



**ASSESSMENT  
OF THE  
BASIC SUPPORT FOR INSTITUTIONALIZING CHILD  
SURVIVAL (BASICS II) PROJECT**

**EXECUTIVE SUMMARY**

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## ACRONYMS AND ABBREVIATIONS

AED	Academy for Educational Development
AFR	Africa Bureau
AFRO	African Regional Office
AIEPI	Atención Integrada a las Enfermedades Prevalentes de la Infancia
AIN	Atención Integral a la Niñez
ARI	Acute respiratory infection
ANE	Asia and Near East Bureau
BASICS	Basic Support for Institutionalizing Child Survival project
CA	Cooperating agency
CAPA	Catchment Area Planning and Action
CDD	Diarrheal disease control
CHANGE	Behavior Change, Communication and Social Marketing Innovation
CHW	Community health worker
c-IMCI	Community-based approach to IMCI
CTO	Cognizant technical officer
ENA	Essential nutrition action
EPI	Expanded Programme on Immunization
FANta	Food and Nutrition Technical Assistance project
f-IMCI	Facility-focused IMCI
FY	Fiscal year
GAVI	Global Alliance for Vaccines and Immunization
GH	Bureau for Global Health
G/PHN	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition
GTL	Global technical leadership
HealthCom	Communication and Marketing for Child Survival Project
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HKI	Helen Keller International
IACH	Integrated approaches to child health
IADB	Inter-American Development Bank
ICC	Interagency coordinating committee
IEC	Information, education, and communication
IMCI	Integrated management of childhood illness
IPT	Intermittent preventive treatment
IR	Intermediate Result
ITN	Insecticide-treated bed net
JHU	Johns Hopkins University
JSI	John Snow, Inc.
LAC	Latin America and the Caribbean Bureau
MEDS	Monitoring, Evaluation and Design Support Project
MinPak	Minimum Package of Nutrition Interventions
MNH	Maternal and Newborn Health Project
MOH	Ministry of Health
MOST	USAID Micronutrient Program
MSH	Management Sciences for Health
NGO	Nongovernmental organization
NID	National Immunization Day
OER	Operations and evaluation research
ORT	Oral rehydration therapy
PAHO	Pan-American Health Organization
PAIN	Paquet d'Activités Intégrées Nutrition
PASA	Participating agency service agreement
PATH	Program for Appropriate Technology in Health
PCHC	Partnership for Child Health Care, Inc.
PEB	Performance evaluation board
PNN	Perinatal and neonatal
PRITECH	Technology for Primary Health Care Project
PRM	Program results monitoring
PVO	Private voluntary organization

REACH	Technologies and Resources for Child Health Project
RFA	Request for Application
SARA	Support for Analysis and Research in Africa
SANA	Sustainable Approaches to Nutrition in Africa
SEARO	Southeast Asia Regional Office
SET	Strategic Experience Transfer
SO	Strategic Objective
SOAG	Strategic Objective Grant Agreement
TASC	Technical Assistance and Support
TBA	Traditional birth attendants
TFA	Technical focus area
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WARO	West Africa Regional Office
WARP	West Africa Regional Program
WHO	World Health Organization

## EXECUTIVE SUMMARY

The Basic Support for Institutionalizing Child Survival (BASICS II) project was designed to be an innovative flagship<sup>1</sup> program that would increase the use of child survival interventions in 10–15 United States Agency for International Development (USAID) countries. The program vision was to move beyond BASICS I small-scale activities to support a much broader implementation of well-known and generally accepted child health interventions. The results of this program would be measured largely by major improvements in coverage (e.g., 50 percent increase in appropriate care seeking and treatment of acute respiratory infection [ARI] in 10 countries). Increased coverage would be achieved by providing critical USAID technical and financial support and by obtaining other resources.

This \$79 million, five-year program design had four novel features for a Bureau for Global Health (GH) flagship program:

- the clear focus on expanding the coverage of child health interventions and concentrating program support on those USAID field programs that shared this objective,
- use of public health indicators to measure program performance,
- increased delegation of responsibility from GH to the contractor (e.g., responsibility for negotiating Mission participation in the program), and
- the use of a performance-based contract to provide incentives to the contractor.

BASICS II had difficulties in the beginning years. Once the contract was signed in June 1999 (a year behind schedule), much of the first 12–15 months focused on the transition to a results-oriented program and the accompanying long-term and implementation-level planning. This lengthy and intensive planning frustrated many of the action-oriented technical staff. BASICS II staff was accustomed to BASICS I activities-level planning and could not provide a first year work plan that demonstrated clear links to the results in its five-year program strategy. BASICS II also had major senior leadership problems with four directors (including two interim directors) through the contract's first 27 months. These planning and leadership problems were only resolved about halfway through the five-year program with more experience in the use of results-oriented planning tools and the appointment of an experienced director. Over the past 15 months, the program has operated smoothly and has begun to achieve significant results.

## PROGRAM RESULTS

Program results to date (approximately 15 months before contract completion) are substantial. Some examples are discussed in the following sections.

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<sup>1</sup> In USAID terminology, flagship suggests a consolidation of partner agencies that share the same objective under one procurement vehicle, led by one or more of the partners.

## Technical Focus Areas (TFAs)

- **Immunization:** BASICS II has provided strong global leadership and country support in vaccine security, strengthening routine vaccination programs, improving vaccine safety, and encouraging the proper use of new vaccines.
- **Nutrition and Child Growth:** BASICS II has helped define and successfully implement a package of essential nutrition actions, fostered an effective nutrition network of 20 countries in West/Central Africa, and established community-based growth monitoring as both a key intervention integrated within other community health activities (community-based approach to the integrated management of childhood illness [c-IMCI]) and as a platform for the delivery of community and household nutrition and health services.
- **Perinatal and Neonatal Health:** Unlike the previous two TFAs, perinatal and neonatal (PNN) health was not ready for full-scale implementation when BASICS II began. BASICS II advocacy efforts and operations and evaluation research (OER) were needed and have been effective, but have taken longer than anticipated. At present, BASICS II is only supporting PNN programs in four countries.
- **Integrated Approaches to Child Health (IACH):** With GH guidance, this has effectively become support for the c-IMCI program concept. Adoption in some countries has been hampered by a continuing controversy between the World Health Organization (WHO)/Pan-American Health Organization (PAHO) and a USAID/private voluntary organization (PVO) coalition over the relative priority and sequencing of c-IMCI in relation to facility-focused IMCI (f-IMCI). BASICS II has successfully worked with WHO and other key global agencies to define c-IMCI, which emphasizes community/household action while strengthening ties to local health facilities. It is very different from the precise algorithm for case management prescribed by WHO for f-IMCI. BASICS II has successfully supported expansion of the c-IMCI model and Mission demand for BASICS' c-IMCI support is growing.
- **TFA Integration:** The four TFA units in BASICS II function as separate, almost vertical programs; some observers believe that stronger integration of their efforts into a child health program is needed. Most Missions, however, only wanted BASICS II assistance for one or two selected interventions, not for a complete package of the four TFAs or an integrated approach.

## Use of Flagship Functions

- **Support for Field Programs:** BASICS II has supported child health interventions in 16 countries (only one or two TFAs in most of these countries). Most USAID Missions highly rate BASICS field staff and its programs. Many have complained, however, that BASICS II headquarters has not been flexible in meeting Mission program needs.
- **Global Leadership:** The BASICS II immunization and nutrition leadership is internationally known and has worked closely with USAID GH staff to

provide global leadership. Several African members of the African regional office (AFRO) technical staff are highly respected and have provided effective regional leadership. It has proven difficult, however, to measure the impact or results emanating from global leadership activities.

- **Operations and Evaluation Research (OER):** OER has not been effectively built into TFA agendas or BASICS II country programs. OER has rarely been undertaken and OER objectives have not been met.
- **Strategic Experience Transfer (SET):** BASICS has struggled to define SET and to put it into operation; the most recent SET strategy seems unnecessarily elaborate and costly. It was difficult to determine whether SET was indeed important or essential in the successes claimed thus far (e.g., adoption of the Atención Integral a la Niñez [AIN] model in Guatemala).
- **Program Results Monitoring (PRM):** An effective PRM system has been established that should provide valid measures of program results.

## KEY FACTORS THAT CONTRIBUTED TO SUCCESS OR LACK OF SUCCESS

These factors can be summarized as factors primarily under the control of BASICS II, under the control of USAID, or important outside factors that neither party might have effectively managed.

### BASICS II Factors

- **Leadership:** The contractor (including the three partner organizations) should be held responsible for a significant failure in the initial selection and slow replacement of program leadership. The absence of qualified and stable leadership had far-reaching impact on program cohesion and on the pace of program implementation.
- **Grasping the Program Vision:** BASICS II had great difficulty absorbing the contract's results orientation and using the USAID concepts of "scale up, leveraging, and attribution."
- **Making Needed Operational Adjustments:** The contractor (who had also implemented BASICS I) was not adept at making a timely adjustment from a level-of-effort contract designed to provide one-stop shopping for field Missions (BASICS I) to a performance-based contract designed to bring measurable improvements in child health interventions (BASICS II). Major changes were needed in staff skills, leadership vision, planning/programming tools, and cost controls.
- **Strong Technical Leadership:** BASICS II's technical leadership is renowned and effective, especially in immunization and nutrition.
- **Management:** The headquarters structure encourages vertical programming by each of the TFAs rather than program integration. Staffing decisions and the use of subcontractors have been influenced by the three partners' desire to

maximize their use of program level of effort. Program financial management has been good.

### **USAID–Related Factors**

- **Problem Resolution:** GH set the vision for the results-based program, but the cognizant technical officer (CTO) team’s initial approach to problem resolution with the contractor was not helpful in finding ways to implement the vision. Coordination to facilitate results-based program achievements was also a new concept for USAID.
- **Varied USAID Agendas:** The GH program vision for BASICS II was not based on an explicit Agency child health policy/strategy and often was not shared by other USAID regional and Mission health officers. These officers required that BASICS meet its regional or country-level agendas and complained if BASICS was slow to agree. Many USAID health officers did not internalize the change in program vision from BASICS I to BASICS II and did not understand the new rigidity of program focus.
- **Timeframe:** USAID’s five-year contract period is very short for achieving and measuring changes in many public health indicators. The contract period, in many cases, did not coincide with the timing of USAID Mission strategies and their timetables for achieving/measuring impact.
- **Funding Levels and Earmarks:** The contract has a fixed ceiling so it was difficult to accommodate higher than planned levels of Mission demand. Unanticipated polio and malaria earmarks also had to be accommodated under the fixed ceiling. The latter earmark, along with anticipated micronutrient earmarks, was easily absorbed into BASICS II country programs. However, polio funds were difficult to absorb due to their magnitude and program implications, especially in Nigeria.
- **Performance-Based Contract:** Both the funding ceiling and performance standards have proven more difficult to change than under a cooperative agreement. The annual performance reviews have allowed USAID tight control, but have absorbed a great deal of BASICS II’s level of effort and management attention.

### **Other Factors**

- **Readiness to Expand Coverage:** Interviews with BASICS II, USAID, and other child health experts with field experience provided a list of essential factors that have not always been present in BASICS II countries and have hampered program expansion. Most of these factors are outside the direct management control of the contractor:
  - the technical intervention(s) has(ve) been tested and adapted to the satisfaction of the Ministry of Health (MOH),

- the MOH can provide strong program leadership and effective nationwide coordination,
  - a reasonably effective health structure is in place with trained staff,
  - adequate local cost funding is consistently available,
  - donor and international organization presence and donor cooperation is sufficient, and
  - there is a continuity of vision among the MOH and donors (willingness to continue).
- **Complementary Donor Funds Are Available:** Non-USAID donor funding for child health has gradually dwindled, even in Africa where child mortality and morbidity remains very high. USAID funds were limited, but the design assumed that other funding could be obtained from other donors and the private sector for major expansion efforts. Despite some BASICS II successes, this assumption has not been widely validated.
  - **Host Country Can Finance Local Costs:** Most MOH budgets remain stagnant and are allocated primarily for curative care and to pay salaries. Although child health interventions are relatively inexpensive, local cost funding is needed at the health post and clinic levels and to pay for supervisory visits to outlying villages where community-based programs need periodic monitoring and resupply. Health reform and government decentralization efforts offer new options for local cost financing.

## RECOMMENDATIONS

### BASICS II

- Finalize its GTL agenda and plan a response to concerns about the appropriate balance of resources in achieving GTL. Progress during the remainder of the project should be measured in accordance with this mutually agreed plan.
- Focus on achieving the desired balance between its GTL efforts and obtaining in-country investments by other partners. Achieving this balance will help both to expand child survival efforts to achieve impact and to assist in achieving sustainability.
- Reassess the scope, purpose, cost, and utility of SET. Develop a more focused role for SET.
- Assess the demand for and use of SET materials, including the effect of having such materials available only in English and French.
- Consider separating SET functions into two categories:

- country programs, which would emphasize replication of best practices within and outside the country; and
  - global leadership, which would emphasize the dissemination of lessons learned for technical and policy applications.
- Ensure that all possible resources (host country governments, other partners) are directed toward achieving sustainability in the areas in which BASICS II has been active in each country. BASICS II has only one more full planning cycle and should do its best to overcome the shortcomings in the planning process so as to leave a viable planning process in place for the successor project.
  - Continue the integration of c-IMCI and other community approaches in existing country programs, with emphasis in implementing an exit strategy to help ensure program sustainability when BASICS II support ends.
  - Work with partners in BASICS II countries to increase their support of c-IMCI.

## **USAID**

- Participating Missions need to be informed again about BASICS II contract requirements, especially when they conflict with Mission strategies.
- USAID should replace the performance indicator (4b) in the upcoming amendment to focus more on financial management.

In addition to these recommendations, the assessment team prepared comprehensive recommendations for the design team, as called for in the scope of work.