

INTERIM EVALUATION OF THE BASICS PROJECT
(Basic Support for Institutionalizing Child Survival)
Project No. 936-6006

PREPARED BY:

JAMES R. BRADY, TEAM LEADER
MASSEE BATEMAN, MD
WILLIAM H. FOEGE, MD
IAIN McLELLAN
JOHN M. MILLER

PREPARED FOR:

THE CHILD SURVIVAL DIVISION
OFFICE OF HEALTH AND NUTRITION
CENTER FOR POPULATION, HEALTH AND NUTRITION
BUREAU FOR GLOBAL PROGRAMS, FIELD SUPPORT, AND RESEARCH
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

APRIL 1997

Interim Evaluation of the BASICS Project was prepared under the auspices of the U.S. Agency for International Development (USAID).

The report was written and revised by the
Health Technical Services (HTS) Project
(Project No. 936.5974.10, Contract No. HRN-5974-C-00-3001-00)
of TvT Associates and The Pragma Corporation.

The opinions expressed herein are those of the authors and do not necessarily reflect the views of TvT, Pragma, or USAID.

Information about this and other HTS publications may be obtained from:

Health Technical Services (HTS) Project
1601 North Kent Street, Suite 1104
Arlington, VA 22209-2105
(703) 516-9166 phone
(703) 516-9188 fax
<http://www.htsproject.com>
hts@htsproject.com

Acknowledgments

As is the usual case in broad reviews like ours, the BASICS Evaluation Team owes a large debt to the many people who contributed their time and information here and overseas. We are therefore extremely grateful to the USAID and Contractor staff who helped us attempt to ask and answer the right questions about an excellent project and contract. We are specially indebted to the overseas USAID and contract staff who not only provided information but also excellent logistical support and warm hospitality. Finally we would not have been able to complete the assignment without the competent and cheerful support at every stage by the HTS wing of our Team: Linda Sanei, Melinda McLister, and Holly Whalen. Bless you all!

Project Data Sheet

Project Title: Basic Support for Institutionalizing Child Survival (BASICS)

Project Number: 936-6006

Contractor: The Partnership for Child Health Care, Inc.
Partners: Academy for Educational Development
John Snow, Inc.
Management Sciences for Health

Subcontractors: Clark Atlanta University
Emory University
Johns-Hopkins University-School of Public Health
The Kingsbury Group
The Manoff Group
Program for Appropriate Technology in Health (PATH)
Porter-Novelli

Type of Contract: Cost Plus Fixed-Fee Level-of-Effort

Contract Number: HRN-6006-C-00-3031-00 (Core)
HRN-6006-Q-00-3032-00 (Requirements)

Contract Term: September 30, 1993-September 29, 1998

Total Estimated

Cost: \$ 73,154,982 (Core)

Funds Obligated: \$ 64,879,459 (Core)
\$ 17,992,862 (Delivery Orders)

Contracting Officer's

Technical

Representative: Dr. Alfred Bartlett, G/PHN/HN

Previous

Evaluations: None

Acronyms

AED	Academy for Educational Development
AFRO	African Regional Office/WHO
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival (Project/Contract)
BHR/PVC	Bureau for Humanitarian Response/Private Voluntary Cooperation
BMIS	BASICS Management Information System
CA	Cooperating Agency (contractor/grantee)
CAP	Country Activity Plan (BASICS strategy and planning tool)
CAR	Central Asian Republics
CBC	Communication and Behavioral Change
CBO	community-based organization
CCH	Community and Child Health
CDC	Centers for Disease Control and Prevention (U.S. agency)
CDD	Control of Diarrheal Diseases
CEO	Chief Executive Officer
COTR	Contracting Officer's Technical Representative
DHS	Demographic and Health Survey (survey + Project name)
DO	delivery order
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
F&A	Finance and Administration
FP	Family Planning
FSN	Foreign Service National
FY	fiscal year
HEALTHCOM	Communication for Child Survival Project

HFQR	Health Facility Quality Review
HN	Office of Health and Nutrition (USAID)
HTS	Health Technical Services (Project/Contract)
IEC	Information, Education, and Communication
IMCH	Integrated Management of Child Health
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IQC	Indefinite Quantity Contract
JHU	Johns Hopkins University
JSI	John Snow Inc.
KAP	Knowledge, Attitudes, Practices survey
LAC	Latin America and the Caribbean
LOE	Level of Effort
LRT	linear relationship chart
M&E	monitoring and evaluation
MCH	Maternal and Child Health
MIR	Management Information Report
MOH	Ministry of Health
MSH	Management Sciences for Health, Inc.
NGO	nongovernmental organization
NID	National Immunization Day
NIS	New Independent States
ORANA	Organisme de Recherche sur l'Alimentation et la Nutrition (Pan African Regional Nutrition Institute located in Dakar, Senegal)
ORS	Oral Rehydration Salts
OYB	operational year budget
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health (organization)
PATHWAY	Pathway to Survival (BASICS framework for viewing child health issues)
PBT	Preceding Birth Technique
PHN	Center for Population, Health & Nutrition (USAID)

ACRONYMS

PRITECH	Primary Technologies for Health Care (Project)
PVO	private voluntary organization
PY	project year
RAPID	Resources for the Awareness of Population in Development (Project)
REACH	Resources for Child Health (Project preceding BASICS)
REDSO	Regional Economic Development Services Office (USAID)
RFP	Request for Proposal
RPM	Rational Pharmaceutical Management
SANAS	National Service for Feeding and Applied Nutrition (Senegal)
SMC	Senior Management Committee
SO	strategic objective
SOMARC	Social Marketing for Change
TA	technical assistance
TAG	Technical Advisory Group
TCN	Third Country National
TD	Technical Directive
TKG	The Kingsbury Group (subcontractor)
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VAD	Vitamin A Deficiency
WAG	Working Advisory Group (BASICS)
WHO	World Health Organization

Contents

Acknowledgments	i
Project Data Sheet	iii
Acronyms	v
Contents	ix
List of Tables and Figures	xiii
Executive Summary	xv
Principal Recommendations for Current Contract and Follow-on Contract	xix
1 Purpose, Scope, and Methods of the Evaluation	1
2 Project Background and Environment	5
2.1 New Structures to Move the Child Survival Initiative Forward	5
2.2 Going Beyond Previous Child Health Projects	6
2.3 Recent USAID Trends Affecting Contract Operations	7
2.3.1 USAID Staff Reductions and Program Concentration	7
2.3.2 The Reengineering of Programming and Monitoring Processes	8
2.3.3 Linking BASICS to New G/PHN Strategic Objectives	9
3 Technical Leadership	11
3.1 Technical Foci	11
3.1.1 Choices of Foci	11
Conclusions:	12
Recommendation (Current Contract):	13
Recommendation (Follow-on Contract):	13
3.1.2 Contractor Capabilities	13
Conclusion:	15
Recommendation (Follow-on Contract):	16
3.1.3 Internal Organization Around Technical Foci	16
Conclusion:	19
Recommendation (Current Contract):	19
Recommendation (Follow-On Contract):	19
3.1.4 Linkages to Other Organizations	20
Conclusion:	20

	Recommendations (Follow-on Contract):	20
3.1.5	Quality of Work	21
3.1.6	Main Areas of Achievement	21
	Conclusions:	25
	Recommendation (Current Contract):	25
	Recommendation (Follow-on Contract):	26
3.2	Balance of Interventions	26
	Conclusions:	27
	Recommendation (Current Contract):	31
	Recommendations (Follow-on Contract):	31
3.3	The Need for Continuous Operational Innovation	31
	Conclusions:	33
	Recommendations (Current Contract):	34
	Recommendations (Follow-on Contract):	34
3.4	Relations With Other USAID Projects	34
	Conclusion:	35
	Recommendation (Current Contract):	35
	Recommendations (Follow-on Contract):	35
4	Communication and Behavior Change (CBC)	37
4.1	Defining the Role of CBC	37
4.2	Illustrative CBC Innovations	38
4.3	Transfer of CBC Skills	41
4.4	Application and Implementation	43
	Conclusions:	44
	Recommendations (Current Contract):	45
	Recommendations (Follow-up Contract):	46
5	Implementation of Field Activities	49
5.1	Impact of Recent USAID Changes on Field Implementation	49
5.2	Overview of the BASICS Field Portfolio	51
5.3	Role of Regional Offices in Field Implementation	59
5.4	Relationships with Clients and Other Stakeholders	61
5.5	The Pace of Field Implementation	62
5.5.1	USAID Staff Views on Timeliness of Operational Support	62
5.5.2	Speed of Contract Start-Up	63
	Conclusions:	64
	Recommendations (Current Contract):	64
	Recommendations (Follow-on Contract)	65

6	The General Impact of BASICS	67
6.1	The Changing Global Health Environment	67
6.2	BASICS Impact	68
6.2.1	Development of Coalitions	68
6.2.2	Quality of Staff	68
6.2.3	Technical Leadership	69
6.2.4	Impact on Other Donors	69
6.2.5	Impact on Cooperating Countries	69
6.2.6	Community Mobilization	70
6.2.7	Measuring Progress	70
6.2.8	Reaching the Vulnerable	72
6.2.9	Partnerships and Alliances	72
6.2.10	Surveillance	72
6.3	Challenges to USAID and BASICS	73
6.3.1	Adopting a Longer-term Perspective on Health Development .	73
6.3.2	Maximizing the Returns on IMCI	73
6.3.3	Immunization Infrastructures	74
6.3.4	Integrated Management for Child Health (IMCH)	74
6.3.5	Leveraging More Resources for Child Health	74
6.3.6	Knowledge Systems for Decision Making	75
	Conclusion:	75
	Recommendations (Current Contract):	75
	Recommendations (Follow-on Contract):	77
7	Organization and Management	79
7.1	USAID	79
7.1.1	USAID Project Management Structure and Role	79
7.1.2	Funding and Cost Trends	80
7.1.3	BASICS Monitoring and Reporting	83
7.1.4	USAID's Impact on Contract Management	83
7.1.5	Future Design and Implementation Issues	84
	Recommendation (Follow-on Contract)	86
7.2	The Contractor: The Partnership for Child Health Care, Inc.	87
7.2.1	Impact on the Contract of New USAID Priorities	87
7.2.2	The Partnership Organization and Staffing	88
	Recommendations (Current Contract)	98

ANNEXES

Annex A: Principal Contacts 101
Annex B: Selected References 112
Annex C: BASICS Expenditure Graphs 119
Annex D: BASICS as a Partner and Collaborator 129

List of Tables and Figures

Table 1.1:	Evaluation Team	2
Table 2.1:	G/PHN Questionnaire on BASICS' Responsiveness to Reengineering	8
Table 3.1:	BASICS Staffing (and Educational Degrees)	14
Table 3.2:	G/PHN Technical Assistance Questionnaire	21
Table 5.1	Long-term and Periodic Assistance Countries	52
Table 5.2:	Summary of Major BASICS Country Interventions	53
Table 5.3:	BASICS Outputs in Long-term Countries, as of 3/97	54
Table 5.4:	Immunization Activities Carried Out With BASICS Support (1996)	55
Table 5.5:	Annual Cost Savings (\$US) Due to Revision of Immunization	56
Table 5.6:	Timeliness of BASICS' Operational Support	62
Table 6.1:	NIGER - Summary Results of Baseline and Follow-up Facility Surveys	71
Table 7.1:	Expenditures through September 30, 1996	81
Table 7.2:	Subcontract Financial Ceilings, Obligations, and Expenditures	90
Figure 3.1:	BASICS' Pathway to Survival	22
Figure 3.2:	Level of Effort by Pathway Quadrant	27
Figure 4.1:	Maternal and Child Health Emphasis Behaviors	40
Figure 6.1:	Actions and Actors Affecting Child Health	76
Figure 7.1:	Organizational Chart -- BASICS Contract	92

Executive Summary

This interim evaluation of the BASICS Project and Contract has the dual purpose of providing feedback on the current five-year Contract and making suggestions for follow-on activities and contracts. Eight cooperating countries were visited by one or two persons from the Evaluation Team during January-February 1997. The Team also reviewed extensive documentation, conducted interviews, and reviewed 18 Mission responses to an e-mail questionnaire on BASICS which was disseminated by the BASICS Project Management Team in G/PHN (Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support, and Research, U.S. Agency for International Development).

Initiated in September 1993, the BASICS core and requirements contracts currently support significant activities in about 30 countries and 14 regional programs. The Contractor (The Partnership for Child Health Care Inc.) unites three established international health development organizations (JSI, MSH, and AED). The Partnership has succeeded in assembling a critical mass of first class technical specialists and operations officers who generally receive high marks from clients and colleagues on the quality of their work. The e-mail questionnaire responses from Missions were also generally very positive about BASICS Contractor support, although less so in the areas of progress and financial reporting. This feedback suggests that USAID and the Contractor may need to simplify reporting requirements, reduce processing time, and better link reports to operational concerns of the Missions. The Contractor's annual reports for 1996 represent significant progress toward more operationally-oriented reporting.

The implementation of the BASICS Project and Contract has been significantly affected by broad internal changes at USAID, including the reengineering of program planning systems and the increased delegation of funding decisions to the field. The BASICS Contract has fulfilled its original purpose of serving as a major source of Technical Assistance to Missions; and all field activities observed by the Evaluation Team appear to be fully integrated with the new assistance strategies and plans of Missions. However, it is not clear how the current field-oriented decision making within USAID has impacted on the Agency's global priorities and technical leadership role in child health. Maintaining a global edge in technical leadership requires adequate central support, resources for experimentation, and testing of new ways of increasing child health service

quality and access. In planning the BASICS follow-on strategies and activities, USAID thus needs to ensure that there is an effective balance between support for field implementation of existing approaches and the need for continually pursuing new and better ways of addressing child health problems.

The Contractor's six priority areas are: (1) sustaining immunization programs; (2) integrated case management of childhood illness (IMCI); (3) incorporating nutrition into child health programs; (4) identifying, promoting, and sustaining key positive health behaviors, especially in the home and community; (5) establishing innovative and effective public/private sector partnerships; and (6) improving techniques for monitoring and evaluation.

The BASICS conceptual framework "Pathway to Child Survival" provides a useful tool for identifying the most effective entry points for improving child health (among such choices as health facilities, community-wide interventions, or home-based prevention and treatment). The Contractor has tended to focus more on curative and clinic-based services, although some field activities are moving beyond this to promote more preventive and more community- or home-based interventions. The Integrated Management of Child Illness (IMCI) model developed by World Health Organization (WHO) has been refined and applied by the Contractor as its program centerpiece in several countries. This is consistent with the major Project aim of moving beyond earlier vertical or specialized approaches to more comprehensive and integrated service delivery strategies. The early IMCI emphasis in most countries has been on training to improve service provider competence; and surveys show some significant gains in this area. In some countries, IMCI is now trying to go beyond training to address other constraints on the improvement of health services quality and access. The challenge is to move fast enough to produce adequate numbers of trained service providers to impact on client needs, but not so fast as to exceed a country's capacity to have the other delivery system components in place (e.g., adequate supplies, staffing, and supervision). It is suggested that the Pathway framework be elaborated to incorporate more preventive, community, and household approaches.

The range of BASICS program interventions in a particular country depends largely upon the priority of child health in the Mission portfolio. Consequently, while there are broad child health activities in many cases, other country programs may stress specific interventions (e.g., immunization, nutrition, or control of diarrheal diseases). Since many BASICS country activities are still in the early stage of implementation, the Evaluation Team was asked to focus more on assessing the likely outcomes of current BASICS strategies and activities. The Evaluation Team's observations indicate that the Contractor's field activities are

generally consistent with the Contract's technical strategies and with the annual BASICS work plans (which are approved by Missions and USAID/Washington staff). Much of the Contractor's efforts have focused on getting new strategies and programs in place in cooperating countries. Many of the BASICS country activities currently operate in limited geographical areas or serve relatively small populations. Some are pilot projects with the expectation that scaling up will occur over time. However, the more mature immunization programs in the New Independent States have yielded data showing increases in coverage of target clients and some cost savings realized through better program management. The Evaluation Team encountered differing viewpoints on the pace of implementation under the Contract. Some USAID staff felt that BASICS should have had a faster start-up since it built on the efforts of earlier USAID child health projects. Others noted that BASICS rapidly responded to Mission needs and also needed time to establish alliances with other CAs and donors (particularly where USAID's presence was being reduced).

Given the large volume of activities in the early or middle stages of implementation, the Evaluation Team is concerned about the level of results and documentation of experience that will be realized before the Contract ends in September 1998. Maintaining adequate implementation momentum may require a special effort to focus on the more promising activities and to encourage key contract employees not to "jump ship" during the last year.

Questions raised during this Evaluation by G/PHN senior management about the Contractor's impact may indicate a need to also review the actual health outcomes and impacts which can be reasonably expected by the end of the Contract. USAID and the Contractor may need to streamline current approaches to contract administration, so that they will have time to concentrate on maximizing returns from the more promising field activities during the next 18 months. While a few field staff view current BASICS costs as being high, others note that costs reflect the outcome of prescribed competitive contracting processes; therefore, costs must also be judged in terms of the quality received. Consequently, while other contracting and staffing approaches may appear less costly, these may lack the critical synergy and quality of staffing present under the current set-up. For future planning, the Evaluation Team suggests that USAID consider developing a new Results Package for BASICS, rather than work from the current ten-year Project Paper. One possible advantage of this approach would be to permit a longer time perspective for addressing the long-term problems of Child Health. (e.g., a 20-year strategic planning time frame and 7-10-year contracting periods).

One important need under the new contract will be to target more country programs with the potential for achieving national coverage of Child Health

interventions within a reasonable time frame. The project should continue its strategies of pursuing a balance between prevention and treatment, expanding beyond a facility-based strategy to home and community interventions, and increasing private sector involvement in child health. The challenge is to maintain the important gains made in improving service delivery systems, but going beyond these to harness the additional resources available through private sector and community structures. This also involves efforts to empower and more fully engage mothers and other caregivers in the prevention and treatment of child illness. Some movement in this direction is reflected in the current testing of new Community Participation and Decentralization models in selected countries. However, it will also be important to track the cost effectiveness of all major interventions, since the potential for replication and expansion of new approaches must remain an overriding concern of BASICS. BASICS should also continue to give priority to the Project aim of identifying and reaching the most vulnerable subgroups in the child health population. Finally, the next stage of BASICS may also entail moving mentally and symbolically from a focus on child survival and illness to child health. The centerpiece intervention should then grow from Integrated Management of Child Illness (IMCI) into Integrated Management of Child Health (IMCH).

In summary, BASICS is an excellent program which plays a very vital role in USAID's continuing global effort to improve child survival and health.

Principal Recommendations for Current Contract

1. Focus on Priority Activities: USAID and the Contractor should immediately begin to prioritize, track, expedite, and document the BASICS approaches, activities, and interventions which show the greatest potential for replication and expansion. The challenge is to complete important core and field activities during the final 18 months while documenting experiences relevant to USAID and other Child Health activities. As available, information generated from this review should be provided to the USAID team involved in designing the new BASICS follow-on activities.

2. Prioritize Tasks and Reduce Work Plan Details: USAID and the Contractor Management Team should act to reduce the number of routine tasks and indicators covered in BASICS work plans, monitoring and reporting systems, and daily decision-making. The basic question for prioritizing each task could be, "What impact will this have on improving the health of children in our cooperating countries?" The goal of simplification and prioritization would be to free up more staff time to devote to: (a) the priority needs covered under Recommendation 1; and (b) the work of designing the follow-on activities and contracts (USAID staff).

3. Expand the Strategic Framework: USAID and the Contractor, in cooperation with other relevant CAs, should further develop the "Pathway to Child Survival" conceptual framework in all dimensions: Wellness (prevention) and Illness (treatment) at the household, community, and facility levels (i.e., toward Integrated Child Health Management). The development of the elaborated framework should be done by an interdisciplinary team. As available, results of this effort should be provided to the USAID Team designing the BASICS follow-on activities.

4. Document the Benefit-cost of IMCI: Since IMCI is the centerpiece of many BASICS programs, the Contractor should make a special urgent effort to document the cost, benefits, and effectiveness of IMCI in several countries. Efforts should also be made to implement IMCI fully in a large service area (e.g., group of districts or provinces) and document the process and health outcome improvements.

5. Assess the Opportunity for Covering Neonatal Health: Because of its important role in child survival, USAID and the Contractor, in collaboration with other concerned CAs, should prepare a background document and action proposal on neonatal health, including options for covering this area in the new BASICS follow-on activities.

6. Issue a Comprehensive Toolkit for Assessment: The Contractor should assemble a "Child Survival Assessment Toolkit" from existing staff experience and documentation. This effort could be related to development of the new elaborated version of the "Pathway to Child Survival" where each point in the Pathway could be linked to specific assessment methodologies. The kit should also include qualitative approaches.

7. Disseminate Experiences in Communication and Behavioral Change (CBC): The Contractor should give priority to tracking significant CBC innovations and preparing "lessons learned" in the form of practical case studies. These materials should be geared toward the needs of people charged with planning effective CBC interventions or programs.

8. Assess Alternative Paths to Community Participation: The Contractor should use BASICS and other relevant experiences to develop Community Participation models for different kinds of local environments. For example, in some countries BASICS works more through the Ministry of Health to engage the community, while in others it works more through NGOs.

9. Lead an Effort to Strengthen Immunization Infrastructures: USAID and the Contractor (in union with other donors) should consider making a special effort to strengthen national immunization infrastructures in cooperating countries (especially in Africa). Countries without an adequate immunization infrastructure will not benefit from the new vaccines being developed.

10. Streamline the BASICS Information and Reporting Systems: Feedback from some Missions on the slowness or non-receipt of reports and publications suggests a need for USAID and the Contractor to review and improve trip and progress reporting, information dissemination, and publication systems. Priority should be given to completing the planned survey of publication users or targeted customers by the BASICS Information Center and then linking information outputs to expressed customer needs.

11. Focus Evaluation Efforts on Priority Countries: During the next 18 months, BASIC's Monitoring & Evaluation efforts should focus on the larger or more significant country programs and activities, with the aims of identifying models

for broad replication of BASICS approaches to improving child health and documenting critical "lessons learned". (This task is also related to Recommendation 1, above.)

PRINCIPAL RECOMMENDATIONS FOR FOLLOW-ON CONTRACT

- 1. Strategic Framework:** USAID should strive for a balance of activities in key areas of the BASICS conceptual framework (an elaborated Pathway to Child Survival). While continuing the important gains made in curative and facility-based services, attention should also be given to prevention and treatment at the home and community level. USAID should also consider adding neonatal health and HIV/AIDS as technical foci in the follow-on Contract, although such areas should be addressed in partnership with other relevant USAID supported activities.
- 2. Developing a Results Package for USAID's Child Health Initiative:** USAID should consider the development of a new Results Package for BASICS, rather than operate under the framework of the current Project Paper. This approach has the potential of providing greater flexibility with respect to life-of-project time frame and implementation options. USAID should consider adoption of strategic planning cycles of 20 years for child health and contracting frameworks of seven to ten years. Regardless of the instrument used, the aim should be to produce a strong Agency-wide focal point for strengthening and expanding USAID's global leadership role in Child Health.
- 3. Using BASICS' Comparative Advantage:** In designing the follow-on core activities and contract, USAID should highlight the general child health strengths which BASICS has demonstrated in such areas as assessment, policy and program design, progress monitoring, and evaluation. While there will be other child health activities supported by USAID and other donors, BASICS may logically take a leadership role in these areas.
- 4. Priority for Scaling up Program Coverage:** USAID should give priority to providing assistance on child health programs which have the greatest potential for impacting on a national scale. While the emphasis should be on more comprehensive or integrated approaches, support can also be provided for specialized or vertical interventions to be carried out on a national basis. At this point in the progress of USAID's child health initiatives, it is important to achieve more national level coverage and impact.

5. Leveraging More Resources for Child Health: Given USAID's reduced funding and staff presence in many countries, USAID should continue and expand strategies and techniques for mobilizing outside resources for Child Health programs. BASICS would continue to focus on providing technical leadership and assistance, but also attend to the packaging and marketing of interventions to other potential funders. As is currently the case in some countries, BASICS could be a part of bilateral or multilateral agreements covering larger country or regional programs. The Contractor could also directly try to leverage funding from other groups, foundations, or corporations for activities approved by USAID. USAID and the Contractor should allocate adequate staff time to marketing BASICS' successful models and aggressively pursuing support for replication from other donors and from NGOs, private practitioners, and commercial firms in cooperating countries. There are several past and ongoing USAID central and bilateral experiences in PHN and other areas which should be relevant to the design of such resource mobilization strategies.

6. Funding for Operational Research and Innovation: To maintain USAID's global technical leadership role in child health, G/PHN will need some centrally-controlled funding to support the definition and development of new interventions and approaches (e.g., for improving service quality/coverage and testing new household and community level interventions). Field funds may be more accessible for implementing interventions which have been well defined under BASICS or other projects. However, there may also be special opportunities for joint innovation efforts with Missions, local stakeholders, and other donors. The Contractor should quickly develop procedures for systematically tracking and documenting approaches and replication costs for all significant research and innovation activities.

7. Tracking and Focusing Staff Resources: Since human talent is the most critical resource in BASICS, USAID and the Contractor should clearly identify and effectively utilize the specific expertise needed to implement each major activity or task. This can be done through a staffing/linear relationship chart (LRT) incorporated into the Project/Contract Work Breakdown Structure (WBS) and/or implementation action plan. The LRT should also show which organizational entity will provide the staff for each task (e.g., USAID Bureau/Mission, contractors [core, requirements, or IQC], subcontractor, or other CA). (Such information would have facilitated the efforts of the Evaluation Team to determine who was doing what priority tasks under the current Contract.) In addition to the major child health specialities, USAID should ensure that there is adequate staff coverage for such areas as: (1) program design and resource leveraging; (2) private sector involvement (e.g., commercial firms, NGO's, private practitioners); (3) communication and behavior change (CBC); (4) training and

organizational development; and (5) community organization and participation. Actual staff levels would be influenced by the need to balance talent among task areas and pursue an effective division of labor between the field and headquarters activities under the new Contract.

8. Flexible but Formal Systems for Collaboration: Given the many actors involved in Child Health, USAID should determine whether there is a need for more formalized approaches to division of labor and collaboration among CAs. For example, BASICS will probably benefit from a strategic alliance with MotherCare to address neonatal health, one with LINKAGES and OMNI to address nutrition, and one with the HIV/AIDS project to address the impact of HIV/AIDS on child health. Similarly, formal agreements with other donors may be appropriate to promote effective coordination on some global, regional, or country efforts. However, the price of collaboration is time and there are some cases where USAID's need to move on urgent BASICS goals may make it impossible to fully engage the participation of certain sluggish or reluctant partners. At the same time, USAID and the Contractor should ensure that their own internal procedures and clearances are sufficiently simple and speedy to elicit the collaboration of other partners and stakeholders.

9. Action-oriented Structures and Teams: USAID should require the Contractor to develop organizational structures, teams, and staff tasking systems which ensure a problem-based, time-sensitive, and interdisciplinary approach to achieving objectives in the Life of Contract Work Plan and Annual Work Plans. The aim is to encourage productive interaction among specialists and emphasize the need for teams to produce specific operationally-oriented outputs within a given time frame.

10. Regular External Reviews: USAID should provide for regular external reviews of the Contractor's technical activities and field implementation strategies. Such reviews may be best provided by a multidisciplinary team in order to promote an interdisciplinary perspective within BASICS and to identify any gaps across the disciplines represented within the Project. USAID should also consider scheduling a brief and informal general review of the Contract early in the implementation cycle, to allow time for effecting any needed changes in approach. It is assumed that the experience achieved and documented under the current BASICS contract will facilitate a quick start-up of the next Contract and thus produce results earlier in the cycle (so there should be enough activities to assess by Year 2). The members of the Technical Advisory Group or the Working Advisory Groups could help conduct such technical and program reviews.

11. Guidelines on Communication and Behavior Change (CBC): USAID and the Contractor should establish joint guidelines and standards of practice for the design and implementation of CBC interventions as early as possible after the Contract is initiated. These guidelines should include concrete examples of strategic alternatives for Missions and include cost-effectiveness information on the different approaches.

Purpose, Scope, and Methods of the

1 Evaluation

The BASICS Project (Basic Support for Institutionalizing Child Survival) is a ten-year activity initiated in 1993 by G/PHN to continue USAID assistance for child survival and health programs around the world. The principal implementation instrument for the first five years of the BASICS Project is a contract with the Partnership for Child Health Care, Inc. (a Massachusetts nonprofit corporation). This is an interim or formative evaluation of that five-year Contract, which began September 30, 1993. In addition to assessing the Contractor's performance during October 1993-December 1996, the Team was asked to use appropriate findings as the basis for suggestions regarding follow-on activities. The design and competitive procurement processes for the follow-on BASICS activities will be initiated soon after the completion of this evaluation.

Given the relatively short implementation period for this large and complex project, the Evaluation Team was asked to focus more on the strategies, systems, and interventions being implemented by the Contractor to assess if these could be expected to lead to the desired longer-term outputs and impact. For more mature programs, output and impact data were to be collected where available. Evaluation Team site visits and documentation reviews confirmed that many BASICS field activities are still in the early implementation phase. Exceptions include the Immunization Initiatives in NIS countries (some of which began under earlier child health projects). The Evaluation Team thus concentrated more on the extent to which current technical strategies, work plans, and field implementation activities show promise for achieving the contract objectives of improving the quality and accessibility of child health services and information at all levels: household, community, and health service outlets.

This collaborative evaluation was a joint effort between the Evaluation Team and concerned USAID and BASICS staff. The Evaluation Team members, areas of focus, and site visits were as follows:

TABLE 1.1: EVALUATION TEAM

TEAM MEMBER	AREA OF FOCUS	COUNTRY VISITS
Massee Bateman, MD	Technical Strategies and Leadership	Bolivia, Honduras, Kazakstan, and Kyrgyzstan
William H. Foege, MD., MPH	Technical Influence and Impact	Nigeria and Zambia
Iain McLellan	Communication and Behavioral Change	Senegal and Russia
John M. Miller, MBA	Organization and Management	Bolivia and Honduras
James R. Brady	Team Leader (Organizational Systems)	Senegal and Zambia

In spite of the formal division of labor, team members covered other areas as interests and conditions dictated. Dawn Liberi, G/PHN/DAA, participated as an adjunct Team Member when her schedule permitted and joined in the site visits to Senegal and Zambia. Linda Sanei, HTS Project, served as a Team Member when possible and coordinated the Team's schedule and support. Linda also prepared a summary of the USAID Missions' e-mail responses to the G/PHN evaluation questionnaire on BASICS. Throughout the evaluation, the Evaluation Team also worked closely with the USAID Project Management Team for BASICS: Al Bartlett, Linda Lankeau, Melody Trott, and Murray Trostle. Dr. Bateman served on the Evaluation Team as part of his preparation for joining the USAID BASICS Project Management Team under a JHU Fellowship. Dr. Foege is a member of the Contractor's Board of Directors (Partners for Child Health Care, Inc.). Finally, it should be noted that the BASICS staff in Arlington and the field went above and beyond the call of duty in responding to the Team's demands for information and "just a few more details, please."

The Evaluation began January 6, 1997, and the Evaluation Team formally disbanded on March 7, 1997. During the evaluation period, participation was staggered since some Team members had other commitments. Field visits were also staggered and completed between January 14 and February 23. The median

duration of field visits was one week, although some members spent only three days in some countries. Team members reviewed extensive documentation and conducted both face-to-face and telephone interviews with a wide range of BASICS stakeholders and observers. The Team also used information from the Mission e-mail responses to the questionnaire on BASICS sent out by the G/PHN BASICS Project Management staff. (The summary of responses to the G/PHN questionnaire is not part of this Evaluation Report, but may be requested from G/PHN's project management staff for BASICS.)

During the Evaluation Team's February debriefing, some G/PHN staff asked for more quantifiable measures of the Contractor's results. Consequently, some tables in Chapter 5 (Field Implementation) were prepared by the Contractor to provide an overview of interventions, persons trained, and clients served in the 15 country programs receiving long-term assistance from BASICS. USAID and the Contractor could also use these tables as a point of departure for identifying and tracking future results of the greatest concern to the G/PHN management staff.

After March 7, Evaluation Team members maintained contact through fax and phone. The draft Evaluation Report was submitted on March 24, 1997. Extensive comments and suggestions on the draft evaluation report were received from the Contractor and G/PHN staffs. These are addressed in this final evaluation report, to the extent permitted by the information available to Evaluation Team members. Some of the questions addressed to the Evaluation Team could perhaps be more appropriately treated in planned evaluation follow-up discussions between the Contractor and USAID (e.g., CBC priorities and strategies, expenditure breakdowns and implications, and optimal progress reporting formats and processes). The final Evaluation Team debriefing was on April 30, 1997.

Project Background and Environment

2

2.1 NEW STRUCTURES TO MOVE THE CHILD SURVIVAL INITIATIVE FORWARD

The G/PHN staff wanted to encourage potential BASICS contractors to create new organizational structures which would effectively attract the critical mass of high quality interdisciplinary skills needed to continue and expand USAID's global child health initiatives. This included a desire to move beyond the previous specialized or vertical structures toward more integrated approaches to improving child health. Given the continuing cuts in USAID's direct-hire technical staff, the project planners also assumed that the substantial talent pool to be provided under the BASICS Contract would be a vital resource for the smaller USAID Mission and regional staffs who were designing and managing the field programs required to give substance to the Agency's global leadership aims in child health. Missions would thus be able to acquire TA and other Child Health support services from one source.

The successful bidder for the BASICS Contract was The Partnership for Child Health Care, Inc.. This Partnership was formed specifically to compete for the BASICS Contract through the alliance of three long-established international development organizations (MSH, JSI, and AED). The Partnership also joined forces with several subcontractors to further broaden the resource pool available to cover the various Child Survival tasks in the Contract. The generally successful results of this new approach to forming USAID program implementation alliances are discussed below. Given USAID's increasing concern with structuring partnerships and collaborative approaches, the BASICS

experience should contain some "lessons learned" on alliances which are relevant for other programs.

2.2 GOING BEYOND PREVIOUS CHILD HEALTH PROJECTS

The BASICS Project design suggests that the Contractor must build on and go beyond the approaches of previous child health projects (e.g., PRITECH, HEALTHCOM, and REACH) by pursuing more integrated or comprehensive child health interventions. The aim is to pursue both (1) improvements in the availability of quality services and (2) empowerment of families and communities to effectively identify their health problems and

seek solutions to these. There is to be a focus on both preventative and curative interventions in the key areas affecting child mortality and health. Mention is made of such areas as diarrheal diseases, acute respiratory infections, malaria, vaccine-preventable diseases, and malnutrition. Attention is also to be given to identifying approaches which will be cost effective and within the replication capacities of cooperating countries and communities. The Project also seeks to identify and attract the talent and other resources available from non-USAID sources, including other donors and local NGOs/PVOs or commercial firms. Finally, the Project design calls for efforts to move beyond local or pilot efforts to national level implementation of child health interventions. These longer term strategic aspirations of the BASICS Project are ambitious, but provide important check points for assessing approaches and progress in USAID's pursuit of its global child health objectives.

The specific implementation tasks delineated by the Core Contract (Section C.3.b, page 18) suggest that the Contractor will primarily focus on Training, TA, and Operational Research. These are normal tasks for contractors, but experience in some countries suggests that they may be insufficient to achieve the improvements in national health delivery systems suggested by the Project design. For example, USAID and the Contractor may need to go beyond training and TA to design

The United States can be proud of the contribution it has made over the past decade to improving the health of the world's children. Our national resolve to reduce child mortality will remain prominent within USAID's broader development program; and our commitment to complete the job begun a decade ago remains as firm as ever.

J. Brian Atwood
USAID Administrator

("Saving Lives Today and Tomorrow..."
Draft USAID Report, December 1996)

strategies for leveraging the additional support and resources required to address the supply, equipment, facilities or other deficiencies which prevent even well-trained staff from improving the quality of child health services. Such leveraging strategies may be particularly crucial in scaling up from pilot projects to broader country coverage of new child health interventions. Some BASICS field staff have already established close ties with host countries, UN agencies, and bilateral donors. Such experiences should be used by USAID and the Contractor in formulating specific guidelines for attracting non-USAID resources, especially in priority BASICS countries.

The [PHN] Center's global leadership focuses on two principal activities: policy dialogue and resource mobilization. Moreover, global leadership contributes to the achievement of all results and strategic objectives by enhancing the implementation capacity of USAID-funded field programs and by influencing the wider global community of countries, donors, and nongovernmental organizations.

From: *Strategic Plan, USAID G/PHN Center, December 1995*

Confusion sometimes results when people do not distinguish between the BASICS Project and the BASICS Contractor. However, the term "BASICS" has come to refer most often to the current Contractor, and even official USAID messages on BASICS often tend to equate "contract" and "project." We perpetuate this practice, but try to specify the "BASICS Project" or "BASICS Contractor" where it is important to distinguish between the two entities.

2.3 RECENT USAID TRENDS AFFECTING CONTRACT OPERATIONS

Since the initiation of Contract operations in 1993, the following developments within USAID have affected both the design and pace of implementation of some BASICS activities:

2.3.1 USAID Staff Reductions and Program Concentration

The continuing cuts in Mission and Washington technical staffs have been accompanied by pressures for Missions to cover fewer Strategic Objectives or program activities. Some Mission Directors and PHN staffs have therefore been reluctant to add Child Survival activities, in spite of the high priority formally accorded to this global initiative by top USAID officials. Moreover, some PHN staffs who are more accustomed to managing vertical programs perceive BASICS activities as more complex and higher risk efforts. However, other Missions have

taken the initiative to use Child Survival funding earmarks and BASICS support to expand or begin new programs. Some Missions have thus seen the BASICS Contract as an important source of TA and other assistance for the design and execution of new child health initiatives. This includes important "bridging activities" needed by Missions to sustain cooperating country interest between the design of bilateral programs and their actual start-up. Some Missions have also asked BASICS to be the lead organization in implementing new Strategic Objectives and Results Packages focusing on child health and related areas. In short, BASICS has played an important role in facilitating the continuation and expansion of USAID's Child Survival field operations in a time of significant decreases in USAID field offices and inhouse technical staffs.

2.3.2 The Reengineering of Programming and Monitoring Processes

The new program design and monitoring processes developed under USAID "reengineering" exercises have produced mixed results for Missions and BASICS. Considerable staff time and energies have been devoted to the development of new (or newly stated) Strategic Objectives (SOs), results frameworks/packages, and schemes for monitoring, measuring, and reporting progress on a fairly frequent basis. In a few cases, BASICS had to postpone implementation of its approved work plans until the Mission completed its reengineering efforts and linked BASICS to these. Some Missions have reported that the Contractor was slow in aligning BASICS planning with the new USAID SOs. However, the Evaluation Team's site visits suggest that BASICS' in-country activities are now rather well integrated with the new strategic frameworks and activities of most Missions.

Similarly, most USAID field replies to the G/PHN questionnaire item on BASICS' responsiveness to Reengineering were positive. (See following table).

TABLE 2.1: G/PHN QUESTIONNAIRE ON BASICS' RESPONSIVENESS TO REENGINEERING

Question 2b: "How responsive has BASICS been to changes in working relationships demanded by 'reengineering' and your strategic planning exercises?"	<p>RATING SCALE: Mark on scale of 5 (highest) to 1 (lowest):</p> <p>5 4 3 2 1</p>				
USAID Field Staff Responses:	6	6	3	1	1

Source: Linda Sanei, Summary of responses from 18 USAID field offices to G/PHN Mid-term Evaluation Questionnaire on BASICS, February 27, 1997.

2.3.3 Linking BASICS to New G/PHN Strategic Objectives

The BASICS Contractor has also added or expanded activities to be responsive to changing G/PHN program priorities and emphases. For example, Nutrition was not included as a major focus area in the original BASICS contract. However, USAID's new global PHN priorities have restored Nutrition as a significant health intervention in USAID, so the Contractor now includes Nutrition as a basic component part of the child health program. The other principal interventions in the Contractor's current Annual Work Plan also appear to be consistent with G/PHN's new strategic objectives (SOs), especially SO #3: "Achieving increased use of key child health and nutrition interventions."

As an Evaluation Team, we may tend to focus this report more on the "problems" or areas to be improved (now or in future BASICS activities). However, all of the Team members want to also clearly communicate that we believe that BASICS is an outstanding activity, and a very critical part of USAID's global effort to improve child health. The Contract and USAID staff involved in BASICS are a competent and committed Team. So, readers should please bear in mind that the primary aim of the report is to help make a strong enterprise even better!!

Technical Leadership

3

3.1 TECHNICAL FOCI

3.1.1 Choices of Foci

The global foci of technical activities are defined by the Technical Working Groups (TWG) at the central office of BASICS. Activities in country and regional programs generally address a subset of the TWG areas; and are developed based on local priorities.

Global technical foci include six areas: Integrated Management of Childhood Illness (IMCI), Sustainability of Immunization, Private/Public Sector Collaboration, Communication and Behavior Change, Monitoring and Evaluation, and Nutrition. The conditions addressed within these areas include Acute Respiratory Infections (ARI), Diarrheal Diseases, Malaria, Malnutrition, and Vaccine Preventable Diseases. To a great extent, these areas represent the three predecessor projects: PRITECH (Diarrhea, Nutrition, and Private/Public Sector Collaboration), REACH (ARI, Sustainability of Immunizations), and HEALTHCOM (Communications and Behavior Change).

Country technical foci are defined within the context of each country program. The development of these activities follows many different patterns. In some cases, the first step is the development of a "Country Activity Plan" (CAP) by BASICS, as specified in the Project Paper. These plans were meant to provide an analysis drawing on existing data and evaluations already conducted by the Mission and the country and taking into account the country's political,

socioeconomic, cultural, epidemiological, and institutional conditions. The CAP was meant to provide a strategy to guide the BASICS activities for each country or project site. CAP's have been done in various fashions in many countries where BASICS is now working. Even where CAPs are available, implementation of activities has not always conformed to the CAP's recommendations. Some Missions have not agreed to the development of a CAP by BASICS because they have already completed their own analysis and wish to get implementation activities started as quickly as possible.

In all cases, BASICS activities must now fit within the USAID Mission's priorities and strategic framework, where developed, and within Ministry of Health (MOH) priorities, where activities involve the public sector. During site visits, the Evaluation Team found consistently that BASICS activities fit within the priorities of the Mission and the MOH. One exception to this is the Central Asian Republics (CAR), where BASICS activities have been based on two funding earmarks (for immunizations and infectious diseases), rather than the strategic framework for the region. Nonetheless, BASICS activities in the CAR were felt by the USAID staff to have made important contributions and were highly valued by the MOH for their contributions to high priority programs. Moreover, the e-mail responses to the G/PHN questionnaire on BASICS suggest that most respondents see BASICS staff as being responsive to Mission priorities, although a few indicate there is still room for improvement.

CONCLUSIONS:

1. The conditions being addressed through the global technical foci account for over two-thirds of infant and child mortality in developing countries, and are appropriate for a comprehensive child survival project. These priority areas are also consistent with those of other key actors in child survival—WHO, PAHO, and UNICEF. Neonatal mortality may account for a large proportion of the additional mortality, and is now a more important cause of mortality than diarrhea in some countries. Childhood HIV/AIDS is important in many countries where USAID works, but is normally not being taken into account within the current BASICS interventions. Consequently, neonatal health and HIV/AIDS may merit more attention in the BASICS strategic framework and in follow-on contract activities. These would seem to be two areas of need which logically fit into the BASICS strategy. The childhood HIV/AIDS effort would entail close cooperation with the HIV/AIDS Project.

2. The country and regional activities of BASICS generally address issues of high priority for child survival and are effectively tailored to local priorities. The

CAP's, though potentially providing for a systematic approach to initiating activities, have not served the original intention in many cases. While reasons for their low usage reportedly vary, it is assumed that many Missions preferred to rely on new program planning documents required under the Agency reengineering initiative.

RECOMMENDATION (CURRENT CONTRACT):

The Contractor, in collaboration with other concerned CAs, should prepare a background document and action proposal on neonatal health, including options for interventions which could be included in the follow-on BASICS activities.

RECOMMENDATION (FOLLOW-ON CONTRACT):

USAID should consider including neonatal health and childhood HIV/AIDS as technical foci in the follow-on Contract. These new areas should be addressed in partnership with other USAID supported projects, rather than as the sole province of BASICS.

3.1.2 Contractor Capabilities

The BASICS contract staff include a wide range of expertise, in both headquarters and the field. A current "snapshot" or summary of the BASICS staff allocation and academic degrees as of March 1997 is provided in Table 3.1. In summary, there are about 75 headquarters staff, 28 Level of Effort (LOE) field staff, and 110 local hire staff for a total of 213. Among the 75 headquarters staff there are eight MD's, seven PhD's, and 27 with Masters degrees. Among the 28 LOE staff in field offices, there are 15 MD's, five PhD's, and five with Masters degrees. Among the 110 local hire employees, 29 are technical staff, and 81 are administrative support staff.

TABLE 3.1 BASICS STAFFING (AND EDUCATIONAL DEGREES)

Educational Degrees ==>	MD	PhD	Masters	Bachelors	Non e	
BASICS HEADQUARTERS	75	8	7	27	32	1
Technical Division	28	7	6	8	6	1
- Deputy Director	1	1				
- IMCI	4	2		2		
- Immunization	5	2		3		
- M&E	2	1	1			
- Nutrition	1		1			
- Private Sector	3	1	1		1	
- Behavior Change	3		3			
- Information Center	5			2	2	1
- Program Assistants	4			1	3	
Operations Division	29	0	1	12	16	0
- Deputy Director	1			1		
- Officers	6		1	4	1	
- Assoc Officers/Coordinators	9			5	4	
- Program Assistants	13			2	11	
Evaluation and MIS Division	5	1	0	2	2	0
- Deputy Director	1	1				
- MIS Specialists	4			2	2	
Program Mgmt/F&A Division	13	0	0	5	8	0
- Project Director	1			1		
- Deputy Director	1			1		
- F&A Specialists	9			3	6	
- Program Assistants	2				2	
Field Offices LOE Staff	28	15	5	5	3	0
- Technical LOE Advisors	26	15	5	5	1	
- Administrative LOE Advisors	2				2	

TECHNICAL LEADERSHIP

Educational Degrees ==>	MD	PhD	Masters	Bachelors	None	
TOTAL BASICS LOE STAFF	103	23	12	32	35	1
Local Hire Staff *	110					
- Technical Staff	29					
- Admin Support Staff	81					
TOTAL BASICS STAFF	213					

* May exclude some local hire staff supporting other CAs (e.g., drivers). LOE = Level of Effort

In addition to the strong professional credentials and international health development experience of the staff, the quality of BASICS staff is perceived to be high by clients and colleagues. During site visits, the Evaluation Team found consistently that the quality of BASICS staff (both field and headquarters) was judged to be of very high caliber by USAID Missions, counterparts in the cooperating country agencies (CAs), and counterparts in other agencies.

One area which may merit attention is the current skill mix as related to Contract tasks. In looking at the full time core staff in Headquarters, there appears to be an uneven distribution of positions relative to task areas. There may be merit in reallocating LOE staffing resources to strengthen BASICS initiatives in the following areas: private commercial sector, private practitioners, PVOs/NGO's, nutrition, community organization and participation, training and adult education, and national program planning and management. It is recognized that in some of these areas, full time LOE staff are complemented by subcontractor or consultant staff and local-hire specialists on BASICS country staffs.

CONCLUSION:

BASICS capabilities are excellent in terms of the quality and expertise of staff. The LOE headquarters staff mix does not appear to cover some task areas as well as others, so certain areas probably deserve more attention in allocating staff resources. For example, given the importance of training, education, and behavior change to all BASICS activities, staffing in these areas may need to be strengthened. Similarly, the importance of increasing the role of private sector investment and involvement in child health suggests that more of the core staff expertise should be used to cover this area in future BASICS activities.

RECOMMENDATION (FOLLOW-ON CONTRACT):

Given their importance to the achievement of Project goals, USAID should ensure that adequate staff resources are allocated for the Contractor to play an appropriate role in: (1) communication and behavior change; (2) private sector involvement (e.g., commercial firms, NGO's, private practitioners); (3) nutrition; (4) training and adult education; and (5) community organization and participation. The division of labor among the contract core staff, consultants, local hires, etc. should be clearly defined and related to the staffing requirements identified in the contract implementation plan and Work Breakdown Structure (WBS).

3.1.3 Internal Organization Around Technical Foci

The internal organization around technical foci is primarily through the Technical Working Groups (TWG's) in the Technical Division of BASICS. In addition, the organization of clusters in the Operations Division is important for implementation and will be treated briefly.

3.1.3.1 Technical Working Groups

The main objectives for five technical working groups (TWG) are summarized below. The sixth area (Communication and Behavior Change) is covered in Chapter 4 of this report. The number of headquarters staff listed for each group is approximate, since staff may serve on more than one group. Moreover, staff from subcontractors and other sources may also serve on the working groups. For more details on BASICS staffing, see Table 3.1, above.

Integrated Management of Childhood Illness (IMCI):

Number of headquarters staff - 4

Main objectives:

1. To support the development and implementation of an approach to training primary care staff in integrated management of childhood illness.
2. To arrive at an international consensus on such a training approach through collaboration with WHO, UNICEF, and other USAID-supported agencies.

Note: G/PHN reports that the IMCI group has extended its area of action beyond these objectives to include supervisory training, improving support to health workers, ensuring availability of drugs, and improving the organization of services and client relations.

Sustainability of Immunization:

Number of headquarters staff - 5

Main objectives:

1. Improve the delivery of routine immunization services so that children and women are immunized in as complete, effective, efficient, and timely a way as possible.
2. Introduce strategies to reduce morbidity and mortality from EPI target diseases.
3. Work towards ensuring the availability of required funds and commodities for EPI.

Private/Public Sector Collaboration:

Number of headquarters staff - 3

Main objective:

To enhance the contribution of private sector entities to achieving public health objectives by focusing on five strategic areas: private health care providers; NGO's and PVO's; commercial manufacturers, marketers and distributors; government; and global leadership.

Monitoring and Evaluation:

Number of headquarters staff - 1 from the Technical Division and 1 from the Evaluation/MIS Division

Main objectives:

1. Technical Monitoring and Evaluation Leadership: Develop, test, implement, and document innovative approaches to monitoring and evaluation in developing countries.
2. Monitoring and Evaluating BASICS: Provide ongoing support to BASICS project staff, BASICS country programs, Ministries of Health and other partners to facilitate regular and ongoing monitoring and evaluation of routine programmatic activities in developing countries.
3. Information Technology Support: Provide ongoing information technology support to BASICS project staff, BASICS country programs, and counterpart institutions to maintain and increase productivity and the capacity to monitor program activities through the use of computer technology, office automation, and database applications.

Nutrition:

Number of headquarters staff - 1

Main objectives:

1. To identify and promote a minimum package of proven best nutritional practices (termed "MinPak") as an integral part of all child survival programs in BASICS countries.
2. To develop, test, and document technically sound and feasible methods for improving child feeding and for integrating MinPak practices in health programs, especially in the household, community, and first level health facility.
3. To increase information available to decision makers at all levels about the importance and feasibility of reducing malnutrition, especially in the context of scaling-up nutrition programs.

Each Technical Working Group (TWG) developed a strategy document, which has been useful as a guide to the work of some groups, and less so in others. The TWGs vary in cohesion and productivity, depending upon such factors as group leadership and individual member interests. The IMCI and Immunization TWGs are tightly focused around well-defined areas of intervention. The nutrition and private sector working group activities are to a large extent defined along the lines of interest and capabilities of individuals within the groups. In all cases, annual work plans are developed by the working group, and meetings tend to cluster around the time of work planning. There are no formal mechanisms to assure regular interchange among working groups.

3.1.3.2 Country or Regional Clusters

Clusters are formed as needed within the Operations Division to manage the implementation of country or regional activities. Clusters are composed of members of the Operations Division with responsibility for the specific geographic areas, but also include a liaison member from the Technical Division. Other members may be included on an ad hoc basis. Clusters were designed to be interdisciplinary, as they are organized around activities and geographical areas rather than disciplines or specific interventions. In general, the representation of the Technical Division in clusters is thin, and often limited to one individual. There are no formal mechanisms to assure regular interchange among clusters or operations managers.

CONCLUSION:

The internal organization around technical foci provides for concentrating technical expertise in specific areas of intervention. This approach has been very successful in pushing toward specific technical agendas (see Section 3.1.6). One of the advantages of the integration of the three predecessor child health projects into one "flagship" project—and one potential major strength of BASICS—is the opportunity to form interdisciplinary teams focusing on specific problems. To some extent this may happen in clusters, teams on mission, and/or in field offices, but several activities still appear to be operating in relative isolation from the others. For example, the work of the Public/Private Sector Collaboration Working Group (in the Technical Division) appears to have limited connection with PVO activities managed by clusters (e.g., Nigeria, Madagascar, Pakistan, Bangladesh, and Ecuador). Similarly, training activities often appear to have little input from training specialists. The limited success in bringing some program and technical areas or disciplines together may partially relate to work load, since staff tend to focus on activities for which they have primary implementation responsibilities. Some BASICS staff have also suggested that additional inhouse training on interdepartmental and interdisciplinary teamwork might be useful.

RECOMMENDATION (CURRENT CONTRACT):

The Contractor should review the current mechanisms for sharing information across disciplines and across clusters, and between the Operations and Technical Divisions. The goal is to increase the cross-fertilization of project experience and the interdisciplinary interaction within specific activities.

RECOMMENDATION (FOLLOW-ON CONTRACT):

USAID should stress the use of organizational and team structures and tasking systems which promote a problem-based and interdisciplinary approach to contract objectives. The aim is to encourage interaction among specialists and emphasize the need for managers and teams to produce specific operational outputs on time.

3.1.4 Linkages to Other Organizations

BASICS has strong linkages to a number of technical entities. Subcontractors supplement the capabilities of the prime contractor and have been accessed to varying degrees. There is also frequent interaction with the USAID COTR team.

Interactions with other CAs and health organizations frequently center around specific technical issues. No provision has been made for regular use of an outside Technical Advisory Group (TAG), although it is required under the BASICS Contract. Such a group is normally seen as a way of providing both the Contractor and concerned USAID staff with objective feedback on strategies and implementation progress. A "Program Advisory Group" was convened for Nutrition on one occasion, but the staff did not feel that this was successful in providing direction for the initiation of activities in this area. A similar approach to review the Communications and Behavior Change component of BASICS was discussed, but not pursued.

CONCLUSION:

TAGs or other available review mechanisms have not been sufficiently used to (a) periodically and systematically assess general or specific technical directions and (b) generate suggestions for improvements. In a USAID project as large and technically varied as BASICS, it is impractical to rely on ad hoc reviews or more formal but infrequent evaluations to provide needed feedback on a timely and regular basis.

RECOMMENDATIONS (FOLLOW-ON CONTRACT):

1. USAID should provide for regular external reviews of the Contractor's technical activities and field implementation strategies (e.g. using TAG's and/or other structures). Such a review may be best provided by a multidisciplinary team in order to promote an interdisciplinary perspective within BASICS and to identify any gaps across the disciplines represented within the project.
2. USAID should schedule an informal general evaluation of the Contract early in the contract implementation cycle, to allow more time for effecting any needed changes in approach. This assumes that the thorough documentation of approaches and lessons learned under the current BASICS contract will facilitate startup operations of the next contract so that there are sufficient activities to review by Year 2.

3.1.5 Quality of Work

Work by BASICS on specific technical assistance activities has been reported by most Missions, MOH counterparts, and counterparts in other agencies to be of very high quality. Based on its review of selected activities, the Evaluation Team

also concluded that the quality of work was generally quite high. High marks were also given to the quality of BASICS technical assistance (TA) by most of the USAID field staff responding to the G/PHN questionnaire (see following table).

TABLE 3.2: G/PHN TECHNICAL ASSISTANCE QUESTIONNAIRE

Question 1a. How would you rate the quality of the technical assistance that your country program has received from BASICS?	Rating Scale: From 5 (highest) to 1 (lowest)				
	5	4	3	2	1
TA from BASICS Headquarters staff:	5	5	4	1	0
Long Term TA (e.g., country advisors):	7	2	2	0	0
Short Term TA: [including regional staff]	3	10	3	0	0
Source: Linda Sanei, <i>Summary of Responses to BASICS Mid-Term Evaluation Questionnaire, 2/27/97.</i>	Note: Some of the 18 respondents did not answer all questions.				

3.1.6 Main Areas of Achievement

BASICS achievements in each of the technical areas have been numerous. A few selected examples will be discussed here.

General

The collaborative development and effective application of the "Pathway to Survival" has been an important achievement for BASICS. (See Pathway Chart on next page.) In the management of childhood illness, the Pathway provides a useful framework for addressing the question: "Where is the problem?" This approach has been directly applied with success in the Mortality Survey activity described below. The Pathway has also been a very effective tool for communicating with Missions and others to explain where and how to intervene in improving child health programs.

FIGURE 3.1: BASICS' PATHWAY TO SURVIVAL

Graphic Not Available in Electronic Version.

IMCI

BASICS has worked collaboratively and successfully with WHO and PAHO to adapt the WHO IMCI package and make the changes needed for effective local implementation. With PAHO a partnership has been formed to introduce IMCI in eight Latin American countries. In Zambia, the Ministry of Health has adopted the IMCI framework for national dissemination and BASICS has initiated training of health providers, as well as training of trainers. With training facilitation support from the World Education subcontract, BASICS staff and Zambian health providers are also adapting the IMCI training and materials for use by less literate front line health workers. Technical monitoring of this adaptation of IMCI curricula and materials is being provided by a member of the BASICS headquarters technical staff and the Training Advisor of the BASICS staff in Zambia.

Sustainability of Immunization

In the CAR, an innovative activity was developed and successfully implemented to address the unique challenges in sustainable immunization in the newly independent states. The challenges included: a long list of contraindications which assured that over a third of the children were excluded from routine immunizations, the lack of a cold chain, the lack of adherence to a generally accepted immunization calendar, and the fragmentation of responsibility for immunization across ministries. Capitalizing on an opportunity presented by a funding earmark for immunizing a number of children once, REACH—and later BASICS—developed a program that successfully addressed these issues, reduced the contraindication rate to less than five percent, and saved the government considerable money by rationalizing the vaccine schedule.

Private/Public Sector Collaboration

Work with the private commercial sector is an area where BASICS has been innovative, although the scale of its activities is still rather small. The process of working with the commercial sector has been documented in a systematic way (including issuance of a joint BASICS/UNICEF guide for mobilizing private resources for health). BASICS's program in Bolivia to promote the private sector's manufacture and marketing of ORS is important not only as an example of successfully getting private firms to support public health objectives, but also as an example of effective collaboration among various actors - including USAID, UNICEF, PAHO, the Bolivian Secretary of Health, and local pharmaceutical companies.

Work with private health practitioners has also been systematically approached and is well justified, considering that the majority of consultations for childhood health conditions is with private rather than public sector practitioners in many settings. Important innovations have been made in developing interventions to improve the quality of care provided by private practitioners and in monitoring and quality improvement.

Work with NGOs has focused largely on evaluations of innovative programs. In the course of these undertakings, the methodologies for such assessments have been improved. In Zambia, BASICS is involving NGOs in community mobilization activities and coordinating the award of small NGO grants funded by the bilateral Child Health Project.

Monitoring and Evaluation

The monitoring and evaluation Working Group has made good progress towards developing the elements of an assessment toolkit. Specifically, a Rapid Integrated Health Facility Assessment Survey has been refined and implemented in selected countries, and a Rapid Integrated Household Survey has been field tested and will be refined and documented based on field experiences. A Community-Based Mortality Surveillance Methodology has been developed and tested in Bolivia, and has proved to be very useful in analyzing the pathway to child survival to assess points for priority interventions. This surveillance methodology is a promising tool at an early stage of elaboration to be used as a community-based mortality surveillance tool.

Nutrition

The Nutrition Technical Working Group has developed "MinPak", which identifies six "best practices" that should be included in all child and maternal health programs. BASICS' efforts to promote these practices are coordinated with two other USAID nutrition projects: LINKAGES and OMNI. Important activities are also underway to integrate nutrition counselling into IMCI and to develop community-based nutrition

SIX BEST PRACTICES IN NUTRITION

- 1. Exclusive breastfeeding for about six months.**
- 2. Appropriate complementary feeding and breastfeeding from 6-24 months.**
- 3. Two doses of Vitamin A for measles cases.**
- 4. One Vitamin A dose every 6 months to all children >6 months, in areas of VAD.**
- 5. Iron supplements to pregnant women.**
- 6. Use of iodized salt by all families, in areas of iodine deficiency.**

approaches. A new data-based policy analysis and advocacy tool for nutrition ("PROFILES") is discussed in Chapter 5.

CONCLUSIONS:

1. Many high quality technical activities have been completed or are underway in priority areas to improve child survival.
2. BASICS has successfully collaborated with a wide range of other agencies and donors for the development and implementation of many of its activities.
3. In some areas where it is important for BASICS to play a key role, the activity is not the unique territory of BASICS, so tasks are shared with other projects.
4. BASICS has a critical role to play as USAID's "global" or lead project for child survival. It is the logical activity to provide technical leadership in such areas as assessment, policy and program design and planning, and monitoring and evaluation. Many pieces of a general assessment puzzle are being defined by BASICS, within the technical working groups. It will be important to put these together and highlight this general assessment function of BASICS in the future.

RECOMMENDATION (CURRENT CONTRACT):

1. The Contract should assemble a "Child Survival Assessment Toolkit" from existing staff experience and documentation. This may best be presented together with a more elaborated version of the "Pathway to Child Survival," where each point in the pathway can be linked to specific assessment methodologies. Qualitative investigations should be included as part of the assessment toolkit.
2. At this point in the Contract, it is important to review the many activities initiated and then identify and especially focus on a limited number of manageable activities with the greatest potential for impact on child survival. The Contractor should also fully document such efforts and systematically share the experiences with other organizations working in Child Survival.

RECOMMENDATION (FOLLOW-ON CONTRACT):

In the follow-on contract, USAID should highlight the following areas where BASICS should logically exercise a global leadership role: assessment, policy and program design, monitoring and evaluation, and technical leadership and innovation. While there will be many actors in child survival interventions, BASICS can logically take the lead in these areas. A hierarchy of assessments may be presented, from a CAP-like national assessment to more narrowly focussed qualitative and/or quantitative assessments at specific points in the "Pathway to Child Survival."

3.2 BALANCE OF INTERVENTIONS

The technical foci of BASICS have been reviewed above and the health conditions addressed by the Contractor are judged to be those most likely to have an impact on child survival. BASICS activities may also be characterized by the relative emphasis on each condition and the means by which these conditions are addressed. These are described as balances:

- (1) among different types of public and private sector counterparts and partners
- (2) between treatment interventions and prevention interventions
- (3) between program and disease interventions (e.g., ARI versus nutrition).

The funds devoted to these three categories are described in a series of BASICS Expenditure graphs in **Annex C**. Using information provided by the Contractor, the three line graphs give cumulative expenditures for each category by quarter for the first three years of the current Contract. The pie charts provide a snapshot of cumulative expenditures at the end of the third year of the current Contract. The pie charts use two funding categories: "Global Core" (controlled by G/PHN) and a combined total for all other funds: "Designated/Field Support/Delivery Orders" (controlled by the Regional Bureaus and Missions). The expenditure patterns suggest the following program trends:

1. Counterpart/Client Organizations: Expenditure patterns suggest that BASICS funding has focused primarily on the public sector and secondarily on international organizations. Working with the private sector (including NGO's, private practitioners, and the private commercial sector) has received relatively little emphasis under the current contract. Some differences in emphasis may exist between the expenditure of Global Core funds and the other three funding

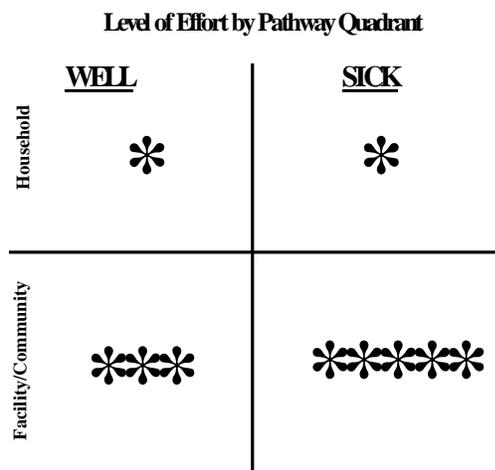
categories (Designated/Field Support/Delivery Orders). For example, where the expenditure of Global Core Funds could be directly related to specific types of counterpart or client organizations, there was slightly more emphasis on the private commercial sector, NGOs, and international organizations. However, it is difficult to link some expenditure data to type of organization because of the broad accounting categories used.

2. Treatment Versus Prevention Interventions: The Contractor's expenditure data suggest that BASICS has focused primarily on Case Management (ARI/CDD/Malaria/IMCI) and immunization (EPI) activities, with much less emphasis on nutrition or other preventive activities. Expenditures on nutrition have tended to increase over time, but the overall level of effort in this area remains relatively low (less than 5% of the total). Compared to the use of the Designated/Field Support/DO funds, the Global Core fund expenditures were slightly higher in the "Other Prevention" and "Nutrition" categories; less in "EPI" and about the same for "Case Management." The heavy use of Designated/Field Support/DO funds for "EPI Prevention" is influenced by large funding earmarks for immunization activities in the NIS and Russia.

3. Disease and Program Interventions: Expenditure patterns for this category are similar to those for Treatment versus Prevention. It is difficult to make specific comparisons because BASICS' tracking and expenditure attribution systems have tended to place many outlays under the general category of "Child Survival." Given this limitation on analysis, we can only estimate that more than half of the Global Core funds expended under the Disease versus Program breakdown were for IMCI, versus about 40% of the Designated/Field Support/DO funds.

FIGURE 3.2: LEVEL OF EFFORT BY PATHWAY QUADRANT

Figure 3.2 suggests the relative share of resources going to the four quadrants or general intervention approaches, as defined in the Pathway to Survival conceptual framework.



CONCLUSIONS:

1. In spite of the impressive progress made by the Contractor in installing modern activity monitoring and accounting systems, it is sometimes difficult to obtain reasonably precise information on some activity categories and

related costs. For example, the accounting category of "General Child Survival" is not analytically useful and the classification system for tracking costs related to the most vulnerable subgroups is also deficient. It might be useful to again review the tracking system with the aim of defining and covering the more relevant program categories and then perhaps eliminating some of the other categories (to reduce the large total number of items being tracked by the MIS and accounting systems).

2. BASICS expenditure patterns suggest that resources have been concentrated on work with the public sector and on treatment and immunization activities. Early emphasis in these areas is to be expected since BASICS built on the previous work of PRITECH and REACH and sought to focus on areas where interventions were better defined, early success could be expected, and where clearly defined demand had already been created in the Missions and other partners.

3. As a "flagship project" in Child Survival, BASICS should also logically provide direction and leadership in promising areas where there is less experience and/or areas where interventions have been less well defined. However, there has been relatively little emphasis on community and household interventions, primary prevention (other than immunizations), or working with private sector partners (including commercial groups NGO's, and private practitioners). Although BASICS has some important and innovative activities in each of these areas, there are compelling arguments for doing more. For example, BASICS demonstrated in the Mortality Survey in El Alto, Bolivia that the majority of infant and child deaths were associated with the mother either not recognizing that the child was ill, or not seeking appropriate care outside the home if she did. These findings clearly illustrated that a focus on care-seeking behavior is important for the management of the sick child in this setting, as in many others. The challenge in Bolivia, and elsewhere, is how to use such findings more effectively to improve the impact of Child Survival programs.

An analysis of available expenditure information from BASICS for the first three years of the Contract suggests that Global Core funds have been more focused on primary prevention activities and private sector activities than have the Designated/Field Support/Delivery Order Funds. USAID (headquarters and Missions) needs to consider whether it is necessary to shift more resources into preventive and private-sector activities to meet the goals for these areas in the Project Paper.

As suggested elsewhere in this report, the global technical leadership and innovation roles for BASICS implied in the Project Paper have not been fully realized because of the shifting of many BASICS funding decisions to Missions.

Because of the transfer of funding from Global Core to other sources, less than expected levels of support were available for needed general innovation development and diffusion efforts. Given the apparent preference of field staff for more established child health interventions, planning for the follow-on BASICS activities should ensure that adequate resources are devoted to the innovation activities essential to supporting USAID's continuing global leadership role in Child Health.

4. The "Pathway to Survival" conceptual framework has been a very successful and influential tool for developing interventions, communicating about them, and analyzing existing health systems. This Pathway was developed to frame a broader context for IMCI and facility-based approaches; it is less developed in the household, community, and prevention (wellness) dimensions. Logically, the elaboration of the "Pathway" conceptual framework to better define intervention options in these areas would be a useful step in developing a more comprehensive approach to child survival. Such improvements would not be at the expense of gains already made in the other areas of the Pathway, but complement and enhance the effectiveness of the other approaches and interventions.

5. While the relative emphasis or balance of BASICS activities is largely determined by the Missions and Regional Bureaus, BASICS can probably influence Mission requests through: (a) the offer of well-defined services in the household, community, and prevention dimensions; and (b) a clear articulation of these options and how they fit into the child survival conceptual framework. The further elaboration of the "Pathway" conceptual framework would be helpful as a first step here.

6. Seeking a balance on the child survival intervention map (an elaborated "Pathway") is a complex task. There are six areas of strategic concern: managing wellness in the household, community, and facilities, and managing illness in the household, community, and facilities. Interventions have been better defined in some areas than in others. Moreover, the type of work and source of funding may differ among areas. In improving care-seeking behaviors, for example, the first step is to do further work to develop a package to address problems in this area—from analysis to intervention options. In IMCI, innovation in the implementation of well defined interventions is more appropriate.

7. The level of effort in working with commercial organizations, PVOs/NGOs, and private health practitioners has been small relative to the increasing importance of these areas in implementing sustainable child survival interventions. Private organizations also present many important opportunities for developing and testing innovative approaches to child survival programming.

Working more with the private commercial sector also makes sense in view of USAID's concern about decreased public sector funds for health in many countries.

8. IMCI has become a centerpiece of BASICS activities and may illustrate options for effective planning of future BASICS activities. The reasons for IMCI's success include the following:

- (a) IMCI is a well-articulated, well-focused intervention.
- (b) The efficacy of IMCI (and its different components) to reduce infant and child mortality is well accepted.
- (c) There has been strong leadership and support for IMCI within BASICS.
- (d) IMCI is well-accepted by other major actors in child health and there are collaborative efforts to promote it (e.g., BASICS and PAHO in LAC).
- (e) IMCI has a clear programmatic framework and defined means of implementation (including components for training health providers and delivering curative services).

The substantial investment of resources in IMCI can be traced through the available information on BASICS expenditure patterns. About half of the Global Core expenditures in the category of Case Management/Treatment were for developing and promoting IMCI. Expenditures on IMCI from Mission and Regional Bureau sources have also increased over time. Other donors have also funded IMCI activities in some country programs.

As noted elsewhere in this report, some survey data show that the IMCI training is having positive impacts on the performance of service providers, but there is still room for improvement. The Contractor needs to ensure that the results and costs of major IMCI country activities and outcomes are adequately tracked and documented during the coming months. For USAID and the Contractor, the challenge is to build on and go beyond current IMCI service-oriented accomplishments to strengthen other child health elements, including illness prevention, interventions at the home and community level, and increased involvement of private sector entities.

RECOMMENDATION (CURRENT CONTRACT):

The Contractor should further develop the "Pathway to Child Survival" conceptual framework in all dimensions: Wellness (prevention) and Illness (treatment) at the household, community, and facility levels. This should be done by an interdisciplinary team.

RECOMMENDATIONS (FOLLOW-ON CONTRACT):

1. In designing the follow-on activities, USAID should provide for a balance of activities in all areas of the BASICS conceptual framework (an elaborated Pathway to Child Survival). It will be important to provide G/PHN with some centrally-controlled core funding to support the continued development and definition of new Child Health interventions and approaches (e.g., for household and community level interventions, as well as improved private and public service delivery systems). The funds for implementing Interventions which have been well defined under BASICS or other projects could come primarily from Mission or regional sources. However, ideally, both central and field activities in Child Health should earmark some funds for promoting continuous operational improvement.
2. USAID should provide an adequate level of effort for expanding BASICS' work with NGO's, private practitioners, and the private commercial sector. This would be an important element in leveraging additional resources and promoting sustainability of all BASICS activities.

3.3 THE NEED FOR CONTINUOUS OPERATIONAL INNOVATION

In order to make continuous improvements in its operations and services to Missions, BASICS must make a reasonable investment in applied research and testing activities. In BASICS, technical innovation may be either innovation in program implementation or more formal research activities. BASICS is not a R&D [Research and Development] project and was not designed to perform basic research for the development of new technologies. However, BASICS was charged with responsibility in Operational Research, which would support the implementation of defined interventions, or the further refinement of interventions in some cases, through a systematic comparison of intervention options.

Innovation in program implementation is an area where BASICS has considerable achievements and where the atmosphere in BASICS appears to foster innovation. This type of innovation includes work in areas with a known impact on child

health, in order to refine interventions to be more effective (e.g., locally appropriate), more cost effective, and/or implemented through innovative partnership arrangements. The type and scope of innovation in BASICS varies appropriately from one technical area to another. For example, the Private/Public Sector Working Group pursues an innovative concept of partnership (with important but limited prior experiences) and has continued to identify new means and opportunities for building such partnerships. The IMCI and Immunization groups have worked with well defined interventions, but have innovated in the refinement and/or operational implementation of existing approaches. The IMCI working group in BASICS has thus sought to refine and further develop the WHO model so that IMCI could be more reliably adapted and implemented to improve the management of ill children.

In some cases, research techniques have been used to adapt or refine interventions. For example, the adaptation of nutrition counselling guidelines in IMCI to local terms, beliefs, and practices is being done using qualitative research methods. The Immunization Working Group has been effective in assessing at what point intervention is needed, and then in adapting systems to meet critical needs. In some cases, this has led to a new type of activity, adapted to special local circumstances, as in the CAR. The Monitoring and Evaluation (M&E) Working Group has also been very active in helping to further develop some assessment tools and design other new ones, such as the mortality survey mentioned earlier.

Innovation through Operational Research (OR) has been limited by the lack of OR leadership in BASICS, the general lack of a systematic approach to OR, and a risk-averse atmosphere which insures that OR is generally a low priority for Missions. Although some staff have been involved in specific OR activities, there is no Operational Research working group, director or leader, strategy, or plan. Early in the current contract, some assessment of research needs and opportunities was done (e.g. in care seeking behavior), but these efforts appear to have been dropped altogether. Achievements in this area have not been as substantial as initially conceived and the lack of a systematic approach means that important opportunities for learning new approaches will have been missed. An important part of the rationale for keeping the field support and global technical leadership components of the BASICS Project together is to facilitate the exchange of ideas and identification of opportunities for program problem solving and innovation. For example, in the course of supporting field activities, staff may identify specific opportunities for conducting relatively low-cost operational research into critical implementation activities. Mission programs could thus benefit from enhanced technical inputs from BASICS' core specialists and the cumulative results of country OR enterprises should contribute to answering child health

questions of more global importance. Many such opportunities have been missed under the current contract.

CONCLUSIONS:

1. BASICS has been successful in supporting innovation in program implementation. This is the innovation that naturally grows from the efforts of expert, motivated, and creative staff who strive to do a better job rather than mechanically carrying out repetitive tasks. This type of innovation reflects the high quality of the staff and the positive professional atmosphere of BASICS.
2. The value of these innovations will be greatly increased when they are effectively and systematically evaluated, documented, and transferred to others working in child survival. At this point in the Contract, it should be high priority to concentrate on adequately capturing and diffusing innovations.
3. BASICS has not been successful in supporting a systematic program of Operational Research (OR), since many elements of such a program are missing (e.g., OR leadership, strategy, plan). At the same time, many elements are present. These include a small number of staff members trained in research techniques; sufficient funds (5% of the budget was initially identified in the RFP to go to research activities); and a subcontractor with the capacity and scope of work to support an OR program (Johns Hopkins University). Also, the BASICS project setting provides proximity of: (a) technical leadership (technical expertise in Child Survival interventions, research priority setting, research design and support); and (b) field operations and program settings that offer specific opportunities for OR.

Another obstacle to the development of a more effective OR effort appears to be the demands made on staff by the need to attend to a very large number of implementation activities covering many countries. Paradoxically, but not surprisingly, such a large number of activities presents many opportunities for structured learning through OR, but the staff have been so busy with implementation that they have not been able to exploit the potential for extracting lessons learned or advancing the state of knowledge in Child Health. Even a modest OR program could yield important benefits at relatively low cost, provided that the USAID and Contract field/headquarters leadership work together to facilitate achievement of OR priorities.

RECOMMENDATIONS (CURRENT CONTRACT):

1. USAID and the Contractor should give high priority to identifying, documenting and diffusing key innovations achieved to date.
2. USAID and the Contractor should review ongoing activities and decide whether additional research in a few critical areas is desirable and feasible under the current contract. If so, a limited OR agenda and action plan can be prepared to cover these. At this late stage of Contract implementation, the Evaluation Team does not recommend the development of a comprehensive or detailed operations research plan.

RECOMMENDATIONS (FOLLOW-ON CONTRACT):

1. USAID should try to strike a balance between the Contract staff's (a) need to provide global technical leadership and stimulate critical research and innovation and (b) the need to provide support for USAID field programs. Concerned staff must be provided with adequate time and other resources to develop, assess, and disseminate new ways of addressing Child Health needs.
2. USAID should provide for specific leadership roles and a systematic approach to Operational Research in both the project and contract structures.
3. USAID planning should continue to provide for adequate funding of core and Mission OR activities. Some global core funds should be earmarked for the support of innovative (OR) activities. USAID/Washington and the Contractor will also need to actively market the benefits of small scale OR to the Missions.

3.4 RELATIONS WITH OTHER USAID PROJECTS

Coordination and collaboration with other USAID projects are important for BASICS to achieve its objectives. With declining resources, combining and leveraging resources to achieve common objectives is an important priority for USAID and other donor activities. In many areas where BASICS does or may work, collaboration is absolutely essential. For example, BASICS will need to collaborate with the LINKAGES and OMNI projects on nutrition and with MotherCare on neonatal health. Moreover, the current atmosphere in USAID increasingly supports such collaborations.

BASICS has already made important progress in collaboration in many areas. And, BASICS is being implemented by the Partnership for Child Health Care,

Inc, a partnership among competitors. The atmosphere at BASICS is generally one of working together towards common objectives, rather than one of protecting more parochial, individual contractor interests. BASICS has also played a proactive and successful role in collaborating with other USAID projects, and there are many examples—from more casual coordination to a complex relationship of interdependency with several other projects. (See **Annex D** for a one-page summary of BASICS' working relations with other organizations.)

BASICS collaborations have often developed on an ad hoc basis, depending on opportunities within a local context. While local conditions will necessarily guide collaboration, the lack of a structured process for initiating collaboration has sometimes hampered or slowed the development of collaboration. More structured processes are developing, e.g., the collaboration among BASICS, CDC, and Rational Pharmaceutical Management (RPM) in the CAR. But these processes are longer and less efficient than necessary in many cases.

CONCLUSION:

Collaboration with other USAID projects is a very high priority for the current BASICS contract, and will increase in priority in the future. This is an area that deserves increased attention. BASICS has made important progress in developing collaborations and these experiences should be summarized and exploited to the greatest extent possible. A more strategic and structured process for collaboration is needed and should be a priority for the next BASICS activity.

RECOMMENDATION (CURRENT CONTRACT):

USAID and the Contractor should review and summarize BASICS experience with collaboration in a short "lessons learned" document.

RECOMMENDATIONS (FOLLOW-ON CONTRACT):

1. USAID should provide for the formation of strategic alliances of the BASICS Project and Contract with other USAID activities and organizations in key areas. The strategic alliance should normally be initiated at the central level and provide a basis and parameters for specific collaboration in country and regional activities. The respective roles of G/PHN, Missions, and the Contractor in forming these alliances need to be specified, but logically G/PHN should take the lead by defining the general strategy and constraints.

2. USAID and the Contractor should develop and disseminate a structured process for initiating and sustaining collaboration in specific country and regional activities. This process may include such elements as project planning or start-up workshops. The process should take into account experiences to date, the aims of collaboration, and general principles of team planning. Care should be taken to cover all key actors, including the USAID Mission, host country government, other donors, and major local stakeholders.

Communication and Behavior Change

4 (CBC)

4.1 DEFINING THE ROLE OF CBC

Communication and Behavior Change is one of the Technical Working Groups in the BASICS structure. CBC is also considered a “lens” through which other dimensions of the project pass. Due to the growing recognition of the importance of behavior change in preventive health interventions, it was decided to give special attention to CBC in this evaluation. The CBC area is difficult to assess because it is treated both as a speciality (with its own Technical Working Group and CBC activities) and as a general change process which is built into other activities (such as IMCI, Nutrition, or Immunization). There are also differing views on how CBC should be handled within the BASICS project.

The Evaluation Team first examined CBC as a speciality with its own technical talent pool and strategy. The initial core staffing pattern showed three positions for "IEC/Marketing" and none with the title of CBC specialist. There are also staff positions for a community participation specialist and a social science advisor. CBC approaches do appear to be as well represented in early programming as those of other technical specialities. To some extent, this is attributed to the fact that there were fewer CBC "specialists" on the staff and/or the CBC specialists were not as influential in BASICS decision making. The Contractor reports that there are currently eight field staff covering CBC activities and three new IEC/CBC persons under recruitment (for Senegal, Guatemala, and Nigeria).

The Contractor's CBC strategy appears to have gone through several permutations. Over time, plans for CBC activities have increased, but there still

appears to be some uncertainty as to when it should be treated as an "activity" and when it should be a change process built into other BASICS activities. The Contractor's Year Four Work Plan suggests that efforts are still underway to clarify CBC's role in the BASICS program.

[There is a] "Need to achieve consensus on [the] desired 'profile' for CBC within BASICS over the next two years: how to strike right balance between integrating behavior change inputs into other BASICS technical programs (i.e., IMCI, nutrition, immunization) and highlighting [the] unique contribution CBC is making."

The Project Year (PY) 4 Work Plan notes that: "The main focus of the program is now upon developing and testing approaches for achieving positive impact on caretaker and community behaviors through community-level interventions, working through local health facilities and health workers, NGOs and PVOs, and community-based organizations (CBOs). The development of new tools and approaches will be focused in a few countries: the large new African programs (Zambia, Ethiopia, and Eritrea)." In addition to the community oriented initiatives, several CBC activities are underway to support other operational areas like IMCI, Malaria, immunization surveillance, and ARI/CDD.

The Evaluation Team did not emerge with any strong position on the best way to approach CBC issues. However, it does seem important that valid and appropriate CBC approaches to individual and group behavioral change be integrated into the planning and execution of all major BASICS activities. This means, for example, that IMCI training and national implementation efforts need to fully reflect appropriate behavior change techniques. Conversely, "CBC activities" like community participation programs or mass media/IEC campaigns need to be appropriately linked to service improvement and other health development activities. Evaluation Team site visits suggest that such linkages are not always apparent. It is important that the focus on new countries not displace the need to systematically assess and disseminate the results of CBC efforts in more established country programs.

4.2 ILLUSTRATIVE CBC INNOVATIONS

Emphasis Behaviors and Community Participation. BASICS, in collaboration with other organizations, selected 15 "MCH Emphasis Behaviors" targeted to the mothers or other caretakers of infants and young children. The emphasis behavior approach has been tested in several countries, including Guatemala, Haiti, and

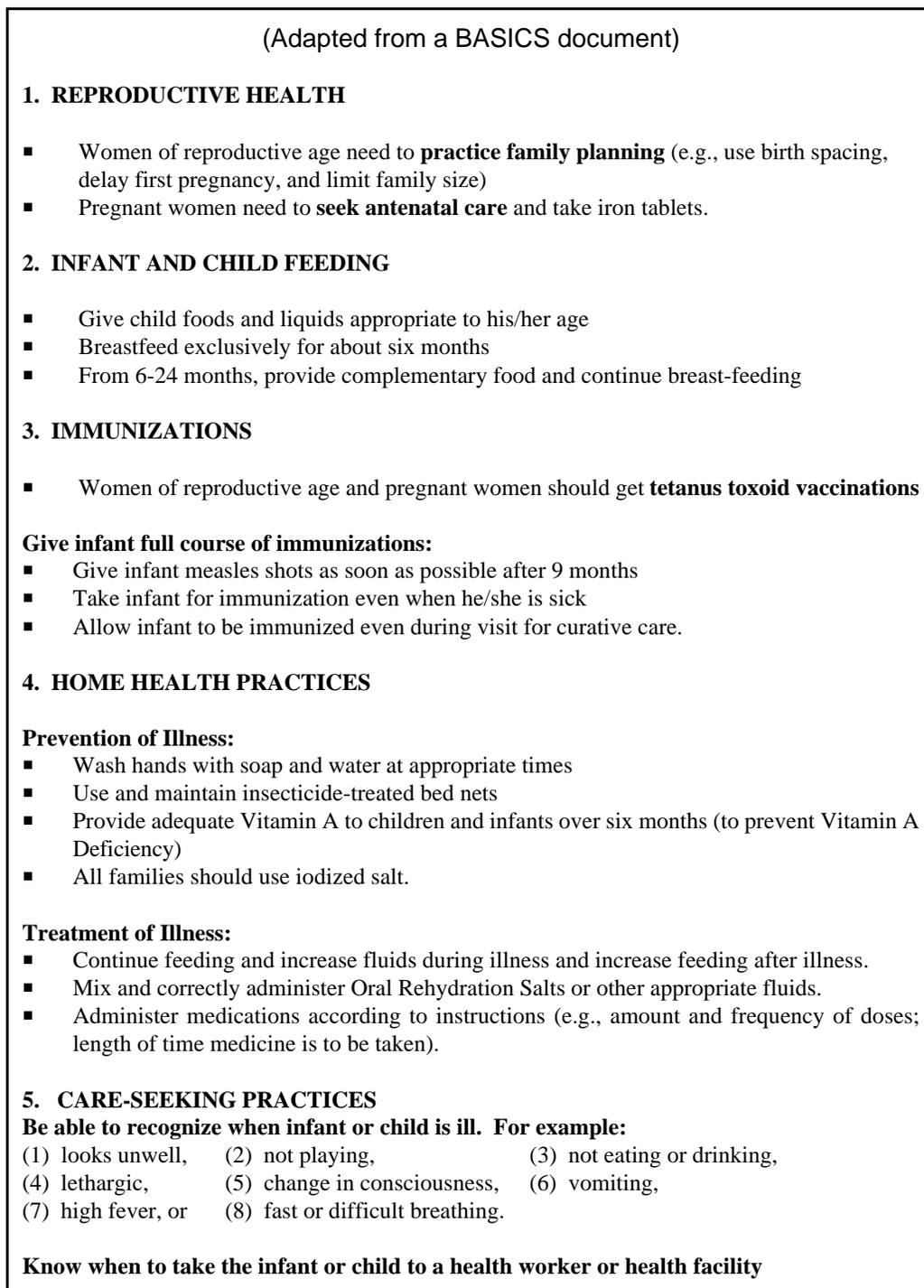
Eritrea. The specific behaviors were selected for their potential to have a measurable impact on multiple diseases. These include exclusive breastfeeding, complementary feeding, immunization, use of bed nets, and hand washing with soap. (See next page for a summary of the Emphasis Behaviors).

To foster community involvement with the Emphasis Behavior interventions, a community level participatory problem-solving process was developed. Two BASICS guides to do this are being field tested in Zambia and Ethiopia. The guides are also designed to stimulate "bottom-up" planning and permeate behavior change thinking among health workers and policymakers. Local Ministry of Health staff and community organizations (such as Church, School, and Women's groups) learn to collect household data, establish priorities in terms of the Emphasis Behaviors they wish to focus on, and then discuss improvement options and obstacles. Finally, action plans are developed by the community and health staffs which focus on two to five priority Emphasis Behaviors. Families and communities can thus pursue the health changes which they deem important. In short, the strategy is to go beyond reliance on traditional health facilities and outreach systems to add improvements in prevention and treatment at the family and community levels. This approach should not be resource intensive, but BASICS does need to track costs and compare its cost effectiveness with that of other methods. Experience suggests that the challenge will come in scaling up from pilot community efforts to cover larger areas.

The Pathway to Child Survival. As mentioned in Chapter 3, this conceptual and analytical framework is a potentially powerful tool to get health policymakers to focus not only on service delivery systems, but also community and household level actions and interventions. The Pathway model provides a graphic illustration of influences on both child wellness and illness. Presently, most health resources are spent on service delivery, but most childhood illness and death occur outside its reach (or "above the line" in the Pathway model). A revised or elaborated Pathway model (discussed in Chapter 3) should result in a balancing of resources which better reaches and engages communities, households, and caretakers in improving child health. As a result, CBC strategies—particularly those with a community participation approach—should be given greater priority by health planners.

Private Sector Social Marketing. In order to increase the private sector's awareness, interest, and participation in child health, BASICS has developed a newsletter and a practical guidebook: "Mobilizing the Commercial Sector for Public Health Objectives: A Practical Guide" by Sharon Slater, UNICEF, and Camille Saade, BASICS (issued in 1996). Largely through the work of one employee, a number of

FIGURE 4.1: MATERNAL AND CHILD HEALTH EMPHASIS BEHAVIORS



promising initiatives have been launched in the areas of hand washing with soap, use of impregnated bed nets, and marketing Oral Rehydration Solutions. These have been developed by conducting market assessments, identifying commercial partners, and linking these partners to public health planners. CBC is central to the BASICS Social Marketing approach and the sound methodology being used appears to have considerable potential for replication.

Integrated Management of Childhood Illness. The success of the IMCI approach is greatly dependent on the interpersonal communication skills of the health workers. The workers need to effectively listen, advise and motivate the mothers and other caretakers of infants and children. BASICS has had a positive influence on the WHO, its primary partner with IMCI, to ensure that Communication and Behavior Change is given sufficient importance. A chapter on communication was included in the Guide for Introducing IMCI. BASICS is also refining the IMCI health worker training modules to make them more appropriate for less literate health workers. To be effective, the IMCI model will ultimately need to go beyond training to identify and address other constraints on the provision of accessible, high quality child health services. BASICS work plans do include this as a goal, but implementation is uneven.

4.3 TRANSFER OF CBC SKILLS

CBC Staffing and Performance. During the first year of BASICS, the limited CBC staffing and lack of strong representation of CBC views at the senior level meant that CBC was not as significant an activity as might be expected from a reading of the original project and contract planning documents. Consequently, CBC expertise was sometimes missing from country activity planning (CAP) teams, country and regional clusters, and technical working groups. BASICS did use outsider CBC staff on some field planning teams, but these persons were often not present for later follow-up planning at BASICS headquarters. The BASICS staff concerned with CBC represent diverse backgrounds and specialty areas, including formative evaluation, behavior change theory, community development and social marketing. The CBC staff appears to be stronger in working on specific interventions, rather than formulating broad strategic frameworks for presenting CBC alternatives to USAID Missions. The staff working on CBC have usually been well received in the field and able to respond to country requests when made. As mentioned above, some staff have been more comfortable with pursuing specific approaches with which they are familiar, and less so in identifying and marketing a broader range of CBC options to Missions.

Use of Subcontractors. The primary CBC-related subcontract, Porter-Novelli, appears to have been underutilized, relative to the funding ceiling established for

it in the Contract. Since Porter-Novelli staff were not involved in many of the initial planning or CAP missions, there was reportedly less CBC work planned for them to do in some country programs. Porter-Novelli played an important role in the Russian immunization/CBC efforts, especially in the areas of strategy and evaluation. Russia is one of the few country CBC efforts where the planning cycle was completed by moving from formative evaluation through strategy development to measuring behavior change. World Education Inc. was subcontracted to help facilitate the recent work in Zambia on refining the IMCI curricula and materials. The Manoff Group has been tasked with developing models for community-based work in Nutrition in Honduras and Zambia. The Manoff activity will identify variables for success in promoting volunteerism and community participation.

CBC Training. BASICS has developed experience-centered training modules for training in formative evaluation, CBC strategic planning, and using radio to promote child survival. In countries where the CBC training has been conducted, like Russia and Senegal, the tools have proved to be appropriate and useful. One early action was to provide all BASICS staff with a two day introduction to Communication and Behavior Change to increase awareness of the importance of CBC to Child Survival. Although there is an increased appreciation of the role of CBC among BASICS bio-medical staff, there is little evidence that this training accelerated the programming of CBC activities at the country level.

CBC Products. The "Tool Box" is a practical guide developed earlier by HEALTHCOM for planning and executing CBC. Under BASICS, it has been revised; translated into French, Spanish, and Russian; widely distributed; and used in several training programs. The Tool Box does not include participatory community interventions but otherwise is a comprehensive reference that takes CBC specialists through the planning cycle from needs assessment through message and material development to monitoring and evaluation. A guide for exploiting the Emphasis Behaviors ("Community Assessment and Planning for MCH Programs: A Participatory Approach") is being pretested in Zambia. BASICS is also drafting a "District Managers' Guide to Community Mobilization" which covers how to inventory and exploit community resources.

The "Food Box" is a list of child feeding recommendations which are part of the standard IMCI training protocols. A participative process was developed to get mothers to identify feeding problems and find ways they can improve practices. Through a subcontractor, the Manoff Group, the instrument is also being used for formative evaluation in community programming by identifying motivations and constraints in a representative sample of communities. Several other CBC

products are still being developed or tested, including a case study of behavior change planning and "pocket guides" for planning CBC.

Relations with Partners. BASICS is looked to for CBC leadership and innovation by many of its partners. WHO thus asked BASICS for CBC assistance on the IMCI model. The Chief of Social Mobilization and Communications at UNICEF headquarters is a member of the BASICS CBC advisory group. In several countries BASICS has been involved in coordinating the CBC work of other USAID contractors, international organizations and cooperating countries. This collaboration in CBC is viewed as timely, valuable, and appropriate. This is particularly the case in West Africa where the presence of a CBC expert on the BASICS Regional Office staff has been viewed favorably by partners.

4.4 APPLICATION AND IMPLEMENTATION

Household and community level interventions. The environment in which public health operates has been rapidly changing in many countries. For example, the "Pathway" model and other conceptual frameworks have increased awareness of the need for reaching and engaging caretakers, households, and communities. Political decentralization and the emergence of more open and democratic societies have also contributed to a more receptive climate for participatory approaches to improving child health. While democratic participation is a major concern of USAID, its role in health development has received a mixed reception. For example, some USAID staff see BASICS as being slow to embrace the challenge of developing innovative approaches to community participation. On the other hand, some USAID staff prefer more tried and true health interventions like EPI or health worker training, rather than the unfamiliar approaches being pursued through community participation or other CBC strategies. If community level approaches are important to USAID global priorities in health, this needs to be more clearly communicated to field staff.

Impact at Country level. Because of the staffing and other issues discussed above, BASICS has been relatively slow in getting field implementation started. The volume of activity has been steadily increasing, but many field efforts are still in the early stages of implementation. Impact is naturally greater when the concerned staff persons are able to spend more time in country. The CBC country activities should have a positive impact on child health over time, but it is not clear how much will be accomplished by the end of the current Contract (September 1998). Consequently, as in other operational areas, it will be important for the Contractor to track the more promising CBC activities to maximize impact and "lessons learned."

Some of the newer country programs may merit special support, study, and documentation of results during the next 18 months. For example, Zambia now appears to present a positive environment for developing and implementing innovations in the area of community participation. With the presence of a CBC community participation specialist on the BASICS/Zambia staff, useful results are expected which can be adapted or replicated in Zambia and elsewhere. Similar work is ongoing in Ethiopia and Eritrea, countries with a large USAID presence. The work of the BASICS West Africa Regional Office in radio is also promising, especially with the explosion of private sector media on the continent. The NGO-based community participation work in Nigeria is important since BASICS is dealing directly with communities which then seek the health expertise they need (increasingly from private providers). This contrasts with most BASICS activities where its principal partner for community outreach is the Ministry of Health. In Honduras, BASICS needs to document the sustainability of the work with community volunteers in Growth Promotion. In Bolivia, useful information on the cause of death of young children was obtained through verbal autopsies. This information was then used as the basis for a social drama or soap opera on child health. Although questions have been raised about the lack of health content in the initial soap opera scripts, this example of collaboration between medical and social science/media specialists needs to be assessed for "lessons learned" and the potential for replication.

The BASICS CBC intervention in Russia is viewed by CBC staff as one of their most important achievements. BASICS succeeded in introducing 30 years of Western experience in public health to very receptive Russian counterparts. Through learning-by-doing methods BASICS introduced strategic planning and completed research-based interventions. Madagascar and Bangladesh are other countries where there are CBC country advisors. In Bangladesh, BASICS has achieved measurable behavior changes on the part of urban poor who have increased their participation in immunization programs.

CONCLUSIONS:

1. To date, much of the CBC activity has been concentrated on preparing the ground for future interventions. CBC country activities are increasing, but most have not yet had a significant impact at the household level. Little measurable behavior change has been documented, although there is some evidence of impact resulting from communication campaigns in support of immunization in Russia and Bangladesh. It will be important for BASICS to systematically document the effects of its country CBC efforts during the balance of the contract.

2. Measuring behavior change and attributing the changes to specific interventions is always a difficult task. BASICS' predecessor project, HEALTHCOM, devoted considerable resources to measuring behavior before and after interventions to prove that their models worked. The Contractor's technical proposal states that data required by the Contract on behavior change will be collected from such sources as Knowledge, Attitudes, and Practices surveys (KAP) and interviews with opinion leaders and policymakers. USAID and the Contractor thus need to decide what level of resources they will dedicate to providing evidence of behavior change in given activities. By the end of the Contract (September 1998), there may be relatively little evidence of behavior change because few baseline studies were done to permit "before" and "after" comparisons, particularly at the household level. Moreover, many interventions will not have been up and running long enough to produce much change.

RECOMMENDATIONS (CURRENT CONTRACT):

1. The Contractor should prepare an "Emphasis Behaviors" package to help communities: (a) define and understand the child survival challenges they face; and (b) set priorities for taking action. This Emphasis Behaviors-Community Participation framework should provide Communities with strategic options for each Emphasis Behavior. It could include:

- lessons learned from around the world (including BASICS work)
- common resistance points and suggestions for overcoming them
- guidelines on engaging health services
- state-of-the-art examples of interventions
- prototype messages and materials
- cost effectiveness of each response

2. The Contractor should develop different Community Participation models for different local environments. For example, the Emphasis Behaviors Community Participation model being tested in Zambia has BASICS working through the Ministry of Health to engage the community and NGOs. Another model should be developed which has BASICS working directly with community groups or

NGOs who then engage the health system for the support that is needed (e.g., as in the Nigeria program).

3. The Contractor should give priority to tracking significant CBC innovations and preparing "lessons learned" in the form of practical case studies (geared toward the needs of future CBC program planners). Give the limited time left in the current Contract, it may be necessary to finish the CBC interventions and evaluate them at the same time. Even if the interventions aren't complete, a "snapshot" of what has happened to date can be prepared.

4. USAID and the Contractor should identify and strive to link the critical mass of CBC talent working in BASICS, other CAs, International Organizations, etc. Efforts should be made to share results, organize forums, develop training packages, establish common research protocols, and formulate CBC program strategies.

5. BASICS should expand the existing CBC advisory board to help review and shape innovations, considering the urgent need to continue developing innovative approaches to reach and engage the households and communities in child health.

Consideration should be given to supporting a workshop which would focus top international talent on assessing successes and defining future challenges and directions in CBC.

RECOMMENDATIONS (FOLLOW-UP CONTRACT):

1. USAID should ensure that adequate resources are allocated to develop and implement innovative designs to reach and engage households and communities for both preventative and curative interventions ("above-the-line" in the Pathway Model).

2. USAID should ensure that the following types of specialists are available (through contracts, subcontracts, or alliances with other CAs) to support field programs and provide global technical leadership in CBC: Communication and Community Behavior Change Strategists or Planners; Social Researchers; Mass Media Specialists (especially radio); Community Participation Specialists; Public Health Physicians with experience in Communication and Behavior Change; Social/Commercial Marketing Specialists; and NGO specialists.

3. USAID should include provisions in the Contract to establish guidelines and standards of practice for the design and implementation of CBC activities

throughout the organization. These guides should use concrete examples to present strategic options and cover the cost effectiveness of different interventions. Such guidelines should be linked to USAID's program planning frameworks. The CBC options should be clear and presented as an integral part of a complete Child Survival package.

4. USAID should pursue a balanced approach to stimulating local action through community participation models versus mass media models. There is increasing demand for community participation models, but there remain serious questions about the cost effectiveness of such interventions and the difficulty of bringing them to scale. Development Communications/Social Marketing approaches which use mass media have proven valid in inspiring behavior change when done well. Such interventions are also relatively cost effective and are already to scale, so it would be unwise to reject these models in favor of more experimental community participation models. In fact, both models are more effective if they are designed to be complementary. Community participation can be amplified by use of mediated communications. For example, regional or local radio can be used to inspire behavior change and support community-level interventions. It is important to ensure that strategic planning skills in communication are developed in each country. With the emergence of private sector media in many countries the chances of developing sustainable resources are increased if the private sector is trained and partnerships developed.

5. USAID should ensure that the new Contract's Operational Research (OR) component includes provisions for defining and evaluating CBC innovations. OR can then provide needed evidence that CBC investments can help achieve measurable health results and it can compare the cost effectiveness of different options for pursuing behavior change.

Implementation of Field Activities

5

5.1 IMPACT OF RECENT USAID CHANGES ON FIELD IMPLEMENTATION

The BASICS Project has always had a two-fold mission:

- (1) to provide **global technical leadership** on child health, and
- (2) to provide **technical assistance (TA) to USAID Missions**

While the Project design anticipated that the emphasis would be on field program support, this aspect of BASICS has become even more dominant than expected because of the major internal USAID management and programming changes made since the BASICS Contractor began operations in September 1993. Consequently, both the planning and execution of BASICS field activities have been affected as USAID has acted to:

- (1) Implement a new **Agency-wide programming system** which required new Bureau and Mission strategic objectives, results packages, monitoring schemes, etc. Some Missions still have not completed installation of the new programming system.
- (2) Encourage Missions to **focus on fewer sectors** and program activities. Some Missions have used this guidance as the reason for not including child survival activities.

- (3) Continue **the reduction of USAID's field presence** through Mission closings and staff cut-backs. Decreased bilateral staff levels is a factor contributing to the high level of BASICS use by Missions.
- (4) **Decentralize** more funding decisions to field staff (through "field support" and other mechanisms). Missions and Regional Bureaus now fund most of the Project's activities. Consequently, Missions make many BASICS contract decisions which were formerly handled by G/PHN staff.

One important outcome of these Agency changes has been the transfer of more authority and control over project activities to the Missions. It was originally assumed, for example, that the BASICS contract funding would be shared on roughly a 50-50 basis between core and field sources. However, by FY 1997 the increased use of field allocations to fund the contract resulted in G/PHN providing only \$4.6 million of the estimated total annual expenditures of around \$33 million. The net result of the new approach is that USAID Mission staff make the major decisions regarding the initiation, scope, and design of the BASICS Contractor's country activities.

G/PHN and BASICS Contract staffs have sometimes been able to influence Mission reengineering and programming decisions through the provision of expert advice and other support (including "bridging" TA until new bilateral projects become operational). According to Evaluation Team contacts, BASICS staff have played key roles in the design and start up of several bilateral child health activities. USAID/Washington can also affect a Mission's position through the earmarking of funds for Child Health programs. All BASICS workplans must also be approved by USAID/Washington so this provides another opportunity for the G/PHN staff to shape the field portfolio. In short, while the USAID field staffs now have more authority over central projects like BASICS, the USAID/Washington and BASICS contract staff still have various avenues and opportunities for exerting influence over Mission decisions.

The Contract's original implementation strategy called for: (a) a series of global technical strategy papers in the major intervention areas (discussed above); and (b) country-specific strategies reflected in a **Country Activity Plan (CAP)** for each longer term country program. CAPs have been prepared for 16 countries but there has been considerable variance in their preparation and use. Some Missions had already completed needs analyses and plans, so they regarded a CAP as unnecessary. In other cases, Missions had become involved in the new USAID reprogramming and reengineering exercises, so they required BASICS to conform to the new programming and documentation requirements. The net result of the new USAID decentralized programming system is that the current BASICS

portfolio represents an array of activities which reflect Mission child health priorities and collaboration among the staffs of USAID/Washington, Missions, and the Contractor.

Some G/PHN staff have expressed concern that the resulting mix of BASICS countries does not include enough of the "joint programming countries" which have been given high priority under a G/PHN global ranking system. However, the BASICS Contractor is largely responding to country assistance requests which have been approved by both Mission and USAID/Washington program managers. Moreover, this concern about coverage goes beyond the BASICS Project and Contract since it involves relationships between Washington and Mission managers on the issue of global targeting and assignment of country priorities for PHN and other assistance.

Before preparing the next Contract for BASICS, it would be useful to have a clear definition of the linkages between the G/PHN global priorities and the individual Mission priorities for Child Health. Once the division of labor is clarified, USAID could consider the use of a life-of-contract **Strategic Implementation Plan (SIP)** to better link the Contractor's annual workplans to both central and field program priorities. The SIP can be updated as needed. Moreover, flexibility could be gained by keeping the formal Contract document as brief and simple as possible and then putting more detailed guidelines in the SIP or similar guide prepared by the COTR. The SIP would provide a program and budget framework to guide the Contractor in preparing operational strategies and both the life-of-contract and annual workplans. At present, there is no overall strategy document like the SIP which effectively links the very general tasks in the Contract document to the Contractor's Workplans. The resulting system has produced overly detailed workplans and progress monitoring systems which are difficult to link to broader operational aims of Missions and G/PHN.

5.2 OVERVIEW OF THE BASICS FIELD PORTFOLIO

As suggested above, the current BASICS portfolio of country programs is primarily determined by individual Mission priorities, although USAID/Washington and BASICS staffs have been influential in some of the country selections and in the mix of child health interventions. Countries assisted under the Contract are classified into three categories:

- Long-term countries (16):** Long-term program with resident technical staff.
- Periodic countries (15):** No resident team, but may have resident coordinator.

TABLE 5.1 LONG-TERM AND PERIODIC ASSISTANCE COUNTRIES

<u>LONG-TERM COUNTRIES</u>	
AFRICA (10)	
Eritrea	Ethiopia
Mali	Madagascar
Mozambique	Niger
Nigeria	Senegal
South Africa	Zambia
ASIA/NEAR EAST (3)	
Bangladesh	Cambodia
Morocco	
LAC (3)	
Bolivia	Ecuador
Guatemala	
<hr/>	
<u>PERIODIC COUNTRIES</u>	
AFRICA (3)	
Benin	Guinea
Kenya	
ASIA/NEAR EAST (3)	
India	Indonesia
Pakistan	
LAC (1)	
Honduras	
NIS (8)	
Moldova	Kazakhstan
Kyrgyzstan	Russia
Tajikistan	Turkmenistan
Ukraine	Uzbekistan
NOTE: Haiti program was closed out in December 1996	

Ad-hoc Countries: Those requesting special short-term TA.

Table 5.1 lists the 31 countries currently receiving "long-term" or "periodic" assistance. The Contractor is also involved in 14 regional activities (ten of which are in Africa). Table 5.2 provides an overview of the program scope or size, child health interventions, and stage of implementation for regular country and regional programs. The Contractor cautions that Table 5.2 table may oversimplify the profile of a given country effort. Table 5.3 focuses on general outputs in the long-term countries since the Contract started in 1993. The range and variety of interventions included in the country programs are consistent with the Project's two-fold aim of developing and using more integrated approaches (like IMCI), while continuing to develop and use successful specialized or "vertical" approaches (like EPI or Malaria). Table 5.2 also confirms the observations made in Chapter 3, above, that few activities have been undertaken with the private sector—particularly the commercial sector.

As shown in Table 5.3, some long-term country programs have been limited to a specific intervention or focus area (e.g., the child health aspects of Female Genital Mutilation in Kenya). Immunization is the dominant intervention in the NIS, Russia, and Bangladesh. The Contractor reports some results of these more mature country activities in Table 5.4 (covering immunization coverage during polio NIDs and decreases in diphtheria

incidence) and Table 5.5 (estimates of cost savings resulting from improving immunization schedules).

TABLE 5.2 SUMMARY OF MAJOR BASICS COUNTRY INTERVENTIONS

Showing phase of implementation of each as of March 1997

Region/Country	Prgrm Age to 3/97	Scope In FY 97	Disease-Specific Interventions					Behavior Change		Health Systems Interventions					Private Sector				
			Prevention	Nutrition	Case Management	IMCI	CDD	ARI	Malaria	IEC/Soc. Marketing	Commun. Mobiliza	Nat. Policy Planning	Decentralized Mgmt	City Assur Supervision	HMIS/Surv	Training	Hlth Finance/Other	NGO/PVO	Prvt Provider
Africa																			
<i>Country Programs</i>																			
Benin (3/97)	1 mo.	S		D					D		D						D		
Ethiopia (12/94-9/95; 2/96-)	12 mos.	VL	E	E	E				E	E	E	F	F	E	E	HF-D	E	E	
Eritrea (10/95)	18 mos.	L	E	E	E				E	D	F	F	E	F	F	HF-D	O	E	
Guinea	new	VS																	
Haiti (10/95-12/96)	14 mos.	closed	C		C		C		C		C	C	C		C		C		
Kenya/FGM (3/95)	24 mos.	S							E	E	E	F					F	F	
Kenya/AMI	new	S			D		D	D	D	D	to be determined						to be determined		
Niger (10/93-)	42 mos.	M		E	E	F	F	F	F		F	F	F		F				
<i>Nigeria</i>																			
Urban EPI (3/94-2/96)	24 mos.	closed	C						C		C	C	C	C	C		C	C	
Private Sector (3/96-)	20 mos.	L	E	E	E				E	F							F	F	
Madagascar (1-9/94; 6/95-)	21 mos.	L	E	E	E	C	C		F		F	F		E (EPI)	F		E		
Mail (10/95-3/96)	restart '97	?	D	D	D				D	D	D		D	F	D		D		
Mozambique	new	S																	
Senegal (10/93-)	36 mos.	M		F	E	F			F	E	F	F	E		F		E	E	E
South Africa (4/95-)	24 mos.	M	C	C	C	C	C	C	C		C	C		C					
Zambia (5/96-)	11 mos.	VL	E	E	F		F		E	E	F	F	E	F	F		E	E	E
<i>Regional Programs</i>																			
REDSO/ESA CS Adv (1/95-)	27 mos.	S	all MCH																
REDSO/ESA Hlth Net (1/95-)	27 mos.	L	all MCH								F		E			HF-F			
REDSO/WCA FHA (10/96-)	6 mos.	L			D	E			E	E					E		E		E
REDSO/WCA Hlth Net (5/97-)	new	M	to be determined								to be determined					ID-D	D		
Asia/Near East																			
Bangladesh (8/94-)	31 mos.	VL	F		D	D	D		F	F	F	F	F	F (EPI)	F		F		
Cambodia (12/96-)	4 mos.	L			E	E	D		D	D	E	E	D	D (mort)	D		D	D	
India (3/95-) PVOH	25 mos.	S										F					F	F	
Indonesia (8/95-)	20 mos.	VS									E	E			F		D	E	
Morocco (1/97-)	3 mos.	M	E																
Pakistan (12/95-)	15 mos.	VS		E		E	E		E								F		
Latin America/Caribbean																			
<i>Country Programs</i>																			
Bolivia (10/93-)	40 mos.	M		E	E	C	C		F		F	F	E	F (mort)	F		E	F	F
Ecuador (10/96-)	6 mos.	S		E	E				C		F	F	E		E		C		
<i>Guatemala</i>																			
CDD/ARI (1/94-12/95)	24 mos.	NA			C	C			C	C	C		C		C			C	
Mayan Highlands (10/96-)	6 mos.	L		D	D				D	D	E	E			D		D	D	
Honduras (10/94-)	30 mos.	M		F	D	C	C		C	F	F				D				
<i>Regional Programs</i>																			
Regional IMCI (12/96-)**	4 mos.	M		E	E						E	E	E		E				
Regional Cholera (10/93-9/96)	36 mos.	NA			C				C		C	C		C	C			C	C
Newly Independent States																			
<i>Country Programs</i>																			
Moldova (10/94-9/96)	24 mos.	NA	C						C	C	C	C	C	C	C		LP-C		
Russia (10/95-3/96)	24 mos.	S	C						C		C	C			C		ID-C	C	
Ukraine	new	VS	D										D						
<i>Regional Programs</i>																			
CAIDP* (10/96-)	6 mos.	L		F		F	F		D		F	F	F		F				
CA Immunization ** (4/94-)	36 mos.	M	F						F		F	F	F	F	F		LP-F		

Notes: * Central Asia Infectious Disease Program covering Kazakhstan, Kyrgyzstan, and Uzbekistan
 ** Central Asia Immunization Program covering Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, Turkmenistan
 *** LAC IMCI Program with PAHO covers eight countries: Guatemala, Honduras, El Salvador, Nicaragua, Haiti, Bolivia, Ecuador, Peru

Key:
 Order of Financial Magnitude in FY97: VL= Very Large >\$2million, L= Large >\$1million<\$2million, M = Midsize >\$.5million<\$1million, S = Small >\$.2 million<\$.5million, VS = Very Small <\$.2 million
 Phase of Intervention: D=Design, E=Early Implementation, F=Full Impl., C=Completed
 Other System Strengthening Interventions: HF = Health care financing, LP-Logistics and Procurement, ID-Information Dissemination

TABLE 5.3 BASICS OUTPUTS IN LONG-TERM COUNTRIES, AS OF 3/97

Long-Term Countries (start date)	Ethiopia (2/96)	Madagascar (2/94)	S. Africa (4/95)	Zambia (5/96)	Eritrea (10/95)	Nigeria (3/94)	Senegal (10/93)	Niger (10/93)	Bangladesh (8/94)	Cambodia (12/96)	Morocco (1/97)	Bolivia (10/93)	Ecuador (10/96)	Guatemala (10/96)	NIS#		Total	
															EPI (4/94)	CAIDP (10/96)		
Developing IMCI, CM &/or EPI policies	x	x	x	x	x	private sector		x	x	x	x	x	x	x	7 c'ntries	3 c'ntries in CARs	20	
Areas training in IMCI, CM &/or EPI	5 woredas	2 dist.	1 prov.	10 districts	3 zones	6 CPHs	4 regions	2 dist.	89 munic.	4 prov	2 prov.	14 dist.	1 prov.	4 depts.	7 c'ntries (Rus - 3 oblasts)	3 oblasts	158 areas	
Nationally adapted IMCI, CM &/or EPI curriculum	x	x (6/97)	x	x	x (12/97)	x (9/97)	x	x	x		x	x	x	x	x (7)	x	21	
HWs/ToTs trained in IMCI, CM &/or EPI	70	155	75	100	31	80	95	37				30	60	2,000	35	45	2,813	
District plans/improved supervision	x	x		x	x		x	x	x			x	x	x	x (7)	x	18	
Surveys (baseline & follow-up)	5	3		4	2	3	4	2	3	1 (5/97)	2 6 & 8/97	6	1 (4/97)	2	1	3	42	
Pop. covered in millions	<5s in project area	0.165	0.1	1.0	0.413	0.245	0.184	0.384	0.066	2.162	0.270	0.102	0.192	0.047	0.3	7.351	0.688	13.669
	total in project area	1.1	0.65	6.65	2.76	1.636	0.9	2.56	0.437	14.413	1.8	0.68	1.28	0.312	2.0	52.538	4.551	94.267
	c'ntry	55.1	14.8	41.5	9.5	3.5	6.399 (Lagos)	8.3	9.2	14.413*	10.3	27	7.4	11.5	10.6	196	44.6	425.512

The Evaluation Team gained some appreciation of the range and complexity of the country programs from its country visits. Although there is a rather broad array of activities at different stages of development in the long-term program countries, programs appear to be consistent with the Contractor's technical strategies (discussed in Chapter 3). Some Evaluation Team contacts did express concern that the pace of field implementation may be too slow to produce significant results in some areas before the end of the Contract (see discussion in Section 5.5, below).

TABLE 5.4 - IMMUNIZATION ACTIVITIES CARRIED OUT WITH BASICS SUPPORT (1996)

Countries	Polio NIDs* (children under 5)		Diphtheria Incidence		
	Coverage (%)	Number Immunized	# of cases		Percent Reduction
			1995	1996	
Kazakstan	99	1,397,900	1,106	455	59
Kyrgyzstan	99	501,700	704	412	41
Tajikistan	99	693,400	4,455	1,464	67
Turkmenistan	99	494,000	87	80	8
Uzbekistan	98	2,981,350	639	160	75
Moldova	-	-	418	97	77
Russia	-	-	35,652	13,604	62
Bangladesh (urban areas)	91	1,976,485	-	-	-
Total	97%	8,044,835	43,061	16,272	62%

*National Immunization Day (NID) 2nd Rounds, 1996

Source: Prepared by BASICS Contract Staff, March 3, 1997

TABLE 5.5 - ANNUAL COST SAVINGS* (\$US) DUE TO REVISION OF IMMUNIZATION Schedules (after 7 MOH/USAID/WHO Policy Seminars, 1992-1995)

Country	Date of Seminar	Current Cost Per Fully Immunized Child (0-16 years)	Annual Savings Due to Revised Immunization Schedule	
			Absolute	As Percent
Uzbekistan	12/92	4.46	\$119,000	3.8
Kyrgyzstan	12/92	4.32	40,000	6.7
Turkmenistan	6/93	4.08	73,000	11.9
Tajikistan	6/93	3.91	161,000	15.6
Kazakhstan	6/95	3.60	246,000	16.5
Moldova	11/93	3.08	107,000	33.5
Georgia	11/93	3.91	58,000	15.6
Total			\$804,000	

Source: Provided by BASICS Contract Staff, March 1997

* Assumptions:

- (1) Costs assume procurement through UNICEF (for standardization) and include vaccines (BCG \$.07, DPT \$.09, OPV \$.09, measles \$.16, DT \$.10, and Td \$.10), vaccine wastage (BCG x 2, measles x 2, DPT x 1.5, OPV x 1.5, DT x 1.5, and Td x 1.5), syringes/needles (\$.05 for one syringe and one needle), and transport and fee (20% of value of goods).
- (2) Costs exclude mumps vaccine and hepatitis B vaccine (used in Moldova).
- (3) Costs exclude significant savings due to fewer contacts required in revised immunization schedules.

Notes: Population of each cohort: Uzbekistan 700,000; Kyrgyzstan 130,000; Turkmenistan 133,000; Tajikistan 223,000; Moldova 69,000; Georgia 81,000; and Kazakhstan 347,000.

Earlier schedule used for cost comparisons was the Soviet schedule, except for Kazakhstan where the comparison is with an earlier schedule in effect from early 1994.

In the NIS/CAR countries, the BASICS program has focused primarily on upgrading national immunizations systems. This effort continued and built on a previous REACH Project activity (funded by a USAID regional earmark for immunization). The Contractor notes that in 1996 the NIS efforts expanded into a social marketing activity in Russia and into ARI/CDD activities in Kazakstan, Kyrgyzstan, and Uzbekistan. BASICS has thus assisted cooperating countries to achieve higher immunization coverage for specific diseases and achieve cost savings by improving program operations and scheduling. The USAID and cooperating country staff in Russia were ebullient in their reports to the Evaluation Team on the practical and flexible approaches taken by the BASICS staff to improve immunization systems. The BASICS CAR program is scheduled to end in 1997 and the USAID regional strategy does not call for continuation or expansion of child health activities.

In some larger programs, Missions have asked BASICS to **be the lead CA for Child Health** and related activities. In Zambia, for example, the Mission looks to the BASICS staff for overall technical leadership and CA coordination in the implementation of the Zambia Child Health Project. The Mission has also required BASICS to assemble an "integrated" project work plan and reporting system which reflects the efforts of BASICS and several other CAs working on child health in Zambia. A wide range of BASICS activities is being initiated, including IMCI training, community mobilization, and support for national program reform and decentralization. The Ministry of Health leadership is leading a radical restructuring of health systems to reduce staff costs and move more services to the community level. Since the Ministry looks to USAID and BASICS for support on these new reforms, the Contractor's role has rapidly expanded. USAID/Zambia has also asked BASICS to provide **logistical support for other health CAs** (e.g., local transportation and administrative support for training). The Mission and affected CAs are apparently pleased with how this arrangement has worked so far.

Using a contractor to assume such CA coordination and logistical support duties is a natural response to reduction of USAID field staffs. However, there are some potential risks in such approaches: (1) confusion over who is actually implementing project tasks in areas where the contractors' work overlaps; (2) conflicts of interest if the lead contractor gets too involved in the administration of other contracts; and (3) reduction of time spent by the lead contractor's staff on regular technical tasks when administrative and coordination tasks start to consume more of their time.

The USAID Zambian Child Health Project only began in 1996. The BASICS Delivery Order (DO) was approved in May 1996, following about 14 months of

bridging TA. Therefore, many activities under the DO are still in the early stage of implementation. The unusually dynamic environment created by the ongoing government health reforms means that BASICS will be involved in a wide range of interventions at all levels. While BASICS is playing a major role in health improvement in Zambia, the expanding staff work load may make it more difficult to complete all BASICS Workplan activities in Zambia before the current Contract expires in 18 months. The Evaluation Team does see Zambia as an important program to track for "lessons learned" in most major areas of BASICS operations. There are also unique aspects of national policy and organizational reform which merit priority attention for extracting information and options for other countries.

In some countries, BASICS plays a relatively small role in the PHN program. For example, in Senegal, BASICS is assigned only to handle Nutrition/CDD interventions under the Mission's Child Survival/Family Planning Project. The major bilateral project effort is in Family Planning and the coordinating CA is MSH. The BASICS/Senegal staff consists of a Country Advisor, Accountant, and a Nutrition Specialist, with plans to add an IEC specialist. BASICS staff participated in the Mission's recent PHN reprogramming exercises and share responsibility for implementing the new Results Package. The country staff is located in the regional BASICS office in Dakar and operates under the supervision of the BASICS Regional Director. The five regional staff also provide part of the TA for the Senegal bilateral program. (The Regional Office is discussed below.) The USAID staff are appreciative of BASICS' help, but are currently not very interested in expanding Child Health interventions. The Mission has contributed about \$1.7 million via a Delivery Order and the Africa Bureau has provided about \$200,000..

Many activities in Senegal are still in the early implementation stage, although BASICS began operations here early in the Contract and was to build on the nutrition efforts of the previous USAID child health contractor. The BASICS program currently focuses on improving Nutrition/CDD in four pilot regions and strengthening the MOH nutrition unit (SANAS) to cover the other six regions (with support from other donors). Local costs of activities in the pilot districts are being separately funded through MSH under the bilateral Project. The BASICS Senegal staff reported that progress had been made in getting officials in the pilot areas informed and concerned about nutrition issues. Moreover, in 1996, all 16 districts in the four target regions included nutrition interventions in their health plans for the first time. BASICS is also assigned to help produce a national nutrition policy and to identify ways of using the commercial sector to distribute Oral Rehydration Salts (in cooperation with SOMARC).

In cooperation with several government agencies and NGOs, BASICS has also developed a computer-based audio-visual presentation (PROFILES) on Child Health and Nutrition in Senegal. The advocatory "PROFILES" presentation (in French) has been made to the Minister of Health and other senior officials, as part of the plan to develop a national nutrition policy. Senegal is apparently a BASICS test site for PROFILES and the plan was to use it in other countries. There are varying views within and outside of BASICS on the potential value of "PROFILES" as a tool for influencing policymakers. Some note that it lacks the drama and impressive quantitative approach of the RAPIDS presentations on national population issues. However, the process of developing the Senegal module actively involved and informed a wide array of health and nonhealth leaders and officials. An impartial review should be made of this or other pending models for communicating child survival issues to decision makers and planners, especially those outside of the health field.

5.3 ROLE OF REGIONAL OFFICES IN FIELD IMPLEMENTATION

The organization and location of BASICS regional offices sometimes appear to be responses to specific requests for assistance or legacies from previous child health projects, rather than a systematic effort to link such structures to BASICS' own program priorities. Since March 1995, BASICS has assigned a person to USAID/REDSO/East and South Africa. This person serves as REDSO's de facto child health officer, so in this case BASICS appears to be performing a general staffing function rather than implementing specific technical tasks under the Contract. The LAC Regional BASICS Office consists of one person, who was hired primarily because of his strong professional reputation and LAC experience. This Regional Advisor has provided important assistance on both the design and execution of various country programs.

The BASICS West Africa (Francophone Africa) Regional Office is reportedly located in Senegal because that was the location of the regional staff of a previous child health project (some of whom were employed by BASICS). This office has a director and three regional specialists (Child Survival, IEC, and Nutrition) which now cover activities in several countries, including Senegal. The BASICS/Senegal Country staff are essentially a part of the Regional Office. Mission relations with both staffs are reportedly quite good. There seems to be agreement that the Regional Office might be more appropriately located in Abidjan to be near the USAID/REDSO and other donors' regional offices. However, no action is being taken to move the office because of the cost involved and the relatively short time remaining in the Contract. The BASICS regional staff has devoted considerable time to developing close relationships with UNICEF and WHO/AFRO. There is, for example, a joint 1997 work plan with

WHO/AFRO to provide training and TA on IMCI, CDD/ARI, Breastfeeding, Facility Assessments Methods and other areas to programs in Burkina Faso, Togo, Cote d'Ivoire, Mali, Niger, and Senegal. With the exception of Senegal, the Evaluation Team did not visit countries served by this regional office.

USAID/REDSO's e-mail response to the G/PHN questionnaire on BASICS was positive about the assistance received from the BASICS regional staff. The impression is that both the Africa Bureau and REDSO staff see the importance of the BASICS regional staff, but feel that it is not given adequate autonomy from BASICS Headquarters to be responsive to local needs.

As noted earlier, regional BASICS activities in the Central Asian Republics are not expected to continue beyond 1997.

The Evaluation Team did not reach any firm conclusions on the relative value of regional BASICS offices, versus using staff from country or headquarters offices. Significant personnel cost savings are not evident, given the costs of supporting locally-based expatriate staff versus U.S.-based staff. Regional travel costs vary with the region. In short, G/PHN and each USAID regional bureau may have to determine whether regional contract staffs make sense.

For example, the plan to close out several more country Missions in Africa may increase the role of REDSOs. These regional offices may then require ready access to contract talent to maintain and advance the Africa Bureau's child survival initiatives.

Following are some of the commonly reported benefits of using regional staffs:

1. Staff is familiar with local health conditions, programs, and key actors.
2. Staff has local cultural and/or language skills.
3. Staff provides better coverage of multiple countries in program through regular visit cycles.
4. Regional staff is more cost effective than having one person in each country since they can cover more countries (especially where individual country activities are small or erratic) and a multiple person regional staff can permit more specialization than multiple one-person offices at the country level.
5. Regional staffs can cover USAID target countries where there is limited or no USAID Mission presence.

6. Regional staff is effective means for teaming up with other donors or partners on special programs.

5.4 RELATIONSHIPS WITH CLIENTS AND OTHER STAKEHOLDERS

The relationship between BASICS staff and other program implementation staffs is generally excellent. Even though a few Missions complained about pressures from BASICS to initiate more contract activities, most of these also acknowledged that current interpersonal relations with BASIC staff were quite positive. Missions are particularly appreciative of having access to a pool of high quality individuals to help them in various areas of child health.

Relationships with key donors like UNICEF and WHO are also generally very good. The exceptions include a few country-specific cases where BASICS is playing a dominant technical leadership role in child health and a UN agency representative resents the competition. As mentioned above, the Regional BASICS staff in Dakar has spent considerable time in building up its relationships with WHO/AFRO and UNICEF in Francophone Africa, with resulting good relationships. The BASICS regional director is careful to preserve the role of the WHO representative in giving the international imprimatur to a country effort, while BASICS is portrayed as providing "implementation expertise."

Some Evaluation Team contacts suggest that some WHO/Geneva staff are ambivalent about BASICS' role in child health. On the one hand they need the assistance BASICS is providing to adapt the WHO IMCI training materials to local conditions. On the other hand, they seem to feel BASICS is getting too much "credit" for what it does and WHO is getting too little. Where country relationships with other donors are negative, BASICS staff should make a special effort to keep the other parties informed and involved in appropriate activities, but not at the expense of seriously delaying program implementation. Obviously, the USAID staff play an important role in defining the BASICS Contract staff's relationship to other stakeholders and other donors. Where BASICS is assigned a strong coordinating and leadership role, the potential for resentment and conflict may be greater. Consequently, BASICS staff may need to demonstrate more tact and willingness to compromise. As one WHO country representative expressed it, "When you are the kid on the block with the biggest stick, you can afford to bend a little."

5.5 THE PACE OF FIELD IMPLEMENTATION

While BASICS has established good working relationships with most partners and is pursuing the right kinds of field activities, questions have been raised about the speed with which BASICS makes decisions and completes program tasks. The views provided to the Evaluation Team were quite mixed, so it is difficult to generalize. In short, the pace of implementation is perceived by some observers to be relatively slow, while others perceive BASICS as moving rapidly in several areas. However, one more common area of concern is the short amount of time left in the current Contract to complete the myriad tasks laid out in BASICS' work plans for core and country activities. We will return to this issue below.

5.5.1 USAID Staff Views on Timeliness of Operational Support

In responding to the G/PHN questionnaire on BASICS, most USAID field staff gave high marks in most areas of TA and field support. Even though still generally favorable, the field staff ratings on timeliness of support and provision of reports are relatively lower. The following table shows how 16 USAID field units rate BASICS' on its timeliness in providing operational support.

TABLE 5.6: TIMELINESS OF BASICS' OPERATIONAL SUPPORT

Question 2d. How would you rate BASICS operational support to the implementation of technical assistance to your country program?	Rating Scale = 1 (lowest) to 5 (highest):				
	5	4	3	2	1
Ratings of "timeliness" of support: <i>Number of responses:</i>	5	2	4	3	2
<u>Source:</u> Linda Sanei, Summary of Responses to G/PHN e-mail Questionnaire on BASICS Midterm Evaluation. 2/27/97. Two of the 18 respondents did not answer this item.					

If the middle ranking (3) in the table is removed, there are seven positive ratings (4 and 5) and five negative ratings (1 and 2). Only one of the five latter respondents included an explanatory note regarding their rating: "Report took too long." (Slowness in reporting is mentioned by some respondents in other sections of the questionnaire.) Given the higher ratings which BASICS received for other support areas, there may be a need for the Contractor to review reporting and other support processes with a view to speeding up implementation.

5.5.2 Speed of Contract Start-Up

Some USAID staff report that the start-up of BASICS operations was slow, especially since the Contractor had the benefit of the experience of three predecessor projects (REACH, PRITECH, and HEALTHCOM). While some BASICS staff acknowledge that country activities were slow in taking off, they note that BASICS was expected to take a broader and more integrated approach to Child Health issues than the earlier projects. They also point out that establishing relationships with other key partners and donors (notably WHO and UNICEF) took time. The Contractor staff also note that BASICS set up 20 offices and initiated activities in 30 countries during Years 1-3 and this required hiring and orienting about 140 field staff as well as establishing local administrative support systems.

Several Mission and USAID/Washington staff report that BASICS provided critical and speedy help in designing new bilateral programs and providing TA and other support until Mission programs became operative. Some USAID staff also agree that BASICS has been justified in investing the time required to establish collaborative networks with other bilateral and multilateral partners, especially where USAID presence is limited or nonexistent. Given the continued closing of USAID Missions, the BASICS Contract staff will probably be expected to play an even greater role in establishing collaborative approaches to the design and implementation of child health activities which are important to USAID.

Some BASICS activities were also delayed because Missions were sorting out their program priorities and documentation under USAID's reengineering exercises. And in some countries, local political crises disrupted or delayed implementation of approved BASICS activities. Without making judgments about the pace of start-up, the Evaluation Team is concerned about the reported gap which commonly occurs in a USAID program when one contractor is closing down and another is starting up. The last year of the current BASICS Contract (August 1997-September 1998) could thus become a high risk period when staff start departing and planned activities do not get completed. This concern is heightened by the very large number of tasks (around 1,700) covered in the BASICS work plans and monitoring systems. Both USAID and the Contractor need to make a joint effort to prioritize tasks so that the most important work gets completed and adequately documented during the next 18 months. This effort is particularly important for the USAID staff who will be concerned with both the oversight of the current contract and the design of the follow-on activities. Given USAID's large financial investment in the current BASICS Contract, it is crucial to thoroughly document the "lessons learned" about improving child health in all global technical areas and in all of the significant country activities. USAID has

been operating in the child health area for decades, but the documentation of successes and failures leaves much to be desired. For example, relatively little has been published on practical options for moving beyond the usual pilot project approach to achieve national coverage for various integrated or vertical health interventions.

CONCLUSIONS:

1. USAID's new programming and decentralization policies have significantly increased the influence of Mission staff in the selection and design of BASICS country activities. However, G/PHN and BASICS staff still have important opportunities to influence the direction of Mission efforts through: (a) the provision of expertise and other implementation support; and (b) the process of reviewing and approving BASICS workplans.
2. The current BASICS portfolio of country programs is varied, but consistent with current USAID planning priorities and guidelines. Progress reports and information from site visits indicate that many activities are still in the early or middle stages of the implementation cycle, but the Contractor has only 18 months left to complete the work. Both the USAID and the Contractor management teams need to agree on the most important activities to support, complete, and thoroughly document during the balance of the Contract.
3. G/PHN may need to review the existing global schemes for assigning priorities to different countries and ascertain how these relate to the Agency's new decentralized approach to programming. The BASICS portfolio reflects individual Mission priorities and there should be congruence between these priorities and the G/PHN priorities for child health. This assumption could be tested by making a systematic inventory of BASICS activities and comparing the results against G/PHN's expectations. Such a review should also assess the extent to which field and core programs are addressing the Agency's need to pursue technical innovation. Staying on the cutting edge of health development is crucial to USAID's global leadership role in child survival.

RECOMMENDATIONS (CURRENT CONTRACT):

1. USAID and the Contractor should immediately begin to track, expedite, and document the BASICS approaches, activities, and interventions which show the greatest potential for replication and expansion under future child health programs. The documenting process should focus on learning from the more

successful and less successful approaches to designing and executing specific child health interventions at different levels (national, district, or pilot project). Special attention should be given to integrated or vertical programs being implemented on a national scale.

2. USAID, in cooperation with the BASICS Contractor, should immediately create a special team (which includes outsiders) to produce a brief informal report on "lessons learned for project design" from BASICS and related child health projects. This would cover both the successes and shortcomings of different project management and technical approaches. This special report should be focused on assisting those who will be designing and implementing USAID's follow-on efforts in Child Health.

RECOMMENDATIONS (FOLLOW-ON CONTRACT)

1. USAID should give priority to providing assistance on country child health programs with the greatest potential for impacting on a national scale. Since USAID has been supporting child health for 10-15 years, it is important to show more national level impact (through both vertical and integrated approaches).

2. USAID should develop specific strategies and staff orientation on such strategies to improve the skills of USAID and Contract staff in leveraging more non-USAID resources for child health programs. All USAID-supported activity designs should include coverage of options for leveraging resources needed to sustain the activity after USAID assistance ends.

The General Impact of BASICS

6

6.1 THE CHANGING GLOBAL HEALTH ENVIRONMENT

The BASICS program began work in an environment of change. Health problems have changed as, for example, immunizations have reduced some burdens. At the same time, conflict and malnutrition have exacerbated others, smoking rates continue to increase and chronic diseases are becoming significant problems in developing areas. At the same time possible interventions continue to expand. New vaccines are on the horizon, micronutrients are gaining in acceptance, new possibilities to use folic acid and zinc are available, antihelminths have reached a point of safety and efficacy where they can be used on a mass basis, and the malaria field has been heartened by the possibilities of a new vaccine and the reality of a new drug.

In the midst of such changes, the roles of WHO and UNICEF continue to change, more NGO's have entered the field, corporations have become active in the development of public-private coalitions, USAID itself has seen profound changes in funding and areas of activity and, especially in Africa, countries are fluid in their interests and abilities to deliver child health services. In the midst of all of these revisions, there is an increasing desire to change the way child health services are delivered by integrating approaches into a more logical framework. BASICS has therefore been pursuing a constantly moving target, but perhaps most important, from a moving foundation.

6.2 BASICS IMPACT

BASICS has frequently been called a flagship. Perhaps a better image is to see BASICS as a tugboat, attempting to pull all child health activities through a channel with both hidden and obvious barriers. It would be desirable, of course, to evaluate the impact of the program based on health outcome data. In no place is this possible after 3½ years; therefore, the Evaluation Team members were forced to use their judgment based on the processes in place or about to be initiated. Some specific observations follow.

6.2.1 Development of Coalitions

The future of health work is undoubtedly going to reward those capable of organizing coalitions and networks. The BASICS program is itself a coalition of three organizations (MSH, AED, JSI) and therefore the staff understand the need for combining resources to meet a shared goal. The Evaluation Team is impressed with the fact that the participants have a genuine interest in child health outcomes above loyalty to the employing agency. This successful partnership is remarkable and USAID can take pride in such a contract.

Some remarkable alliances were also seen in the field. The donor coalition in Zambia is noteworthy. It is of great benefit to a country to have country priorities supported by donor contributions into an MOH "basket" of commingled funds for agreed on program uses. Zambia's "basket" concept is worthy of study for other countries. Likewise, the Nigeria program has exceeded expectations by getting trade unions, health facilities, and church groups to work together for community organization. The amount of health care delivered is increasing in these areas, requiring the providers to expand staff, and patients ultimately feel better about the way they are being treated. The work has implications for health, community development and even democratization (as evidenced by the involvement of people in the community and the sense of empowerment they obviously felt).

6.2.2 Quality of Staff

As suggested elsewhere in this report, the BASICS staff constitutes one of the most qualified group of people ever seen in the field of child health for developing countries. They are held in high regard by international organizations, nongovernmental organizations and by health authorities in the countries served. There may be no similar concentration of experts today. This unusual array of talent, field experience and tenacity extends also to the USAID project management staff. Such high-quality outcome-oriented people already make a statement about the character of the program.

6.2.3 Technical Leadership

In some places, such as Zambia, BASICS has become an important reference point for child health. The work being done on simplifying the training course for the Integrated Management of Childhood Illnesses (IMCI) is expected to have a significant impact on the practice of child health programs around the world. BASICS leadership in immunization is well known and was well demonstrated in the former Soviet Union. Urban health training and consultation has provided guidance in an area of increasing concern. A special challenge is how to handle areas where new technical developments have emerged or where new interest has emerged, such as the role of helminths or approaches to neonatal problems.

6.2.4 Impact on Other Donors

BASICS has had a positive impact on international organizations. The relationship is at times bitter-sweet as the international organizations are constrained by budget from doing some of the innovative work of BASICS. When challenged on criticism of BASICS, the same people who carp also indicate they would like to see even more support of the BASICS program. Great care must be taken on the country level to keep the international organizations fully involved.

It can be very difficult for organizations accustomed to being the authority in an area to now share that distinction with another program. In general there is great sensitivity on the part of BASICS staff to this dilemma. A special opportunity for cooperation may exist in Nigeria where UNICEF is interested in assisting with community mobilization projects. This may provide a way to institutionalize the approach in a donor organization that will have long term involvement in the country.

6.2.5 Impact on Cooperating Countries

Outcome measures for many aspects of BASICS country programs are simply not yet available; therefore, it is necessary to make judgments based on current activities. The Evaluation Team's judgment is that BASICS is having a positive impact on country activities and has the potential of having a positive impact on health outcomes. It is important that BASICS's efforts and results be well documented. For example, it is anticipated that the IMCI training in Zambia will provide improved sick child care in clinics throughout the country if plans for training in every district are realized. What is not certain is that clinic health workers can actually be supported logistically to make use of the training.

Therefore, while the IMCI work is praiseworthy in principle, it must meet the test of practice. What is clear is that countries are looking to BASICS for guidance and great opportunities exist for child health improvement.

6.2.6 Community Mobilization

As mentioned earlier, the NGO-based form of community mobilization that has occurred in Nigeria merits attention. Born of necessity because of the inability to work with government institutions, BASICS has forged partnerships in community development that are not just interesting second choices, but may well provide ideas for community health improvement throughout Africa. The Evaluation Team observed that both adults and teenagers were investing in their communities, health care was improving, communities were involved in national immunization days, garbage had been removed from the streets (by community initiative), and people expressed hope in the future. In Zambia, early work in communities was successful in identifying what the people regarded as their major health problems. The analysis of community responses to questions about health priorities was pertinent and could be a useful entry point for improving health services outreach and community health education. (Priority needs posed by the community include wanting to know: the symptoms and signs which indicate a child should be taken to the clinic; how to use medications obtained at the clinic; and what foods can be given during illness.)

6.2.7 Measuring Progress

BASICS has put significant attention into the many ways of measuring process changes and outcomes. While it is too early to expect changes in health outcomes, several examples of process change are available.

One approach to measuring health worker and supervisory performance is the use of observation teams ("facilities surveys") before and after the IMCI course. Table 6.1 shows some results of such surveys in Niger.

TABLE 6.1 - NIGER - SUMMARY RESULTS OF BASELINE AND FOLLOW-UP FACILITY SURVEYS

Health Worker Performance Indicator	Jan. 1995 (Baseline)		Dec. 1996 (Follow-up)	
	N	% positive	N	% positive
Assessment of danger signs -- at least one sign evaluated	151	11%	153	45%
Assessment correct -- ARI cases*	84	12%	101	30%
Respiratory frequency checked	84	13%	101	73%
Chest in-drawing checked	84	25%	101	37%
Assessment correct -- diarrhea cases*	44	23%	81	26%
Assessment correct -- Skinfold checked	44	34%	81	42%
Assessment correct -- fever cases*	85	0%	119	25%
Temperature taken	85	60%	119	83%
For all cases, percentage of mothers given advice on: - How to administer drugs at home	151	62%	153	88%
- Feeding and breastfeeding	151	7%	153	61%
Child's nutritional status correctly determined*	151	3%	153	38%
Child weighed	151	41%	153	74%
Child's vaccination status checked	151	25%	153	60%
Health workers report receiving at least 2 supervision visits in the last 6 months	36	33%	18	72%
Health workers report receiving constructive, written feedback and discussion from supervision	26	31%	18	61%

* Indicators used indicate a "correct" score which requires successfully fulfilling multiple conditions.

Source: Prepared by BASICS Contract Staff

The data in Table 6.1 suggest that there have been significant improvements in worker performance in some areas and increases in supervisory visits and

performance feedback. However, the table also suggests that there is still considerable room for improving the quality of client services.

6.2.8 Reaching the Vulnerable

One goal of the program is to provide health programs for the more vulnerable and underserved groups. The national health reform efforts in Zambia are intended to redistribute resources to that end and progress there should be tracked and documented. A concerted effort should be made throughout the BASICS program to: (a) identify the more underserved and vulnerable groups in every area of work; and (b) develop measures of tracking to verify that the program is changing health indices in those populations. The current BASICS MIS scheme for tracking vulnerable groups is not useful and needs to be revamped. (For example, the classification scheme for vulnerable groups suggests that most BASICS expenditures are for "urban poor" but there is no category of "rural poor.")

6.2.9 Partnerships and Alliances

As suggested earlier, impressive work is already underway in developing coalitions and partnerships. BASICS and USAID should continue and expand efforts to team up with other USAID programs for nutrition, neonatal care, HIV/AIDS, etc. In addition, ongoing attempts to find long-term partners and donors who will continue country or regional programs should be continued and intensified. Consideration might be given to detailing BASICS staff to regional and headquarters offices of other donors to support joint endeavors. Where feasible, it is also important to look for ways of cooperating with others to address some of the broader issues of poverty and development which impact on child health. Of special note is the attempt in Nigeria to foster microcredit projects as a way of providing women with new independence and reduced poverty; these gains will in turn contribute to improving the health status of a community. Health projects could thus be well served by finding partners who have experience in credit and financing.

6.2.10 Surveillance

Fundamental to any health program is continuing access to factual information on the disease burden, changes in disease status, intervention techniques, impact of interventions, the potency of tactical changes, and suggestions for changes in the program. There is impressive information coming to the program for evaluation of the BASICS program as a whole. What is still unclear is whether the BASICS program will be able to imbed such techniques into country program delivery so

that information and reaction will be optimal at all levels of the program, national, district, and local.

6.3 CHALLENGES TO USAID AND BASICS

As important as measuring the impact of BASICS to date is the determination of changes that are possible and suggested by current trends. A number of possibilities were identified.

6.3.1 Adopting a Longer-term Perspective on Health Development

A realistic approach to health improvement may require us to make outcome the constant and time the variable. Most USAID health programs are for a fixed period and this may be impossible to change. But it would be helpful to determine an outcome desired by USAID and then find ways to contract for that outcome with time being the variable, and with incentives for early attainment of the goal. Eradication programs have such a characteristic. Would it be feasible for USAID to determine a 25-year or 50-year strategy, set intermediate goals for ten years, and then contract for ten-year goals with a bonus for early completion?

6.3.2 Maximizing the Returns on IMCI

The BASICS approach to simplifying IMCI training is an important step forward. However, the challenges to BASICS will also increase if the program is successful in developing a course that can be used in field conditions in Africa. The challenges include:

- (a) Demonstrating improved health outcomes in a sufficiently large geographic area.
- (b) Identifying resources and expertise to provide the training on the large scale desired by Zambia and other countries.
- (c) Developing programs for supervision and logistics that allow the health system to make good use of the trained personnel.
- (d) Increasing the time available per patient to allow the health workers to effectively use the skills they have acquired in the IMCI training.

6.3.3 Immunization Infrastructures

Immunization systems in Africa improved greatly between 1985 and the early 1990's. The question of concern is whether the immunization infrastructure is now being weakened. Certainly in Nigeria the answer is yes, but the question exists also in Tanzania, perhaps in Zambia, and other places? One challenge is to ensure that the necessary concentration on IMCI and health reform does not detract from immunization. Another is to make the immunization infrastructures sufficiently robust to accommodate the new vaccines about to be marketed in the developing world (including H. influenza B, Rotovirus, and combination vaccines).

Great care should be taken to be sure that polio eradication and especially national immunization days strengthen the immunization program. In some places they are becoming a detraction from other immunizations.

6.3.4 Integrated Management for Child Health (IMCH)

As discussed in Chapter 3, it is time to put all of the elements of the BASICS "Pathway to Survival" framework together in pursuing the ultimate contribution to the field of child health, namely an Integrated Management for Child Health (IMCH) that includes IMCI plus all other aspects of prevention and treatment. BASICS has the unique experience, interest, and capacity to start this process moving. And it should do this as quickly as possible. Figure 6.1 suggests some of the activities which might be included in such an approach.

6.3.5 Leveraging More Resources for Child Health

Resources will always be relative, however, the challenge of the program is to exploit the opportunities that are now possible in such areas as IMCI, immunization, community mobilization, the introduction of micronutrients, or the introduction of anti-helminths on a mass scale. BASICS is now on the cutting edge of child health innovations and with additional resources could lead a new child health revolution. It would seem important for the BASICS Project and Contractor to seek resources beyond those provided by USAID, in order to fully utilize the opportunities and the talent that has been assembled. The next contract design should also provide encouragement and authority for the contractor to seek outside funds from public or private sources for Child Health activities approved by USAID.

6.3.6 Knowledge Systems for Decision Making

One of the great gifts that the program could leave to developing countries is the ability to collect information, analyze that information, and respond to the changing burden of disease. A special effort to adapt the surveillance and evaluation techniques now being used at the program level to the national, district and local levels would be a major step in public health self sufficiency.

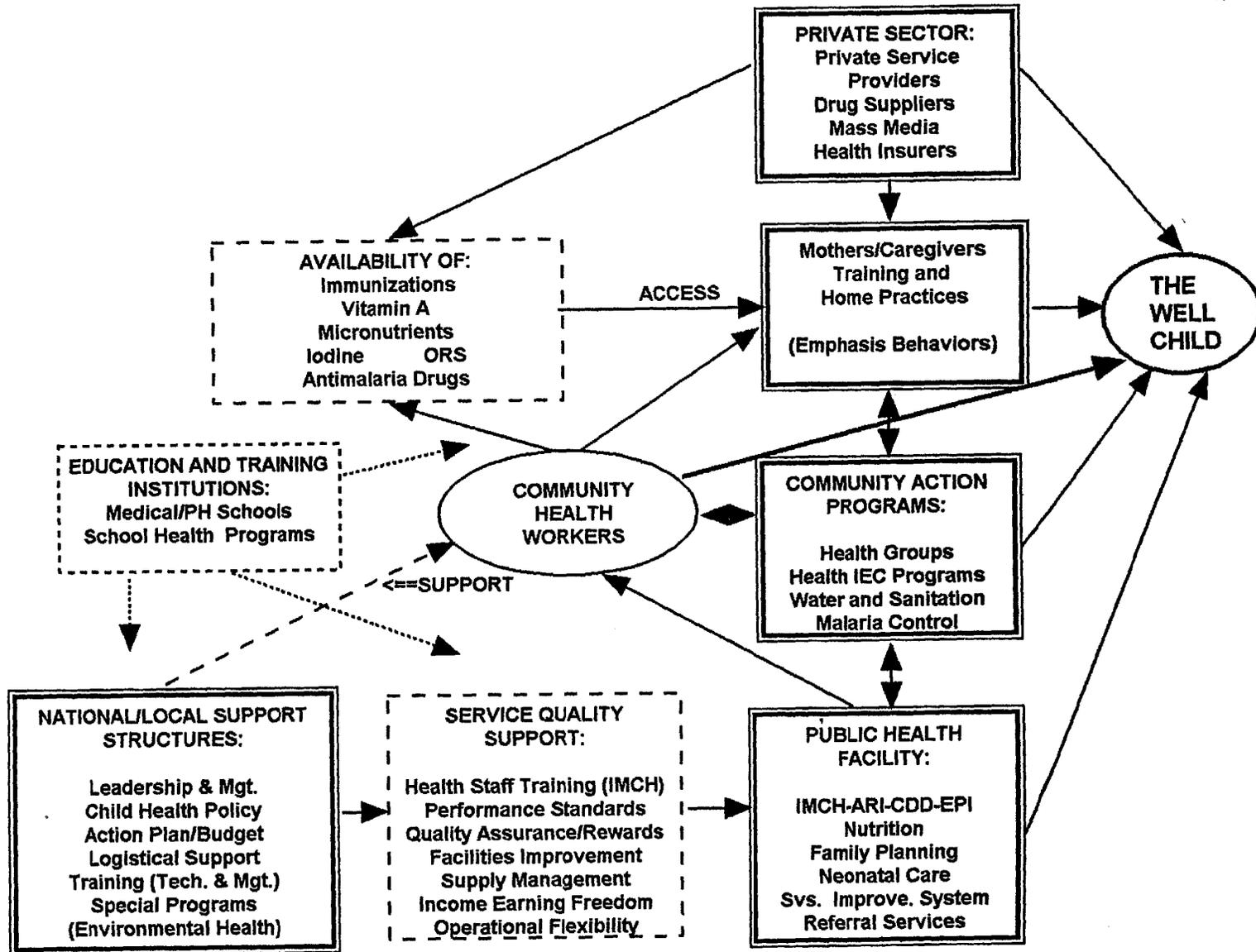
CONCLUSION:

The Evaluation Team is highly impressed by the talent assembled, the programs in process, and the potential for improving health systems and health outcomes. The United States has an impressive amount of health science applicable to developing areas. BASICS is a laudable program for improved delivery of that science. USAID should take pride in the accomplishments and also continue efforts to tell the story of U.S. involvement in the health problems of the world to the American public. They would be proud also.

RECOMMENDATIONS (CURRENT CONTRACT):

1. USAID and the Contractor should develop a design and strategy for Integrated Management for Child Health (IMCH) and try to initiate operations at appropriate sites. The expertise is available to provide the world with algorithms for a comprehensive approach to child health in developing areas.
2. USAID and the Contractor should prioritize Outcome and Process indicators. A very large number of indicators are being tracked, but it is important to focus on the key ones to make sure that current activities actually improve the service systems and the health of children.
3. The Contractor should document the impact of IMCI in several places. The impacts will be there, but it is important to document them. Efforts should be made to implement IMCI fully in a district or group of districts and document the process improvements and the health outcome improvements. Since the program deals with children currently sick, it would not take a long period of follow-up to show results. Indeed, some health outcomes could be measured in the first months of such an effort.
4. USAID and the Contractor (in union with other donors) should make a special effort to strengthen national immunization infrastructure in cooperating

FIGURE 6.1 ACTIONS AND ACTORS AFFECTING CHILD HEALTH



countries (especially in Africa). Immunizations will continue to be the foundation stone of child health. New vaccines will become available in the near future and even a malaria vaccine can be anticipated. Countries without an adequate immunization infrastructure will simply not benefit from the new science.

RECOMMENDATIONS (FOLLOW-ON CONTRACT):

1. USAID and the Contractor need to develop specific strategies and techniques for mobilizing outside resources for Child Health. The momentum from assembling a highly qualified group of experts in BASICS will be fully exploited only if the programs and interventions developed are fully used and replicated. The Contractor should also directly seek resources from other bilateral groups, foundations, corporations, etc. This could also include efforts to team with other sector programs which impact on health (e.g., microcredit for women or increased use of high protein maize).
2. USAID should ensure that the Contract design strives to balance scientific and medical concerns with social concerns in child health. There is a need to close the gap between Scientific Capital and Social Capital. In all areas of medicine and health, our science is ahead of our ability to use it. If that gap is to be filled, it will be because those pushing science want it to happen. This requires strengthening BASICS efforts in the behavioral sciences, communications, community organization etc., in order to more fully use the technical abilities that abound.

Organization and Management

7

7.1 USAID

7.1.1 USAID Project Management Structure and Role

The G/PHN Project Management Team for BASICS consists of five staff: a COTR and four liaison officers (all are assigned to the Child Survival Division of G/PHN/HN). With regard to BASICS, each member of the team has country (and three of the five regional) backstopping and technical area responsibilities. All team members also work on other G/PHN activities. In general, the USAID team members have a close and collaborative working relationship with the Contractor's staff and joint USAID-Contractor staff teams operate in several areas. In addition to this Project Management Team, the Core and Requirements contracts are overseen from a contractual standpoint by a Contract Negotiator and Contracting Officer in USAID/Washington. The BASICS Contractor also deals with six other Contracting Officers and COTRs for activities funded under Delivery Orders in Bangladesh, Mali, REDSO/East, Zambia, Ethiopia/Eritrea, and Senegal.

The USAID Project Management team is responsible for oversight of the contractor's work. The COTR is responsible for clearing/approving:

- (a) hiring/use of key staff, consultants, and subcontract staffs
- (b) travel of staff and consultants
- (c) purchase of nonexpendable property (must also be approved by Contracts Office)

- (d) placement of regional advisors
- (e) international and regional workshops
- (f) participation of contract staff/consultants in activities of international organizations
- (g) services and reports for payment
- (h) requests for activities/effort outside the existing scope of the contract (must also be approved by Contracts Office)
- (i) employee salaries, when required
- (j) initial salaries of all professional staff (must also be approved by the Contracts Office).

Another member of the team is responsible for the procurement of restricted goods, including vehicles and pharmaceuticals, and the use of goods/services/commodities which are not of U.S. or cooperating country origin. The project management team as a whole also approves:

- (a) operations research, surveys, and model projects
- (b) all implementation strategies and approaches
- (c) annual work plans
- (d) monitoring and evaluation plan
- (e) implementation indicators.

In addition, the team members attend the contractor's management review meetings and review the agendas for these, selectively participate in clusters and Technical Working Groups, and review and, as necessary, comment on reports.

7.1.2 Funding and Cost Trends

The source of funding for the BASICS contract is becoming increasingly problematic for the Global Bureau and Project Management Team. The Global Bureau's funding for the BASICS contract has declined to an estimated 10% or about \$4.0 million of the total Core and Requirements contract budgets of about \$40 million for Project Year 4. Expenditures for PY 4 are estimated to be \$33 million against the total contract budgets. According to the Contractor, the other major sources of funds to support these budgets are regional bureaus through designated core (estimated at about 24% or \$9.7 million of the total PY 4 budget) and USAID Missions through field support (estimated to be about 36% or \$14.6 million for PY 4) to the Core contract or through Delivery Orders (about 30% or over \$12 million for PY 4). The allocation of funds is driven by the annual work plans prepared by the contractor and approved by the USAID Project Management Team. Based on information from the Contractor, an analysis of the

contract's expenditures through September 30, 1996 (the end of Project Year 3) indicates the following general breakdown:

TABLE 7.1: EXPENDITURES THROUGH SEPTEMBER 30, 1996

Program Categories	Expenditures (thru 9/30/96)	Share
Country/Regional Programs (of which Africa represents \$14,493,551)	*26,069,228	56.4%
Technical Innovation	*4,796,596	10.4%
Program Management (including allocable costs of \$6,270,092 and startup costs of \$1,226,656)	15,366,119	33.2%
Total:	\$46,231,943	100.0%

Source: BASICS Contractor, Project Year 4 Financial Summary, January 1997

Note: *Allocable cost (covering general management and administration) is normally about 25% of the total attributable country/regional and technical budgets. These budgets are billed to the various funding sources—Global, Designated Core, or Field Support—according to agreements with Missions and the Global/Regional bureaus.

The total expenditures for country/regional and technical programs (which also included information dissemination and conferences) totaled about \$30,865,824 or 67% of total contract expenditures. Total program management costs (which also included evaluation/MIS, Information Center management, and start-up costs) represented about \$15,366,119 or 33% of total expenditures.

The program management costs of the contract are substantial. This is in large part due to the costs charged to the Finance and Administration Division, which represented (through September 30, 1996) \$7.3 million in expenditures or about 48% of total program management costs. Contributing to these costs was the initial charging of program start-up expenses to this category. Most of the Project Director's costs are also absorbed here, along with the relatively high cost of office rental and administrative support in the Washington, D.C. area. Lastly, the expanding nature of the contractor's field presence—as well as the extensive approvals and financial and administrative reports required by USAID—represent costs which are largely absorbed under program management. Nonetheless, as a percentage of total annual expenditures to date, program management costs have declined. For example, such costs were estimated at \$4.3 million or 20% of total expenditures in PY 3.

Of the total contract expenditures through September 30, 1996, about \$37.4 million or 81% has been through the Core contract (including all program management costs) and about \$8.8 million or 19% through Delivery Orders under the Requirements contract. As the financial ceiling under the Core contract is approached, much of the future funding is expected to flow through Delivery Orders under the Requirements contract. Basically due to management ease, Regional Bureaus and Missions have sought to provide funding to the Core contract rather than taking on the workload associated with a Delivery Order. As a result, the Core contract has funded long-term assistance to countries which was originally envisioned to be carried out under Delivery Orders. This, in turn, has led to pressures on the financial ceiling for the Core contract and, to a lesser degree, the Level of Effort ceiling. The USAID Contracts Office will not consider increasing this latter ceiling due to competition in contracting considerations. It has recently been determined by USAID and the contractor that future assistance to Missions must be funded, to the maximum extent possible, through Delivery Orders under the Requirements contract. Since field Contracting Officers and COTRs are responsible for the implementation of Delivery Orders and, even though they are to coordinate actions relative to the Requirements Contract with the COTR in Washington, this increase in field involvement could put significant strain on the Project Management Team's ability to manage contract components over which they have no direct control.

The type and nature of the Core and Requirements contracts have generally dictated the costs of the contract services provided. These costs are audited under USAID regulations. Beyond such audits, the control of costs has been basically through the Project Management Team's approval/disapproval of activities proposed in the contractor's annual work plans, as well as the Contracting Officer's approval of rates and certain expenditures. Some Evaluation Team contacts observed that the contractor is too responsive to field requests and thus not very rigorous in screening proposed new activities. Some activities under proposed Contractor work plans are pending at USAID until more information is provided on their value and feasibility. And, some proposed activities have been disapproved by the Project Management Team. For its part, the Contractor has undertaken outsourcing for administrative as well as Information Center functions as a means to reduce contract costs. In another case, the budget for the Information Center was reduced for Project Year 4 from the requested level, resulting in more focused activities, specifically more emphasis on publishing.

7.1.3 BASICS Monitoring and Reporting

A member of the USAID Project Management Team expressed concern with respect to the contractor's ability to program and track tagged funds. Such funds are provided under conditions as to the type of activity and/or location to be supported. In discussing this with the contractor, it was indicated that the tracking of tagged funds had previously been a problem. However, the Contractor provided assurances that funds with conditions are now identified through individual contract amendments and operations; technical staff are informed of any restrictions on the use of funds to assist in programming; and a reports capability is in place to answer USAID queries regarding such funds.

One USAID official commended the Contractor's work on the identification of indicators for child survival activities that can be used to measure progress. This work was characterized as having an impact far beyond the BASICS project, with other donors drawing increasingly on the results of the contractor's efforts. The contractor relies heavily on work plans to explain current efforts and accomplishments under the contract. The level of detail in these plans has resulted in too much attention being paid to a large number of activities, while insufficient attention has been given to identifying and replicating critical activities or successful efforts. A number of USAID Missions expressed a strong desire to have regular progress and financial reports provided by the contractor to help in monitoring in-country activities and progress against work plans. The contractor recently introduced a country-level report which covers progress and financial status. If produced and distributed on a timely basis, it should go far towards meeting Mission needs.

7.1.4 USAID's Impact on Contract Management

The Project Management Team has worked effectively with the Contractor on issues of staffing and structure. The organizational structure and systems put in place are generally responsive to both USAID Mission and G/PHN requests. The contractor's staff at headquarters and in the field is generally considered to have excellent technical and, to a somewhat lesser extent, managerial competencies.

As noted earlier, the representatives from UN organizations, host governments, and other cooperating agencies (CAs) praised the professionalism and responsiveness of the Contractor's staff. The Contractor's Project Director has demonstrated an ability to balance the interests of the members of the Partnership with the Child Survival objectives of the BASICS project and contract. Morale is judged to be high among most of the contractor's field and headquarters staff.

7.1.5 Future Design and Implementation Issues

7.1.5.1 *Using a New Results Package to Expand Options*

As observed in Chapter 6, the achievement of Child Health improvements is a long-term proposition, but USAID tends to operate in five-year cycles. For a five-year contract, the productive period is often 3-4 years, given slow startup and a decrease in productivity as staff leave during the final year. Considerable USAID staff time is also invested in the process of simultaneously managing one project/contract while designing a new one about every three years. A longer time frame might therefore be more productive. Some USAID staff observe that the risk of this is getting stuck with a bad contractor. However, this risk can be addressed by using a shorter contract period but including up-front options in the contract for extensions (if performance is satisfactory). The resources available for improving Child Survival services may be in decline, so increased attention must be given to issues of longer-term sustainability, including the mobilization of more resources from cooperating country and other non-USAID sources. G/PHN should thus consider using the purported flexibility of the new USAID programming systems to design a longer-term package of activities which attempts to use new implementation channels and garner new types of support for the BASICS operations in each country.

Some G/PHN staff note that the simplest approach to designing the next phase of BASICS is to use the existing Project Paper (PP) and Project Authorization as the basis for the follow-on contract. However, the PP ten-year life of project (LOP) would limit the duration of the next contract to five years, unless the PP is amended. Another design option for G/PHN is to develop a new Results Package under the reengineered system and include a range of options (grants, contracts, etc.) for implementing the BASICS activity over a period of at least ten-15 years. This approach also facilitates involvement of other USAID actors to ensure that the next BASICS program will be perceived as an Agency-wide enterprise, rather than a "G/PHN project." For example, HPN officers from several Missions with major Child Survival programs could be brought to Washington to participate during key phases of the redesign. The bottom line is whether the G/PHN management team sees a Results Package as the most desirable approach, given the time frame for the follow-on contracting tasks.

7.1.5.2 *Future Contracting Issues and Options*

Regardless of the project design mode, it is assumed that G/PHN must pursue new approaches to contracting for the next cycle of BASICS. For example, there are

staff concerns about the high administrative costs of the current contract and the fact that more of the Mission activities should have been under the Requirements, not the Core contract. Moreover, the general trend in the Federal Government toward performance-based contracts means that Contract Officers tend to dislike the level-of-effort or Cost Reimbursement-Fixed Fee form of contract awarded to the current BASICS contractor. Following are some possibilities to consider when selecting future contracting options:

1. The first decision is the number and purpose of the contracts to be awarded. One approach is to have two separate contracts, one dealing with the mandate of the Global Bureau (e.g., Research and Development) and the other an Indefinite Quantity Contract (IQC) to provide services to USAID Mission or regional programs. Some in the USAID Contracting Office support this model. The cost of such an arrangement may be cheaper to the Global Bureau because efforts could be more focused. Missions might also save since the cost to maintain a cadre of first class technical talent in the Washington area would not need to be borne by Missions. The serious downside to this option is that it would probably de-link the research and development, monitoring and evaluation, and information dissemination components of the current contracts from field activities and the important synergy which now exists would be lost.
2. Some have suggested a Cooperative Agreement (CA) to replace the current contracts. However, the formal criteria for a CA suggest that this instrument is inappropriate for BASICS. For example, a CA is an assistance, not acquisition instrument, i.e., the grantee is carrying out a program that it will continue with or without USAID assistance. Also, contracting regulations have extremely limited the "substantial" involvement in operations that a grantor could formerly exercise. CA recipients are required to be nonprofit organizations. Finally, cost-sharing is required—usually at least 25% of the total program cost is to be provided from other than U.S. government sources. Cooperating Agreements have perhaps been more common in the Population area and some COTRs in that area see them as more flexible tools than contracts. However, the attraction of the CA approach has apparently been reduced by recent restrictions imposed on the ability of USAID staffs to become involved in the grantee's operations under a CA.
3. Another option is a performance-based (cost plus award fee) contract. A great advantage of such a contract is that there is no need for USAID to micro-manage the effort. USAID looks for results from the contractor and how these results are obtained is basically the contractor's decision. This type of contract is advertised to have much more flexibility than the current contracts. For example, although USAID would still need to approve salaries in excess of the FS-1 (or the more recent ES-6) level, it would not generally be involved in further personnel issues,

procurement of goods, and subcontracting. Once the contract award is made, the intent is for the USAID staff to step back and let the contractor proceed. The challenge is that USAID staff would need to know specifically what they want and be able to articulate and negotiate their expectations. This is due to the fact that the contractor would be required to achieve, for example, the Results Packages or measurable results which are set forth as benchmarks or milestones. Such contracts are cost reimbursement plus fee, but the fee is released in tranches based upon the achievement of the milestones set forth in the contract.

Contract Progress Reviews can be held quarterly or semi-annually (to coincide with Mission submittals of their semi-annual "R4" reports to Washington covering progress on Results Packages). Given the importance of the Mission programs to BASICS, USAID field staff should be involved in judging contractor progress during the semi-annual reviews through requested reporting cables or e-mail reports. Extensive work has already been done in establishing Strategic Objectives, Results Packages, and indicators for Child Survival activities at both the Global, Mission, and Project/Contract level. Consequently, all parties should be able to agree on a set of indicators which is responsive to needs of the Global Bureau and Missions with a significant BASICS involvement (i.e., those with long-term BASICS technical assistance programs).

While short-term assistance could continue to be provided on a selective basis to field programs, USAID should not devote much effort to measuring this or other assistance for which results are expected to be rather limited. If considered necessary, benchmarks for this type of assistance should be limited to, for example, number of assignments completed. If "major" new country/regional or technical programs are initiated, these could be reflected in amendments to the Contract or Life-of-Project action plan (depending on which document is used to define the country- or program-specific benchmarks to be used to measure contractor performance).

RECOMMENDATION (FOLLOW-ON CONTRACT)

USAID should consider the development of a new Results Package for BASICS, rather than operate under the framework of the current Project Paper. This approach has the potential of providing greater flexibility with respect to life of project time frame and implementation and support options.

7.2 THE CONTRACTOR: THE PARTNERSHIP FOR CHILD HEALTH CARE, INC.

7.2.1 Impact on the Contract of New USAID Priorities

Since 1993, Project and Contract planning and implementation have been affected by USAID reengineering and organizational changes; the still ongoing process of establishing Strategic Objectives and Results Frameworks; and fundamental changes in the USAID budgeting system (which are also still in process).

All things considered, the Contractor has done very well in accommodating to these major changes in the operating environment since 1993. The Core Contract signed in September 1993 defined the purpose and the outputs expected from the contractor. Since then, the Contractor has increasingly been required to relate its activities and progress reporting to the new Strategic Objectives and priorities of G/PHN and the Missions. The major activities being implemented by BASICS appear to be consistent with the strategic frameworks of G/PHN and the Missions. As mentioned earlier, there is some G/PHN staff concern that Joint Programming Countries should be receiving more attention under the Contract. However, this appears to be more of an internal USAID program management issue, since the Contractor's country programs are approved by USAID field and Washington staff. BASICS Contract staff are working with about 30 Missions and 12 regional programs to implement the following types of activities specified in the Contract: increased quality and coverage of Child Survival services; development and application of service provider performance standards; improved training to address the new standards; locally-appropriate information, education, and communication (IEC/CBC) strategies; development and evaluation of approaches to better integrate the delivery of Child Survival services; and identification and application of approaches to increase the participation of the private sector in the production, promotion, and delivery of child health related goods and services. Under USAID's current decentralization policies, the specific mix of interventions and scope of client coverage in cooperating countries usually depend on the role assigned to BASICS by USAID Missions and regional offices.

7.2.2 The Partnership Organization and Staffing

One of the critical concerns of USAID in designing BASICS was to have a contract organization which could effectively attract and organize the broad range of talent needed to provide technical leadership and field support in Child Health.

This section provides an overview of the Contractor's structure and the use of subcontractors to provide complementary skills.

The Partnership: The Partnership for Child Health Care, Inc. is organized as a Massachusetts nonprofit corporation. Its members are the Academy for Educational Development (AED), a Delaware nonprofit corporation; John Snow Inc. (JSI), a Massachusetts for-profit corporation; and, Management Sciences for Health, Inc. (MSH), a Massachusetts nonprofit corporation. The officers of the partnership are the CEOs of three long-established PHN contractors: Ronald W. O'Connor of MSH, Joel H. Lamstein of JSI, and Stephen F. Moseley of AED. The Chairman of the Board of the corporation is rotated annually among the officers of the partnership. Other board members include Dr. William H. Foege (a member of the BASICS Evaluation Team) and Allison B. Herrick (retired senior USAID foreign service officer). The Board meets as required to deal with policy issues and provide guidance with respect to the implementation of the contract, but apparently few meetings have been held. Dr. Foege has attended one meeting of the Board, while Ms. Herrick has attended three meetings.

Each Partner has equal status under the Contract and efforts are made to equitably distribute BASICS jobs and revenues among the three organizations. The three Partner organizations are to be given priority in providing technical assistance under the Contract and only the subcontractors named in the original proposal are authorized to perform work without approval of the Board of Directors (and the USAID Contracting Officer). The Project Director and some in-country field office staff are the only direct employees of the Partnership. Other staff, including long-term advisors stationed abroad, are employed by one of the founding partners or subcontractors. They are, however, seconded to the Partnership and work under the supervision of the Project Director.

Subcontractors: Subcontractors identified in the Partnership's proposal to USAID included:

- (1) Clark-Atlanta University - in its capacity to plan and manage a range of training activities.
- (2) Emory University Center - for International Health based upon its strengths in the technical disease aspects of disease prevention in the developing world.
- (3) The Johns Hopkins University's Department of International Health - to: (a) supplement project expertise in CDD, ARI, infant feeding and nutrition, aspects of malaria prevention and treatment, operations research, and a range of functional specialties relevant to child survival service delivery programs;

and (b) assist in the design, implementation, and analysis of research and evaluation activities.

- (4) The Kingsbury Group International, Inc. - a firm specializing in communications and marketing for international economic development.
- (5) Program for Appropriate Technology in Health (PATH) - which has a long and successful history in working in developing nations and in the development and application of new technologies in health.
- (6) Porter-Novelli, Inc. - a public relations firm focusing on the application of marketing and communications techniques to health and social programs.

Subsequently, the Board of Directors approved the addition of the Manoff Group, Inc. as a subcontractor. This firm has experience and expertise in nutrition. Its president and one other Manoff employee serve on the Contractor's Nutrition Working Group. The Manoff employee also serves on the Behavior Change Working Group. At the current time, long-term staff assigned to the BASICS headquarters office from subcontractors include one from Johns Hopkins University, three from Clark-Atlanta, and one from PATH.

Many of the Contract staff stressed to the Evaluation Team that the Partnership arrangement has been a surprising success, as evidenced by the lack of serious problems and issues among the partnership members. The BASICS contract staff also indicated that no significant problems had arisen in relations with original subcontractors, although some subcontractors have indicated an interest in obtaining more business under the Contract. While two Manoff employees serve on the Nutrition Working Group at the contractor's headquarters, the outputs of this working group and utilization of its members by country-based teams (clusters) have apparently been less than optimal. Efforts to improve its operations are currently underway, including recruitment of a full-time nutritionist to chair the Group.

Following is a summary of **subcontract** financial ceilings and obligations for the Core contract as well as expenditures under the Core and Requirements contracts through September 30, 1996 (all figures are \$US).

TABLE 7.2: SUBCONTRACT FINANCIAL CEILINGS, OBLIGATIONS, AND EXPENDITURES

Subcontractor	Ceiling	Obligations	Expenditures
Clark-Atlanta Univ.	3,450,575	732,209	448,073
Emory University	347,963	271,671	210,445
Johns Hopkins Univ.	1,559,722	1,224,727	490,631
The Kingsbury Group*	379,249	81,743	64,505
PATH	1,584,591	586,973	575,624
Porter-Novelli	1,450,234	573,765	282,683
The Manoff Group*	450,423	450,423	245,893

*Notes: The BASICS Contractor reports that The Kingsbury Group (TKG) is "dormant" but its services are being procured through one of the Partnership companies. Since the financial ceiling for The Manoff Group has been reached, the Board of Directors was to deal with this issue during a recent Board of Directors meeting.

Staff Growth and Turnover: The BASICS Contract staff has grown steadily since the contract's inception. As shown in Table 3.1 (Chapter 3), BASICS reports a total staff of 213 (counting the U.S., international, and local-hire overseas staff). Level of Effort or LOE staff total 103, and overseas local-hires total 110. Out of the total staff of 213, about 138 are based overseas. The Project Director is employed by the partnership; about 39, 29, and 28 staff are employed by JSI, MSH and AED, respectively; and seven are on the payrolls of subcontractors.

Most staff contacts reported to the Evaluation Team that morale is generally good and cited the challenging and interesting work of BASICS as an important motivator. The Contractor's senior management note that staff turnover has been low, permitting considerable task continuity in most areas. Total turnover has been 33 since the contract began. Turnover or staff relations issues may have slowed BASICS's pace of progress in such areas as Nutrition or Communication and Behavior Change.

Systems for Recruiting New Staff: Assignments to the BASICS Contract organization are presumably quite attractive, so the Contractor has been able to be selective in hiring new long-term employees. A detailed process is in place to ensure a thorough review of candidates. Recruitment Committees are established to (a) assure the adequacy of position descriptions; (b) oversee advertising of vacancies internally (among BASICS staff and the three Partner firms) and

externally; and (c) interview prospective new hires. If selected by the BASICS recruitment committee, a prospective employee is then directed to one of the member companies for salary negotiations. If a key position on the contract is involved, the new hire must also be approved by the USAID COTR. And the USAID Contracting Officer must approve all new hires. Recruitment processing reportedly averages 90 days for domestic positions and 120 for those overseas, although some USAID staff reported that the time was probably longer for some positions. The August 1996 BASICS program review report for Eritrea notes that several country activities were significantly delayed or dropped due to delays in recruiting specialists in such areas as health planning, MIS, and health finance.

7.2.2.1 Overview of Headquarters Operating Structures

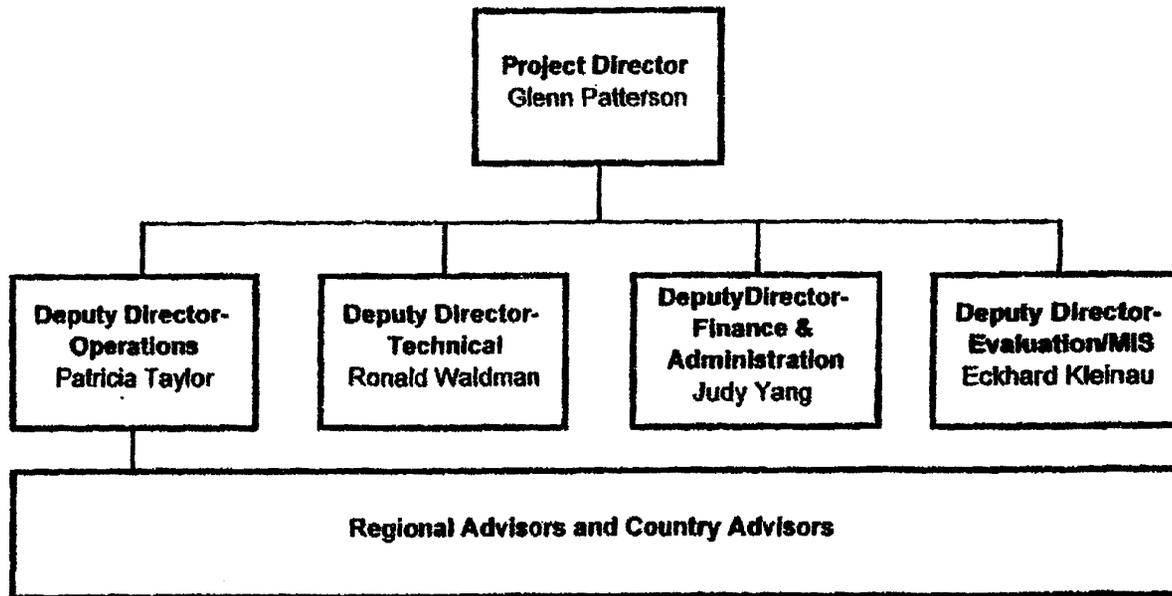
At its headquarters in Arlington, the BASICS Contract organization is divided into four divisions: Technical, Operations, Finance and Administration, and Evaluation and Management Information Systems. (An overview of the BASICS structure is shown in Figure 7.1) The **Project Director** provides overall guidance and is the primary contact for representing the Partnership before USAID as well as other organizations. Each division is headed by a Deputy Director. Both the Technical Division's and Operations Division's Deputy Directors are employed by JSI, and the Finance and Administration Division's and Evaluation Division's Deputies by AED. There is also a **Senior Management Committee (SMC)** which meets weekly and deals with a range of programmatic, management, and administrative matters. Its members include the Project Director (Chair), the Deputy Directors for the four Divisions, and a representative of MSH.

Use of Clusters and Technical Working Groups: The general responsibility for oversight of field programs rests with the Operations Division, but other units are involved through various types of teams. A "Cluster" of concerned staff is established for each long-term or periodic country program as well as for a regional program requiring technical and operational input from headquarters. As needed, the Senior Management Committee (SMC) acts as a court of appeal if cluster members cannot resolve an issue.

In addition to the Clusters, Technical Working Groups are organized in line with the key technical area under the Contract. Chapter 3 provides more information on the clusters and working groups. Here we will only note some administrative difficulties encountered by the BASICS Private Sector group in the planned

FIGURE 7.1 BASIC SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL

ORGANIZATIONAL CHART
BASICS PARTNER/SUBCONTRACT COMPANIES STAFF



provision of grants to PVOs and NGOs for private sector activities. In fact, Purchase Orders, rather than grants, have been used to date, in part due to the PVOs' preference for a subcontract rather than a grant. Effective systems to link BASICS headquarters to U.S. PVOs working in child survival have yet to be developed. Reasons for this include the fact that USAID's Private and Voluntary Cooperation office (BHR/PVC) has a contract to provide technical assistance to PVOs, and both PVC and its contractor appear to be uncertain as to the role which BASICS might play.

Program Review Committees are formed according to the program being reviewed. These usually consist of the Project Director, the Deputy Directors (or designees), the Chairperson of the Cluster or Technical Working Group and key Technical Division representatives. These committees review, inter alia: 1) country, regional, and global programs; 2) technical strategy papers; 3) research and development activities; 4) information dissemination strategies and work plans; and, 5) annual, quarterly, and management information reports. The Senior Management Committee also holds semi-annual program reviews. Agendas and reports of the results of these reviews are normally prepared by the concerned Operations Officer (assigned on a geographical basis). Any staff with an interest are also welcome to attend such reviews. The USAID COTR and project liaison officers also regularly attend these meetings.

7.2.2.2 Information Dissemination and Reporting Structures

The BASICS Information Center, under the direction of the Technical Division, documents programmatic aspects of the Project, publishes and disseminates technical information on child survival to target audiences, and maintains a collection of published documents that focus on child survival issues. The Information Center is disseminating several publications of which Contractor staff are quite proud. These include the Current Issues in Child Survival Series, BASICS Highlights, and Child Survival BASICS. There is a desire among Information Center staff to turn out even more information as part of its dissemination objective. A BASICS page is being established on the World Wide Web, with versions available in English, Spanish, and French. At the same time, the Information Center has faced serious problems, including lack of continuity in leadership and a lack of a clear understanding of USAID's expectations for the unit. This situation has contributed to budget cuts which have limited the expansion of activities.

With respect to the dissemination of information resulting from the BASICS contract, field visits by the Evaluation Team and responses to a G/PHN E-mail questionnaire suggest that several Mission staff were not receiving reports and

publications (or not receiving them in a timely manner). Feedback suggests that USAID field staff want timely, brief, and analytical materials which are closely linked to their Mission's program issues. Several USAID officials could not recall having received any information or publications from the BASICS project. There is thus a need for BASICS to strengthen its report processing and information distribution processes. Some BASICS staff note that there is also a need for USAID to better define the types of information which BASICS should be providing.

7.2.2.3 *Monitoring and Evaluation Systems*

The BASICS Contractor's overall evaluation goal consists of two components:

- (1) global technical leadership in developing, testing, and implementing monitoring and evaluation methods that will increase the capacity of developing countries to plan, implement, and sustain effective public health programs; and
- (2) monitoring and evaluating the BASICS contract activities to measure inputs, results, and, possibly, the impact that is produced by each country program and by the entire BASICS Project.

To accomplish the second goal, the Contractor is to develop and implement a project-wide approach to measuring and reporting inputs, processes, outputs, and outcomes consistently and routinely. The approach is to be based on core indicators that will be measured across programs of similar technical contents. All country programs are to: (a) include these core indicators and data collection activities in their annual work plans; and (b) report results at least annually following a standard format. Management Information Reports, for use by program managers and clients, will link key results with inputs.

Senior contractor officials indicate that, for a number of reasons (including methodological), they will be unable to measure the impact of their activities on infant mortality. The contractor does anticipate being able to measure: (1) demonstrated improvement in health provider capabilities; (2) increased access to health services; (3) changes in utilization, e.g., breastfeeding; and, (4) behavior changes in target populations. Much effort has been expended to date working with the Global Bureau, cooperating country governments, and Missions in the identification and establishment of indicators.

Constraints to the comprehensive evaluation of activities include the fact that BASICS assistance in many countries is relatively small and its activities are often

not of a national scope. Thus, national or even local direct program impact may be rather limited. While the DHS [Demographic and Health Survey] can be used, it is national in scope and does not measure regional and local changes within countries. And BASICS is frequently operating at these subnational levels. Systematic evaluation approaches are also constrained by BASICS' need to respond to the increasing and more frequent demands being made by USAID Missions for special evaluation data and information.

The contractor's evaluation and reporting system—the BASICS Management Information System (BMIS)—tracks activities from their initiation through termination. Only when an activity is new, is an activity number assigned. This permits the tracking of individual activities throughout implementation. Over 1,700 activities are currently being tracked. In addition, the system uses "designators" which, among other things, describe the technical focus of an activity. Designators include: 1) type of objective/activity (e.g., program and project development); 2) program/disease intervention (e.g., ARI); 3) system strengthening focus (e.g., IEC, social marketing, communications, behavior change); 4) counterpart/client organization(s) (e.g., NGO/PVO health providers); 5) special at-risk groups (e.g., urban poor, minority ethnic groups); and 6) USAID strategic objective (e.g., improve the performance of public health workers). A seventh indicator is under development to reflect USAID Missions' strategic objectives. A BMIS report, using these designators and covering the period ending September 30, 1996, estimated that total expenditures have been about \$46.2 million and were roughly allocated among categories as follows:

- (1) On the basis of the designator titled **type of objective**, over 40% of expenditures have gone for headquarters support (20%) and program and project development (22%). The latter type of activities reflects a relatively higher proportion of expenditures in the first and second years of the project, declining in PY 3. External advisory groups at 0.1% and small grants at 0.5% hardly registered among total expenditures, reflecting the nonuse of the required Technical Advisory Group (TAG) for BASICS and problems in implementing a grants program with PVOs and NGOs.
- (2) Over 40% of program expenditures for the program/disease **intervention** designator have been for "general child survival," indicating perhaps that this category is being used as a catch-all for activities that do not easily fit within other categories or for smaller individual interventions within an activity that can not be disaggregated. War victims at about 0.6% and malaria at 0.8% represented the smallest expenditures for this designator.

- (3) For the **system strengthening** focus designator, planning/evaluation—at about 33% of total expenditures—easily headed the list, followed by policy/strategy development at about 20%.
- (4) Within the **counterpart** designator, about 38% of expenditures reflect public sector counterparts with another 45% being identified as BASICS headquarters specific. Only about 11% of expenditures covered private sector groups, including NGO/PVO counterparts. As a percentage of field activities only, public sector expenditures represent close to 69% and private sector about 20%. To some extent, these allocations reflect: (a) the continuing major role played by many governments in providing health care in countries where BASICS is operating; and (b) the nature of assistance which USAID Missions are requesting from BASICS.
- (5) With respect to the **special at-risk groups** designator, the evaluation team was informed that problems exist with respect to its proper use. As a result, this designator is no longer being used by the contractor.
- (6) In looking at the USAID **Strategic Objective** designator, strengthened commitment for sustainable child survival showed the highest expenditures at about 18%, while new child survival technologies and products reflected a minuscule 0.2%.

The current monitoring system is thus yielding mixed results in terms of providing useful information for program decision making or evaluation. Further breakdowns of categories may be needed to make the information more specific and hence more useful for assessing particular Project activities. The Monitoring and Evaluation Working Group is trying to move increasingly from the measurement of outcomes (end of project status) to impact, but members realize that this will be difficult to do. Its aim is to reach this objective by the end of the current contract period, i.e., September 30, 1998. It appears that there are also different interpretations among Evaluation Team contacts as to what is an "outcome" and what is an "impact." In those countries where long-term programs are being carried out, the Contractor expects to know, for example, how much health worker performance has been improved as a result of BASICS activities. To some observers, this is an outcome of IMCI training and other systems improvements, not an impact measure. Consequently, there are pressures from some USAID staff for BASICS to go beyond this and measure the impact of improved worker performance on service access and utilization rates. Such data may be available in countries where BASICS is playing a major role in upgrading training and services (especially in IMCI) and the MIS systems. At this late stage

of the Contract, it is important for USAID and the Contractor to be in agreement on what it will be reasonable and feasible to measure during the next 18 months.

7.2.2.4 Contract Finance and Administration

The Finance and Administration (F&A) Division has five groups: including F&A Management, Financial Reporting and Budgets, Accounting, Contract Administration, and Human Resources and Office Services. The Deputy Director for F&A (1) acts as liaison to BASICS senior management and to USAID Contract Officers in Washington and Missions served under Delivery Orders; (2) manages the Delivery Order process; (3) oversees field administration; and (4) manages financial reporting. Accounting is done on a Solomon accounting system which processes all financial transactions from the partners, subcontractors, and vendors; and produces monthly invoices to USAID. The Solomon system has limitations, including the fact that it operates on a cash basis only and is thus unable to generate cost accrual information. Efforts are being made to use the BMIS to address such shortcomings but, even here, accruals must be calculated manually before entry into the BMIS. The F&A Division works closely with the Operations, Technical, Evaluation, and MIS Divisions.

If there are no field offices in countries where technical assistance is needed, the F&A Division supports the Technical Division in developing mechanisms for implementing grants or subcontracts and recruiting consultants. The Operations Division coordinates with the F&A Division to hire and train host country staff in the Contractor's administrative and financial systems. The F&A Division also coordinates with the Operations Division in designing and reviewing field office personnel policy, salaries, and benefits. The F&A Division also works with the Evaluation and MIS Division in coordinating and developing BMIS reports for the project. Some of the BASICS administrative support functions (such as reception, mail room, and printing) are now outsourced as cost-saving measures.

7.2.2.5 Staff Performance Evaluation System

The performance of each Headquarters staff member is evaluated annually using a comprehensive evaluation system adapted from the three Partnership companies and approved by the respective CEOs for use under the BASICS contract. Performance is judged against work plans established with supervisors at the beginning of each rating cycle. Supervisors also meet with a rated employee's peers to obtain information on performance, including service as a team member. Reportedly, only three employees have been separated for unsatisfactory performance since the contract's inception.

RECOMMENDATIONS (CURRENT CONTRACT)

1. The Contractor should, in cooperation with the COTR, assess the strengths and weaknesses of the current report processing, information dissemination, and publication programs as soon as possible. This review should include a survey of publication users or target customers and be directed to making improvements and/or cost-savings in the BASICS information dissemination activity.
2. The Contractor should refine the BASICS Management Information System (BMIS) to permit smaller individual activities to be captured rather than subsumed under a more general heading (such as General Child Survival). The contractor also needs to develop a new scheme for identifying and tracking assistance provided to the special at-risk groups targeted by the BASICS project.
3. During the next 18 months, BASIC's Monitoring and Evaluation efforts should focus on the more significant country programs and activities with the aim of identifying models for replication and "lessons learned" in improving access to and quality of child health services.

Annexes

Annex A: Principal Contacts

USAID/WASHINGTON:

Duff Gillespie, DAA, G/PHN
Dawn Liberi, AAA, G/PHN
Joy Riggs-Perla, Director, G/PHN/HN
David Oot, (former) Director, G/PHN/HN
Robert Clay, Deputy Director, G/PHN/HN
Richard Cornelius, Deputy Director, G/PHN/FPS
Victor Barbiero, Division Chief, G/PHN/HN/CS
Al Bartlett, G/PHN/HN/CS (BASICS COTR)
Murray Trostle, G/PHN/HN/CS (BASICS Project Team)
Melody Trott, G/PHN/HN/CS (BASICS Project Team)
Linda Lankenau, G/PHN/HN/CS (BASICS Project Team)
Holly Fluty, G/PHN/HN/HIV/AIDS
Carol Rice, ANE/SEA/SPA (phone)
Hope Sukin, Child Survival Specialist, Africa Bureau
Carol Dabbs, LAC/RSD-PHN
Sheila Lutjens, LAC/RSD-PHN
Marcus Johnson, Contracting Negotiator, MGT/OP
Joyce Frame, Chief, Contracts Division A, MGT/OP
Anthony Meyer, G/HCD/PP (Communication and Social Marketing)
Bonnie Pederson, COTR, SEATS Project, G/PHN/POP
Margaret Neuse, Deputy Director, G/PHN/POP

BASICS CONTRACTOR (HEADQUARTERS-ARLINGTON):

Glenn Patterson, Project Director
Pat Taylor, Deputy Director, Operations Division
Judy Yang, Deputy Director, Finance and Administration Division
Ron Waldman, Deputy Director, Technical Division
Eckhard Kleinau, Deputy Director, Evaluation and MIS Division
Ronald O'Connor, CEO, MSH

Joel Lamstein, CEO, JSI
Stephen Moseley, CEO, AED
Robin Anthony-Kouyate, Operations Officer, Africa 2
Jean Asam, HR Manager, F&A
Angela Baines, HR Coordinator, F&A
Pat Bandy, Senior Information Specialist
Vickie Barrow-Klein, Hqs. F&A Manager
Karabi Bhattacharyya, Social Scientist
Karen Blyth, Operations Officer, Africa 3
Lyndon Brown, Operations Officer, NIS
Bart Burkhalter, Operations Research/Grants/Nutrition
Kimberly Cervantes, Coordinator LAC
Paultre Desrosiers, Training Coordinator
John Durgavich, Operations Coordinator, Africa 3
Rebecca Fields, Technical Officer
Jean-Jacques Frere, Technical Officer, Policy Development
Lauralea Gilpin, Program Assistant, Africa 2
Jean Patrick Guichard, Program Assistant, Africa 3
KenHeise, Operations Officer, Africa 1
Mark Husen, Program Assistant, ANE
Carolyn Kruger, Operations Officer, Africa 2
Rose Macauley, Technical Officer, Malaria
John Murray, Technical Officer (DDC/Cholera)
Richard Nelson, Operations Officer, LAC
Robert Pond, Technical Officer, Training (contacted in Zambia)
David Pyle, Senior Evaluation Specialist, Evaluation/MIS
Mark Rasmuson, Technical Officer, Communications
Sangeeta Raja, Operations Coordinator, Africa 1
Marcia Rock, Operations Officer, NIS
Jonathan Ross, Operations Officer, ANE
Camille Saade, Technical Officer, Private Sector/Soc. Marketing
Rene Salgado, Technical Officer, ARi
Tina Sanghvi, Nutrition Specialist
Diana Silimperi, Technical Officer, High Risk/Urban Health
Bob Simpson, Operations Coordinator, ANE
Jaidev Singh, Program Coordinator/Analyst, Evaluation/MIS
Robert Steinglass, Technical Officer, Immunizations/Tetanus

BASICS SUBCONTRACTORS/PARTNERS/CONSULTANTS:

Robert E. Black, Professor and Chairman, Department of International Health,

Johns Hopkins University School of Public Health
Judy Graeff, BASICS CBC Consultant (New Jersey)
Marcia Griffiths, President, Manoff Group
Deborah Helitzer, BASICS CBC Consultant, (University of New Mexico)
Margaret Burns Pareto, Vice President, Nutrition & Population Programs, AED
Robert Porter, Sr. Program Officer, AED
Suzanne Prysor-Jones, SARA Project Director, AED
William Smith, Senior Vice President, AED

OTHER DONORS:

Silvia Luciani, Communication Officer, UNICEF/New York
Julie McLaughlin, Human Resources Operations Division, Southern Africa
Department
World Bank (contacted in Zambia)
Caby Verzosa, External Affairs, World Bank

BOLIVIA

USAID/Bolivia:

Paul Ehmer, Director, Office of Health and Human Resources
Rob Cahn, Director, Development Programs
Margaret Dula, Regional Contracting Officer
Karen Kreise, IDI

BASICS/Bolivia:

Ana Maria Aguilar, Country Representative
Dilbert Cordero, Technical Advisor, IMCI
Ruth Alvarado, Technical Advisor, Mortality Survey
Carmen Casanovas, Technical Advisor
Gribvia Kuncar, Technical Advisor, Communications
Bridgette Escalante, Accountant
Paola Salas, Administrative Assistant

CCH (Community Child Health Project):

Ignacio Caballero, Executive Director, CCH
Antonio Gomez, Chief, DDM Program

Oscar Gonzales, Chief, Under Fives Program
Fador Balderrama, Regional Coordinator, Cochabamba
Rene Zumaran, Chief, District Development
Andres Yale, Administrator

National Health Secretariat:

Marilin Aparicio, National Director of International Relations
Victoria Urioste, National Director of Medicines
Juan Jose Beltran, Director of CEASS (Central de Abastecimiento y Suministros)

Regional Health Secretariat:

Eduardo Mazzi, National Coordinator for IMCI
Oscar Zuleta, National Director of MCH
Miriam Lopez, Chief, Pediatrics Department

El Alto:

Adalid Zamora, Regional Coordinator for Health, El Alto
Juan de Dios Sanchez, Director, Health District III of El Alto
Hortensia Andrade, Health Center "Villa Exaltacion", Area Exaltacion, Distrito III

Other Partners/Cooperating Agencies:

Guillermo Seoane, Director, MotherCare/Bolivia
Jack Antelo, Director, PROSALUD
Bertha Pooley, Executive Secretary, PROCOSI

Other Donors:

Guido Cornalle, Program Coordinator, UNICEF

CENTRAL ASIAN REPUBLICS: KAZAKSTAN

USAID:

Jatinder Cheema, Supervisory General Development Officer
Indira Aitmagambetova, Program Management Specialist
Marilynn Schmidt, Director, Office of Social Transition

BASICS Contract:

Laurence Laumonier-Ickx, Regional Advisor for Central Asia
Paul Ickx, Resident Consultant (Child Survival)
Natasha Ibraeva, Office Manager
Bibigul Alimbekova, Regional Technical Officer
Aigul Kuttumuratova, National Technical Officer
Eva Kudlova, Training Consultant
Victor Maleev, Training Consultant
Elisabeth Szumilin, Training Consultant

Abt Associates/Almaty:

Sheila O'Dougherty, MIS Specialist, *ZdravReform* Project

Ministry of Health:

Erkin Durumbetov, Deputy Minister of Health
Anatoly Dernovoi, Former Deputy Minister of Health
Gulnur Kembabanova, Chief Specialist, Department of SES
Sofia Ayupova, Chief Pediatrician
Aman Dusekeev, Deputy Minister of Health
Ivan Ivasiev, Chief, Department of MCH
Svetlana Zhakisheva, National CDD-ARI Coordinator

CDC:

Bruce Ross, Public Health Advisor, CDC/Almaty

CENTRAL ASIAN REPUBLICS: KYRGYZSTAN

Ministry of Health:

Victor Glinenko, Deputy Minister of Health
Saberjan Abdugarimov, Chief, Department of SES
Kasymbek Mambetov, Chief, Department of Health Services
Svetlana Firsova, Director, Republican Center for Immunoprophylaxis
Apisa Kushbakaeva, Chief Pediatrician, National CDD/ARI Coordinator
Staff of the Republican Center for Immunoprophylaxis
Ludmila Rojkova, Chief Epidemiologist
Inna Chernova, Deputy Head of SES

BASICS Contractor:

Noorgoul Seitazieva, Country Coordinator
Damira Bibosunova, National Technical Officer

UNICEF:

Gulsana Turusbekova, National Officer for Health and Nutrition

World Bank/MOH Health Sector Reform Project:

Kalyskan Kultraeva, Coordinator for Primary Health Care

USAID:

C.J. Rushin-Bell, Country Representative

Alamudun Rayon:

Vera Mikhailchenko, Head Epidemiologist, Alamudun Rayon SES
Ismailakahunov, Chief Pediatrician, Alamudun Rayon SES
Alla Toropova, Head of the Children's Polyclinic No. 2
and Staff of the Children's Polyclinic No. 2

Osh Oblast Health Department:

Damir Rysaliev, Chief of Osh Oblast Health Department (by telephone)

HONDURAS

USAID/Honduras:

Elena Brineman, Mission Director (contacted in Washington)
Mary Ann Anderson, Director, Human Resources Development (HRD)
Richard Rhoda, Director, Development Programs
David Losk, HPN Officer
Luis Flores, Contract Negotiator
Ross Hicks, Budget Analyst, HRD
Dick Loudis, Development Finance
Alvaro Gonzalez Marmol, Technical Assistance Coordinator
Richard Monteith, CDC Advisor

Ministry of Health:

Mirtha Ponce, Director of MCH Division, MOH
Gustavo Flores, Head of CDD Program, MCH Division, MOH
Carlos Villalobos, Director, Integrated Child Health Care (AIN) Program,
MCH Division, MOH
Jorge Melendez, Chief of the ARI Program, MCH Division, MOH
Enrique Zelaya, Director General, Population Risk

BASICS Contract:

Patricio Barriga, BASICS consultant in Training and IEC
Gustavo Corales, BASICS consultant on AIN
Marcia Griffiths, Head of Nutrition Working Group, BASICS (and President,
Manoff Group)
Barry Smith, LAC Regional Technical Officer, BASICS

USAID/Madagascar:

Carol Payne, Director, HPN Office, (contacted in Washington)

NIGERIA

USAID/Nigeria:

Felix Awantang, Director

BASICS/Nigeria:

John Olu Ayodele, Country Advisor
Cecilia Bimbo Williams, Child Survival Program Officer
Adesina, Monitoring and Evaluation Program Officer
R. Sam Orisasona, Community Development Program Officer
Ene Obi, Women Empowerment Program Officer
Kayode Adewale, Financial Officer
Titus Animaku, Building Manager
Ayodele Iroko, Secretary
Nike Odega, Secretary

Others:

Akpaka Kalu, CDC Program Manager (Nigeria)
Stella Goings, Nutrition and Health Officer, UNICEF (Nigeria)
Community leaders from the six Community Partners for Health

RUSSIA:

USAID/Russia:

Jane Stanley
Natalia Vozianova

Ministry of Health/Others:

Natalia Barsukova, Dep. Dir., Federal Research Institute for Health Education
and Promotion, MOH
Yuri Fyodorov, Chief, Division of Licensing and Emergency Situations, MOH
Oleg Larshin, Supervisor, Medicine for You Information Center
Vladimir Polessky, Director, Federal Research Institute for health Education and
Promotion, MOH

SENEGAL

USAID/Senegal:

Charles Gary Merritt, HPN Advisor and Coach
Fatamati Sy, SO Team Leader
Chris Barratt, Deputy SO Team Leader
Amadou Ly, Project Management Specialist

BASICS REGIONAL OFFICE (WEST/FRANCOPHONE AFRICA):

Adama Kone, Regional Director
Mamadou Sene, Country Advisor for Senegal
Mutombo wa Mutombo, Regional Child Survival Specialist
Yaya Drabo, Regional IEC Specialist
Serigne Mbaya Diene, Regional Nutrition Specialist
Coumba Diop Daffe, Adm. and Finance Officer

Ministry of Health:

Guelaye Sall, Chef de Service, SANAS
Amadou Djibril Ba, Medecin Chef Region de Louga

Others:

Amadou Moctar Mbaye, Office de Recherche en Alimentation et Nutrition
Africanes
Kadri Tankari, WHO Country Representative
Papa Malick Sylla, Epidemiologist, WHO
Laurence Codjia, African Center for Advanced Studies (Management of Health
Sciences)

UNITED NATIONS AGENCIES HEADQUARTERS:

Dr. Foege contacted present and former staff members of WHO and UNICEF
headquarters under the condition that they would not be identified in the
evaluation report.

ZAMBIA

American Embassy:

Ambassador Arlene Render

USAID/Zambia:

Walter North, Mission Director
Rudy Thomas, Deputy Mission Director
Paul Hartenberger, PHN Officer
Paul Zeitz, Technical Advisor, PHN (JHU Fellow)

BASICS/Zambia:

Oluremi Sogunro, Chief of Party
Abdikumal AliSalad, Child Health Advisor
Elizabeth Burleigh, Community Mobilization Advisor
Mary Kaoma, Health Training Advisor
Michael McGunnigle, Administrative Officer

Francis Mutumbisha, Logistics Officer
Vera Mwewa, Program Development Specialist
Mabel Mwila, Accountant
Patience Siawwela, Administrative Assistant

Other Cooperating Agencies:

Mary Ettling, Environmental Health Program (Part-time, BASICS)
Mimi Church, Data for Decision Making
Jolee Reinke, University Research Corporation
Karen Wilkins, Data for Decision Making, CDC
James A. Bates, Drug Management Program, MSH

Other Donors:

Wilfred S. Boayue, WHO Representative, Zambia
Andy O'Connell, Program Administrator/Urban Health Advisor, Overseas
Development Assistance (UK)
Tshidii Moeti, Project Officer for Health, UNICEF/Zambia
Marashetty Seenappa, Programme Officer, UNICEF/Zambia
M. P. Shilalukey Ngoma, Medical Officer, WHO/Zambia

Ministry Of Health:

D. Chintu, Chairman, Pediatrics Department, Zambia University Medical School
E. Chomba, Head of Pediatrics Department, University Teaching Hospital, Lusaka
H. B. Himonga, Director, Directorate of South-West Region, Central Board of
Health
Priscilla Likwasi, Head, Public Health and Community Nutrition, National Food
and
A. K. Luneta, Executive Director, National Food and Nutrition Commission
Rose M. Lungu, Principal Nutritionist, National Food and Nutrition Commission
Nutrition Commission.
Rebecca Nois, Nurse-in-Charge, Kamwala Clinic, Lusaka District
Samuel Nyaywe, Reforms Implementation Team, Ministry of Health
Gavin Silwamba, Executive Director, Central Board of Health
Ruth Siyani, Nutritionist, National Food and Nutrition Commission

Annex B: Selected References

BASICS HEADQUARTERS DOCUMENTS

- A Conceptual Model of Community Participation (Paper based on evaluation of Honduras growth promotion program)
- A Tool Box for Building Health Communications Capacity (May 1996 Reprint of AED HealthCom Publication, April 1995)
- Annual Report PY 3, BASICS Evaluation/MIS Division, Draft, January 31, 1997
- BASICS, InfoCenter Reference, BASICS InfoCenter Capabilities and Services
- BASICS Annual Program Reports to USAID Missions, October 1, 1995 - September 30, 1996, February 4, 1997
- BASICS Project Year 4 Workplan, October 1, 1996 - September 30, 1997
- BASICS Project Year 4 Workplan, Volume II: Technical Leadership, Information Dissemination, October 1, 1996 - September 30, 1997
- BASICS Technical Proposal [to USAID], June 7, 1993
- BASICS Information Center, Paper assembled for BASICS Midterm Evaluation 1994 - 1997
- BMIS Designator Percent, January 31, 1997
- BMIS Financial Summary - Dollars, F&A, January 31, 1997
- BMIS Designator Type, January 6, 1997
- Briefing Book on BASICS, December 3, 1996

- Child Survival BASICS (Newsletter)
- Child Survival: 1996 BASICS Annual Report (Draft February 1997)
- Communications - Chapter 8 in Guide for Introducing IMCI (Guide for organizing Communications aspects of IMCI program.)
- Design Workshop: "Los Angelitos" - Radio Drama (Report on drama design workshop in Bolivia to produce radio program based on case studies of actual infant deaths)
- Draft BASICS Project Year 4 Budget, Financial Summary, February 6, 1997
- Emphasis Behaviors in Child Survival: Focusing on Caretaker Behaviors to Development Child Health Programs in Communities (Technical Report)
- Emphasis Behaviors of Caretakers of Young Children: An Overview for District and Community Health Planning Teams (Guide for Community Workers)
- Extending Immunization Services to the Urban Poor in Bangladesh: A Strategy for Action.
- FAX Simpson/Miller, Subject: Family Planning Management Development, Management Sciences for Health, Approval and Reporting Under FPMD, February 5, 1997
- Finance and Administration at BASICS, January 8, 1997
- Guides on Participatory Problem-Solving to Improve Community Health (Two guides for district health management teams and health facility staff)
- IEC Conference Activities in the Russian Federation (Trip Report)
- Kleinau, Eckhard, BASICS Management Information System, "Monitoring, Evaluating and Reporting Project Performance, An Overview," January 1997
- Letter from Patterson to Gushue (USAID/OP/Contracts), Subject: The Partnership for Child Health, Inc - The BASICS Project Streamlining, June 1, 1995
- Malnutrition and Child Mortality: Program Implications of New Evidence. Research Update issued by BASICS and others (September 1995)

Memorandum Patterson/Bartlett, Subject: Revised Information Strategy, February 8, 1995

Mobilizing the Commercial Sector for Public Health Objectives: A Practical Guide (by Sharon Slater, UNICEF and Camille Saade, BASICS) Issued by BASICS and UNICEF, 1996.

Monitoring and Evaluation, Report January 8, 1997

Pathways and Partnerships for Healthier Children, BASICS Annual Report, October 1, 1994 - September 30, 1995

Planning Multi-level Interventions: A Case Study in Behavior Change Planning (Report)

Principles of Partner Equity: Making BASICS Workable While Ensuring Partner Equity, March 15, 1994

Process Evaluation of the First National Immunization Day (NID) in Bangladesh (Evaluation Report)

Program Planning & Management Guide, January 10, 1996

Project Status Report for Core Contract as of September 2, 1996, September 16, 1996

PY 4 Workplans, Anglophone Africa II

Response to Technical Questions [from USAID Contract Selection Panel] Related to Contract Proposal, BASICS, August 26, 1993

Results of the Community Demand Study for the Essential Services for Health in Ethiopia Project (ESHE). (Study report to help build local assessment capacities.)

Subcontract Ceiling and Obligations Tracking, February 19, 1997

Subcontract Register, 1996

USAID Review of EHP/BASICS Performance from October 1994-September 1995 (BASICS Summary - covers Eritrea Health and Population Project). Issued August 15, 1996.

USAID/WASHINGTON

"Saving Lives Today and Tomorrow," A Decade Report of USAID's Child Survival Program, U.S. Agency for International Development, December 1996 (Draft)

Basic Support for Institutionalizing Child Survival (BASICS), Project Paper No. 936-6006

BASICS FY 96 Funding, January 13, 1997

Core Contract, HRN-6006-C-00-3031-00, BASICS Partnership for Child Health Care (Joint Venture), September 30, 1993

Delivery Order No. 13 (Bolivia), Contract No. HRN-6006-Q-00-3032-00, September 30, 1994

Draft, Field Support Funding: A Discussion of Cost Structures

FAR 90-41, Part 16, December 2, 1996 (Federal Acquisition Regulation - Sections on Selecting a Contract Instrument)

Field Accounts One-Write Manual, John Snow, Inc., October 1996

Information from G/PHN's Workshops: Field Support Funding

Letter Bartlett/Patterson, January 3, 1996

Letter Bartlett/Patterson, Subject: Information Dissemination Activities of the BASICS Project, January 21, 1995

Letter Nelson/Dabbs, January 7, 1997, enclosing a proposal for the LAC Regional Integrated Management of Childhood Illness (IMCI) Results Package

Memorandum Bartlett/Patterson, Subject: Management Issues Memorandum #4 - Key Management Actions for PY 4-5

Memorandum Bartlett/Patterson, Subject: End of Project Accomplishments in Integrated Case Management, February 20, 1996

Memorandum Bartlett/Patterson, Subject: Management Issues Memorandum #2 - Budget and Funding Issues Relevant to Project Planning, December 28, 1995

Memorandum Bartlett/Patterson, Subject: Management Issues Memorandum #1 - Workplan Development, Review, and Approval, December 28, 1995

Memorandum Bartlett/Patterson, Subject: Discussions of BASICS Technical Strategies and End of Project Accomplishments, February 20, 1996

Memorandum #3 - PY 3 Information Dissemination Workplan Proposal, December 28, 1995

Notes on Various Aspects of the BASICS Project and its Evaluation, from the USAID Project Management Team [G/PHN/HN, January 1997]

Office of Field and Program Support, Vision Statement, December 13, 1995

Requirements Contract, HRN-6006-Q-00-3032-00, BASICS Partnership for Child Health Care (Joint Venture), September 30, 1993

Strategic Plan, Center for Population, Health and Nutrition, Bureau for Global Programs, Field Support and Research, U.S. Agency for International Development, December 1995

Summary of BASICS Accomplishments (to date and planned)

The BASICS Project Financial Summary, January 13, 1997

OTHER REFERENCES:

Ferraz-Tabor, Lucia and William H. Jansen II, Forging New Partnerships, PRITECH's Pakistan Experience, 1991

Health Technical Services Project. [Linda Sanei]. Summary of Responses, BASICS Midterm Evaluation Questionnaire [G/PHN]. February 27, 1997

The Commonwealth of Massachusetts, Articles of Organization, The Partnership for Child Health Care, Inc., June 4, 1993

BASICS/HONDURAS

Smith, Barry, Draft BASICS Trip Report, Reviewing the Honduras PY 3 Workplan with the USAID Mission, March 3-4, 1996

Smith, Barry, McCarthy, David, Salgado, Rene, Barriga, Patricio, BASICS, Draft Honduras Country Activity Plan, April 17, 1995

USAID/HONDURAS

1995 Net ODA Flows to Honduras, Source: OECD, prepared by the Economic and Social Data Service

Action Memorandum Brown/DAA, Center for Population, Health and Nutrition, Subject: Utilization of Global Field Support for the USAID/Honduras Population, Health, and Nutrition Program (PHN), February 23, 1995

Briefing Materials USAID

FY 96 Child Survival Funding for USAID/Honduras, August 8, 1996

Health Sector II, Strategic Framework and Results Indicators

USAID Economic Assistance to Honduras

BASICS/BOLIVIA

Aguilar-Liendo, Anna Maria, Alvarado-Caceres, Ruth, Cordero-Valdivia, Dilberth, Salgado, Rene, Zamora-Gutierrez, Adalid, "Mortality Surveillance: An Analytic Approach to How and Why Children Die"

BASICS/Bolivia, August Monthly Report, 1996

BASICS Annual Program Report, Bolivia, for Fiscal Year 1996, submitted to BASICS headquarters, December 16, 1996

La Atencion Integrada a las Enfermedades Prevalentes de la Infancia (A.I.E.P.I.) Bolivia, Ministerio de Desarrollo Humano, 1996

Letter Velasco/Aguilar, February 5, 1996

Letter Velasco/Aguilar, May 23, 1996

Monthly Report, January 1996

Objetivo Estrategico por Salud, Marco de Resultados Propuesto and Draft Indicators for Intermediate Results

USAID Congressional Presentation FY 1997, October 7, 1996

OTHER REFERENCES FOR HONDURAS AND BOLIVIA:

1994 Post Report, Bolivia, United States Department of State, June 1994

1996 Post Report, Honduras, United States Department of State, June 1996

Background Notes, Bolivia, Volume V, No. 15, United States Department of State, November 1994

Culturgram '96, The Americas, Republic of Honduras and Republic of Bolivia, Brigham Young University, July 1995

Dustert, Pierre Etienne, Latin America, 1995, The Republic of Honduras, 29th Edition, The World Today Series, Stryker-Post Publications

Organizaciones Miembros de la Red "Procosi"

PROCOSI, Programa de Coordinacion en Salud Integral

The World Factbook, Honduras and Bolivia, pps. 51-53 and 187-189, U.S. Central Intelligence Agency, 1995

BASICS/ZAMBIA

BASICS Logistical Manual

BASICS Personnel Policy Manual

Briefing Book: Mid-Term [BASICS] Evaluation Visit to Zambia, January 1997

Lusaka Health Centre Survey Guide. [undated]

Zambia Child Health Project: FY97 Work Plan Narrative (for BASICS and partners).

Zambian Child Health Project: A Summary of Achievements (BASICS? January 1997)

USAID/ZAMBIA:

Briefing Materials [HPN Program], USAID HPN Team (undated. January 1997?)

Delivery Order 19, for BASICS Contract (Contractor: The Partnership for Child Health) May 1, 1996.

Proposed USAID Results Framework to Support the Zambian Health Reforms 1997-2002 (USAID/Zambia. Draft 1/13/97)

Papers Prepared for the USAID/Zambia Workshop on Collaborative Strategic Planning for the USAID Population, Health, and Nutrition Results Framework Within the Priorities of the Central Board of Health [Ministry of Health] held February 1, 1997. For example of outcome, see the Draft Strategy for Practical Interventions for Nutrition Components of Health February 12, 1997. This draft paper on nutrition summarized results of meetings participated in by people from World Bank, Wellstart, GOZ Central Board of Health, GOZ National Food and Nutrition Commission, BASICS, OMNI, and UNICEF.

ZAMBIA - OTHER:

Republic of Zambia. Ministry of Health. Circular No. 4 of 1995, "Exemption From Paying User Fees and Pre-Payment Fees".

Republic of Zambia. Ministry of Health. The National Health Services Act 1995. (November 1995)

Republic of Zambia. Ministry of Health. Contract for Delivering District Health Services in 1997 Between the District Health Board and the Central Board of Health (Sample Form).

Republic of Zambia. Ministry of Health. Establishment of the Central Board of Health: Why? What? How? (December 1996?)

Republic of Zambia. Ministry of Health. Management of Childhood Illness
[Guide charts or clinical algorithms for use by health workers. Adapted from
UNICEF and WHO materials with assistance from USAID and BASICS.]
[Undated]

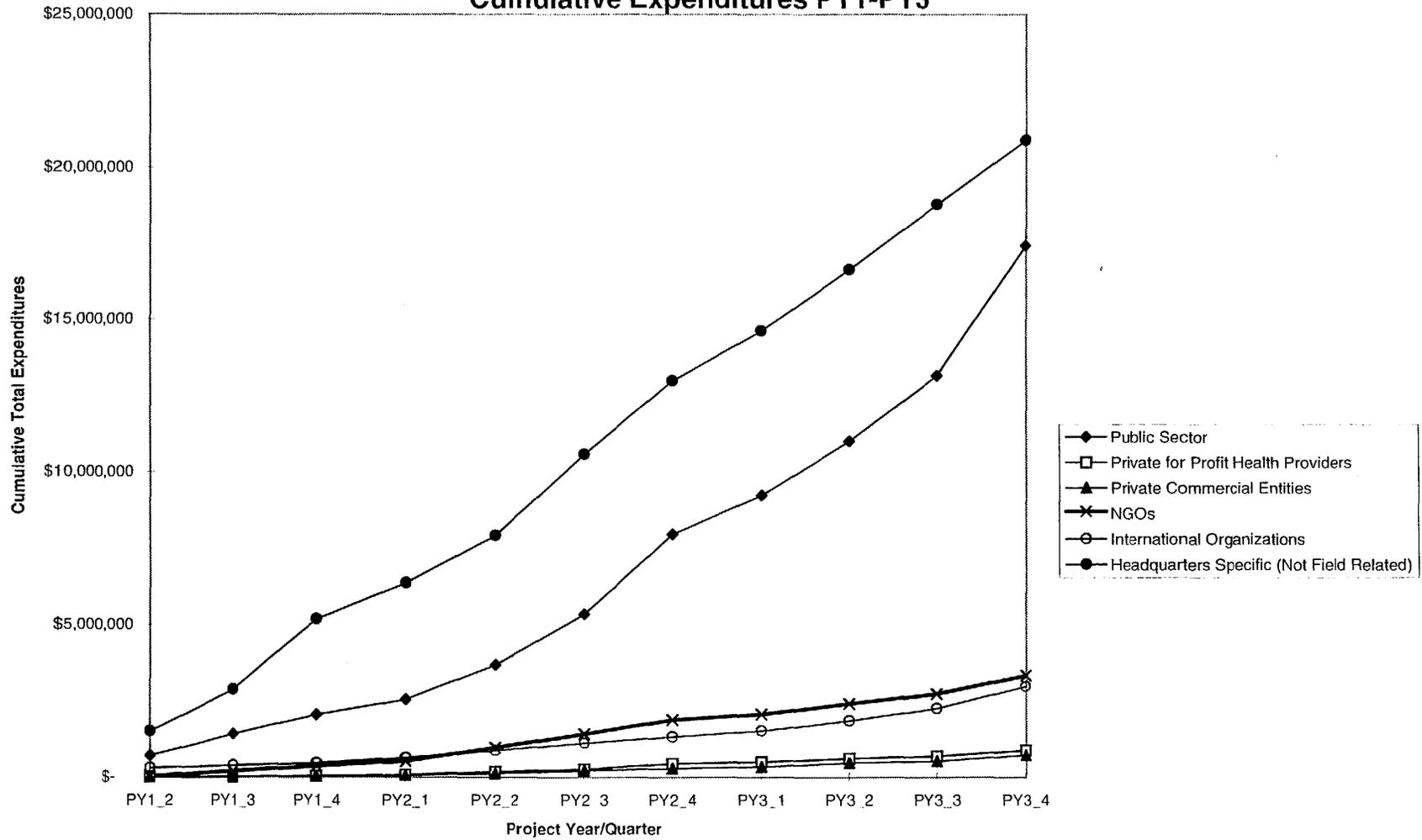
Republic of Zambia. National Food and Nutrition Commission and UNICEF.
Report on the Vitamin A Technical Planning Meeting for the 1997 Vitamin A
Deficiency Program, Held in Siavonga, May 27-28, 1996.

Macro International Inc. The 1996 Zambia Demographic and Health Survey:
Provisional Findings (Extract). (January 1997)

van den Broek, A. A. L. J. . A Manual for District Planners: Guidelines for the
Planning of Reproductive Health Services and Child Health Services for
District Managers in Zambia. (xerox copy), [Ministry of Health? 1995?]

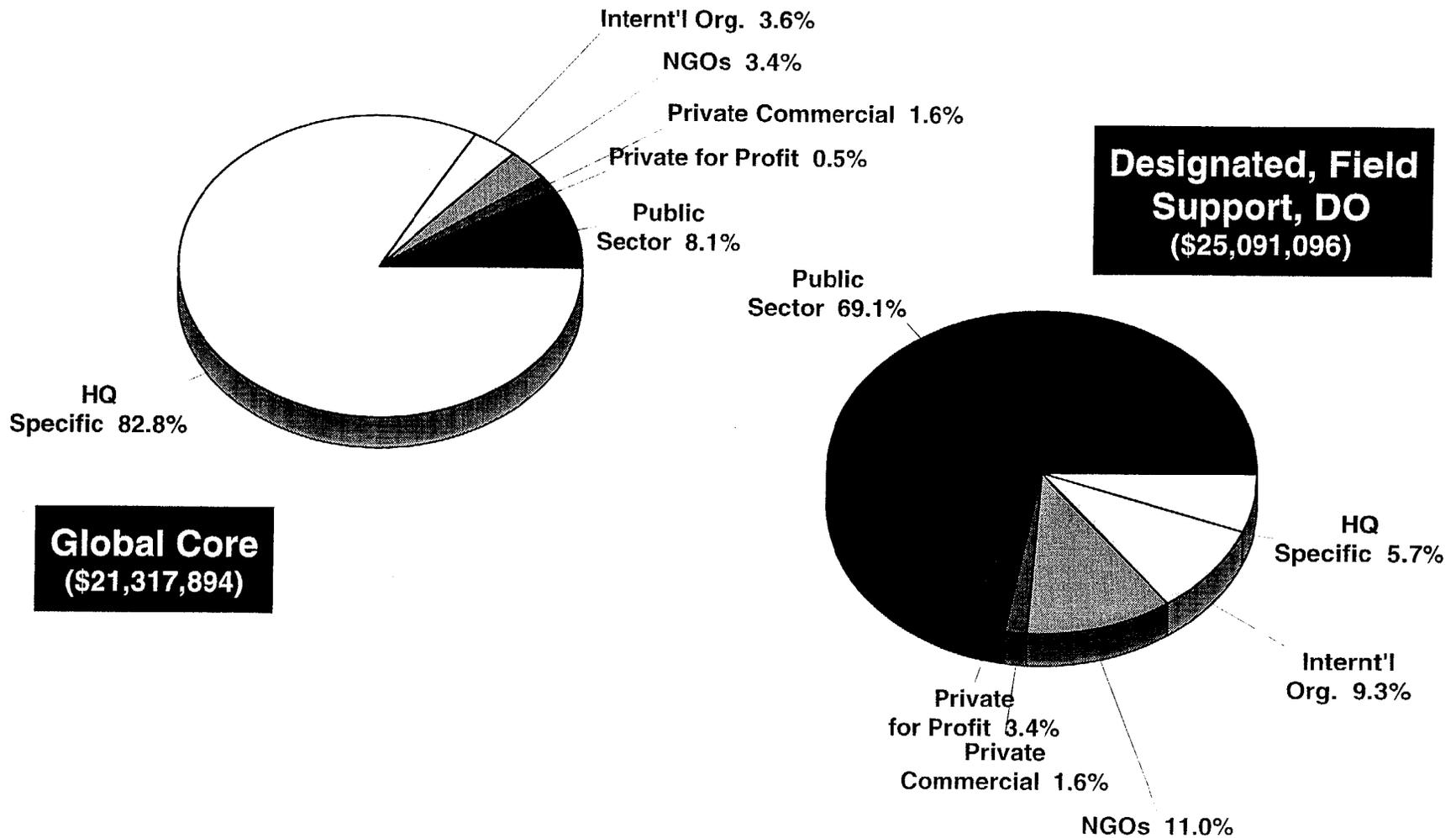
Annex C: BASICS Expenditure Graphs

Counterpart/Client Cumulative Expenditures PY1-PY3



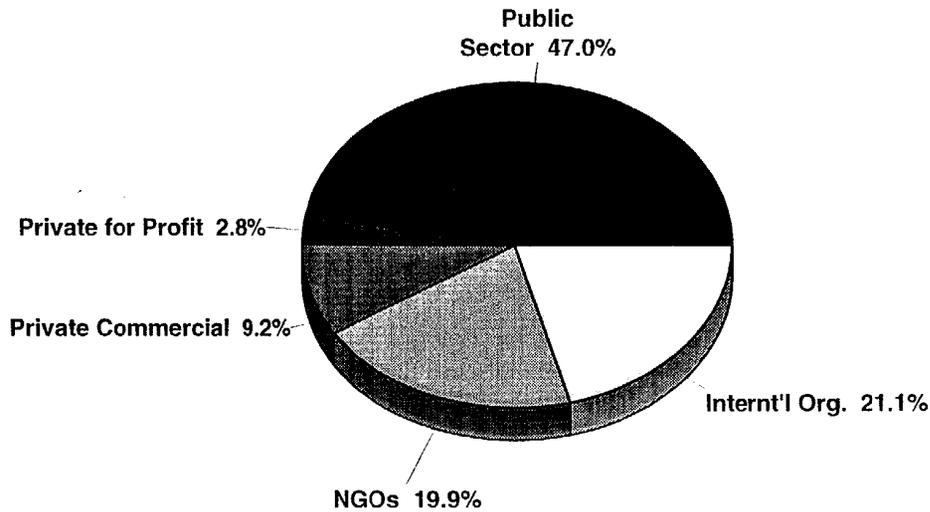
Counterpart/Client Organizations

PY1-PY3 Expenditures



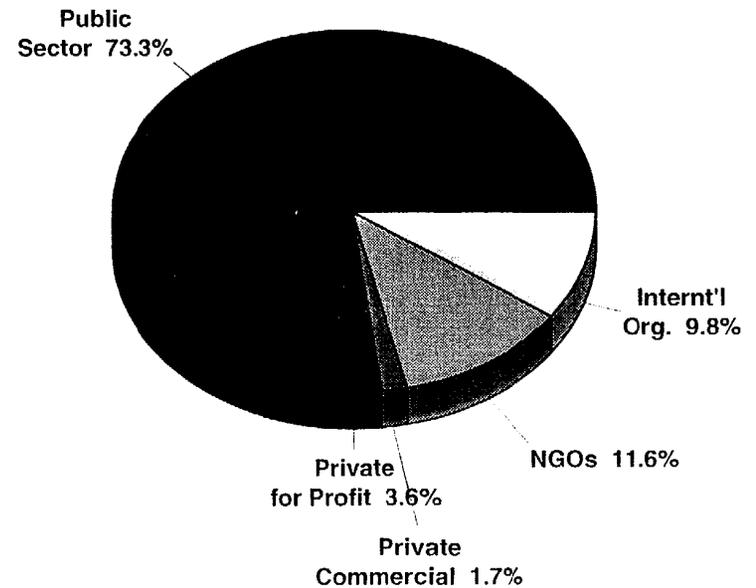
Counterpart/Client Organizations

PY1-PY3 Expenditures

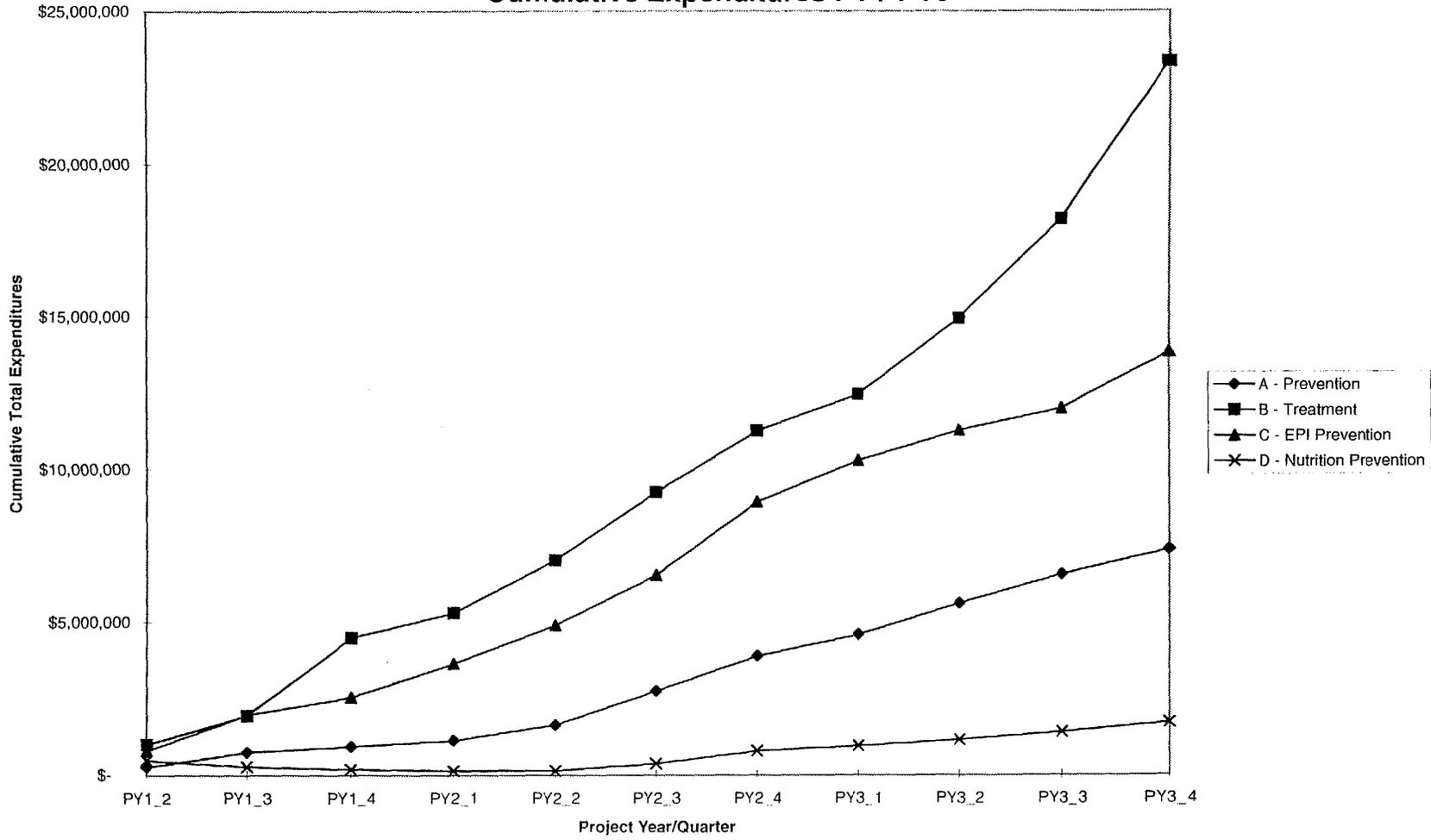


Global Core
(\$3,666,678)

Designated, Field Support, DO
(\$24,072,925)

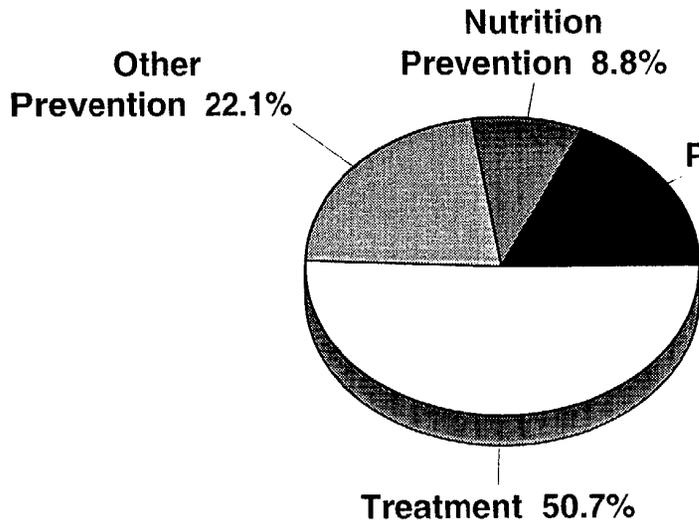


Prevention vs. Treatment Cumulative Expenditures PY1-PY3



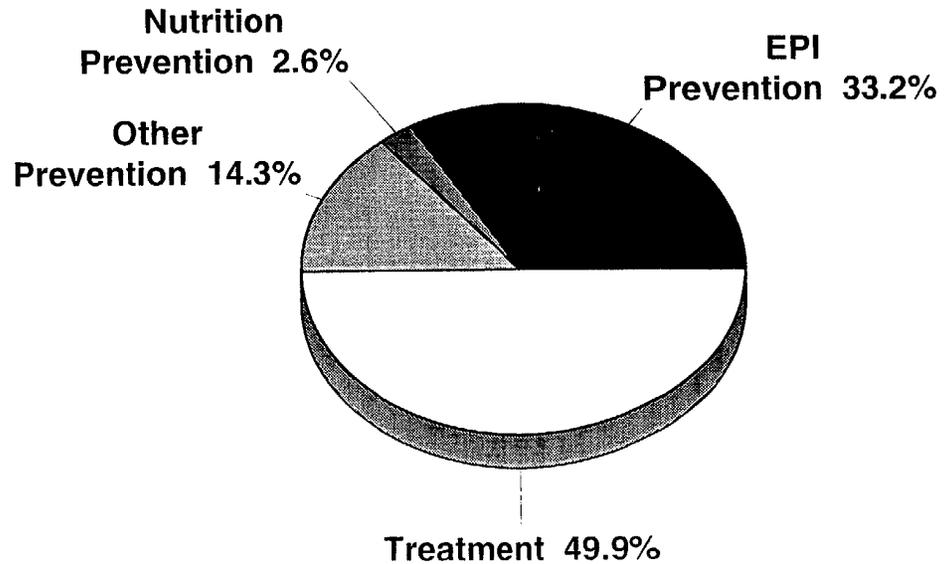
Prevention vs. Treatment

PY1-PY3 Expenditures

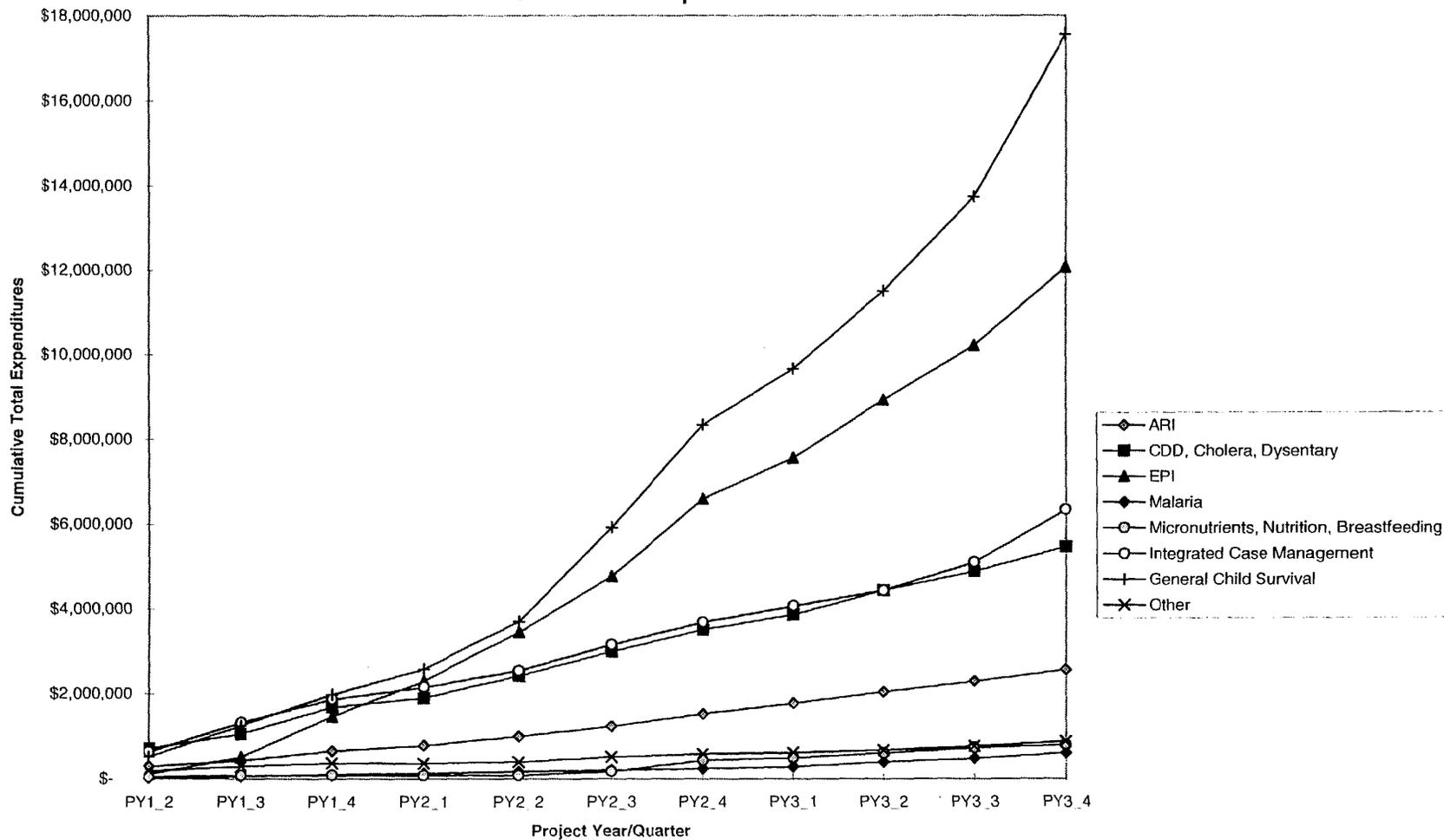


Global Core
(\$21,317,894)

Designated, Field Support, DO
(\$25,091,096)

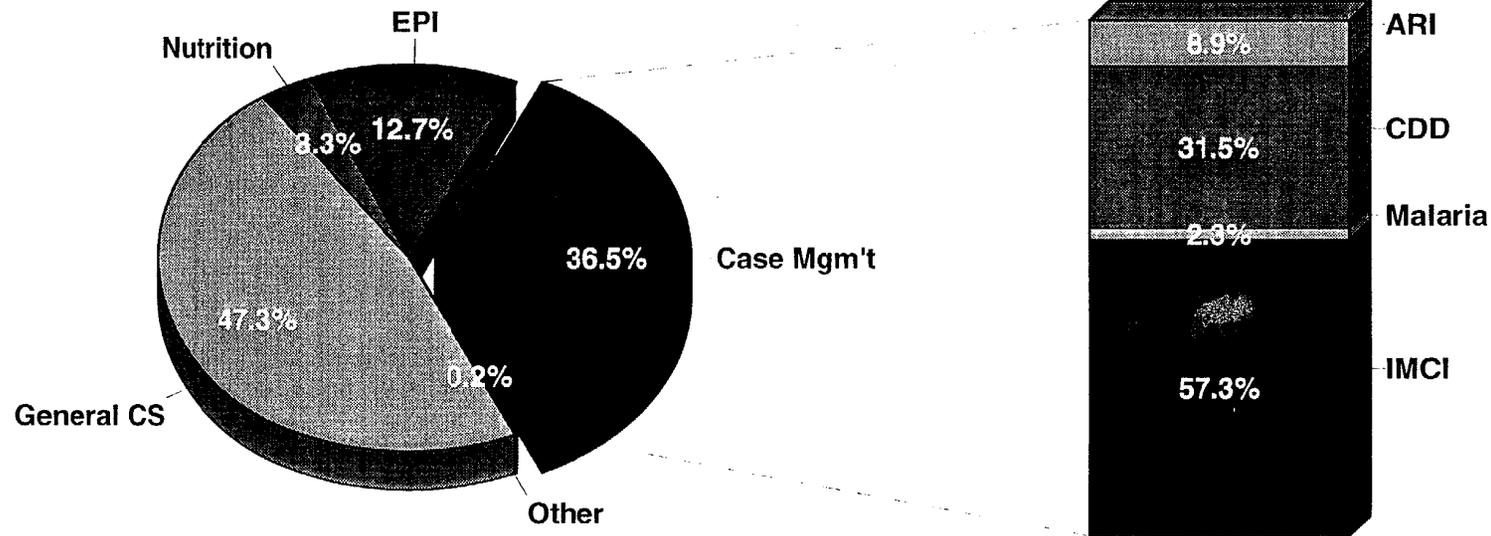


Program/Disease Prevention Cumulative Expenditures PY1-PY3



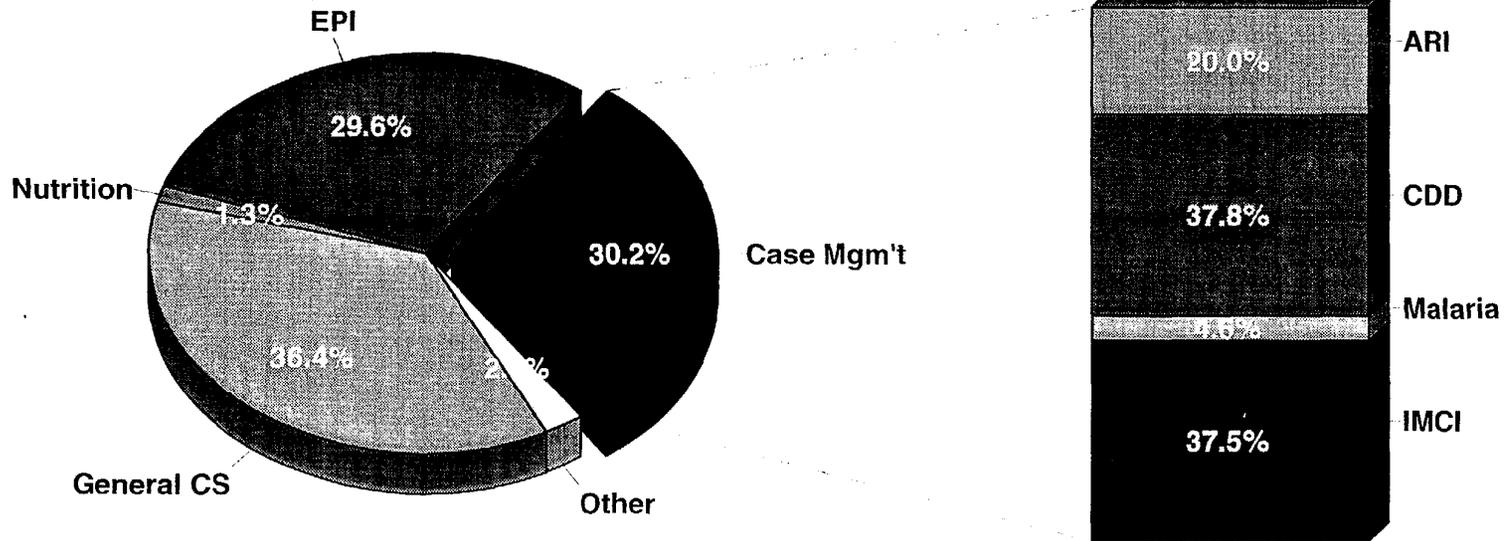
Program/Disease Intervention

PY 1-PY3 Global Core Expenditures (Total \$21,317,894)



Program/Disease Intervention

PY 1-PY3 Designated, Field Support, DO Expenditures
(Total \$25,091,096)



Annex D: BASICS as a Partner and Collaborator

Eritrea -	SEATS, <i>OMNI WHO</i> , UNICEF, <i>Italian Assistance</i> , Save (UK)
Zambia -	<i>QAP</i> , <i>OMNI</i> , <i>CDC/DM</i> , <i>PHR</i> , USAID bilateral family planning project, WHO, UNICEF, and others
Cambodia -	<i>SEATS</i> , <i>AVSC</i> , PSI, CARE, World Vision, MSF, PACT, UNICEF, WHO
Indonesia -	World Bank CHNIII, and <i>HPIV Projects</i>
Madagascar -	<i>APROPOP</i> , US Peace Corps, PVOs, WHO, UNICEF
Nigeria -	<i>JHU/PCS</i> , <i>Initiatives</i> , <i>CEDPA</i> , <i>Pthfinder</i> , <i>CDC</i> , AIDSCAP
Bangladesh -	Urban Health Contractor of new USAID bilateral project, JHU/ICDDR urban health operations research project, UNICEF, WHO
Senegal -	<i>USAID Child Survival and Family Health Project</i> , Wellstart, Lindages, <i>OMNI</i> , World Bank-funded nutrition project
Niger -	<i>QAP</i> , <i>WHO/AFRO</i>
Central Asia -	<i>CDC</i> , UNICEF, WHO/EURO
Bolivia -	<i>CCH Project</i> , UNICEF, <i>PAHO</i> , PROSALUD
Honduras -	MotherCare, Wellstart
Guatemala -	<i>USAID Child Survival Project</i> (ended), <i>PAHO</i> , INCAP
India -	<i>PVOHII</i> , <i>MotherCare</i> , <i>FHI/PRIME</i>
South Africa -	<i>CDC/DDM Project</i> , <i>FHI/PRIME</i>
Morocco -	<i>USAID bilateral health and family planning prjoect</i> , PSI, <i>OMNI</i> , etc.

Africa Regional Technical Initiatives

EPI/Polio -	WHO/AFRO, UNICEF, CDC
IMCI -	WHO/AFRO
Nutrition -	UNICEF, World Bank

REDSO/Family Health and AIDS Project -

JSI, *PSI*, *PCS*, Tulane, JHPIEGO, Africare

LAC Regional Programs

Cholera - EHP Project, INCAP, PAHO

IMCI - *PAHO*

**italics indicate that the relationship includes financial interdependence*