PN-ACH-446
104567

SUMMARY REPORT:

High Impact PVO Child Survival Programs Volume I

Proceedings of an Expert Consultation
Gallaudet University, Washington, D.C.
June 21-24, 1998

Publication date:
March, 1999

Edited by:
Barton R. Burkhalter and Cynthia P. Green

Co-sponsored by:
BASICS Project
CORE Group
U.S. Agency for International Development,
Office of Health and Nutrition, and
Office of Private and Voluntary Cooperation

Published by:
BASICS Project, Arlington VA
CORE Group, Washington DC
For:
The PVO Community
U.S. Agency for International Development

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BASICS
BASICS is a global child survival support project funded by the Office of Health and Nutrition of the Bureau for Global Programs, Field Support, and Research of the U.S. Agency for International Development (USAID). The agency's Child Survival Division provides technical guidance and assists in strategy development and program implementation in child survival, including interventions aimed at child morbidity and infant and child nutrition.

BASICS is conducted by the Partnership for Child Health Care, Inc. (contract no. HRN-C-00-93-00031-00, formerly HRN-6006-C-00-3031-00). Partners are the Academy for Educational Development, John Snow, Inc., and Management Sciences for Health. Subcontractors are the Office of International Programs of Clark Atlanta University, Emory University, The Johns Hopkins University's School of Hygiene and Public Health, Porter/Novelli, and Program for Appropriate Technology in Health.

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Recommended Citation
Barton R. Burkhalter and Cynthia P. Green, eds. 1999. *Summary Report: High Impact PVO Child Survival Programs, Volume 1.* Proceedings of an Expert Consultation, Gallaudet University, June 21-24, 1998. Published for the PVO community and the U.S. Agency for International Development by the CORE Group, Washington, DC, and Basic Support for Institutionalizing Child Survival (BASICS) Project, Arlington, VA.

Abstract
The Expert Consultation on High Impact PVO Child Survival Programs sought to identify the elements of successful child survival projects operated by U.S. PVOs and other NGOs worldwide, and to recommend to the child survival community how those lessons could be used in the design and implementation of child survival activities in the future. Twenty-four papers were selected following a worldwide call for abstracts. The papers addressed the effectiveness, sustainability and spread of PVO child survival programs that used different strategies, including integration of services, partnering with government, participatory community strategies, operations research, management by information and perinatal focus. This volume presents the complete list of conclusions and recommendations emanating from the meeting, as well as other information in summary form.. A second volume (Volume 2) provides the full text of the papers presented.

BASICS
Basic Support for Institutionalizing Child Survival
1600 Wilson Blvd., Suite 300
Arlington, VA 22209 USA
Phone: 703-312-6800
Fax: 703-312-6900
E-mail: infoctr@basics.org
Internet: www.basics.org

CORE
Child Survival Collaborations & Resources Group
220 "I" St, NE, Suite #270
Washington, D.C. 20002 USA
Phone: 202-608-1800
Fax: 202-543-0121
E-mail: vgraham@worldvision.org

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Executive Summary

For decades PVOs have implemented successful child health and survival programs throughout the world. This experience shows that the barriers to child health and survival are complex and varied from one community to the next. Effective and sustainable solutions are likewise varied. Effective child survival happens when there is a locally appropriate combination of technology, communication, and management-based data. There is no single "magic bullet" to keep all our children alive and healthy.

The full impact of programs is determined by a combination of their effectiveness at the community level, their sustainability, and their spread (coverage). The challenge ahead is for PVOs and the broader child survival community to share the many effective solutions that have been found at the community level, and to learn more about how to sustain program effects over time and to expand coverage to a larger population. These are the major conclusions of the Expert Consultation on High Impact PVO Child Survival Programs.

Held on June 21-24, 1998 in Washington, D.C., the Expert Consultation was sponsored by the CORE Group, the BASICS project, USAID's Office of Health and Nutrition (USAID/G/PHN/HN) and USAID's Office of Private and Voluntary Cooperation (USAID/BHR/PVC). The 55 participants, all with expertise in child health and survival, included 35 representatives of 15 private voluntary organizations (PVOs) and others from cooperating agencies (CAs) working in child survival, USAID, universities, and UNICEF.

The meeting was designed to: (1) identify and document the strategies, approaches and results of the most successful PVO child survival projects; and (2) analyze common elements in the most successful PVO projects and extract lessons that can be used to improve PVO and government-operated programs. In preparation for this meeting, the planning committee distributed a worldwide call for abstracts on successful PVO projects. The committee selected 24 papers from among the responses to be presented at the meeting. (Abstracts of the papers are in Appendix E and the full texts of the papers are available in a companion report entitled *Presented Papers: High Impact PVO Child Survival Programs, Volume 2.*)

During the planning phase, the planning committee identified three major factors that determine the level of public health impact of child survival interventions:

> **Effectiveness**: the extent to which a program reduces child mortality, morbidity, malnutrition or other key survival threatening conditions in a small population;
>
> **Sustainability**: activities or their results that continue over a long period of time; and
>
> **Spread (coverage)**: includes both scale-up of programs and diffusion of benefits by other means; in other words, the number of people who benefit from the program and its influence.

Public health impact is a combination of these three factors, as reflected by the formula:

$$\text{Impact} = \text{Effectiveness} \times \text{Sustainability} \times \text{Coverage}$$

This report identifies programs that have been particularly strong or instructive for one or more of the three factors. See Table 1 (community effectiveness), Table 2 (sustainability) and Table 3 (spread).

PVOs have used different strategies to achieve success in each of the three different impact factors. For example, a focus on perinatal deaths has been an important component in several programs that achieved high effectiveness, but has not by itself been of special importance for achieving sustainability or spread. Community participation appears to be the key to sustainability in many programs, and is also a strategy used to achieve effectiveness at the community level. Partnering with the ministry of health and documentation of results through operations research and community-based information systems are strategies that have been used to increase coverage.

In fact, the consultation identified six strategies used by many of the successful PVO programs:

- **Integration**: integrated multifaceted development across all health programs and beyond health;
- **Partnering**: close collaboration with the MOH, other PVOs, the private sector, and other public and private agencies;
- **Community**: community participation and empowerment (e.g. involvement of volunteers and capacity-building);
- **Information**: information for management to detect and diagnose problems, provide feedback, and conduct situational analysis;
- **Operations research**: problem-focused operations research; and
- **Perinatal/neonatal focus**: special attention during pregnancy and the first month of life to prevent infant deaths and stillbirths.

The Expert Consultation analyzed the contribution of these six strategies to each of the three impact factors, and drew conclusions about elements of the strategies and the conditions of their application which made them successful. This extensive list of conclusions is reported in this document, along with the many recommendations for action to PVOs, to USAID, and to the general child survival community that emanated from the Expert Consultation.

Participants recommended that USAID and other donors work with PVOs to find flexible funding mechanisms to support operations research in community level effectiveness, sustainability and spread.

Finally, participants expressed the expectation that this meeting will lead to an extended dialogue among PVOs, USAID and others in the child survival community about how to design and implement child survival activities with the greatest long-term impact.

1. Introduction

This report summarizes the major conclusions and recommendations from the Expert Consultation on High Impact PVO Child Survival Programs, held June 21-24, 1998 at Gallaudet University in Washington, D.C. The four-day meeting was sponsored by the CORE Group, the BASICS project, USAID's Office of Health and Nutrition (USAID/G/PHN/HN), and USAID's Office of Private and Voluntary Cooperation (USAID/BHR/PVC). The 55 participants (listed in Appendix F) included 35 representatives of 15 private voluntary organizations (PVOs) and others from Cooperating Agencies (CAs) working in child survival, USAID/Washington, universities, and UNICEF.

The purpose of this Expert Consultation was to:

1. Identify and document the strategies, approaches, methodologies, conditions, and results in successful PVO child survival projects, and document analyses of multiple PVO child survival projects (successful or not) that draw general lessons that can be used to improve future projects.

2. Identify and analyze common elements or patterns in the successful PVO projects, as well as lessons from successful and unsuccessful projects, that can be used to improve PVO and government-operated child survival programs, and/or identify gaps in our knowledge about how to design and implement such programs.

The meeting sponsors anticipate that this meeting will lead to an extended dialogue among PVOs, USAID and others in the child survival community about how to design and implement child survival activities with the greatest long-term impact.

To find successful and instructive PVO child survival activities, a worldwide call for abstracts was issued in December 1997. Fifty-three abstracts were received, most of very high quality, and reviewed by the PVO Expert Consultation Planning Committee (see Appendix C for a list of committee members). The Planning Committee selected the abstracts for elaboration into papers to be presented at the Expert Consultation based on the following criteria:

- documented impact of the program on child survival;
- documented impact on indicators known to be related to child survival and the strength of the relationship;
- strength of the evidence that improvements occurred and that they were the direct result of the program;
- evidence of sustainability, either of the program or its effect; and
- evidence of spread, either through program scale-up, influencing policy or otherwise diffusing program benefits to more people (increased coverage).

These criteria formed the organizing principles of the Expert Consultation, as discussed in the next section.

Originally the planning committee anticipated that a small number of projects (5 or 6) would be selected that had demonstrated substantial impact on child survival at the community level, and that these few projects would undergo in-depth critical analysis at the expert consultation, leading to conclusions and recommendations based on the projects as presented and analyzed during the expert consultation. However, the picture that emerged from the submitted abstracts caused the planning committee to modify

its original view. Additional importance was given to sustainability and scale, in addition to short term impact at the community level. This enlarged focus is discussed in the section on Conceptual Framework below. Twenty-four papers were selected for presentation, leaving less time for in-depth discussion and analysis of each paper than originally anticipated. To accommodate this development, the design of the expert consultation was modified to include synthesis papers on the main sub-themes (see Appendix A).

Thus the 24 selected papers, prepared and presented by representatives from 11 PVOs, form the core resource materials from which the participants developed their conclusions and recommendations. Each paper covered several sub-themes of the meeting, as shown in Appendices B (Authors, Synthesizers and Themes of Papers) and D (Presented Papers Organized by Sub-Themes). The full text of these papers is available in a companion volume, *Presented Papers: High Impact PVO Child Survival Programs, Volume 2*, jointly published by the CORE Group and the BASICS Project for the PVO community and USAID. Summaries of the 24 papers are given in Appendix E.

It is important to note that many excellent PVO projects were not submitted among the 53 abstracts. Thus, the 24 selected papers form a representative subset of a larger group of very successful and informative PVO child survival projects and programs.

2. Conceptual Framework

In establishing criteria for selecting papers, the Planning Committee for the Expert Consultation identified three major impact factors that determine the public health impact of child survival interventions:

1. **Effectiveness**: the extent to which a program reduces child mortality, morbidity, malnutrition or other conditions in a small population;
2. **Sustainability**: activities or their results that continue over a long period of time; and
3. **Spread and scale-up**: the number of people covered by the program and its influence.

Roughly speaking, public health impact equals the three factors multiplied together. Programs are not necessarily equally successful in all three factors, however.

In reviewing the abstracts, it became clear to the Planning Committee that certain general strategies, or approaches, were applied frequently by the successful programs. These included:

1. **Integration**: integrated multifaceted development across all health programs and beyond health;
2. **Partnering**: close collaboration with the MOH, other PVOs, the private sector, and other public and private agencies;
3. **Community**: community participation and empowerment (e.g. involvement of volunteers and capacity-building);
4. **Information**: information for management (to detect and diagnose problems, provide feedback, and conduct situational analysis;
5. **Operations research**: problem-focused operations research; and
6. **Perinatal/neonatal focus**: special attention during pregnancy and the first month of life to prevent infant deaths and stillbirths.

The Expert Consultation was organized around the nine sub-themes — the three impact factors and six approaches. The conceptual framework of nine sub-themes was deemed a success by the participants. It marks the first time that such an analytical structure has been developed to examine the work of PVOs and identify key program components. This structure can be applied to both program planning and evaluation. It also provides a framework for organizing lessons learned and ideas for future demonstration projects.

3. Conduct of the Meeting

The meeting covered the nine sub-themes sequentially: on Day One (an evening session) overall objectives and themes for the meeting were introduced; on Day Two presentations and discussion focused on the three impact factors — effectiveness, sustainability and spread/scale-up; on Day Three subgroups of participants discussed each of the six approaches, considering the strength of each approach in influencing the three impact factors and the universality of its application; on Day Four, participants consolidated the work of the previous three days into a final set of conclusions and recommendations on program design, implementation and evaluation (see Appendix A, Program). These final conclusions and recommendations were summarized and presented to the Annual Meeting of the Global Health Council (formerly NCIH) on the following day (June 25).

The sessions on the three impact factors and six approaches each included: (1) a synthesis, or overview, presented by a leading expert on that topic, and (2) presentations of one or more papers that included interventions related to the theme of the session, followed by participant discussion of their own views and experiences. This led to conclusions and recommendations for strengthening child survival projects related to the theme of the session (see Appendix B, Authors, Synthesizers and Themes of Papers). A chair person and a facilitator were appointed for each session.

Each step of the meeting yielded a new modified set of conclusions based to varying degrees on the conclusions of the previous step. As the first step, the authors of the 24 papers drew conclusions in their papers. These papers were given to the synthesizers approximately one week prior to the meeting. The synthesizers provided the second round of conclusions, drawing on the subset of presented papers that were most relevant to their sub-theme. Subsequent rounds of conclusions came from the discussion groups on days 2, 3 and 4, and the presenters to the Annual Meeting of the Global Health Council. While the conclusions reached by the papers and syntheses were generally based on the data presented in the papers, the subsequent sets of conclusions depended less on the data in the papers than on the conversations among the participants of the discussion group.

The conclusions and recommendations in the next section are taken from discussion groups consensus on days 3 and 4 and the presentations to the Global Health Council.

4. Major Conclusions and Recommendations

Participants agreed with the basic paradigm that:

Impact = Effectiveness X Sustainability X Coverage

These three factors (effectiveness, sustainability, coverage) each contribute to a program's impact on child health. Indicators of impact include changes in mortality rates and pattern of causes of death, changes in incidence of disease, and changes in prevalence of malnutrition.

Although most of the conclusions and recommendations reached by the Expert Consultation were organized by the three impact factors and six strategies, several major overarching conclusions were derived and presented to the Global Health Council:

PVO experience shows that the barriers to child health and survival are complex and vary from one community to the next. As a result, effective and sustainable solutions are likewise varied.

Effective child survival happens when there is a locally appropriate combination of technology, communication, and management-based data. There is no single "magic bullet."

The full impact of programs is determined by a combination of their effectiveness at the community level, their sustainability, and their spread (coverage). More attention needs to be given to sustainability and spread.

Effective programs are based on efficacious child survival technologies, some curative but most preventive.

Integrate child survival activities with general community development and poverty alleviation.

Do community outreach and home visits.

Target high risk, including special attention to high risk families and to the perinatal period.

Do community organization and participatory decision making.

Partner with the MOH at all levels.

Tailor interventions to the local conditions.

The summary of conclusions and recommendations presented below is organized by the three impact factors, with conclusions first and recommendations second for each factor.

4.1. Community Effectiveness

Community effectiveness was defined as a program that produces a desirable change in one or more indicators of child health within a community or small population. If this change continues over time

(sustainability) and expands to cover more people (coverage), then it will have a broad impact on child health.

Many of the papers reported impressive quantitative results, with program populations experiencing dramatic improvements in child survival and other factors closely related to child survival. Some of these results are summarized in Table 1 below. Naturally, special conditions and caveats apply to all of these summarized figures, and the reader is referred to the project summaries in Appendix E, and to the complete papers in Volume 2.

Table 1: Ten Programs that Reported High Effectiveness

Program and author	Indicators	Before	After	Time	Comments
AHRC Bolivia; Shanklin	IMR (deaths/1000 LB)	68	18	3 yrs	dose related effect
	U5MR (deaths/1000LB)	164	63	3 yrs	dose related effect
PATH Indonesia; Muller	% of all infant deaths from tetanus	20-25%	<5%	3 yrs	
SCF Bolivia Warmi; O'Rourke, et al	perinatal MR (deaths/1000 LB)	117	44	2 yrs	case control study
SCF Burkina Faso; Findley et al	IMR (deaths/1000 LB)	139	70	3 yrs	dose related effect
Africare Ethiopia Guber; Wubneh	Measles vaccine coverage	23%	53%	1 yr	
Aga Khan India; Mathur & Pulikkal	Low birth weight	70% decrease		3 yrs	
CARE Bangladesh; Islam, et al	Fully immunized cover.	6%	54%	4 yrs	post-control=16%
	Vit A supplement cover., U6	16%	74%	4 yrs	post-control=44%
PLAN Dom.Rep.; Tam	Measles vaccine coverage	30%	60%	1 yr	control 27 to 36%
	Exclusive BF at 4 mths	18%	30%	1 yr	control 18 to 3%
PCI Indonesia; Robinson, et al	Immunization coverage	40% increase		1 yr	low coverge areas
SCF Vietnam; Sternin, et al	mod+sev malnutrition, U3	36%	4%	2 yrs	

Major conclusions related to the theme of effectiveness reached during the expert consultation include:

Community participation. Active community involvement and participation in child survival activities will increase the effectiveness of quality health services and other health interventions. PVOs have been highly effective in involving communities in program planning and implementation.

Program planning. An initial assessment of the current situation regarding community as well as health service conditions, done with community participation, is important in determining the appropriate balance of community-oriented and health service interventions as well as in identifying barriers to health intervention effectiveness.

Assessment of impact. The collection and use of data and other information, including qualitative data, has been critical in achieving effectiveness, through identification of problems for solution, engaging the community, and documenting progress or lack of it. Participants agreed that changes in behavior could serve as a proxy for health indicators, since many projects do not measure health and nutrition indicators.

Spread/scale-up. More work is needed to understand the mechanisms and generalizability of successful programs. Program managers should give more attention to projects that pose questions in advance, especially regarding the application of effective approaches to different settings. Studies are underway to further clarify the dependability of the relationship between outcomes and impact.

Integration. Integration of child survival services with each other, with other health services, and with non-health-sector interventions has the potential for improving effectiveness through synergy and efficiency. In some settings, programs that integrate health and non-health/development interventions, as determined by the community, may provide the entree for child survival programs or increase their effectiveness. On the other hand, integration may also lead to loss of focus and simplicity, task overload and management failure. As such, integration should be actively considered but weighed carefully against potential tradeoffs. Integration can have both positive and negative effects.

Partnerships. Recognizing the role of multiple actors through partnering can enhance effectiveness, but like integration, partnering should be considered carefully against potential tradeoffs and losses in effectiveness. Partnerships should be designed carefully to avoid problems and weaknesses. Joint activities should be launched deliberately, with careful planning and negotiation of roles and tasks. Partner agencies should receive recognition for their contributions.

Neonatal and perinatal mortality. Reducing mortality in the perinatal period should be given high priority in the future for developing effective approaches. PVOs should be leading collaborators in efforts to develop, document, and implement effective interventions in this area, particularly in community-level and integrated maternal-child approaches.

The following recommendations were made regarding community effectiveness for all child survival programs, for PVOs, and for USAID and other donors.

For All Child Survival Programs:

1. *Balance community-level and health interventions.* Child survival programs should strike a balance between community-level interventions and health services.

2. *Build in research.* Future child survival efforts should have a strong emphasis on assessment, monitoring, and evaluation, including built-in operations research.

For PVOs:

1. *Maintain technical expertise.* U.S.-based PVOs should seek continuing support for the presence of highly qualified technical persons in their headquarters office.

2. *Do more research and documentation.* PVOs need to develop a research agenda, test various program models in other settings, and document failures as well as successes.

3. *Be proactive in supporting social justice.* PVOs should continue to play a proactive role in social justice efforts around the world, especially in their support of traditional peoples.

For USAID and Other Donors:

1. *Develop flexible funding mechanisms.* To support community-based approaches, new funding mechanisms are needed that allow substantial flexibility in programming in response to community demand.

2. *Support operations research.* Donors should support built-in operations research, especially on mechanisms responsible for effectiveness and the application of successful approaches to different settings. Donors should also support further studies on the relationship between outcomes and impact/effectiveness. Process studies and use of qualitative data will also be helpful in exploring these factors.

3. *Strengthen public-sector capacity.* Donors should support approaches to bring about sustained improvement in the performance of government counterparts/partners.

4. *Foster information exchange.* Donors should facilitate exchange of information among agencies working in child survival, especially among groups working to reduce perinatal mortality.

5. *Give priority to projects with a research component.* In rating proposed child survival projects, the USAID PVO office should give preference to projects with built-in research.

4.2. Sustainability

In the context of the expert consultation, sustainability refers to the continuation of either the program or the program's impact beyond the period of the original funding and development. This definition implies that certain interventions or programs may not need to be sustained once they have achieved their goal (e.g. polio eradication). Similarly, changes in values and behaviors can be self-sustaining, although in many settings they require periodic reinforcement.

Participants prepared a model to assist in the development of sustainability strategies. The model posits three major types of sustainability: (1) behavioral (sustaining beneficial practices); (2) programmatic (sustaining programs); and (3) organizational (sustaining the organizations that operate programs and provide health services). Individuals and organizations at all levels need to take action to achieve one or more of the three types of sustainability. For example, families and family members can focus on behavioral sustainability. Community groups can work on both behavioral and programmatic sustainability by influencing community health worker programs and incentives, availability of simple supplies, information dissemination and training, and access to health facilities. Field projects and their staff should focus on programmatic sustainability through the design of systems for supplies, supervision, transportation, remuneration, and training. National and international organizations, including international PVOs, are best suited to tackle organizational sustainability by addressing continued funding, planning, accounting, and advocacy.

Table 2. Eleven Examples of Sustaining Programs

Program and Author	Key Approaches Contributing to Sustainability
Africare - Ethipia - Wubneh	Community participation. Appropriate local technology (e.g., horses). Self-financing.
Africare - Mali - Clemmons, et al	Useful and culturally-appropriate invention.
Aga Khan - India - Mathur& Pulikkal	Local cost recovery.
ARHC - Bolivia - Shanklin & Robison	Create and transfer to local NGO. Cost recovery. Measure and display results in community.
FFH - Ghana - Vor der Bruegge	Partnering with local banks. Women's credit and income generation.
LLL - Guatemala - Maza	Community participation. Mother support groups. Mutual support structure among different actors. Self funding.
LLL - Worldwide - Canahuati, et al	Community participation. Mother support groups.
PCI - Indonesia - Robinson, et al	Partnering with MOH at district and provincial level. Information and operations research. Low cost and high benefit/cost.
SCF - Bolivia - O'Rourke, et al	Community participation. Women's groups.
SCF - Vietnam - Sternin, et al	Community participation. Appropriate local technology (via positive deviance).
WV - Senegal - Aubel, et al	Community participation. Partnering with district MOH with WV in facilitating role.

After reviewing the achievements and strategies of the programs with regard to sustainability (Table 2), participants reached several conclusions regarding objectives and plans for sustainability.

Planning for sustainability. In planning, executing, evaluating and costing PVO programs, sustainability and cost-effectiveness need to be considered within the context of long-term economic development. Building programs using already identified local resources gives a better chance of sustainability because self-sufficient programs are not dependent upon external agencies and factors. Linking programs with government objectives and services also helps to promote sustainability.

Strengthening management systems. Technical provision of services is incomplete without management systems to support them. PVOs need to focus on the structural and management issues that lead to sustainable country programs. Implementing agencies need to set up realistic systems to sustain the flow of interventions. Donors and governments should participate in building toward this longer-term sustainable future. Sources of funding should be judiciously applied to enhance sustainability; the potential payoffs are great.

Operations research. Sustainability derives from effectiveness. Research that demonstrates effectiveness can help to sustain a program. Documenting effectiveness helps sustainability in three ways: (1) analysis such as positive deviance helps to refine the strategy; (2) giving fieldworkers feedback on results can strengthen their motivation and thus help sustainability; and (3) developing cost-effective approaches helps to sustain programs.

Integration. Meeting many health needs through an integrated approach increases coverage and

sustainability. However, there is a tradeoff between the complexity of integrated services and coverage of larger numbers of people. Programs need to determine the right mix of services and coverage. Involving the MOH in programs can make services more accessible to users. By integrating certain strategies with others, programs might sacrifice short-term effectiveness but will be more effective in the long term and thus more sustainable.

Community involvement. Promoting community participation helps to create ownership, which helps ensure sustainability.

Partnering. PVOs need to create a long-term shared vision among all project participants. Each group needs to understand what its role is and make a commitment to assuming those roles and identify resources. All players (including MOH and private sector) should understand, participate and be accountable for fulfilling their respective responsibilities. In the event that any of the players is unable to fulfill its responsibilities, alternative strategies need to be identified to fulfill those roles.

Partnering can be an important strategy for long-term sustainability when PVO funding, program focus, and/or vision runs out. PVOs must identify an indigenous organization to maintain, maximize and expand the program. This organization could be a government entity (e.g., the MOH, or local administration), local NGO, private organization, or another PVO. The initial PVO needs to prepare the local organization to be the long-term implementer and sustain the long-term vision.

Information. Information about project outputs and accomplishments is needed for advocacy, fundraising and enlisting political support. Documenting results and achievements and sharing them with participants and beneficiaries helps to promote sustainability by reinforcing their commitment to the project and providing tools for advocacy.

The following recommendations were made regarding sustainability for all child survival programs, for PVOs, and for USAID.

For All Child Survival Programs:

1. *Pay more attention to advocacy.* PVOs, donors and other health agencies should give more attention to advocacy to ensure adequate political and financial support for sustainable child survival programs. Child survival programs need to develop estimates of the resources needed to achieve long-term sustainability, build good quality health services that consumers will pay for, and create information systems to strengthen advocacy for adequate resources. All stakeholders need to be prepared to assume responsibilities and costs.

For PVOs:

1. *More focus on sustainability.* PVOs as institutions should give more attention to sustainability, recognizing the diverse ways to accomplish this and the various aspects of sustainability.

2. *Start from Day One.* Sustainability strategies have to be incorporated in the planning, implementation, evaluation and costing of projects, especially in the formulation of the detailed implementation plan. The transfer or phase-over process begins on Day One and needs to be inherent in the program design. It should be a consistent part of the daily interaction with

counterparts.

3. *Adopt a long-term perspective.* Sustainability strategies must be considered in relation to their impact on long-term socio-economic and political development.

4. *Use diverse approaches.* PVOs should explore diverse approaches to achieving sustainability.

5. *Ensure competent management.* PVOs should assess the core competencies of their own and local counterpart organizations to insure that appropriate management systems are in place to sustain programs.

6. *Collaborate with national partner agencies.* PVOs should increase their collaboration with national-level PVOs/NGOs and other partners in order to present consistent health messages, share lessons learned and strengthen program approaches and quality of services.

7. *Educate donors on cost and time requirements.* PVOs must assume responsibility for educating donors regarding real costs and time required to achieve sustainability. Donors should be made aware that sustained programs need economic support for scaling up.

For USAID:

1. *Involve PVOs.* USAID staff should invite PVOs to join with them in planning USAID policy for achieving sustainability. PVOs should also be included in the global dialogue on perinatal and neonatal policy issues.

2. *Develop a standard framework.* USAID Missions and USAID/Washington should have a common definition and framework regarding sustainability of child survival and health programs. They should communicate this framework with each other and with host-country governments, regardless of funding source.

3. *Support projects and approaches that foster sustainability.* USAID should support projects that have sustainability as a goal. As new approaches are developed, USAID should give priority to sustainable ones.

4. *Build in existing projects.* USAID Missions should incorporate existing child survival projects in their strategic plans.

4.3. Spread (coverage)

Spread is the increase in program beneficiaries reached by child survival innovations. Spread occurs through the processes of scaling up a program in size or by disseminating innovations into pre-existing community culture or institutional structures. If effectiveness and sustainability are maintained in the processes, the impact of a program is increased.

Participants provided a broad framework that depicts the process of scaling up:

- Design project in partnership with counterparts.
- Train and use counterpart staff for implementation.

- Conduct a pilot project in a small population.
- Measure project effectiveness and adjust interventions as necessary.
- Expand to a larger area at the same level and then the next level up.
- Measure effectiveness on expanded area over a longer period of time.
- Present results of evaluation to leaders at a higher level.
- Seek support from well-respected agencies to validate intervention strategies.

This framework builds in the need to measure project effectiveness, seek political support and obtain funds for expansion.

Examples of the approaches that ten PVO programs used to expand their coverage are given in Table 3. Most projects took at least five years to achieve a broader reach; two projects took a decade.

Table 3: Ten Case Studies of Spread and Scaling Up

Program Innovation	Types of Scaling	Reach	Duration
1. Antenatal care/IEC/Green *Pendelu.* Africare in Mali	Cultural. Empowerment.	600 - 5000+	3-4 years?
2. Healthy start CS. PATH in Indonesia	Quantitative: integration with MOH, replication in NTB and other provinces. Functional: integration of CS interventions.	1500? - 3 million	10 years
3. Immunization mgt. PCI in Indonesia	Quantitative: integration with MOH, replication in project province. Organizational: ITI peer training.	5600 - 1.6 million	5 years
4. CS partnering lessons. PCI in Indonesia	Quantitative: integration with MOH/MOE, replication in other provinces. Political: national health policy. Organizational: ITI, schools, etc.	Irian Jaya	
5. Community health workers. SCF in Philippines	Quantitative: integration with MOH. Political: CVHW law/Federation.	250,000 CHW	5 years
6. Poverty and nutrition. SCF in Vietnam	Quantitative: integration with govt, replication in project province and thru "Living University." Cultural: positive deviance. Organizational: endowments.	20,000 - 1.5 million	7 years
7. Coverage to impact. WVI in Bangladesh	Quantitative: replication Organizational: RBM.	270,000 - 2 million to 202 projects	5 years
8. Maternal and perinatal care. SCF in Bolivia	Quantitative: integration with MOH at multiple levels, replication in 8 NGOs. Cultural: community empowerment. Functional: sectors driven by felt needs. Political: Law of pop. participation.	2000 - 200,000 women	8 years
9. Breastfeeding promotion. LLL worldwide	Quantitative: spread thru LLL membership growth, replication in support group trilogy. Cultural: women's empowerment.	8 -1400 counselors 1 - 5 countries	10 years
10. Expanded health program. PLAN in Latin America	Quantitative: replication in KCPS health staffing.	20,000-200,000 (25 countries)	5 years

Major conclusions on spread include:

Integration. Integration with other child survival or non-child survival components provides a vehicle for spreading effects. Once a structure of child survival and health services delivery is in place, adding new elements can occur relatively quickly and over a widespread area.

Partnering. When partnering with government ministries and NGOs, the best results occur when there is agreement on mutual goals early on and the process is characterized by trust and transparency. Alliances should be strategic, seeking high-level agreement on expected outcomes and complementary roles. Integrating interventions into government MOH or other structures is only as good as the government's infrastructure, coverage and will to manage sound child survival programs. Government partnership not only enhances spread but also sustainability. However, effectiveness may be compromised as programs are adapted.

Community involvement. Finding solutions and imbedding intervention elements or innovations into pre-existing culture and social institutions can spread innovations widely. Also local indigenous staff, social institutions such as churches, and cultural practices (particularly those of women) are valuable program resources that can be readily spread widely. Community ownership and "fit" may be threatened as programs scale up because program adaptations to cultures and felt needs in one context may not apply in new contexts.

Operations research. Pilot testing and demonstration of results and cost-effectiveness of scaling up are key to gaining financial and policy support. Formative research for problem-solving leads to greater understanding of local constraints and possibilities for scaling up.

Information collection and dissemination. Use of information on the approach and dissemination of its results between partners, through mass media and other channels increases spread and reaffirms confidence in the viability of the scale-up. Finding simple ways to articulate the innovation is key.

Reliable external funding. Over time, reliable external funding facilitated scale-up of the PVO projects presented at this meeting. Project cost-effectiveness may not change with scale-up, or it may increase due to economies of scale. However, as the budget increases, the competition for funds increases and the demands for alternative funding sources increase.

Simplicity. Simplicity of the technology and the approach help in spreading interventions widely. More universal messages and technologies are more easily spread. These are often more at the level of approaches than specific techniques.

Tradeoffs. Tradeoffs between scale-up, sustainability and effectiveness are not inevitable if they are managed. Training, quality assurance and codified operations manuals are some strategies to guard quality and effectiveness and ease administration as scale up happens.

Political influence. Political influence increases with size. Sizable projects with demonstrated effectiveness are more credible with government leadership. Influencing policy and gaining government support in this way enhances sustainability of projects.

Program leadership. Program leadership can critically influence the success or failure of scale-up.

Time demands and management complexity. Time demands and management complexity are likely to increase with scale-up, requiring better coordination and capacity building of the local participants.

The following recommendations were made regarding spread and scale-up for all child survival programs, for PVOs, and for USAID and other donors.

For All Child Survival Programs:

1. *Coordinate country programs.* USAID Missions, PVO field staff, Cooperating Agencies (CAs) and donors should form a maternal and child health (MCH) coordinating group at the country level for advocacy, policy change, potential partnering and scaling-up.

For PVOs:

1. *Mentor NGOs.* To advance the scaling-up effort, international PVOs should be more proactive in recruiting NGOs and community-based organizations to join networks to replicate successful health projects. PVOs should also develop enclaves that act as living examples that mentor NGOs in scaling-up techniques.

2. *Document effective approaches to scaling-up.* PVOs/CORE should document and disseminate information on strategies, outcomes, policy development and other effective approaches to scaling-up. Information on successful, less successful and potential efforts is useful.

3. *Collaborate with international agencies.* CORE and other PVO umbrella organizations in countries should develop strategies to increase partnerships with United Nations and other international agencies to support scaling-up efforts.

For USAID and Other Donors:

1. *Stress innovation and spread in programs.* USAID should emphasize innovation, operations research, and spread of successful innovations in proposal guidelines. USAID should ensure that program policies facilitate operations research and spread of successful innovations. For example, flexibility in allocating funds and a longer time frame would strengthen efforts to expand coverage.

2. *Support expansion of effective projects.* USAID Missions with health programs and other donors should support PVOs in-country in the scale-up of recognized effective projects.

3. *Fund scaling-up.* Donors should be aware that successful programs need economic support for scaling up.

5. Synthesis of Conclusions on Six Approaches

5.1. Integration

Integrating child survival services with other program elements has several objectives: to unify a program's purpose, increase synergy, maximize impact and/or spread, provide an initiation point or focus, increase acceptability, and lead to a specific outcome/effect. PVOs have implemented various models of child survival program integration:

- One child survival intervention with other child survival interventions
- A package of child survival interventions with other health interventions, such as family planning and women's health
- Child survival interventions with non-health interventions
- Child survival within an existing health system.

Many health needs demand a multifaceted approach that may require integrated planning but may be operationalized through separately managed and delivered services.

Programmatic integration should be strategically planned and aimed at achieving program goals. It is desirable for PVO child survival programs to indicate their priority goals and objectives and to define their vision and rationale for improving quality and efficiency.

Participants developed a set of ten criteria for selecting an appropriate package of interventions (Box 1).

Box 1:
Criteria for Selecting Appropriate Interventions for Integrated CS Design

1. Needs and opportunities in the community
2. Impact desired; e.g., mortality and disease reduction
3. Program quality
4. Strengths and competence of the implementing organization
5. Constraints to implementation
6. Sustainability
7. Potential for scaling up
8. Proposed partners
9. Women's empowerment
10. Strategies for integration: vertical, fully integrated, mixed or sequential

Participants also prepared a program planning framework for integration that addresses the different types of programs with which child survival can be integrated. The design, cost and expected impact of each combination will differ, and will make varying contributions to the three impact factors. The traditional child survival technologies such as immunizations, oral rehydration therapy and nutrition can be combined with newly emerging child survival strategies such as IMCI, with other health programs such as family planning, women's health, environmental health and HIV/AIDS, and with non-health programs such as microfinance and civil society. Further, these issues need to be planned for different levels of the system, e.g., district, commune, village. A planning matrix was prepared with program combinations and system levels along the vertical and characteristics (costs, effect, sustainability, and spread along the horizontal.

Two models listing strategic decision steps to ensure integration into project design were developed (Box 2). In Model No. 1, the types of interventions are guided by health objectives, whereas in Model No. 2 the emphasis is on PVOs staying within their specific competencies.

Box 2: Two Decision Step Models to Incorporate Integration in Project Design

Model No. 1	Model No. 2
1. Establish your health objectives, making them sufficiently broad and considering the potential role of and linkages with other sectors in achieving objectives.	1. Define health goals and objectives.
2. Prioritize the criteria that will be used to select the interventions. (Use proposed menu of criteria listed above.)	2. Define distinctive PVO competencies. Know what you can do well, and avoid going beyond that.
3. Determine the types of interventions, with an eye to integration.	3. Select and prioritize criteria to be used in project design.
4. Assess trade-offs between sustainability, effectiveness, scaling up and costs.	4. Determine what interventions to integrate.
5. Choose appropriate model for integration: Vertical? Mixed? Sequential? Fully integrated CS package, e.g., IMCI? CS package with other health interventions? CS package with non-health interventions?	5. Identify local obstacles and opportunities.
6. Determine the level of the health system or community where integration will occur - administrative level or service delivery at the user level, or both.	6. Organize structure of program.
7. Plan the number of tasks to integrate at the level of the user to maximize impact. Be realistic with the demands on time, personnel and material resources.	7. Identify other interventions and partners.
8. Budget for quality management and good monitoring.	8. Establish appropriate connections.

Integration often has positive and negative aspects: "trade-ons" (elements that benefit the program) may enhance service availability and comprehensiveness of care, while trade-offs (disadvantages) may reduce effectiveness of care in addressing specific health problems. Integration may cause a loss of focus and a diminution of impact.

The extent of integration should be balanced with operational realities, such as PVO resources in relation to the magnitude of health problems. The integration of too many components or services may lead to task overload. The number of interventions to integrate must be well-titrated with desired levels of effectiveness/impact. Programs may have difficulty documenting effectiveness/impact in the short term.

Sustainability. Integration may facilitate and enhance sustainability. However, the components that are being integrated must have simplicity and focus.

Integration with government services. If a child survival program is integrated with that of the MOH, the level of integration must be carefully considered. Benefits can be derived from integration at both the administrative level (e.g. MOH district level) and the user level in terms of service delivery. The two types of integration do not have to occur at the same time.

Women's empowerment. PVOs should emphasize women's empowerment in their design due to the great influence of such an intervention on reducing child mortality and morbidity.

Cross-cutting issues. Five cross-cutting issues should be integrated into child survival program designs: (1) quality assurance or continuous quality improvement; (2) good management principles; (3) community participation; (4) private and public partnerships; and (5) resource (human, financial and other) planning.

5.2. Partnering

Partnering was defined as a collaborative relationship to achieve a mutually agreed, beneficial purpose or goal. Partnerships should be constructive and complementary. They usually originate from a desire to complement each other's activity. However, the nature of partnering can be different at different times. Either party may play a different role depending on the need and circumstances.

Examples of the types of partnerships in child survival programs are:

- PVO/government
- PVO/NGO
- Commercial company with PVOs
- NGOs/community
- NGOs/private sector
- PVO/donor
- NGO/community/government
- PVOs/religious institutions
- PVO/PVO
- NGO/university
- PVO/Cooperating Agency
- UN/PVO.

Reasons for forming a partnership include: be more effective, promote sustainability, expand scale, and influence policy. While partnership brings tangible benefits in many instances, it has some tradeoffs: partnering usually takes time and thus prolongs or delays program activities. In cases where partnering involved capacity building, it is very difficult to maintain quality for a long time. Certain partnerships may become costly. On the other hand, partnering can expedite project planning and implementation and it can lead to improvements in quality.

Many qualities contribute to successful partnerships:

- A shared vision
- Transparency
- Mutual benefit
- Role clarification
- Clear statement of results
- Tangible results
- Commitment of partners
- Shared credit of results
- Mutual trust
- Agreed system of monitoring.

Selection of partners is crucial to successful partnership. Qualities to look for in selecting partners include:

- Track record
- Background
- Vision/mission/strategic plan/staff
- Objectives
- Potential winner
- Maximize investment and return
- Neutralize opponents
- Ownership
- Sustainability.
- Acceptable to all involved parties

5.3. Community Participation

Participants noted that community participation can be defined in many ways. They suggested it be conceptualized as a "ladder of participation" with four levels, reflecting the varying degrees of community involvement and responsibility in health programs:

Level 1 participation: Programs are developed entirely by the MOH/NGO. Communities are involved at the implementation stage.

Level 2 participation: Program priorities are defined by the MOH/NGO. Communities are involved in problem analysis, strategy development, implementation and evaluation. Health and development workers play the lead role.

Level 3 participation: Program priorities are jointly defined by communities and MOH/NGO staff. Together they identify problems, develop action strategies, and implement and evaluate programs. Community members play the lead role. Health and development workers provide technical and organizational support.

Level 4 participation: Program priorities are identified by communities themselves. They take the lead role in action planning, implementation and evaluation. They request support for their program from MOH/NGO staff.

While some PVOs give the impression that their projects are at level 3 or 4, the reality is that many projects are still at level 1 or 2. Most communities lack the skills and experience required to conduct a project independently. This recognition led to further discussion on community participation, empowerment and capacity-building.

The group developed a design process for community participation, as summarized in Box 3.

Box 3: A Program Design Process for Community Participation

1. Establish objectives/goals.
2. Determine intervention types.
3. Listen to the community. Identify:
   - Community needs
   - Opportunities
   - Constraints
   - Existing resources
   - NGO competence/strengths
4. Develop criteria for intervention:
   - Impact
   - Scaling-up
   - Cost
   - Quality
   - Integration
   - Focus on women.
5. Select intervention structure:
   - Vertical
   - Integrated
   - Mix
   - Sequential.
6. Assess tradeoffs.
7. Identify community partners.
8. Implement.
9. Assess.

Recommendations reached by the group are:

1. In order to strengthen child survival programs at the community level, PVOs should develop strategies

and implement activities which target both the policy level and the institutional/ organizational level, as well as the community and household levels. While in past programs objectives have addressed the individual level, in future programs objectives should be formulated which address the policy and institutional levels and indicators for anticipated outcomes at these levels should be formulated.

2. Vast resources are invested in training programs. Often traditional, didactic methods are used. To increase the impact of training and capacity building, all such activities should be based on adult education and participatory learning approaches. Special resources should be programmed to ensure that appropriate technical resources are available for the development of training strategies and activities.

3. In order to enhance the quality of programs and the potential for "spread" it is essential that qualitative, as well as quantitative indicators and tools be developed, and that lessons learned be developed and shared.

For each of the levels (policy, organizational/institutional and community), specific recommendations were formulated:

Policy level

1. PVO experiences with community participation and capacity building should be synthesized and communicated to policy makers so that they can learn, and so that they can support local initiatives. Changes in their attitudes can lead to changes in policies and allocation of resources in support of community level initiatives. For this purpose both quantitative and qualitative processes and results need to be documented.

2. There needs to be coordination among local organizations in order to advocate for a common agenda and approach to community participation and capacity building.

3. PVOs need to encourage policy dialogue and development in support of multi-sectoral approaches to health development in the training of health and development professionals, for example, curriculum development.

4. Identify positive deviant policy makers and develop strategies to encourage and support them to support community participation and capacity building.

5. PVOs should anticipate the resources, including skills and funds, needed to strengthen multi-sectoral collaboration.

6. Support and facilitate forums for policy dialogue that discuss strategic achievements and the need for support of community participation and capacity building at local levels.

7. Advocate for USAID's facilitative support for policy dialogue between the PVOs and government.

Institutional/organizational level

1. Donors, governments and PVOs need to give more attention and support to capacity building approaches for working with communities at the institutional and organizational level for both the health sector and other allied sectors. Increased capacity in using community supportive approaches will be

essential for scaling up PVO supported community approaches.

2. Key facets of institutional capacity building include increasing development agents' knowledge, skills and commitment to working with communities using an empowerment approach. Different types of training/capacity building strategies are required to develop these three elements.

3. In order to allow programs to respond to the changing realities and needs at the community level, more programmatic and financial flexibility needs to be built into the design and implementation of programs.

4. Most maternal and child health programs target mothers of young children. In addition, PVO programs need to build on the roles of other key influential household and community members such as men, grandmothers and mothers.

5. Mechanisms should be developed within programs to ensure the exchange of experiences, tools, materials and lessons learned at several levels: within individual organizations; between organizations, and between countries. The development and use of such mechanisms will require special resources.

6. Models which are successful in one context should be well documented, and their lessons should be developed and documented. This information should be disseminated and these models should be adopted and used in other contexts.

7. To promote collaboration between organizations, identify and build on the respective strengths of each.

8. Within a given country context, PVOs should work with government partners to identify additional partners outside ministries of health such as universities and other training institutions, religious organizations, NGOs, and international organizations. PVOs should seek to strengthen the capacity and methodologies used by such partners in working with communities.

9. In community based child survival programs, it is essential to collaborate with the Ministry of Health, given their mandate and responsibility for national health services. In addition, such collaboration will (in most cases) enhance the effectiveness and potential for sustainability and scaling up of PVO community approaches.

10. To the extent possible child survival programs should identify and develop linkages with other development sectors and activities to increase participation and impact.

Community level

1. In all community programs an initial step should be to assess social infrastructure, community assets related to sociocultural resources, as well as health related problems and needs.

2. To be effective and sustainable, programs need to promote and support contact, dialogue and communication between community members and health and development workers at all levels. There is a need for greater focus on training and follow-up of health and development workers' skills in interpersonal communication and group facilitation.

3. Programs should be designed to ensure access of the most vulnerable groups in the community.

4. Capacity building/training activities should include increasing the respect of health and development agents, commitment to communities to enable and empower them, engender self-esteem, and build confidence. PVOs should build relationships and partnerships with communities based on transparency, trust and openness.

5. PVOs can enhance community ownership by helping communities monitor and evaluate their achievements.

5.4. Information

Information was used in three ways in the case studies: (1) as a means to share lessons learned among and between programs; (2) as a management tool to detect and diagnose problems (and positive deviance), provide feedback, and improve intervention quality; and (3) as a component of advocacy or fund raising to promote an idea or concept. Data can also be used to empower communities if it is organized for their use. Involving communities in data gathering strengthens their sense of ownership. Increasingly donors are requesting information on program evaluation and impact assessment.

Participants mentioned several lessons learned in collecting, using and disseminating information:

- Projects should use team approaches, implement integrated programs and demonstrate quality.
- In designing projects, PVOs need to first identify the desired impact and then work backwards to the necessary inputs. The budget should contain irreducible minimums for baseline and evaluation studies.
- Project managers should learn to use results-based management and should develop policy statements on results-based management for broad use.
- Donors expect projects to show impact on child and maternal mortality, socio-economic status, policy reform and/or behavior change. Generating data on impact requires more rigorous, scientific experimental designs and use of controls where possible. PVOs should develop alternative monitoring systems for use by the community to help to maximize reporting of indicators.
- There is a difference between cost-efficiency (input-related) and cost-effectiveness (impact-related).

Projects collect information at several levels:

1. Pre- and post-intervention knowledge, practice and coverage (KPC) surveys;
2. Pre- and post-intervention KPC surveys with controls;
3. Special studies and operations research;
4. Routine monitoring such as health information systems
5. Disease surveillance and vital registration; and
6. Full-event monitoring (all events recorded on an individual basis).

Many PVOs are also doing situation analyses and facilities assessments, which use both quantitative and qualitative methods. Levels 3, 5 and 6 are the best ways to measure impact. In the context of four-year projects, community monitoring is not an impact measuring tool.

Measuring program impact. When the USAID child survival program for PVOs started in 1985, PVOs

were only required to demonstrate that they had delivered the child survival package of interventions. Assessment of impact was carried out by the Johns Hopkins University. However, the new emphasis on results management has led USAID to ask PVOs to measure impact. USAID needs to clarify whether PVOs are required to ascertain their outputs or their impact.

Collecting data on project impact has generally been expensive. PVOs need to quantify the benefits of having collected the information.

Participants made several recommendations regarding the use of information in successful programs:

1. PVO grants should not be expected to assess impact unless this requirement is explicitly written into the grant agreement.
2. USAID should consider funding a new category of grant: special impact assessment of types of approaches to community-level child survival programs. Once the impact of a particular approach is demonstrated, PVOs would not need to keep showing impact in all projects. This change would facilitate efforts to scale up rapidly.
3. USAID as a technical leader should provide some statement to the donor community on the measurement of impact.
4. Agencies working in child survival should develop a mechanism to identify priority questions and ways of answering them.
5. The monitoring and evaluation working group of CORE should examine the issues raised at this meeting and report back within a year.
6. PVOs should try to resuscitate project data that did document the success of interventions. It would be useful for PVO representatives to give guidance to Dirk Schroeder's work at Emory University to obtain useful information on project impact.

5.5. Operations Research

Operations research (OR) has been useful in improving the effectiveness, sustainability and spread of PVO programs. OR has contributed to effectiveness and cost-effectiveness of PVO child survival programs by developing and refining methods. The HIV counseling study in Kenya (by PLAN International) is an example. OR contributes to sustainability by using methods that involve and motivate participants, reduce cost, and help generate the financial and political support necessary to sustain programs. The positive deviance approach used by Save the Children in Vietnam is an example. Finally, OR contributes to spread by obtaining information that convinces others to adopt the same approach. Africare's Green Pendelu study in Mali is an example.

Although PVOs used appropriate techniques and drew valid conclusions in the OR studies reported at the consultation, additional issues remain that can improve future work. These include:

Internal validity issues. Are reported results really true and free from bias and confounding? What is the true intervention, and how completely implemented was it? What was its quality? Who were the subjects, and how were they selected? How was the data collected, and what were the quality control steps? What was the design?

External validity issues. How representative Are the findings? Even assuming that the report is valid or "true," which other communities could be expected to similarly benefit?

Learning from failures. "Publication bias" tends to limit sharing and publishing unsuccessful programs and interventions. On the other hand, these lessons are as potentially important as the more successful ones, especially if: (1) the reasons for failure can be hypothesized, and (2) others can be dissuaded from making costly mistakes.

Better research and documentation. Can PVO relationships with universities and other technical organizations be strengthened to increase the spread of valid, generalizable findings? Partnerships between PVOs and such institutions benefit graduate students, PVOs, university faculty, and the public's health. Everyone wins.

Participants agreed that PVOs need a technical advisory group for operations research. As PVOs run into operational problems in developing research designs, OR experts within the PVO community could advise them on appropriate solutions.

PVOs need to enhance their skills in conducting operations research. They need to:

- Develop user-friendly training manuals and case studies.
- Disseminate information in PVO meetings, through a computer network and through a journal. Much information is lost, and there are many missed opportunities to spread information. The "grey literature" (unpublished papers) only lasts as long as the project exists. An appropriate journal is needed that is relevant to field programs yet rigorous enough to weed out mis-information.
- Replicate OR results.
- Develop "living universities" to network or partner with PVOs, NGOs, the MOH and CAs.
- Identify ways to retain field experiences. PVOs need to accumulate and refine field experiences to create a knowledge base that would be beneficial in field applications.

5.6. Perinatal/Neonatal Focus

PVOs should give special attention to preventing perinatal deaths (from 28 weeks of gestation through the first week of life) and neonatal deaths (during the 28 days after birth), since many of these deaths are preventable. Two-thirds of all infant deaths are neonatal. An estimated 8 million infants annually die during the neonatal period, and there are about 4.3 million fetal deaths or stillbirths annually. Nearly all of these deaths occur in developing countries. Many of these infant deaths could have been prevented through good prenatal services and nutrition, clean and safe deliveries, emergency obstetric care, and good practices and services during the neonatal period.

Some of the major constraints to good pre-, peri- and neonatal health services are:

- *Policies.* The lack of national commitment to maternal care and services, lack of legal protection to pregnant and lactating women, the low priority of female education, and the low support given to family planning.
- *Socio-cultural and economic factors.* The low status of women (In India men place more value on the cow than the woman, who is more easily replaceable.), heavy workloads of women, social taboos

against revealing pregnancy status (making it difficult to promote prenatal care), and a preference for small babies.

- *Health systems*. Fragmented services, lack of equity in access to care, poor use and allocation of resources to maternal and newborn care, and centralized allocation of resources.
- *Health facility*. Untrained or poorly trained providers, lack of education and counseling skills, lack of staff supervision and follow-up, lack of community outreach, and lack of community ownership of health services.
- *Community level*. Lack of knowledge about maternal and neonatal risks, poor coordination of community-level services and lack of community involvement in the management and supervision of health services.
- *Family/Individual level*. Poor understanding about maternal and neonatal risks, inadequate resources to purchase transport and care; traditional beliefs, lack of planning for birth, and practices regarding family planning and maternal nutrition.

Nine case studies dealt with perinatal/neonatal health. Cross-cutting themes that emerged from these papers were:

- A long-term commitment to the project
- Participatory approaches
- Sensitivity to socio-cultural customs and norms
- Active involvement of partners (local NGOs) and the community
- Community-based registration and follow-up systems
- A decentralized approach
- Community-based planning
- Capacity building in partner institutions and the community
- Attempts to scale up and replicate
- Integration (MCH as a package, grouping services together)
- The value placed on women (showing that project participants value women, paying attention to women during a difficult period).

Lessons learned from the case studies were:

- Providing prenatal, perinatal and neonatal services through intensive community outreach and systematic home visits may be cost-effective, particularly in rural areas and among certain ethnic groups with low actual or perceived access to health services. Such services help to bring people into formal health system and treat other child health problems, thereby avoiding lost opportunities.

- When PVOs partner with technical assistance groups, projects have the potential for attaining greater technical sophistication. External technical assistance can serve to motivate and energize PVO in-country staff and partners and increase the commitment to improved planning, research, supervision, monitoring and evaluation.

- Almost all projects make extensive use of participatory methodologies at all levels of program planning, implementation and monitoring.

- The project activities give importance to the state of motherhood itself, thereby placing more value on women's contributions in society.

- Individualized attention given by health providers to women during vulnerable periods brings them more effectively into the formal health care system and affords the opportunity to provide well-child and family planning services to even hard-to-reach segments of society.

- Community outreach through home visits during the postpartum period is effective and acceptable in overcoming socio-cultural norms of seclusion.

- Family census systems and pregnancy and birth notifications reduce the number of children that do not enter the formal health care system.

- Developing roster/census-based systems may initially require more time and human and financial resources but may reduce health care expenditures in the long term.

- Multiple funding sources may also be accompanied by technical expertise from multiple sources, increased motivation and enthusiasm.

Participants noted that some actions need to be taken for ethical reasons rather than in the expectation that they would reduce infant or maternal mortality rates.

Participants recommended that child survival programs:

1. Develop a recommended package of services based on causes of perinatal deaths.

2. Formulate clear strategies to address perinatal and neonatal care and identify those that could be taken to scale. The knowledge base regarding strategies and interventions needs to be strengthened. More information is needed about the effectiveness of home visits, use of traditional birth attendants (including research on factors affecting their effectiveness, the selection process, and ways to use them more effectively), community-based registration systems, and health facility registration. PVOs would benefit from better information on strategies that have been used for transport and emergency evacuation.

3. Facilitate information exchange through: (1) a "listserv" system so that PVOs can share lessons learned via regular e-mail distribution; (2) a publications search and distribution of abstracts and articles; (3) theme-based group meetings at headquarters and field level; (4) a casebook on strategies, including successes and failures; and (5) discussion groups with technical experts on specific topics. Materials could be translated into other languages and made available through a Website and e-mail.

4. Partner with other organizations working on maternal health. Collaborate with national agencies to improve the consistency of messages.

5. Involve PVOs in the global dialogue on safe motherhood.

6. Encourage PVOs to standardize messages and deal with advocacy issues.

7. Promote breastfeeding immediately after birth and colostrum feeding.

8. Provide appropriate clusters of preventive interventions delivered in the home in the perinatal period: health education on immediate and exclusive breastfeeding, hygiene and basic immunizations; iron, folic acid, iodine, vitamin A supplements; well-baby care; immunization; taking the infant to well-child facilities; and education on maternal and newborn danger signs. Information on family planning should be provided at six weeks postpartum. Men can be educated on danger signs and on the benefits of oral rehydration therapy.

9. Work with women's organizations.

10. Identify pregnancy in early gestation. Involve the community. Young women can take a community census.

11. Increase or improve the quality of care, supervision and availability of services. Service has to have a tangible result, respond to traditional beliefs, and meet a need.

12. Identify positive and negative forces impacting on pregnant women.

PVOs can play a critical role in developing and implementing effective approaches that reduce perinatal and neonatal mortality.

6. The Human and Spiritual Side of Success and Next Steps

6.1. The Human and Spiritual Side of Development Success

Amid the extensive discussions of technical issues, Alonzo Wind made a powerful argument that human values — the spiritual side of development — are essential to success in improving peoples' lives and future prospects. Excerpts from his speech appear below. The full text is included in the companion volume *Presented Papers: High Impact PVO Child Survival Programs, Volume 2.*

> "Beyond the technical and political questions as to how child survival and sustainable development can be promoted, how child survival interventions can truly be brought to scale for hundreds of millions of people around the world and who will pay for it all, an important question facing the world community is this: How can we overcome entrenched patterns of conflict, self-interest, and short-sighted behavior, and contribute to enlightened cooperation and long-range planning on a global scale? . . .
>
> Although there are mystical aspects that are not easily explained, the spiritual dimension of human nature can be understood, in practical terms, as the source of qualities that transcend narrow self-interest. Such qualities include love, compassion, forbearance, trustworthiness, courage, humility, cooperation and willingness to sacrifice for the common good, all qualities of an enlightened citizenry.
>
> The profound and far-reaching changes, the unity and unprecedented cooperation, required to reorient the world toward a sustainable and just future, will only be possible by touching the human spirit, by appealing to those universal values that alone can empower individuals and peoples to act in accordance with the long-term interests of the planet and humanity as a whole. The appeal is most profoundly established through the dynamic force of example, an example that is expressed with humility by project managers and leaders.
>
> . . . whether our approach be religious or secular, we won't fully address issues of community effectiveness without finding ways to both enable and ennoble the human spirit; we won't fully address sustainability without being able to demonstrate and evoke values of sacrifice, sharing and solidarity; we won't fully address scale or spread without restating our implicit commitments to social justice, refusing to disregard or ignore fundamental human rights, and by acting in such a way to touch the human spirit of donors and beneficiaries alike, appealing to those universal values that alone can empower individuals and peoples to act in accordance with the long-term interests of the planet and humanity as a whole."

6.2. Other Issues and Next Steps

This consultancy has shown that the field has progressed from "a paucity of data" to "effectiveness data" and now to "data on effectiveness, sustainability and spread." What more is needed and possible? How can inferences be strengthened? What are the next steps? David Marsh and others raised questions which were sometimes overlooked in the analysis and presentations. Aida Lo spoke forcefully on some of these over-looked issues on behalf of the many field representatives in attendance. On behalf of all the participants, Mimi de Maza thanked USAID for giving the PVOs the opportunity to share their views and experiences and thanked BASICS and the Planning Committee for the excellent organization of the meeting that allowed everyone to share and participate.

The commitment to continue the dialogue between PVOs and USAID was restated. The consultation urged PVOs, CORE and USAID to consider the many conclusions and recommendations made at the meeting and to take action to implement these recommendations.

APPENDIX A

PROGRAM: Expert Consultation on High Impact PVO Child Survival Programs

Gallaudet University, June 21-24, 1998

Sunday, June 21, 1998	
3:30-4:30 pm	*Special planning meeting for synthesizers and facilitators*
5:00-6:00 pm	Check-in {Registration area}
6:00-7:15 pm	Dinner {Patio}
7:15-7:45 pm	{Ballroom D} Welcome and Objectives of Meeting, USAID and CORE spokespeople
7:45-8:00 pm	Conceptual framework and processes for meeting, Bart Burkhalter & Joe Coyle
8:00-9:30 pm	Presentations of High Impact projects FFH/Ghana, Ellen Vor der Bruegge (20 min) PATH/Indonesia, Nancy Muller (20 min) SAVE/Burkina Faso, Sally Findley (20 min) Questions and Answers (30 min)

Monday, June 22, 1998		
7:00-8:30 am	Breakfast {in Bistro}	
8:30-10:15 am	{Auditorium} High Impact Plenary Session Morning kick-off (15 min) SCF/Bolivia Warmi, Lisa Howard-Grabman (30 min, including discussion) ARHC/Bolivia, David Shanklin (30 min, including discussion) Synthesis on high impact, Rob Northrup (30 min, including discussion)	
10:15-10:45 am	Coffee Break	
10:45-11:45 am	High Impact Plenary continued in auditorium ... Discussion and conclusions on High Impact theme (60 min)	
11:45-12:15pm	Spread/Scale-up Plenary - Case Study PCI/Indonesia, Steve Robinson & Linggawijaya (30 min, including questions)	
12:15-1:45 pm	Lunch {Ballroom C}	
1:45-3:15 pm	Sustainability Breakout {Room 2} AKF/India, Arvind Mathur (15 min) LLL/LAC, Judy Canahuati (15 min) WV/Senegal, Judi Aubel& Banda Ndiaye (15 m) Synthesis, Carl Kendall (20 min) Discussion (25 minutes)	Spread/Scale-up Breakout {Room 3} Africare/Mali, Laura Hoemeke&Aissatou Lo (15 m) PLAN/LAC, Luis Tam (15 min) SCF/Vietnam, Jerry Sternin (15 min) Synthesis, Tom Marchione (20 min) Discussion (25 min)
3:15-3:45 pm	Coffee Break	
3:45-5:15 pm	Sustainability Breakout continued ... Discussion & conclusions (90 min)	Spread/Scale-up Breakout continued ... Discussion & conclusions (90 min)
5:15-6:00 pm	Sustainability and Spread/Scale-up Plenary Session {Auditorium} Report back from breakout sessions and Discussion (45 min)	
6:30-8:00 pm	Dinner and Research Report on PVO Data Sets, Dirk Schroeder& D. Marsh {Ballroom C/D}	

Tuesday, June 23, 1998			
7:00-8:30 am	Breakfast {in Bistro}		
8:30-8:45 am	Approaches for achieving impact: Morning kick-off in plenary {Ballroom D}		
8:45-10:15 am	{Room 2} Integration Breakout CARE/Bangl, Wahidul Islam Synthesis, Milton Amayun Discussion	{Room 4} Community Breakout Africar/Ethiop, HaileWubneh CARE/Niger, Sani Alou & Michelle Kouletio LLL/Gua, Mimi de Maza Synthesis, Judi Aubel Discussion	{Room 3} OperationsRes. Breakout PLAN/Kenya, Nancy Vollmer PCI/Indonesia Training, Steve Robinson Synthesis, Joe Valadez Discussion
10:15-10:45am	Coffee Break		
10:45-11:45am	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations
11:45-12:30 pm	Plenary report on morning break-out sessions (15 min each) {Ballroom D}		
12:30-1:45 pm	Lunch {Patio}		
1:45-2:00 pm	Approaches for achieving impact: Afternoon kick-off in plenary {Ballroom D}		
1:15-3:00 pm	{Room 2} Partnering Breakout ARHC/Bolivia, David Shanklin SAVE/Philipp, Naida Pasion Synthesis, Steve Robinson Discussion	{Room 4} Information Breakout PLAN/Dom.Rep., Luis Tam SAVE/Bolivia, Fernando Gonzales WVI/Banglad, Sri Chandler Synthesis, Roy Miller Discussion	{Room 3} Peri/Neonatal Breakout Synthesis, Bettina Schwethelm Panel Discussion
3:30-4:00 pm	Coffee Break		
4:00-5:30 pm	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations
5:30-6:15 pm	Plenary report on afternoon breakout sessions (15 min each) {Ballroom D}		
6:30-8:00 pm	Dinner and open time {Patio}		

Wednesday, June 24, 1998			
7:00-8:30 am	Breakfast {in Bistro}		
8:30-9:30 am	{Ballroom D} What have we achieved so far: Morning kick-off in plenary (15 min) Panel discussion on limitations of analysis so far (Alonzo Wind., Sani Alou) (30 min) Instructions for breakout groups: Synthesis of results on approaches for each impact factor, including estimated universality and reliability of results. (15 min)		
9:30-10:30 am	{Room 2} Effectiveness Breakout	{Room 4} Sustainability Breakout	{Room 3} Spread/Scale-up Breakout
10:30-11:00am	Coffee Break		
11:00-11:30am	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations	Breakouts continued ... Discussion, conclusions and recommendations
11:30-12:30 pm	Plenary report on morning break-out sessions (20 min each) {Ballroom D}		
12:30-1:30 pm	Lunch {Patio}		
1:30-2:30 pm	Forging the final paper, in plenary {Ballroom D}		
2:30-3:15 pm	Analyze usefulness of final conclusions in user specific breakout groups. user group 1 user group 2 user group 3 user group 4 user group 5		
3:15-3:45 pm	Coffee Break		
3:45-4:45 pm	{Ballroom D} Plenary report on afternoon breakout sessions and modification of final draft		
4:45-5:00 pm	Conclusion of Expert Consultation		

Thursday, June 25, 1998	
12:00-2:00 pm	Noon session at NCIH reporting results {Salon H at NCIH}

APPENDIX B

PRESENTERS, SYNTHESIZERS and FACILITATORS

Presenters			Synthesizers & Facilitators		
PVO	**Country**	**Names**	**Theme**	**Synthesizer**	**Facilitator**
Africare	Ethiopia	Haile Wubneh	High Impact	Rob Northrup	Joe Coyle
	Mali	Aida Lo & Laura Hoemeke	Sustainability	Carl Kendall	David Newberry
AKF	India	Arvind Mathur	Spread/Scaleup	Tom Marchione	Nancy Keith
ARHC	Bolivia-1	David Shanklin	Integration	Milton Amayun	David Newberry
	Bolivia-2	David Shanklin	Partnering	Steve Robinson	Mizan Siddiqi
CARE	Bangladesh	Waidul Islam	Community	Judi Aubel	Laura Hoemeke
	Niger	Sani Alou & Michele Kouletio	Operations Res.	Joe Valadez	Nancy Keith
Emory U	"many"	Dirk Schroeder	Information	Roy Miller	Alonzo Wind
FFH	Ghana	Ellen Vor der Bruegge	Peri/Neo-Natal	Bettina Schwethelm	Victoria Graham
LaLeche	Guatemala	Mimi de Maza			
	Expansion	Judy Canahuati			
PATH	Indonesia	Nancy Muller			
PLAN	Dom. Rep.	Luis Tam			
	Kenya	Joe Valadez & Nancy Vollmer			
	LAC	Luis Tam			
PCI	Indonesia-1	Steve Robinson			
	Indonesia-2	Linggawijaya & Steve Robinson			
SCF	Bolivia-1	Lisa Howard-Grabman			
	Bolivia-2	Fernando Gonzales			
	Burkina Faso	Sally Findley			
	Philippines	Naida Pasion			
	Viet Nam	Jerry & Monique Sternin			
WV	Bangladesh	Sri Chander			
	Senegal	Judi Aubel & Banda Ndiaye			

APPENDIX C

PLANNING COMMITTEE MEMBERS, STAFF and OTHER SPEAKERS

Members of Planning Committee

Al Bartlett, USAID/G/PHN/HN
Massee Bateman, USAID/G/PHN/HN
Bart Burkhalter, BASICS
Victoria Graham, CORE Group
Kate Jones, USAID/BHR/PVC
Rob Northrup, BASICS
David Oot, Save the Children
Dory Storms, The Johns Hopkins University
Joe Valadez, CORE Group and Plan International
Alonzo Wind, Medical Care Development International

Speakers, other than presenters of selected PVO papers and synthesizers

Al Bartlett, Office of Health and Nutriton (USAID/G/PHN/HN/CS)
John Grant, Director, USAID Office of Private and Voluntary Cooperation (USAID/BHR/PVC)
Aissatou (Aida) Lo, Africare/Mali
Irma (Mimi) de Maza, La Leche League/Guatemala
Joy Riggs-Perla, Director, USAID Office of Health and Nutrition (USAID/G/PHN/HN)
Dirk Schroeder, Emory University
Alonzo Wind, Medical Care Development International

Meeting Organizers and Staff

Chief Planner: Bart Burkhalter, BASICS.
Logistics Manager: Kathie Miller, BASICS; **Logistics Support**: Kavita Bali, BASICS.
Main Facilitator: Joe Coyle, BASICS consultant.
Facilitators for Subgroups: Victoria Graham, CORE Group; Laura Hoemeke, Africare; Nancy Keith, BASICS; David Newberry, CARE: Mizan Siddiqui, BASICS/Bangladesh; and Alonzo Wind, Medical Care Development International.
Rapporteur: Cynthia Green, BASICS consultant.
Note-takers: John Durgavich, BASICS; Nancy Keith, BASICS; and Mizan Siddique, BASICS/Bangladesh.

APPENDIX D

PRESENTED PAPERS ORGANIZED by SUB-THEMES

PAPERS	IMPACT SUB-THEMES			APPROACH SUB-THEMES					
	Effective	Sustain	Spread	Integrate	Partner	Commun.	Ops Res	Informa	PerNeoNat
Theme Synthesizers --->	Rob Northrup	Carl Kendall	Tom Marchione	Milton Amayun	Steve Robinson	Judi Aubel	Joe Valadez	Roy Miller	Bettina Schwethelm
Africare/Ethiopia, Wubneh		o				X	o		
Aficare/Mali, Clemmons, et al		o	X			o		o	panel
AKF/India, Mathur &.Pulikkal		X		o					o
ARHC/Bolivia-1, Shanklin	X			o				o	o
ARHC/Bolivia-2, Shanklin & Robison		o			X			o	
CARE/Bangl, Islam, et al	o			X	o	o		o	
CARE/Niger, Kouletio, Alou, et al						X	o	o	
FFH/Ghana, Vor der Bruegge	X	o		o	o				o
LLL/Guatemala, Maza		o				X			
LLL/Expansion, Canahuati, et al		X	o		o	o			o
PATH/Indonesia, Muller	X		o						panel
PLAN/Dom.Rep., Tam	o					o	o	X	
PLAN/Kenya, Vollmer & Valadez						o	X		
PLAN/LAC, Tam		o	X						
PCI/Indonesia-1, Robinson, et al			o		o		X		
PCI/Indonesia-2, Linggawijiaya & Robinson			X		o		o	o	
SCF/Bolivia-1, O'Rourke, et al	X	o			o	o		o	panel
SCF/Bolivia-2, Gonzales, et al			o					X	
SCF/Burkina, Findley, et al	X	o		o		o			
SCF/Philippines, Pasion		o	o		X	o	o		o
SCF/Vietnam, Sternin, et al	o		X	o	o	o	o	o	
WV/Bangladesh, Saha & Chander	o		o					X	o
WV/Senegal, Aubel, et al		X			o	o			
Emory Univ & SCF, Schroeder & Marsh	X								

KEY: "X" = Presentation. "o" = Key paper for synthesis. "Panel" = special panel for peri/neo-natal session.

APPENDIX E

SUMMARIES of 24 PAPERS PRESENTED at the EXPERT CONSULTATION

Summaries of 24 Papers Presented at the Expert Consultation

(Presenters underlined)

Africare

1. ***Guber Child Survival Project and The Horses.*** Haile Wubneh, Africare/Ethiopia. The Gumar District of Ethiopia faced many problems that hindered the delivery of health services to its people, including insufficient health infrastructure, high attrition among health workers (85% in 5 years), and ineffective and non-existent transportation. In order to improve maternal and child health and survival under its USAID child survival grant, Africare addressed the barriers to health service delivery. A stable source of funding to pay community health agents was established by collecting a small contribution (about 15 cents per year) from each household. This stopped attrition. The transportation problem was solved by acquiring ten horses that were used by the health workers to visit villages. This proved to be a lower cost and more sustainable solution than the alternatives, such as motorcycles. These and other culturally appropriate interventions achieved the desired results, with service coverage increasing dramatically. For example, measles coverage jumped from 23% to 53% in one year.

2. ***Turning the Ordinary into the Extraordinary: The Green* Pendelu *and Maternal Health in Mali.*** Lydia Clemmons and Yaya Coulibaly, Africare/Mali. (Presented by Laura Hoemeke and Aissatou Lo of Africare.) This paper introduces the philosophy and elements of the Dioro Approach in which indigenous resources, including songs, storytellers (*gnats*) and traditional clothing, were used in a successful campaign to increase communication between husbands and wives regarding pregnancy and to improve health-seeking behavior during pregnancy. In a culture where pregnancy has traditionally been a taboo subject and rarely discussed at the household level between husbands and wives, Africare's Dioro Child Survival Project in Mali successfully increased communication and health-seeking behavior during pregnancy. Assisted births in the project area increased from under 20% at the start of the project to 77% in the year after the program was implemented. Of particular note was the development of the green pendelu, a traditional sleeping garment for women in Mali which, when colored green, came to signify pregnancy. This nonverbal communication invention and other aspects of the Dioro Approach are being widely used throughout Dioro four years later, have been recognized nationally, and are spreading to other parts of the country.

Aga Khan Foundation

3. ***Improving Child Survival Programmes in a Rural Health Care System: The Aga Khan Foundation (I) and the Aga Khan Health Services (I) Experience in India.*** Arvind Mathur and Aravind Pulikkal, Aga Khan Foundation/India. This paper describes two Aga Kahn projects in India and the strategies used to achieve sustainability in those projects. The projects provide basic preventive, promotive and curative health services to more than 70,000 residents in 48 selected villages in two widely separated sites. Large improvements in key child survival indicators such as immunization coverage and incidence of low birth rate are reported. The paper discusses the contribution of key program elements to this improvement, including innovative approaches for systematic project planning and implementation, community participation, health sector modeling, support systems, and intensive public education to convert need into demand. The proportion of the program budget generated by fees for service climbed from 16% in 1994 to 68% in 1997, evidence of growth in program financial sustainability. Interventions that helped achieve financial sustainability such as operational efficiency analysis and the introduction of alternative health financing mechanisms are discussed.

Andean Rural Health Care (ARHC)

4. ***Dramatic Reduction of Child Mortality in Three Bolivian Child Survival Projects***. David S. Shanklin, Andean Rural Health Care (ARHC). This paper analyzes the impact of ARCH's primary health care program on infant and child mortality in three Bolivian project areas over eight years (1990-97), compared to a control area. The ARHC "Census-Based, Impact Oriented" (CBIO) model employs community health workers to perform home visits, preventive education and vital events registration, meanwhile coordinating very closely with nearby clinics and government health services. Infant and child mortality rates declined significantly over the course of the intervention and an increased utilization of pre-natal and delivery services was observed. Under five mortality dropped from 164 to 63 deaths per thousand live births over approximately five years, compared to no change in the comparison area. There was a clear dose-related effect; for example, programs where prenatal care and delivery services were available and used experienced much greater reduction in infant mortality than programs where such services were not well utilized.

5. ***The Long, Hard Road to Child Survival Program Sustainability***. David S. Shanklin and Nat C. Robison, Andean Rural Health Care (ARHC), Consejo de Salud Rural Andino (CSRA). During its 15 year tenure in Bolivia, ARHC has increasingly focused on the sustainability of its programs. The chief sustainability intervention was the creation of a permanent local counterpart NGO, CSRA, to take over and operate the health programs. This paper analyzes the progress made towards sustainability by AHRC and CSRA. A key measure of CSRA's sustainability is its financial autonomy; AHRC's support to CSRA dropped from 75 percent of program expenses in 1987 to 35 percent in 1997. Based on ARHC's experience, the paper concludes that sustainability is definitely possible but may require a 20 to 25 year period and requires in-country NGO capacity in leadership, administration, finance, marketing, fund-raising, and health information systems.

CARE

6. ***Capacity Building Approach in Health and Family Planning in Bangladesh***. Wahidul Islam, Nizam Uddin, Zia-ur-Rahman, CARE/Bangladesh. CARE's efforts in Sylhet District, Bangladesh, to strengthen the Ministry of Health and Family Welfare's capacity to deliver outreach services are described. Significant improvements in various child survival indicators are noted; for example, the percentage of fully immunized children increased from 6% in 1991 to 54% in 1995 while the percentage of children under 6 receiving vitamin A supplements increased from 16% to 74%. Seven "elements of success" of child survival programs are described that include training, supervision, coordination between services and community mobilization. The importance of the long-term effort by CARE and the MOHFW to create a partnership which began in 1986 is also noted.

7. ***Promotion of a Simple Energy-Rich Recipe for Improved Child Nutrition in Niger***. Michelle Kouletio, Sani Aliou, Eleonore Seumo, Inousssa Malaam, Judiann McNulty, Laminou Sani, Rahila Omarou, CARE/Niger. This paper describes CARE's effort to introduce a new weaning food into its Sanu Yara child survival project in Niger. The weaning food was a PRITECH-developed method for adding peanut oil to porridge, in order to increase the energy intake of young children. The behavior change strategy used by CARE included ethnographic studies to identify barriers to change, application of "trials for improved practices" (TIPS) to find feasible approaches, and use of various types of health workers to promote the new food in one-on-one interaction with mothers. The nutrition intervention met criteria for appropriateness outlined in the paper. The probable success of the intervention is supported by a study which indicates that 40.7 percent of children in the program area are receiving the improved weaning food and that those children are receiving an average of an additional 120 kcal per day as a result. The paper makes four recommendations for achieving impact in such activities: are included in the conclusion, among them promotion of the father's role, building on existing practices, engage the community in research, and use of health workers as change agents.

Freedom from Hunger (FFH)

8. ***Freedom from Hunger's "Credit with Education" Strategy in Ghana.*** Ellen Vor der Bruegge, FFH/Ghana. FFH's Credit with Education program combines village bank services for women with non-formal education in breastfeeding, child nutrition, diarrhea control, immunization and family planning. This paper presents an analysis of the key elements of the program by Vor der Bruegge, followed by a summary of an evaluation of the program in Ghana by Barbara MkNelly and Christopher Dunford. The 3-year program achieved significant gains in the nutritional status of one-year old children, improved breastfeeding practice and improved knowledge of diarrhea prevention and treatment in mothers. The program affected financial, behavioral and psycho-social factors which, while broader than the health agenda, actually appear to have a greater and more durable impact on health behaviors than on women's economic capacity. Interest paid by borrowers under this program covered 81 percent of the rural banks costs of delivering the credit and educating women.

La Leche League (LLL)

9. ***Strategies to Motivate and Sustain Volunteer Work.*** Irma Ch. de Maza. LLL/Guatemala. La Leche League International (LLLI) and La Leche League Guatemala (LLLG) implemented a program of mother-to-mother support in poor peri-urban areas of Guatemala City under a USAID child survival grant in 1988-92.The project trained 214 local mothers to be breastfeeding counselors, and incorporated them into a volunteer structure in ten communities where they ran breastfeeding support groups, provided one-on-one counseling and made referrals to health facilities. A 1996 study four years after the grant ended found that most of the counselors were still active, although the number of support groups had declined, that approximately 25% of women of child-bearing age in the community surveyed were in contact with a counselor, and that over 90% of the mothers referred to a facility actually went. The paper suggests that the reasons the program was able to sustain after the grant ended included: (1) high personal motivation of the volunteer breastfeeding counselors, and (2) a support structure that provides "bidirectional support" and motivation to the mothers, the volunteer counselors, the elected coordinators in each community, and the staff and volunteers in LLLG.

10. ***Expanding Mother-to-Mother Support: Lessons Learned in Creating and Implementing a Model for Community-based Mother-to-Mother Support.*** Judy Canahuati, Maria Jose de Suarez, Naveeda Khawaja, Janine Schooley, Carmen Casanovas, Yanet Olivares de Saez, Pricilla Stothers, LLL. This paper, authored by representatives from La Leche League, Mothercare and Wellstart who live and work in several countries, provides a history of La Leche League International followed by case studies from Dominican Republic, Egypt, Honduras and Pakistan that highlight different critical program aspects such as training, IEC materials development and supervision. The success of La Leche League derives in part from its focus on motivational and behavior change strategies that are more broadly applicable beyond breastfeeding and weaning. La Leche League provides a model that offers NGOs concrete guidelines for working at the community level. The paper discusses the spread (to over 60 countries) and sustainabiliy of the LLL program, and provides an extensive list of lessons learned.

PATH

11. ***Where Child Meets Survival: Healthy Start for Child Survival in Indonesia.*** Nancy Muller, PATH/Indonesia. PATH's Healthy Start program in Lombok Province, Indonesia has as its goals the strengthening of Lombok's existing birth-centered system by delivering preventive services to postpartum women and infants within one week of birth, and replicating the government's new model of having trained midwives rather than TBAs assist home deliveries. It aims to improve immunization coverage, iron, iodine and vitamin A status, exclusive breastfeeding, breastfeeding during illness, and cord care practice. Key elements of

the project include community-based vital events registration, integrated birth-centered preventive health interventions, including family planning, and active outreach to newborns in the home. An evaluation shows substantial improvements in most of the key indicators. PATH's integrated approach in Indonesia began in 1987 with the Hepatitis B Model Immunization Program. The long, continuous association between PATH and the Government of Indonesia is cited as a key contributor to the program's success. In addition, new technologies were field tested such as the UNIJECT and new monitoring and evaluation tools like the verbal autopsy were applied in the course of implementation.

PLAN International

12. ***Effectiveness of PLAN International in Immunization Coverage and Breast-Feeding Practices.*** Luis Tam, PLAN International/Dominican Republic. PLAN implemented a child survival program in poor, peri-urban areas of Santo Domingo, Dominican Republic during 1989-92. The project focused on increasing immunization coverage and improving breastfeeding practices. This paper reports on an evaluation of the project that uses a rigorous methodology not usually applied in the evaluation of other PVO child survival projects. Midterm and post household surveys were conducted in program and control areas, with a sample of about 400 in each of the four surveys. Life tables and a Cox proportional hazards model were used to estimate program impact. Results showed that the program was responsible for statistically significant improvements in both immunization coverage and breastfeeding practices, as well as feeding during diarrhea.

13. ***Improving Training for HIV/AIDS Counseling: A Psychological Epidemiology of People with HIV/AIDS in Kenya.*** Nancy Vollmer and Joseph Valadez, PLAN International/Kenya. This paper describes a 1992 study in Kenya that attempts to establish a basis for provision of care to people with HIV infection and AIDS. The study is one of the first systematic attempts to identify the psychosocial needs of HIV infected people in Africa. It develops a typology of psychological problems reported by 307 people with HIV infection during counseling. A factor analysis enabled the 109 different types of problems reported to be grouped into 15 general categories, which then provided a framework for the development of a curriculum to train paraprofessional HIV counselors in East Africa. Data indicates that counselors can expect a client to present one or more of the fifteen categories of problems during counseling. A key finding is the sheer number of different problems that many patients report.

14. ***The Role of the USAID/BHR/PVC Child Survival Projects in Enhancing Health Policy and Programming in the South American Region of PLAN International.*** Luis Tam, PLAN International. PLAN International operates child-focused health and development programs in many countries and communities serving hundreds of thousands of children throughout Latin America and the world, funded by contributions from the public. This paper shows how three USAID-funded child survival grant projects in Latin America operated by PLAN influenced the policies and practices of all of PLAN's programs in Latin America. The conclusion states six elements which contribute to institutional success. For example, PLAN has begun holding annual country planning workshops, initiated field exchanges of project staff, and adopted household surveys and other evaluation techniques as a result of the child survival projects. PLAN has also given higher priority to activities that promote the health of children in its annual budgets.

Project Concern International (PCI)

15. ***Evaluation of a Peer-to-Peer On-the-Job Immunizer Training Program in Indonesia.*** J. Stephen Robinson, Barton R. Burkhalter, Barbie Rasmusssen and Ristanto Sugiono, PCI/Indonesia. As part of its immunization improvement activity in Maluku Province, Indonesia, PCI and the Provincial Department of Health implemented an on-the-job peer training program for nurse immunizers at health centers with poor

immunization performance. The evaluation concludes that reported immunization coverage increased by 40% in the program group relative to the control, and that the quality of immunization practices also improved. Cost analysis indicates that the cost of the peer training was very low, with a marginal out-of-pocket cost of about $.50 per additional fully immunized child.

16. ***Partnering with Government for Child Survival Interventions.*** Linggawijaya and J.Stephen Robinson, PCI/Indonesia. This detailed overview of the implementation of PCI's child survival interventions in Indonesia focuses on the practical issues of partnering with government. The paper describes six immunization interventions that were implemented in concert with the Maluku Province Ministry of Health and that proved to be successful, dramatically so in some cases. The six interventions include: (1) advocating policies for tetanus vaccination of all women of child bearing age rather than just pregnant women, (2) lifetime TT cards, (3) on-the-job peer training, (4) computerized local area monitoring, (5) school based MCH, and (6) student immunization week force. The implementation of these six interventions in Maluku initially and then in East Kalimantan and Irian Jaya provinces of Indonesia is reviewed and lessons drawn about partnering and about replication. Successful elements of the partnering approach includes: (1) joint government-PCI intervention design, (2) training and use of government staff for implementation, (3) involvement of government staff in monitoring and evaluation, (4) providing assistance to government staff in preparing budgets for continuation, and (5) allowing time for a gradual turnover. This paper concludes that programs that work well in one setting may not transfer to another setting successfully without a substantial amount of fine-tuning.

Save the Children Federation/USA (SCF/USA)

17. ***The Impact of Women's Community Organization on Perinatal Outcomes in Rural Bolivia.*** Kathleen O'Rourke, Lisa Howard-Grabman and Guillermo Seoane, SCF/USA/Bolivia. A maternal-child health intervention was conducted in a remote Bolivian province with limited access to modern medical facilities. The intervention focused on organizing and strengthening women's groups, developing skills in problem identification and prioritization, and training community members in safe birthing techniques. The intervention was evaluated by comparing perinatal mortality rates and behavioral changes among 409 women before and after the intervention. Perinatal mortality decreased from 117 deaths per thousand births to 44 deaths per thousand births following the intervention. There was significant increase in the number of women's organizations as well as women's participation in organizations following the intervention. The percent of women receiving prenatal care and initiating breastfeeding on the first day after birth increased significantly. The timing of care given to newborn infants improved in controls, but this change was not statistically significant. This study demonstrates that community organization can be effective in improving maternal-child health in remote areas.

18. ***Scaling up the Warmi Project: Lessons Learned Mobilizing Bolivian Communities Around Reproductive Health.*** Fernando Gonzales, Elizabeth Arteaga and Lisa Howard-Grabman SCF/USA/Bolivia. This paper describes eight major steps in the process of scaling up from the experience of SFC/Bolivia. From 1995 through 1997, SCF/Bolivia, working with the Ministry of Health, PROCOSI (a national PVO umbrella group), and other partners, expanded the Warmi Project from a pilot in three rural communities in one province to a national program affecting 513 communities in Bolivia. Their experience demonstrates how participatory approaches, specifically the "community action cycle," can be brought to national scale through flexibility, inter-institutional coordination and establishment of common goals. As the Warmi model expands to other countries in Latin America and Africa, health planners need to examine lessons learned from this seminal work in Bolivia.

19. ***Stretching the Limits of Health Interventions in Burkina Faso.*** Sally Findley, Ahmed Zayan, Maria Kere, Youssof Kone and Gaston Sogbo, SCF/USA/Burkina Faso. An evaluation of Save the Children

Federation's child survival program efforts in Sapone, Burkina Faso found that in the 18 program villages infant mortality rate dropped from 139 deaths per thousand live births in 1993 to 70 in 1996, while child mortality dropped from 54 to 35 deaths per thousand live births during the same period. Further, the data show a clear dose related effect; mortality reduction was greater in villages operating for more time and with more program elements implemented. Mortality data and focus group commentary support the hypothesis that complementary programs which facilitate the accomplishment of basics needs both free time for participation in health education and positively expand the resources required for maintaining health. Villagers comments clearly reflect an understanding of the synergism between health and non-health development efforts. Health is not enough.

20. ***Policy-Level Impact of the Save the Children/Department of Health Partnership on the Community Volunteer Health Workers Program.*** Naida G. Pasion, SCF/USA/Philippines. In 1995, the government of the Philippines legislated an impressive package of benefits and incentives for village health workers. This paper documents the remarkable three-year effort by SCF and the Philippine Department of Health to enhance each other's programs by developing a partnership which combined the flexibility and international experience of SCF and the political and logistical support of the government. After detailing the key policy and implementation actions, the paper draws seven "significant insights" critical to the partnership between a government and an NGO.

21. ***Scaling up a Poverty Alleviation and Nutrition Program in Vietnam.*** Monique Sternin, Jerry Sternin and David Marsh, SCF/USA/Vietnam. Sternin et al. provide a case study on how a successful nutrition program in Vietnam was scaled up from the 1991 Save the Children-managed "Povert Alleviation and Nutrition Program" covering four communes with a population of 20,000 to a largely government-managed, multi-district program covering 1.2 million persons on 1998. Evaluations of the program find that it virtually eliminates severe malnutrition in young children; for example in the original four communes the prevalence of moderate and severe malnutrition in children under three years of age dropped from 36% to 4% after the program had been in operation for two years. Many innovations were incorporated into the program to enhance sustainability and replicability. For example, the use of positive deviance to identify sustainable local practices which lead to healthy child nutritional status was key to designing the village-based interventions. Many different lessons can be drawn from this experience.

World Vision International (WVI)

22. ***Impact and World Vision's Child Survival Programs.*** Ratu Saha and Sri Chander, WVI/Bangladesh. This paper describes the development and current state of WVI's impact monitoring system, including a prototype Community-Based Death and Disease Surveillance System which has been introduced in two WVI child survival projects in Bangladesh. In addition to presenting data collected through this system, the authors discuss an evaluation of the system that includes completeness of data collection and the five key elements for quality program design: (1) integrated program designs, (2) draft impact objectives first and then proceed to output, process and input objectives, (3) identify and budget against key project milestones, (4) develop a detailed implementation plan, and (5) implement a community-owned information system. The paper concludes that PVO impact on child health can be measured through the discipline of documentation. Further, it proposes that such documentation come through a community owned and initiated bottom-up information system that facilitates health decision-making at the individual, family and community level.

23. ***Strengthening Partnerships between Communities and Health Workers for Child Survival: Fostering Dialogue and Commitment.*** Judi Aubel, Mamadou Diagne and Banda Ndiaye, WVI/Senegal. This paper assesses the elements of WVI's child survival strategy in Senegal from 1986-89 which threatened program sustainability by creating dependency on WVI, both in the Ministry of Health and the communities. In

1991, a philosophical shift towards building partnerships between the Ministry, the health workers and the communities at the district level redefined the role of WVI so that dependency was not created and sustainability was enhanced. By contrasting the child survival program before and after 1991, this paper illustrates many key elements of long-term program sustainability. The authors also present a "Ladder of Community Participation" which provides a scale for comparing levels of community participation.

Emory University - SCF Data Sets

24. ***Analysis of Longitudinal Data Sets from Save the Children Programs: A Preliminary Report.*** Dirk Schroeder and David Marsh, Emory University and Save the Children. Emory University and Save the Children have organized large, longitudinal data sets from SCF program sites in eight countries for the purpose of undertaking retrospective research on the relation of program to outcome. The data sets include information on vital events and weights for over 50,000 pre-school children. Although a formal written paper was not produced, data tables were prepared and distributed at the presentation.

APPENDIX F

LIST of PARTICIPANTS

name: Sani Aliou
title: Project Manager
organization: CARE- Niger
address: BP 10155
Niamey, Niger
phone: 227-740213 or 740370
fax: 227-740755
email: CARE-ZR@intnet.ne

name: Milton B. Amayun
title: Co-Director, International Health Programs and Team Leader for Asia/ Middle East/ Eastern Europe
organization: World Vision Relief and Development
address: 220 I Street, NE, Suite 270
Washington, DC 20002
phone: 202-608-1845
fax: 202-543-0121
email: mamayun@worldvision.org

name: Judi Aubel
title: Independent Consultant
organization:
address: c/o S.P.C., Private Mail Bag
Suva, Fiji
phone: 679-321-889
fax: 679-370-021
email: jatao@is.com.fj

name: Alfred Bartlett
title: Senior Technical Advisor for Child Survival
organization: USAID/ G/PHN/HN
address: Ronald Reagan Building 3.07-075M
Washington, DC 20523-3700
phone: 202-712-0991
fax: 202-216-3702
email: abartlett@usaid.gov

name: Massee Bateman
title: Child Survival Advisor
organization: USAID/G/PHN/HN
address: Ronald Reagan Building
Washington, DC 20523-3700
phone: 202-712-5002
fax: 202-216-3702
email: mbateman@usaid.gov

name: Bart Burkhalter
title: Technical Officer
organization: BASICS Project
address: 1600 Wilson Boulevard, Suite 300
Arlington, VA 22209
phone: 703-312-6819
fax: 703-312-6900
email: bburkhal@basics.org

name: Judy Canahuati
title:
organization: La Leche League
address: P.O. Box 512
San Pedro Sula, Honduras
phone: 504-550-9737
fax: 504-550-7482
email: Judy@mayanet.hn

name: Jean Capps
title: Consultant
organization: Adventist Development and Relief Agency
address: 12501 Old Columbia Pike
Silver Spring, MD 20904
phone: 301-680-6390
fax: 301-680-6370
email:

name: Larry Casazza
title: Director of Health/ Child Survival Programs
organization: World Vision Relief and Development
address: 220 I Street, NE, Suite 270
Washington, DC 20002
phone: 202-547-3743
fax: 202-547-4834
email: lcasazza@worldvision.org

name: Sri Chander
title: Regional Health Advisor
organization: World Vision International, Asia Pacific Region
address: 1 Sophia Road, #04-05 Peace Center
Singapore 228149
phone: 65-3345837
fax: 65-3345848
email: schander@worldvision.org

name: Joe Coyle
title: Facilitator, Consultant
organization: The Business Communications Group
address: 4833 Western Ave, NW
Washington, DC 20016
phone: 202-686-6267
fax: 202-686-9190
email: BusCommGrp@aol.com

name: Irma (Mimi) de Maza
title: Executive Director
organization: La Leche League Guatemala
address: 16 Calle 14-39, Zona 10
Ciudad de Guatemala
Centro America
phone/fax: 502-232-3696 (office)
phone/fax: 502-368-1440 (home)
email: lll@guate.net

name: John Durgavich
title: Project Assistant
organization: BASICS Project
address: 1600 Wilson Blvd, Suite 300
Arlington, VA 22209
phone: 703-312-6800
fax: 703-312-6900
email: jdurgavi@basics.org

name: Bob Emrey
title: Senior Technical Advisor
organization: USAID/G/PHN/HN
address: 1300 Pennsylvania Avenue
Washington, DC 20523-3700
phone: 202-712-4583
fax: 202-216-3702
email: bemrey@usaid.gov

name: Arlen Erdahl
title: Executive Director
organization: Minnesota International Health Volunteers
address: 122 West Franklin Avenue, Suite 110
Minneapolis, MN 55404
phone: 612-871-3759
fax: 612-871-8775
email:

name: Sally Findley
title: Associate Clinical Professor of Public Health
organization: Columbia School of Public Health
address: 60 Haven Avenue, B2
New York, NY 10032
phone: 212-304-5214
fax: 212-305-7024
email: sef5@columbia.edu

name: Stephen Gloyd
title: Executive Director
organization: Health Alliance International
address: 1107 NE 45th Street, Suite 410
Seattle, WA 98105
phone: 206-543-8382
fax: 206-685-4184
email: gloyd@u.washington.edu

name: Fernando Gonzales Salguero
title: Health and Nutrition Advisor
organization: Save the Children
address: Calle Luis Crespo No. 2031
Casilla 15120
La Paz, Bolivia
phone: 413011-412839
fax: 591-2-412455
email: bolivia@savechildren.org

name: Victoria Graham
title: Manager
organization: The CORE Group
address: 220 "I" Street, NE #270
Washington, DC 20002
phone: 202-608-1800
fax: 202-543-0121
email: vgraham@worldvision.org

name: Cynthia Green
title: Consultant
organization:
address: 5512 Westbard Avenue
Bethesda, MD 20816
phone: 301-654-4085
fax: 301-652-1147
email: cpgreen@aol.com

name: Laura Hoemeke
title: Technical Advisor, Family Health Team
organization: USAID/Benin
address:
phone: 229-30-05-00
fax: 229-30-12-60
email: lhoemeke@usaid.gov

---

name: Lisa Howard-Grabman
title:
organization: Save the Children
address: 1620 I Street, NW, Suite 202
Washington, DC 20006
phone: 202-530-4385
fax: 202-293-4167
email: lhowardg@dc.savechildren.org

---

name: Wahidul Islam
title: Project Coordinator
organization: CARE- Bangladesh
address: GPO Box 226
Dhaka, Bangladesh
phone: 880-2-814195, 96, 97, 98
fax: 880-2-814183
email: carebang@bangla.net or
carehnp@bangla.net

---

name: Katherine Jones
title: Chief, Child Survival and Health Division
organization: USAID/BHR/PVC/CSH
address: Ronald Reagan Building
1300 Pennsylvania Avenue
Washington, DC 20523-7600
phone: 202-712-1444
fax: 202-216-4041
email: kjones@usaid.gov

---

name: Nancy Keith
title: Senior Program Officer, Linkages Project
organization: Academy for Educational Development
address: 1875 Connecticut Ave, NW
Washington, D.C. 20009
phone: 202-884-8887
fax:
email: nkeith@aed.org

---

name: Carl Kendall
title: Professor
organization: London School of Hygiene and Tropical Medicine
address: Keppel Street
London WC1 E7 HT, U.K.
phone:
email: c.kendall@lshtm.ac.uk

---

name: Michelle Kouletio
title: Child Survial Manager
organization: CARE-Tanzania
address: P.O. Box 10242
Dar-es-Salaam, Tanzania
phone: 255-51-666775
fax: 255-51-666944
email: care-tz@twiga.com

---

name: Linggawijaya
title: Senior Project Manager
organization: PCI- Indonesia
address: JL Wolter Monginsidi 11
Nabire 98816
Irian Jaya, Indonesia
phone: 62-984-23005
fax: 62-984-22574
email: pcinabir@rad.net.id

---

name: Aissatou (Aida) Lo
title: Health Programs Coordinator
organization: Africare-Mali
address: Africare
P.O. Box 1792, Bamako, Mali
phone: 223-24-37-03
fax: 223-24-02-90
email:

---

name: Tom Marchione
title: Evaluation Officer
organization: USAID/BHR/PPE
address: Ronald Reagan Building 8.06.09H
1300 Pennsylvania Avenue, NW
Washington, DC 20523
phone: 202-712-1645
fax: 202-216-3385
email: tmarchione@usaid.gov

name: David Marsh
title: Child Survival Specialist
organization: Save the Children
address: 51 Wilton Road
Westport, CT 06880
phone: 203-221-4145
fax: 203-221-3799
email: dmarsh@savechildren.org

name: Arvind Mathur
title: Programme Officer (Health)
organization: Aga Khan Foundation
address: Sarojini House, 2nd Floor
6 Bhagwandas Road
New Delhi 110001, India
phone: 91-11-3782173/ 3782157/ 3782185
fax: 91-11-3782174
email: akfind@nda.vsnl.net.in

name: Kathleen Miller
title: Project Assistant
organization: BASICS Project
address: 1600 Wilson Blvd, Suite 300
Arlington, VA 22209
phone: 703-312-6800
fax: 703-312-6900
email: kmiller@basics.org

name: Roy Miller
title: Director, MOST Project
organization: International Science and Technical Institute
address: 1820 N. Ft Meyer Drive, Suite 600
Arlington, VA 22209
phone: 703-248-3308
fax: 703-807-1126
email: rmiller@istiinc.com

name: Nancy Muller
title: Program Officer
organization: PATH
address: 4 Nickerson Street
Seattle, WA 98109-1699
phone: 206-285-3500
fax: 206-285-6619
email: nmuller@path.org

name: Banda Ndiaye
title: Health Coordinator
organization: World Vision- Senegal
address: BP-51 Thies
Senegal
phone: 221-9512470
fax: 221-9512472
email: bndiaye@worldvision.org

name: David Newberry
title: Senior Advisor, Children's Health
organization: CARE
address: 151 Ellis Street, NE
Atlanta, GA 30303-2439
phone: 404-681-2552 ext. 170
fax: 404-577-1205
email: newberry@care.org

name: Robert Northrup
title: Principal Program Associate
organization: Management Sciences for Health
address: 1600 Wilson Boulevard, Suite 300
Arlington, VA 22209
phone: 703-312-6800
fax: 703-312-6900
email: rnorthrup@msh.org

name: Maureen Norton
title: Technical Advisor
organization: USAID/G/PHN/POP/FPSD
address: Ronald Reagan Building 3.06-041U
Washington, DC 20523
phone: 202-712-1334
fax: 202-216-3046
email: mnorton@usaid.gov

name: David Oot
title: Director, Health/Population/Nutrition Office
organization: Save the Children
address: 1620 I Street, NW, Suite 202
Washington, DC 20006
phone: 202-530-4369
fax: 202-293-4167
email: doot@dc.savechildren.org

name: Vincent Orinda
title: Senior Advisor, Child Health
organization: UNICEF
address: 3 UN Plaza
New York, NY 10017
phone: 212-824-6330
fax: 212-824-6460/2
email: vorinda@unicef.org

name: Naida Pasion
title: Health/Population/Nutrition and Olongapo Program Manager
organization: Save the Children
address: G/F PSDC Building
Magallanes corner Real Street
Intramuros, Metro Manila, Philippines
phone: 632-527-37-50
fax: same
email: naidz@mkt.weblinq.com

name: Joy Riggs-Perla
title: Director, Office of Health and Nutrition
organization: USAID/G/PHN/HN
address: Ronald Reagan Building
Washington, DC 20523
phone: 202-712-4626
fax: 202-216-3702
email: jriggs@aol.com

name: Stephen Robinson
title: Senior Consultant
organization: PCI/ COR Inititatives
address: P.O. Box 435, Balikpapan
Kaltim, Indonesia
phone: 62-542-64622
fax: same
email: corinit@indo.net.id

name: Dirk Schroeder
title: Assistant Professor
organization: Emory University School of Public Health
address: 1518 Clifton Road
Atlanta, GA 30322
phone: 404-727-9856
fax: 404-727-1278
email: dschroz@sph.emory.edu

name: Bettina Schwethelm
title: Director, MCH
organization: Project HOPE
address: Project HOPE
Millwood, VA 22646
phone: 540-837-2100
fax: 540-837-1813
email: bschweth@projhope.org

name: David Shanklin
title: International Program Director
organization: Andean Rural Health Care
address: P.O. Box 216
Lake Junaluska, NC 28745
phone: 704-452-3544
fax: 704-452-7790
email: davids@haywood.main.nc.us

name: Theresa Shaver
title: Safe Motherhood/ Child Survival Advisor
organization: PVO/NGO Networks
address: 1620 I Street, NW, Suite 900
Washington, DC 20006
phone: 202-955-0079 ext. 18
fax: 202-955-1105
email: tshaver@dc.savechildren.org

name: Mizan Siddiqi
title: Country Representative
organization: BASICS- Bangladesh
address: House 1, RD 23
Gulshan, Dhaka, Bangladesh
phone: 888-596
fax: 886-229
email: ms@citechco.net

name: Eric Starbuck
title: Child Survival Specialist
organization: Save the Children
address: 1620 I Street, NW, Suite 202
Washington, DC 20006
phone: 202-530-4389
fax: 202-293-4167
email: estarbuck@dc.savechildren.org

name: Jerry and Monique Sternin
title: Field Office Director, Egypt
organization: Save the Children
address: 10 Itehad El-Mohameen El Arab St
Apt. 8, Third Floor
Garden City, Cairo
Egypt 11461
phone: 20-2-3563510
fax: 20-2-3556343
email: egypt@savechildren.org

name: Luis Tam
title: Consultant
organization: PLAN International
address: Madrid 102
Lima 21, Peru
phone: 51-1-4615214
fax: same
email: luistam@amauta.rcp.net.pe

name: Joe Valadez
title: Senior Monitoring and Evaluation Advisor
organization: PVO/NGO Networks
address: 1620 I Street, NW, Suite 900
Washington, DC 20006
phone: 202-955-0079 ext. 15
fax: 202-955-1105
email: josephvaladez@compuserve.com

name: Nancy Vollmer
title: Health Consultant
organization: PLAN International
address: 3260 Wilson Boulevard, Suite 11
Arlington, VA 22201
phone: 703-807-0190
fax: 703-807-0162
email: vollmern@plan.geis.com

name: Ellen Vor der Bruegge
title: Senior Vice President
organization: Freedom from Hunger
address: 1644 Da Vinci
Davis, CA 95616
phone: 530-758-6200
fax: 530-758-6241
email: programs@freefromhunger.org

name: Haile Wubneh
title: Country Representative and Health Manager
organization: Africare- Ethiopia
address: P.O. Box 2309
Addis Ababa, Ethiopia
phone: 251-1-15-2484
fax: 251-1-51-1248
email: afrieth@padis.apc.gn.org

name: Alonzo Wind
title: Senior Program Officer
organization: Medical Care Development International
address: 1742 R Street, NW
Washington, DC 20009
phone: 202-462-1920
fax: 202-265-4078
email: mcdi@mcd.org and
ajwind@unforgettable.com