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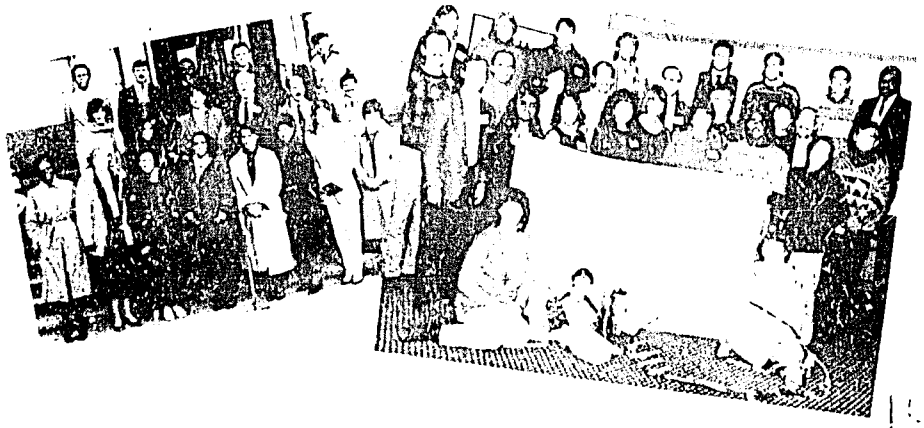

1989

1990

The Changing Context of Child Survival

1993

1992

7th Annual PVO Resources for Child Survival Workshop

January 26–28, 1994

Marriottsville, Maryland

1994

Principles of Community Oriented Health Care

Population Based

Problem Focused

Capacity Building (Empowerment)

- *Community Competence*
- *Organizational Management*
- *Individual Leadership*

Effective Partnerships

- *Between health professionals and community members*
- *Between organizations involved (networks and coalitions)*

Monitored for Equity of Outcomes

This workshop was organized by the PVO Child Survival Support Program, Department of International Health, The Johns Hopkins University, School of Hygiene and Public Health. Funding provided by the United States Agency for International Development, Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation under contract #OP/A/FAO-93-P-001.

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Dear Colleague,

This year, as a group, we have examined the evidence for impact of the PVO Child Survival grants program funded by BHR/PVC. The presentations at the worldwide conference in Bangalore documented that "PVOs, through their diversity of background and experience, are providing innovative cutting-edge inputs into improving the health, child survival, and quality of life of vulnerable populations." As further noted by USAID, the PVOs' "strength emanates from a decentralized, community-oriented approach and from their underlying commitment to address the issues of equity through their diversity of focus, size, human resources, and operational strength."

Behind these impressive accomplishments are many people: the dedicated field worker; the man or woman who donated time to their village health program; the USAID project officer making sure the paperwork gets through so that project funding can continue unimpeded; the person who helped write the proposal, or joined the midterm evaluation team; the technical reviewer of DIPs and proposals and curricula who carefully studied strengths and made recommendations to remedy any concerns; the CSSP staff member and PVO colleagues working together on a field-based regional workshop for field staff; the KPC trainer laboring to make the process of the 30 cluster understandable to new PVO managers; the technical person who backstopped the project from the USA offices, and spent hours in flight time to check on projects, interpret guidelines, upgrade quality. People make programs. Good programs are good because the people in them are first-rate.

Just as new people have entered the PVO Child Survival programs, they have moved on, only to be replaced by others just as dedicated, enthusiastic, and talented. The pictures on this report's cover remind us of the many people who have worked together since 1985 to strengthen the quality, coverage, and sustainability of PVO Child Survival programs. The legend on the opposing page reminds us that these people all made those principles of community-oriented health care the core of their work—despite the fact the projects are in vastly different locations, at different points in time, sponsored by a diversity of private voluntary organizations, and brought to life by people largely unknown to each other.

Recently, there have been important changes in USAID, in the PVOs, and in the problems and diseases in developing countries. (This report is dedicated to covering those changes.) But the commitment remains to programs that promote community participation, partnership, and empowerment and can achieve measurable results. It is a pleasure to work with the PVOs; you are unique—congratulations!

Dory Storms, Director
PVO Child Survival Support Program

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Workshop Planning and Preparation

"These events help those of us who do not have an institutionalized Child Survival unit to keep apace, exchange information, and coordinate program activities."

—PVO Representative

Background

As of January 1994, 21 US-based private voluntary organizations (PVOs) were carrying out Child Survival projects in 22 countries in Africa, Asia/Pacific, and Latin America/Caribbean regions. These projects are funded by the United States Agency for International Development, Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (USAID/BHR/PVC). Since 1985, PVO staff who backstop field projects have participated in the annual PVO Resources for Child Survival workshop. The workshops are funded by USAID/BHR/PVC as part of its Child Survival technical strategy. PVOs have found that these workshops offer an important forum to network and to share information and experiences with each other.

The seventh annual workshop was held in Marriottsville, Maryland, on January 26-28, 1994, and built on the experience of the six previous annual workshops held in Baltimore, Maryland (1986); Lake Havasu, Arizona (1988); Lake Junaluska, North Carolina (1989); Aliso Creek, California (1990); Berkeley Springs, West Virginia (1991); and White Fish Lake, Minnesota (1992). Participating in this workshop for PVO headquarters staff were 29 technical staff from 19 PVOs and three field representatives. All are responsible for overseeing the design, implementation, and evaluation of Child Survival field projects. The workshop organizing team consisted of the facilitator, Dale Flowers; the workshop coordinator, Cynthia Carter; the workshop assistant, Sudha Sivaram; and the director of the PVO Child Survival Support Program, Dr. Dory Storms.

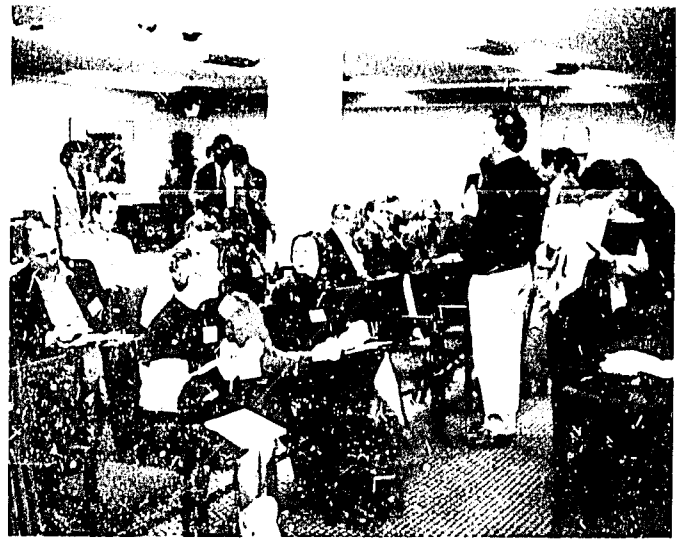
Needs Assessment

Planning for the 1994 workshop began with an analysis of needs as identified by PVOs. Organizers used this information to develop workshop sessions. Many of the needs expressed by the PVOs related to changes within their organization and how they affect their Child Survival programming. PVO staff also wished to learn about the changes taking place at USAID and how these changes affect the implementation of USAID's Child Survival Program. Another topic PVOs were interested in concerned health information systems, including quality assurance and surveillance methods. The PVOs also raised technical concerns, how best to strengthen the newer interventions—pneumonia control and HIV/AIDS prevention. Based on these needs, organizers chose the theme "The Changing Context of Child Survival" for the workshop.

Workshop Goals

The following goals emerged from the needs assessment, project evaluations, and experiences from earlier workshops:

- Explore new developments at USAID and PVO/USA offices affecting Child Survival.



- Examine progress of Child Survival projects based on findings from detailed implementation plan (DIP) technical reviews, midterm and final evaluation reviews, and the pneumonia control curriculum review.
- Present reports from task force advisory groups.
- Develop recommendations to guide strengthening of field projects, USAID-PVO collaboration, and CSSP technical support.

Participants

Participants gathered at Bon Secours Retreat Center in Marriottsville, Maryland, January 26, 27, and 28, 1994. This location enabled Catholic Relief Services, a Baltimore-based PVO, to host the workshop's opening reception. Also PVC project officers and PVO CSSP staff were able to visit the workshop site daily since Marriotsville lies within driving distance from Baltimore and Washington, D.C.

Twenty-nine staff from 19 PVOs were in attendance, including three representatives from CARE/Guatemala, PLAN/Guatemala, and Counterpart/Fiji field offices. Fifty percent of the participants were considered new PVO staff since they had assumed their positions no more than 12 months prior to the workshop, and had not attended a previous PVO/HQ Resources for Child Survival workshop.

PVO needs assessment emphasized the desirability of USAID representation at the workshop. Representatives from USAID included Dr. Robert Wrin, Office of Program Development and Strategic Planning, Global Bureau; John Grant, director of Program Planning and Evaluation/BHR; Lou Stamberg, director of the Office of Private and Voluntary Cooperation/BHR; Rose Miles Robinson, chief of the Child Survival and Health Unit/PVC/BHR; and three PVC project officers, Cathy Bowes, Julia Escalona, and Jaime Henriquez.

Other honored guests included Dr. Alfred Sommer, dean of the School of Hygiene and Public Health, Johns Hopkins Uni-

7th Annual PVO Resources for Child Survival Workshop

Bon Secours Retreat Center, Marriottsville, Maryland
"The Changing Context of Child Survival"
January 26–28, 1994

Wednesday, January 26
Theme of the Day—What Is New?

8:00 Breakfast

8:45 Workshop Opening

9:00 Panel: "The Changing Context of Child Survival"

Moderator: Rose Miles Robinson

Dr. Alfred Sommer: "Acute and Emerging Infant and Child Problems"

Dr. Robert Wrin: "USAID's Child Survival Initiative"

Barbara Heiser: "Support Strategies for Mother and Fathers"

John Grant: "The PVO–USAID Relationship"

Gerald Mills: "Towards Diversity in Community Development"

Open Discussion

10:30 Signing of the International Declaration of Health Rights in Resource Room

11:15 Changes at PVO USA offices—WV, SC, CARE

12:00–1:00 Lunch

1–1:30 Resource Room Open

1:30 Changes at PVO USA offices—ADRA, PCI, HOPE, PLAN, Africare

2:10 Changes at PVO USA offices—HKI, IEF, WRC, MHHV, AMREF

2:45 Coffee / Tea Break

3:00 Changes at PVO USA offices—ARHC, CRS, Counterpart, AKF,

3:40 Changes at PVO USA offices—LLLI, PSI, FHI

4:00 National Networking and Collaboration among PVOs

6:00 Dinner

7-9:00 "Communicating Health Messages"—Black Cherry, Inc.

Thursday, January 27
Theme of the Day—
A Slice in Time

8:00 Breakfast

8:45 Opening Session

9:00 "PVC's Child Survival Program: Constraints and Opportunities"—Rose Miles Robinson

10:00 Coffee / Tea Break

10:30 Meet with CS Project Officers—Small group discussions with project officers Julia Escalona, Jaime Henriquez, Cathy Bowes

12:00–1:00 Lunch / Resource Room Open

1:00 "PVO Progress in Child Survival: Where are we?"—Dr. Dory Storms

Open Discussion

2:00 Action Recommendation for Technical Problem Areas

Small Groups

3:30 Coffee / Tea Break

4:00 Small Group Work on Communicating Health Messages

6:00 Dinner

7-9:00 Child Survival Videos in the Resource Room

Friday, January 28
Theme of the Day—Next Steps

8:00 Breakfast

8:45 Opening Session

9:00 Presentation of Messages about PVO Child Survival Program Partnership

10:00 Coffee / Tea Break

10:15 Reports from Advisory Task Force Groups

11:15 Review of Workshop Recommendations

11:45 Wrap-up

12:00–1:00 Lunch

1:00 Breakdown Resource Room

2:00 Tour of PVO CSSP Offices

versity; Barbara Heiser, board member of La Leche League International; and Gerald Mills, private consultant, formerly director of Save the Children Baltimore. Finally, Michael Lamason, Black Cherry Inc., worked with the participants during the evening sessions on community education and empowerment through the art of puppetry.

Process and Content

The workshop sessions emphasized participatory learning, following the principles of adult learning. The workshop process included small group discussions, panel presentation, and group work. Each day had a specific focus as was reflected in the content and design of sessions. On Day One, the group examined "What is new?" with the presentations from the opening panel. Speakers covered topics ranging from acute and emerging child health problems to the PVO-USAID relationship. That afternoon, a representative from each PVO gave a short talk on changes at their PVO-USA offices and an update on networking and collaboration with other PVOs.

Day Two focused on "A slice in time." The morning centered on the opportunities and constraints of PVO's Child Survival program and the reorganization within USAID. In the afternoon, Dory Storms updated the participants on PVO progress in Child Survival as reflected in findings from midterm and final evaluations. Then, small work groups developed action recommendations for technical problem areas. As is common on the last day of the workshop, participants focused on "Next steps," with a review of all recommendations that had been developed during the previous two days.

International Declaration of Health Rights

This year, the PVOs had the opportunity to sign a unique document, the PVO participants and workshop guests signed the International Declaration of Health Rights, a scroll clearly detailing the principles of equity in health coverage throughout the life span of all sexes, races, and nationalities. It was created by the faculty, students, and alumni of The Johns Hopkins University School of Hygiene and Public Health on the occasion of the school's 75th anniversary, and has since circled the globe many times and has been signed by dignitaries from WHO, UNICEF, the US state and federal governments, and public health leaders of many countries.

International Declaration of Health Rights

We as people concerned about health improvement in the world, do hereby commit ourselves to advocacy and action to promote the health rights of all human beings.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. It is not a privilege reserved for those with power, money or social standing.

Health is more than the absence of disease, but includes prevention of illness, development of individual potential, a positive sense of physical, mental and social well being.

Health care should be based on dialogue and collaboration between citizens, professionals, communities and policy makers. Health services should be affordable, accessible, effective, efficient and convenient.

Health begins with healthy development of the child and a positive family environment. Health must be sustained by the active role of men and women in health and development. The role of women, and their welfare, must be recognized and addressed.

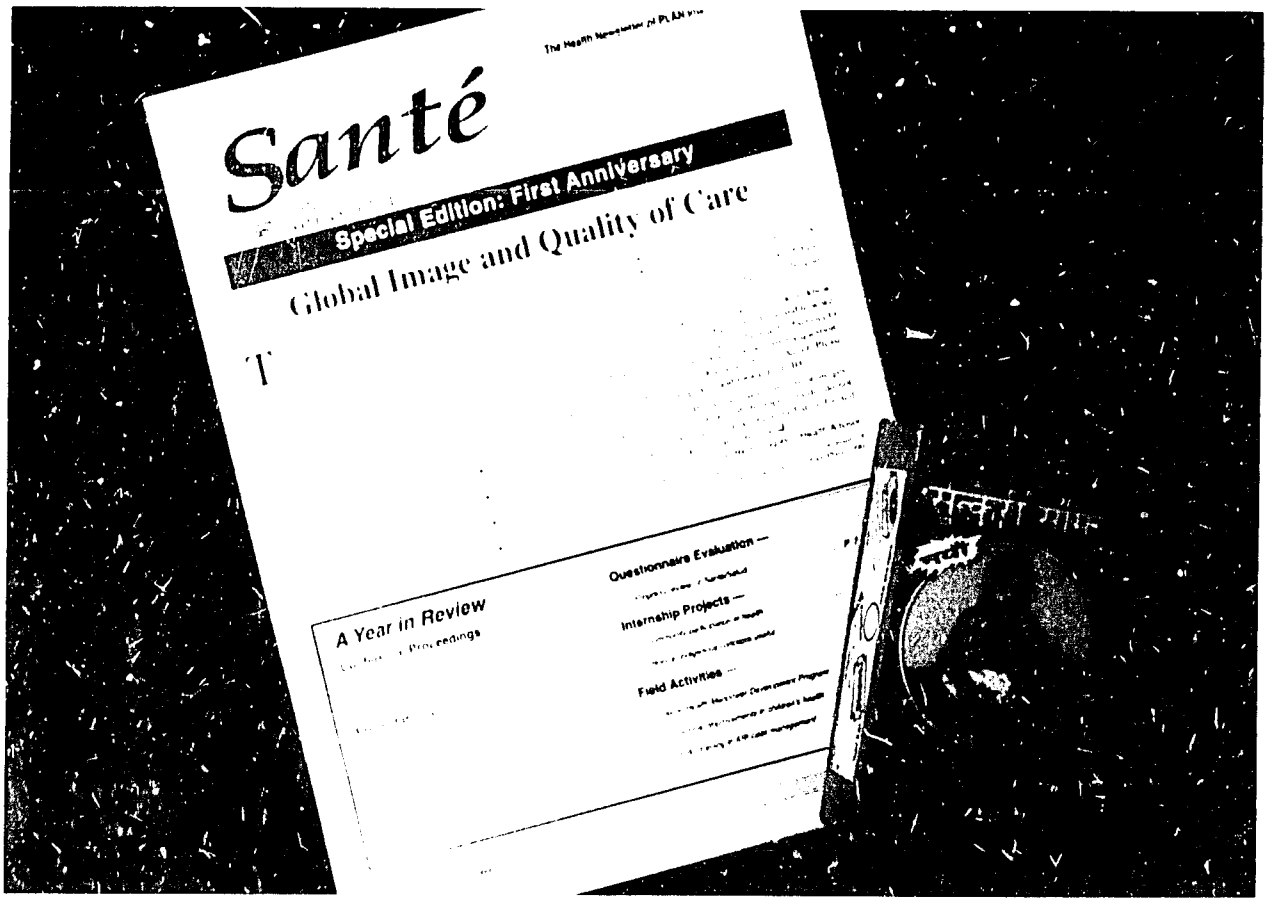
Health care for the elderly should preserve dignity, respect and concern for quality of life and not merely extend life.

Health depends on the availability to all people of basic essentials: food, safe water, housing, education, productive employment, protection from pollution and prevention of social alienation.

Health depends on protection from exploitation without distinction of race, religion, political belief, economic or social condition.

Health requires peaceful and equitable development and collaboration of all peoples.

Created on the occasion of the 75th Anniversary of The Johns Hopkins School of Public Health, April 23, 1992.



Materials Displayed at the Resource Center

PVO participants brought resource materials to share with each other in the resource room, which also contained the International Declaration of Health Rights. The following materials were on display:

Resource Room List

Aga Khan Foundation

Primary Health Care Management Programme

- Computers: Manager's Guide
- Problem Solving: Manager's Guide
- Better Management 100 Tips: Manager's Guide
- User's and Facilitator's Guides
  - Assessing Information Needs: Module 1
  - Assessing Community Health Needs and Coverage: Module 2
  - Planning and Assessing Health Worker Activities: Module 3
  - Surveillance of Morbidity and Mortality: Module 4
  - Monitoring and Evaluating Programmes: Module 5
  - Assessing the Quality of Service: Module 6
  - Assessing the Quality of Management: Module 7
  - Cost Analysis: Module 8
  - Sustainability Analysis: Module 9

Annual Report, 1992

Project Briefs

Northern Pakistan Primary Health Care Programme

Urban Primary Health Care Programme

Rural Development Programme

Kisumu Primary Health Care Project

Andean Rural Health Care

"ARHC's Census-based, Impact-oriented Approach to Child Survival" by Dr. Samuel Ofosu-Amash

Report of an Expert Review Panel to the United States Agency for International Development, January 1994

"The Census-based, Impact-oriented Approach and Its Application by Andean Rural Health Care in Bolivia, South America" by Henry B. Perry III

Final Report to the United States Agency for International Development
Andean Rural Health Care

Grassroots: Building Healthy Families

Opening Doors to Health in Bolivia

Promoting Hope through Health in the

Rural Areas of Bolivia

Catholic Relief Services

Giving Hope to a World of Need
US Catholic Conference

A CRS Chronicle: 50th Anniversary

International Eye Foundation

Fact Sheet, 1993-94

Proyecto de Vitamina A
Para La Supervivencia Infantil Vitamin A

Annual Report 1992

Eye to Eye, Winter 93-94

Eye Care for Developing Nations
Larry Schwab, Second Edition 1990

PLAN International

Santé Salud

The Health of the African Child: The Role of PLAN International, No.2, Summer 1993

Focusing on: HIV/AIDS, Winter 1994

Proceedings of the "Africa's Progress in Child Survival" Conference, Dakar, Senegal, March 29 - April 3, 1993

Strategy for Primary Health Care

Policy on Children Directly or Indirectly Affected by HIV/AIDS

Organizational Overview—1993

Special Report: Surviving Under Fire—June 1993

Child Survival Programs

Keeping Delhi's Children Healthy

"Special Report: Jumpstarting Development" by James Grant *Foreign Policy Magazine*, August 1993

"Training and Practice Supervision Success" *ARI News*, Issue 26, Aug/Oct 1993

Project HOPE

Supervivencia Infantil

Manual Para Personal Voluntario

Population Services International

Marketing Items: condoms, T-shirts, pens, calenders

World Vision Relief and Development

Mobilizing NGO Resources for HIV/AIDS Prevention and Care, Uganda Child Survival Workshop at Lake Katwe, July 3-11, 1993

The Workshop

"A long-term effect of the workshop is that we continue to build networking relationships and share lessons learned."

—PVO Representative

Child Survival: What is new?

The first day focused on changes taking place at donor agencies and centrally funded Child Survival PVOs. Each PVO presented a summary of changes that had taken or were taking place within their organizations.

Opening Panel: The Changing Context of Child Health Survival

The following excerpts are from opening panel presentations.

Acute and Emerging Infant and Child Problems

Dr. Alfred Sommer, dean of the School of Hygiene and Public Health, pointed out in his opening remarks that enormous progress has been made in improving the lives of children and mothers. This progress he attributed in large measure to "inspirational marketing by James Grant and others" and "financial commitment from donors like USAID." The Children's Summit, the Micronutrient Program, and the Hunger meeting at Montreal marked milestones in focusing worldwide attention on child health concerns.

However, despite significant progress in child survival, there are many challenges that the child survival community has to face to sustain achievements already made. One factor is the worldwide recession that has resulted in reduced funds for some assistance programs. USAID funding declined 25 percent in recent years. The other most important challenge is the pandemic of AIDS. The impact of HIV/AIDS on children is staggering. Children born with the disease are ironically the lucky ones, as they will die, compared to millions of children who are born uninfected and lose their parents and caretakers to AIDS. The PVO community has to think hard about these challenges.

USAID's Child Survival Initiative

Dr. Robert Wrin, Office of Program Development and Strategic Planning, Global Bureau, spoke about the contribution of the United States to global child survival initiatives.

Reorganization within USAID will result in greater emphasis on four strategic areas of interest in funding development efforts worldwide.

- Population, Health, and Nutrition
- Sustained Economic Development
- Environment
- Democratization

The intent is to establish a global bureau in Washington, D.C., that will coordinate these issues across regional bureaus and missions. Its purpose is to bring together all of USAID in a unified, technically sound strategy. Child Survival efforts are seen to support these strategies. For example, one of the major elements supporting population control is child survival and maternal health. Also, a good Child Survival program has a strong impact on sustainable economic development. He acknowledged that any effort that helps children survive the first five years of their life in good health is undoubtedly a worthwhile investment.

USAID-PVO partnerships have increased importance in the new development strategy articulated by USAID. PVOs have a good record in making a difference at the grassroots level, and Dr. Wrin predicts that USAID will work much closer with PVOs.

Support Strategies for Mothers and Fathers

Barbara Heiser, board member of La Leche League International, stressed the importance of support groups in facilitating behavior change at the community level. Increasing urbanization and decreasing familial contact are but some factors that influence health behavior. In such changing times, support is very important. Mother-to-mother support, the concept of one mother sharing experiences and supporting another mother in breastfeeding, is based on the fact that breastfeeding is a normal, non-medical female function. Mothers are respected for their skills and for their ability to give information and act upon it for the betterment of their children and themselves. All mothers want the best for their children. A unique aspect of the support group is that its dynamics create an environment that is independent of health professionals. Mothers, fathers, and the community can start and sustain support groups. The result is a sense of communal concern that nurtures and reinforces positive parental skills.

The role of mother support groups is especially important in the context of child survival. Mother support groups serve as focus groups and can be used to do a needs assessment. The group can be used to monitor and evaluate a program to see if it is reaching and having the desirable outcome. They are excellent settings for introducing or adding initiatives. Women in support groups are empowered to reach out and extend beyond the group according to their own needs and desires.

USAID-PVO Relationship

John Grant, director of the Office of Program Planning and Evaluation/BHR, emphasized the importance of the USAID-PVO partnership. PVOs and local USAID missions have the opportunity to work very closely in enhancing community health and can work together with local NGOs and in-country institutions. This approach is crucial in building local capacity a sound strategy for sustainability.

Mr. Grant congratulated PVO participants on their in-country efforts and encouraged them to work closely with local USAID missions. He also made the following recommendations:

- Understand mission strategy and assist USAID local missions in formulating new strategies that will better enable achievement of goals and objectives.
- Demonstrate ability to achieve results and objectives in-country.
- Work with local NGOs and build institutional strength and local capacity.
- Develop innovative funding mechanisms in the light of limited resources and increasing demand.
- Food-aid PVOs should streamline their approach.
- Review USAID's strategy papers and develop project objectives in the context of those strategies.

In closing, Mr. Grant pointed out that the Child Survival Initiative is considered a big success story, especially PVOs' achievements.

Towards Diversity in Community Development

Gerald Mills, an independent consultant involved in community development in Baltimore and overseas, spoke about issues relating to diversity. The communities served by most PVOs are very diverse. This is a challenge, and provides PVOs a unique opportunity for innovative approaches to community development. Hiring staff who are from different backgrounds and races brings in various cultural perspectives and experiences, thus enriching the process of service delivery to all communities.

Changes at the Private Voluntary Organizations

A representative from each PVO gave a short talk on changes in their organization that affect Child Survival programming.

Adventist Development and Relief Agency (ADRA)

Dr. Jerald Whitehouse, Senior Advisor of Health

ADRA headquarters consists of three major divisions:

1) Program (management and technical aspects of ADRA's work)

2) Operations (deals with financial operations)

3) Communications (involved in corporate development)

The last two divisions are undergoing restructuring to facilitate more cross-sectoral task force function.

African Medical and Research Foundation (AMREF)

Lewis Heyman, President

1993 was a year of transition for AMREF/USA. Lewis Heyman assumed the position of president at the beginning of August. Additionally, a search was carried out in the fall for a new accounting manager. Ana Laura Lopez joined AMREF late last year.

AMREF has one Child Survival project in Kenya and one in Uganda. The Kenya project came to an end in March 1994, while the Uganda project has two years remaining. AMREF is working on the development of a Child Survival project in Kisumu, Kenya.

Aga Khan Foundation (AKF)

Pat Scheid, Program Officer

The foundation will focus more sharply in the 1990s on developing health systems that respond to the needs of the poor and underserved communities. In programmatic terms, this means that AKF programs will attempt to integrate efforts to improve socio-economic status (such as promote higher incomes and educational levels for women) and health status. More emphasis will be placed on environmental health and the importance of clean drinking water and sanitation.

AKF has also now completed a major effort, the PHC MAP. Two factors in international health prompted the development of PHC MAP. The findings of the *Evaluation of the Strategy for Health for All by the Year 2000*, a 1987 WHO report, which stated, "the main constraint reported by practically all countries is inadequate information for the managerial process... the information generated by the traditional health system is, in most countries, quite insufficient," and the move in many developing countries is towards decentralization of PHC management, placing new responsibilities on PHC managers at the local level.

Therefore, AKF undertook this project with PRICOR, with the ultimate goal of enabling PHC management teams to collect, process, and interpret information needed to improve the coverage, effectiveness, equity, and efficiency of their health care programs.

Andean Rural Health Care (ARHC)

Dr. Henry Perry, Program Advisor

Henry Perry, founder and current program advisor of ARHC, spoke about new developments in ARHC, which celebrated its 10th anniversary in 1995. Since the last PVO HQ workshop in Minnesota, ARHC has made exciting progress in developing and sustaining quality programs of child survival that can serve as models for future efforts by other organizations. In addition, they are learning from others. Three ARHC staff traveled to the well-known Jamkhed Community Health Project in India, established by Raj and Mabele Arole, to learn in depth about the Jamkhed Project.

ARHC has completed a three-volume document describing their census-based, impact-oriented approach and their experience with it. Henry Perry described other changes taking place. A Bolivian board of directors is now in place and functioning. ARHC's sister PVO in the Cochabamba region of Bolivia, Association of Rural Health Programs (ASPAR), has started to take steps to become semi-independent and diversify its funding base.

Catholic Relief Services (CRS)

Lori Pearson, Public Donor Liaison

The appointment of a new executive director is a major change at CRS. One of CRS's new initiatives was to decentralize the headquarters operations, which meant moving regional directors and many desk officers overseas. The goal is higher level of decision making at the field level, where information is more readily available and where the focus is on the beneficiaries.

CRS has also established a Congressional Liaison Unit, which will be more proactive on Capitol Hill regarding foreign aid issues. CRS has now renewed its membership with InterAction. The headquarters technical unit at CRS has authorization to create a pilot office on environmental issues that will be established in the coming months. The initial focus will be on Latin America and Caribbean regions, and will expand to other regions as experience and lessons learned grow.

CARE

Kathy Tilford, Director PHC

In September 1995, CARE relocated its USA headquarters from New York City to Atlanta. One result of the move was that the entire PHC unit (director and program officer) were new to headquarters.

The Program Division at CARE, of which Primary Health Care is a part, is in the process of conducting a critical review of past and present activities, looking at relevance, effectiveness, and impact. Results of this analysis will undoubtedly have a significant impact on future directions of CARE's health and nutrition programs.

Within CARE, there is a mandate for diversity and shared power, creating relevant and responsive management structures and a strategic focus for maximum impact. There is also clear consensus on the "household" as a unit of impact.

Counterpart Foundation, Inc.

Willis Eschenbach, Regional Health Officer

This PVO changed names last year from Foundation for the Peoples of the South Pacific, to Counterpart Foundation, Inc., and the U.S. headquarters transferred from San Diego to Washington, D.C.

There is now a new program office for Ukraine, Belarus and Moldova, and a new Moscow office has opened in collaboration with Russian Care, a Russian NGO. Counterpart has also expanded relationships between American and Central Asian Republic NGOs through a team trip to Kazakstan and Kyrgyztan.

Helen Keller International (HKI)

Nancy Haselow, Director of VITAP

Programs of HKI have seen a gradual evolution over the years. Seventy-nine years ago, rehabilitation of the blind was the primary focus. This shifted slowly to prevention of blindness and vitamin A interventions. There was a further change to integrate vitamin A with Child Survival initiatives, and now there is increasing focus on micronutrient and general family health.

The Vitamin A Technical Assistance Project (VITAP) served as a vehicle to provide assistance to PVOs and is now helping local NGOs to integrate micronutrients into existing programs, thus building local NGO capacity. HKI has also increased their focus on decentralization to provide more technical assistance at the field, regional, and local levels.

PLAN International

Dr. Remi Sogunro, Child Survival Project Advisor

Despite significant changes at headquarters, the health staff are still in place and are increasing in number. Unprecedented technical assistance was provided to the field offices in the form of visits by headquarters staff and consultants and collaborations with other PVOs, PVO CSSP, JSI, and CDC. Field office staff also attended technical courses and workshops, and received newsletters, policy documents, and videos related to health. PLAN has integrated Child Survival activities into existing development activities. One such example is that development workers are being used to provide Child Survival activities.

Project HOPE

Dr. Bettina Schwethelm, Director MCH Programs

In the past two years, Project HOPE experienced a number of changes that have affected its maternal and child health activities. William B. Walsh, Jr. was named Project HOPE's president and chief operating officer in September 1991, and was appointed as the chief executive officer in September 1992. Robert K. Crone, M.D., serves as the senior vice president for medical operations in the International Health Education Division. Julianne Guy, MPH, joined Project HOPE as assistant director of MCH Programs Child Survival. Juana Rodriguez took on responsibility for Project HOPE's health banks that complement Child Survival activities in Honduras and Ecuador.

Like other PVOs, Project HOPE is increasingly developing non-governmental funding sources worldwide for programs that traditionally were funded by USAID. An International Advisory Board was established in 1991 for the purpose of fundraising for programs in Europe and the Newly Independent States. In 1993, Project HOPE forged a partnership with Chevron Oil to develop clinical and public health programs in Atyrau, Kazakstan.

Over the past two years, MCH programs that are predominantly non-clinical and that focus on major public health concerns and health promotion have begun to assume a more important role at Project HOPE. The scope of MCH activities has also broadened considerably.

International Eye Foundation (IEF)

Jeff Brown, Child Survival Coordinator

IEF is dedicated to the support and implementation of prevention of blindness programs in Eastern Europe, Africa, Central America, and the Caribbean. Implementation programs promote ocular health, child survival, and micronutrient promotion and support. Programs also address the problem of onchocercasis.

IEF has received Child Survival program extensions in Guatemala and Honduras. They are also the recipient of matching grants to support development of private sector ophthalmology in rural underserved areas and to locate and treat visually impaired children. And IEF has had a contract with VITAL to support and assist the Honduran Ministry of Health with the development and implementation of the national program for the prevention and control of micronutrient deficiencies.

Dr. Hernandez Polanco, formerly with IEF, is now the minister of health in Guatemala. With Dr. Polanco's rise to the position of minister and his interest in community-based activities, it is hoped that many Child Survival interventions will be sustained by the MOH.

La Leche League International (LLLI)

Rebecca Magalhaes, Director IAD Department
Betty Crase, Manager of Breastfeeding Resource Library and Database

The International Action and Development department was established a year ago to backstop and provide technical assistance to field personnel and to explore international opportunities to broaden the interest in breastfeeding. The LLLI board of directors has now established geographic zones, with each zone having one seat on the board. Additional seats are determined according to the zone's percentage of active leader population. The zones are Africa/Middle East, Latin America, South Pacific/Asia, Europe, Canada, Eastern US, Western US. Thus, the board of directors will represent the diverse nature of LLLI.

The LLLI Resource Library is an excellent resource for all interested in breastfeeding. It has a variety of material available for sale and distribution that can help mothers breastfeed their babies, and educate health care providers and others who work with the breasfeeding mother. The Reference Library and Database contains LLLI's collection of professional research documentation, numbering almost 10,000 published studies and case reports. LLLI adds between 100-200 studies to the collection each month.

Minnesota International Health Volunteers (MIHV)

Dr. Angie Nelson, Executive Director

Minnesota International Health Volunteers has a dual mission. First, to improve community health by creating and nurturing primary, self-sustaining health care projects around the world; and second, to create partnerships for learning among the US and host country volunteers and community members. MIHV is a volunteer-oriented organization; over 150 volunteers have served in MIHV projects overseas.

MIHV has done some restructuring in the past year. At a recent strategic planning retreat, it was decided to expand MIHV's programs to include four to five projects in various stages of development. Current projects are in Kenya and Uganda.

MIHV added a program officer this past year. Debra Drew is responsible for technical support and backstopping of MIHV's Child Survival projects in Kenya and Uganda. In addition, she will document lessons learned from MIHV's earlier experiences in child survival.

Another major change in the home office is the computerization of the manual accounting system. Dr. Nelson thanked ADRA, IEF, PSI, and PCI for their assistance and sharing of information and material during MHHV's computerization effort.

During this past year, MHHV experienced the biggest tragedy in its history. Michael Graf, project director in Kenya, was critically injured in a motorcycle accident. He was medically evacuated at the end of October and is now in a nursing home in Minneapolis, which specializes in traumatic brain injury cases. This experience demonstrated how important backstopping is. The home office picked up primary responsibility for completion of the midterm evaluation in order to enable the project team in Kenya to concentrate on maintaining the project until a new director arrived—a testimonial to Dr. Graf's excellent work in training his staff.

The experience also demonstrated that barebones staffing and budgeting left the organization no extra resources to shift when necessary. To better sustain its backstopping role, MHHV HQ has undertaken a strategy to maximize the output of their office through computer and communications technology. MHHV is interested in learning how other PVOs are incorporating advanced technology into their organizations.

Project Concern International (PCI)

Barbie Rasmussen, Program Officer

The first priority following the second of two management changes in two years was to strengthen and consolidate existing field programs. Programmatically, there is the need to diversify portfolios to better support Child Survival programs. PCI is placing increased emphasis on family planning, HIV/AIDS prevention, and water/sanitation systems.

PCI has also realized that reliance on government funding should be reduced and private funding increased. One of PCI's main private funding mechanisms—the Walks for Mankind—is no longer providing a satisfactory return on investments. Therefore, except for a few walks, the rest have been discontinued. As there is an average ceiling for the revenue that a non-profit like PCI can expect to earn from foundations, and as the ceiling has nearly been achieved by PCI, there are now new strategies for funding. Part of the strategy is to build on domestic programs. One such domestic initiative is the San Diego Birthing Project, a Child Survival project carried out in collaboration with the Sacramento Birthing Project. There are plans to replicate these efforts in Indianapolis.

PCI is also looking outside the non-profit sector for support of international programs. In the Mexico program, PCI has partnered with a local high-tech company, Pulse Engineering, that operates a factory-based community health program in a light assembly plant that Pulse operates in Tijuana.

Due to the organizational growth of FSP, PCI's alliance with FSP concluded December 1993.

Population Services International (PSI)

David Greely, Program Officer

PSI is involved in social marketing and communication programs worldwide. In 1993, PSI distributed more than 550 million condoms worldwide. PSI protects more couples from unwanted pregnancies and HIV transmission than any other social marketing organization in the world. The changes in PSI involve diversifying the kinds of health products sold to include more contraceptives (injectables, IUDs), STD kits, ORS, and in the future, micronutrients and impregnated bed nets.

Also, PSI is increasing the attention paid to issues surrounding quality control. PSI is expanding—both in terms of diversifying its donor base, and increasing the number of countries in which PSI works. Finally, PSI is increasing collaboration with US-based PVOs. Recent collaborations include AMREF/Tanzania, SC/Cameroon, PLAN/Burkina Faso, and CARE/India.

Save the Children (SC)

Karen LeBan, Manager, HPN

Save the Children's new CEO, Charlie MacCormack, initiated a strategic planning process upon his arrival to SC in January 1993. The overarching theme of the plan was to strengthen SC's commitment to improve services to children, thereby reinforcing Save the Children's mission statement: "In the United States and abroad, Save the Children helps to make lasting and positive differences in the lives of disadvantaged children." The key programming principles of SC remain the same: a focus on the child in context; participation and empowerment of individuals and communities; focus on women as key participants in the development process; multisectoral integration (health, education, economic opportunities, and agriculture); innovation and accountability; and sustainability through low-cost models and strengthening of local institutions.

SC has changed its organizational focus to improve programming of services to children. SC chose to house Program Operations (accountable for day-to-day management issues) and Program Development (accountable for development of new program initiatives) in separate departments. This decision followed management guidance by Peter Drucker (*Reinventing Government*, Osborne and Graeber, 1992) that successful organizations separate government functions (catalyzing and facilitating program change) from operational functions so that adequate time is spent searching for best methods and practice. All of the technical units, including the Health/Population/Nutrition Unit (HPN), are located in the Program Development Department. Since the HPN Unit is responsible for Child Survival projects, continual lateral coordination with Program Operations is essential for successful project implementation.

SC began its history working in the United States in Appalachia in 1932. However, over the past 20 years, the focus has gradually shifted to international relief and development programs. There is a renewed commitment to expanding SC's programs in the USA— with a goal of reaching effort levels of 1/3

US, 1/3 international development, and 1/3 emergencies and relief.

SC has also begun to increase the scale and policy impact of its programming efforts, it is doing this through shifting its development strategy from a primary area-focused approach to one including partnerships, umbrellas, and other inter-institutional relationships. SC has searched for partners that can complement SC's expertise and resources and remain true to its mission and principles. In order to effect broad-scale change, SC is internationalizing its workforce and funneling more resources into improvement of its information, financial, and communications systems.

The change process has created many internal personnel changes, including the appointment of new vice presidents and directors. The new director of the HPN Unit is Dr. James Sarn, former deputy assistant secretary at the Department of Health and Human Services.

World Relief Corporation (WRC)

Dr. Muriel Elmer, Child Survival Specialist

Dr. Muriel Elmer of WRC shared with participants the changes in WRC. Highlights of the new developments within WRC are:

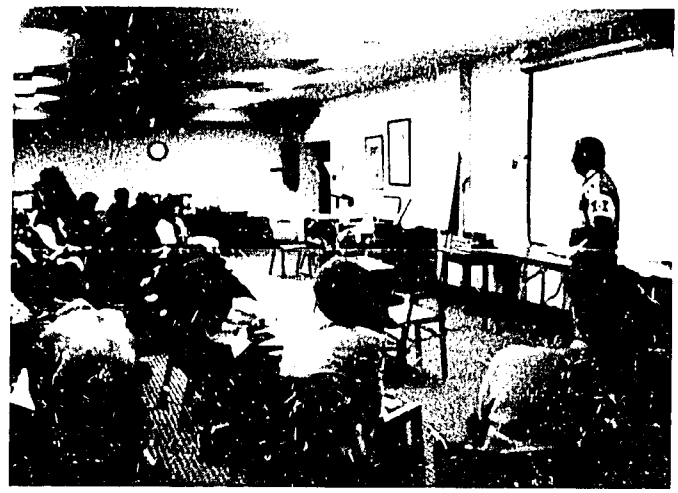
1. Dr. Gretchen Berggren joined World Relief as a maternal and child specialist. World Relief has decided to include in their Child Survival projects the nutrition foyer approach developed by the Berggrens to address malnutrition.
2. Development of a new model for program implementation. At WRC, it is known as the "hub and spokes" model. Initially, one establishes a "hub" program consisting of Child Survival and Community Banking. Then within this "hub," "spokes" are developed. These are facilitators, people with experience who then work with the in-country partners of WRC.
3. Several "USAID/JHU Child Survival grandchildren" have been born in WRC. These are WRC-assisted projects in which Child Survival lessons learned are used to build stronger health programs.

World Vision Relief and Development (WVRD)

Dr. Larry Casazza, Senior Program Manager

For WVRD, Child Survival projects have been the source of experience that has helped to develop a model for similar activities in World Vision "non-health" development programs in multiple countries. The Health Division's portfolio is also becoming diversified to other types of health projects, such as the Moscow Nursing Education Reform project and two projects for prosthetics and rehabilitation of war victims.

WVRD is making an effort to improve the quality of project performance through advancing technical, managerial, communication, and training skills. For health-related activities, there will be increased emphasis on quality assurance of project performance, exploring ways to expand population activities, and continued technical updates and extension of technical assistance resources for headquarters and field staff.



WVRD has also made strategic shifts to enhance the field's capacity in proposal development, grant compliance, and tracking/reporting of projects. And a new unit has been established at WVRD/Monrovia for training staff in grants development and evaluation.

These strategic shifts have led to the appointment of a new WVRD executive director and a broadening of the former International Health Division to become the International Development Program Division (IDP), with Dr. Milton Amayun as director. Within IDP, new staff have been added and there has been regionalization of staff assignments into teams comprised of personnel with finance and grants compliance/contract management responsibilities, in addition to the program officer.

What's new in the Latin America region?

Dr. Mary Anne Mercer, deputy director of CSSP, noted that at the 1992 workshop, PVOs recommended that the PVO Child Survival Support Program provide more regional technical assistance and training. PVO CSSP has responded by establishing a regional technical unit called NETWORK to address the needs of the PVOs.

The main approaches to NETWORK are information sharing and technical assistance. Dr. Marcelo Castrillo is the PVO CSSP Latin America region (LAC) associate. The LAC region NETWORK unit was started in May 1993 as a one-year trial, for the purpose of:

- developing a regional strategy to support PVO Child Survival projects in the Latin America/Caribbean region.
- identifying and training regional resources (consultants) for the USAID-funded PVO Child Survival projects.
- strengthening linkages among PVO Child Survival project staff and key regional universities and health institutions.

During this session, Dr. Castrillo provided the participants an overview of developments in the Latin America region by reviewing the highlights of his report to USAID on PVO regional activities. Excerpts from the report follow:

Trends in the Latin America/Caribbean Region

PVOs in the LAC region are forming consortia or umbrella organizations to support their work in Child Survival.

Some PVOs are reconsidering their role in relation to their counterparts. There is a move toward working with and strengthening local NGOs. PVOs are also training MOH staff and providing technical assistance to the MOH as opposed to directly implementing service activities themselves.

The need in the region is for skills in epidemiology and health program management to assist the MOH with assessments and provide technical support for existing activities at the district level.

Situational Analysis: Honduras

The PVOs in the region have formed a consortium although there have been few meetings to date.

An analysis showed the need for technical support in the following areas: design and review of health information systems, monitoring and evaluation, methodology of training at the grass roots level, strategies for sustainability, and methods for qualitative investigations.

Centrally funded PVO projects are not a high priority for the local USAID mission, as it emphasizes its bilateral programs.

There is a need to reconsider the role of PVOs with the Honduran MOH. It seems desirable that PVOs shift more to upgrading the skills of the ministry, assisting the MOH with innovative ideas, and providing technical support for existing activities.

Situational Analysis: Bolivia

PROCOSI is the umbrella organization for PVOs in Bolivia. PROCOSI has become a self-sustainable organization through a Bolivian government endowment—called the "debt for development swap." Its new role is to broker technical assistance from local and international sources.

USAID/Bolivia mission will continue supporting PVO Child Survival activities, but without increasing activities.

Situational Analysis: Ecuador

PVOs are trying to develop a consortium of organizations after the PROCOSI model in Bolivia.

The USAID/Ecuador mission emphasizes collaboration among the PVOs and their local NGO counterparts. There are

Recommendations

Following the session on regional networking and collaboration, the PVOs worked in groups to discuss networking strategies. Participants also made recommendations to PVOs and to PVO CSSP about regional networking strategies, and strengthening regional capacity for child survival. The recommendations to PVO home offices, USAID, and PVO CSSP include:

To PVOs

Include financial support for in-country PVO-NGO networking workshops in project proposal.

Develop informal in-country PVO-NGO networking groups with minimal financial inputs.

PVOs should develop capability statements as to their interest and their areas of expertise for providing technical support and transferring technology to local NGOs.

Publicize "success stories" on collaboration.

To USAID

Establish a mechanism to link up PVOs and national universities for technical assistance, training, and applied field research.

To PVO CSSP

Collect information on success stories and disseminate.

Develop a list of universities (and other sources of technical assistance) that are of high technical standards.

In the quarterly technical report, compile a list of Child Survival activities on a country basis, discuss upcoming events and travel plans, recent PVO publications, and database updates.

Develop a list of "Opportunities for Collaboration" and send to PVO field staff (for example, sharing consultants, joint evaluations, training materials development, joint training).

about 300 to 400 Ecuadorian NGOs. Most lack management capacity; they fill the MOH absence in some of the most remote or unattended areas of the country. The mission is interested in matching PVOs with NGOs by region, in order to upgrade the NGOs' technical capacity.

The Ecuadorian government has expressed its desire to work with PVOs and NGOs. This is the first time the government has formally recognized the role of private organizations. PVOs should consider shifting their role in the country from providing service to one of providing technical support and transferring technology to the MOH and local NGOs. USAID is willing to provide funding to accomplish this goal.

A Slice in Time

In the morning of Day 2, the group discussed current USAID policies and operations affecting Child Survival—the reorganization within USAID, opportunities and constraints in PVC's Child Survival program, reporting requirements, and procedures.

USAID's New Organizational Context for Child Survival

Lou Stamberg, director of the Office of Private and Voluntary Cooperation/BHR, spoke about the reorganization of USAID and the impact of the restructuring process on the PVOs. Following are excerpts from his talk.

Changes within USAID

USAID's own process of transition is still in progress. There is a focus on a wide range of issues involving USAID's vision and mission, as well as its organizational structure. USAID has proposed new foreign assistance legislation objectives for consideration by Congress; they include sustainable development, promotion of democracy, providing humanitarian assistance, promoting peace, and promoting trade investment flexibility.

USAID will also prepare five strategy papers in close collaboration with the PVO community. The strategy papers will focus on democracy, environment, population and health, broad-based economic growth, and humanitarian assistance, including a strategy for "transitional countries."

At all points of reorganization, there is emphasis on a more focused set of objectives, the need to retain the agency's strength through its country programming while also addressing important cross-cutting global issues and assuring a strong policy-making capacity. Some of the major points of change are reorganization of the agency, consolidation of regional bureaus, establishment of a global bureau for technical support to the field, and a reconstitution of the policy office.

PVC's Child Survival Program

Ms. Rose Miles Robinson, chief of Child Survival and Health Unit/PVC, spoke of opportunities and constraints in PVC's Child Survival Program. The session was followed by a lively discussion about PVO lessons learned, reporting requirements, protocol related to travel, and substantial investment of understanding. PVOs met in small groups with their respective USAID project officers. The sessions were informative, and the PVOs were appreciative for the opportunity to raise these issues. Participants then developed action recommendations to USAID.

PVO Progress in Child Survival: Where are we?

In the afternoon, Dr. Dory Storms, director of the PVO Child Survival Support Program, reviewed the achievements and interventions needing improvement in PVO Child Survival projects during the past year.

Based on a review of actual project evaluations, an admirable quality of PVO projects is the quality of staff and their commitment to Child Survival. The evaluator also considered the extent of community mobilization and support provided by the PVOs to be extraordinary. Dr. Storms said that it is personally encouraging to see PVO projects increasingly adopting strategies for sustainability. PVOs know that it is important to not only achieve financial sustainability, but sustainability of human resources by transfer of skills. Another excellent part is the progress PVOs have made in recognizing the importance of national networking; the benefits of this collaboration between PVOs cannot be overemphasized. Such collaboration and sharing of lessons learned is also an important step toward institutional capacity building.

From these more general observations, Dr. Storms went on to review the highlights of Child Survival interventions. Im-

Recommendations for Maternal Care

To PVO Field

Improve definition of measurable and feasible objectives related to reducing maternal mortality, child mortality, and population growth.

Better utilize baseline survey data for detailed planning of maternal care programs.

Promote fee-for-service approaches and use trained TBAs to improve potential for sustainability.

To PVO Headquarters

Develop linkages with USAID-funded technical support mechanisms for maternal care, such as MotherCare.

To the PVO Child Survival Support Program

Facilitate a vision for women and girls (female) care within more traditional Child Survival projects.

Distill and disseminate current changes in guidelines for anthropometry of pregnant women.

Recommendations for Family Planning

To PVO Field

To reduce missed opportunities for family planning/counselling services, integrate services instead of keeping all interventions in vertical programs.

Involve existing community resources in service delivery; for example, use TBA peer supervisors instead of MOH's few human resources.

Involve more men in family planning programs as promoters.

Include qualitative research (such as focus groups) in projects to define family planning messages that are useful, and pretest.

Establish partnerships with the International Planned Parenthood Federation within countries.

To PVO Headquarters

Add family planning expertise to headquarters staff.

Help field staff develop family planning messages that will be understood and accepted in project areas.

Promote inclusion of contraceptives in "essential drugs" package of UNICEF's Bamako Initiative.

To USAID

Allow project staff to buy, within a ceiling, contraceptives that are not made in the US (as condoms from the US are more expensive).

Improve financial and technical access to USAID Population Office-funded projects for specialized support in family planning to PVOs at the HQ and field levels.

To the PVO Child Survival Support Program

Continue to disseminate lessons learned in family planning programs—for example, programs that have used promotion by males—and create a bridge between lessons learned in US programs and programs overseas.

Conduct short-term training of trainers in family planning for field and HQ staff.

Organize meeting between PVOs and cooperating agencies, such as JHPIEGO, Pathfinders, Futures Group, Population Council, JSI, AED)—or include this as part of the USAID/PVO annual meeting.

Recommendations for Pneumonia Control

To PVO Field

Develop ways to document pneumonia mortality and barriers to access to treatment.

Develop linkages, including with the MOH, for training of supervisors and workers.

Adapt appropriate work tools for illiterate workers.

Develop methods for more effective supervision of volunteers.

Explore effective ways to target fathers, mothers-in-law, and caretakers.

To PVO Headquarters
Provide access to training materials and other resource materials.

Provide information on drugs: supply sources, types, and revolving drug programs.

To the PVO Child Survival Support Program
Develop key implementation guidelines for pneumonia control programs.

Identify experts in pneumonia control who can assist PVOs in their programs.

Recommendations for HIV/AIDS Prevention

To PVO Field
Strengthen ties with national AIDS programs and local PVO/NGOs working in HIV/AIDS prevention.

Develop collaborative activities with other in-country programs.

Involve field staff in qualitative baseline data collection.

To PVO HQ
Identify one person at headquarters who is responsible for HIV/AIDS prevention activities and dissemination of information.

Promote intersectoral efforts to address HIV/AIDS prevention.

Share lessons learned with other agencies.

Identify multiple sources of funding.

To the PVO Child Survival Support Program
Provide guidelines on qualitative and quantitative assessment tools and appropriate indicators for tracking progress.

Locate or establish a list of best HIV/AIDS prevention training materials, lessons learned, and consultants for PVOs.

Computerize HIV/AIDS information on the Internet.

Recommendations for Exclusive Breastfeeding

To PVO Field
Network with other NGOs about the importance of exclusive breastfeeding.

Promote mothers' support groups and document and disseminate lessons learned.

Use KPC survey data to assess breastfeeding objectives.

Explore breastfeeding practices through in-depth studies and observation (for example, use of water).

To USAID
Provide small grant monies to PVOs to conduct qualitative research in both urban and rural settings to identify breastfeeding determinants, obstacles, and roles of fathers and other family members in order to design more appropriate and useful breastfeeding messages.

To the PVO Child Survival Support Program
Disseminate the latest standards to the field, that is, breast feed within first hour after delivery, exclusive breastfeeding through the first six months of life, and breastfeeding along with appropriate complementary foods through 24 months of age.

munization is one intervention that is very strong, and all PVOs are very efficient in reaching their beneficiary populations. However, PVOs need to put more effort into immunizing women with tetanus toxoid vaccine.

In the future, maternal care, pneumonia control, family planning, exclusive breastfeeding, and HIV/AIDS prevention are areas that need more attention and careful planning. For example, there should be more emphasis on stronger referral systems for pregnant women experiencing complications.

In terms of HIV/AIDS prevention, the PVO community plays a major role in addressing the global pandemic of AIDS. The degree of effectiveness of a PVO doing HIV/AIDS prevention is largely dependent on the length of PVO presence in the area, for they must understand the community and have credibility in the eyes of the community. Raising awareness alone is not enough, it is very important to teach skills to the community to protect them from HIV infection.

At the end of the session, the PVOs worked in small groups to frame action recommendations to improve quality of services in the following interventions: maternal care, family planning, pneumonia control, HIV/AIDS prevention, and exclusive breastfeeding.

Communicating Health Messages

Public health professionals face the challenge of communicating health messages and motivating behavior change through health education. But how efficient are we in communicating our ideas? As an exercise, PVO participants were asked to creat a puppet show to illustrate the message they wished to communicate about the theme "The Partnership among PVOs, CSSP and USAID."

As a way of background, Black Cherry, Inc., a Baltimore based puppet theater that carries out public education in communities and schools throughout Baltimore, presented "Requiem for a Landfill." Through its productions and workshops, Black Cherry entertains and exposes its audience to the world of puppetry and to messages about community development.

The show demonstrated that anything, including rubbish, can be used to create objects that communicate. The characters in the show included a dancing banana peel, a dog made of newspaper, and a crushed tin can. After the performance, puppeteers Michael Lamason and Kelly Lennox demonstrated some of their creations. Mr. Lamason demonstrated in a slide presentation the immense potential of puppets as a medium of com-

munication to villagers. Puppeteering is an art form, and is to this day, an intricate part of certain cultures.

Every evening, participants gathered in small groups to work on their puppet show to be presented on the final morning of the workshop. The puppet shows reflected on the dedication of the PVOs to child survival and the importance of collaboration if they are to overcome obstacles confronted in serving vulnerable populations.

Each presentation was followed by reactions from the audience. Typical comments were: "The power of communication...," "the ability to work well with limited resources," "it is amazing how creative you can get with these things!" "The sense of humor in puppetry while still delivering the message..." "The PVO representatives picked up the idea with such enthusiasm and did a great job!" "Interesting and instructive way of demonstrating a particular tool for communicating." "The creative genius of the presenters was amazing!"

Follow-up Action: Recommendations

"While we have made some inroads in improving family planning, nutrition, breastfeeding, and HIV/AIDS prevention interventions, I now realize the time requirement to realistically translate these efforts into meaningful field activities is considerable. Nevertheless, I find all of the recommendations still valid, and will continue to look for opportunities and funding to meet them in the future."

--PVO Representative

Background

The annual PVO/HQ workshop is not only an opportunity for the PVO community to get together and share lessons learned and network, it also gives PVOs a chance to make formal recommendations to alleviate some of the problems PVO staff encounter while implementing Child Survival projects. Each workshop session included a time for discussion and recommendations. Thus, a key output of the PVO HQ workshop is a list of suggestions for improving the activities of USAID, CSSP, and the PVOs, so that the goals of the Child Survival Program are more likely to be achieved.

This year, as with any other, participants were asked to list action recommendations that would improve how the Child Survival Program and Child Survival projects function. And, to make this process more action-oriented, PVOs recommended two steps for workshop follow-ups:

- CSSP should compile and issue to participants a list of recommendations, and ask PVOs to identify which ones are most actionable. (8.1 priority)
- At six months, inform the PVOs on the progress of each recommendation. As necessary, the process can involve a working group of PVO representatives, USAID, and CSSP to discuss the follow-up recommendations. (7.1 priority)

So, CSSP added the critical step of "feedback" to the process.

As PVOs noted at the workshop, there were more recommendations than the time or money available. A prioritization process was necessary to determine what were the most important issues that needed to be addressed. Thus, following the Marriotsville workshop, CSSP staff organized the PVOs' recommendations into three major categories: (1) recommendations to USAID, (2) recommendations to PVO CSSP, and (3) recommendations to PVO grantees in the Child Survival Program. Related recommendations were then grouped into subcategories. The three lists were then forwarded to participants March 18, and 19. Participants were asked to rank the recommendations, within the context of their respective organization's objectives and needs, using the following scale:

10 = "Extreme priority to work on this year"

5 = "Does not require more than average attention this year"

1 = "Least important to do"

0 = "Disagree with recommendation altogether, do not carry out"

The participants were very responsive to the prioritization process. A total of 26 participants from 18 PVOs (of 19 that attended) returned the lists for compilation and analysis. PVOs with several participants had the individual rankings averaged and presented as an average organization ranking so that each PVO had equal input in the final ranking of the recommendations. The final ranking of each recommendation was determined by averaging the total of the rankings of all the

organizations that responded. Those recommendations ranking 6.5 and above were prioritized. The higher the score, the more important priority the PVOs placed for seeing the recommendation carried out in the coming year.

The prompt and enthusiastic response of the participants allowed CSSP to complete the compilation and analysis of the prioritizations by the end of March, and the set of highest-ranking recommendations was disseminated to PVOs and USAID on April 4, 1994. At CSSP, it was possible to take these recommendations and use them as the basis for the Year 2 workplan and budget for technical support. CSSP's Year 2 workplan specifically incorporates PVO recommendations in maternal care, HIV/AIDS prevention, and pneumonia control.

Follow-up Action

The next step was to monitor, at six months, the follow-up to the recommendations and inform the PVOs of the progress of each recommendation. A form for PVOs to report on their action taken since the prioritization process was mailed in March. Ten of the 19 PVOs responded. CSSP compiled the results and sent a six month progress report to all Child Survival PVOs. Notes from PVOs indicated they welcomed the reports as a means of evaluating their own progress in improving the quality of Child Survival projects.

At USAID, the project officers at the PVC Child Survival unit were very interested in the set of recommendations and expressed their desire to improve the functioning of the program. Adele Liskov, deputy director of PVC, called a meeting July 1 with PVOs to discuss PVO recommendations to USAID.

In summary, the recommendations and follow-up process were well received, and CSSP has received encouraging letters asking that they be continued in the future.

USAID Follow-up Action to PVO Recommendations

Following are the recommendations to USAID that were discussed at the meeting and the priority the PVOs placed on follow-up action (10 is the highest priority, and 5 is average). Many of these issues have been considered by USAID, and wherever possible, action is being taken.

Recommendations on Role of the DIP

- USAID should formally recognize that approved program and budget changes in the DIP supersede the statements in the original proposal. (9.4 priority)
- PVC should process amendments in a timely fashion (a maximum time limit should be established). (9.0 priority)
- PVC should give final approval to a project's activities, objectives, and indicators within 60 days of submission of the DIP. (8.8 priority)
- USAID should award grants based on proposals, but use the DIP as the basis for the cooperative agreement. (8.1 priority)
- Following DIP reviews, PVC should submit to Contracts Office the list of revised outputs/objectives, along with the revised budget for PVO Child Survival cooperative agreements. (7.6 priority)
- PVC should keep the current process of requiring a detailed implementation plan, once a proposal is accepted. (7.3 priority)

Recommendations on Grant Agreement

- PVC should allow a PVO project to "flex" dollars once an extension is accepted for funding so that the project can meet the cost of preparing an updated DIP immediately upon being notified of the award. (7.9 priority)
- USAID should allow PVOs to buy contraceptives that are not made in the USA, within a ceiling amount (condoms from the USA are more expensive). (7.8 priority)
- PVC should reduce the number of line items in cooperative agreements and allow flexibility among line items. (7.3 priority)
- PVC should reduce/streamline Child Survival cooperative agreements by changing to a grant format. (7.2 priority)

Recommendations on the PVO Partnership with USAID

- PVC should continue to facilitate information exchange between PVOs and PVC through attendance at the annual PVO/HQ workshop and include representatives from the Office of Procurement. (8.9 priority)
- PVC should increase PVO involvement in the design of annual reports and other reporting formats. (8.4 priority)
- PVC should increase PVO involvement with Procurement Office as PVOs attempt to streamline administrative reporting requirements. (7.7 priority)
- PVC should seek advice from PVOs on the most appropriate indicators for monitoring PVC's efforts to strengthen PVO capacity (institution building). (7.1 priority)
- PVC should issue a brief Q/A newsletter to all PVOs on a regular basis (every six months) about specific issues that arise surrounding the interpretations of the provisions. (7.0 priority)
- PVC should set aside funds for PVOs to access technical assistance and information resources of centrally funded projects (such as BASICS, OMNI). (6.9 priority)

  Discussions are being held by PVC with other USAID offices on this issue.
- PVC should set aside funds for PVOs to access centrally funded projects in the family planning area (e.g., Futures Group, JSI). (6.4 priority)

Recommendations on PVO Child Survival Project Funding

- PVC should give four-year funding (as opposed to three year funding) to allow the PVO greater time following the baseline/DIP to achieve greater results. (8.8 priority)

  PVC announced in the 1995 Request for Proposals that they would consider proposals for four-year project funding.
- PVC should conceptualize a Child Survival grant as a six-year project, with two funding cycles, depending on favorable evaluation at the end of three years. (8.3 priority)

Documentation of Impact

- PVC should carry out a retroactive (nine year) assessment of its PVO Child Survival Program to document the changes achieved, sustainability of activities, and strengths and weaknesses of approaches. (6.5 priority)

  This became the theme of the PVO Child Survival Worldwide Conference held in Bangalore, Karnataka, India, October 1994. The Impact Conference addressed this recommendation, providing quantitative evidence of changes achieved and sustainability of certain Child Survival activities.

CSSP Follow-up Action to PVO Recommendations for Strengthening Interventions

The following are the PVO recommendations to CSSP, their priority ranking (10 is the highest priority, 5 is average), and the follow-up action that has been taken to date.

Follow-up Action to Improving Maternal Care and Family Planning Recommendations

- CSSP should disseminate latest standards of maternal care (prenatal, delivery, postnatal care) to PVO field projects. (8.4 priority)

  Distributed the guide, Mothers and Child Survival, to PVO/HQ and field projects.

  Assisted MotherCare with "Safe Motherhood" workshop funded by USAID following NCIH conference, June 29 - July 1. Met with each PVO to discuss the maternal care component of their respective DIP.

  Requested copies of each project's training curriculum for maternal care to be submitted with the 1994 Annual Report. Technical experts are reviewing each project's curriculum to see that it meets the standards of quality maternal care.

- CSSP should organize a meeting between PVOs and cooperating agencies in family planning (such as JHPIEGO, Pathfinders, Futures Groups, Population Council, John Snow Inc., AED, etc.)— or as part of the PVO/HQ annual meeting. (8.0 priority)

  Did not include in workplan this year because did not wish to duplicate efforts of NCIH, which in June focused on population programming. However, reproductive health (including family planning) was the focus of one session at the October 1994 Impact Conference.

- CSSP should facilitate exchange of lessons learned in successful family planning programs (for example, include in workshops and the PVO TRs). (7.4 priority)

  The NCIH population meeting's objective was to facilitate this exchange. CSSP confirmed that the JHU Population Information Program (USAID's major technical assistance mechanism in family planning communications) distributes their lessons learned publications to PVO Child Survival grantees.

- CSSP should offer PVO field and HQ staff short-term training of trainers courses in family planning. (7.0 priority)

  No funding available for this in the 1994-95 budget year. If PVOs continue to be interested, CSSP can hold a short-term TOT course in Baltimore, given a registration fee. PVOs will be canvassed about their interest in such a training course in the spring.

Follow-up Action to Nutrition (especially exclusive breastfeeding and weaning) Recommendations

- CSSP should keep PVOs abreast of developments of the nutrition management component of the WHO/UNICEF "sick-child" algorithm. (7.5 priority)

  WHO expected to release algorithms by mid-year 1995.

- CSSP should provide guidance on standards/characteristics of weaning (complementary) foods, and guidance on how to determine which local foods meet the standards/characteristics. (6.9 priority)

  Nutrition technical mission is tentatively scheduled for 1995 with BASICS assistance.

  Dr. Karunesh Tuli (formerly of CARE/India) has been added to CSSP staff, and he is assigned to the nutrition technical area, to liaison with PVOs and BASICS.

Follow-up Action to Pneumonia Control Recommendations

- CSSP should facilitate PVO inclusion in WHO-sponsored country-level ARI training for supervisors and workers. (8.8 priority)

  PLAN/Latin America received direct training from CDC and Dr. Marcelo Castrillo through LAC Network. (Spring 1994) Also, WHO Asia Region offered to co-sponsor an ARI TOT in the Asia Region. Dr. Tuli is working on the development of the workshop for 1995.

- CSSP should compile a summary of the key points PVOs must consider for implementing pneumonia control in Child Survival projects. (8.4 priority)

  Summary completed by ARI Task Force, reviewed by WHO, CDC, and CSSP participants. PVO input given at annual PVO/HQ meeting. Copies of the key points will be distributed to PVOs through the Child Survival Technical Report.

- CSSP should facilitate PVO access to WHO/ARI training materials and guidelines. (7.8 priority)

  WHO has provided CSSP with ARI training materials and guidelines. WHO/Geneva is interested in finding PVOs to test these materials at the community level.

- CSSP should provide technical expertise to assist PVO projects in the design and assessment of ARI interventions (6.5 priority)

  CRS requested and received ARI assistance from Dr. Marcelo Castrillo and CDC/Atlanta. (April 1994)

  Following the Impact Conference (October 1994), CSSP began work on developing and pre-testing tools for community assessment of ARI care.

Follow-up Action to HIV/AIDS Prevention Recommendations

- CSSP should provide PVOs with a list of best HIV/AIDS prevention training materials, mass media spots, lessons learned, and consultants. (7.8 priority)

  HIV/AIDS Prevention Task Force met at AIDSTECH August 1994. Report now in final draft and has been distributed to USAID and all PVOs for comments.

- CSSP should provide PVOs with a list of possible objectives, indicators, and quantitative and qualitative assessment tools for monitoring HIV/AIDS prevention interventions. (7.5 priority)

  Report addresses objectives and indicators.

- CSSP should assist PVO field staff with collection of qualitative baseline on HIV/AIDS attitudes and practices. (6.8 priority)

  CSSP will provide technical assistance to any PVO requesting such help.

Field & HQ Follow-up Actions on Recommendations to Child Survival Community

Follow-up Actions on Family Planning Recommendations

- PVO projects should involve more men in family planning programs, including promoters of family planning services. (8.3 priority ranking)

  ADRA: Attempts are being made through one DIP workshop to involve men in family planning with varying degrees of acceptance.

  AMREF: The Urban Child Survival and Development Project trained 161 adults and youths, predominantly young men as CBD agents, who are now actively involved in distribution, promotion, and referrals of clients. The project held leader awareness workshops, where information, communication, and education key messages were discussed for the family planning campaign.

  ARHC: Staff are currently preparing grant proposals to PROCOSI for family planning funding. They expect funds to be available by the end of the year. Community health workers have begun to offer family planning education during home visits.

  HEF: Does not currently implement any family planning activities. In the recently funded extension in Malawi, the project will employ family planning CBDs, some of whom will be men.

  LLLI: The husbands and companions of breastfeeding women are involved as much as possible in encouraging and supporting them in the practice of exclusive breastfeeding.

  PLAN: Included in the CSXI Proposals for India and Haiti.

  SC: Ongoing projects in Bangladesh, Honduras, and Nepal reach and counsel men. Men also serve as family planning agents.

  WV: Presented this recommendation to all LACRO managers in meeting in Quito, Ecuador, August 1994. The Haiti project has engaged its Health and Development committees (consisting mainly of men) in mobilizing men and women to attend family planning education and promotion of family planning services. Also Uganda is directing family planning promotion to men.

- PVO projects should seek to improve community access to a wide range of family planning methods. (8.1 priority)

  ADRA: Addressed in DIP workshop.

  AMREF: The project trained CBDs on counseling skills, promotion skills, and distribution of family planning services. The CBDs work in conjunction with trained family planning technical staff in the health

  ARHC: Available.

  CRS: As a result of interactions with CSSP, the April ARI workshop etc., the Ecuador program is working to improve upon these areas. Evidence that CRS is implementing these recommendations can be seen in the proposal submissions.

  HEF: Will be implementing family planning activities in its Malawi project in the upcoming year.

  LLLI: The League's strategy is to improve community access to a

wide range of breastfeeding information, both visual and written (simply), as well as to provide emotional and practical support, from as broad a base as possible.

PLAN: Included in the CSXI proposals for India and Haiti.

SC: Contraceptives are included in community-managed pharmacies or as part of a drug revolving fund in Malawi and Honduras. Access to contraceptives and/or support to family planning agents are part of project activities in Mali, Bangladesh, and Nepal.

WRC: In Nicaragua, World Relief is working actively with the Ministry of Health, the USAID Missions and PROFamilia to increase access to family planning methods in the very rural area of Rio San Juan.

WV: The Malawi project is incorporating contraceptive distribution into project; and in Haiti, the project has developed a separate family planning program which addresses a wide range of family planning methods using the Child Survival Program organizational structure as a vehicle.

- PVO projects should promote inclusion of contraceptives in the "essential drugs" package of UNICEF's Bamako Initiative. (7.6 priority)

AMREF: The trained community resource persons are the ones managing the UNICEF Bamako Initiative store in the community. The essential-drugs resupply is ordered from Nairobi City Council Store. The family planning commodities and resupply are ordered from MOH. In addition, the private clinics are within community reach, and all methods are available at a reasonable cost.

ARHC: Does not distribute these packets.

SC: None of SC's projects currently are involved directly with the "essential drugs" package.

- PVO projects should integrate family planning and HIV/AIDS prevention activities, as well as other child survival interventions in delivery of messages/services. (7.3 priority)

ADRA: This general principle is being addressed in DIP workshops, and is being encouraged in projects with HIV/AIDS components.

AMREF: The project has integrated family planning and other Child Survival interventions in delivery of messages and services to the communities. The curriculum and training manual are integrated for all the identified priorities needs, e.g., IGAs, environment and sanitation, family planning, and STD/HIV/AIDS prevention activities.

ARHC: Is not involved in HIV/AIDS prevention activities at this time, but community health workers address family planning during home visits, along with other Child Survival interventions.

IEF: In the upcoming year, IEF's extension project in Malawi will integrate family planning in its current HIV/AIDS activities, and the delivery of messages/services for all Child Survival interventions.

LLLI: The League disseminates information to field administrators and leaders on the latest information regarding HIV/AIDS and breastfeeding. In addition, with IRH/Georgetown funding, LLLI/Guatemala carried out a Lactational Amenorrhea Method Training for five LLLI leaders based/living in Central and South America.

PLAN: Family planning is included with HIV/AIDS prevention activities in the CSXI Proposals for India, and integrated with other Child Survival intervention in the CSXI Haiti Proposal.

SC: Family planning and HIV/AIDS are considered part of a larger reproductive health strategy.

WRC: All World Relief Child Survival projects and our Community Bank projects for mothers in Cambodia integrate family planning into the overall Child Survival Program.

WV: Most Child Survival projects have HIV/AIDS and family planning activities integrated into their project, for example, Haiti, Malawi, Uganda.

- PVO project staff should review and reduce "missed opportunities" for family planning and counseling services. (6.9 priority)

ADRA: Not yet implemented in projects.

AMREF: Training curriculum for traditional birth attendants and community health workers include family planning concept, methods, counseling, and referrals. At the health centers the counseling for family planning starts during pregnancy and postnatally. Sexually active teenagers are also targeted.

LLLI: Because of the Lactational Amenorrhea Method Training Course, LLLI/Latin America will be more aware of opportunities for disseminating the breastfeeding message for family planning.

PLAN: Included in the CSXI proposals for India and Haiti.

SC: A recent review of family planning services in our local Haiti VACS grant has led to an improvement in overall services.

Follow-up Actions to Nutrition Recommendations

- PVO projects should promote continued breastfeeding, more foods, smaller more frequent feeds, more fluids during illness and recovery. (7.8 priority)

ADRA: Is being done in all existing projects planned in all proposals and implemented in all DIPs.

AMREF: The project developed a curriculum and a training manual and has trained the community health workers and their leaders on exclusive breastfeeding 4-6 months, lactation management, the initiation of breastfeeding, increased duration of continued breastfeeding, frequent feeds, and more fluids during diarrhea.

ARHC: Currently promotes this philosophy during home visits.

CRS: As a result of interactions with CSSP, the April ARI workshop, etc., the Ecuador program is working to improve upon these

areas. Evidence that CRS is implementing these recommendations can be seen in the proposal submissions.

IEF: All three IEF Child Survival projects (Guatemala, Honduras, and Malawi) promote continued breastfeeding, more foods, smaller more frequent feeds, and more fluids during illness and recovery. IEF has been one of the leaders in promoting exclusive breastfeeding in Malawi at all levels of the government within rural communities.

LLLI: This is an ongoing message for LLLI leaders, with an emphasis on continued breastfeeding as well as breastfeeding as a preventive method.

PLAN: Currently promoted in CSX projects in Bolivia and the Dominican Republic. Included in the proposals for CSXI in India and Haiti.

SC: The component for dietary management of diarrheal disease has improved in the majority of our projects based on a better understanding of mothers' knowledge and practices through the KPC survey tool.

WRC: Health messages for each of these initiatives are included in World Relief projects in El Salvador, Nicaragua, Honduras, Bangladesh, and Cambodia.

WV: The Mozambique project's ongoing training was updated to include these messages. The Malawi and Uganda projects have incorporated these messages into extension project efforts. These practices have been emphasized during technical assistance visits to Mali and Honduras projects.

- PVOs should document lessons learned in promoting exclusive breastfeeding. (7.3 priority)

ADRA: A Lessons Learned workshop is planned for 1995.

AMREF: The lessons learned in promoting exclusive breastfeeding are documented during the bi-annual KAP studies and focus group discussions. The important lessons learned are: 1) another pregnancy is the main reason for abrupt weaning of a child; 2) cultural beliefs advocating stopping all the milk feeds during diarrhea, with the belief that milk aggravates diarrhea; 3) other reasons for stopping breastfeeding exist, e.g., that breastmilk gets sour if a baby has not suckled for a day; 4) the professional health worker's knowledge, attitude, and practices influence the mother's effective breastfeeding.

ARHC: At this time, ARHC has not documented lessons learned.

IEF: The Malawi project sponsored district and regional workshops to promote exclusive breastfeeding and sharing of lessons learned.

LLLI: Although "anecdotally," women who attend LLLI breastfeeding support groups do practice exclusive breastfeeding, this has never been verified with ongoing documentation.

SC: All of our projects promote exclusive breastfeeding; however, SC has not yet documented specific lessons learned.

WV: The Honduras project organized breastfeeding mothers' support groups and trained breastfeeding counselors (mothers).

- PVOs should promote breastfeeding mother support groups. (7.1 priority)

ADRA: Indirectly done through mothers' groups for all Child Survival interventions.

AMREF: The project, in collaboration with local NGOs funded by UNICEF and the health center staff established "baby friendly support groups" including volunteers in every village. The volunteer promoters encourage mothers to carry their breastfeeding babies along when going to their business places for many hours.

ARHC: At this time, ARHC has not established mothers' support groups.

IEF: The Honduras project is currently working with La Leche League to promote breastfeeding mother support groups in peri-urban areas.

LLLI: Breastfeeding mother support groups, as pioneered by LLLI, continue to be a major component in LLLI's work in breastfeeding.

PLAN: Currently promoted in CSX in the Dominican Republic. Included in the proposal for CSXI in Haiti.

- PVOs should conduct qualitative studies in projects in both urban and rural areas to identify determinants, obstacles, and roles of fathers and significant others in breastfeeding decisions and appropriate breastfeeding messages. (6.9 priority)

ADRA: Such qualitative research is being included in new projects (Uganda now) and included in all new proposals.

ARHC: Are considering conducting such a study in the future.

IEF: Wellstart International and the IEF/Malawi project completed a study in 1993, which resulted in major changes in the promotion of exclusive breastfeeding by NGOs/MOH.

LLLI: Because LLLI leaders work mainly on a "one woman" by "one woman" basis, there has never been an attempt by the organization to identify these general situations. This would be interesting to do with the information already existent within the LLLI internal structure.

PLAN: Included in the proposal for CSXI in Haiti.

SC: This was not factored into any current projects.

WV: The Malawi project is interested in pursuing this once funding sources can be identified.

Follow-up Action to HIV/AIDS Prevention Recommendations

- PVO projects should strengthen ties with national programs and other PVO/NGO programs in the country (find out who is doing what and develop collaborative strategies). (8.1 priority)

ADRA: Is being encouraged on all Child Survival projects.

AMREF: The project carried out a situation analysis of PHC activities in Nairobi. AMREF then facilitated the NGOs/UNICEF/NCC/MOH quarterly collaborative meetings. The intersectoral collaborating meetings are also held at Nairobi Divisional Level and at project specific levels in the whole Nairobi now.

ARHC: Bolivia projects do not engage in prevention of HIV/AIDS because it is not a risk in current project areas.

IEF: Malawi project participates in national, regional and district committees with other PVOs and the MOH to collaboratively plan programs and share lessons learned.

PLAN: Included in the proposal for CSXI in India.

SC: In all SC programs, the field office belongs to an NGO or some form of coalition to share lessons learned and to try and influence policy as a group member.

WV: The Malawi project is working closely with the National AIDS program.

- PVOs should share lessons learned, especially regarding condom supplies. (7.0 priority)

ADRA: This is being done at field level. Lessons Learned conference planned for 1995 will document these.

AMREF: HIV/AIDS activities are closely coordinated with those of other national and local government programs, the NGOs, and the efforts of community groups. AIDS control activities at community level are increased in the project area through linkage with other NGOs' efforts and partners, e.g., Red Cross and World Vision. AIDS is linked to the other STDs to enable the community members to relate the risk of STDs to that of getting AIDS infection.

IEF: Regarding the Malawi project, they participate in national, regional, and district communities to share lessons learned. The Honduras project recently participated in a regional HIV/AIDS Prevention workshop organized by PVO CSSP and CARE/Guatemala.

SC: Through NGOs or coalitions, project information is shared. SC has an open policy about sharing documents, working papers, educational tools, resource staff, etc., with other agencies.

WV: The Haiti project is involved with national condom distribution program. HQ sent copies of workshop reports on "Lessons Learned" and "Mobilizing NGO Resources for HIV/AIDS Prevention and Care" to all WV field staff officers and participating NGOs/MOHs.

- PVOs should promote intersectoral efforts to address HIV/AIDS and multiple sources of funding. (6.8 priority)

IEF: The Malawi project participates in intersectoral HIV/AIDS Prevention Committees at all levels of the government. It has successfully secured funding from Action Aid, the EED, UNICEF, GTZ, and others for HIV/AIDS prevention.

PLAN: Included in the proposal for CSXI in India.

SC: The organization's approach to health and development is intersectoral. SC actively seeks funds to increase HIV/AIDS programming. However, funding is limited given the major crisis of the AIDS epidemic, and impending crisis of AIDS orphans and families with children left without economic and social support systems.

WRC: The Haiti project has USAID Mission funding to conduct AIDS education for the pastors and parishes in the Artibonite Valley.

Nineteen PVO headquarters and field representatives gathered on the final day of the Worldwide Impact Conference and developed the following open letter to the USAID administrator. This letter was immediately forwarded to Brian Atwood from India.

An Open Letter
to
USAID Administrator
Brian Atwood
from
PVO Members of the USAID-PVO Child Survival Partnership
Bangalore, India

October 7, 1994

Between October 2 and 7, 1994, a worldwide conference on the "Community Impact of PVO Child Survival Efforts: 1985-1994" was held in Bangalore, India, which was attended by a representative of the Government of India, WHO, UNICEF, USAID, the Government of Japan, Johns Hopkins University and some 25 representatives of PVOs. The PVO participants wish to share the important findings of the conference with you and to thank the Bureau of Humanitarian Response, Office of Private and Voluntary Cooperation for its generous support of the conference and the joint USAID-PVO funding of some 199 worldwide Child Survival Programs over the last decade.

The findings of this conference are startling in demonstrating the dramatic global effectiveness, efficiency, and impact of the strategies and interventions developed by the USAID-PVO partnerships in reducing morbidity and mortality of children and women. These high-impact results are even more impressive when viewed from the context that most of the targeted populations for USAID-PVO programs had been previously unreachable by government or private sector health and family planning services.

For years, many knowledgeable public health and program experts within USAID and the international community have considered the USAID-PVO partnership as the most effective and sustainable approach to achieving long-term improvements in health, family planning, and nutrition improvements. Despite such counsel and capability, financial support from central USAID resources for the PVO Child Survival programs has actually decreased from the initial $15 million during the past decade, even as overall child survival funding from Congress has dramatically increased from $85 million to the current $240 million.

Their findings of repeated evaluations, studies, and, indeed, the results of this conference indicate that the USAID-PVO partnership has produced a number of extraordinary results and observations, which are deserving of policy review and reconsideration of current policy considerations and budgetary allocations. The presentations and discussions of the conference have also outlined a number of key factors responsible for achieving these outstanding results and prompting a review of current policies.

Partnerships

The USAID-PVO partnership extends as a continuum from Washington and PVO Headquarters to individual families, women, and children through the PVO commitment to work with, rather than in place of national, regional, and local governments and community formal and informal leadership. Partnerships enhance ownership and commitment to project impact, effectiveness, efficiency, and sustainability at all levels. Thus, USAID and PVO resources are multiplied, rather than reduced, at each level.

- USAID's resources are immediately multiplied by a 25 percent match from the PVO partner (over $45 million from PVO funds contributed to USAID priority development countries and regional areas since 1985); within the target areas, all PVO programs require a high degree of local government and community participation, individual behavioral change, and, frequently, local government resource commitment and community/participant cost sharing.

Empowerment

PVO programs focus on empowerment at all levels, particularly for communities and women. Enhancing the empowerment of women has been pioneered by PVOs and has proven consistently to be a key factor in improving the health and welfare of children and the family.

- USAID-PVO partnership programs have demonstrated in Bangladesh that even when the poorest women in conservative social settings are provided health information and other opportunities (members of modest local savings groups) that their children are more likely to survive and they will have higher use of family planning methods.

Equity

USAID-PVO programs successfully identify members of the community—regardless of their socioeconomic, ethnic, gender, and age status—in need of information and services to meet their basic health, family planning, nutrition, and development necessities. USAID/PVO/local government/community partnerships rapidly prioritize the needs of neglected groups to target services, effectively and efficiently, to minimize and avoid excess morbidity and mortality.

- In Sudan, the USAID-PVO partnership identified serious health and nutritional conditions in previously underserved ethnic minorities. Treatment and preventive measures rapidly reduced malnutrition by 75 percent, improved immunization coverage and use of ORS/ORT, and assured more equitable future allocation of nutritional supplements.

Effectiveness

USAID-PVO programs work—dramatically—to improve services, introduce positive behavioral changes, and reduce morbidity and mortality. The USAID-PVO programs also provide guidelines and models for national, regional, and international health, family planning, and other development programs.

- In Nigeria, the USAID-PVO partnership within two years improved full immunizations of children by 76 percent, ORT usage rate from 49 percent to 58 percent, and malaria control treatment from 41 percent to 81 percent.

Efficiency and Cost Effectiveness/Benefit

USAID-PVO programs have the capacity to provide the entire package of child survival services; nevertheless, projects are "tailored" to the needs of the specific communities, and services are prioritized and targeted to better utilize local resources, personnel, and volunteers. Population-based information systems, regular surveys, evaluations, sustainability plans, and improving local staff management skills have greatly facilitated project efficiency and cost-effectiveness.

- In India, government services are designed to cover the entire population. Within three years, a USAID-PVO partnership increased children's immunization rates from 31 percent to 88 percent, tetanus toxoid for women from 3.3 percent to 62 percent. In Mali, immunization coverage was dramatically increased and also the cost of achieving complete immunizations was reduced by 50 percent through USAID-PVO partnership programs.

Sustainability

USAID-PVO partnerships achieve significant sustainability in most communities, even those previously beyond the reach of adequate government services. Key factors to the achievement of such sustainability are partnerships with local governments and communities; culturally appropriate education activities for local population that reach a significant portion of the target population, particularly women; collaboration, involvement, and particularly ownership by the community in the educational messages, behavioral changes, and services to be provided; utilization and training of local service providers; motivation and training of existing government services; expenditure of the majority of resources at the target sites and to the final impact sites of the service delivery system instead of diffusion at higher bureaucratic levels; attracting additional donor and national funding to previously ignored or underserved areas; introduction of improved management and evaluation of services, particularly at the service delivery level; and significant enhancement of local knowledge and ability to plan, implement, evaluate, and sustain health and development programs.

- In the five projects reviewed (Uganda, Guatemala, India, Honduras, and Malawi) USAID-PVO program activities have continued (currently, up to four years follow-up) with four of the five showing an upward, enhanced, or stable trend, and one program showing a downward trend but being currently strengthened with local and PVO resource commitments.

Other key issues demonstrated by the USAID-PVO partnership are:

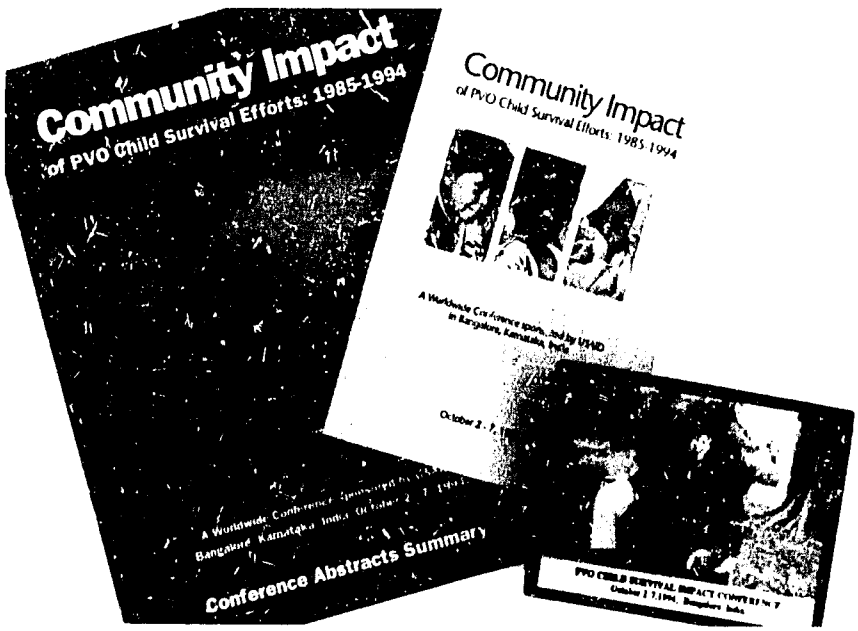
- Program management by USAID and Johns Hopkins University has provided rigorous standards, management inputs, and frequent evaluation of performance;
- Program and project objectives are targeted for impact and closely tied to initial or baseline conditions.

- Programs deliver interventions for low costs per recipient and high impact.
- Initial/baseline and final evaluations have demonstrated dramatic improvements in health, family planning, and nutrition status.
- Major "spin-off" effects have occurred in other social, economic, and political development programs, particularly those empowering women and promoting principles of democratization.
- The quality and effectiveness of existing government services have been significantly improved through the provision of technical and management training for government health workers and professionals.
- The introduction of creative and appropriate technology frequently affects the design and implementation of national and international programs and policy, e.g., many if not most of the currently accepted primary health care, health prevention, child survival, and family planning initiatives were pioneered and developed by PVO and university partnerships.
- Delivery systems demonstrate extraordinary flexibility and routinely function in areas of extreme economic poverty and political instability.
- USAID-PVO partnership programs significantly improve the knowledge and positively change the behavior of target populations to achieve improved indices of health, family planning, nutrition, and other areas significantly affecting the quality of life of underserved populations.

For upwards of 90 percent of the people in many developing countries who remain clearly underserved, despite the best efforts of governments with bilateral and international donors, PVOs appear to be best positioned to readily reach these populations by expanding the scale and solid program base of the current USAID-PVO partnership and to multiply USAID resources by extended partnerships with local governments, communities, and individual participation and ownership of sustainable health, family planning, nutrition, and other development efforts.

We hope that the results of this conference and the formidable cost-effectiveness and benefits of the USAID-PVO partnership program will provide reason to review current policies, strategies, and funding priorities in order to utilize, more fully, the promise and capabilities of an expanded regional and national scale for USAID-PVO partnerships.

We extend our sincere appreciation for USAID's support of USAID-PVO partnership activities and your consideration of the findings of the program evaluations and Bangalore Conference to meet the further needs of underserved populations throughout the world.



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