

PVO RESOURCES FOR CHILD SURVIVAL

January 6-8, 1988
Lake Havasu, Arizona

*A workshop for U.S.-based PVO staff who backstop Child Survival projects in
Africa, Asia, Latin America, and the Caribbean*



The workshop was organized by the PVO Child Survival Support Program at the Institute for International Programs, School of Hygiene and Public Health, The Johns Hopkins University, under a cooperative agreement between the Institute for International Programs, JHU, and the Office of Private and Voluntary Cooperation, Bureau for Food for Peace and Voluntary Assistance, United States Agency for International Development.

The workshop report, published December 1988, was prepared by Mary Anne Mercer, DrPH, and Doris Storms, ScD, with publication assistance from Denise Harrison and JHU Design and Publications.

Address correspondence to:

PVO Child Survival Support Program
The Johns Hopkins University
School of Hygiene and Public Health
Institute for International Programs
103 East Mount Royal Avenue
Baltimore, MD 21202
(301) 659-4100

PREFACE

It has been my good fortune during these past three years to live through the frustrations and the successes of a small group of courageous people committed to improving the life chances of our world's children. They are the people who work with U.S.-based private voluntary organizations. The program is called Child Survival, and it affects families and communities in the developing world.

We who work on Child Survival believe that preventive health services to families are terribly important. Not everyone makes that their priority, though. Curative services are a major concern to some members of the communities where projects are located; others value water supply or economic betterment more than preventive health activity. A community's desire to see Child Survival activities sustained will depend on the extent to which the community perceives direct benefits from the project.

PVO Child Survival projects need the support of the formal health system in order to sustain and advance their community health work. The desire of a ministry of health to commit resources to continuing PVO work will depend on the perceived effectiveness of health activities. If the ministry has a part in creating the services and keeping technical standards high, they will desire to effect the phase-over from the PVO.

The PVOs squarely face the issue of sustainability. Central to all efforts is the commitment to plan and implement projects that are technically strong and acceptable to the community in content and approach. Still, there are more questions than answers. In a 1988 report, *The Effectiveness of Private Voluntary Organizations*, the Advisory Committee on Voluntary Foreign Aid, USAID, stated their belief that sustainability of PVO projects will be enhanced through "the sharing of information and experience with other development agencies," and that "networking . . . provides lessons on avoiding mistakes and capitalizing on successes that can reduce significantly the time and capital needed for research and development of a successful approach."

The workshop described in this report was designed to provide an opportunity for U.S.-based PVO staff who backstop Child Survival projects to share materials developed and the lessons they have learned in the first two years of Child Survival project implementation. Dr. Mary Anne Mercer and I chose to document in detail the specific ideas that crystallized during the workshop so that this report can be of maximum benefit to the many new technical staff currently joining the PVO Child Survival community. Basic to what we have written is our belief that, together, the PVOs can make a difference.



Dory Storms
November 1988

CONTENTS

Workshop Planning and Preparation

Background	3
Organization	4
Process and Content	6

The Workshop

Introductory Session: Expectations	11
PVO Resources for Child Survival Country Projects	12
The Resource Center	15
Lessons Learned in Backstopping Child Survival Projects	17
Sharing Experiences	17
Reporting Requirements for PVO Child Survival Projects	18
The Evaluation Process: PVO Lessons Learned	20
PVO Recommendations Regarding CS Project Evaluation	20
Special Interest Sessions	21
Monitoring Home Management of Diarrheal Episodes	21
Monitoring Immunization Activities and Determining Coverage	22
Quick EPI Surveys for Child Survival Projects	22
Beneficiary Input into Project Evaluation	23
Growth Monitoring and Promotion	23
Assessing Vitamin A Deficiency	24
Surveillance of Nutritional Status Including Vitamin A Deficiency	24
Qualitative Assessments by Focus Groups	25
In-Country Collaboration for Data Collection and Use	26
Training of Field Staff to Strengthen Child Survival Activities	26
Report on PVO Child Survival Field Workshops, 1986–1987	27
Sustainability: Reality Check for Child Survival	29
Sharing Experiences	29
PVO Recommendations Regarding Sustainability	30
Mood Music	30
Final Session: Where Are We and Where Are We Going?	31
Report from A.I.D.	31
PVO Accomplishments and Lessons Learned in the Past Three Years	32
What Are We Still Working On in Child Survival?	33
Next Steps: PVO 90-Day Action Plans	33
PVO Recommendations for Removing Barriers to Child Survival Goals	34

Workshop Evaluation

PVO Participants Evaluate the Workshop	37
Workshop Critique	37
Workshop Accomplishments	38
Suggestions for the Future	39
What Have You Learned from the Workshop?	40
What Long-Term Effects Do You Think This Workshop Might Have?	41
1988 PVO Evaluation of Lake Havasu Workshop	42

Follow-Up Action

Follow-up Activities to the Workshop	45
PVO Task Force on CSI Final Evaluation	45
Lessons Learned Conference for Africa and Haiti CSI Projects	45
Task Force on Vitamin A Components of PVO CS Projects	46
PVO Needs for Follow-up Activities	47
1988 Arizona Workshop–Participant List	48

List of Figures

Figure 1. Funding for U.S. PVO Child Survival Grants and Technical Support
FY 85–FY 87 31

Figure 2. Distribution of PVO Child Survival Grants by Child Survival
Intervention, FY 85–FY 86 32

List of Tables

Table 1. Workshop Agenda 7

Table 2. PVO Child Survival Field Workshops, 1986–1987 28

WORKSHOP PLANNING AND PREPARATION

“The most valuable facet was the collective practical experiences of similar PVOs.”

—PVO representative

Background

A workshop for central office staff of U.S.-based private voluntary organizations having Child Survival grants was held in Lake Havasu, Arizona, on January 6-8, 1988. The workshop was the second annual workshop for U.S.-based PVO staff who backstop Child Survival (CS) projects funded by the Office of Private and Voluntary Cooperation (PVC), in the Agency for International Development (A.I.D.) Bureau for Food for Peace and Voluntary Assistance (FVA).

The Office of Private and Voluntary Cooperation has been described as the agency's laboratory of learning about the expanding role of private voluntary organizations (PVOs) in international development. An A.I.D. information memorandum explains the role of the office: "PVC has two principal responsibilities within A.I.D.: 1) to administer multi-sector, multi-country grant programs with a significant portion of the U.S. PVO community in order to strengthen and expand their international development programs and 2) to provide program and policy guidance and management support to the entire agency partnership with the private voluntary community." In the health sector, PVC administers the competitive Child Survival grants program designed to support the efforts of U.S. PVOs to reduce infant and child mortality in the developing world.

Child Survival Program

In 1985 Congress voted to set aside funds for a specific area of developing country health activities, in what was called the Child Survival Initiative. The Child Survival strategy in health involves focusing efforts on a few major interventions to break the cycle of malnutrition and disease that results in death for millions of infants and small children every year. These interventions are immunizations, oral rehydration therapy (ORT) for diarrhea, nutrition interventions such as growth monitoring, and birth spacing.

The Child Survival Program has attracted much support from the general public and members of Congress, and

there are encouraging signs of achievements in increasing immunization coverage and improving mother's treatment of diarrheal episodes in children. By January of 1988 there had been three cycles of Child Survival grant funding, referred to as CSI, CSII, and CSIII.

A major component of the Child Survival Initiative was the important role of the private voluntary sector, which has a long history of involvement in programs dedicated to the improvement of health in developing countries. Since 1985, a substantial portion of each Child Survival allocation by Congress has gone to improve and expand the work of the PVOs in their international health activities. Members of the Hunger Committee and the Senate Appropriations Committee continue their efforts to see that PVO Child Survival programs receive adequate funding as they develop proposals for FY 1989 funding.

At the time of the workshop in January 1988, PVC had received approximately \$33 million to support the PVO Competitive CS Grants Program. These monies from the funding cycles FY 1985 through FY 1987 provided the means for 22 U.S.-based PVOs to carry out 50 Child Survival projects in 21 A.I.D.-assisted countries. In addition, PVOs matched A.I.D. funds with a 25% cash match from private resources.

Implementation Support

An important part of the strategy for strengthening the work of the PVOs has been a coordinated effort to provide technical support for PVO staff in the planning, implementation, and evaluation of Child Survival interventions. During the first three Child Survival cycles, FVA/PVC set aside approximately \$1.9 of the \$33 million (5.7%) for this effort. The money gave the PVOs access to external evaluation and other specialized technical assistance from PRITECH and REACH, the two major sources of technical consultants for A.I.D.'s government-to-government Child Survival activities. (REACH specializes in immunization and health care financing, while PRITECH focuses on control of diarrheal disease and program problem solving.)

Another mechanism for technical support to PVOs has been through a cooperative agreement with The Johns Hopkins University (JHU) Institute for International Programs. This agreement facilitates a broad range of support services for centrally funded PVO Child Survival activities through a PVO Child Survival Support Office. One activity of the Hopkins office is providing orientation to PVO/HQ and field staff new to the Child Survival Program on program reporting requirements and general technical standards of the program. The cooperative agreement also supports a limited number of special studies, including a review of PVO approaches to sustainability and an evaluation of the impact of CS funding on PVO organizations and relationships with A.I.D. In addition, the agreement funds the organization of technical reviews of CS documents (although the actual technical reviewers come from outside the JHU office).

A major function of the cooperative agreement, however, has been workshop and conference activity. Upon authorization by FVA/PVC, the PVO CS Office at Hopkins works in partnership with PVOs to organize field-based implementation workshops for CS project country nationals. It also hosts an annual workshop for U.S.-based PVO staff who backstop those projects, with the aim of encouraging PVO networking, sharing, and collaboration.

The first PVO problem-solving, resource-sharing workshop was held in Baltimore in December 1986. The day-and-a-half workshop enhanced introductions, and PVO technical staff were able to get to know each other better. Ideas and experiences were exchanged freely, and the practice of networking began. The meeting set the stage for collaborative effort. The participants suggested that a follow-up meeting be held in a year's time, taking into account the timing of new proposals, and recommended that the workshop be lengthened to ease time restrictions on sharing problems and solutions. There was general endorsement of the style of organization and design of workshop process. This positive response was echoed by A.I.D. project officers and

workshop staff. For these reasons, the work plan for the second year of the PVC/JHU cooperative agreement called for another workshop to be held in the USA for PVO central office staff working in Child Survival. FVA/PVC agreed to the work plan.

A review was made of the workshop experience in light of its objectives; outsiders' opinions were solicited, and some changes were made to strengthen what had worked in Baltimore and to abandon what seemed to block the group. Because of the initial focus on problems experienced in Child Survival, the discussions in the first workshop seemed to bog down in unresolved issues, and it was often frustrating, if not depressing. Matters improved when the focus shifted from problem solving to resource sharing, so the early thinking for the second workshop was that it focus on PVO resources and the lessons learned. The year rolled around quickly, and within six months planning began on the second PVO workshop, this time to be held in a western state.

Organization

The workshop core staff consisted of a facilitator, the workshop organizer, and the coordinator of the PVO Child Survival Office at Johns Hopkins. Initial arrangements for the workshop were made by Barbara Johnson, administrative assistant, and by Dr. Dory Storms, of the PVO Child Survival Support Office. For the final six weeks of workshop planning and implementation, Dr. Mary Anne Mercer, a Johns Hopkins faculty member with previous experience as a consultant with the PVO office, assumed the role of workshop organizer.

A facilitator, Suzanne Reier, was hired. The role of the facilitator was to meet with the workshop organizers and resource staff ahead of the workshop to review each team member's perceptions of what needed to be done, listen, clarify objectives, and improve the contribution of people to effectively get the required tasks done. During the workshop the facilitator's job was to ensure that the workshop experience be constructive, frank, rela-

tively flexible, pleasurable, and participatory. The facilitator ensured the continuity of this process throughout the large group sessions, and also through meeting in advance with the resource persons for each special interest group session, discussing useful participatory techniques. In addition, the role of the facilitator was to keep the workshop "on time and on track" so that the workshop outcomes would be consistent with the organizer's objectives and participant expectations.

Ms. Reier was particularly interested in supporting the workshop efforts for the PVO headquarters staff because she had been the facilitator for the Africa Regional Child Survival Workshop hosted by the Adventist Development and Relief Agency (ADRA)/Rwanda for PVO field staff of CSII projects. Having listened to the ideas and views of PVO field workers, she wished to learn more from the experiences of those who backstop the Child Survival projects.

Needs Assessment

Planning for the 1988 workshop for PVO central office staff began with a needs assessment, conducted via telephone interview in mid-1987. Discussions with both field and central office PVO staff had previously indicated that many PVOs were

concerned about improving the ability of field staff to assess the effectiveness of Child Survival interventions. The need for fine-tuning of monitoring and evaluation methodologies was increasingly evident. As the first CS projects progressed into their final year, any deficiencies in project data collection and reporting had grown more troublesome. By January, the CSII projects would be planning for midterm evaluations later in the summer of 1988, while the newly funded CSIII projects were working on baseline surveys and developing health information systems.

Requests to A.I.D. for technical assistance for CSI and CSII projects had centered around the need to obtain health information for project management decisions, whether baseline surveys or evaluation. Previous studies of the PVOs had identified the need to strengthen their capacity to monitor and evaluate interventions. Thus it was no surprise when the needs assessment confirmed that information on various monitoring and evaluation techniques in Child Survival was a priority area for the workshop to address.

In addition, nearly all the PVO staff contacted in the needs assessment said that the sharing of "lessons learned" from the CS projects should be an important function of the annual workshops. There were several areas in which they specifi-



Dory Storms

cally mentioned they wished to learn from each other. PVOs new to Child Survival were interested in learning how other PVOs backstopped their field projects. They believed that one role of central office staff was to assure quality of services at the field level, and so they saw that as an important topic for discussion. Some PVO staff who had worked with Child Survival projects over several years had expressed concerns about the quality and effectiveness of their methods for training field staff in Child Survival interventions. They wished to learn how others approached training.

PVO staff also identified areas in which they specifically wanted to share some ideas or materials that they had developed over the past year. The project midterm evaluation, which some PVOs had recently completed, was a specific evaluation experience that some PVO staff wanted the opportunity to share with other participants. Some PVOs had developed manuals, videotapes, flip charts, etc., which they wanted to show the group.

Finally, others wanted to keep open the communication with A.I.D. They wanted to exchange ideas on project reporting and evaluation guidelines, and to discuss even broader concerns, such as the ultimate usefulness of the Child Survival approaches and strategies both for the communities and for the countries in which they were working.

Workshop Goals

Based on the needs assessment and on the experience of previous workshops for central office staff, the following workshop goals were identified:

1. To facilitate the exchange of ideas, experiences, and materials among PVO home office personnel responsible for technical support to Child Survival country projects, and to promote networking.
2. To provide PVO technical support staff with useful techniques for monitoring, reporting, and evaluating CS interventions.
3. To serve as a forum for PVO technical staff to give guidance to FVA/



PVC, on the conduct and direction of the PVO Child Survival Program.

Selection of Workshop Dates and Location

The best dates for the workshop proved to be early January. PVO staff had a narrow window of time available between the December proposal deadline and the winter travel to projects to prepare Detailed Implementation Plans for submission to A.I.D. in March. The organizers at A.I.D. and the PVO Support Office were similarly constrained. The workshop had to be completed by mid-January to permit enough time to organize the external technical reviews of new proposals. It was agreed that the workshop be scheduled January 6-8, Wednesday to Friday noon.

The 1987 workshop for central office PVO staff was held on the East Coast of the USA, in Baltimore. In order to accommodate the PVOs based on the West Coast, workshop planners decided to host the 1988 workshop in the West. Several possible sites in California were explored. Unfortunately, most of the centrally located meeting sites required more lead time than was available, or were prohibitively expensive.

The site finally selected was Lake Havasu, a small resort town in northern

Arizona for which the winter months are the off-peak tourist season. The Nautical Inn offered a convention facility that included modestly priced guest rooms, dining and recreational facilities, a variety of meeting rooms, and the services of a convention center coordinator.

The town of Havasu, with tourist attractions like its famous London Bridge, was also easily accessible to workshop participants.

PVO Representatives

PVO Child Survival grantees received a written invitation to the workshop in September 1987, requesting them to identify two central office staff to attend who were considered "responsible for providing technical support to field staff implementing Child Survival projects." The final roster of PVO participants consisted of central office staff members from 20 of the 22 U.S.-based PVOs who had been awarded a Child Survival grant from the A.I.D. Office of Private and Voluntary Cooperation during the first three funding cycles. Some PVOs were new to Child Survival; others had been taking part in the program since 1985.

Altogether there were 30 PVO representatives who attended the workshop. They held a wide range of administrative

and technical responsibilities within their organizations—including presidents, health program directors, health advisers, evaluation specialists, medical directors, program coordinators, and contract officers.

Process and Content

The Lake Havasu workshop design built on the experience of prior PVO annual and field-based regional workshops. In general, the design emphasizes participatory methods that encourage optimum interaction among participants, and focuses on practical ideas and techniques useful to PVOs to improve the effectiveness of their CS program. It is essentially action oriented and oriented to the needs of field projects, as seen through the eyes of the field staff, or those in the United States who backstop the projects.

The process follows those principles of organizational development that stress the useful contributions of people to improve effectiveness of organizations. Underlying the workshop approach is the belief that the PVO participants are themselves extremely valuable resources for each other and for other workshop staff. That means that workshop organizers consult others, obtain their ideas, and make use of their talents. Thus, the workshop process utilized principles of participatory training and development that rely on the input of each participant to shape the process and outcome of every session.

The workshop schedule was designed to include a mix of full group or plenary discussions on topics of general interest, and individual small group sessions that would focus on special interest topics relevant to individual Child Survival interventions. Special periods were identified during which PVOs could make recommendations for future actions.

Plenary sessions were designed that would serve as forums for exchange of ideas and experiences about lessons learned in backstopping projects, conducting midterm evaluations, training field staff, and approaching sustainability. Plenary sessions would feature brief presentations by key workshop staff followed by full group discussions. They were de-

signed to maximize the involvement of PVO participants, rather than to provide a forum for the presentation of consultant information.

Several PVO representatives were asked to give presentations during both plenary and small group sessions, or to take part in the workshop panel discussions, by either coordinating/moderating the panel or serving as discussants.

Small group sessions were designed to meet the second objective of providing PVO support staff with useful techniques for monitoring and evaluation of key Child Survival interventions. Workshop participants included both technical and administrative staff, those experienced with A.I.D.'s Child Survival Program and new grantees to the program, and both novice and highly skilled evaluators. The resource persons for each special interest group were therefore instructed to spend the first part of each session in reviewing expectations and learning needs of those who chose to attend their special topic. The resource persons were to present their prepared material, modified to respond to the participants' expressed needs. Ample discussion time and use of practical examples and exercises were emphasized. A small group session on project reporting requirements was also scheduled so that groups new to Child Survival could obtain information on requirements, see examples of forms, and learn about indicators.

The third objective of the workshop was to encourage an exchange of views between A.I.D. and the PVOs, contributing to an environment of openness and sharing that is an important aspect of a workshop's success. The opportunity for an informal exchange of views with A.I.D. is highly valued by PVO field staff and U.S./HQ staff alike. Fortunately, Dr. Gerold van der Vlugt, Child Survival and Health Coordinator for FVA/PVC, accepted the invitation to attend the Arizona workshop and to contribute as a resource person for the special interest sessions.

Expected Outcomes

The organizers of the workshop expected that participants would produce two kinds of recommendations as a result of workshop activities. One involved organization-specific outcomes, encouraging participants to apply the skills acquired during the course of the workshop in their own projects. The second type of desired output was to use the ideas and lessons learned in CSI and CSII and encourage the PVOs to develop recommendations for ways to simplify administrative procedures, remove barriers to project functioning, and further strengthen CS support services for the PVO community. The expected outcomes were expressed as follows:

- Individual participants were expected to develop action plans, identifying specific steps to be taken in the 90 days immediately following the workshop to improve project monitoring and evaluation.
- Participants as a group were encouraged to develop specific recommendations for future approaches and activities for improving the effectiveness of program management and technical support for the Child Survival PVOs.

Workshop Agenda

To include all these elements in the short time available was quite a challenge. After the preliminary workshop agenda was drafted, the workshop organizers contacted each PVO again and reviewed the workshop plans and approaches with them. Whenever possible, additional suggestions from the participants were incorporated into the final agenda, which received approval from FVA/PVC. The workshop agenda, Table 1, outlines the schedule and main activities of the workshop.

An opening session was scheduled in which participant expectations would be elicited, and the workshop objectives and schedule of activities reviewed by participants and revised if needed. This has been found in other PVO/JHU workshops to be quite necessary since the organizers

might not fully have understood what the PVO support staff had said in the initial needs assessment. Or, in some cases, the person interviewed may not be the person who actually attends the workshop.

The schedule included both plenary sessions in which all participants were involved and concurrent special interest sessions, for which individuals selected the topics of greatest interest or relevance to their projects.

The last half hour of each day was scheduled for a brief evaluation or "wrap-up" of the day's activities and preview of the plans for the next day.

Following each day's activities, the workshop staff met briefly to review the day's problems and successes, and to plan the next day's sessions. Changes were made in the agenda, when needed, to incorporate feedback from participants and team members.

Formal evening sessions were not planned, so as to leave open time for the all-important impromptu gatherings as well as participant fun. A buffet dinner and informal entertainment were planned by a joint committee of workshop organizers, consultants, and PVO representatives on the last evening of the workshop.

Table 1. Agenda for PVO Child Survival Resources Workshop, Lake Havasu City, Arizona, January 1988

	Wednesday 1/6	Thursday 1/7	Friday 1/8
8:30 am	Introductory Session Expectations	Exercise: Training of Field Staff to Strengthen Child Survival Activities	Final Session <ul style="list-style-type: none"> • Where Are We Now and Where Are We Going? PVO Accomplishments, Work Remaining, and Recommendations for Removing Barriers to CS Goals. • Next Steps: PVO 90-Day Action Plans
9:30 am	Panel: Lessons Learned in Backstopping Child Survival I & II Projects	Panel: Report on PVO Child Survival Workshops, 1986-1987	
12:00 pm	Lunch	Lunch	Workshop Closes
2:00 pm	Sessions <ul style="list-style-type: none"> • For "Newcomers" Reporting Requirements for PVO CS Projects • For "Oldtimers" Evaluation Lessons and PVO Recommendations 	Special Interest Groups <ul style="list-style-type: none"> • Qualitative Assessments/Focus Groups • Quick EPI Surveys for Child Survival Projects • Surveillance of Nutritional Status/Vitamin A Deficiency • In-country Collaboration for Data Collection and Use • Beneficiary Input into Project Evaluation 	
3:30 pm	Special Interest Groups <ul style="list-style-type: none"> • Monitoring Home Management of Diarrheal Episodes • Monitoring Immunization Activities and Determining Coverage • Growth Monitoring and Promotion • Assessing Vitamin A Deficiency 	Panel: Sustainability—Reality Check for Child Survival	
5:00 pm	Day's Evaluation and Tomorrow's Preview Dinner/Resource Room	Day's Evaluation and Tomorrow's Preview Buffet Dinner/Entertainment	



Consultants

Technical consultants for the workshop were obtained from PRITECH, REACH, ISTI, and GROWTHTECH—consulting firms experienced in supporting A.I.D.'s Child Survival activities. Consultants can be useful when the problem requires specialized, current information. In the case of the workshop, the role of the consultant was to be a resource person for the special interest groups created to discuss appropriate monitoring and evaluation techniques for each specialized technical intervention.

Consultants for the workshop were invited to participate based on several criteria. First, it was expected that they would have recent field-level experience in monitoring or evaluating effectiveness of specific interventions in the technical area that they represented. Second, the consultants needed to have a general understand-

ing of A.I.D.'s Child Survival Program and the problems encountered by PVOs in implementing field projects. However, expertise and experience alone were insufficient.

Consultants were also expected to be able to respond to the requests of PVO participants for information on topics that they identified as important in their projects. Flexibility and sensitivity to the needs of PVO staff, and a genuine desire to understand the situation of the PVOs were thus seen as important qualifications for the consultants who were invited.

Final Plans

Workshop organizers arrived at the workshop site for final planning and coordination two days before the opening session, and were soon joined by the consultants.

The conference center consisted of one large meeting room, suitable for plenary

sessions, and three smaller rooms for the small group sessions. The large meeting room also had space at one end for a Resource Center, a place where participants could look over project materials brought by others. It could be used for small group sessions as well. Seating arrangements were flexible and could be adjusted according to the requirements of the type of session planned.

Team members reviewed in detail the overall training objectives and approaches of the workshop, clarifying the roles of the workshop resource team. Each consultant reviewed with the rest of the resource team the outline of their special interest session, incorporating suggestions for changes into session plans. In addition, team members were allocated management responsibilities, such as staffing the Resource Center.



PVO Support Staff Meet in Baltimore, December 1986

Representatives attending the first PVO Child Survival Resource workshop hosted by the Institute for International Programs at The Johns Hopkins University School of Hygiene and Public Health on December 1–5 gathered for a group photograph after their meeting. Back row (l to r): Ken Flemmer (ADRA), Rudy Maier (ADRA), Dr. Blaise Severe (ICC), Dale Flowers (workshop facilitator), Dr. Neil Nickerson (MIHV), Dr. Warren Berggren (SCF); Middle row: Ellen Vor der Bruegge (PCI), Mona Moore (SAWSO), Ann Biro (WVRO), Dr. Hakon Torjesen (MIHV), Alan Alemian (Africare), John Grant (A.I.D.); Front row (l to r): Marie Alexandre (ADRA), Dr. Dory Storms (JHU), Dr. Nancy Sloan (HKI), Dr. Michele Denize (SCF), Dr. Agnes Guyon (JHU consultant), Dr. Mary Carnell (workshop recorder).

THE WORKSHOP

“The Lake Havasu PVO Child Survival workshop was by far the most productive in my personal estimation. Perhaps it was because so many of the PVOs were veterans in the sense that they were in their second and third years of a CS grant. Discussions were based on field experiences and therefore we could relate to the information and advice exchanged.”

— PVO representative

The workshop coordinator welcomed participants to the workshop and introduced the workshop staff and consultants. Participants introduced themselves by identifying their organization and something that they had "brought with them" to the workshop—e.g., a desire for greater skills in a certain area, a wish to share something they had learned, a special videotape or training manual, etc. Dr. Storms next explained the origins of the workshop and some of the expectations of workshop organizers.

The facilitator then elicited the expectations of workshop participants. Expectations showed a desire to learn more about successful monitoring and evaluation techniques, sustainability approaches, and collaboration mechanisms. Some looked forward to exchanging information with A.I.D. Most of all, the PVO participants desired to share experiences and learn from each other, rather than to focus primarily on learning from the "experts." Similarly, on the part of the consultants and staff, the expectations were to learn from the experiences of the PVOs and to share information. This desire for collaboration and sharing among all participants—PVOs, staff, and consultants—was apparent during the entire course of the workshop.

The following list of participant expect-

tations of the workshop was recorded during the opening session:

PVO Representatives

- Begin to pinpoint "what's working," especially in monitoring and evaluation
- Develop guidelines to assess "where we are"
- Learn monitoring and evaluation techniques
- Work on the evaluation process
- Learn a model of data management
- Learn methods to measure effectiveness of training
- Make "do-able" plans on how to exchange resources for evaluation
- Attempt to coordinate evaluations
- Find out what everyone knows of their field projects
- Share progress with other projects funded from '85
- Learn from others' experiences, training
- Hear lessons learned in the field
- Learn about Sudan, Detailed Implementation Plans (DIPs)
- Meet everyone
- "Group therapy"
- Opportunity to share materials
- Share materials
- Get feedback on materials
- Share effective training strategies, monitoring and evaluation, collaboration efforts

- Work on supervision and clarification as to whom we are training;
- Share lessons learned in nutrition: What are our program needs?
- Learn to build on our common experience
- Develop ways to collaborate
- Share frustrations with A.I.D. re: guidelines
- Make suggestions to A.I.D. re: reality in the field
- Work out the "collaborative" part with A.I.D.
- Learn sustainability techniques
- Cost-benefit approaches to assessing sustainability
- Share ideas on sustainability, ongoing and for new projects
- Learn how to communicate more effectively to motivate sustainable behavior change
- Learn, as much as possible, the current issues in CS
- Get the latest information from "health types"
- Come up with growth monitoring (GM) indicators
- Current ideas on growth monitoring
- Learn prevention of AIDS, share lessons learned

Consultants and Workshop Staff

- Find out expectations of PVOs
- Understand and learn from PVOs: Where are the problems?
- Discuss all ideas about vitamin A
- Share EPI techniques and techniques to simplify neonatal tetanus
- Meet and discuss materials concerned with nutrition and dietary requirements

Staff and participants compared the expectations of participants with the goals and objectives as developed by workshop organizers to determine the extent to which they were congruent. No important gaps between the two were identified, and it was determined that no immediate modifications in the workshop schedule were required.



Doris Storms

— PVO RESOURCES FOR CHILD SURVIVAL COUNTRY PROJECTS —

There were continued efforts during the workshop to maximize contact among the 30 PVO representatives and encourage sharing of the lessons learned to date. Early in the workshop, each PVO was assigned another PVO to interview, with the purpose of identifying the key resources for Child Survival in that organization.

The interviews document the diversity of PVOs participating in the Child Survival Program. Although the 20 PVOs attending the Arizona workshop vary in size and complexity, there are certain similarities in the support they provide to field projects. They all have strengthened technical capacity to backstop Child Survival projects with health professionals trained in the biomedical and behavioral sciences.

Except for the very newest of PVO grantees, the PVOs who attended the workshop sponsored some element of regular training, usually project specific. Nearly all the PVOs routinely send newsletters or excerpts from technical articles to their field projects. Several have developed manuals covering ORT, immunization, primary eye care, growth monitoring, etc.

A summary of PVO responses to their interviews of each other follows. However, the reader should be aware that because of differences in interviewers and lack of standardization of questions, it is not possible to compare the answers given by the different organizations. These responses are only a general guide to the resources which the U.S.-based PVOs are bringing to the country projects.

Adventist Development and Relief Agency (ADRA)

CS Projects: Malawi, Rwanda, Haiti (CSI); Indonesia, Nigeria, Pakistan, Sudan (CSII)

Staff: USA has 55 total, of which 10 are CS related; also six regional.

Information: *Interface*, a quarterly technical journal mailed regularly to all field offices and other nongovernmental organizations that have subscribed. Fill technical requests from Loma Linda University research library.

Training: Pre-implementation workshop for two people from each new CSII project; country workshops in three CSI areas on the Expanded Program on Immunization (EPI), ORT, and health management.

Manuals: Diarrhea and immunizations manuals for community health workers (CHWs) in Rwanda; CS flip charts in Indonesia; manual for training of trainers, project planners.

African

CS Project: Nigeria (CSII)

Staff: USA has three PH specialists, two agronomists, one agribusiness; field has two PH specialists, two agribusiness.

Information: Sends technical materials on health issues to the field in response to their requests

Training: Management/administrative training at special course in the United States (two to three months); on-the-job skills enhancement through visits from HQ, regional staff and consultants; training of trainers who in turn train those who deliver services.

Manuals: ORT manual for CHWs in Chad; survey enumerators manual; community-based workers handbook under development; "Policies and Procedures for Drug Distribution" manual under development.



Aga Khan Foundation (AKF)

CS Project: Pakistan (CSII)

Information: Newsletters, videotapes, posters

Training: Monitor job performance; short-term workshops directed toward identified areas of need, use data-gathering process to develop better understanding; traditional birth attendant training; CHW training; medical and nursing schools.

Manuals: Personnel, administrative, financial, technical training

African Medical and Research Foundation (AMREF)

CS Project: Kenya (CSII)

Staff: USA has five; Africa, 650 of which 85% are African, 50% are professionals (MD, RN, health educators, health trainers, radio technicians, pilots).

Information: Regular radio broadcasts over "Voice of Kenya"; twice weekly article in major Kenya newspaper; bimonthly periodical *Defender*.

Training: Training of CHWs and rural health staff through continuing education teacher training and correspondence courses; staff development policy for advanced training in European or U.S. universities for MPH, DrPH, or management degrees.

Manuals: Rural health manual series; numerous health education materials.

Andean Rural Health Care (ARHC)

CS Project: Bolivia (CSII)

Staff: USA has four; field 15.

Information: Sent at request of field staff

Training: Informal

Manuals: None

CARE

CS Projects: Bolivia, Uganda, Haiti, Indonesia (CSI); Mali, Sudan (CSII); India, Niger (CSIII)

Staff: USA has three health specialists in primary care unit; four health staff members part of regional technical assistance teams in L. America, E. Africa, W. Africa, Asia.

Information: Monthly information packets sent from NY to regional teams; technical report series; general internal newsletter of recent health information.

Training: Training unit in New York City; frequent in-country training; biannual regional training workshops.

Manuals: Country-level, project-specific manuals available.

Catholic Relief Services (CRS)

CS Project: Ecuador (CSII)

Staff: USA in New York plus three regional cluster offices in the process of developing regional advisers

Information: Departmental newsletter; monthly field updates; fill special information reports from technical people in the field.

Training: Training given on project-by-project basis; CHW training by supervisors; training of trainers.

Manuals: Variety of health and nutrition manuals from Ecuador and India

Esperanza, Inc.

CS Project: Bolivia (CSII)

Staff: USA has five staff, one CEO, one deputy CEO (liaison with field), three support clerical staff in field.

Information: Articles collected and sent out to the field

Training: Training of trainers once a year in the field. Local physicians and nurses train voluntary health workers (VHW's).

Manuals: None

Freedom from Hunger Foundation (FFH)

CS Projects: Bolivia, Nepal (CSII)

Staff: 50

Information: Newsletter; current literature review; Resource Center's materials available to the field

Training: Seminars, workshops, and international workshops with staff in the United States; HQ briefings; HQ management visits

Manuals: Credit; vitamin A; growth monitoring/promotion



Dore Storms

Foster Parents Plan (PLAN)

CS Projects: Haiti (CSI), Mali, Bolivia (CSII)

Staff: USA has one person for CS; field, 270.

Information: Various communiques

Training: Task-oriented training in the field; community worker training

Manuals: ORT manual and others in progress

Helen Keller International (HKI)

CS Projects: Bangladesh, Indonesia (CSI); Niger, Indonesia (CSII)

Staff: USA has three administrative, five technical; Africa has one director/country, Asia administrative adviser, technical and support staff in each country.

Information: Technical reference articles and guidelines; prototype educational materials; educational material guidelines available for the target groups; interfield annual reports.

Training: Technical issues/administrative training conducted at regional levels or HQ

Manuals: At all levels from physician to CHW

Project HOPE (HOPE)

CS Projects: Guatemala, and CS funding from A.I.D. mission Brazil and Belize (CSI)

Staff: USA has 150, which include four members of CS task force and CS support staff.

Information: El Salvador and China circulate their own newsletter

Training: Field orientation

Manuals: Pictorial reporting system for Brazil (adapting for others)

International Eye Foundation (IEF)

CS Project: Malawi (CSI)

Staff: USA has one administrator, one technician; field has two technical.

Information: Primary eye care; charts and books available

Training: Consultants to the field

Manuals: Blindness prevention, including vitamin A component

Minnesota International Health Volunteers (MIHV)

CS Project: Uganda (CSI)

Staff: USA has five.

Information: Copies of technical articles; nontechnical newsletter

Training: Field staff orientation; language tapes

Manuals: ORT manual for Uganda; translate MOH materials into local language

Project Concern International (PCI)

CS Projects: Bolivia, Indonesia (CSI); Bolivia, Guatemala (CSII)

Staff: USA has four who work in CS.

Information: Copies of technical articles; nontechnical newsletter

Training: One week in Tijuana

Manuals: Reporting and evaluation of CS programs

Rotary International (Rotary)

Projects: Polioplus projects in Kenya, Nigeria, India (corresponds to CSII)

Staff: USA has six; four task forces in various countries, volunteers throughout the world.

Information: Monthly mailing to project contacts; annual report

Training: Immunization workshops with EPI counterparts and Rotary clubs in country

Manuals: Immunization manual; technical assistance manual; Club manual for Rotaries

Dave Norman



Salvation Army World Service Office (SAWSO)

CS Projects: Kenya, Haiti, Bangladesh, Pakistan (CSI)

Staff: USA has eight total—three project officers, health educator, evaluator, director, assistant director.

Information: Religious as well as medical newsletters; women's group newsletter biannually.

Training: CS income-generating training including project leaders; training of trainers at the village level.

Manuals: Health education flip chart for Kenya; evaluation manual.

Save the Children Federation (SCF)

CS Projects: Zimbabwe, Bolivia, Ecuador, Bangladesh, Indonesia (CSI); Cameroon, Malawi, Sudan, Bolivia (CSII); Bolivia, Honduras, Nepal (CSIII)

Staff: HQ has seven, of which MD four (pediatrics, tropical medicine, public health) MCH, GMP, nutrition, social scientist/epidemiologist; health educator/regional physician in each country project.

Information: "Mothers too" newsletter; "Update on AIDS" newsletter

Training: Regional and country-specific technical training and supervision

Manuals: Project management information; family enrollment; computer manual; growth monitoring and promotion manual under development; "Bridging the Gap"; nutrition demonstration fliers.

World Relief Corporation (WRC)

CS Projects: Haiti, Bangladesh (CSIII)

Staff: HQ has two technical staff (one MD, one MPH) and one administrative coordinator; field project staff are country nationals with specialties in income generation, medicine, public health, nursing.

Information: No formal newsletter or journal

Training: Health educator in Haiti project develops curriculum, coordinates training of health workers and uses supervisory checklists to evaluate effectiveness. Bangladesh CS project has core team of six to eight trainers from existing pro-

gram who train and supervise health workers, and also use a supervisory checklist to monitor performance.

Manuals: No manuals, but Haiti has good documentation of training

World Vision Relief and Development, Inc. (WVRD)

CS Projects: Zimbabwe (CSI); Senegal (CSII); Kenya, Mali, Haiti (CSIII)

Staff: HQ has two MD/MPHs; field has two MD/MPHs in Africa; two MD MPHs Asia; two MD MPHs Latin America.

Information: Quarterly international health newsletter; quarterly development journal *Together*.

Training: Annual workshop for HQ and regional technical staff; country workshop for each new project on technical and administrative issues; country coordination workshop with other PVOs for each new project.

Manuals: Illustrated manual about ORT and diarrhea disease control



Sally Fowler

The best source of useful and relevant program materials for workshop participants is likely to come from the participants themselves. With that in mind, a Resource Center was planned to serve as a display and exchange center for materials brought by participants, including PVO representatives and consultants. These included posters, flip charts, manuals, videocassettes, literature, survey instruments, bags, pins, T-shirts, and other similar materials. Materials that could be ordered by participants were accompanied by appropriate order forms. The Resource Center was open in the evenings for browsing and for viewing the videocassettes.

The following materials were displayed in the Resource Center:

Ankai Rural Health Care

ARHC brochure

"Grassroots" Newsletter (most recent issues)

Rural primary care in Bolivia. *The Journal of Rural Health*. In press.

African

Child Survival manual for community-based health workers (Nigeria MOH draft)

Draft and final survey questionnaires, draft manual for survey enumerators, and survey results/analysis for intervention and control areas (Nigeria)

Family health card, CS project (Nigeria)

ORT manual (Chad MOH)

The Aga Khan Foundation

Seven health education posters

Flipchart on hygiene

MCH pamphlet for mothers

Three videocassettes: "Primary Concerns," "Actions Iodine," and "Dhaka Initiative"

CARE

Data management manual (draft)

Household registration forms (Haiti)

Health education guide (Haiti)

Baseline survey report (Indonesia)

Monitoring and evaluation packet (Indonesia)

Midterm evaluation report (Indonesia)

Supervision scheme (Uganda)

Baseline survey and cost analysis of survey (Mali)

Monitoring, supervision, and reporting forms (Mali)

Baseline survey (Sudan)

Major points for ORT focus group interviews (Sudan)

ORT "how-to" manual (Sudan, draft)

EPI reporting statistics form and protocol (Sudan)

Catholic Relief Services

CS training manual (Ecuador, Spanish draft)

Esperanza

Sample questionnaires (Bolivia)

Newsletters: "Reader's Digest," "Letter from Brazil"

Newsletters for village health workers, "Onde Ha Atendente E Promotor" (Brazil)

Photos of CS activities (Bolivia)

T-shirts: "Project Esperanza—El Chaco"

Videocassette: "Esperanza: Road to Hope" (Bolivia and Brazil)

Freedom from Hunger Foundation

Child Survival: Guidelines for the field

Guidelines for growth monitoring and promotion (draft)

Policies and guidelines for vitamin A (draft)

Helen Keller International

Seminar training/information kits on vitamin A, including background technical references, educational materials, sample slides, signs/symptoms of xerophthalmia chart

Videocassette: "20/20" TV series segment on vitamin A in the Philippines

International Eye Foundation

Primary care eye chart

Primary eye care in developing nations, by Larry Schwab, MD

Minnesota International Health Volunteers

Orientation to International Health service for volunteers

KAP study of community for primary health care (PHC) program (Uganda)

KAP immunization study (Uganda)

CS survey, 1987 (Uganda)

Community-based health care program, 1987 (Uganda)

Second annual report to A.I.D., Kasangati Health Center (Uganda)

Midterm evaluation (Uganda)

"Benefit Sustainability" (Development Alternatives Inst.)

"Accelerating Institutional Development" (ISTI)

"Monitoring and Evaluating Small Business Projects" (PACT)

National guidelines for implementation of PHC (Kenya MOH)

Dosage schedule cards for primary health care workers

ORT and EPI teaching charts (UNICEF and MOH, Uganda)

Rotary International

Three videocassettes: "Polioplus: From Vision to Reality," "The Polioplus Story," and "Social Mobilization: A Role for Rotary"

Salvation Army World Service Office

Videocassette: "Haiti after the Fall of the Duvaliers"

Save The Children Federation

Visual aids, health strategy, and health information system

Health information system manual

Workbook for Child Survival health information system

Health workers roster

Generic training-of-trainers manual (English, French)

Sample health training-of-trainers design (Malawi and Honduras)

Nutrition Demonstration Foyer (a nutrition intervention, through community-based training)

Notes from November 1987 growth monitoring project (GMP) workshop held at SCF

Growth monitoring manual (draft)

ORT manual (draft)

Small scale used for training in gauging weight of pinches of salt, scoops of sugar, etc.

Videocassette: "Sembrando el Manana"

World Vision Relief and Development, Inc.

Staff education booklet on AIDS

Zimbabwe Workshop reports (full-length and abridged versions)

REACH

UNICEF. 1986. Lessons learned—An assessment of the EPI program in Nigeria. *Evaluation Publication*, no. 1.

WHO. 1986. EPI cold chain. *UPDATE*, general.

PATH. 1985. PATHWATCH cold chain monitor. *Product Development Bulletin Update* (September).

WHO. *Vaccine cold chain monitor*. EPI/CCIS/85.1. Geneva.

WHO. *Chemical indicators for monitoring the cold chain*. EPI/CCIS/83.8. Geneva.

WHO. *EPI cold chain bibliography*. EPI/CCIS/87.1. Geneva.

WHO. 1987. *Sterilization alert*. *UPDATE* (July). Geneva.

PATH. 1983. *Disinfection and sterilization of immunization equipment*. (November).

WHO. 1986/7. *The cold chain: EPI production information sheets*. EPI Technical Services, no. 1. WHO/UNICEF/EPI.T3/86.1.

WHO. 1985. *EPI training for mid-level managers*. EPI/MLM/CC/Rev. 2. Geneva.

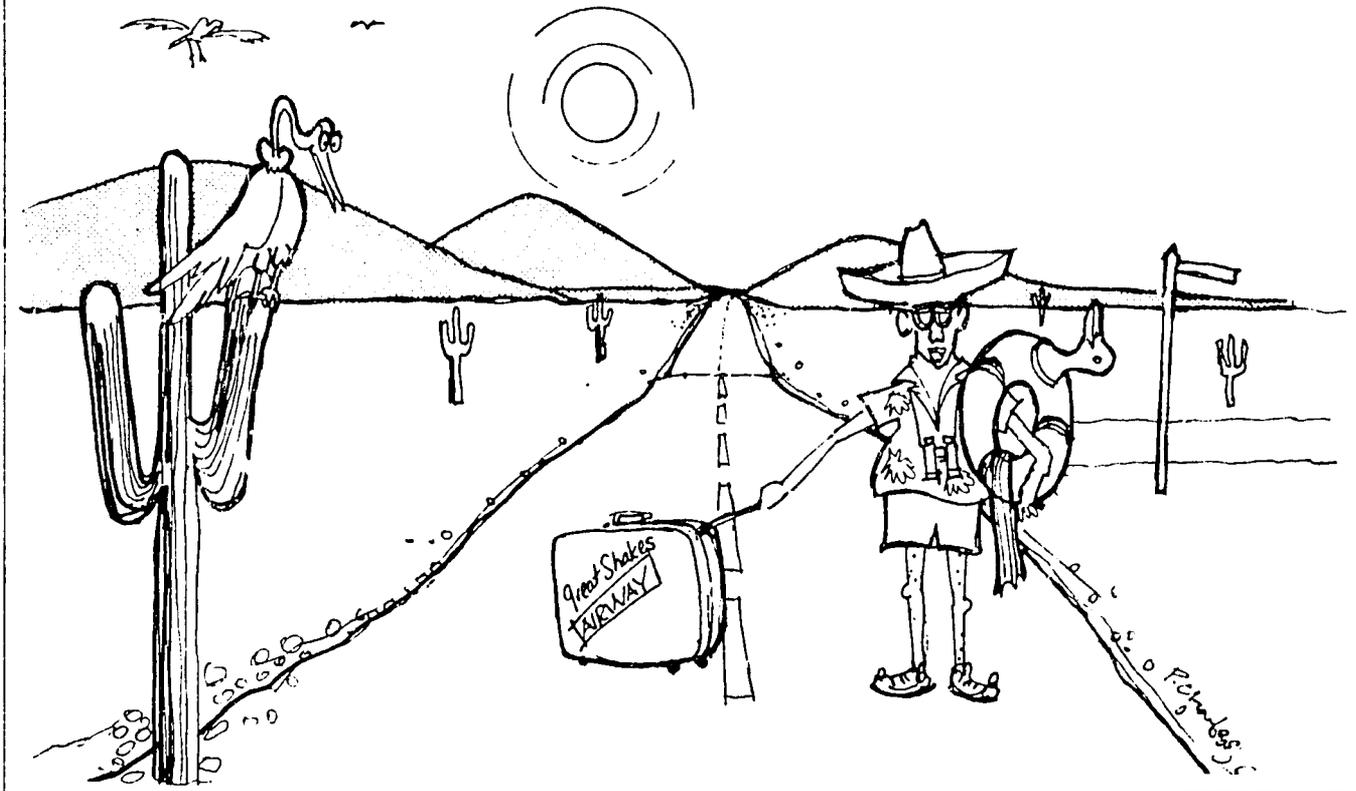
WHO. *EPI training course on planning and management*. Geneva.

LAKE HAVASU, WHERE ARE YOU???

On the evening of their arrival at the workshop site, participants were greeted in The Captain's Cove, at the Nautical Inn, with a "mood-maker" social hour. This provided an opportunity for participants to meet or renew their acquaintances with each other, to become

acquainted with workshop staff, and to obtain their workshop materials. A number of the participants encountered unexpected travel difficulties in reaching Lake Havasu, due to flight cancellations. As a result, one contingent of participants, led by Dr. Jake van der Vlugt, arrived rather

late in the evening by rental van across the Arizona desert rather than by air. Several participants commented on the workshop planners' remarkable ability to duplicate developing country adversity on such short notice.



Peter Charles

LESSONS LEARNED IN BACKSTOPPING CHILD SURVIVAL PROJECTS

Sharing Experiences

A panel session chaired by Dr. Victor Lara, Foster Parents Plan, presented the lessons learned by representatives from CARE, ADRA, SCF, and PCI in backstopping their CSI and CSII projects. The session was intended to inform PVOs about the various strategies taken by U.S.-based staff in working with country project staff to assure quality of Child Survival services since 1985. Each PVO representative outlined the general approach of their PVO to backstopping and training field staff, and then discussed some of the major lessons that had been learned in this program. For several, Child Survival is one type of health and development project that the PVO is supporting. A full group discussion ensued, in which other PVOs shared their experiences.



CARE

How they backstop:

- CARE has eight CS projects funded from the FY 1985–87 cycles.
- Home office has two people in charge of Child Survival located in the Primary Care Unit.
- One health person is on the four-person regional technical advisers (RTA) team in each of four regions.
- The CS project manager goes to the RTA first, then to Home Office. RTAs usually can handle most problems.
- Average of two contacts with the field project per year.
- HQ staff and RTAs often are the liaison with national level programs, e.g., Combatting Diarrheal Disease (CDD) and the Expanded Program on Immunization (EPI).

Lessons learned:

- Train HQ staff and RTAs to be trainers of project managers.
- Supplement technical skills with program management, communications, and community motivation skills.
- Complete field reports early so that HQ can review and return to the field in a timely manner; this will encourage field participation in decisions.
- Encourage project managers to have as

much awareness of the overall budget process as possible.

- Select the type of baseline survey that is most useful for the specific project area.

Adventist Development and Relief Agency

How they backstop:

- ADRA has seven CS projects funded from the FY 1985–87 cycles.
- Child Survival is an added component to ADRA's existing hospital/clinic programs; CS projects focus on outreach activities.
- Home office works through an already established system—the community development unit.
- Team approach draws on long-term field staff who have a variety of skills and expertise.
- Train regional staff in development approaches.

Lessons learned:

- Use own staff to start up a project.
- Use consultants who are familiar with our organization.
- Two-stage evaluations are efficient and useful—collect and organize the relevant data first, then schedule the actual evaluation team.

Save The Children Federation

How they backstop:

- SCF has 12 CS projects funded from the FY 1985–87 cycles.
- HQ has technical backstopping team of seven located in Primary Care Unit. Expertise in several different areas, including health education, parent training, project management, health information systems, materials development, and the Child Survival interventions.
- Field office guides and provides TA to programs. Requests come to HQ from the field; team discusses and assigns to appropriate persons.
- Average one visit to each field office per year. This visit is initiated by the home office, lasts long enough to allow for a training-of-trainers session and responses to specific requests from the field.

Lessons learned:

- Give project managers responsibility for looking at project objectives and assessing progress, and train them for this.
- Encourage field staff to initiate guidelines for Child Survival interventions.
- Establish a clear supervisory structure,

with parallels at HQ, project manager, and field levels.

- Provide more assistance from HQ early in the project.
- Use a "theme-of-the-year" approach to focus technical assistance (e.g., growth monitoring is the theme this year).
- Midterm evaluations very valuable; use a team approach composed of field, HQ, MOH, and outside consultant.

Project Concern International

How they backstop:

- PCI has four CS projects funded from the FY 1985-87 cycles.
- PCI CS projects work through established MOH structures in primary health care or maternal and child health services.
- HQ staff work with country directors and project directors to educate about Child Survival.
- HQ informs local staff of activities, screens information, and gives out to the field.
- Attempt to collaborate with other PVO field staff.
- Use consultants early in project life.
- Provide mostly U.S.-based training for field staff.

Lessons learned:

- A good supervisory system is essential; need to stress improved administration and management.
- Work with field staff to enhance their understanding of the need for their participation in preparing reports. Is time-consuming, but beneficial.
- Need to identify materials that are most useful and appropriate for the field.
- A.I.D.-arranged technical assistance has been very helpful and best utilized when accompanied by someone from HQ.
- Midterm evaluations were very beneficial to the projects.

Reporting Requirements for PVO Child Survival Projects

Resource Persons: Ms. Jean Pease, International Science and Technology Institute (ISTI), and Dr. Gerold van der Vlugt, AID/FVA/PVC.

A small group session on the reporting requirements for PVO Child Survival projects was held on the first day for "newcomers"—representatives from PVOs who were new to A.I.D.'s Child Survival Program, or who were themselves newly employed by a PVO with a CSI or CSII grant.

To begin this session, Dr. van der Vlugt noted that every PVO project will develop its own evaluation and monitoring plan in accordance with the guidelines of the organization, the Ministry of Health, and A.I.D. Everyone is concerned to avoid duplication of effort and make the data as useful as possible for program decision making. Developing a simple, useful health information system takes time. In the past PVOs have not given as much attention to reporting and accountability. However, the past few years have seen increasing commitment on the part of PVOs to developing a monitoring and evaluation system at the field level. The process of developing the necessary skills is now under way among all the Child Survival grantees.

He then outlined the FVA/PVC reporting requirements for each PVO CS country project. Basically, the project must submit:

- Detailed Implementation Plan, due approximately six months after the start of the grant
- Annual reports (includes the Child Survival and Health Reporting Schedule), due approximately mid-October
- Midterm evaluation, organized by the PVO and carried out approximately midway in the project's life, for the purpose of assessing progress toward project objectives and making mid-course corrections
- Final evaluation

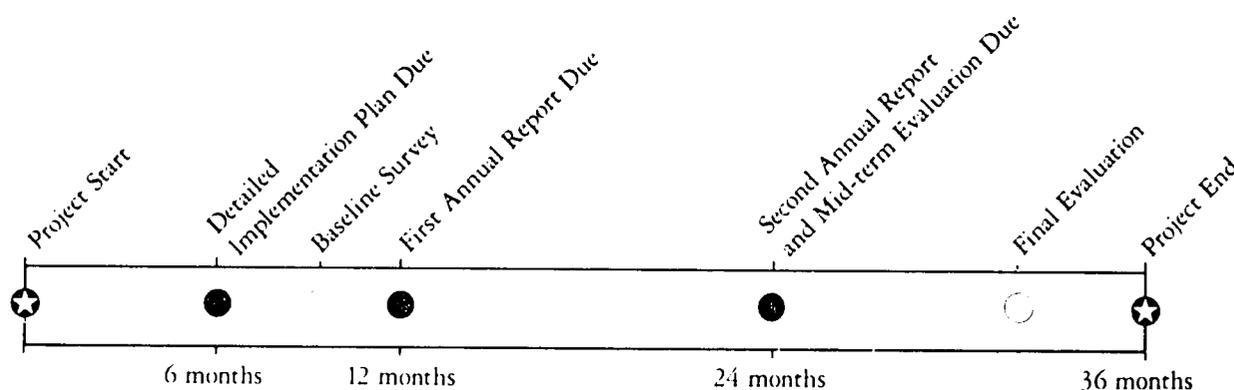
Dr. van der Vlugt spoke of the streamlining of reporting that has taken place, and solicited PVO comments for future updating and improvement of guidelines. Available were examples of recent guidelines for each of the required reporting documents.

Ms. Jean Pease, of ISTI, then spoke on the monitoring of A.I.D.'s Child Survival Program. She noted that A.I.D. has adopted a strategy for monitoring and evaluation of Child Survival projects that provides an overall unified framework. One feature of this strategy has been the selection of a few key indicators that relate to interventions from at least four vertical programs (immunization, ORT, nutrition, reduction of high-risk births). These core indicators appear on one form, making a single system for evaluating multiple CS interventions.

A second feature of A.I.D.'s monitoring system is the stratification of indicators into three "tiers," which differ in the level of program activity, data collection source, and the complexity of the data collection process.

- Tier 1 measures inputs and outputs of the project (for example, amount of expenditures, number of persons trained, number of packets distributed, etc.). All A.I.D.-funded Child Survival, health, and vitamin A projects track these routine indicators.
- Tier 2 measures effectiveness of project interventions (that is, it contains both numerator and denominator data so that it is possible to estimate changes in coverage). Projects that collect and use service statistics on registered, stable populations will be able to estimate most Tier 2 level data. Periodic community surveys will be necessary if no adequate registration system exists. Tier 2 indicators were specifically designed so that an adequate sample for every indicator could be obtained using the same survey technique.
- Tier 3 measures program impact and is for special studies of the morbidity or mortality impact of Child Survival funding. Meeting the cost, complexity, and technical requirements of such studies is possible for only a few institutions.

PVO CHILD SURVIVAL PROJECT LIFELINE



36 Month Grants

CSI	October 1, 1985 — September 30, 1988
CSII	October 1, 1986 — September 30, 1989
CSIII	October 1, 1987 — September 30, 1990

All projects funded out of Child Survival and Health monies must report Tier 1 data. Projects are encouraged, whenever possible, to document changes in Tier 2 coverage and utilization rates, but Tier 2 data collection is required only of those projects that receive over \$1 million life-of-project funding. However, Tier 3 special studies are definitely not required, nor expected of PVO projects.

A.I.D. has established a standard format for reporting on every project funded by USAID Health and Child Survival accounts. Ms. Pease distributed copies of the 1987 A.I.D. Health and Child Survival Reporting Schedule to participants and addressed two basic questions: Why collect these data? What is done with the data from these forms once they are received by USAID?

A chief reason for collecting data is the need for accountability to Congress. Individual project data form the basis for the Annual Child Survival Report to Congress, which details the results of the year's funds. Since it is necessary to report to Congress by a specific date, timely reporting is vital, possibly influencing future funding.

The Annual Reporting Schedule asks the grantee to estimate the approximate level of effort directed toward the chief intervention areas: oral rehydration therapy, immunization, nutrition, etc. The percent of effort is applied to the amount of the total grant funding, and an estimate in dollars for each intervention is obtained. Congress therefore can see what each intervention costs, in light of the benefits that are reported.

USAID, WHO, and UNICEF have agreed on certain standard health indicators. This enables data from diverse sources to be combined and permits comparison among projects sponsored or funded by different agencies. Thus, statistics that are obtained from USAID-funded projects can be included or compared with those from WHO or UNICEF sources.

Reports are required every 12 months. For USAID the reporting year is October 1 through September 30, because this corresponds to the fiscal year. However, the PVO may desire to use a different reporting period. This is alright as long as the PVO is consistent from year to year.

Ms. Pease had brought a laptop computer so that she could demonstrate a

menu-driven computer program that is currently being field-tested for its usefulness in simplifying CS reporting. This computer software is written in DBase III Plus. Participants were encouraged to examine the program.

Materials Distributed/Displayed by Ms. Pease:

1987 A.I.D. Health and Child Survival Reporting Schedule (English, French, and Spanish versions) and instruction manual List of Tier II Indicators for Child Survival interventions

Copies of the 1987 Reporting Schedules submitted by PVOs

Country-level health statistics, including coverage data from A.I.D.'s health information system

Also recommended

Office of Health, U.S. Agency for International Development. 1988. *Monitoring and evaluation of the effectiveness of Child Survival programs in developing countries: Selected indicators*. Washington, DC.



The Evaluation Process— PVO Lessons Learned

Participants with more experience with A.I.D.'s Child Survival Action Program met for a discussion, facilitated by Dr. Mercer, of the midterm and final evaluations required of the Child Survival projects by FVA/PVC. The group discussion focused on the most useful configurations for planning the evaluations, both in terms of team composition and approaches. A number of recommendations were developed by the group, both for the PVOs themselves and for the Child Survival Office of AID FVA/PVC.

Lessons Learned about Midterm Evaluations

- The midterm evaluation is an important and valuable part of the process of developing viable Child Survival projects by PVOs.
- The selection of the evaluation team is critical in assuring a helpful and comprehensive evaluation:
 - a) A participatory approach is important in making the evaluation as useful as possible in improving project performance. Local staff, therefore, should be included on the evaluation team.

b) Several PVOs have found that including representatives of other PVOs on the evaluation team can be beneficial to both groups.

c) Having "outside" opinions and ideas represented on the team can also be helpful. This can be provided, for example, by a technical consultant familiar with the standards of performance of the Child Survival projects, whose fees and travel expenses are paid from non-PVO funds.

d) Where sustainability of effective project activities is a concern, it is prudent to have an evaluation team member who represents the Ministry of Health, or another relevant local organization that is expected to be involved in maintaining the essential health activities once A.I.D.'s grant funding terminates.

e) Sometimes it can be helpful to include a representative of a multilateral agency such as UNICEF who can disseminate information about the project to other groups.

- The evaluation team can spend more time in actually observing project functioning if data that are to be used in the evaluation are readily available and in a usable form. For some PVOs this will require a "pre-evaluation"

effort, where staff (perhaps especially hired for this purpose) make initial tabulations of data that will be needed for the evaluation team.

- PVOs need to plan for the sometimes substantial costs of doing a comprehensive project evaluation.

PVO Recommendations Regarding CS Project Evaluations

- A.I.D. should consider dropping the annual report requirement for the second year and allowing the midterm evaluation to be used in place of the narrative requirements of that report. This would optimize the usefulness of the midterm evaluation and avoid duplication of reporting.
- A.I.D. should find a way to facilitate PVO sharing of the most helpful lessons learned from the midterm evaluations completed by PVOs. Suggest that samples of the better evaluation instruments, relevant summaries, and key findings for the PVOs involved should be circulated among the groups represented at the workshop.
- A.I.D. guidelines for the CS project final evaluation need to be developed with input from PVOs themselves, and be disseminated early enough that the PVOs will have adequate time for advance planning for the process (several months, at a minimum).
- Some participants urge that a "post-project" evaluation also be conducted, for the purpose of evaluating the longer-term impact of projects. This would require that the PVO and/or A.I.D. set aside funds for this purpose to be spent after the project is officially terminated.

Special interest groups began the first afternoon of the workshop. Topics to be discussed in each of the sessions were briefly introduced to the entire group so that participants would understand the focus of each session. Participants then selected one of four concurrent groups to attend, permitting individuals to pursue areas of greatest need in monitoring and evaluation techniques.

A second set of special interest groups was held the second day of the workshop and included many topics similar to the first set, but with a somewhat different focus. Outlines of the topics covered by each of the eight groups and the resource bibliography follow.

Monitoring Home Management of Diarrheal Episodes

Resource Person: Jeannine Coreil, PhD, PRITECH

Discussion covered the following issues:

- Ways to use local personnel, such as community health workers, neighborhood volunteers, etc., to monitor cases of diarrheal disease
- Purpose, advantages, and limitations of focus groups, including ways to draw a random sample for recruiting participants
- Use of existing local personnel for implementing an evaluation plan, and implications for training needs, time requirements, quality of results
- Importance of using the local definition and terminology for diarrhea when evaluating the effectiveness of project interventions, and the need for translation of interview instruments into local dialects
- Advantage of preparing an analysis plan before collecting data
- Methods for cross-checking reliability of results

Documents Distributed by Dr. Coreil

Bentley, Margaret E., et al. 1988. Rapid

ethnographic assessment of the dietary management of diarrhea. Outline.

Coreil, J. A typology of Child Survival interventions. Unpublished.

Coreil, J. Assessing home management of diarrhea. Unpublished.

Scrimshaw, Susan C. M., and Elena Hurtado. Figures 7 and 8 entitled taxonomy of diarrhoea, and taxonomy of treatments for diarrhoea. In *Rapid assessment procedures for nutrition and primary health care: Anthropological approaches to improving program effectiveness*. See below.

Also of Interest

Agar, Michael H. 1986. *Speaking of ethnography*. Vol. 2, Sage Publications Qualitative Research Methods. Beverly Hills: Sage.

Bentley, Margaret E., et al. 1988. Rapid ethnographic assessment: Applications in a diarrhea management program. *Social Science and Medicine*.

Coreil, Jeannine, and J. Dennis Mull, eds. 1988. Anthropological studies of diarrheal illness. Special issue of *Social Science and Medicine*.

De Zoysa, Isabelle, et al. 1984. Perceptions of childhood diarrhea and its treatment in rural Zimbabwe. *Social Science and Medicine* 19(7): 727-734.

Frankel, S. J., and D. Lehmann. 1984. Oral rehydration therapy: Combining anthropological and epidemiological approaches in the evaluation of a Papua New Guinea programme. *Journal of Tropical Medicine and Hygiene* 87: 137-142.

Kendall, Carl, Dennis Foote, and Reynaldo Martorell. 1984. Ethnomedicine and oral rehydration therapy: A case study of ethnomedical investigation and program planning. *Social Science and Medicine* 19(3): 253-260.

Kumar, Krishna. 1987. Conducting group interviews in developing nations. *A.I.D. Program Design and Evaluation Methodology Report*, no. 8. Washington, D.C.: Agency for International Development.

Special issue of *Social Science and Medicine*, Summer 1988. Guest editors: Jeannine Coreil and J. Dennis Mull. Contents:

Jeannine Coreil and J. Dennis Mull. Introduction.

G. Mitchell and C. Weiss. Cultural models of diarrheal illness: Conceptual framework and review.

Carl Kendall. The implementation of a diarrheal disease control program in Honduras: Is it "selective primary health care" or "integrated primary health care"?

Marilyn K. Nations and L. A. Rebhun. Mystification of a simple solution: Oral rehydration therapy in Brazil.

Mark Nichter. From *axalu* to ORS: Sinhalese perceptions of digestion, diarrhea, and dehydration.

J. Dennis Mull and Dorothy S. Mull. Mothers' concepts of childhood diarrhea in rural Pakistan: What ORT program planners should know.

Sharleen H. Simpson. Some preliminary considerations on the *sobada*: A traditional treatment for gastrointestinal illness in Costa Rica.

Margaret E. Bentley. The household management of child diarrhea in rural North India.

Jeannine Coreil and Eddy Genece. Adoption of oral rehydration therapy among Haitian mothers.

Susan C. M. Scrimshaw and Elena Hurtado. Anthropological involvement in the Central American diarrheal disease control project.

Margaret E. Bentley, Gretel H. Pelto, et al. Rapid ethnographic assessment: Applications in a diarrhea management program.

Alfred Newmann. Commentary.

Scrimshaw, Susan C. M., and Elena Hurtado. 1987. *Rapid assessment procedures for nutrition and primary health care: Anthropological approaches to improving program effectiveness*. Los Angeles: UCLA Latin American Center Publications.

Weiss, Carol H. 1972. *Evaluation research: Methods of assessing program effectiveness*. Prentice-Hall Methods of Social Science Series. Englewood Cliffs: Prentice Hall.

Werner, Oswald, and G. Mark Schoepfle. *Systematic fieldwork: Foundations of ethnography and interviewing*, vols. 1 and 2. Newbury Park: Sage.

World Health Organization. 1981. *Manual for the planning and evaluation of national diarrhoeal disease control programmes*. WHO/CDD/SER/85.1. Geneva: WHO.

Monitoring Immunization Activities and Determining Coverage

Resource Person: Richard Arnold, MD, REACH

Members of the group individually expressed their expectations and needs for the session. In response, Dr. Arnold then:

- Discussed the infant mortality rate and the proportion of the infant mortality rate that is attributable to vaccine preventable diseases; noted that measles and neonatal tetanus account for about 90 percent of that EPI portion.
- Reviewed and discussed the types of monitoring activities available for EPI: "accessibility" and "completion" indicators, dropout rates, and cold chain indicators. Much of the discussion focused on uses of the WHO immunization monitor and on how to determine and locate suitable denominators.
- Presented the steps of conducting a standard WHO 30-cluster EPI

coverage assessment survey: the division of the "universe" or population into subunits; the selection of 30 cluster sites by a random method; the location of starting points; interview concerns; sample size rationalization; tabulation; and action needs after the survey.

Quick EPI Surveys for Child Survival Projects

Resource Person: Richard Arnold, MD, REACH

On Day 2, Dr. Arnold reviewed the rationale and methods of the standard WHO 30-cluster coverage assessment technique for members of the group who did not participate in the previous day's immunization session, especially the resources needed (time and manpower), statistical variability, stepped sampling procedure, and sample size. The discussion then turned to "quick" surveys as a management tool. Key points about "quick surveys":

- Used to rapidly determine coverage in a particular village at a specific time, without a big investment of time and human resources.
- Survey teams usually visit *all* households in a small village or subunit of a bigger village, and interview not fewer than 100 households (or at least 10 under-age-one infants, if a quick survey is primarily being done to estimate immunization status).
- Keep interview tool very brief so that the interview can be completed in five minutes or less at each household. (For an example look at the sample tools used in the April 1986 PVO workshop in Sierra Leone—Infant Location Form A, Infant Information Form B, and the "quick and dirty" analysis results shown in the appendices of the workshop report.)
- Interviewers (a health worker usually not responsible for the CS interventions at this particular village, or a "local guide") can survey 50–100 households in two to three hours in most village settings. The Infant Loca-

tion Form A usually takes less than a minute per household, and one expects to find only 10–15 under-ones who will need the five-minute Form B interview.

- Forms must be tailored to specific project and cultural needs. Conclusions are for that village or subunit only and are not meant to estimate coverage for a larger area, for statistical reasons.
- At the end of this effort, the project manager will have a list, by name, of under-ones living in this specific village or subunit, whose immunization status is known and who can then be located for follow-up. A PVO might do all or only a few villages, which should be termed "sentinel sites," depending on their resources.

This special interest group also discussed neonatal tetanus mortality surveys. These can be done by a PVO, but are more likely to be done in cooperation with the MOH or WHO. They are valuable to provoke awareness of what is usually not recognized as a problem, in that most infants who die from neonatal tetanus are born at home and thus seldom are noted by health authorities.

Documents Distributed by Dr. Arnold
World Health Organization. *Evaluation and monitoring of national immunization programs*. EPI/GEN/86.4 Rev 1: 1–31.

World Health Organization, Expanded Programme on Immunization and Centers for Disease Control, U.S. Public Health Service. *Evaluate vaccination coverage. Training for mid-level managers module*.

World Health Organization, Expanded Programme on Immunization. *Prevention of neonatal tetanus*. EPI/GEN/86.9 Rev 1:1–8.

QUICK Forms A & B. 1986. Child Survival Workshop, Meals for Millions PVO CS Workshop: Sierra Leone.

USAID/CHIPPS. 1987. Forms A & B Neonatal Tetanus Survey, Kabupaten Pidie, Aceh Province, Indonesia. (August).

Also of Interest

Arnold, R.B., T.I. Soewarso, and A. Karyadi. 1986. Mortality from neonatal



tetanus in Indonesia: Results of two surveys. *Bulletin of the World Health Organization* 64(2): 259–262.

Berman, P., and J. Quinley. 1987. *Mass campaign or routine program: A cost-effectiveness comparison of tetanus immunization programs in Aceh*. Johns Hopkins University/USAID-CHIPPS Aceh Province Health Department.

Fendy, R., A. Jacob, F. Bahauddin, R.B. Arnold, and R. Feldman. 1984. *Results of a survey for neonatal tetanus mortality, infant mortality, and mortality caused by measles complications, in rural areas of West Sumatra Province*. USAID-CHIPPS/West Sumatra Province Health Department.

Haaga, J. 1986. Cost-effectiveness and cost-benefit analysis of immunization programmes in developing countries. In *Advances in international maternal and child health*, eds. D. Jelliffe and E.E.P. Jelliffe. Vol. 6, 901-927. New York: Oxford University Press.

Halsey, N.A., R. Boulous, E. Mode, J. Andre, L. Bowman, R.G. Yaeger, S. Toureau, J. Rohde, and C. Boulous. 1985. Response to measles vaccine in Haitian infants 6 to 12 months old. *New England Journal of Medicine* 313: 544–549

Henderson, R.H., and T. Sundaresan. 1982. *Cluster sampling to assess immunization coverage: A review of experience with World Health Organization* 60(2): 253–260.

Hill, A.G., and S. Macrae. 1985. Measuring childhood mortality levels: A new approach. *UNICEF Social Statistics Bull.* 8(2): 1–11.

Immunization coverage survey methodology studies: Expanded programme on immunization and epidemiological surveillance and health situation and trend assessment. 1987. *WHO Weekly Epidemiological Record* 62: 213–216.

Key issues in measles immunization research: A review of the literature. 1987. EPI Global Advisory Group Meeting, Washington, DC. (9–13 November 1987). WHO/EPI/GAG/87.10

Kok, P.W. 1986. Cluster sampling for immunization coverage. *Soc. Sci. Med.* 22 (7): 781–783. Great Britain: Pergamon Press Ltd.

Lemeshow, S., and D. Robinson. 1985. Surveys to measure programme coverage and impact: A review of the methodology used by the expanded programme on immunization. *World Health Statistics Quarterly* 38:65–75.

Rothenberg, R., A. Lorantov, K.B. Singh, and G. Stroh. 1985. Observations on the application of EPI cluster survey methods for estimating disease incidence. *Bulletin of the World Health Organization* 63(1): 93–99.

Yusuf, B., S. Solter, Z. Bakri, A.A. Haibuan, T.I. Soewarso, E.R. Aiyub, and R.B. Arnold. 1986. Neonatal tetanus mortality in Aceh Province, Indonesia. *Ann. Soc. Belge Med. Trop.* 66: 349–354.

Beneficiary Input into Project Evaluation

Resource Person: William Steeler, MD, The Aga Khan Foundation

The second part of the EPI quick survey session discussed issues in obtaining beneficiary input into project evaluation. Dr. William Steeler reviewed the experience of his organization, The Aga Khan Foundation, in involving community leaders in evaluations of primary health care projects. They identify three types of leaders—Ministry of Health officials, local political appointees, and the natural leaders of the community. All are involved in some manner in the PHC project. This is done very early in the project's development. It involves convincing the local leaders that the PVO has a valuable service to offer and that they will be able to "take credit" for the project's success.

These leaders are asked to identify issues to be covered in the project evaluations, especially the midterm evaluation. Local leaders are involved in both data collection and tabulation so that they might inform the community at large of the activities.

PVO representatives were urged to commit to an action plan to begin such a process, if they have not already done so.

Growth Monitoring and Promotion

Resource Person: Charles Teller, PhD, International Nutrition Unit, Logical Technical Services

This session reviewed issues related to the implementation of growth monitoring and promotion (GMP) components in CS projects.

- A matrix of the three main uses of GMP by types of users was presented, along with a list of eight key GMP activities.
- PVOs identified action plans and intervention follow-up as the weakest parts of the assessment and interpretation phases of most GMP activities.
- Participants reviewed a table of key indicators for growth monitoring and evaluation, which are useful for either cross-sectional or longitudinal analyses.
- Three PVO participants presented their efforts in developing GMP guidelines and a training manual for use by PVO field staff.
- Consensus was reached on the need for GMP design guidelines, a GMP training manual for project managers, and a manual for training of trainers; participants agreed on a plan of action for follow-up action.

Documents Distributed by Dr. Teller

Yee, V., and A. Zerfas. 1987. Issues in growth monitoring and promotion (Summary). INU/LTS. (May).

Also of Interest

APHA. 1987. Information packet: Growth monitoring.

Mora, J. 1987. Impact evaluation of the Applied Nutrition Education Program (ANEP) of CRS/CARITAS in the Dominican Republic. INU/LTS. (December).

Nutrition in primary health care. 1984. International Nutrition Planners Forum. INU/LTS, Rockville, Maryland.

Teller, C. 1987. Community nutrition assessment and evaluation: Towards model building—Thailand. INU/LTS. (August).

Teller, C. 1987. Revision del componente de vigilancia del crecimiento dentro de

Programas de Supervivencia Infantil: Hacia una estrategia coordinada en Bolivia. INU/LTS. (September).

Thesaurus for primary health care: Growth monitoring. 1987. PRICOR II, URC, Chevy Chase, Maryland (November).

WHO. 1986. Guidelines for training community health workers in nutrition (second edition). Geneva.

WHO. 1986. The growth chart. Geneva.

Wilcox, J. C. Teller, and J. Aguilar. 1985. Guidelines for incorporating nutrition in the design of primary health care and related development projects. INU/LTS.

Yee, V. 1987. Operations research on growth monitoring/promotion—Togo. INU/LTS.

Assessing Vitamin A Deficiency

Resource Person, Anne Gadomski, MD, The Johns Hopkins University

The following questions and concerns were raised by participants in the first 15 minutes of the session and covered either during the prepared remarks or during the discussion that followed:

- Why is vitamin A singled out for discussion?
- How can a PVO know/recognize that vitamin A delivery is a problem in the area that they serve?
- What is the target group for vitamin A interventions?
- What are the risks and benefits associated with vitamin A dosing?
- How does a PVO convince the MOH that vitamin A projects are needed?
- What training and educational materials are available for field personnel?
- How does a PVO monitor and evaluate an agricultural-based vitamin A intervention or a nutrition project designed to change knowledge, attitudes, and practices regarding vitamin A intake?
- What is the relationship between vitamin A deficiency and infection (i.e., the degree of causality, if any, in the relationship)?
- Is it realistic for PVOs to use morbidity/mortality indicators to evaluate their project?
- What are the process indicators that can be used to evaluate a project?
- What is conjunctival impression cytology?
- Why can't vitamin A blood levels be

used to evaluate vitamin A deficiency?

- How can existing data be used?
- How can vitamin A capsules be procured?

Susan Eastman and Anne Raalte of Helen Keller International were helpful resources to the group, particularly with regard to educational materials and programmatic issues.

After reviewing the current methods of assessing vitamin A deficiency, the group discussed in greater detail the technique, feasibility, and validity of conjunctival impression cytology as a means of assessing vitamin A status. Slides were presented to demonstrate exactly what is involved in impression cytology. This was followed by a discussion of obtaining impressions in field settings vs. doing a survey of clinical xerophthalmia.

Given the breadth of issues raised, some issues were discussed in more detail in individual consultations after the formal session.

Surveillance of Nutritional Status Including Vitamin A Deficiency

Resource Persons: Charles Teller (INU) and Anne Gadomski (JHU)

- After reviewing participant expectations, this group discussed community nutrition surveillance systems, five possible uses of such a system, and learned of some existing PVO systems.
- Identified minimum indicators useful for monitoring nutrition components of CS projects, including community nutrition. There was interest in defining techniques and strategies for analysis and feedback of results to the community.
- Reviewed the Freedom from Hunger Foundation's draft of policies and guidelines for vitamin A projects, including the process of their development as a collaborative effort between FFH and HKI.
- Addressed three specific questions on vitamin A: clinical signs, sample size determinations for assessing the preva-



lence of vitamin A deficiency, and the feasibility and validity of using mortality as an impact indicator for a vitamin A project.

Qualitative Assessments by Focus Groups

Resource Person: Ms. Peggy Koniz-Booher, GROWTHTECH, Academy of Educational Development

Since focus groups are usually employed to aid a health project in determining how best to shape their educational messages, Ms. Koniz-Booher first reviewed the basic principles of the communications development field. The essential steps involved in planning an effective communication strategy are analysis, design, development, pretesting, and revision. In the implementation stage, an effective communications strategy means monitoring, assessment, review, and replanning of the health communication. Development communication is a two-way process; one must communicate with people in order to judge how best to communicate some health message to them.

The discussion then moved to an overview of qualitative assessment, a type of formative research intended to discover what people think and how they feel. It enables project planners to gain insight into attitudes, beliefs, motives, and behavior. It can provide a greater depth of understanding. Such research deals with emotional and contextual aspects of human response, rather than objective, measurable behavior and attitudes. Thus, it is interpretive rather than descriptive and usually deals with relatively small numbers.

Pragmatic reasons for using qualitative research:

- Relatively cheap cost
- Quick timing, not reliant on data processing capabilities
- Flexible, can be modified while research in progress
- Direct links with target population
- Logistics easier, not reliant on sophisticated technical facilities or equipment

Problems associated with using qualitative research:

- Flexibility of method sometimes undercuts discipline and thoroughness needed to conduct research
- Highly susceptible to observer bias
- Often not appropriately conducted
- Often analyzed as if it were a quantitative study, drawing hard and fast conclusions instead of hypotheses and insights

Individual depth interviews and focus groups are two techniques used in qualitative research. Factors that must be considered in choosing one technique over the other, or a combination of techniques, include sensitivity of subject matter, group interaction, peer pressure, depth of individual responses desired, interviewer fatigue, stimulus of materials, and logistics, cost, and timing.

The group discussed the strengths, weaknesses, and specific applications of focus groups.

- Focus groups have been found valuable to help clarify the determinants of basic behavior or reactions to specific stimuli. The resulting qualitative information complements numerical data.
- Focus groups are inappropriate when hypotheses are to be tested, or when

data are needed to describe representative or typical information from a larger population. Focus groups should not be used in place of a full-scale survey.

- Factors to consider when setting up a focus group
 - How many groups are needed?
 - What should be the composition of each group?
 - What is the appropriate length for a group discussion?
 - What is the optimum size of the group?
 - What is the ideal group setting?
 - What are the desirable personal characteristics, style, and background of the moderator?

Those attending this special session expressed particular interest in learning more about how to develop a topic guide for use in conducting a focus group, and also more about how to analyze and interpret focus group findings. It was suggested that workshops organized by GROWTHTECH on qualitative assessments would be helpful for both PVO headquarter staff and field staff.

Documents Distributed by Ms. Koniz-Booher
Folch-Lyon, Evelyn, and John E. Trost.
1981. Conducting focus group sessions.



Studies in Family Planning 12(12): 443-449.

Scrimshaw, Susan C. M., and Elena Hurrado. 1987. Focus groups. *Rapid assessment procedures for nutrition and primary health care*. UCLA Latin American Center Publications. Los Angeles: University of California.

In-Country Collaboration For Data Collection and Use

Resource Persons: Ms. Mary Harvey, REACH, and Gerold van der Vlugt, MD, DrPH, United States Agency for International Development

Collaboration takes place at many levels and can occur among many different groups. The following types of collaboration were identified, and the advantages and problems or constraints associated with each type were discussed.

Collaboration among PVO headquarter personnel

Advantages: information sharing, including technical, political, resources, lessons learned; joint project activities; evaluation activities and ideas

Constraints: competition for funds; fear of loss of originality or initiative; conflicting policies

Collaboration among PVOs at field level

Advantages: joint project activities, resulting in more efficiency; prevention of conflicts or duplication of efforts

Constraints: fear of loss of identity; conflicts of interest; "guilt by association"

Collaboration with indigenous PVOs

Advantages: possibly helpful for sustainability; better information on local situation; improved cultural sensitivity and influence

Constraints: can slow down activities; lack of technical expertise; political ties can be counterproductive when political situation changes

Collaboration with other country donors

Advantages: additional resources; new ideas/information

Constraints: conflicting political or social objectives; bureaucratic snarls

Collaboration with host country governments

Advantages: sustainability; legitimacy

Constraints: changes of political party in power; fear of government interference in operations



TRAINING OF FIELD STAFF TO STRENGTHEN CHILD SURVIVAL ACTIVITIES

In addition to the external consultants, Dr. Michelle Denize, participant from Save the Children Federation, assumed responsibility for a workshop session on training of field staff. Dr. Denize has conducted workshops for SCF field personnel on the development of their information systems and is highly skilled in participatory training methods.

Dr. Denize led a series of small group exercises designed to encourage the work-

shop participants to examine training needs and training approaches for their particular Child Survival projects. Participants were divided according to "regions," roughly the geographic area of the world in which they most typically worked.

The exercise was designed by Dr. Denize, partially in response to the summaries of training approaches that PVOs had provided to organizers in advance of the workshop.

REPORT ON PVO CHILD SURVIVAL FIELD WORKSHOPS, 1986-1987

Value of Field Workshops

Weeklong, field-based workshops for PVO CS staff have proved to be a good way to reduce the technical isolation of field staff, to provide access to state-of-the-art information on the chief CS interventions, and to foster the exchange of information and ideas among different PVOs on issues such as community participation, supervision, or sustainability. A.I.D. has supported implementation workshops for PVO field staff early in project development. Four have been held since the initiation of the Child Survival Program in 1985. (Table 2).

Participants are country nationals working in PVO CS projects throughout the region. Sometimes participants include representatives from local or regional government health services. This emphasis on training country nationals strengthens the health infrastructure in the region. The workshop is held in the language of the participants.

The workshops take place in a modest setting, close to a Child Survival project site. Visits are made to the community, to observe maternal and child health services, or to talk with community health committees. These experiences enrich the learning of those who attend.

Process

A PVO is selected by FVA/PVC to be the host organization for a regional workshop, and money is deposited into the PVO's CS grant for participant airfares, facilitator fees, and in-country costs. Invitations are issued by the host PVO to the other PVOs identified by A.I.D. as having an eligible project to attend.

The host PVO appoints a person from the USA office to work with JHU on developing the overall content and process of the workshop, based on needs identified in reviews of the project's Detailed Implementation Plans, and from a needs assessment survey of invitees. One or more persons are appointed from the project staff to organize the logistics, inform the MOH, and coordinate workshop activities with community leaders and local government health staff.

Before the workshop a meeting is held

in the USA with the core workshop organizing team (PVO field coordinator, PVO HQ representative, JHU workshop coordinator, other A.I.D. identified resource persons, and the workshop facilitator). The team agrees on the goals, objectives, and expected outcomes of the meeting, outlines the week's schedule, and identifies potential resource persons for each of the proposed sessions. The next meeting is held in country, the week before the workshop begins. The schedule takes final shape before everyone arrives. A general principle guiding these work-

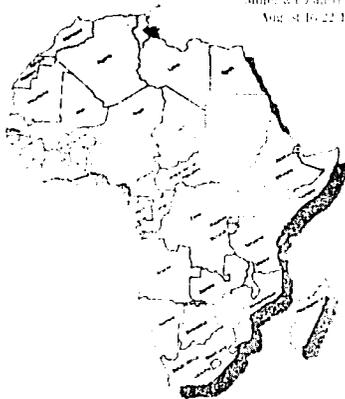
shops is that everyone counts, every view is important, and everyone takes part in the workshop.

Activity Report

PVO representatives who had taken part in organizing the PVO implementation workshops held in 1986-87 reported to the full group on the planning, successes, problems, and lessons learned during the implementation of those workshops. Jim Becht reported on the very first workshop, which was hosted by Freedom from Hunger Foundation in Makeni, Sierra Leone.

And If the Children... Zimbabwe Child Survival Workshop Summary Report

Harare, Zimbabwe
August 19-22, 1987



REPORT OF THE
BOLIVIA PVO CHILD SURVIVAL PROJECT
MONITORING AND EVALUATION WORKSHOP

September 15 - 18, 1987
Buenos Aires, Bolivia



THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF HYGIENE AND PUBLIC HEALTH
CHILD SURVIVAL SCIENTIFIC PROGRAM

REPORT OF THE RWANDA WORKSHOP

"INTEGRATION OF CHILD SURVIVAL ACTIVITIES
INTO COMMUNITY DEVELOPMENT"

July 17 - 24, 1987



A Regional Training Workshop For Administrators Of Child Survival Health And Nutrition
Projects Carried Out By PVOs In Transafrican Africa

Child Survival and Health Science Foundation
100 East Broadway, New York, NY 10038
August 1987

REPORT OF THE SIERRA LEONE WORKSHOP
"INTEGRATION OF CHILD SURVIVAL ACTIVITIES
INTO COMMUNITY DEVELOPMENT"

April 6 - 12, 1988



Meals for Millions
Freedom from Hunger Foundation

Dr. Gordon Buehler spoke of the workshop in Kigali, Rwanda, hosted by the Adventist Development and Relief Agency. Mark Publow of World Vision Relief and Development, Inc., told of the highlights from the workshop held in Murewa, Zimbabwe. Then Dr. Michael Gerber filled the group in on the planning for the 1988 workshop to be hosted by AMREF at Kibwezi, Kenya.

According to the PVO panel, the workshops are seen as providing valuable input into the refinement of the PVOs technical expertise in Child Survival interventions. They also are important in improving the spirit of collaboration and cooperation within the countries or regions, both among PVOs and between PVOs and representatives of other local governmental and non-governmental groups (many of whom attended the workshops).

A brief description was also given of the ADRA-sponsored workshop in India to orient CSII project directors, and the CARE-sponsored workshop, also in India, for field staff.

Future Workshops

JHU plans in the summer of 1988 to host a "Lessons Learned Conference" for the PVO projects from Haiti and countries in

Africa whose CSI grants are terminating this year. Work is also proceeding on the first Asia Regional PVO Child Survival Workshop to take place in the spring of 1989. Save the Children/Nepal has been selected to host this workshop for the FVA/PVC funded CSII projects in Asia. Plans are under way for a Central America regional PVO workshop, to be held in late spring 1989.



D. G. Norman

Table 2. PVO Child Survival Field Workshops, 1986-87

Type	Date	Host/Location
Africa Regional PVO CS I Implementation Workshop (English)	Sept. 1986	EfH/Sierra Leone
Africa Regional PVO CS II Implementation Workshop (French)	July 1987	ADRA/Rwanda
Africa Regional PVO CS II Implementation Workshop (English)	August 1987	WV/Zimbabwe
PVO/MOH Child Survival Collaboration Workshop (Spanish)	Sept. 1987	USAID/Bolivia

Sharing Experiences

Child Survival has been criticized for being counter to the goals of primary health care because of the emphasis on achieving real increases in immunization coverage or ORT use within the three to four year period of CS funding. Certainly three or four years seems too short a time to build a solid foundation for all primary health care. PVOs new to Child Survival fear that short-term gains will be made at the expense of long-term PHC goals. Will the short-term gains be sustained after Child Survival funding has ceased?

Facing each PVO in Child Survival is the fundamental, nagging question of how to ensure that the benefits of Child Survival continue after their development assistance is over. A panel of five PVO participants, chaired by Karen Woodbury of Freedom from Hunger Foundation, discussed the approaches and successes of their organizations in promoting sustainability of project benefits. Panelists represented Africare, CARE, Catholic Relief Services, and Helen Keller International. They gave the following presentations.

Africare

Projects start with village priorities, usually agriculture, health, or water. The Africare/Nigeria CS project works through a cooperative structure to support health activities. The community-owned cooperative distributes ORS packets. This gives the community a sense of ownership. The cooperative provides services and medicines, and finances a communal plot. It provides an economic base for the community. A cottage industry produces a cowpea food supplement and a local weaning food. The resulting profit will be used to pay salaries of the health workers and the support system. It keeps money in the village!

CARE

CARE's Child Survival and health projects encourage and promote community participation. Also, at the project level, sustainability is dealt with in counterpart development and participation in decision making. CARE is just beginning to work in income generation and small enterprise development.

At the national level there is a need to understand grass roots activities. Community participation is not always welcomed. In unstable political conditions, CARE works with the private sector.

At the organizational level, CARE has hired a consultant from PRICOR to help CARE look at sustainability as an organizational issue.

The CRS/Ecuador CS project has garden and income generation components. These are under development now and are expected to complement project activities in ORT education, growth monitoring, and promotion. In this project, they have found that on the land available it is possible for mothers to raise chickens for income. The addition of the income generation components have given new life to the mothers' clubs, which previously drew participants partly because of food distribution. Now that the food distribution is being phased out, the garden and income generation components give mothers the tools by which to better their family's nutrition.

Freedom from Hunger Foundation

The emphasis of all FfH projects is self-reliance and the development of local capabilities to solve nutrition and health problems. FfH works through local institutions on a partnership arrangement. All field staff are either regional or local people. Local consultants are used as much as possible.

The end-of-project status is planned from the inception of a project. FfH is getting more and more involved in credit and micro enterprise development activities to ensure that communities have the financial means to sustain development projects. The Nepal and Bolivia CS projects work through government structures and seek to strengthen government's capability to deliver services.

Helen Keller International

The "three generations" theory of development assistance, proposed by David Korten, provides HKI with a framework for its approach to sustainability. An example of "first generation" assistance is that of a PVO doing famine or flood re-



lief. The role of the PVO is to be the one who acts, the one who carries out the relief work. A "second generation" approach is one of the PVO and the community engaged in community development, with the PVO mobilizing the community to act. In the "third generation" of development assistance (presumably a higher order activity in Korten's scheme), the PVO is a catalyst at national or regional levels, influencing policy and operations, but not responsible for implementation.

HKI practices "third generation" assistance by:

- Integrating vitamin A into government curricula
- Including vitamin A on essential drug lists
- Developing vitamin A protocols
- Producing promotional and educational materials
- Developing model vitamin A activities
- Providing vitamin A technical assistance to other PVOs

HKI works through existing structures and tries to institutionalize vitamin A activities at the national and regional levels. They also act within the private sector, bringing vitamin A expertise to local and U.S.-based PVOs working in country.

HKI employs country nationals, and if none are available, then hires regional applicants. Technical assistance is provided from the New York City office only if skills higher than what is locally available are required for a task.

At this point the discussion was opened to all and soon centered on what is meant by the term "sustainability." Does it mean to keep the project going? Sustain the delivery system? Sustain the services themselves? Or the behavior change that generates a continuing demand for services? Dr. Berggren from SCF argued that it is health behavior change that PVOs must seek to maintain. SCF gave an example of a demand created 10 years ago for tetanus immunization that still exists in Haiti today. One million women were vaccinated for free, and today people pay for the same service and seek it out. The Haitian women have accepted that neonatal tetanus can be prevented and have

changed their behavior in regard to seeking tetanus immunization.

Another point was made that improvement of government services is no guarantee of sustainability. There are issues of central drug supplies, vaccine stocks, and cost recovery. Also, it is important to recognize the private sector and the role of local PVOs in sustaining behavior change, and not place all the burden on government.

Whatever the individual approach the PVO has taken to sustainability, the participants agreed that the "poorest of the poor," the group most needy of Child Survival services, will find it nearly impossible to meet recurrent costs on their own.

PVO Recommendations Regarding Sustainability

- PVO field and USA staff must think of sustainability early in project design, not as an afterthought. PVOs recommend that FVA/PVC include in the CS proposal guidelines a request that country project proposals have objectives for a transitional phase at the end of A.I.D. CS funding.
- Case studies are needed of different approaches to sustainability used by existing CS projects. PVOs recommend that FVA/PVC sponsor such studies this year and report back at next year's workshop as to the results.
- CS projects should use a cost-benefit approach in looking at sustainability issues. PVOs recommend that project staff concentrate on how best to sustain activities that are perceived by the community and the MOH to be effective and affordable in achieving health behavior change.
- PVOs recommend that A.I.D. urge contractors to share current articles or other information on sustainability with the PVO community.

MOOD MUSIC



The following song, sung to the tune of "Let It Be," is a sample of the PVOs creative output for the evening's entertainment following the buffet dinner.

Fortunately, all photos of this party have been suppressed.

O - R - T

When I find myself with diarrhea,
Mother Dory comes to me;
Speaking words of wisdom,
O - R - T, O - R - T.

And when borborygmi hits me
I call for Jake at A.I.D.,
Speaking words of wisdom,
O - R - T, O - R - T.

ORT, ORT, ORT, ORT.
Speaking words of wisdom,
O - R - T, O - R - T.

And just when things are getting
better

PRITECH comes to question me
Speaking rhetorically,
Can it be? Can it be?

Can it be, can it be, can it be,
ORT?

Speaking rhetorically,
Can it be?

Report from A.I.D.

Dr. van der Vlugt presented an update on the Agency's Child Survival Program and funding for PVO Child Survival activities. Congress has increased the Agency's Child Survival Fund over the past three years from \$25 million in FY 1985, to \$36 million in FY 1986, and \$75 million in FY 1987. During this same period funding for PVOs from the CS fund has decreased as a relative proportion of the total funds from 52 percent in FY 1985 to 30 percent in FY 1986, and 27 percent in FY 1987. Also, PVO funding as a portion of the combined accounts has declined to 17 percent in FY 1987. Among the reasons for this trend is that the Agency is interested in integrating PVO Child Survival projects into mission programs and is thus encouraging its missions to develop bilateral Child Survival programs. To date however, mission support for PVO Child Survival projects has remained constant at

about \$14 million or less each year. Still unresolved is a process that will bring adequate mission support to PVO Child Survival activities.

Results of the Three PVO Funding Cycles

The Agency's Office of Private and Voluntary Cooperation has administered the central office funding for PVO Child Survival activities. Several slides were presented that summarized the use that FVA/PVC has made of CS funds to date—funds that total \$33 million for the first three CS funding cycles. Overall, the program has achieved a remarkable record of assuring that Child Survival monies reach the field. The first graph, Figure 1, showed that approximately 94 percent of the \$33 million administered by FVA/PVC has been awarded to PVOs in a competitive grants program. The remaining 6 percent has provided support in the form of baseline survey assistance, implementa-



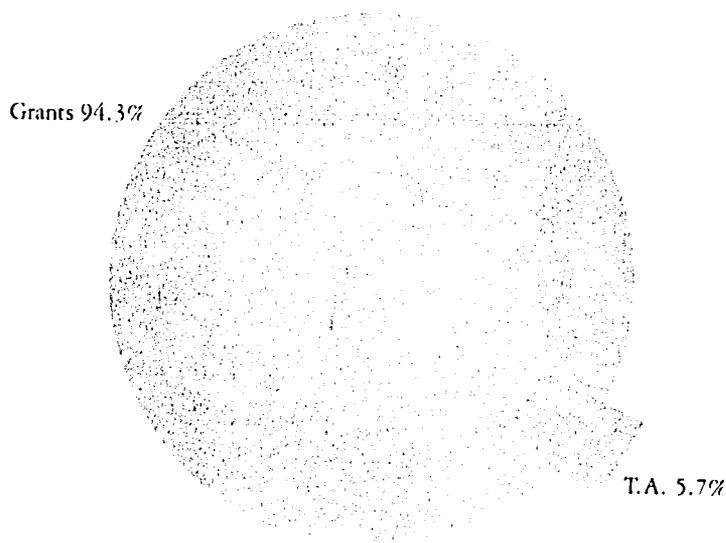
David Sturges

tion workshops, specialized technical consultancies, and external evaluators for many of the 50 projects funded in the first three cycles.

Dr. van der Vlugt pointed out the efficiencies that had been achieved by coordinating implementation support. He noted that if instead of concentrating technical support resources, this money had been spread among the projects, it would have amounted to less than \$13,000 per year per project. He also pointed out that the PVO CS Program had been quite successful in assuring that the implementation support monies were directed to the field. Close to 80 percent of the implementation support monies went for work outside the USA. The remainder (\$10,000) paid for technical reviews of CSI, CSII, and CSIII documents, including proposals, DIPs, and other reports. In addition, the implementation support has promoted sharing among PVOs and encouraged collaboration among field and backstopping staff of different PVO organizations.

The majority of FVA/PVC funded Child Survival grants in the first three cycles are within the Africa and Latin America/Caribbean region. Dr. van der Vlugt discussed the countries where PVOs were eligible to apply for FY 1988 CS grants and promised continuing efforts to broaden the PVO CS effort to new countries.

Figure 1: FY 85*-FY87 Funding for U.S. PVO CS Grants & T.A. Bureau for FVA Funding Only



NOTE: *Includes FY 85 Health Account earmarked for Child Survival Grants
A.I.D. Health Information System ISTI, 1/01/88

He also noted that, despite initial worries that PVO projects would become too specialized, the PVO projects actually had a good spread of primary health care activities. The major areas are immunization, ORT, and nutrition, with birth spacing activities, Figure 2, only a small part of projects to date.

Computer networks and health information systems development are among Dr. van der Vlugt's ideas as to future prospects and directions. He also strongly advised the PVOs to examine their organizations' AIDS policies and to acquaint themselves with the activities of AIDSTECH and AIDSCOM.

In summary, with at least two years of PVO experience with CS field activities, some encouraging trends in increasing coverage and access to health services are being seen. He noted that FVA and other parts of the agency are more aware of the improved Child Survival capabilities of the PVOs, and thanked those in attendance for their hard work in the past year.

Technical and professional competence is improving at all levels. He also spoke of the efforts of A.I.D. to simplify the reporting system, and to be responsive to the concerns of the PVOs about restrictive targeting. He pledged to keep open the PVO-AID dialogue and to remain an active partner with the PVOs on improving the Agency's Child Survival program.

PVO Accomplishments and Lessons Learned in the Past Three Years

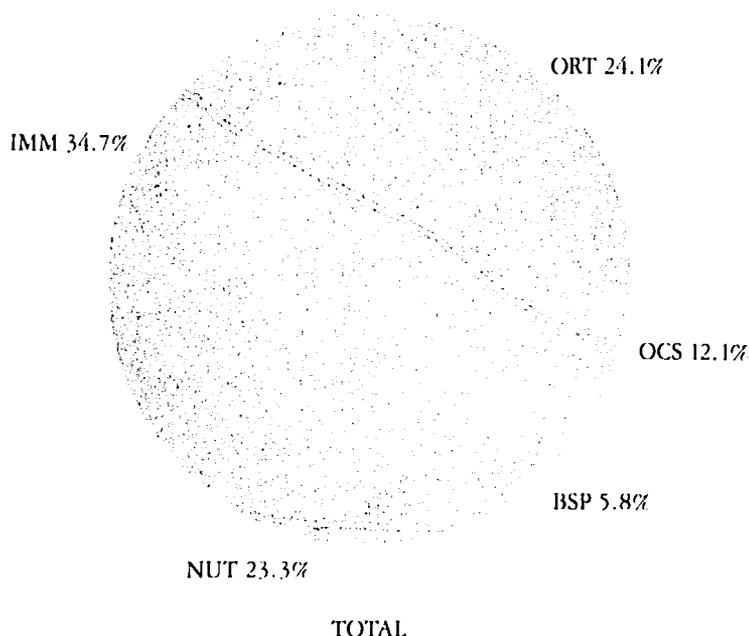
A full group discussion followed in which the PVO representatives identified the accomplishments that have resulted from their involvement in the CS Program. Then they discussed major areas of continuing efforts and identified some barriers that they perceive to hinder the accomplishment of country project goals. The group agreed upon actions that

A.I.D. might support to further CS gains and made recommendations to AID/FVA/PVC for follow-up action to overcome barriers to achieving CS goals.

What have we accomplished so far in Child Survival?

- Having an impact on many groups that we relate to: Congress, other funding agencies, the recipient community, and host country governments at the ministerial level
- Stimulated behavior change, both in the PVOs and in the communities in which we work (e.g., greatly increased condom use in the outreach area of one of the PVOs)
- Having an impact on policies and awareness of the national governments
- Increased the existence and use of population-based statistics by ministries of health
- Improved the networks available to deal with new and upcoming issues
- Increased coordination among PVOs, including a willingness to share human and material resources
- Making linkages in-country with UNICEF, other PVOs
- Increased technical competence and organizational strength
- Increased use of in-country personnel and resources
- Strengthening of (and introduction of new) infrastructure in-country
- Increased our technical areas, for example have added EPI, vitamin A interventions
- Improved staff development
- Planned and carried out training of trainers
- Developed training manuals
- Carried out baseline surveys, improved survey methodology
- Utilized KAP studies in program development
- Improved use of social marketing methods
- Improvements in planning, design, implementation, and evaluation of projects have spilled over from CS into other project areas

Figure 2: U.S. PVO Child Survival Grants by CS Interventions
Bureau for FVA Funding Only FY 1985-FY 1986

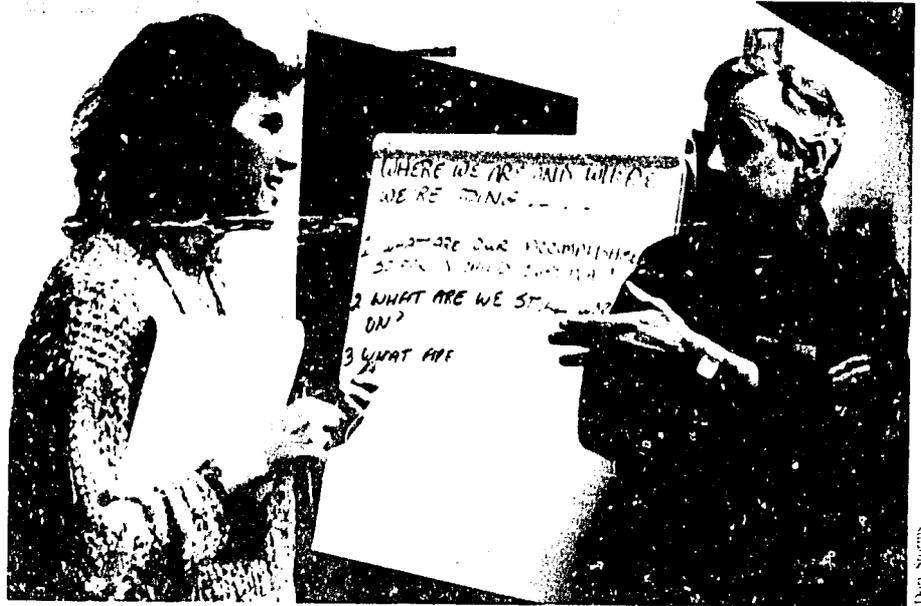


What are we still working on in Child Survival projects?

- Sustainability
- Evaluation and monitoring systems; surveillance
- Use of data—need to be able to better synthesize the information gathered, use it in projects, and share it with the community in a timely manner
- Establish the impact of CS project interventions on mother's treatment of childhood diarrheal diseases
- Need reliable growth indicators for measuring effectiveness and setting realistic goals
- Cost-benefit assessments of service interventions
- Greater awareness among project staff of need for better control of neonatal tetanus
- Better definition and focus in nutrition programs
- Incorporating women's issues, such as safe motherhood, into projects
- Better control of acute respiratory infections
- Need an AIDS initiative within agency as a whole, including assessment of impact on health program activity
- Stronger project management skills
- Better supervision systems—standardization of supervisory visit, including understanding of what is involved, the time needed, and realistic desirable outcomes (behavior change)
- Better quality control
- Development of project guidelines and good, appropriate materials, such as training manuals
- More awareness of CS issues on the part of key decision makers and PVO country managers
- Creating a community demand for all CS interventions

Next Steps: PVO 90-Day Action Plans

In the final plenary session, participants utilized lessons from the workshop to produce action plans for the 90



days (or three month period) immediately following the workshop. PVO representatives identified the tasks that they expected to take to strengthen monitoring and evaluation of their projects, using some of the ideas, information, and skills that they had acquired at the workshop. Representatives of eight PVOs presented those plans to the group.

Africa

Headquarters:

- 1) Report to senior staff on workshop activities
- 2) Identify funding for private match
- 3) Investigate sources for procurement
- 4) Look at potential support, arrangements for case study on community-level sustainability

Nigeria CS Project:

- 1) Share with field recent learning from this workshop (insights, materials, resource leads, networking possibilities, etc.)
- 2) Involve self heavily in planning with field the midterm evaluation (for obtaining useful quantitative/qualitative measures of process, constraints, and guidance for future activities)
- 3) Visit project site approximately two weeks for personal observation and to

provide for ongoing work and planning

- 4) Analyze project expenditures and project use of remaining funds
- 5) Look at new project possibilities in family planning
- 6) Explore AIDS as a component of CS initiative

Chad/Niger/Mali Projects:

- 1) Participate in Chad ORT evaluation
- 2) Alert Mali field office to identify resources incountry for project implementation
- 3) Dialogue with Niger field staff on proposal concerns resulting from FVA/PVC inquiry

Catholic Relief Services

- 1) Meet with decision makers and report on workshop; disseminate materials from workshop to field; write up report on workshop
- 2) Midterm evaluation of Ecuador project (three to six weeks in January)
- 3) Child health OPG in Madras, India, next three to six months; training and development workshops
- 4) Routine office handling of project needs

Freedom from Hunger Foundation

- 1) Finalize Growth Monitoring and Promotion guidelines with input from Save

the Children and Logical Technical Services

- 2) Draft FfH sections of vitamin A training manual
- 3) Pursue funding sources for vitamin A guidelines training manual—professional publication
- 4) Assist with preparing DIPs for Nepal and Bolivia
- 5) Read materials from CS workshop
- 6) Work with Dory Storms on training program information
- 7) Prepare CS input into new FfH five-year plan
- 8) Seek out resources for developing acute respiratory infection interventions
- 9) Investigate possibility for sustainability study
- 10) Backstop Nepal CS project

Helen Keller International

- 1) Publish vitamin A newsletter (quarterly)
- 2) Collaborate with Freedom from Hunger on a vitamin A training manual
- 3) Develop, translate, and circulate new IVACG guidelines and vitamin A materials for French-speaking countries
- 4) Determine need for workshop at HKI/ NYC offices, in Mali and in other PVO headquarters
- 5) Plan for future vitamin A/PVO strategies: Where are we going?

Project HOPE

- 1) Summarize to field and headquarters staff the findings of this workshop—highlighting the concerns of major interest to our particular programs
- 2) Increase the level of neonatal tetanus prevention activities in our CS programs
- 3) Monitor midterm evaluation of Brazil CS, especially regarding cost-benefit studies (possible spinoffs for more general use? share useful results with others?)

Minnesota International Health Volunteers

- 1) Work on sustainability of Uganda CS project. "Fee for service" to start February; train manager for fee-for-service scheme; identify consultant on sustainability and coordinate his/her visit with HQ visit to field
- 2) Share growth monitoring and nutrition surveillance information with home office

team and field project, and use to revise program

- 3) Consider no-cost extension for a year to strengthen the fee for service scheme

Project Concern International

- 1) Build on and continue networking with other PVOs, in terms of a growth monitoring manual, vitamin A manual, further examination of monitoring, evaluation, and sustainability issues
- 2) Incorporate workshop information into activities maintaining current CS projects
- 3) Disseminate appropriate technical information to field
- 4) Report on workshop to country directors and HQ staff
- 5) Continue work on CS manual

Rotary/Polioplus

- 1) Circulate reports to newsletters, other news sources, organizations, projects
- 2) Focus on project finances; analyze and assess social mobilization costs
- 3) Address the "create demand" concept; instill community "want" of immunization workshops and other parts of the project
- 4) Further explore in-country project resources, indigenous and other

Workshop Closing

Following the presentations, the workshop was closed with expressions of appreciation to and from the participants for the spirit of genuine interest, responsiveness, collaboration, and sharing that characterized the workshop.

PVO Recommendations for Removing Barriers to Child Survival Goals

Barrier #1: Incomplete understanding of the resources needed for CS activities at the field level

Recommendations:

- Distill the "lessons learned" to date, along with PVO "success stories," and make available to the PVO community.
- Invite PVOs to participate in developing the guidelines for CSI Final Evaluation. Encourage final reports to include interesting and creative aspects of project experience rather than restricting them to those areas in guidelines. Disseminate a summary of the main lessons to the PVO community.

Barrier #2: Conditions in the field—logistical constraints, poor communications, etc.

Recommendation:

- Investigate possible modifications in Cooperative Agreement to overcome special constraints, e.g., purchasing of cold chain equipment from UNICEF rather than U.S. vendors.

Barrier #3: Poorly developed collaborative mechanisms among PVOs in the States and within third world countries

Recommendations:

- Continued support for Dr. Dory Storms and the work she is doing to support and respond to PVO needs in CS
- Find a means of communicating relevant information among PVOs to improve collaboration and make better use of existing resources. For example, information on training programs, national and regional, that would be relevant for PVO project staff.
- Investigate keeping a list of consultants that have been satisfactorily employed by CS PVOs, so that when a PVO wants to hire a technical consultant directly, they can draw on a pool of names that have been recommended by other PVOs.

WORKSHOP EVALUATION

“What worked is informal friendly atmosphere, good resource people, flexibility in agenda and schedule, A.I.D. presence.”

— PVO representative

Evaluation forms were mailed to the PVO participants following the workshop. An open-ended questionnaire encouraged comments and suggestions for future workshops. It was accompanied by an experimental rating form. Responses were received from 17 individuals representing 14 PVOs.

Workshop Critique

Overall, respondents were enthusiastic about the workshop. They believed it had achieved its goal of facilitating the exchange of ideas, experiences, and materials among PVO home office personnel responsible for technical support to Child Survival country projects.

They also reported that the workshop was successful in serving as a forum for PVO technical staff to give guidance to FVA/PVC on the conduct and direction of the PVO Child Survival Program. A few individuals wanted more immediate feedback, "for example, daily summaries/responses from A.I.D./W," but the majority felt good about the exchange.

Although the majority believed the workshop provided PVO technical support staff with useful techniques for monitoring, reporting, and evaluating CS

interventions, a minority regarded this area less adequately covered. A chief problem seemed to be the heterogeneity of the group. As one PVO representative noted, "The workshop participants were a mixed bag of technical and general administrative staff." Another person empathized, "The level of interest and technical background among PVO staff always seems to make it difficult to present a topic at a level that will be useful to all."

For some who have strong medical and public health training, it was frustrating for old ground to be re-covered, when they were looking for technical information new to them. As one respondent wrote about the special interest groups, "Should be more directed or focused. If want to transmit new or updated information, need very specific objectives as to what 'new' is to be taught." However, this respondent, like others, appreciated the contacts for future technical assistance.

On the other hand, one respondent was keenly aware of the needs of the newcomers to Child Survival: "Providing new technical information and technical resource people for M&E and reporting on CS interventions were accomplished, but it could be useful to consider that there are those in the group who appear to require additional input on the design phase

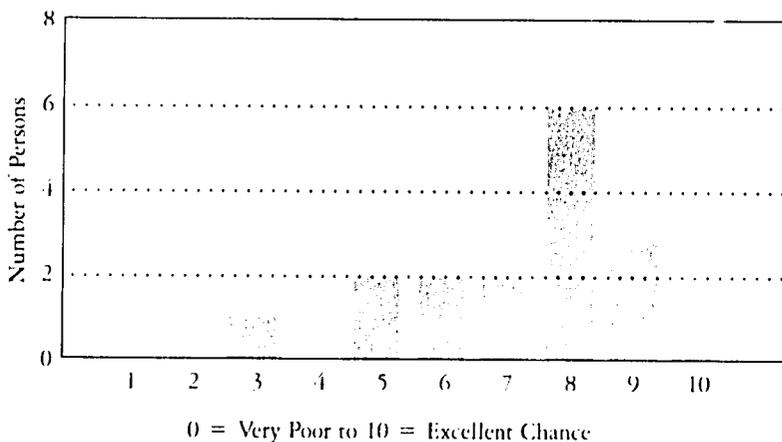
of the interventions. Many attending have new projects and there was not sufficient time for them to acquire information on the basics."

Some were frustrated that they could not take advantage of all the substantive technical information that was available in the special interest sessions. Making a choice between overlapping sessions was difficult. One suggested, "Should allow time for more than two choices." Another wrote, "It would be helpful to offer more in-depth coverage of fewer technical issues so that we can all get past that routine exchange of the first 10 percent of the information and really get down to the specifics."

One individual thought that a contradiction was inherent in the special group format. The small group structure seemed to conflict with the guideline for flexibility of format and content. "Discussion group leaders had clearly been assigned specific topics, had prepared presentations, and were therefore—and not unreasonably—invested in covering their agendas." Despite this structure, for most participants the small group sessions were very useful in learning certain techniques and approaches in the various CS technical areas.

Four sessions generated critical comments. One was the small group session on Child Survival reporting requirements and the evaluation process, where at least one individual expected some immediate response from A.I.D. to PVO suggestions and comments. Another thought that the diarrheal disease session could be strengthened. And, one respondent criticized the discussion on surveillance of nutritional status/vitamin A deficiency because it concentrated mainly on nutrition surveillance, leaving little time for the needs and inquiries of the participants interested in surveillance of vitamin A deficiency. However, it was the session on training that received the most mixed comments. Several persons liked this session very much, regarding the training presentation one of the most useful. In contrast, one person reacted very negatively and regarded it as having been "imposed upon us," an "example of deviation from the stated participatory format."

Belief that Workshop will Lead to Action
Lake Havasu Workshop - 1988 PVO Participant Evaluation



17 responses, 1 no answer

Workshop Accomplishments

Despite the constraints, however, the workshop met, or exceeded, almost all participants' expectations. A participant summarized, "I found the whole process useful and informative." The overall sharing and contact with other PVO technical staff was, as always, stimulating. One participant noted, "The workshop enabled me to meet other PVOs and learn about their projects." In the opinion of another, "The exchange of ideas and expressions

among PVOs was most valuable." This comment was echoed by another respondent: "The most valuable facet was the collective practical experiences of similar PVOs."

Workshop participants also appreciated the opportunity for an informal exchange with A.I.D. and others involved in the management and reporting of the centrally funded PVO CS program. The workshop helped more than one respondent learn "how the 'system' operates and how some of the 'operators' work."

Respondents to the evaluation form identified certain aspects of workshop process, content, and format that seemed to go well in this workshop. For some, the content was most important. They found it generally good, particularly the smaller group sessions. "The small sessions on individual topics and some of the panel sessions went particularly well." For others, workshop process was paramount, noting "constructive interchanges with colleagues," and "the interactions (facilitator/participants and participants/participants) were orchestrated very well."

For a third group of respondents, the general workshop organization and presentation seemed most noteworthy. "The overall organization was very good. The workshop covered an amazing amount of territory in a short time." In general, the comments echoed the individual who wrote: "I think on the whole that the workshop was well organized, well structured, and very successful. Participants were actively involved in the running of the sessions and shared 'ownership' of the workshop. Good principles of community development were at work here."

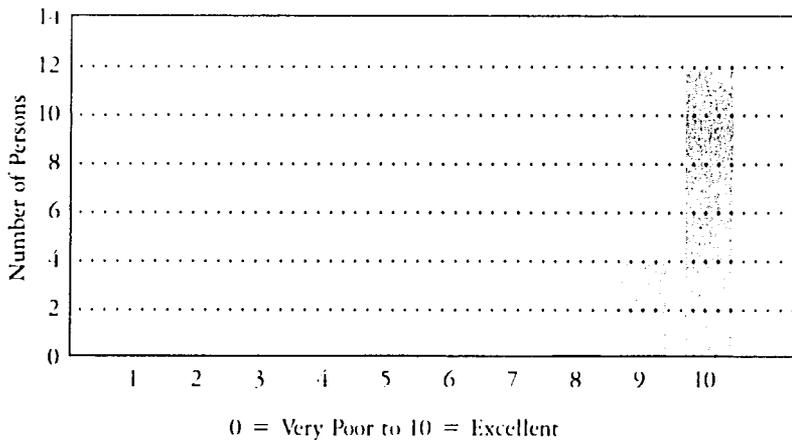
The workshop materials, meeting rooms, and presence of technical resource persons also received praise. The majority of respondents reported that the quality of the resource people was excellent, especially in GMP, immunization, and vitamin A. It was gratifying for staff and consultants that the PVO participants also found the materials and technical input useful. The participation of technical consultants was strongly endorsed by many. As one person commented, "The technical resource people were invaluable and should be a part of any future conference."

Others Who Could Benefit

All the respondents regarded it as appropriate that they had been invited to the meeting. They felt their job made such attendance logical and necessary. Respondents also identified others from their respective organizations who could benefit from a workshop like the one at Lake Havasu, including regional directors, field directors, management information systems managers, and direct supervisors of participating field offices.

Degree of Freedom to Express any View

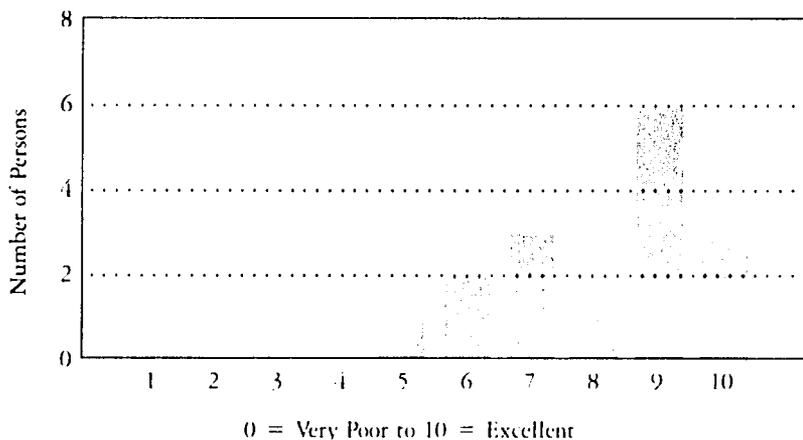
Lake Havasu Workshop 1988 PVO Participant Evaluation



18 responses

Acceptance of Participant Suggestions

Lake Havasu Workshop 1988 PVO Participant Evaluation



17 responses, 1 no answer

Suggestions for the Future

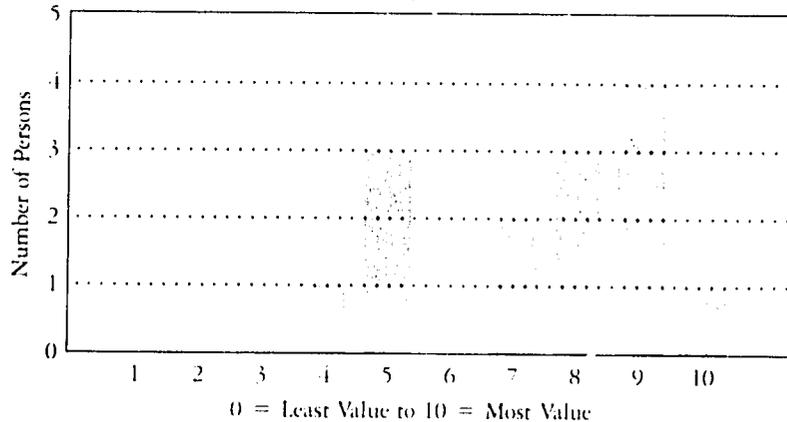
However, the PVO representatives saw room for improvement. Hotel accommodations were good as was the food, but the location was just too difficult. The logistics of getting to Lake Havasu had been a real ordeal for some, taking all day. (In addition, flight cancellations had complicated departure plans.) The accessibility of venue needed to be improved. As one person commented, "It was a lot of time to get out there, which could have been more productively used in workshop content areas."

Others felt some pressure due to the time factor and would have enjoyed the workshop a bit more if more time had been allocated for the workshop in general. "There was so much good resource material but it was too difficult with time constraints to go through it all thoroughly and get maximum benefit of sharing potential." The attempts to provide exposure to training and evaluation techniques in such a brief period were distressing to several. "I did not have time to work with resource people on immunization coverage assessment." "There just wasn't enough time for everything that needed to be done."

A good suggestion came from one respondent: "I would have benefited from a session for general discussion (as opposed to special interest group discussions) on monitoring and evaluating CS interventions, outlining general principles or guidelines to be followed for A.I.D.-funded projects with examples from different types of interventions."

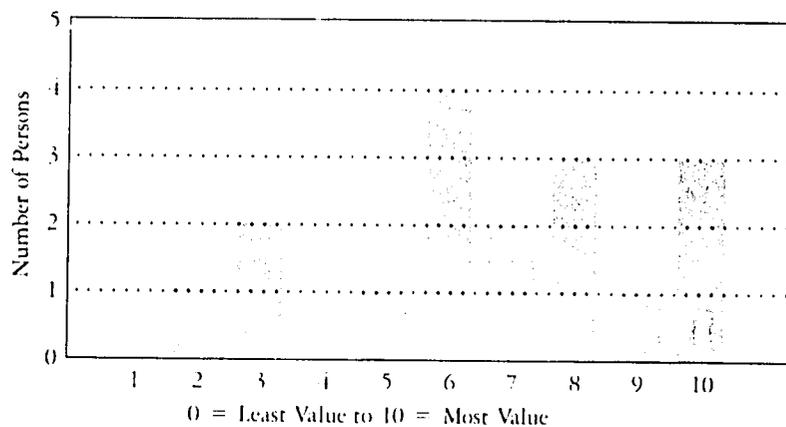
The evaluation respondents endorsed another PVO/HQ Resources Workshop. A few persons thought regular regional meetings, or a series of more frequent workshops might be helpful. But the vast majority thought that meeting in a year's time would be appropriate—January 1989. They noted that would place the workshop after the holidays, when all reporting requirements had been completed.

Value of Session on Lessons Learned in Backstopping CSI & II PVO Projects
Lake Havasu Workshop 1988 PVO Participant Evaluation



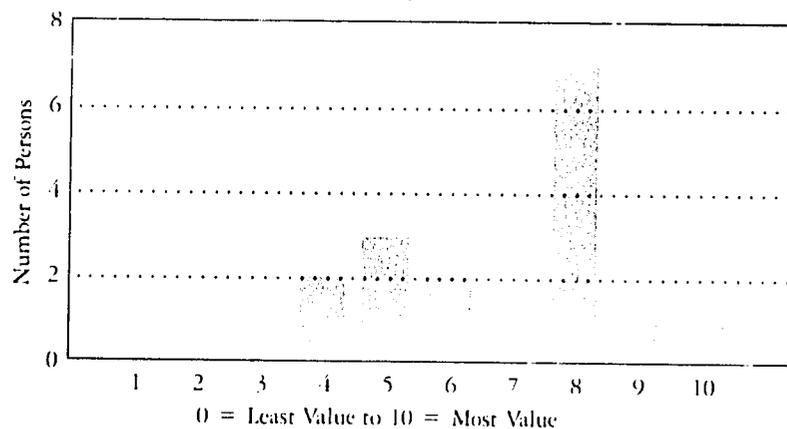
14 responses, 1 no answer

Value of Session on Training Field Staff
Lake Havasu Workshop 1988 PVO Participant Evaluation



17 responses, 1 no answer

Value of the Panel on "Sustainability"
Lake Havasu Workshop 1988 PVO Participant Evaluation



17 responses, 1 no answer

What have you learned from the Arizona workshop?

"The workshop gave me an opportunity to learn a bit about the structure and administration of the Child Survival Program, to learn about some of the technical support resources available through A.I.D. and collaborating organizations, to hear an update on some of the Child Survival technologies, and to get to know individuals working with other PVOs involved in Child Survival."

"The workshop sessions presented a number of good strategies or techniques to adapt for our programs as specific CS interventions."

"I gained some particular technical information on vitamin A and survey methodology that is helpful in my field support activities."

"I learned some about focus groups, growth monitoring, and promotion."

"More about how to deal with the support to the field personnel and interagency coordination."

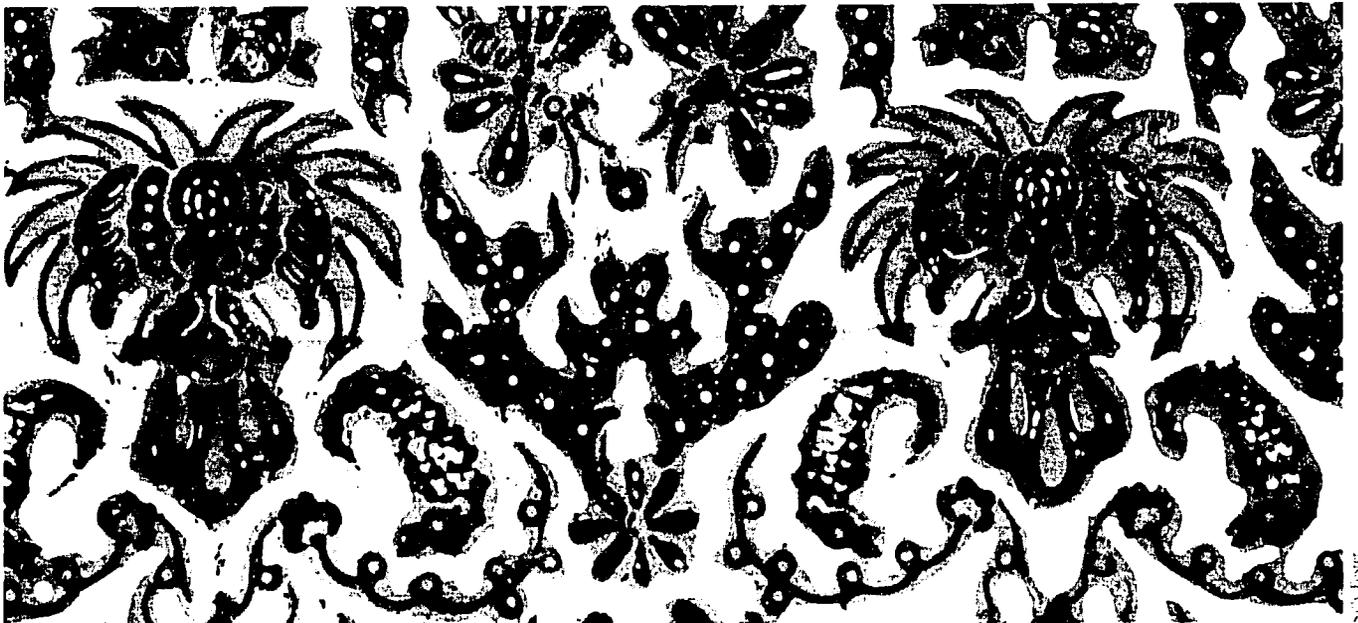
"The session on 'training' was by far the most important to me, for it was an issue I am concerned with at this time with our Child Survival projects"

"I learned specific guides for the training of local health workers and trainers and for ongoing monitoring evaluating."

"As a newcomer to the PVO network, it has given me an insight to what the different PVOs are doing and the problems we share. Most important, it left me with an admiration of the different PVOs for the dedication and enthusiasm with which they carry out their objectives in Child Survival."

"That a lot is going on in the PVO community to refine skills and improve CS programs; that we are not alone in facing some real challenges in that process; and that there seems to be a more positive climate for true cooperation among PVOs and between PVOs and A.I.D."

"I am much clearer now on the whole reporting system and it doesn't seem such a burden as it once did. I learned where some new technical resources are and how to get my hands on them. I learned a great deal about focus groups and communications. I learned to think very differently about sustainability and what we really need to be looking at in terms of long-term impact. But far beyond these scattered tidbits, I learned about the people who are backstopping Child Survival efforts and how to work more effectively with them."



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

"Strengthening our organization's own Child Survival initiative."

"It will change some of our procedures."

"I personally made several strong technical resource connections for my organization, which I think will continue over time."

"Keep me reminded and motivated about the value of this concept."

"First, personal contacts. Second, it dramatically improves our ability to use the USAID funds the way they are intended."

"Hopefully, the workshop will result in collaborative efforts among small groups of PVOs to address specific mutual technical problems and share solutions/recommendations with other PVOs."

"Reinforces collaborative projects among PVOs."

"Strengthen skills/collaboration among project backstop staff."

"Possible cooperation among PVOs for evaluations and resource sharing."

"Most importantly there will be more productive collaborative efforts to develop tools and resources for field efforts. I also think there will be more sharing of what we are doing, less reinventing of the wheel, and more support for one another."

"A broader, less provincial perspective will be the chief long-term effect for me personally."

"It does serve to facilitate communication between PVOs. Equally, the opportunity to meet the technical assistance groups provided insight into how they work and as to how best they might serve as programmatic resources."

"The workshop contributes to the larger network of PVOs and USAID."

"The workshop will continue to strengthen the working relationship between FVA/PVC and PVOs—as the workshop demonstrated the existence of a friendly and forthright channel of communication between the two. Among the PVOs, it has and will continue to strengthen the bonds and collaboration in common areas of interest."



1988 PVO EVALUATION OF LAKE HAVASU WORKSHOP

0 = Little value (or Very poor) to 10 = Excellent

	Average Rating	Number Persons
<i>Organization</i>		
• Relevance of workshop theme/objectives	9.0	17
• Degree to which workshop was organized	8.3	17
• Workshop schedule	7.8	18
• Pre-workshop communications	7.8	17
• Resource documents and materials	7.7	18
<i>Process</i>		
• Freedom to express any view	9.4	18
• Friendliness of atmosphere	9.4	17
• Degree to which cliques did not develop	8.7	17
• Acceptance of suggestions from participants	8.1	17
• Degree to which discussion kept to the topic	7.7	17
• Effectiveness of facilitator	7.4	17
<i>Special Events</i>		
• Value of Thursday evening Buffet Dinner	9.6	17
• Value of Resource Center activities	7.1	14
<i>Follow-up Action</i>		
• Degree to which PVOs believe that this workshop will lead to action	7.3	17
<i>Content</i>		
• Value of the PVO panel on sustainability "Maintaining Gains Made in Improving Child Survival and Health"	8.6	17
• Value of the PVO panel on "Lessons Learned in Backstopping CSI and CSII"	7.6	17
• Value of the plenary session on "Where Are We and Where Are We Going?"	7.2	13
• Value of the session on "Training Field Staff to Strengthen Implementation and Monitoring of CS Activities"	6.7	17
• Value of the PVO exercise "Next Steps"	6.7	10
• Value of the panel "Report on Four PVO CS Implementation Workshops"	6.6	14
<i>Small Group Presentation</i>		
Individual responses are shown when the number of respondents seems too small to permit meaningful averages.		
• Value of the 'Newcomers' session on "Reporting Requirements for CS Projects"	7.7	9
• Value of the 'Oldtimers' session on "Plans for Midterm and Final Evaluation"	(8,8,5,5,3)	
<i>Special Interest Groups</i>		
• "Conjunctival Impression Cytology Method to Detect Vitamin A Deficiency"	(10,9)	
• "Issues in Collaboration"	(10,8)	
• "Quick EPI Surveys" and "Beneficiary Input into Evaluation"	(10,9,9,7,6)	
• "Monitoring Immunization Activities and Determining Immunization Coverage"	(9,9,7,5)	
• "Growth Monitoring and Promotion"	(8,8,8,7,7,7)	
• "Surveillance of Nutritional Status Including Vitamin A Deficiency"	(8,8,8,7,7,7)	
• "Qualitative Assessments by Focus Groups"	(10,9,3,3)	
• "Monitoring and Evaluation of Programs for Household Diarrheal Disease Management"	(7,7,7,7,4,3)	

FOLLOW-UP ACTION

“For the most part, my expectations of the workshop were met. I was primarily interested in networking and building some collaborative strategies. I found overwhelming support for more joint efforts and a thorough willingness to share tools, materials, and ideas for common purposes. I believe this non-competitive mode will serve us all well.”

–PVO representative

PVO Task Force on CSI Final Evaluation

PVO Child Survival projects funded under AID/FVA/PVC's FY 1985 Child Survival Competitive Grants Program reached the end of their three-year grant period October 1, 1988. At the Lake Havasu workshop participants suggested that a PVO task force be formed to make recommendations on the final evaluation process for CSI projects. In response to this request, on April 11, 1988, the PVO Child Survival Support Office convened a daylong meeting at the Hyatt Regency Baltimore Hotel to obtain PVO input concerning the CSI final evaluation guidelines under deliberation by A.I.D.

The task force consisted of representatives from nine of the 13 PVOs receiving CSI funding. The attending PVOs were ADRA, CARE, CRS, PLAN, HKI, HOPE, SAWSO, SCF, and WVRD. Absent were ICC, IEF, MIHV, and PCI (both IEF and PCI communicated their recommendations by mail). Also in attendance were Ms. Hope Sukin of AID/FVA/PPM, and Dory Storms and Mr. Martin Garcia-Bunuel of the PVO CS Support Office, JHU. The facilitator for the meeting was Mr. Dale Flowers.



Nine priority recommendations were agreed upon by all the members of the task force. They concerned the questions:

- When should the evaluation take place?
- What will be evaluated?
- What are the core questions that should be addressed?
- Who should be the members of the evaluation team?

- Is there need for A.I.D.-funded technical assistance?

In addition, consensus was reached by approximately one-third of the group for 12 other priority recommendations.

The draft priority recommendations were circulated to members of the task force for revision and comments before being submitted to A.I.D. The broad scope of recommendations regarding the final evaluation was considered very helpful and the final guidelines incorporated much of the PVO input on approach, timing, team composition, and technical assistance.

BOLOGNA · THE JOHNS HOPKINS UNIVERSITY · USAID JUNE 1988



Lessons Learned Conference for Africa and Haiti CSI Projects

In response to the recommendations made at the Lake Havasu workshop to draw together the lessons learned by the Child Survival projects and disseminate those findings among the PVOs, JHU hosted a weeklong international conference of PVO staff at the university's facilities in Bologna, Italy.

The 1988 "Lessons Learned -- Africa, Haiti" Conference was held June 5-10 at The Bologna Center, Johns Hopkins University School for Advanced International Studies (SAIS). The conference focused on the lessons learned during the first two



and a half years of implementation of the Child Survival I projects located in the Africa region and Haiti. The projects are

ADRA/Haiti, CARE/Haiti, PLAN/Haiti, SA/Haiti, and International Child Care/Haiti

ADRA/Malawi, IEF/Malawi, ADRA/Rwanda, SA/Kenya, MIHV/Uganda, SCF/Zimbabwe, and W/V/Zimbabwe

One country national from each of 10 PVO Child Survival projects actively participated in the conference, under the sponsorship of the PVO Child Survival Support Program. Additionally, one U.S.-based representative from each of nine PVO Headquarter offices attended. Representatives from ADRA/Rwanda and IEF/Malawi Child Survival field projects, and IEF USA Headquarters were, regrettably, unable to attend the 1988 Lessons Learned Conference.

Conference activities included the presentation of papers on project accomplishments in relation to national health priorities and programming; small group discussion on lessons learned; formation of task forces to identify the most useful strategies for implementing key CS interventions. Conference participants identified key recommendations for

strengthening conduct and direction of the PVO Child Survival Program. A Resource Room displayed various materials developed by CSI projects.

Mr. Dale Flowers facilitated the conference. Collaborating agencies included the World Health Organization, USAID, The Johns Hopkins University School of Hygiene & Public Health, International Science & Technology Institute, and John Snow, Inc./Resources for Child Health.

Conference proceedings will be disseminated to PVOs, USAID, host governments, and NGOs working to improve health of mothers and children.

Task Force on Vitamin A Components of PVO CS Projects

As of September 1988 about one-quarter of the PVO Child Survival projects funded under AID/FVA/PVC's competitive Child Survival grants program have, or are planning, a vitamin A component. PVO field staff are given extensive guidelines for the key CS interventions of EPI, CDD, nutrition, and birth spacing, which govern project proposal development, the DIP, annual reports, midterm and final evaluation. However,

PVO project managers need guidelines to aid in planning, health information systems reporting, training, management, and operations of the vitamin A component of CS projects. The successful experience with the first task force on evaluations led to the decision to try a similar approach to obtain PVO input into vitamin A guidelines development.

Limited time and money prohibited a large scale meeting. Instead a small technical task force of professionals was formed. All the members had practical field experience with vitamin A deficiency assessment, as well as experience with the management and evaluation of vitamin A interventions in PVO CS field projects. On September 9, 1988, the Technical Task Force on Vitamin A met at the PVO Child Survival Support Office in Baltimore, in order to develop practical, field-based suggestions for guidelines that can be used by PVO Child Survival projects that have a vitamin A component.

The task force decided to take as a guide for discussion the questions that were raised by Lake Havasu workshop participants during the special interest session on assessing vitamin A deficiency.

The outcome of this meeting was to supply FVA/PVC with a broad scope of recommendations regarding objectives, indicators, and activities for vitamin A interventions in Child Survival projects. At the time of this writing, the draft recommendations were being circulated to task force members for editing. Once corrected, the recommendations will be given to FVA/PVC, and possible circulation to all U.S.-based PVOs with CS grants.

January 1989 Workshop for PVO Child Survival Support Staff

The next PVO Resources for Child Survival workshop will be held at Lake Junaluska, North Carolina, from January 9 through 11, 1989. Transferring lessons learned from past to future Child Survival projects will be a major theme. There will also be skills training in weighing and measuring infants and children.

PVO NEEDS FOR FOLLOW-UP ACTIVITIES

PVO representatives at the workshop were asked, "What are your needs and the needs of your technical colleagues at HQ for follow-up to this meeting?" The answers to that question are

found in the left-hand column. On the right are comments on action that has been taken since the workshop ended.

PVO Request	Response
Summary of the workshop with a list of the ideas presented for follow-up. Follow-up support from A.I.D. as determined.	Workshop report lists all recommendations from participants. Workshop report includes section on follow-up action.
The written technical papers were important in the follow-up in that they could be shared with those not attending the meeting. Perhaps additional information along this line is needed.	Workshop report includes bibliography of all technical papers distributed or referred to during the workshop.
It would be good to get a quarterly newsletter from Dory with updates on CS activities, i.e., regional workshop information, new materials being developed, possible training programs, etc.	Sorry, but insufficient time and staff to follow through on this request. Instead, have worked with NCIH Child Survival Action newsletter to make it more useful for PVO HQ and field staff.
Set up task force to focus on each intervention with members of appropriate PVOs (such as on growth monitoring with Freedom from Hunger, Save the Children, etc.) and appoint a facilitator to keep it on track. A task force on the final evaluation process could begin work now.	Task force on CSI final evaluation process was held in Baltimore in April 1988, and recommendations submitted to FVA/PVC. Final guidelines incorporated PVO input. In September 1988, a task force on vitamin A components of CS projects was convened, and draft outcomes are under review.
We need to stay in touch with working groups that were formed.	Good idea! Has it happened?
Would like to see examples of good midterm evaluation designs and project monitoring.	JHU will be pulling together examples of baseline surveys and midterms for distribution to PVOs this winter.
I continue to wish for more sharing of inter-PVO programmatic information, for comparison and to avoid needless duplication of effort, i.e., survey design, training modules, health education materials design. Perhaps the evaluations will provide more opportunity for that to happen.	This fall will see the distribution of inter-PVO information on regional approaches to sustainability; this winter we will summarize baseline and midterm designs. Also PVC has hired consultant to synthesize the lessons learned from this year's midterms—results to be shared at January 1989 PVO workshop.
We have already had a very important follow-up CS final evaluation meeting. Still needed would be some work on measuring training effectiveness, and I would hope, how to collate, disseminate and incorporate into new programming the lessons learned in the early projects.	Yes, input from final evaluation task force was very important in formation of A.I.D. guidelines. "Lessons Learned" Bologna conference in June 1988 disseminated information learned in the CSI Africa and Haiti projects. We need feedback from PVOs on their use of such information.
For true lasting impact, I wonder if there could not be some mechanism for small-scale clinics to be held periodically, maybe regionally. Limited size and focused content could allow only those truly interested in the workshop to get maximum benefit. The idea of having the health information systems attached to NCIH this year is in the right direction, but will be too large and too vague, as always.	Interesting idea. Will follow through on this at next workshop and inquire about "who, what, when, and where" PVOs could participate in such problem-oriented, in-depth small group presentations. Benefit would have to offset the cost of multiple regional activities. PVOs within a particular U.S. region would have to agree on the clinic's focused content. Need somehow to deal with the different levels of technical training.
Our biggest needs in beginning our projects are administrative rather than technical. Issues about how flexible we can be in expending funds, for instance, are our concern with developing our DIP.	Now that the new project officers are on board, Jake is hopeful that PVC can improve its work with you in clarifying contractual and administrative issues.
Timely and clearer guidelines on reporting requirements. Feedback on annual reports. Continued open channel of communication and support from FVA/PVC. Flexibility to adapt to overcome constraints in actual implementation of project.	PVC put considerable effort into simplifying CS V RFP and accompanying forms. New budget format. Annual CS reporting schedule reprinted in larger type, easier to read. Increased PVC staffing will make feedback on annual reports possible this year.
More of the same.	We can promise you more of the same that you like and find helpful, discarding what is not, and willingness to try out new suggestions. This learning process is mutual!

1988 ARIZONA WORKSHOP - PARTICIPANT LIST

PVO Representatives

- Dr. Gordon Buchler
Mr. Rudy Maier
Adventist Development and Relief Agency
6840 Eastern Ave., NW
Washington, DC 20012
(202) 722-6770
- Dr. Michael Gerber
African Medical & Research Foundation
420 Lexington Ave., Suite 244
New York, NY 10170
(212) 986-1835
- Mr. Alan Alemian
Ms. Alameda Harper
Africare
440 R Street, NW
Washington, DC 20001
(202) 462-3614
- Dr. William Steeler
Aga Khan Foundation
Suite 920
1800 K Street, NW
Washington, DC 20006
(202) 293-2537
- Dr. Henry B. Perry
Andean Rural Health Care
P.O. Box 216
Lake Junaluska, NC 28745
(704) 452-3544
- Ms. Helen Bratcher
Ms. Grace Hauck
Catholic Relief Services
1011 First Avenue
New York, NY 10022
(212) 838-4700
- Ms. Sue Toole
Ms. Catherine McKaig
Primary Care Unit CARE
660 First Avenue
New York, NY 10016
(212) 686-3110
- Dr. William Dolan
Esperanca, Inc.
1911 West Earll Drive
Phoenix, AZ 85015
(602) 252-7772
- Dr. Victor Lara
Dr. David A. Goldenberg
Foster Parents Plan International
804 Quaker Lane
East Greenwich, RI 02818
(401) 826-2500
- Ms. Susan Eastman
Ms. Anne Ralte
Helen Keller International
15 West 16th Street
New York, NY 10011
(212) 807-5800
- Ms. Patricia Chiancone
International Eye Foundation
7801 Norfolk Avenue
Bethesda, MD 20814
(301) 986-1830
- Mr. Jim Becht
Ms. Karen Woodbury
Freedom from Hunger Foundation
PO Box 2000
Davis, CA 95617
(916) 758-6200
- Dr. Neil Nickerson
Minnesota Int'l Health Volunteers
122 West Franklin Ave., Rm. 440
Minneapolis, MN 55404
(612) 871-3759
- Mr. David Wilson
Ms. Ellen Vor der Bruegge
Project Concern International
3550 Afton Rd.
San Diego, CA 92123
(619) 279-9690
- Dr. Harold Royalty
Project HOPE
Health Sciences Ed. Ctr.
Carter Hall
Millwood, VA 22646
(703) 837-2100
- Ms. Marcia Rock
Rotary International
Polioplus Program
1560 Sherman Avenue
Evanston, IL 60201
(312) 866-3343
- Ms. Mona Moore
Salvation Army World Service Office
1025 Vermont Ave., NW
Suite 305
Washington, DC 20005
(202) 737-3330
- Dr. Gretchen Berggren
Dr. Michelle Denize
Save the Children Federation
54 Wilton Road
Westport, CT 06880
(203) 226-7272
- Dr. Howard Searle
World Relief Corporation
PO Box WRC
Wheaton, IL 60189
(312) 665-0235
- Mr. Mark Publow
Ms. Leslie Hornung
World Vision Relief and Development, Inc.
919 West Huntington Drive
Monrovia, CA 91016
(818) 357-7979
- Workshop Staff and Consultants*
- Dr. Gerold van der Vlugt
Child Survival & Health Coordinator
USAID/FVA/IVC
Room 327, SA-8
Washington, DC 20523
(703) 235-3494
- Ms. Suzanne Reier
Workshop Facilitator
Institute for Health Policy Studies
210 High Street
Santa Cruz, CA 95060
(415) 621-0109 (b)
- Dr. Mary Anne Mercer
Dr. Dory Storms
Workshop Organizers
Dr. Anne Gadomski
PVO Child Survival Support Program
Institute for Internat. Programs
Johns Hopkins School of Hygiene
103 East Mount Royal Avenue
Baltimore, MD 21202
(301) 659-4100

Ms. Jean Pease
*Child Survival Reporting System
International Science and
Technology Institute (ISTI)
Suite 1001
1601 North Kent Street
Arlington, VA 22209
(703) 524-5226*

Dr. Richard Arnold
*REACH consultant
PO Box 156
Hayford, AZ 85615
(602) 366-5553*

Dr. Jeannine Coreil
*PRITECH consultant
415 Belle Claire Ave.
Temple Terrace, FL 33617
(813) 974-4860*

Ms. Mary Harvey
*REACH consultant
9th Floor, 1100 Wilson Blvd.
Arlington, VA 22209
(703) 528-7475*

Ms. Peggy Koniz-Booher
*GROWTHTECH consultant
Academy for Educational
Development
1255 23rd Street, NW
Washington, DC 20037
(202) 862-1900*

Dr. Charles Teller
*GROWTHTECH consultant
International Nutrition Unit
Logical Technical Services
Chery Chase, MD 20815
(301) 951-3601*

**Addresses have been updated to reflect changes
since the workshop occurred.*



Diakane B. B. B.

Back row (l to r): R. Arnold, H. Perry, V. Lara, H. Royalty, J. Becht, R. Maier, W. Dolan, A. Gadomski, H. Searle, D. Wilson, M. Gerber, E. Vor der Bruegge, M. Rock, M. Mercer, C. McKaig, J. Pease, G. Buchler, K. Woodbury, S. Reier; Middle row (l to r): D. Goldenberg, P. Chiancone, C. Teller, N. Nickerson, G. van der Vlugt, S. Toole, A. Alemian, H. Bratcher, A. Harper; Front row (l to r): D. Storms, P. Koniz-Booher, L. Hornung, A. Raalte, M. Harvey, M. Moore, M. Denize, S. Eastman, G. Berggren, G. Hauk.