines

EPI Supervisory Checklist Guidelines & Exit Interviews

Pre-Workshop Activities

The evening before the 4th annual PVO Headquarters Workshop began, the organizing team and the California PVOs hosted an orientation to help acclimate first-time participants.

Afternoon registration was followed by a reception complete with pinata and games to acquaint everyone.

"Initiates" next moved on to an introductory meeting, where workshop organizers brought each person up to speed with brief sessions describing the Agency for International Development, Bureau for Food for Peace and Voluntary

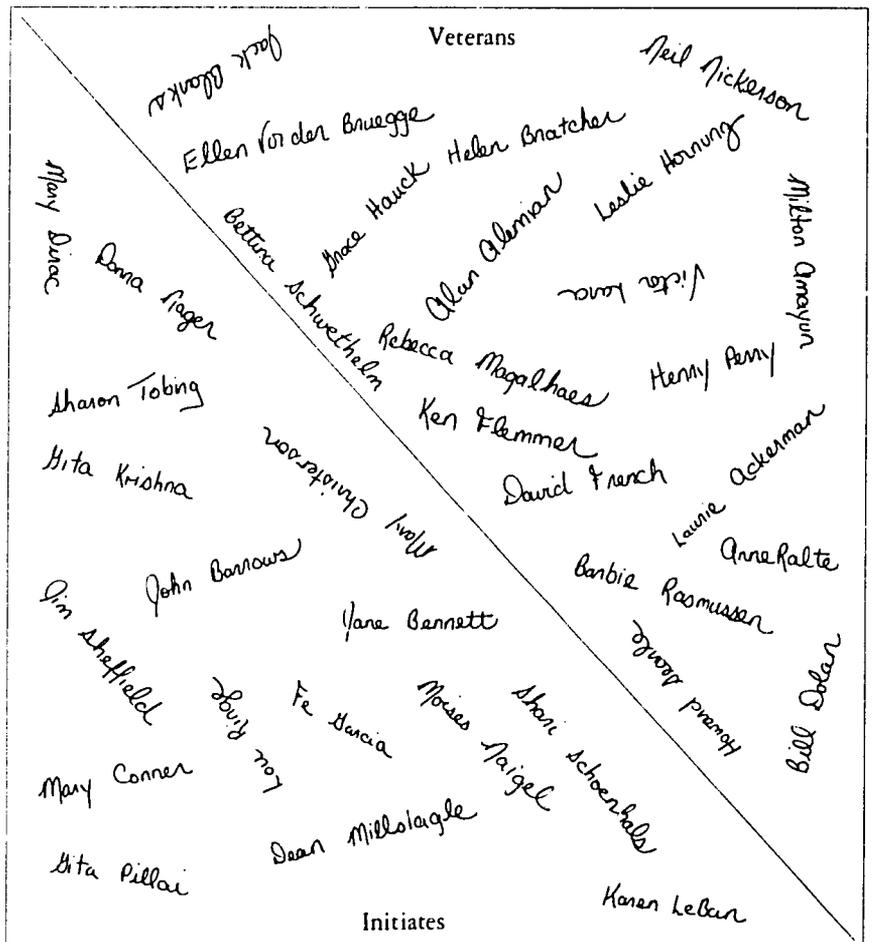
Cooperation (AID/FVA/PVC) and the PVO Child Survival Support Program. Session coordinators presented goals, guidelines, child survival indicators, agendas, even reviewed terminology and acronyms for the new participants. Written synopses were handed out for easy reference in the future.

Then came the pairing of veterans and initiates.

To the veteran-buddies: "You have just been called by the White House to join a special spaceship voyage, leaving in a week's time to travel to a distant planet. You learn that you will be out of communication with Earth until the spaceship returns in the year 2001. You will have just five days to communicate those things that are important for the principles and ideas to which you are

committed for your work to continue. What are those key pieces of information that you feel you must pass on to your buddy?

To the initiate-buddies: "You are the person who has been chosen to carry on the work of your buddy in Child Survival. You have just five days to learn from your buddy about what he or she has learned, accomplished, perhaps even failed to reach. You must communicate to your buddy your values, your strengths, your management style, and perhaps any self-doubts about the job. What are the key pieces of information about Child Survival that you need to know in order to make you a more effective worker?"



Have you kept in touch with your buddy?

The Workshop

“Programmatically, the long-term impact of this workshop will be PVO’s increased emphasis on the quality of Child Survival programs, and closer ties with other PVOs and the FVA/PVC office. Personally, I left the workshop feeling like I am part of a large Child Survival/ primary health care international movement.”

—PVO Representative

Introductory Session

Ed Sliman, general manager of Aliso Creek Inn, opened the workshop by welcoming the group to "the most beautiful spot in Southern California." Dale Flowers then led introductions of each PVO representative, the resource persons, and members of the organizing team. Dory Storms, head of the PVO Child Survival Support Program, gave a brief history of PVO Child Survival workshops; Cynthia Carter, who coordinated the workshop, reviewed the workshop purpose, its goals, and agenda.

Progress in PVO Child Survival: How are we doing?

The theme for Day One focused on feedback on PVO progress in Child Survival. Reviews of annual reports and midterm and final evaluations were sources by which to measure PVO training, EPI programs, and health-information systems. A review of Child Survival grant agreements revealed

interesting donor-cost-per-potential beneficiary data.

Achievements in Training

Cynthia Carter of the PVO Child Survival Support Program reviewed and analyzed recent annual report data regarding health workers and community members trained by seventy-two CSI, II, III, and IV projects in Africa, Asia, Latin America, and the Caribbean. The following are highlights of her findings, recommendations, and points for discussion:

Twenty-four PVOs to date have implemented eighty-one projects in twenty-four less-developed countries worldwide. Some PVOs have large-scale health projects where service delivery is the main focus; others have relatively small projects that focus on community mobilization. All projects, however, share a common tenet: the importance of training programs to achieve project goals and to enhance project sustainability.

Reporting questionnaires on A.I.D.

Child Survival and Health from 1987, '88, and '89 include numbers of health workers and community members trained in ORT, EPI, nutrition, and high-risk births. Paid and voluntary health workers and community members—mothers, TBAs, teachers, teenage students, religious and community leaders—are the ones who implement health interventions, disseminate educational messages, and will continue Child Survival efforts with or without external resources. Given this perspective, then, effective and appropriate training efforts become a key issue to sustained development.

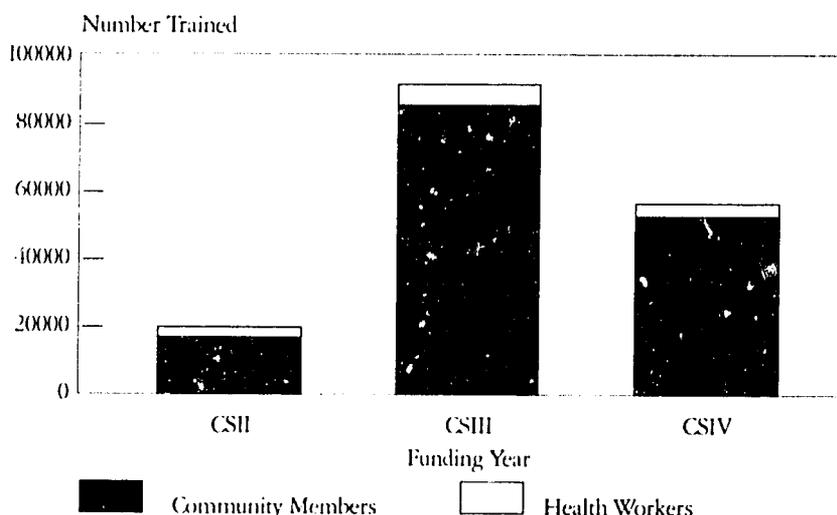
PVO CS training programs have had quantitative success: from 1987 to 1988, twenty-three CSI projects trained a total of 1,520 health workers and 40,000 community members; fourteen CSII projects trained 3,600 health workers and 37,000 community members. After one year of implementation, twenty CSIII projects trained 2,650 health workers and 81,400 community members. Finally, CSII, III, and IV together trained 8,726 health workers and 161,000 community members in 1989.

PVOs have invested tremendous resources to make their training programs both viable and effective. Now PVOs approach the funding of the sixth cycle of CS projects; it is time to step back and assess PVOs' successes or shortcomings in meeting goals. Only then can PVOs focus on and ensure a high level of quality in their training programs.

Yet few PVOs have test systems in place that effectively measure long-term effects of training in terms of sustained knowledge and changing health behavior. Many PVOs also face constraints that inhibit their ability to plan or budget for consistent follow-up that would strengthen existing educational programs. These constraints include:

- lack of human resources: project staff are responsible for not only ten-to fifteen-day training courses, but also daily health clinics, project monitoring, personnel supervision, and liaising with other in-country agencies

Figure 1. Total Number Health Workers and Community Members Trained, CSII-CSIV



1989 A.I.D. CS&H Questionnaire



Cynthia A. Carter

Volunteer health workers preparing the community center for an EPI clinic

- lack of financial resources: some projects have found that effective training programs are not enough, and monetary incentive becomes important to maintain CHW motivation, which introduces its own problems
- staff expertise: often those assigned to conduct training programs or to supervise workers have little experience in adult education or management

PVOs have proposed various solutions, some of which are:

- evaluation of knowledge, attitudes, and practices of trainee graduates to measure long-term effectiveness of CS services
- more trained supervisors and more supervisory visits
- more staff training sessions on group dynamics, adult education, and community organization
- increased training in general for

health workers and volunteers

Trained health workers and community members provide tremendous reinforcement to sustain success in CS projects, and substantial financial and human resources are being expended to train them. PVOs that offer these services must now turn an objective eye to project long-term effectiveness in order to ensure sustainability of their efforts.

Achievements in EPI: Lessons Learned from CSI and CSH Evaluations

Mary Harvey of JSI/REACH reviewed evaluations of early CS projects with regard to EPI, and presented areas of progress and weaknesses for discussion afterwards. The following is a synopsis of her report:

In 1985, sixteen PVOs received grants to implement twenty-six CS projects in

twelve countries throughout the world. Eight of these countries are listed in the twenty highest infant-mortality rates in the world. The rest rank in the top fifty.

Most of the projects are devoting 20 to 40 percent of their funds to EPI, the majority of which goes to providing financial and educational support rather than the immunization themselves. Training ministerial and community health workers to encourage improvements in health behavior has increased both accessibility of EPI to the target population and utilization of these services.

Despite these successes, drop-out rates between DPT1-DPT3 are as high as 25 to 50 percent in some areas. Reasons may include:

- migration
- long intervals between immunization sessions, where the strategy is mobile teams and the campaign approach
- lack of effective follow-up by the CHW
- lack of supervision
- high rate of missed opportunities for immunizations

Drop-out rates can indicate the quality of EPI and, to some extent, the success of PVOs to increase community practice of EPI as well as knowledge.

Targeting of the under-one-year age group is improving; the age at which a child completes her/his immunizations series is on its way down. Mobile and campaign strategies, the unavailability of vaccines at every health facility, and national policies to vaccinate children up to six years of age are difficulties PVOs encounter when targeting the under-one group.

Coverage with tetanus toxoid for women either pregnant or of childbearing age is improving but remains very low. While many projects report an increase in women using prenatal services, the opportunity to vaccinate women with TT is being missed. Until recently, WHO and other international organizations that establish

EPI global policies have placed little attention on neonatal tetanus and the protection of newborns through the vaccination of their mothers and through clean and safe delivery practices. The statistical difficulties of following multiple injections of a group that is continually losing and gaining individuals, as well as the lack of immunization cards for women, are two more factors that may account for the low coverage.

Taking a historical perspective, however, the quality of many CS activities has certainly improved: health information systems are better organized, and data is slowly being fed back to those who can use it for programming and management; quality of training has improved; communities' awareness of preventative health measures certainly has increased, judging by the improvement in utilization rates of EPI services, ORT, and growth monitoring.

Key to a program's success seem to be truly effective supervision and training. Unfortunately, this policy is also a PVO's greatest obstacle. For example, several PVOs have mentioned ways to follow up on babies of defaulters; a lack



Dory Storms

Participants Bettina Schwetbelm, Project HOPE, and Gita Krishna, PLAN International

of time and means on the part of the health worker, however, defeats many good intentions. Training courses on supervision—*if* scarce—appear vital.

As immunization coverage increases, PVOs must spend more time assessing and improving the quality of these services. Field staff, for example, could

assess missed opportunities for immunizations: at a typical child health clinic, almost 70 percent of children who needed vaccination but were brought to the clinic for some other purpose were sent home without being immunized. For all immunization programs, bringing the child into contact with the clinic is more than half the battle.

Conducting vaccination coverage surveys and utilizing the Coverage Survey Analysis System also may be useful in indicating what corrective measures can be taken to increase coverage and the quality of the EPI. Another suggestion is to look for trends in reported cases and deaths from measles, neonatal tetanus, and pertussis among health-facility records for the past five years.

Finally, few evaluations were able to assess the cost of EPI and of other project activities. Management systems must improve in order to assess costs, especially those systems that list the different project costs. This information should prove useful in determining how practical it is to consider that a country could sustain the current programs. It also could show the cost-efficiency or benefit of the PVO's intervention.



Cynthia A. Carter

Mothers singing a song about childhood immunizations, led by ADRA field staff

Small-Group Discussion: Quality Assurance in Training and EPI

After the reviews of CS training and of EPI, workshop participants broke into seven small groups to propose and discuss questions, then strategies, of management and of quality assurance.

Training:

1. Establish objectives.

- Has a task analysis been performed? What are the training objectives? Are they appropriate to the project objectives and task analysis? Are the curriculum design and training methods appropriate?
- Who are the trainees? What are their educational levels? Literacy levels? Sex, marital status, age? Political connections? Status in community?
- How can we motivate the trainees? To what level of services or technical capacity do we want to bring them?

2. Define supervision.

- How do personnel supervise and educate simultaneously? How are training and supervision linked?
- Who is actually responsible for which aspects of a program? What training and experience have they themselves received?
- What is the MOH capacity to take over project activities, including training? How do we involve the MOH and critical NGOs in project training programs, eventually supervision?

3. Follow up training.

- Who should evaluate training? How? When?
- Was knowledge transfer achieved? Skill transfer? Was this training sustainable?
- Is the health behavior of the community altered? Improved?
- Was the training budget adequate?
- What are additional needs?

Strategies suggested to answer these questions included defining the relationship between the government and PVO; carrying out observations of the training process; maintaining project and training focus; conducting pre-tests, post-tests, exit interviews of trainees, and evaluation by the participants. The groups suggested that monitoring of supervision be carried out with records review and with interviews of those supervised.

EPI:

1. Assess needs.

- What is the disease problem in the country?
- How do we establish scope of EPI activities? Does the program fit with national policies?
- How much does the community know about disease and immunization? What are their attitudes? How much do we want them to know?
- How do we keep accurate information on both individual and community?

2. Target groups.

- What are the special target groups within a population? How do we draw them in?
- Who are the people dropping out? How do we approach them? How do we tap into a mother's desire to protect and care for her child?
- What are the reasons for low rates and poor level of awareness? Missed opportunities? Poor CHW motivation?

3. Measure success.

- What standard will we use to measure success of our EPI efforts? How will we analyze our statistics? Follow trends?
- Are the immunizations actually effective? The vaccine stable? In adequate supply? Is this activity sustainable?
- What is the community reaction? Further needs? Are we responsive to them?
- Is there an organized effort to raise mother's awareness, community awareness, family support?

Suggested strategies to address these issues focused on early and detailed planning for a community needs-assessment, data and feedback collection, a system for family registration, frequent surveys of the cold chain and community attitudes, and a strong training program with concentration on follow-up and supervision.

What Child Survival Means to Me

Once the small groups had met, then presented their questions and strategies to the group as a whole, the facilitator suggested a few minutes of informal exchange. He asked everyone to find a person whom they had not met, to get together, and to share with each other their backgrounds in and purpose for working in Child Survival.

Pros & Cons of Impact Analysis

The workshop devoted an hour in the afternoon of Day One to debate the controversial issue of impact analysis. Henry Perry of Andean Rural Health Care and Karen LeBan of Save the Children Federation represented the proponent view, while Milton Amayun of World Vision Relief and Development, Inc. and Mary Conner of World Relief Corporation formed the team that discouraged investment in impact analysis.

Perry and LeBan, in favor of impact analysis, proposed establishing a family registration system as a logical way to track the target population and to measure impact over time. In contrast, Amayun and Conner based their views on an entirely different definition of impact analysis. To this team, impact analysis was academic research with short- or long-term pilot projects set up to measure significant reduction in morbidity and mortality rates.

Both debate teams presented strong evidence for their respective positions; the rest of the group had their own ideas as well. One participant was surprised at the different definitions presented of impact analysis. She felt that some Child Survival interventions were more effective than others, and that impact analysis should be carried out to help in programming decisions. A second suggested that since we cannot distinguish which of the many Child Survival interventions actually affect morbidity and mortality rates, impact analysis

findings are irrelevant.

Another participant commented on the power of information: when the community can see reductions in death, they themselves will sustain improvements in health behavior. Thus impact analysis provides important feedback to the community. Yet another felt it premature to speak of impact analysis before we develop simple and effective health information systems that project staff can handle.

Study of Project Costs

Dr. Dory Storms, PVO Child Survival Support Program coordinator, reported on a review of PVO grant agreements and annual reports that have provided information on the average donor costs for sixty-eight of the seventy-two community-based PVO projects awarded funding by FVA/PVC in the first four cycles of Child Survival. (Documents were incomplete for four projects.) The analysis excluded the ROTARY Polioplus projects and vitamin A projects of HKI that operate at the national level.

The review found that 68 PVO projects have directed \$31.3 million of A.I.D. central funding toward the promotion and strengthening of Child

Survival interventions for 5.3 million potential beneficiaries. In the past four years of the centrally funded PVO Child Survival program, A.I.D. spent an average of \$5.87 per potential beneficiary per year for surveys, project design, training, educational materials design, HIS development, and evaluation. Figure 2 shows the average A.I.D. cost/potential beneficiary/year for each of the 68 projects, between \$3 and \$10 dollars is available to spend each year on services for each beneficiary.

"Potential beneficiaries" are those members of the population who will directly benefit if they are reached by the Child Survival interventions. In most cases, this includes children from birth to 60 months, plus the estimated number of live births in each succeeding year of the project, plus women of reproductive age, 15-49 years. However, if the project plans no interventions for women, such as tetanus immunization, or prenatal care, or family planning services, then the women, ages 15-49, will not be considered potential beneficiaries.

The A.I.D. cost/potential beneficiary/year for new PVO Child Survival projects was lower in funding cycles III and IV than in CSI. This suggests that PVOs and A.I.D. have become more conscious of sustainability issues.

Figure 2. A.I.D. \$/Beneficiary/Year CSI to CSI^{IV}

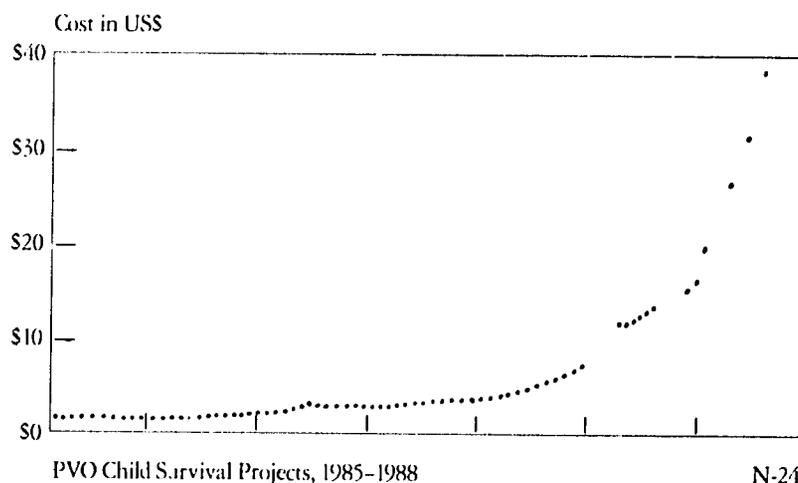
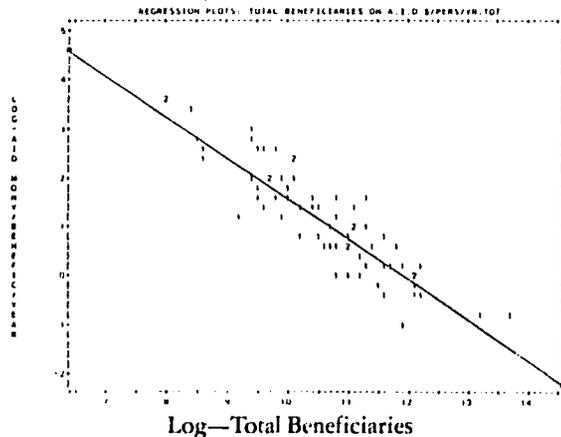


Figure 3. Graph in Natural Logarithms of Relationship between Number of PVO Project Beneficiaries and A.I.D. \$/Beneficiary/Year, CSI-CSIV



68 cases plotted. Regression statistics of AIDPYR1G on TOTBEN1G:

Correlation	-.90020	R Squared	.81036	S.E. of Est	.18449	2-tailed Sig.	.0000
Intercept (S.E.)	10.11043 (.53601)	Slope (S.E.)	-.84434 (.05028)				

However, it seems more difficult to reduce cost per beneficiary for a project expansion than to design a lower-cost project from the start. CSI projects that received expansion funding in CSIV lowered their costs from approximately \$10/potential beneficiary/year in CSI to \$8 in CSIV. New CSIV grants averaged only about \$3 per potential beneficiary per year.

The review also showed that the larger the target population, the lower the donor cost/potential beneficiary/year. In Figure 3, the two variables "size of intended beneficiary population" and "A.I.D. \$/potential beneficiary/year" have been converted into natural logs. Figure 3 shows a simple and direct relationship. When the beneficiary population increases by 1 percent then the A.I.D. \$/potential beneficiary/year decreases by 0.8 percent. Simply put, it is more efficient for PVOs to provide inputs to a larger beneficiary population than to a smaller one.

During the discussion following the paper presentation, the audience raised questions about cost effectiveness—for example, the cost per completed immunization. PVO representatives pointed out that in addition to being careful of costs, the field staff must

address the quality of the services the beneficiary receives. Questions were also raised about the impact of PVO match funds on cost per beneficiary and on project quality. Dr. Stormis agreed these are important issues and promised these analyses would be carried out once the data from the CSI and CSII final evaluations became available.

Review of Health Information Systems 1987-88

The closing session of Day One foreshadowed the theme of Day Two with a review of health information systems in PVO CS projects, presented by Donglu Zeng of the PVO Child Survival Support Program.

Dr. Zeng opened by addressing critical questions: Are the project objectives clearly stated and measurable? Do the data collected relate to these objectives, and are they appropriate to project monitoring? Is information shared with project staff and community? What are the constraints of the HIS in PVO CS projects?

More than four-fifths of projects funded in 1987-88 had objectives; 71 percent had measurable ones. But less

than two-thirds of the projects collected data related to their objectives: 52 percent collected data regularly; only 45 percent collected data appropriate for monitoring purposes.

Monitoring efficiency differed by interventions. Projects were strongest in data collection pertaining to EPI and to CDD objectives, but weakest in assessment of nutrition and reduction of high-risk-birth interventions. A major problem was the lack of a responsible person for management of the HIS. The project was also haphazard in giving feedback to those who collected the information.

Constraints pointed out by PVO projects included a lack of human resources and an information/monitoring system that was too complex.

Dr. Zeng's review led to a lively discussion of the main obstacles in HIS



Cynthia A. Carter

Donglu Zeng, PVO Child Survival Support Program

and suggestions for improvements. The PVO representatives also made some comments and suggestions to A.I.D. and to the PVO Child Survival Support Program regarding their efforts to strengthen HIS in Child Survival projects.

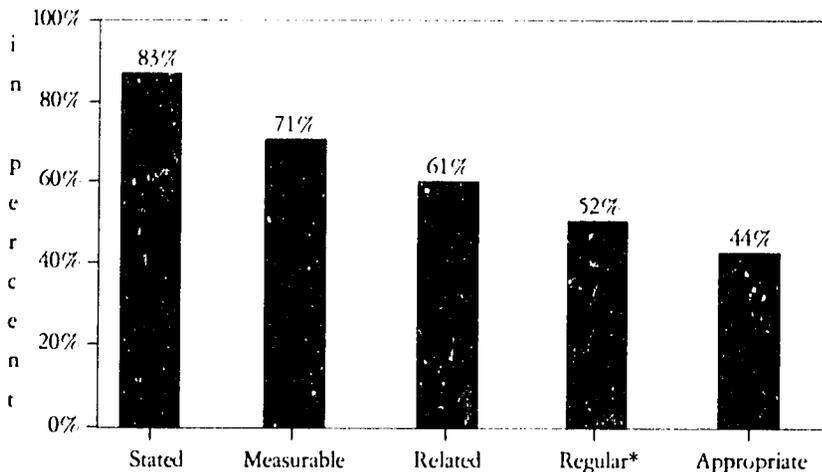
Health Information Systems

The theme for Day Two of the workshop focused on presenting a view of health information systems from the field.

Table 1. Problems and Constraints in HIS PVO CSIII & IV Projects

<ul style="list-style-type: none"> ■ Problems with human resources <ul style="list-style-type: none"> Lack of staff Lack of training Problems recruiting/retaining CHWs ■ Problems with system design <ul style="list-style-type: none"> Complexity Difficulties in obtaining needed information Difficulties in implementation of health information system ■ Problems in reaching the priority population <ul style="list-style-type: none"> Changes in the priority population Difficulties due to climate or geography ■ Problems due to political factors <ul style="list-style-type: none"> Political instability Staff strike ■ Problems obtaining needed material resources ■ Problems obtaining needed technical support

Figure 4. Objectives as Related to Data Collection PVO CS III & IV Projects



Data from 29/36 projects Unweighted averages *Data collected at least annually

A Consultant's View of CS Project HIS

Sally Stansfield opened Day Two of the workshop by expounding her impressions of health information systems. She prefaced her discussion with the caution: "I have some well-developed prejudices about the design and function of information systems for CS projects run by PVOs. PVO projects provide A.I.D. and the development community with one of the richest available sources of data regarding the effectiveness of CS development assistance. What follows are my personal observations about what works, how to build an HIS, and how to ensure that an HIS is worth the effort."

Project managers are infrequently the happy owners of their HIS; more often they find that HIS comes to own them, as well as their community health workers. Most PVO CS projects have put in place an (often overly) ambitious HIS, so most often the current need is to revise, to eliminate elements that are less useful (the so-called "slash and burn" approach to HIS revision), and to strengthen mechanisms to ensure prompt use of data collected. Thus many information systems seem to produce more work than benefits.

What works: The most successful systems have several characteristics in common. The following are principles PVOs may want to follow:

- Let the field define the needs. Data gathered to meet the needs at A.I.D. or headquarters will often not be seen as useful by project managers. Data are exciting only to those who decide they need the data.
- Select project objectives that define indicators. In this era of "management by objectives" and with the current emphasis on accountability, it's best to select indicators before—or, at least, along with—selecting project objectives. Be sure that definitions, such as of ORT or "completely immunized," reflect national policies as much as possible.



Participants Barbie Rasmussen, PCI, and John Barrows, IEF

Dary Storms



World Vision CS project manager working with the health information system

- Collect data only if it alters decisions. The "so what" principle should guide decisions to collect data. For example, remember that while studies of knowledge or attitude, such as opinions on ORT, are useful for program design, tracking changes in attitudes over time is not likely to be useful as long as the bottom-line practice (such as ORT use) is improving on schedule. The decisions triggered by data from the HIS can be as simple as whether you need more information.

- Make sure the data collection method is appropriate.

- Don't try, for example, to get information about attitudes from a big survey. If data collection will be time consuming—such as ORT competence testing or long interviews—be sure the sample is small and the interviewers highly trained. Use small qualitative studies, like key-informant interviews or focus groups, to explore issues, and larger surveys to land quantitative clout to these observations.

- Keep it quick and easy. Whether the data collection is for ongoing monitoring or for periodic evaluations, quicker is better. Never add questions to a data-collection instrument "just because" or "as long as we're there." Time data collection to maximize

usefulness. Information is much more exciting if it makes us look smart. For example, baseline surveys conducted before the DIP can prevent the pain of discovery of important facts at the midterm or end of project, when it's too late to alter project design. Graphics prepared from the project HIS or additional mini-surveys just before an evaluation or meeting with the MOH can help to show that project managers have recognized and are tackling problems.

How to build an HIS: Keep in mind that HIS design cannot be separated from project design. A strong HIS reflects good management practices. It

should track HIS progress toward project objectives and measure activities, input, and outputs necessary to support that progress. So if starting from ground zero, here are steps to design a successful HIS:

1. Design objectives that define data needs.
2. List activities required to meet these objectives.
3. List inputs and outputs required to support those activities.
4. Determine the time, place, and personnel to monitor the activities, inputs, and outputs.
5. Develop simple records to track activities, inputs, and outputs.
6. Devise strategy for addressing periodic data needs such as measures of effectiveness (progress toward objectives) or quality (completeness of population registration, proportion of children given appropriate doses of vitamin A).
7. Devise a plan and schedule for use and dissemination of the information obtained.

Addressing the periodic data needs can be the most complex part of the HIS. Qualitative research or small surveys may be profitable ways to identify strategies that address problems pinpointed by routine monitoring. Yet such special studies, especially surveys, frequently

**Table 2: Baseline Surveys:
The Bad News and the Good News**

	Most Common	Better
Design	Outside	Project staff
Duration	3-8 weeks	4-5 days
Initiation	7th-24th month	Before DIP
Length of instrument	20-40 questions (20-40 minutes)	One page (3-7 minutes)
Analysis	Within weeks	Within hours (under 2 days)
Feedback	Unclear	Immediate
Cost	1-2.6% LOPS*	Under 1% LOPS

* LOP = Life of Project

demand more resources than any other HIS activity. Although surveys can be the best approach to practices, many managers are justifiably concerned about the costs, which frequently outweigh the benefits.

A review of the report from last year's workshop shows that baseline surveys have the characteristics listed in the "most common" column in Table 2. Under these "most common" circumstances, few good managers would encourage completion of a midterm or end-of-project survey. Judiciously designed surveys, on the other hand, can be more cost-efficient if we strive for the characteristics listed under the "better" column.

Making the HIS worthwhile: The data produced by the HIS of most PVO CS projects are simply "too much too late." So after a vigorous slash-and-burn operation according to the above guidelines, the next task is to ensure prompt use of the remaining essential information. A small amount of

information, if thoroughly exploited, will be more than enough. Some suggestions for optimal use of information:

- Require health workers to collect only that information that they must use to guide their work at that moment. Health workers should rarely be a conduit for information they do not themselves use.
- Use the HIS to structure supervisory encounters.
- Supervisors should review, interpret, and perform simple quality checks on primary records kept by the health worker. They should be taught to use the information to identify successes and to earmark workers for special recognition or awards.
- Supervisory reports should summarize project outputs and activities, and should be collated by project managers to inform health workers and supervisors of their successes and needs for

accelerated efforts.

- Respond immediately to records and reports as they are submitted. Congratulations on the quality or promptness of reports does more to improve quality than any other measure. Although some collation and interpretation must sometimes await receipt of other reports, you should complete analysis and report back to workers within two or three days of the due date. This, too, will encourage timeliness in subsequent reports.
- Do not underestimate the power of such data in the hands of community leaders, who can use it to motivate community members to seek project services. In practice, however, information is rarely returned to the community to which it belongs. We thus leave our project beneficiaries feeling forgotten or exploited.
- Be creative in presentation of your data. Colorful cardboard pie charts are often more powerful than computer graphics to motivate health workers or communities. Consider experimenting with methods like baskets of rice or maize to communicate concepts of proportion.
- Do not underrate the usefulness to others of the information obtained through the project HIS. Once we know the quirks and limitations of our data, we tend to assume that others will not find it useful. Yet all data have such quirks and limitations. Yours are likely the best quality or even the only information available for your project area. Other PVOs, the MOH, and other sectors like agriculture or education may be able to refine their own decision making with the benefit of your project's data.

In sum: eliminate all but the essentials for your HIS, then invest the time and resources saved in strengthening creative uses and presentation for the information. Only then can the HIS serve the project staff, rather than having project staff serve the HIS!



Dory Storms

World Vision central & regional offices team, Leslie Horning, Sri Chander, & Fe Garcia

Why Are We Doing So Badly with HIS and What Can We Do about It?

The workshop next broke into seven small groups to spend an hour responding to issues brought up in "A Consultant's View of CS Project HIS." Then participants reconvened to share each group's discussion of pitfalls and obstacles they encountered in HIS, and possible solutions.

<i>PITFALLS</i>	<i>SOLUTIONS</i>
Surveys too long, complex, costly, or oriented to research instead of results	<ul style="list-style-type: none"> a. Focus only on objectives—limit number of indicators b. Avoid collecting information for other organizations c. Encourage field to simplify d. Limit time, especially if data collectors are paid e. Determine critical questions, and clarify them
Baseline survey didn't relate to project objectives or design	<ul style="list-style-type: none"> a. Plan realistically and comprehensively from start—involve community b. Be sure of manual analysis before we computerize
Staff unmotivated	<ul style="list-style-type: none"> a. Clarify who collects, who analyzes, who receives data and re-evaluate periodically b. Show staff use and value of data collected c. Clarify roles and responsibilities at all levels, develop HIS diagram of information and supervisory flow
Training or preparation poor or too long	<ul style="list-style-type: none"> a. Choose knowledgeable, objective, culturally appropriate surveyors b. Use practical, well-focused field training c. Give initial training to set group of people and keep using them throughout project
Information needs unclear Monitoring system does not give info. needed for informed management decisions	<ul style="list-style-type: none"> a. Identify difference between management information system and HIS b. Understand monitoring vs. evaluation
Need to measure activities and objectives against expenses	<ul style="list-style-type: none"> a. A.I.D. should encourage functional budgets or budgets by objectives b. Budget-line items should be close to activities
Quarterly field reports late—not enough time for field staff to analyze data	<ul style="list-style-type: none"> a. Link disbursement of money with HQ receipt of quarterly reports on time
Information unreliable	<ul style="list-style-type: none"> a. Anticipate common errors and build in mechanisms to deal with them b. Maintain quality of supervision c. Get immediate feedback from information
Feedback lost	<ul style="list-style-type: none"> a. Establish system for feedback at each level b. Analyze data at grass roots
Dissemination of analysis difficult	<ul style="list-style-type: none"> a. Keep headquarters and field communicating b. Commit at planning stage to provide for dissemination—e.g., use Health Committees to give feedback to community
Audience needs and donor needs conflict with management	<ul style="list-style-type: none"> a. Distinguish between health objectives and issues b. Distinguish aspects of program under our control in our objectives c. Design mechanism to help each level of data collection address its audience
Government, Ministry of Health expands survey instrument	<ul style="list-style-type: none"> a. Show Ministry "bad" data—let Ministry of Health analyze data they require b. Give government raw data after PVOs have extracted and analyzed what they need
Local government sensitive when data differs from government's self-image. Direction toward sustainability ambiguous	<ul style="list-style-type: none"> a. Involve government and Ministry of Health in entire process b. Hold community meeting during planning stage. Identify what is needed to build-in sustainability—perhaps one sustainability objective for each activity—and monitor objective in HIS

Concurrent Sessions:

Computer Software

Hands-on was the watchword for the computer software session. PVO staff members set up computer stations to demonstrate a variety of software from statistical packages to desktop publishing that Child Survival PVOs could find useful. PVOs utilize a diverse array of software at the field and home office level.

Statistical Packages

SPSS
EPI-Info*

Database

Dbase (Spanish)*
Reflex
Q&A
Paradox

Wordprocessing

WordPerfect *
Word
Multimate
DisplayWrite

Spreadsheet

Lotus Agenda*
Excell

Financial Accounting Packages

AccountMate
DAC Easy

Graphics

Harvard Graphics *
Freelance

Desktop Publishing

Ventura
PageMaker

Project Management

Timeline
Harvard Project Manager

Communications

SmartCom
Relay

*Displayed in Computer Lab.

Project Reporting

John McEnaney, chief of AID/FVA/PVC/CSH office, led a lively group discussion about the current A.I.D. Child Survival and Health reporting system. The purpose of this session was to clarify common problems in project reporting. The question-answer period focused on discussion of FVA/PVC's expectations for PVO headquarters and field project reporting as well as PVO's expectations in regard to feedback from FVA/PVC.

Development and Computerization of HIS

Marilyn Christensen and Gita Pillai of Save the Children Federation walked the workshop participants through the development of both manual and computerized health information systems at their organization.

Save the Children shares with other PVOs the belief that families and communities can learn to care effectively for the health of their own members. Their HIS presents a way, complementary to each country's formal health-care system, to identify every member of a geographically defined community and to involve them in the care of their own health and that of their family members

and neighbors. This goal is accomplished through enrolling every family, creating separate rosters for the follow-up of children and of women, and registering births, deaths, and migrations of community members.

Five steps constitute development of a computerized system: definition, analysis, coding, testing, and installation. Of the five, coding and analysis require the most time.

1. Definition of request and feasibility study: Define task to be automated, including why automated system is needed. Identify what will and will NOT be included in the system.

Ensure there is a fully functioning manual system to be computerized. Identify anticipated benefits. Then conduct study of requirements and alternate solutions. Identify potential costs (hardware, development, and so on).

2. Analysis and design: Evaluate business needs in detail. Define technical requirements of system, including file structures, input, output, processing. Identify system hardware requirements.

3. System development: Identify system modules. Write code to develop system. Test unit. Document.



Fishbowl exercise during project reporting session

Joseph Cummins

4. System and beta testing: Test system in-house, then in field. Make necessary modifications.

5. System implementation and review: Install system on-site and train. Switch over to automated system. Then review system development and evaluate product performance.

Pitfalls of which to be wary include no manual system, time-pressured development, unsupervised consultant, variety of systems, no plan for support, and no disaster-recovery plan.

During the question-and-answer session that followed, one participant asked how manual data was transferred into the computer system. Christensen suggested a flow from community health workers to supervisors to the central office, with seven to twelve volunteers per supervisor and forty to fifty families per volunteer.

Next Steps for Improving Health Information Systems

Participants formed small groups to discuss recommendations related to health information systems. Their recommendations are listed below.

Recommendations to PVO Headquarters

- Commit not to compete, and be willing to take positive action toward networking, sharing lessons learned, experiences, failures, suggestions, and technical expertise both at headquarters and in the field.
- Develop a clearinghouse for sources of effective TA, model instruments for data collection, software.
- Commit to employing full-time health staff.
- Commit to working with each in-country HIS in order to truly address sustainability.
- Provide field support to analyze their collected data.
- Interpret and analyze data, give rapid feedback.
- Don't necessarily get caught up in computerization of HIS. In some cases

the resources may not be there. Be technically as sophisticated as the most sophisticated field-location system.

- Clarify your own information needs.
- Simplify field requirements.
- Show appreciation for field efforts.

Recommendations to PVO Field

- Institutionalize mechanisms for exchange of information among PVOs in each country to share HIS information and experiences
- Analyze data at this level
- Increase networking and encourage staff exchanges
- Document activities better
- Institutionalize "lessons learned" despite staff turnover
- Ensure compatibility of HIS with local community
- Make time for planning and training
- Monitor staff and activities more closely, promote less staff turnover
- Be able to say when you can't technically cope
- Involve community—for example, provide feedback in form they can understand

Recommendations to AID/FVA/PVC

- A.I.D., PVOs, and the PVO Child Survival Support Program should form a task force to review the health information system guidelines for the PVO Child Survival Program proposal, detailed implementation plan, annual reports, CS & H questionnaire, midterm evaluation, and final evaluation.
- Develop more specific guidelines for appropriate effective, standardized HIS
- For thirty-six-month projects combine midterm evaluation and second annual reports
- Send project officers to field sites more often
- A.I.D. should continue to provide feedback on annual reports and midterm evaluations

- Consider funding regional HIS workshops
- Continue to compile and disseminate lessons learned with suggestions for improvement
- Continue to support development of new (simpler) data collection technologies
- Coordinate the selection of core indicators for sustainability, childhood pneumonia, and malaria
- Make financial commitment to help PVOs strengthen their HIS
- Ensure that adequate funding is available for HIS technical assistance
- Circulate information on technical meetings related to HIS—further expand the pool of consultants and mechanism for utilizing their services
- Provide technical assistance for systems analysis
- Encourage SCF to share with other PVOs the outcome of their computerization project

Recommendations to the PVO Child Survival Support Program, JHU

- Develop practical field guides (~10 pages each) for HIS development model, quantitative and qualitative methods for survey design, sampling, and computer applications
- Develop guidelines for cost effectiveness analysis and nutrition indicators
- Continue to develop core of HIS expert consultants who can assist the PVOs to improve their HIS
- Promote HIS interchange among PVO network
- Continue to give feedback on reports
- Hold HIS regional workshop and continue to devote one day to HIS at regional implementation workshops
- Continue to make technical assistance visits to PVO home offices and, when possible, do so in conjunction with FVA/PVC Project Officers



John McEnaney, FVA/PVC/CSH, preparing a talk on "New A.I.D. Initiatives"

New A.I.D. Initiatives

Day Three focused on new initiatives in Child Survival. PVOs have always looked forward to A.I.D.'s presentation of Child Survival activities for the coming year; this year proved no exception as PVOs responded with great interest to the following presentation by John McEnaney:

In 1989, FVA/PVC took a serious look at the current activities supported through the FVA/PVC Child Survival program. Recognizing both the relatively few years of the program and the number of PVOs implementing Child Survival activities, it became apparent that the time had come to launch FVA/PVC into supporting activities that would contribute to long-term sustainability objectives of both A.I.D. and the PVOs.

Thus FVA/PVC moved to launch initiatives to help maintain project activities and adequate resources within the PVO Child Survival community:

In the area of interventions and locus of activities:

- The FY 1990 FVA/PVC RFA began to address other Child Survival interventions, epidemiologically

demonstrated, with the inclusion of malaria as a fundable intervention.

- Recognizing demographic shifts from rural to urban areas that have taken place since the early 1980s, the FY 1990 Child Survival program emphasizes projects that have a focus on urban and peri-urban populations.

In the area of technical assistance:

- FVA/PVC will promote a concerted effort to identify and involve developing-country nationals to provide technical assistance to FVA/PVC-supported Child Survival programs.

Through the A.I.D.-participant training program, A.I.D. has supported the training of hundreds of health workers in developing countries. FVA/PVC will promote the identification of these persons and, where possible, utilize their expertise in providing technical assistance to the FVA/PVC Child Survival program.

- FVA/PVC proposes institutional training support for PVOs:

Traditionally, U.S. PVOs have had difficulty providing long-term technical assistance in public-health management and information technology to their projects. Strategies designed to remedy this deficiency have not been very effective to date. Now FVA/PVC proposes to address this problem by establishing a program that will assist the institutional growth of PVOs working with Child Survival programs. University settings will provide them with technical resources, training in management-information systems, and evaluation and training technology. The program will have three objectives: to improve PVO field staff skills through academic opportunities; to provide PVO field offices with public health interns; and to establish a university setting for PVO staff to obtain short-term training over a specified period of time. The result will be a dynamic, two-way interchange that will help PVOs provide human-resource training and profes-

sional development of staff, while offering a chance to those entering the public health field to experience implementing field projects first-hand.

In the area of communications:

- FVA/PVC will support the publication of a technical report for PVOs, to address technical issues relating to the CS interventions. The publication will provide PVOs with technical information to implement projects, invite feedback, and be a forum for discussion of PVO CS issues.

- It will also support the publication of a series of monographs addressing Child Survival interventions from a field perspective.

- FVA/PVC will help develop an electronic bulletin board to promote PVO networking and to provide quick interchange of ideas and events among CS PVOs.

- Finally, FVA/PVC will explore the possibility of initiating regional technical workshops on a small scale, to foster networking and information exchange.

Improving Quality: PRICOR's Operations Research

The Thursday morning session on improving quality of Child Survival implementation began as the participant group viewed a video which focused on the impact of primary health care programs worldwide. After a lively discussion of participant reaction to the video, Dr. Stewart Blumenfeld reviewed the results of the Philippine System Analysis carried out by PRICOR.

The purpose of the analysis was to identify potential operational problems (operational problems were defined as health worker activities and conditions that did not meet norms established by the Philippine Department of Health Management or internationally recognized standards if local norms had not been promulgated). The interventions examined in the systems analysis included immunization, ORT, growth monitoring, and ARI. The systems area focus included process and inputs for



Dorcy Strömms

Presentation of PRICOR's operations research

service delivery, supervision, logistics, and training for four Child Survival interventions. The immunization activities review included data on information systems and payments for immunization service. Findings across the four intervention areas were fairly consistent with fewer operational problems in the area of service delivery and logistics than in training and supervision.

Concurrent Sessions:

The purpose of the two technical sessions, ARI and Malaria Control, was to learn steps to incorporate these interventions into Child Survival projects. The technical assistance session was organized in order to clarify common problems in obtaining and using local, regional, and U.S. technical assistance and to answer questions regarding the FVA/PVC-funded TA mechanisms.

ARI Program Implementation

Nils Daulaire of JSI/Intercept presented practical issues of implementing ARI programs. The following is a synopsis of his report:

Over the past few years ARI has been increasingly recognized as a major killer of children in the developing world, including Nepal. A.I.D. has funded support to several Nepali organizations, with technical assistance from John Snow Inc., in order to determine what elements would be needed to implement an effective large-scale ARI control program in an underserved population.

The main thrust of our program has been the in-home treatment of childhood pneumonia in a Nepali community called Jumla, where this disease is second only to diarrhea as a leading cause of death in the very young. Specially trained villagers seek out cases of childhood pneumonia by visiting each household in their communities every two weeks ("active case detection") and

THE QUALITY OF HW PERFORMANCE MAKES A DIFFERENCE

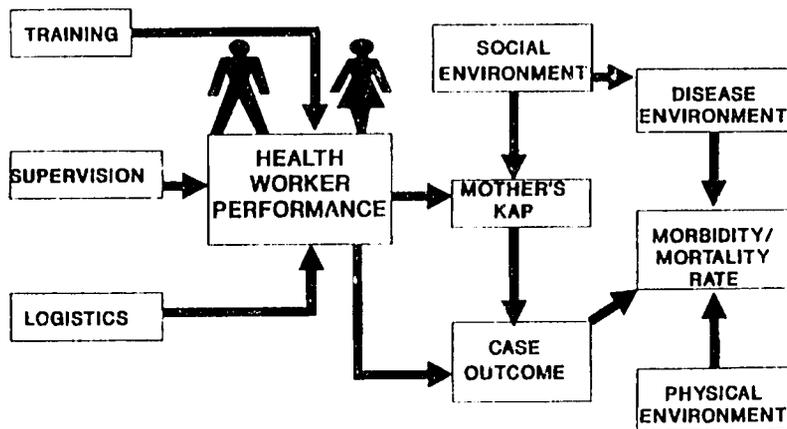


Table 3. Systems Analysis Methodology: Premises

- The performance of health workers plays a major role in determining the impact of the PHC service system
- "PERFORMANCE" can be defined as a set of specific operational tasks for each intervention which essentially constitute the process component of a classic input/output model
- It is possible to measure objectively whether or not a health worker performs each operational task
- [Corollary: the sum of the performance of individual health workers is a measure of the overall quality of service provided by the system]
- Supporting system components can also be defined operationally



"Veteran" participants Alan Alemian, AFRICARE, & Ken Flemmer, ADRA

Dory Storms

through on-site supervision.

The antibiotic we use is cotrimoxazole (sulfamethoxazole) syrup: it is effective against most varieties of pneumonia; it is administered twice daily, in the generally acceptable form of syrup.

To our surprise and concern, we found after analyzing the first year of our data that, despite extremely high coverage rates—nearly 100 percent of households were visited every two weeks—and high overall treatment rates of approximately 0.9 antibiotic treatments per child per year, only 25 percent of the children who died of pneumonia had received treatment. This led to concern that our coverage was not as good as we had believed it to be, or that it was misdirected. In program reviews, however, we found that adherence to our protocols was extremely high.

It turned out that the explanation for low coverage of fatal episodes related to the disease pattern itself: among those children who died of pneumonia, information collected from mothers indicated that the average duration of major symptoms prior to death was on the order of only three and a half to four days, leaving only a small window of opportunity to initiate treatment in time. Obviously, a biweekly home-visiting schedule relying entirely on active case detection would miss most of the serious cases; yet more frequent visits are hardly feasible.

This has necessitated a shift in our program emphasis from one that focuses on effective service delivery to one that generates appropriate demand for these services in a timely fashion. The obvious key to effective demand is to involve the mother in active case presentation.

This goal requires several conditions. The first is to overcome a sense of fatalism in Nepali culture and help the mother develop a sense of empowerment—she can in fact do something that will have an effect on the survival of her child. The second is maternal recognition of the signs and symptoms of pneumonia. The third is effectively conveying to mothers the importance of



Participants and resource persons preparing a session with the workshop facilitator

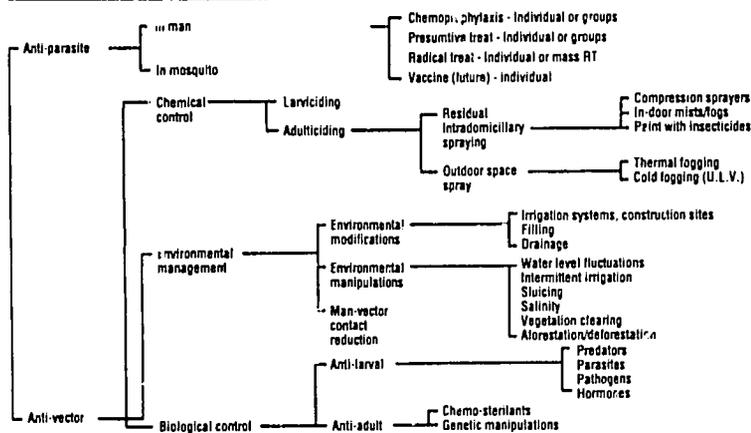
Sally Foster

responding to calls from parents to see sick children ("passive case detection"). They also treat confirmed cases of pneumonia in the household with oral antibiotics according to protocol. To date the program has treated nearly 30,000 cases of childhood pneumonia. Through it we have learned a great deal about the practical needs of program implementation and about the epidemiology of childhood pneumonia.

Even though the techniques regard-

ing pneumonia recognition and treatment are fairly simple, we have found that actually conveying and maintaining the necessary skills requires considerable training time and continuous ongoing supervision. Our training course takes nine days of lectures, demonstrations and field work devoted almost exclusively to pneumonia detection and treatment. And even the well-trained will rapidly lose his or her skills if they are not regularly reinforced

Malaria control measures



and the need for action on their part to seek care when they recognize pneumonia in their children.

The fourth and fifth necessary conditions are trust in and accessibility of the health worker, often lacking in the developing world because of poor services, indifferent care, or simply great distances. Mothers are very practical: they will use what they think works. It is our job to make sure that the service providers are in fact trustworthy.

We have worked to meet these conditions in Nepal with the assistance of behavioral scientists, community-education tools, and discussions; by using community members as local health workers; and by increasing the number of trained workers to increase accessibility. Thus we come to the sixth condition—appropriate response from the health-care provider.

The Jumla ARI-Intervention Trial has shown conclusively that clinical case management of childhood pneumonia can be appropriately carried out at the community level. It has also taught us that simply delivering appropriate services is a necessary but not a sufficient condition of promoting the survival of children. This program has been a valuable source of experience and information that can help with the

development of effective pneumonia control programs throughout the developing world.

Malaria Control

Larry Cowper reported on the worldwide problem and control of malaria. Here are highlights of his presentation:

Malaria is widely recognized as one of the world's most killing diseases. It is less widely recognized that the burden of malaria mortality is borne overwhelming by infants, toddlers, and pregnant women. In some parts of the world, 25 to 50 percent of child mortality is due to malaria as either a primary or secondary cause of death.

In addition to its role in infant and child mortality, malaria affects the general health parameters of children under five years of age. Anemia and low birth weight are among the most pervasive consequences of malaria, since its long-term effects include stunting of growth, general debilitation, and higher susceptibility to other diseases.

Decreased response to vaccines for meningitis, typhoid, and tetanus is often another result of malaria infection.

In a world where two billion people—40 percent—live under the risk of malaria, the disease has not only a

serious effect on health, but also important economic implications.

To understand the disease, and basic factors for its control, we must consider three elements: man, mosquito, and parasite. Each of these parameters of malaria carry social and cultural factors such as occupation, housing, migration, as well as biological factors. We must understand each aspect of this worldwide disease to develop programs for control that have sound epidemiological, operational, and social bases.

Malaria control programs most often target the mosquito and parasite: a number of mechanisms using anti-malaria drugs help control the parasite; biological, chemical, and environmental methods help control the mosquito.

Incorporating malaria control into the Child Survival program is based on its importance to infant and child health in many parts of the world—especially Tropical Africa, Papua New Guinea/Solomons, outer islands of Indonesia, Amazon region of Brazil, Haiti, and countries of Southeast Asia, such as Kampuchea, Laos, and Union of Myanmar (formerly Burma).

Discussions among PVOs have brought out a variety of possible malaria control interventions. Suggestions include:

- Assist in integrating malaria control in PHC/MCH programs
 - Motivate community, enhance awareness
 - Train health workers
 - Provide for rapid diagnosis through provision of equipment, supplies, and anti-malarial drugs
 - Carry out prevalence surveys and evaluations
 - Engage in operational research—for example, use of bednets
 - Help in environmental measures
 - Encourage prophylaxis for pregnant women in high risk areas
 - Coordinate activities with government and others in PHC/MCH
- One of the groups recommended that

guidelines for a management-level person be drawn up and distributed so decisions could be made on appropriate techniques. Defining PVO involvement in malaria control and establishing criteria and priorities for such programs are also important issues.

PVO Involvement in Malaria Control

- Basic to all actions for control of malaria is training both PVO staff and village communities. Surveillance posts, for example, are often set up and supplied by PVOs: a specially trained member of a household serves the village by providing anti-malaria drugs, taking blood samples, making slides, acting as liaison agent with the national malaria programs, and providing health education. The PVOs provide training for the village volunteer; supervise and monitor the action; supply the village worker with pricking needles, glass slides, stains, and drugs; assist in health education.
- PVOs have carried on environmental actions to control the breeding of mosquitoes in the villages through drain-and-fill operations, provision of larvivorous fish, and village sanitation to remove breeding sites/harborage. They have also applied residual insecticides and larvicides. These and other practical efforts like encouraging bednets and animal barriers are ideally suited to PVO activities.
- Provision of technical assistance (TA) at various levels is entirely appropriate to PVO programs. TA can include basic control demonstrations, use of equipment or supplies, data management, environmental management, fish culture, bednet impregnations, entomological assessments, basic epidemiological surveys, and so on.
- Community health education is another aspect of PVO programs that is most helpful. Interactions with schools, religious groups, civic organizations, and key village leaders are all important areas for PVO attention.

Criteria for PVO Programs in Malaria Control

- The health priority and importance of malaria as a disease should be established with epidemiology studies before initiating a malaria-control program. The seasonal pattern of malaria outbreaks should also be established so that actions can be taken at the correct time to make a health impact. Where malaria occurs year-round, this fact should be known.
- Knowledge of existing programs of malaria control in the area is important in order that coordination can take place for areas under existing control or new areas.
- A simple data-management system is critical to keep track of supplies and equipment, and to evaluate ongoing efforts—treatment, operational research, training, community health education. Evaluation should be planned early and carried out on schedule by an external group at regular intervals and by the PVO itself on a periodic basis.
- Training of village and community level workers is normally required and the PVO should have experience in such training activities. For large-scale programs, a PVO staff member should

be versatile in a variety of malaria-control interventions. Provision of teaching aids, course outlines, direct participation, training trainers, and evaluation are all part of the training package.

- The ability to provide community health education is important as most of the interventions will require village participation, and it is necessary that the actions be understood by the people involved.

Technical Assistance

Many participants this year were new to Child Survival and had not experienced accessing A.I.D. evaluation or specialized technical assistance (TA). And since the TA system has evolved from its early days in 1986, impressions varied about PVOs' involvement in TA activities for the field. Thus, Sallie Jones of AID/FVA/PVC and Cynthia Carter of the PVO Child Survival Support Program discussed the structure of the TA-funding mechanism and the nuts and bolts of requesting and receiving technical assistance to Child Survival field projects.

Some of the common interests discussed were:

- How early should a TA request be submitted?
- Is there a list of available consultants?
- What are plans for TA now and in the future?
- What happens when a PVO is unhappy with the results of a TA activity?
- Will TA be available to headquarters?
- What other groups might offer TA: U.S.-based, regional, and in-country resources?



Sallie Jones, FVA/PVC/CSH

Sally Foster

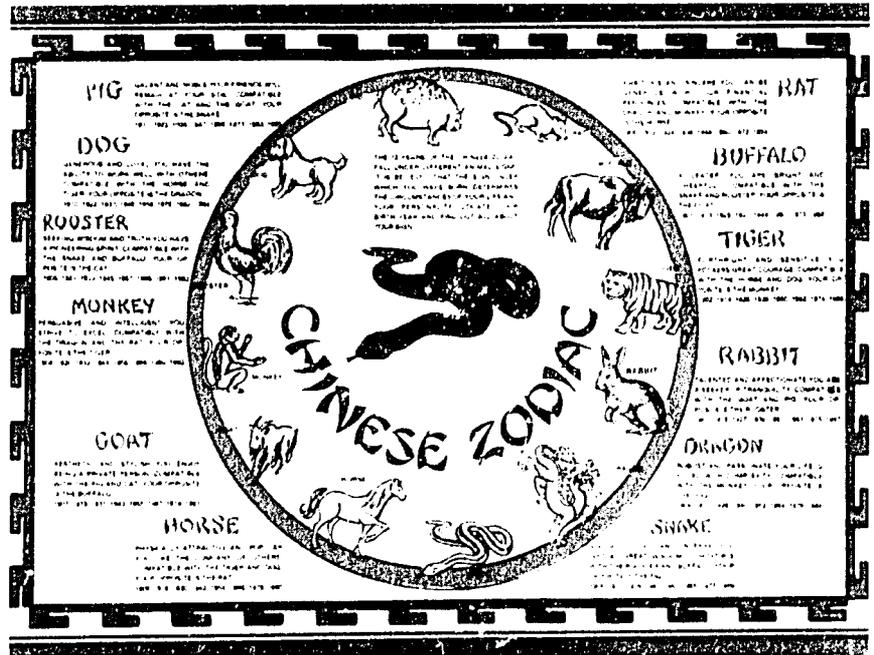
恭賀新禧

— 春节联欢晚会 —

Chinese New Year

Many thanks to the Aliso Creek Workshop Entertainment committee:

- Eve Berry
- Jack Blanks
- Irene Chander
- Bill Dolan
- Ken Flemmer
- Faye Garcia
- Sallie Jones
- Rebecca Magalhaes
- Jim Sheffield
- Donglu Zeng



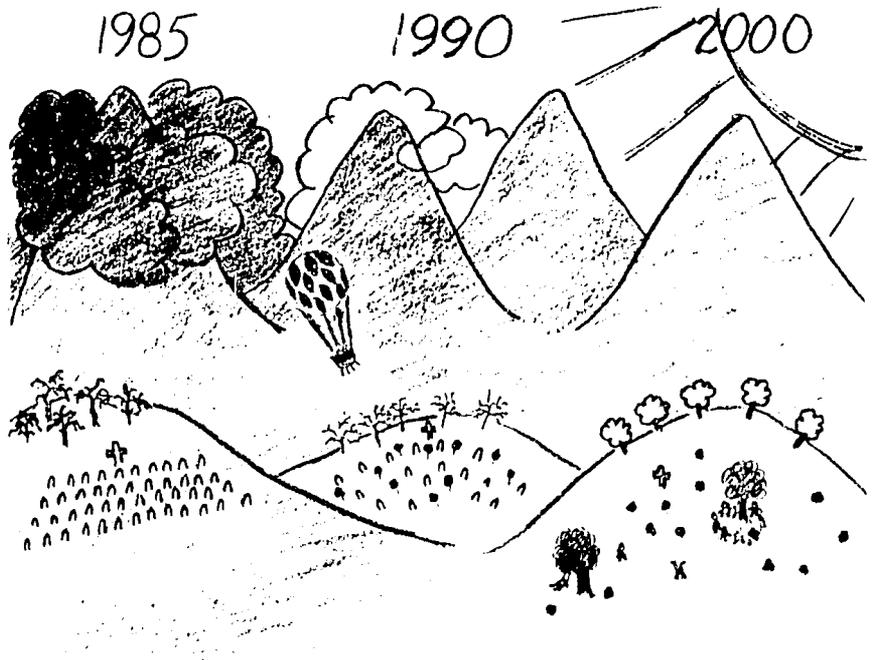
JHU Pathology Photography

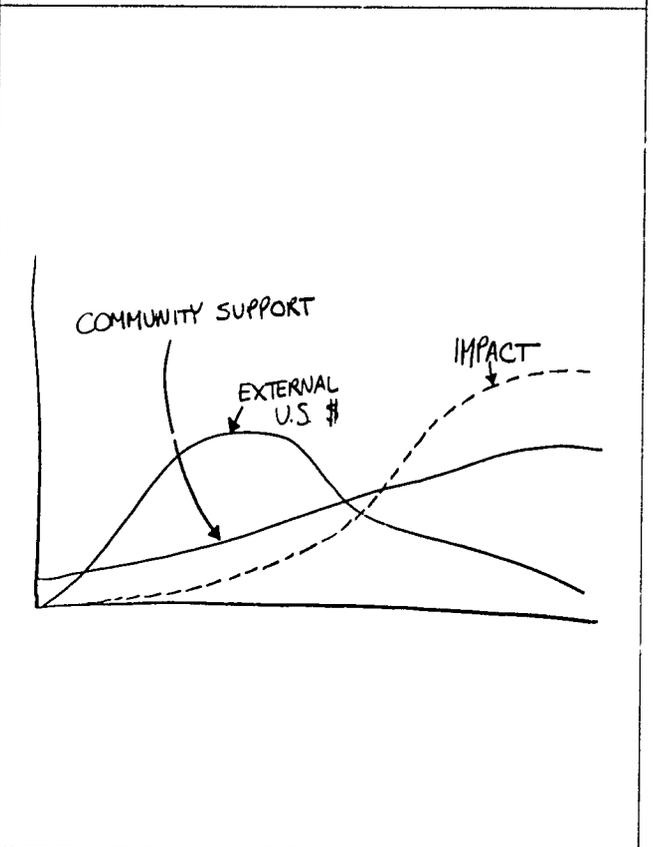
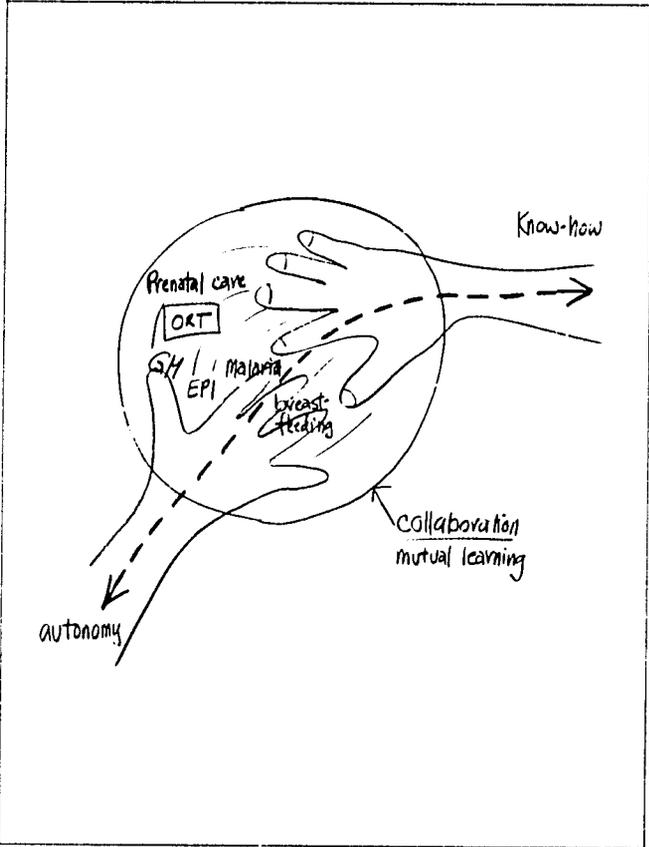
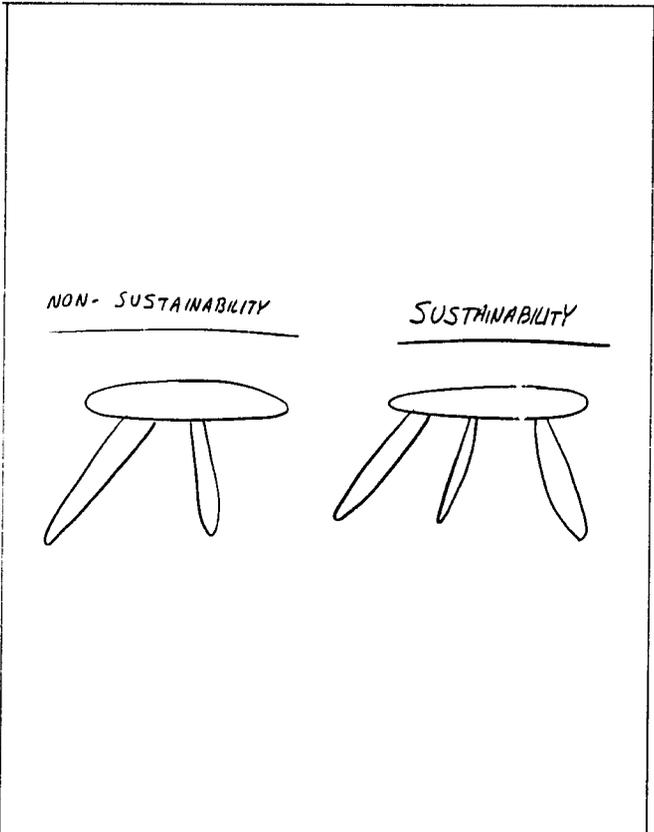
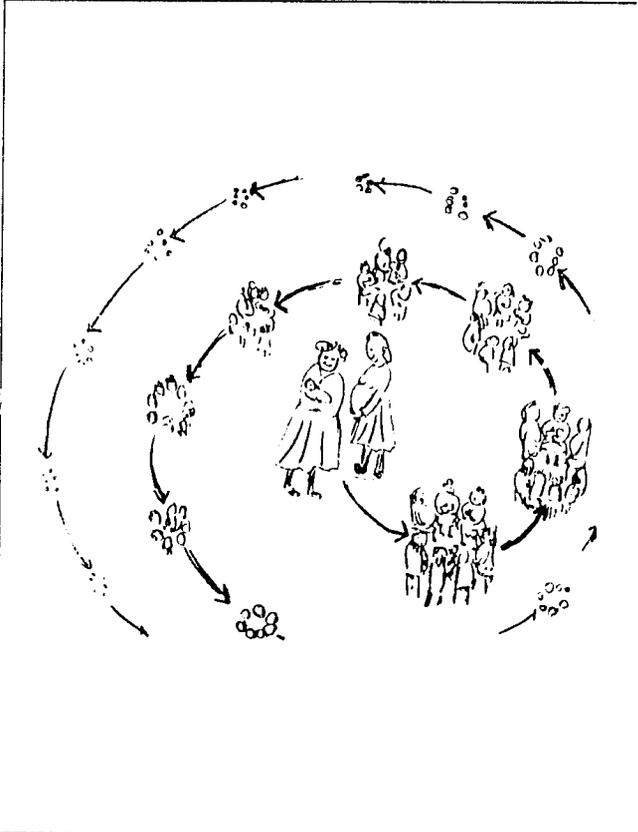
What Sustainability Means to Me...

The theme for Day Four focused on sustainability. PVO representatives dealt with this often confusing idea in, perhaps, the most practical way ever: stages of discussion about sustainability began with definitions; moved to presentations of various methods PVOs use to cope with sustainability; then applied these ideas at the organizational level, in order to institutionalize lessons learned about effective methods to strengthen child survival programming.

Everyone participating in this workshop at Aliso Creek went home the prior evening carrying butcher paper and colorful crayons. Our mission: draw sustainability—somehow illustrate what it means to each of us.

The next morning, drawings adorned the Resource Room walls as we began to explore unstated assumptions about the meaning of sustainability. The major themes that threaded through these creative glimpses of thoughts on sustainability included transfer of knowledge at the family level, improved





quality of life across several generations, partnership between governments and outside agencies, and economic development. The drawings shown here are just a few samples of these ideas.

Round Table Discussion: Sustainability Case Studies

After discussing sustainability in abstract terms, it was time to hear presentations of concrete experience in implementing strategies to enhance program sustainability. PVOs with practical experience in developing volunteer corps and training programs, and enhancing community ownership of project activities, formed roundtable discussion groups to share practical advice on how to achieve sustainability.

Dr. James Sheffield of AMREF launched one discussion with several points about special characteristics that PVOs possess that often help them achieve a greater degree of program sustainability than governments can.

PVOs can often work more efficiently as well as more closely with local groups; they can mobilize local resources and set up self-help mechanisms. In AMREF's experience, churches have served as institutions with strong local constituencies and with links to external resources. This group pointed out that sustainability is likely to occur as Child Survival efforts are integrated within government programs and local community programs.

Another way to strengthen the potential for project sustainability is to initiate management decisions at the community level, or "bottom-up," versus donor or government driven, "top-down" management decisions. The concept of community ownership of Child Survival projects was discussed, but some group members pointed out that the project should ultimately be seen as joint collaboration between the community and government.

Many governments, on the other hand, face an inability to function at a grass-roots level, thus failing to meet the basic needs of the population. Ineffective

management systems, economic problems, civil unrest, and high population growth rates have also added to the burdens on government health programs.

Laurie Ackerman of Rotary International led a discussion that focused on the sustainability of volunteerism, a particular strength of the Rotary PolioPlus programs in Nigeria and India. The Rotary PolioPlus program aims to mobilize private sector volunteers in support of nationwide immunization programs. Such an endeavor, requires a highly organized infrastructure of volunteers at national, state, district, and local levels.

In Rotary's experience, volunteers are most attracted to short-term, highly visible activities like national immunization days. Stimuli that have proved popular include national meetings, lapel pins, and letters of recognition from the government. Such incentives, however, are recurrent and often expensive, and may not be appropriate to a project's budget or strategies. Some strategies Rotary uses to strengthen the potential for sustainability:

- focus on effective project manage-

ment and set measurable goals

- foster teamwork through regular meetings with volunteers at the local and district level, and, less frequently, at the state and national level
- maintain regular feedback to volunteers with newsletters

Various participants shared practical experience: the high turnover rate of community health workers, for example, affects the chances of sustainability. Thus, development of strong mechanisms for community support is clearly important.

One PVO's costs for training programs was very high: members suggested collaborating with MOH trainers to defer this cost.

Another participant experienced severe limitations to sustainability, mostly due to a civil war in that country. There the community, distracted by political upheaval, had difficulty committing to assuming responsibility for the project. Remoteness of the project was also a constraint. Workers were nevertheless fairly successful in initiating a rabbit-raising project to generate income.



Sustainability Round Table discussion

Dory Storms

Report on Regional Workshops

Bettina Schwethelm of Project Hope updated the group on the results of the First Central America Regional PVO Child Survival Implementation Workshop, held in August 1989 at the HOPE Child Survival field site in Quezaltenango, Guatemala. The

highlights of this workshop were field trips in which the participants carried out focus group discussions with health workers and conducted a mini-KAP survey.

Dean Millslage of Project Concern International discussed the 1st Asia Regional PVO Child Survival Implementation Workshop, carried out in



"Building on Lessons Learned," 1st Asia Regional PVO CS Workshop participants



"Viva el Niño," 1st Central America Regional PVO CS Workshop participants



Dory Storins

Participant Jim Sheffield, AMREF

December 1989 at the PCI Child Survival project in Kendari, Southeast Sulawesi, Indonesia. Dr. Sri Chander, World Vision Asia regional director, talked about the workshop from a participant's point of view. One of the many highlights of this workshop was participant discussions on sustainability.

Electronic Mail Services

During the afternoon unstructured time, Marilyn Christensen offered another computer display—this time demonstrating electronic mail services.

Electronic mail combines the advantages of postal mail and telephone calls: one sends mail to a specific address, but instantly, via computer. An electronic mail letter can go to another individual anywhere in the world, or to a bulletin board for others to read and answer if they wish. E-mail can even be posted on a conference board, where the audience can communicate back to the sender immediately—like a conference call with keyboards.

E-mail service can be a lower-cost, efficient alternative to communicate with office staff, field staff, and other organizations. Requirements are a personal computer, modem, communications software, and membership to an electronic mail service.

Institutionalization of Lessons Learned

Dory Storms introduced the concept of institutionalizing lessons learned with an eye-opening visual aid: group photographs from three previous PVO Headquarters workshops with blacked-out faces of colleagues who have moved on from the program. This exercise brought to light the reality of high staff turnover and the need to develop strategies to work within this system.

How can a PVO ensure that its Child Survival lessons are appropriately

- recognized
- understood
- shared
- stored
- recalled
- used . . . over time?

With the workshop drawing to a close, it was time to hear from the buddy pairs. What had many hours of talking, sharing, laughing, agreeing, disagreeing produced?

Veteran buddies had much advice to share with new buddies, ranging from how to prevent burnout to how to ensure quality.

Early Days

- Jump in immediately—try it yourself
- Walk through your organization and meet everyone
- Find out about all the activities in your organization
- Don't be afraid to question or to ask for help
- Read all standard provisions and A.I.D. guidelines
- Get an interpreter for A.I.D. guidelines
- Find a mentor
- Keep it simple

Working Together

- Be open to suggestions and to change

- Give creative input yourself
- Collaborate with others to get the work done
- Leave clear instructions when you are away so others can support your work
- Know where departing persons can be located
- Start early on reports
- Document key processes and systems you helped establish
- Delegate, delegate

Ensuring Quality

- Read and write for sustainability
- Keep costs down while improving quality over time
- Get outside perspective to see if what you are doing is clear
- Motivate staff to be involved in all steps of the implementation process
- Be concerned with child survival, not just provision of services
- Give value to what communities can bring to the process of implementation
- Institutionalize regular communication sessions with field

- Understand constraints field staff work with

Keeping in Touch

- Interview each staff person
- Visit a neighbor PVO—get to know what other PVOs are doing
- Get to know your board and regional teams
- Get out to the field
- Keep a good relationship with beneficiaries
- Learn from people working at the community level and from those you're there to serve
- Go to a workshop

Words of Wisdom

- You are not alone in your problems
- Keep your eyes on the ultimate goal
- There is no such thing as a dumb question
- Pace yourself!



Dory Storms

A most veteran "veteran" participant, Ath timer, Ellen Vor der Bruegge, FFI

Workshop Evaluation

“The strategy of bringing PVO headquarters staff together annually, and field staff together in periodic regional workshops is an excellent one.

These workshops foster a development of a closer relationship among PVOs working in Child Survival and provide an opportunity to strengthen implementation through sharing of ideas and receiving technical information.”

—PVO representative

PVO Participants Evaluate the Workshop

Evaluation forms were mailed to all PVO participants after the workshop. Evaluations consisted of an open-ended questionnaire to encourage comments and suggestions for future workshops, and a rating form that considered the organization, content, and process of the workshop. Responses were received from nineteen participants.

Workshop Goals

Participants were asked whether they believed that the workshop had met its goals. Most responded positively. Participants believed that the workshop met its first two goals: to provide feedback on projects' achievements and lessons learned, and to share experiences and materials related to technical backstopping. Feedback and sharing were appreciated, particularly those that took place informally.

It was the general opinion of the participants that the workshop did succeed in raising awareness of issues affecting quality, the goal most pertaining to the theme and title of the workshop. "Raising awareness of issues regarding quality of implementation was fully achieved and provoked a great deal of thought and reflection," wrote one respondent. Participants see that the next step is to identify how best, within each organization, to sustain high-quality technical support to Child Survival field projects. Participants feel that a solution has barely begun to be found. The issue of sustainability will continue to demand further attention and consideration.

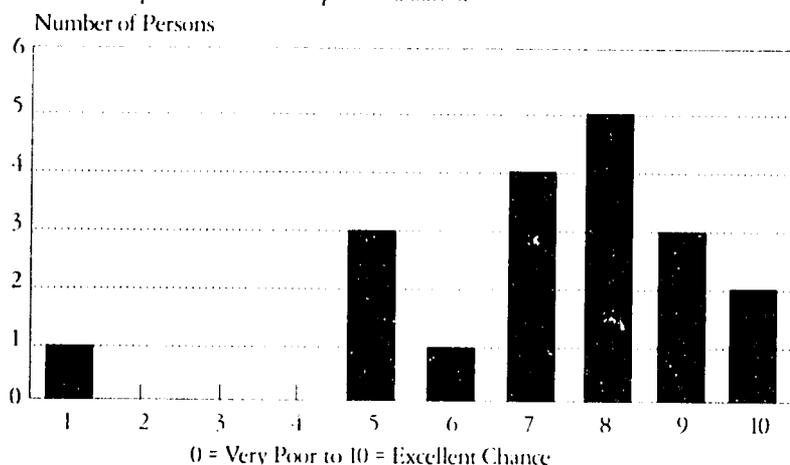
Efforts to examine PVO Child Survival health information systems left some participants unclear as to what directions to take in 1990. The computerized health information system presented by Save the Children interested many participants, but is not seen as a direction in which most PVOs are prepared to head.

Workshop Achievements

"Overall, the technical resource presentations were beneficial, interesting, and thought provoking." Participants found specific sessions to be most valuable. All were impressed by the session debating the pros and cons of impact analysis. Concurrent sessions on ARI and malaria, and the "Consultant's View of CS Project HIS" were definite favorites. Respondents also cited the session on improving quality given by PRICOR and John McEnaney's talk on new A.I.D. initiatives as particularly productive.

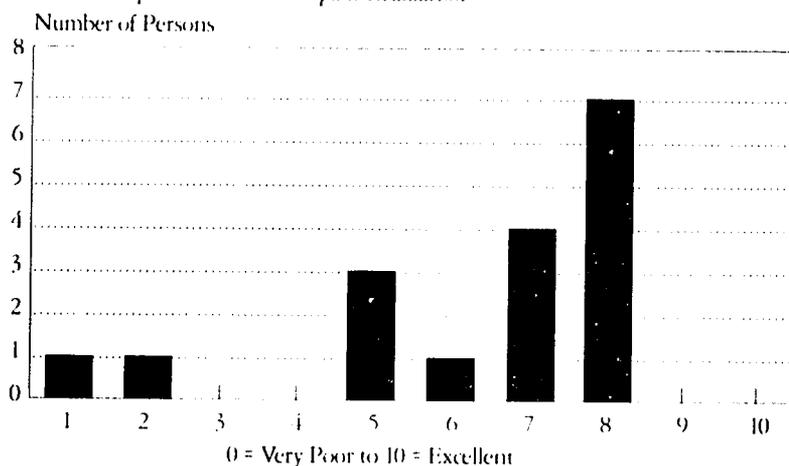
Respondents consider the presence of FVA/PVC project officers to be crucial to the workshop's success. One respondent summed up a commonly expressed opinion of the participants, "It was not only useful but necessary that John McEnaney and Sallie Jones attended the workshop. This workshop provided the time to exchange ideas, to understand each other's constraints, to establish better relationships, and to clear up pending issues."

Acceptance of Participant Suggestions
Aliso Creek Workshop, 1990 PVO Participant Evaluation



19 responses

Value of Session on "Progress in PVO Child Survival: Achievements in EPI"
Aliso Creek Workshop, 1990 PVO Participant Evaluation



17 responses, 2 no answer

Recommendations for the Future

The presence of workshop consultants provided human resources that, respondents felt, should have been expressed further: "I felt like some of the persons could have played a larger part throughout the entire conference by actively participating beyond their short presentation." Some sessions had potential to be improved if more time had been allowed. "In some small group sessions, we did not have time to meet again in a large group and come to a conclusion on the exercise."

Another recommendation was made which may further enrich utilization of the resource room. "Although the materials were displayed well and were available, they did not appear to be widely collected. Maybe a brief statement by the PVOs as to what was being offered would have stimulated interest and facilitated collection."

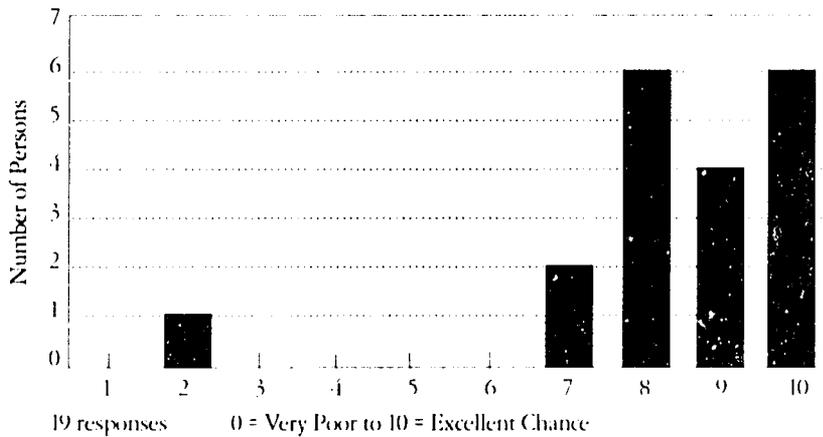
Time is a constant constraint of the PVO Headquarters workshops. Optimal utilization of the time available is the responsibility of the staff, consultants, and participants. Although participants are encouraged to take advantage of the accessibility of consultants and USAID project officers for informal discussion during meals and unscheduled time, many respondents felt the need for more structured consultation and interaction.

One participant wrote, "It would be excellent if some mechanism for providing individual feedback to each PVO was established. For instance, mealtime or after hours meetings with representatives from each PVO." This idea was echoed by another respondent who suggested "including more time [for participants to meet] with FVA/PVC to resolve problems and constraints in implementing CS projects."

Despite the addition of another full day to the workshop schedule, respondents lamented the lack of time to develop fully topics of individual concern, and for informal discussion among participants and workshop staff. Some respondents recommended that

Freedom to Express any View

Aliso Creek Workshop, 1990 PVO Participant Evaluation



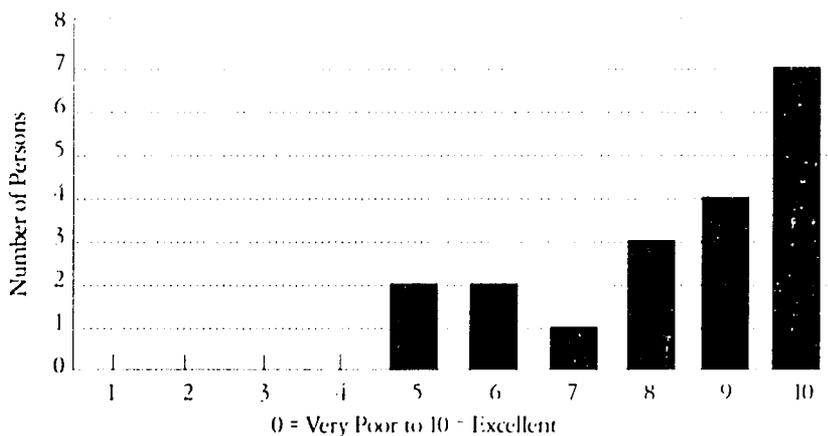
Belief that Workshop will Lead to Action

Aliso Creek Workshop, 1990 PVO Participant Evaluation



Value of Talk on a "Consultant's View of CS Project HIS"

Aliso Creek Workshop, 1990 PVO Participant Evaluation



19 responses

greater time be devoted to asking a PVO to give more presentations.

The request for more PVOs to present their projects is a result of efforts not to repeat presentations given in past years, and the expectation that there would be sufficient informal time for discussion between PVO representatives. Perhaps the rapid turnover of PVO Child Survival staff and the introduction of new PVOs to Child Survival necessitate more scheduled time for PVO presentation, even at the expense of repetition.

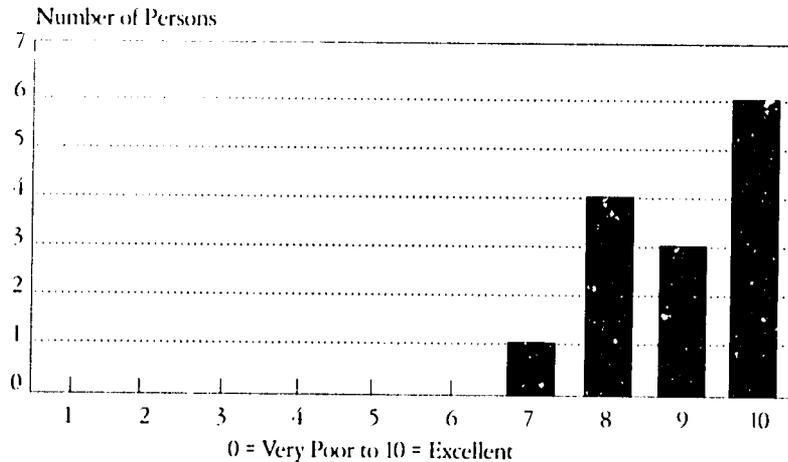
It is clear that to facilitate these requests, the overall group size must remain small, and needs assessment must continue to take place prior to the workshop so that time will be best spent in addressing the individual concerns of the PVOs.



Participant Rebecca Magalbaes, LaLeche League

Value of Special Interest Session: ARI

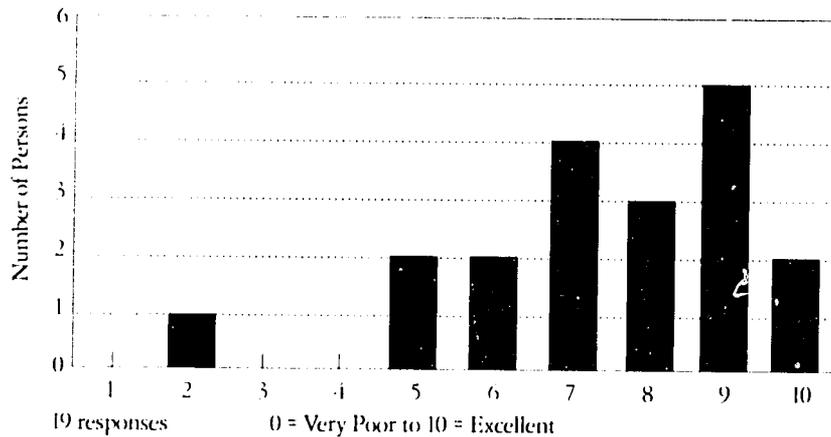
Aliso Creek Workshop, 1990 PVO Participant Evaluation



11 responses, 5 no answer

Value of "What Sustainability Means to Me" discussion

Aliso Creek Workshop, 1990 PVO Participant Evaluation



19 responses

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What have you learned from the Aliso Creek Workshop?

"The most important thing I learned about was the network within which we are working. I have a much greater sense of the PVO child survival 'context.'"

"I have learned more about the capability of the PVOs."

"I learned a new appreciation of the ever changing participants in Child Survival."

"I left with a much better understanding of the overall A.I.D. Child Survival Program."

"Learned the following: developed a better understanding of Child Survival programs, A.I.D. reporting requirements, views and experiences of other PVO staff."

"The PVO community is dedicated and committed to their work. However, we still have challenges ahead of us, especially in nutrition, where more effort is needed to improve outcome."

"The most important things I learned: issues in malaria control and childhood pneumonia, the divergence in opinion on what is impact analysis and how Chinese can be learned quickly."

What long-term effects do you think this workshop might have?

"Continued communication among participants, more emphasis on quality of programs, focus on HIS for the next few years."

"The issues of quality of interventions came out as a challenge to me and my team. The other issues that we are now confronting as a PVO in our programming are the health information system and costing/financial sustainability. Our awareness of these issues was intensified during the workshop."

"It provided opportunity for PVOs to network and share common constraints and successes. Excellent for bonding PVOs together."

"The long-term impact of this workshop on our program will be a closer tie with other PVOs and the FVA/PVC office. This link has already benefited our projects in terms of quality."

"Hopefully there will be more concern over the issue of quality. Every time I am in the field it becomes more and more clear that improvements in quality are a necessity."

"One of the effects that will probably have the longest impact is getting to know people with similar duties in other PVOs. It is helpful to be able to compare notes with others, and to know FVA/PVC staff on a more personal basis."

"How to expand coverage of interventions. How to bring programs to locally sustainable transition."

0 = Least value (or very poor) to 10 = excellent

	Average Rating	Number Respondents
<i>Organization</i>		
• Degree to which the workshop was organized	9.0	19
• Relevance of workshop theme and objectives	8.1	19
• Workshop schedule	7.9	19
<i>Process</i>		
• Effectiveness of facilitator	9.0	19
• Friendliness of atmosphere	8.8	19
• Freedom to express any view	8.4	19
• Degree to which discussion kept to the topic	8.2	19
• Degree to which cliques did not develop	7.8	19
• Acceptance of suggestions from participants	7.2	19
<i>Resulting actions</i>		
• Degree to which you think what was learned in this workshop will result in action	6.8	18
<i>Presentations</i>		
• Value of the session on "Progress in PVO Child Survival"		
Part 1: Achievements in Training	6.8	18
Part 2: Achievements in EPI	6.4	17
• Value of "A.I.D. Cost per Beneficiary" presentation	6.3	18
• Value of the presentation of the paper, "Review of Health Information Systems 1987-88"	7.6	17
• Value of the session on a "Consultant's View of CS Project HIS"	8.4	19
• Value of presentation of SCI's computerized HIS	7.3	19
• Value of talk, "New A.I.D. Initiatives"	6.8	18
• Value of video and discussion on "Improving Quality" & PRICOR operations research	6.4	18
• Value of report on Regional Workshops	6.7	17
<i>PVO Discussion Groups</i>		
• Value of PVO debate, "Pros & Cons of Impact Analysis"	7.6	15
• Value of small group discussion of, "Why are we doing so badly and what can we do about it?"	6.8	19
• Value of discussion of drawings, "What Sustainability Means to Me"	7.4	19
• Value of "Sustainability Case Studies" roundtables	5.9	17
• Value of group feedback on Institutionalization of Lessons Learned and the Buddy System	6.5	15
<i>Special Interest Groups</i>		
• Computer Software	7.0	18
• Project Reporting	6.7	15
• ARI	9.0	14
• Malaria	(10, 9, 10, 7, 9, 7)	
• Technical Assistance	6.0	16
• Demonstration of Electronic Mail	(7, 9, 7, 4)	

(Individual responses are shown when the number of respondents seems too small to permit meaningful averages.)

Activities since the Workshop

“Since the workshop, my team’s contact and interaction with other PVOs, FVA/PVC, and the PVO Child Survival Support Program has increased. I look forward to the next workshop.”

—PVO representative

PVO Child Survival Technical Report

As John McEnaney's speech on A.I.D. initiatives stated, FVA/PVC is supporting the publication of the Child Survival *Technical Report (TR)*. This quarterly report lets PVOs address technical issues related to Child Survival interventions. In 1989, a team evaluating the technical-support strategy for Child Survival programs proposed a recommendation: develop a newsletter, and distribute it regularly to all PVOs involved in Child Survival activities. The idea of a technical newsletter also reflected suggestions of project field staff, PVO headquarters, and project consultants.

At first, PVC questioned the usefulness of an additional technical publication. Closer examination, however, revealed that project staff often lacked access to necessary information, and felt a strong need to exchange their experiences in Child Survival.

After discussion with A.I.D. in May and June of 1989, the PVO Child Survival Support Program (PVO CSSP) hired a consultant to review, with public-health professionals, the issues of format, production, and distribution. A.I.D. also advised an emphasis on implementation issues and information update, rather

than the usual newsletter format. The newsletter was meant to assure a steady flow of information between PVO field projects, especially with regard to areas such as technical support resources, scope of activities, lessons learned, and constraints in the field.

For the implementation of the project the PVO CSSP asked PVO field staff about their projects' needs and preferences for the publication. The answers of thirty-four PVO respondents formed the basis for the report's specific objectives, which were defined as follows:

- to encourage exchange of information and experiences between projects
- to inform PVO project staff of the latest developments and techniques in Child Survival
- to provide a forum to discuss interesting issues in implementation and evaluation of Child Survival interventions
- to explain A.I.D. guidelines for project reports and reviews, as well as A.I.D. policies and initiatives in Child Survival and health.

In late 1989 the first *Technical Report (TR Vol. 1, No.1)* was published in English, French, and Spanish and sent to PVOs and other organizations. Since then a second and third *TR* have come

off the press, thus meeting the goal of a quarterly publication scheme.

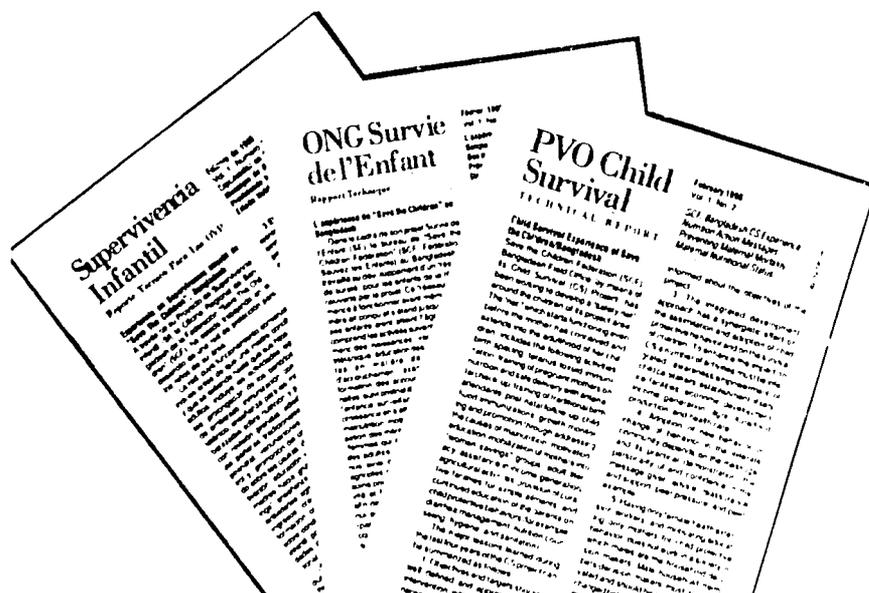
Through a survey assessment and regular feedback from PVO headquarters and field staff, the PVO CSSP team, and *TR* consultants are trying continuously to modify the report so it will reflect the target group's interests and needs. Contributions from PVO field staff are encouraged.

Mickey Leland Internship

In the summer of 1990, the PVO Child Survival Support Program had for the first time two African-American students from Baltimore City high schools as Mickey Leland Summer Interns. The internship lasted ten weeks, and two new students will be selected each of the following summers until 1992. Save the Children Foundation initiated a similar program last year, and Dr. Dory Stornas carried the idea back to the PVO Child Survival Support Program office.

Congressman Mickey Leland, who died in a plane crash in Ethiopia in August 1989, was a African-American leader known for his strong commitment to eradicate famine and hunger around the world, especially in Africa. He initiated legislation to promote U.S. foreign aid to help African countries become economically self-sufficient. This internship program honors Congressman Leland by recognizing and continuing his commitment to assist disadvantaged people around the world. It will also help to expose Baltimore City teenagers to the problems in international public health.

This year's interns, LaTarsha Russell and Andre Ham, were chosen by a three-member committee, based on nominations by their schools and on a personal interview. The internship awardees were announced during an award ceremony that was attended by Baltimore's commissioner of health, Dr. Maxi Collier; by Dr. Andrew Sorensen, assistant dean of the Johns Hopkins School of Hygiene and Public Health; and by representatives of local and state politicians, school officials, and families of the interns.



Quarterly PVO Child Survival Technical Report

JHU Pathology Photography

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Debra Curbeam

Andre Ham, 1990 Mickey Leland summer intern, at the PVO Child Survival Support Program



Debra Curbeam

LiTarsha Russell, 1990 Mickey Leland summer intern, at the PVO Child Survival Support Program

Lessons Learned in Practical Nutrition

On May 13-17, 1990, the "Lessons Learned in Practical Nutrition: Approaches and Actions in Bangladesh" workshop took place in Dhaka. This country-specific workshop was organized by Save the Children (USA) and hosted by the SCF/Bangladesh field office. Funding support was provided by AID/FVA/PVC. Both USAID/Bangladesh and the PVO Child Survival Support Program provided workshop development support. The workshop report can be obtained from the SCF/Connecticut office.

5th Africa Regional Child Survival Workshop

The 5th Africa Regional PVO Child Survival Workshop was held June 23-30, 1990 at the Bishop Caukin Church Center, Atta, Imo State, Nigeria. The workshop was held in rural, east Nigeria, hosted by the Imo State-Africare Child Survival project, and sponsored by AID/FVA/PVC. After a review of participant and headquarters needs assessments and technical comments from DIP reviews, the workshop theme, goals, and objectives were developed. The theme, "Child Survival: The Challenges We Face...", centered around discussions of

project sustainability strategies, management by objectives, community participation, and effective health information systems. Highlights of the week included an opening address by the Governor of Imo State, two all-day field visits to Child Survival impact areas, intensive group-work in which participants developed 90-day action plans for sustainability. The workshop goals included:

- to share resource materials and foster networking among PVO Child Survival field staff
- to examine and strengthen activities that effectively involve key segments of the community in Child Survival project efforts
- to share PVO experiences and develop strategies for integrating sustainability in all phases of the project including developing relationships with the community and the MOH, and income generation activities
- to strengthen CS project management through the selection of appropriate project objectives, indicators, and targets
- to share lessons learned in data gathering, monitoring, supervision, project evaluation, and feedback to the community

The 20 workshop participants included country national PVO staff from MIHV/Kenya, IEF/Malawi, SCF/Malawi, Sudan, Zimbabwe, ADRA/Nigeria, Africare/Nigeria, Rotary PolioPlus/Nigeria, WV/Nigeria, Uganda, CARE/Sudan, and one Imo State MOH representative.

Lessons Learned in Urban Child Survival

A conference will be held in Mexico City September 10-15, 1990, on the theme "Lessons Learned in Urban Child Survival." The purpose of the conference is to provide a forum for eleven urban and peri-urban pioneer projects to discuss the unique opportunities and



Sally Foster

"Lessons Learned in Urban Child Survival" conference planning meeting

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Cynthia A. Carter

Workshop participants making their way to a meeting with SCF field staff

constraints they have encountered, and to identify strategies that have proved more successful in an urban setting. Participants will include country national staff from Kenya, Bangladesh, India, Indonesia, Honduras, Guatemala, Haiti, and Dominican Republic. Also invited are U.S.-based PVO staff who monitor and provide technical support to the urban field projects. Expected are representatives from A.I.D., UNICEF, the World Health Organization, and the World Bank. The proceedings will be sponsored by AID/FVA/PVC. Conference proceedings and recommendations

will be compiled, published, and distributed to all PVO CS grantees.

Knowledge and Practice Surveys

Based on recommendations made at the Aliso Creek Workshop, the PVO CSSP is developing various survey modules for the different Child Survival intervention areas. Depending on the PVO, the project's objectives, and the geographic location of the survey, the most appropriate questions out of a larger pool of possible questions for different child survival intervention areas are chosen.

These surveys can provide baseline

data for identifying target groups for action messages, measure changes in knowledge and behaviors of mothers (influencing the health of their children < 5), assess coverage estimates for immunizations, and provide an estimate of the diarrhea and ARI incidence for the previous two weeks. Furthermore the surveys allow an estimate of the percentage of high risk children < 24 months.

The basic idea is to have survey instruments available that can be used by the PVO CSSP and later by PVOs, on their own, to carry out quick and inexpensive knowledge and practice surveys.

In order to be cost-effective it is not sufficient for the surveys to be inexpensive, they also have to provide scientifically valid data. Therefore, the PVO CSSP has been consulting with national and international experts, with universities, and international organizations to assure the validity and reliability of the questions used.

By August 1990, three KAP surveys had been successfully completed in Honduras, Guatemala, and Kenya. Surveys for Bolivia, Nepal, and Vanuatu have been prepared and will be carried out in the near future. Cooperating PVOs to date are: ARHC, FfH, FPSP, Hope, LaLeche League, and MIHV.

Experiences from each survey are used to improve the questionnaires as well as the survey implementation.

During this preparatory phase the "survey planning team" communicates frequently with the PVO field staff and headquarters by telephone and telefax, to receive PVO input for the selection of questions, as well as for planning of the survey.

Generally the KAP surveys follow a fixed in-country schedule: three days of final in-country preparation, three days of training for supervisors, interviewers and data entry personnel (including field testing), three to four days of interviewing and three days of data analysis and tabulation. A draft report with the survey results is completed within this time frame.



Imo State MOH Photographer

"PVO CS: The Challenges We Face," 5th Africa Regional Workshop participants

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