2001

CHILD SURVIVAL GRANTS PROGRAM REVIEW

November 30, 2001

Child Survival Technical Support Project

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Child Survival Grants Program Review is a publication of the Child Technical Support (CSTS) Project. CSTS is funded by the Office of Private and Voluntary Cooperation, Bureau of Humanitarian Response (BHR/PVC), of the United States Agency for International Development (USAID), under contract number FAO-C-00-98-00079-00, and is managed by ORC Macro. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of USAID. For further information on the Child Survival Technical Support Project please contact: ORC Macro, CSTS Project, 11785 Beltsville Drive Calverton, MD 20705; (301) 572-0823; e-mail csts@macroint.com; www.childsurvival.com.

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FOREWORD

This document represents a part of the ongoing efforts of the Child Survival Technical Support (CSTS) project to facilitate an understanding of the breadth and depth of the activities and achievements of the Child Survival grantees funded by the U.S. Agency for International Development (USAID), Bureau for Humanitarian Response (BHR), Office of Private and Voluntary Cooperation (PVC). It draws from a sample of grantee-produced documents, primarily final and midterm evaluations, for projects funded between 1996 and 2000 and seeks to describe the overall contributions of PVC's Child Survival Grants Program (CSGP) in the areas of specific technical health interventions, capacity development, monitoring and evaluation, and sustainability.

OVERVIEW AND CONTEXT

USAID/BHR/PVC's Child Survival Grants Program—A Historical Perspective

Since 1985, BHR/PVC has funded more than 300 grants with a total value of $294 million. As of November 2001, there are 71 projects in 35 countries implemented by 27 private and voluntary organizations (PVOs) that may have from one to eight child survival projects. Thirty-two of these projects are in the Africa Region, 18 are in Latin America and the Caribbean, 16 are in Asia/Near East, and four are in Europe/Eurasia. Grantees in PVC's current Child Survival Grants Program are responsible for managing projects that implement anywhere from two to eleven technical interventions through multiple local government, nongovernmental, or private partners.

The objective of the Grants Program is to improve the capacity of U.S.-based PVOs and their local partners to carry out effective child survival programs that measurably improve infant and child health and nutrition and contribute to the reduction of infant and child mortality.

Through resources, training, and technical assistance, the CSGP strengthens the ability and capacity of PVO staff to design, manage, and evaluate effective child survival activities; to fund and manage a child survival and health portfolio; to engage in long-term partnerships with local government, NGO, or community partners; and to disseminate information on the comparative advantages of PVOs for child survival and health activities. This program supports institutional strengthening of U.S. PVO field and headquarters operations, as well as those of their local partners, enhancing their capacity to reduce infant, child, and maternal mortality and morbidity.

Congress created the Child Survival Fund in 1985 to deal directly with the special health needs of children and mothers, stating that "Such activities should utilize simple, available technologies which can significantly reduce childhood mortality, such as improved and expanded immunization programs, oral rehydration to combat diarrheal diseases, and education programs aimed at improving nutrition and sanitation, and promoting child spacing."[1]

There were several reasons that PVOs figured prominently in this legislation. First, supporters of the initiative believed that "what was necessary to bring about a dramatic reduction of infant mortality rates was a broad-based social mobilization of the different sectors of society, including public and private organizations and local community members. PVOs were seen as one of the groups which could make a vital contribution to this mobilization."[2] Second, the initiative was to focus at a grassroots community level, "toward small-scale projects that directly help the poorest of the poor, rather than large-scale infrastructure projects far removed from benefiting these peoples."[3]

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[1] Congress, House. *International Security and Development Cooperation Act of 1984*, 98th Congress, H.R. 5119, as quoted in Grant, John P. "The U.S. Private and Voluntary Organizations (PVOs) and the Congressional Child Survival Initiative." Office of Private and Voluntary Cooperation, Bureau of Food for Peace and Voluntary Assistance, Agency for International Development: November, 1985.

[2] Grant, 1985.

[3] Senate Congressional Record, 10/02/84, S12731.

When the Grants Program began in 1985, each grant cycle was only three years long. Many of the PVOs receiving grants felt that a period of three years simply was not long enough to accomplish their goals. The first year was dedicated to startup and the second to gearing up project implementation and beginning service delivery activities. By the third year, as the project was ending, the interventions and activities had become more routine.[4] Beginning in 1996, PVOs could propose programs for up to four years. Responding to PVO suggestions, in FY 2001, the CSGP moved to five-year grants, allowing more time for the project approaches to become institutionalized and to reduce workload.

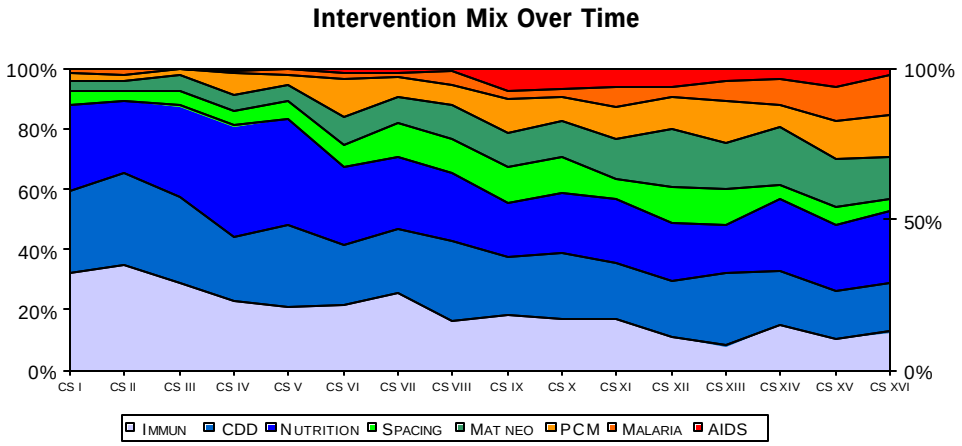
Since its inception in 1985, the Child Survival Grants Program has challenged PVO grantees and their local partners to build their organizational capacities not only in technical interventions but also in areas related to management, measurement, and sustainability. It is important to note the following:

When the Child Survival Grants Program first began, 90 percent of PVO effort went to immunization, control of diarrheal disease (CDD), and nutrition. Over the course of the past 15 years, however, the intervention mix has broadened to address other issues that are critically related to maternal and child health, including child spacing, acute respiratory infection (ARI), malaria, maternal and neonatal health, and prevention of HIV/AIDS and other sexually transmitted infections (STIs). The focus has also shifted away from treating individual diseases in isolation toward a more integrated approach to managing childhood illness.

By the sixth funded child survival (CS) cycle of programming, which began in 1990, the original trio of activities (CDD, nutrition, and immunization) had begun to take less precedence in the overall intervention mix. In 2000 the intervention mixes of CS XVI grantees showed that immunization, CDD, and nutrition accounted for only slightly more than 50 percent of the total child survival effort. The overall trends in intervention mix are outlined in figure 1 below.

At the same time that the overall intervention mix was broadening, the focus of the programs was moving from direct service delivery (with the grantee as the primary implementing organization) toward a partnership/capacity-building model in which the grantee organization builds the capacity of local institutions to deliver key project interventions. Since 1994, nearly all child survival projects have incorporated specific activities designed to build the capacity of local partners to improve the health status of their target populations.

[4] Pyle, 1989.



The role of monitoring and evaluation (M&E) has changed as well. Although it was at first seen as resource consuming and inconsistent, M&E came to be accepted as both a mechanism to improve project management and as a means to guide project activities. Within the first several years of the program, projects moved from having a dearth of monitoring activities and information to collecting huge amounts of baseline data. "A mountain of data was collected, and then six months to a year was required to analyze it."[5]

In light of the complex intervention mixes and focus on working through local partners, grantee approaches to monitoring and evaluation have also evolved to feature a range of quantitative and qualitative techniques. These techniques have allowed PVOs to measure and track a range of factors that affect the management and implementation of their programs. Although most CS grantees today continue to use the Knowledge, Practices, and Coverage (KPC) Survey to measure population-level changes, these measures are routinely reinforced or supplemented by data from participatory appraisal techniques, health facility assessments, organizational assessments, and quality assurance techniques.

Where Do the Child Survival Grantees Work?

Although the intervention mix and partnership focus of the program have evolved a great deal since its inception, the general sociocultural context in which CS grantees work has remained largely the same. PVOs participating in BHR/PVC's Child Survival Grants Program *are* working at a grassroots level, and they are doing so in some of the most challenging places in the world.

The University of Maryland's Center for International Development and Conflict Management recently published *Peace and Conflict 2001*, which rates the 160 largest countries in the world on their peace-building capacity and their ability to avoid destabilizing political crises. Only six out of 35 countries in which CS projects are presently operating were rated as showing a capacity for managing conflict. Fifteen countries were rated as in transition, "with a mix of positive and negative

[5] Pyle, David. *Inventing the Wheel: Lessons Learned in the Early PVO Child Survival Projects.* (Prepared for USAID/BFPVA/PVC under ICQ Contract number PDC-0262-I-00-7150-00, John Snow, Inc., 1989), 10.

factors that could push them into crisis and instability." Eleven were rated as having a "volative mix of high conflict risks and limited capacity to deal constructively with those risks."[6]

Even within countries, child survival projects tend to be located where health indicators are worst and the need is greatest. Graph II in the technical intervention section compares Demographic and Health Survey (DHS) results for whole countries to baseline survey results for areas in which there are child survival projects. In most cases, the child survival project area shows much lower immunization rates than the county as a whole—sometimes dramatically lower.

Examples of challenges from the CS XI and XII final evaluations include the following:

- **Political and economic instability in Cambodia**

  More than 40,000 families in the project district depend on farming and fishing for their livelihood and are vulnerable to frequent flooding and occasional droughts. Civil unrest, along with Khmer Rouge activities until as recently as two years ago, have created a sense of instability and have caused an interruption in project activities for three months and caused the local USAID mission to curtail activities. This comes in addition to the social and personal trauma caused by the 30 years of civil war, which presents real obstacles to community mobilization and capacity-building.[7]

- **Environmental challenges in Nicaragua**

  Tropical jungle, river travel, long distances, and at least six months of rainy season complicated access to the communities. All of the promoters who worked in rural areas had to walk five hours or more to some communities during the tropical rainy season.[8]

- **Political, economic, and geographic difficulties in Indonesia**

  In Indonesia, the economic crisis that started in July 1997 resulted in a sudden decline of the value of the Indonesian rupiah against the US dollar, causing transportation costs to soar. Since the fall of Suharto on May 21, 1999, there have been signs of political instability, including what the final evaluator called a "movement of disintegration" in different parts of the country. Project midwives were stationed in areas that required 13- to 82-hour treks to the nearest public health center.[9]

The foreword to CARE/Mozambique's final evaluation illustrates how difficult environments and the changing focus of the Grants Program can challenge even the most experienced PVOs:

> CARE/Mozambique was in transition from doing only emergency relief to implementing development programs. Lack of qualified administrative staff and the geographic spread in a country with such limited infrastructure led to slow development of efficient administration systems.

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[6] Gurr, Ted Robert, Monty G. Marshall, and Deepa Khosla. *Peace and Conflict 2001: A Global Survey of Armed Conflicts, Self-Determination Movement, and Democracy*. (College Park: Center for International Development and Conflict Management, University of Maryland, 2000), 22.

[7] World Vision/Cambodia, CS XII Final Evaluation, December 2000.

[8] World Relief/Nicaragua, CS XII Final Evaluation, December 2000.

[9] Project Concern International/Indonesia, CS XI Final Evaluation, December 2000.

Perhaps the most serious of the challenges to implementing a child survival project in Mozambique was the relationship with the provincial health directorate (DPS). Due to years of foreign paternalism during the war and afterward, the DPS expects international agencies to give them resources, not skills. They demand cash, buildings, equipment, and personnel. Even though they were involved in project design discussions, they still had these expectations of the project. They blocked project activities in an attempt to pressure the PVOs to use the funding for material resources.[10]

[10] CARE/Mozambique, CS XII Final Evaluation, December 2000.

HIGHLIGHTS OF KEY FINDINGS

In general, the strengths of the PVC-funded PVOs continues to lie in mobilizing communities, local partners, and local health authorities to address pressing public health needs. Increasingly, PVOs are demonstrating a unique ability to build capacity in their local partners to sustain health benefits beyond the life of the project. The key findings of this program review are summarized below. Each is discussed in further detail later in this report.

- Important gains are evident in all technical health interventions addressed by Child Survival grantees. Comparisons of baseline and final evaluation data demonstrate significant increases in childhood immunization, maternal tetanus immunization, and exclusive breastfeeding.

- In countries that have recently conducted Demographic and Health Surveys and where PVC-funded PVOs are also implementing immunization activities, a comparison of data suggests that PVO programs are having a major effect. PVOs tend to implement projects in areas where immunization coverage is significantly lower than the national average and then tend to raise immunization coverage to levels that are higher than the national average by the end of the project.

- A further analysis of immunization data suggests that PVO efforts in this intervention alone lead to as many as 200 childhood measles deaths averted per year.

- The Child Survival Grants Program itself continues to build the capacity of PVO grantees and their local partners in the areas of program planning, monitoring and evaluation, and technical excellence. This is evident through the following:

  - ✓ Increased use of data triangulated from multiple data sources, including Knowledge, Practices, and Coverage Surveys; Health Facility Assessments (HFAs); qualitative techniques such as focus group discussions and PLA techniques; and Organizational Capacity Assessments.

  - ✓ PVO adaptation of PVC's program guidelines to projects implemented for other donors and in other areas of development.

  - ✓ PVO adaptation of tools developed for the Child Survival grantees to other settings. For example, the KPC tool has been used as a baseline tool for other donors, including USAID-funded food aid programs. The Institutional Strengths Assessment Tool has been adapted to the PVO country office level. PVC's Technical Reference Materials have been developed into a Web-based learning tool by Project HOPE, and this tool is slated to be shared with the larger CS community in the near future.

- There is evidence that PVC-funded PVOs are developing the capacities of their own organizations and their local partners in areas that extend beyond the technical health interventions in which they are working, including management practices and governance, human and financial resource management, administrative infrastructure and procedures, and organizational learning.

- PVOs are increasingly using participatory approaches to evaluation that include local partners and communities in the decisionmaking processes that drive the focus of the program. This is an important trend as PVOs move from the role of direct-service providers to a facilitative role in which they build the capacity of local partners and communities to implement health services.

- CS grantees are playing an increasingly important role in supporting decentralized health systems and helping build the capacities of those systems to provide health services in regions that have traditionally had little or no health infrastructure.

- Projects that have been reviewed have developed many conditions, mechanisms, capacities, and linkages that are not only supportive of but also necessary for sustainability. The effort going into these elements certainly increase the prospect that many of the projects' achievements will be maintained. Across the Child Survival portfolio, there is evidence of critical and strategic thinking about sustainability factors related to the following:

  - ✓ Achieving progress on crucial health conditions and community-based health care services

  - ✓ Implementing intervention approaches (appropriate technologies, partnership, leadership building, community participation)

  - ✓ Building local capacity (technical skills, management skills, functionality of community associations, management of health district operations)

  - ✓ Increasing the long-term viability of community associations and the relationships between key local stakeholders (thus increasing the prospect that flexible adjustments can be made with time in order to sustain intervention components) in developing public-private partnerships

  - ✓ Increasing community support for health workers at the cultural and organizational level, in increasing the ownership and institutionalization of more effective supervision and quality of care with health districts and in demonstrating increased client satisfaction for services

  - ✓ Advocating policy change, and in linking health intervention with environmental and agricultural interventions.

PVC grantees today are well positioned to focus on the unfinished agenda of improving child health globally. They have played a key role in defining a framework for household and community Integrated Management of Childhood Illnesses (IMCI) and can place emphasis on promoting household behaviors not dependent on the performance of health systems, while building the capacity of the formal health system to better reach underserved populations.

Recommendations for further strengthening PVO Child Survival projects and the overall Grants Program are included in the last chapter of this document.

METHODOLOGY

Several types of documents were analyzed for this program review, including final evaluations, midterm evaluations, detailed implementation plans (DIPs), and applications written in response to the CSGP FY 2001 request for applications (RFA).

As mentioned in the introduction, the current Child Survival Grants Program portfolio consists of 71 projects in 35 countries, which are implemented by 27 PVOs. The approach we have taken to this review is to look at the most current key documents across the program, although this means that not every document for each of the 71 projects came under review.

Each section in this analysis draws on a slightly different set of resources and project documents, which together provide an overall view of the CSGP. Within each section is a detailed description of how the documents were used in preparing this document. Below is a summary of the documents reviewed:

Technical Section

- Seventeen final evaluations from CS XI, XII, and XIII
- Child Survival Collaborations and Resources Group (CORE) Nutrition Working Group (WG) review of nutrition behavior interventions to improve child nutrition.

Monitoring and Evaluation Section

Each of the documents listed below were completed in 2000.

- Five CS XI final evaluations
- Eleven CS XII final evaluations
- One CS XIII final evaluation
- Eight CS XIII third annual reports
- Seventeen CS XIV midterm evaluations
- Nine CS XV first annual reports.

Capacity Building and Sustainability Sections

- Sixteen final evaluations for CS XI grantees
- Twelve final evaluations for CS XII grantees
- One final evaluation for CS XIII grantees
- CS XIV midterm evaluations
- Nineteen CS XV DIPs
- CS XVI funded applications.

CSTS used the Crucial Child Survival Interventions checklist (otherwise known as the "SOTA Checklist") for the nine CS technical intervention areas. A capacity-building matrix was used to capture the levels and areas where projects reported strengthening capacity. In addition to using these tools, reviewers also analyzed the KPC indicators at the baseline and final surveys to construct the performance index.

One of the potential weaknesses of this approach to reviewing the CSGP portfolio is its total dependence on the content of evaluation and other documents for an accounting of the strengths and weaknesses of the program. At times, this can result in an incomplete view of the issues, particularly for process aspects of the program.

Although the evaluation guidelines have evolved to include discussion of additional aspects of the programs under review, many of the evaluations still do not paint a complete picture. Whereas most evaluations included substantial quantitative information, very few reports included sufficient qualitative information to allow a full understanding of the dynamics of the project. Some reports briefly mention innovative ideas or promising practices, but frequently there is no followup information about how these ideas were implemented, what effect they have had on the project, or whether the idea might be useful in other areas. Overall, there is very little information that can be used to transfer learning from project to project within the Grants Program.

This program review is based on information found in annual reports and final and midterm evaluations finished in 2000-2001. Because project documents are of varying quality, this information may at times be incomplete.

TECHNICAL INTERVENTIONS

As discussed earlier in this review, the intervention mix of programs has shifted since the inception of the CS Grants Program. In the initial years, about 90 percent of the effort went to immunization, nutrition, and control of diarrheal diseases. In recent years, these three interventions still account for about 50 percent of the total effort, but other interventions such as maternal and newborn care (up to about 20 percent), malaria, and pneumonia case management (together, 25 percent of the effort) have taken on more importance (see the graph in the Overview and Context section of this report).

The projects under review for this year's program review are a mix of CSGP XI, XII, and XIII. The intervention mix of these projects is as follows: nutrition, 24 percent; control of diarrheal disease, 23 percent; maternal and newborn care (MNC), 17 percent; immunization, 13 percent; child spacing and pneumonia case management (PCM), both 8percent; HIV/AIDS, 4percent; and malaria, 3 percent.

As part of the program review, CSTS reviewed 17 final evaluation reports for CSGP projects. The child survival technical interventions of the PVOs were assessed according to the State of the Art Interventions (SOTA) checklist, which is included in each section. This section uses information from the review of final evaluations to outline where the Child Survival Grants Program stands in relation to the technical intervention areas.

The SOTA checklist used in this assessment reflects the suggestions made in the most recent Technical Reference Materials that accompany the DIP guidelines. By listing the most crucial components of any given intervention, the checklist provides a standard for determining the strengths and weaknesses in the CS portfolio. It is not necessary or suggested that a PVO take on all potential components of each technical intervention, but a proposal, DIP, or other project document will be more complete when it clearly indicates why certain components are or are not part of the PVO's approach to the intervention.

Example of the checklist: Behavior Change Communication (BCC) activities

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
14	BCC—general BCC strategies
3	Social marketing—marketing techniques for promoting social/health norms
14	Interpersonal communication—from professional/community health workers (CHWs) to mothers
5	Support group—breastfeeding (BF) support group, young mother support group, etc.
5	Media audiovisual (radio, TV)
7	Peer communication—mother to mother, child to child, peer educators
9	Social mobilization—wide range of community mobilization and diverse media
4	Traditional media—Song, theater, griots, storytelling, etc.

There was considerable variation among the PVOs and programs under review. Some of the PVOs implementing programs had very large health programming units, while others were relatively small. CS programs differed in approaches as well as in the populations targeted. Some PVOs appeared to be technically stronger than others; however, it was noted that there was substantial variation among

projects (sites) of the same PVO. PVOs that focused their activities on or specialized in one or a few technical areas were generally strongest in those areas. PVOs tended to score lower in the more complex technical areas such as nutrition and immunization, where multiple SOTA technical interventions are possible. Technical areas that had less than 10 percent of the allocated effort were excluded from the analysis because they were deemed to have too little effort dedicated to the intervention to be reviewed.

Nine project intervention areas were reviewed for this analysis. The areas include immunization; nutrition, including micronutrients, vitamin A, and breastfeeding; control of diarrheal disease; acute respiratory infections and pneumonia case management; malaria; maternal and newborn care; child spacing; STI, HIV, and AIDS; and the Integrated Management of Childhood Illnesses strategy.

Nineteen projects had final evaluations due in the year 2000: five from projects in cycle XI, 12 from cycle XII, and two from cycle XIII. Seventeen projects submitted their final evaluation reports in time to be included in this analysis.

Immunization

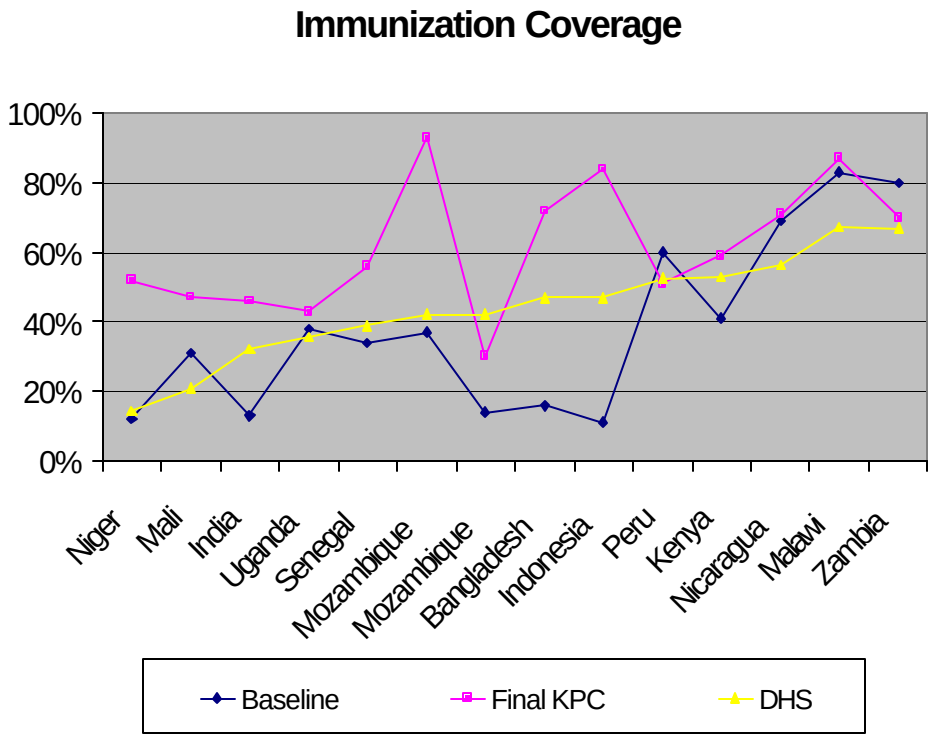
Final Evaluation Review Results

An analysis of the final evaluations of projects that ended in 2000 shows that 16 of the 19 PVOs were involved in some type of immunization activity. Of the 17 PVO projects under review, nine spent 10 percent or more of their effort on immunization. Almost all of these PVOs increased coverage in their intervention areas, some exceeding 90 percent coverage for children completely immunized before 12 months of age. In areas where coverage goals were not reached or dropped below the baseline, the cause was usually outside of the PVO's control, such as a vaccine shortage in the country. PVOs excel in community-based behavioral-change approaches and social mobilization, involving the community or community members in efforts to increase coverage, and are able to create or increase demand for services. As illustrated in the BCC example checklist above, 14 of the 17 projects reported using interpersonal communication for behavior change, and nine reported on social-mobilization efforts.

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
10	Immunization general
10	Coverage—promote activities to increase coverage of the "classic six" and according to national policy, the "new" vaccines (Hep. B, Hib.)
0	Missed opportunities—introduction or strengthening of approaches to reduce "missed opportunities" (integrated in other programs such as in IMCI or in community-based activities such as *Commerce Business Daily* [CBD]), introduction or strengthening of approach to reach the "difficult to reach"
3	Cold chain—cold chain monitoring and strengthening, including the use of Vaccine Vial Monitors (VVMs)
0	Injection safety—activities to ensure injection safety (autodestruct syringes, disposal of sharps)
1	New vaccines—introduction of "new" vaccines (Hep. B, Hib.)
3	Vitamin A with immunization—inclusion of vitamin A distribution into the Expanded Program on Immunization (EPI) activities

Number of PVOs	"Criteria" or "Standard"
3	Polio eradication—participate in polio eradication activities (for example, national immunization days [NIDs], acute flaccid paralysis [AFP] surveillance)
0	Surveillance (participation)—participation in surveillance activities (AFP and other).
0	Coordination (interagency) multiyear plan—participate in Interagency Coordination Committee (ICC) or equivalent collaboration mechanism or participate in development of a multiyear plan for immunization partnership has gone
0	Assessment of services—participate in or conduct assessment of immunization services

We compared baseline and final evaluation data gathered by the PVOs with comparable statistics from the most recent Demographic and Health Survey in countries where PVOs have implemented immunization activities. The chosen indicator is the proportion of children one year of age fully immunized before their first birthday. From the graph presented below, we can conclude that PVOs have the greatest effect when they target areas where coverage is low. PVOs have also most often targeted the areas where immunization coverage was under the national average and have in general been able to increase the coverage above the national average (DHS data). Their effect is the highest



in areas where the need is the greatest (for example, national coverage below 50 percent).

Discussion

From the final evaluation reports it was not always clear that immunization activities were based on a comprehensive assessment of immunization services in the country or intervention area. It is not clear whether the PVOs were involved in ensuring vaccine quality. Although it is apparent that the PVOs under review contributed substantially to higher levels of immunization coverage, it is the

conclusion of this report that the interventions could have been strengthened by additional support to ensure safe injection practices and better monitoring of the cold chain. This would have resulted in ensuring or improving the quality of immunization services.

No PVOs adopted a comprehensive approach to immunization. An analysis of the final evaluations shows that few PVOs promoted the inclusion of vitamin A distribution in EPI activities or participated in polio eradication activities (for example, national immunization days and acute flaccid paralysis surveillance). In fact, from the review of the final evaluations, there was no evidence that any of the PVOs participated in surveillance activities (AFP or other). For PVOs to become major players in the immunization field at the national level and gain respect at the international level, they will need to participate in the Interagency Coordination Committee or an equivalent collaboration mechanism. PVOs and countries would benefit if PVOs participated in the development of multiyear district, regional, or national plans for immunization.

Although it is generally accepted that child immunization is one of the most cost-effective public health interventions for reducing child morbidity and mortality, we see that over the life of the CSGP, PVOs have become less involved in immunization activities. The combined level of effort (LOE) spent by PVOs on immunization-related activities has shrunk by more than half over the past 15 years. Whereas during the late 80s almost all PVOs included immunization activities, in the late 90s, only about half of the PVO grantees have. At the same time, immunization coverage has declined worldwide. (In many sub-Saharan countries, coverage is currently less than 50 percent.)

Where PVOs have opted to support immunization, coverage rates have generally increased, and in some intervention areas, rates have more than doubled. The strength of PVOs lies in 1) harnessing community involvement and participation to increase immunization coverage and 2) introducing or strengthening efforts to reach the difficult to reach.

Potential Impact

The average child survival project targets 110,000 children and women of childbearing age. Of those 110,000 people, 10,000 are children under one year of age—the target population for childhood immunization programs. From the graph above we know that baseline coverage in many project areas is below 20 percent. Assuming conservatively that the average project works in an area where child immunization coverage is 50 percent, the 30 percent gap closure discussed in the Monitoring and Evaluation section would mean an extra 15 percent or 1,500 children (10,000 x 0.5 x 0.3) completely immunized yearly in such a project area. This means, among other things, that fewer children would get measles. Thus, since measles in the target countries can have a case fatality of 15 percent and higher, thanks to PVO interventions in the project area, approximately 200 measles deaths are averted yearly.

Assuming worse conditions and targeting interventions in districts where the baseline immunization coverage is 30 percent, the same gap closure of 30 percent and a case fatality of 20 percent (documented in northern Nigeria) would contribute to more than 300 measles deaths being averted.

Areas for Support

Since the start of the CSGP, there has been a steady decrease in the percentage of the total budget that child survival projects spend on immunization activities. As discussed earlier, this is linked to an increase in effort dedicated to other activities, such as maternal and newborn care, malaria, and pneumonia case management. During past annual CORE meetings, little time was devoted to immunization activities not related to polio eradication, and immunization does not have its own working group.

Some major areas that are not always addressed in child survival project documentation and thus may be strengthened are the following:

- Cold chain monitoring and strengthening, including the use of Vaccine Vial Monitors
- Activities to ensure injection safety (sterilization, autodestruct syringes, disposal of sharps)
- Participation in surveillance activities (measles, AFP, and other illnesses)
- Introduction of approaches to reduce "missed opportunities"—incorporated into IMCI or community-level activities such as community-based distribution
- New approaches to bring about increased tetanus toxoid (TT) coverage
- Introduction or promotion of new vaccines (Hepatitis B, Hib.).

Nutrition, Micronutrients, Vitamin A, and Breastfeeding

In addition to reviewing project final evaluations for the nutrition component of this analysis, we also looked at a CORE-sponsored paper on PVO nutrition behavior interventions to improve child nutrition. The CORE Nutrition Working Group included this review in its 1999-2000 work plan. The CORE Nutrition WG and the CSTS project agreed to collaborate on this review, with CSTS providing the funding for a consultant to conduct the review. All CORE Group member organizations were asked to describe one or more behavior-change interventions implemented by their organization to improve child nutrition. Therefore, this review was not an inventory, and it was not a representative sample of the nutrition behavior-change interventions implemented by PVOs. However, because the PVOs themselves selected the projects to be reviewed, it is likely that they selected from among their best projects and projects that interviewed staff knew well. Twenty-two managers from 22 organizations were interviewed concerning 30 projects.

Nutrition WG Study Findings

Coverage

Coverage ranged from 240 to 70,000 children, from 16 to 400 communities, and from two cities (Bangladesh) to entire countries (Haiti and Pakistan).

Care Practices and Targeted Behaviors

Nineteen out of 30 projects aimed to change breastfeeding practices. Fifteen of the 19 breastfeeding projects aimed to increase exclusive breastfeeding. Of the 15 projects that targeted exclusive breastfeeding for behavior change, 10 of them did not specify exclusive breastfeeding until about six months of age. Of the 11 projects that targeted early initiation of breastfeeding, none specified breastfeeding in the first hour after birth.

Sixteen out of 30 projects aimed to change child feeding practices other than breastfeeding, most of them, complementary feeding practices (13 out of 16). Four projects targeted frequency of feeding, although none specified the number of times a day according to age that the child should be fed.

Fifteen out of 30 projects aimed to change consumption of specific foods or food groups or dietary diversity (the number of different foods consumed). These foods included oil (six projects, of which five were in Africa), foods rich in vitamin A, iron-rich foods, iodized salt, and animal food sources.

Of the 10 projects that targeted feeding during illness, eight out of 10 only mentioned diarrhea, not all child illnesses.

Only two projects explicitly stated that changing maternal-child interactions were part of their behavior-change interventions.

Interventions and Delivery Systems

Twenty out of 30 projects used multiple intervention types or delivery systems to change behavior, for example, peer counseling and women's or community groups. Multiple delivery systems were used most often in Asia (all six projects), followed by Latin America (nine out of 13 projects) and Africa (five out of 11).

Women's or community groups were the most common delivery system. Twenty-five out of 30 projects used women's or community groups, 14 out of 30 projects used peer counseling, 13 out of 30 projects used health worker training, and seven out of 30 projects used mass media. Only one project in Africa used mass media.

Five out of 30 projects were Hearth projects using a combination of peer counseling and women's groups.

Two projects in Nicaragua and Honduras compared the effectiveness of health worker training and women's support groups for changing breastfeeding practices. Both projects found that while both health workers and breastfeeding groups had a positive effect on breastfeeding practices, health worker training had a greater effect on changing breastfeeding practices than women's groups.

Evaluation of Outcomes

Thirteen out of 17 projects reported only positive behavior changes. Four out of 17 projects reported mixed changes or no change.

All projects evaluated outcomes based on behavior change. In addition, eight out of 17 projects evaluated outcomes based on an anthropometric indicator such as weight-for-age.

Four Hearth interventions, in Haiti, Guinea, Mozambique, and Vietnam, which used child weight-for-age for evaluation of effect on nutritional status, showed that the intervention still had a positive effect on child growth one to three years after program participation.

Two breastfeeding projects, in Honduras and Nicaragua, also used child weight-for-age to evaluate outcome. Only one project, in Ghana, used a comparison group to evaluate the project.

Final Evaluation Review Results

Ten of the 17 PVOs whose final evaluations were reviewed spent 10 percent or more of their effort on nutrition-related activities. About one fourth of the total effort of all projects combined was spent on nutrition activities, which is one of the technical areas with the greatest number of possible interventions. The PVOs that spent more effort on nutrition tended to include a wider range of interventions.

Nutrition

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
7	Nutrition—general
0	Minpack—introduction of the minimum package of nutrition activities
1	Sick child—nutritional management of the sick child
0	Foodbox for IMCI—participation in the development or promotion of the nutrition toolbox of the IMCI material
3	Iron—promote or introduce innovative approaches to increase iron intake (compliance, supply, counseling) by pregnant and postpartum women
4	Iodine—promote the consumption of iodized salt and/or innovative approaches to iodine supplementation
6	Growth monitoring and Hearth—introduction, promotion, or scaling up of the Hearth nutrition model or introduction and documentation of innovative ways to introduce or promote rational growth-monitoring programs that not only identify "problem children" but include corrective actions.
Vitamin A	
10	Vitamin A—general
4	Women—promote and or introduce vitamin A supplementation for pregnant women or supplementation within the first eight weeks postpartum
7	Well child—promote or introduce regular (every four to six months) vitamin A distribution (as part of EPI, polio eradication effort, CBD, growth monitoring, or any other known or innovative program)
2	Sick child—promote or introduce supplementation with vitamin A into treatment protocols of targeted diseases such as measles
5	Vitamin A and gardens—promote or introduce gardening and consumption of foods rich in vitamin A
Breastfeeding and weaning	
8	Breastfeeding—general
7	Exclusive—introduce and or promote exclusive breastfeeding for up to six months, including the initiation of breastfeeding during the first hour postpartum, the "utilization" of colostrum, and on-demand feeding
2	Support groups—introduce or promote breastfeeding support groups

Number of PVOs	"Criteria" or "Standard"
0	Techniques—train health workers in the skills necessary to support breastfeeding mothers
0	Baby friendly—support the baby-friendly hospital initiative, take appropriate steps to change hospital policy and practices in accordance with the "ten steps for successful breastfeeding"
0	HIV prevalence situation—introduced a practical approach to breastfeeding in a high HIV/AIDS prevalence situation
0	LAM (lactational amenorrhea method)—introduced or promoted LAM
1	Complementary feeding—appropriate complementary feeding from 6 months and continued breastfeeding until 24 months
1	Promote BF to 24 months—promote breastfeeding up to 24 months
0	Weaning foods less than six months—develop or promote utilization of appropriate weaning foods for children six months of age

PVOs adopted the promotion of breastfeeding and vitamin A supplementation almost universally as a strategy to improve infant nutrition. Most PVOs adopted exclusive breastfeeding up to six months as a standard indicator or objective.

There are still few PVOs working at the health facility or hospital level, and none was involved in supporting the baby-friendly hospital initiative or training of health workers in the skills necessary to support breastfeeding mothers. Instead, the focus was on the community. PVOs have trained community workers and traditional birth attendants (TBAs), who can play a crucial role in promoting immediate and exclusive breastfeeding.

Ten PVOs sought to promote vitamin A status in children, mostly through supplementation, but half of them promoted cultivation and consumption of vitamin-A-rich foods. Only four PVOs promoted vitamin A distribution to mothers in the first weeks after delivery, and two incorporated vitamin A in treatment protocols for sick children. Likewise, only four PVOs promoted the use of iodized salt, and there is little evidence that PVOs actively participated in the promotion of adequate nutritional management of the sick child or the development and promotion of the nutrition "foodbox" of the IMCI material.

The strength of the PVOs lies in working with the community in promoting growth monitoring. Some have spearheaded cost-effective, community-based nutritional rehabilitation methods such as the Hearth method.

In only three final evaluations under review was there evidence that the PVO promoted or introduced innovative approaches to increase iron intake by pregnant and postpartum women.

Discussion

It is widely accepted that malnutrition contributes to more than half of all under-five deaths. In CS grants, nutrition has received a consistently high level of effort. However, as with immunization, few PVOs take a comprehensive approach to nutrition or introduce a minimum package of interventions for addressing the problem of malnutrition.

Areas for Support

The PVO community has three main foci for nutrition: 1) promoting breastfeeding, 2) promoting increased vitamin A intake (by supporting vitamin A supplementation and consumption of vitamin-A-rich foods), and 3) growth monitoring. With the rise of HIV/AIDS, there is an urgent need for PVOs to address breastfeeding in high HIV/AIDS prevalence situations.

Few PVOs promote vitamin A supplementation during pregnancy, during the early postpartum period, or as part of the treatment protocols of sick children (for example, when the child has measles). Whereas several PVOs now participate in promoting micronutrients other than vitamin A and promote the use of iodized salt, only a few PVOs promote iron consumption.

However, one PVO was outstanding and innovative in promoting iron consumption. Project HOPE was involved in microenterprises for local fortification of cocoa with iron (see the story below).

HOPE Peru
Cocoa fortified with heme iron
An effective strategy for combating iron-deficiency anemia

HOPE Peru's Child Survival XII project implemented in the rural Amazon basin encountered a high level of anemia in women and children during the baseline study in 1997. The prevalence was 56 percent in children under three and 33 percent in women of reproductive age.

Because the main cause of anemia is iron deficiency, the findings spurred the project to find a way to increase the availability and consumption of iron. After researching various possibilities, the staff selected a fortified food offering a low-cost, acceptable source of micronutrients for vulnerable families: cocoa.

The final product was developed in four steps: formulation, acceptability testing, effectiveness testing, and marketing.

Formulation: The first step was to identify a locally available product that was compatible with fortification. After examining plantain flour, cocoa was selected as the vehicle. A document review of fortification indicated that the most acceptable and available product to provide iron would be Ferrimin, a cow's blood source of protein and iron produced in Chile. Ferrimin provides a source of iron that is easy for the body to absorb and use.

Laboratory and cost studies evaluated physical characteristics of products that offered approximately 150 percent of the daily requirement of a child at an affordable cost. Studies were done for cocoa, plantain flour, and fudge. The resulting product, fortified cocoa, consisted of 25 percent Ferrimin and 75 percent locally grown cocoa.

Acceptability: The formula underwent acceptability studies in four different products: cocoa mixed with water, mixed with milk, thickened with banana flour, and fudge. Men, women, and children took part in taste tests in both urban and rural areas. Fortified cocoa-flavored milk had an overall acceptability rate of 87 percent.

Effectiveness: Students from the University Peruana Cayetano Heredia carried out four studies in the project area on the effectiveness of the product in reducing anemia. A summary of the studies shows a high level of recuperation from anemia in various population groups.

A. Quijano	K. Alarcón	L. Diaz	B. Casanova
56% in 30 days	50% in 56 days	63% in 56 days	100% in 28 days
Schoolchildren	Adults—both sexes	Adults—both sexes	Women >14 years
With antiparasite	With antiparasite	With antiparasite	

Researchers concluded that cocoa fortified with Ferrimin had a high level of efficacy—greater than a 50 percent rate of recuperation of anemia with 1 to 2 months of treatment. It is recommended that for use in treating iron-deficiency anemia, the cocoa be used in conjunction with an antiparasite drug, particularly in rural tropical areas.

Marketing: The project developed a package of technical information on fortified cocoa that was made available at no cost to small-business entrepreneurs on the efficacy and merits of the product. Fortified cocoa is now available on the local market with limited distribution. The project continues with the challenge of acting as intermediary to encourage the production and distribution to a wider market, particularly those most affected by malnutrition.
For more information on Project HOPE's CSXII project in Peru, please contact:
Luis Benavente, M.D., M.Sc., Associate Director MCH (lbenavente@projecthope.org)

Control of Diarrheal Disease

Final Evaluation Review Results

Fourteen of the projects reviewed spent 10 percent or more of their effort on the control of diarrheal diseases. Almost all (12) of them reported promoting the use of appropriate oral rehydration and appropriate feeding practices during diarrheal episodes. Six promoted the proper recognition and care-seeking for serious cases (dehydration, dysentery, chronic/persistent diarrhea) at the household level. Only four promoted proven activities to decrease the incidence of diarrheal diseases (prevention), for example, the promotion of appropriate hand-washing practices. Two promoted proper case management and counseling for diarrheal diseases by health workers at all levels.

CDD

Number. Of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
13	CDD—General—reference to diarrhea and control of diarrheal disease not specified below
4	Prevention—promote or introduce proven activities to decrease the incidence of diarrheal diseases (prevention), for example, the promotion of appropriate hand-washing practices
12	Oral rehydration salts (ORS)—promote or introduce the early use of ORS and or the use of appropriate home-based fluids in case of diarrhea
12	Feeding—promote or introduce appropriate feeding practices (continuation of breastfeeding, frequent small feedings, catchup feeding) in case of diarrhea
6	Care-seeking—promote or introduce proper recognition and care-seeking for serious cases (dehydration, dysentery, chronic/persistent diarrhea) at the household level
2	Case management—promote or introduce proper case management and counseling for diarrheal diseases by health workers at all levels

Discussion

It is estimated that in developing countries more than two million children die yearly from diarrheal diseases. Interventions to reduce this cause-specific mortality are usually "low tech," for example, community-based interventions to promote the use of ORS. Therefore, control of diarrheal disease has always been a popular intervention among PVOs. In recent years, however, PVOs have become more active in intervention areas other than the classic three (immunization, nutrition, and diarrheal diseases). Although most PVOs are still involved in diarrheal-disease control programs, the level of effort has steadily decreased from about 30 percent to 15 percent.

PVOs have certainly contributed to a reduction in child diarrheal-disease mortality by promoting oral rehydration therapy (ORT) for the prevention and treatment of dehydration caused by acute watery diarrhea. As mortality from acute watery diarrhea is reduced, the relative importance of child diarrheal-disease mortality attributable to dysentery and persistent diarrhea will increase. Oral rehydration therapy alone will not have an impact on mortality from dysentery or persistent diarrhea, for which more comprehensive case management strategies (for example, IMCI) are needed.

To achieve a reduction in the incidence of diarrhea, more attention to primary prevention is needed. Several interventions have been demonstrated to be effective and are components of an integrated approach to child health.

Areas for Support

Most PVOs have directed their efforts toward the promotion of early use of ORS or appropriate recommended home fluids to treat or prevent dehydration caused by diarrhea and the promotion of appropriate feeding practices during and after diarrheal episodes. Few PVOs have taken on the challenge of introducing comprehensive activities to decrease the incidence of diarrheal disease (prevention). Many promote prevention through better feeding practices, such as exclusive breastfeeding, and measles immunization, but few promote key hygienic behaviors such as proper disposal of feces and appropriate hand-washing practices.

It is hoped and expected that as more PVOs actively involve themselves in the IMCI strategy, they will become more involved in prevention of, promotion of, proper recognition of, and care-seeking for serious diarrheal cases (dehydration, dysentery, chronic/persistent diarrhea) at the household level. PVOs could also play a greater role in promoting proper case management and counseling for diarrheal diseases by health workers at all levels.

Acute Respiratory Infections and Pneumonia Case Management

Final Evaluation Review Results

Only seven of the 14 PVOs reviewed spent at least 10 percent of their effort on improving pneumonia case management. All of them included community actions among their activities to improve care-seeking behavior of mothers with sick children. PVOs also contributed to improving the quality of care children received from health care providers.

Pneumonia

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
7	PCM—general—reference to pneumonia and pneumonia case management not specified below
5	Quality—appropriate assessment, classification, treatment (and/or referral), and counseling; PCM should also include supervision of trained health workers and ensure an adequate supply of antibiotics
5	Access—ensure that the target population has proper access to the provider (for example, one hour travel max)
7	Demand—proper care-seeking behavior, including early recognition of danger signs, compliance with prescribed treatment, and knowledge of location of provider

Discussion

Pneumonia case management has increased in interest over time and now gets about the same attention as control of diarrheal disease.

However, in settings where malaria is a public health problem, pneumonia-specific interventions should be promoted only where IMCI has not been introduced. With the advent of IMCI, PCM should become part of that strategy.

Malaria

Final Evaluation Review Results

Only three PVOs included malaria as one of their priority interventions. All three promoted the use of insecticide-treated bednets, and two included the provision of quality care of children with fever. Only one included malaria treatment and prevention in the antenatal care program in its intervention area.

Malaria

Number. of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
3	Malaria—general
2	Case management—improve malaria recognition and appropriate case management in infants
0	Drug resistance—drug resistance is addressed (this is an integrated part of the adaptation process of the "generic" IMCI algorithms to the national conditions)
0	Nutrition—case management includes nutritional interventions to address anemia and provide for micronutrients such as iron/folate
1	Pregnancy—improve malaria prevention and appropriate treatment in pregnant women
3	Bednets—promote the appropriate communitywide (especially children and pregnant women) use of insecticide-treated mosquito nets including a provision for regular re-treatment of the nets

At the end of 1999, 20 of the 75 projects that were active at that time had activities aimed at reducing mortality and morbidity caused by malaria. Those 20 projects spent on average 23 percent (from 10 to 35 percent of their LOE) on malaria activities. Seven of the 20 projects promoted the use of bednets. Those projects spent on average 30 percent of their LOE on malaria-related activities. Of the 72 currently active projects, 28 have malaria-related interventions. Projects allocate from 5 to 100 percent of their effort to malaria, averaging 26 percent. Nineteen active projects currently promote the use of bednets and spend on average 30 percent of their LOE on malaria. Whereas several projects implement net activities on a pilot basis—in some cases in only a few villages—one project focuses all its efforts on the promotion of bednet use and (re-)treatment with insecticides and has a countrywide focus.

It is not yet known how sustainable these bednet interventions are, especially the re-treatment aspect. However, as more PVOs promote the appropriate use of insecticide-treated bednets by

women and children, the experience gained and lessons learned through partnering with the private sector and the incorporation of microenterprise elements will be beneficial.

Discussion

Malaria, still a major cause of death among infants and young children, typically received little attention up to CS X. This has changed in the more recent cohort. PVOs implementing current child survival projects are now committed to the Roll Back Malaria effort. The reviewed projects (final evaluations) are thus not representative.

Integrated Management of Childhood Illnesses

The technical areas discussed above can best be dealt with in the context of IMCI. Malaria, pneumonia case management, and diarrheal-disease control will most likely be absorbed into the IMCI strategy in the near future. However, IMCI was only recently introduced, and in the mid-90s, when the programs under review were designed, IMCI was not a national strategy. The CORE IMCI working group was formed in 1997, and it is thus no surprise that in the evaluations reviewed, only one PVO was strongly committed to IMCI, defining and introducing community IMCI in its area of intervention.

IMCI

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
0	IMCI—general—participate in or promote the introduction of IMCI in health facilities that serve the target area, including strengthening of the health system (in planning, supervision, drug and other supply management, M&E, personnel management
0	Adaptation—participate in the adaptation of generic materials for local use
0	Training primary health workers—adapted material used in training of primary (first-level) health care workers
0	Complementary course—complementary course training (first-level health workers with limited literacy)
0	Training CHWs—IMCI training for community health workers
0	Self-assessment (including self-assessment tool)
0	Referral—ensure the possibility for severely ill children to be referred to the next level of the health system when necessary
0	System support—influence some of the "system" or "support" factors, such as the drug distribution system
0	District planning—improve capacity for district planning and management of IMCI activities at health facility and community levels
0	Community IMCI—invent and define plan for community IMCI

Discussion

Although few PVOs have been actively involved in developing or adapting IMCI algorithms, PVOs can play a role in promoting the introduction of IMCI in the health facilities that serve their target area. The major role for the PVOs is to participate in defining and introducing community IMCI

both in their target area and on a global level (see "Reaching Communities for Child Health and Nutrition: NGO Contributions to Community IMCI" at http://www.childsurvival.com/documents/csts.cfm#c-imci).

Maternal and Newborn Care

Final Evaluation Review Results

Nine projects included maternal and newborn care in their intervention mix. None included postabortion care, and one included child spacing its MNC package. Seven promoted antenatal care. Six projects promoted the quality of basic maternity care, mostly focusing on improving practices of primary providers (TBAs). Similarly, five projects promoted quality of postpartum care, but only one focused on newborn care.

MNC

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
9	Maternal newborn—general
1	Family planning—promote, introduce, or improve programs that integrate family planning: delay the age of first pregnancy, reducing the total number of children and increasing birth spacing
0	Abortion complications—promote or introduce programs to reduce complications of abortion
7	Antenatal care—promote, introduce, or improve quality of antenatal care
8	TT coverage—(one project failed to increase TT coverage)
6	Maternity care—promote, introduce, or improve quality of basic maternity care
5	Postpartum—promote, introduce, or improve quality of postpartum care
0	Eclampsia—promote, introduce, or improve programs to reduce maternal death caused by eclampsia
3	Emergency/obstetric—promote or introduce programs to reduce maternal deaths caused by hemorrhage, sepsis, prolonged/obstructed labor, and birth asphyxia
1	Newborn care—promote, introduce, or improve quality of newborn care (recognition of danger signs, reduce neonatal hypothermia, reducing unsafe/harmful practices, umbilical cord care, immediate breastfeeding)

Discussion

After nutrition, maternal and newborn care is the intervention that receives the highest level of effort in current child survival grants. MNC is a complex intervention, and when it aims for impact, it requires a comprehensive approach. PVOs wishing to implement MNC projects spend a considerable amount of their effort/resources on this intervention—between 15 and 50 percent in the case of the projects under review. Newborn care is potentially the area in which the greatest progress can be made in reducing child mortality. PVOs can make significant contributions to ensure that skilled attendants attend all mothers during delivery.

Areas for Support

PVOs have focused on improving preventive measures during antenatal care and on care during normal deliveries. It is now generally accepted that to reduce maternal mortality, high-quality emergency obstetrical care must be made accessible. However, only a few PVOs have started to address this issue in a comprehensive manner. Efforts have been made to promote recognition of danger signs during pregnancy by the mother, people in her immediate environment, and first-line providers of antenatal care. Few PVOs are actively promoting early detection and management of pregnancy-related problems such as anemia, pre-eclampsia, increased susceptibility to malaria, and STIs. The current technical reference materials promote improved care of the mother during the postpartum period and improved care of the newborn, and we hope to see a reflection of this in upcoming evaluations.

Child Spacing

Final Evaluation Review Results

Six PVO projects spent 10 percent or more of their effort on child spacing. A seventh project integrated child spacing into its MNC intervention. Most ensure a reliable and adequate supply of an appropriate range of contraceptive methods that are easily available to the target population, mostly through CBD agents. Child spacing is still not often integrated into antenatal and postnatal services.

Child Spacing

Number of PVOs	Criteria" or "Standard"
17	Number of PVOs under review
6	Child spacing—general—promote, introduce, or improve programs that promote family planning: delay the age of first pregnancy, reducing the total number of children and increasing birth spacing
3	Commodities/supplies—Ensure a reliable and adequate supply of an appropriate range of contraceptives easily available to the target population and appropriate counseling by technically competent staff
0	Postabortion counseling—promote, introduce, or improve programs that provide postabortion family planning counseling to all women
0	Integration with perinatal services—Integrate child spacing, maternal health (care, nutrition, prevention), and newborn care

Discussion

Child spacing benefits the health and well-being of women, children, families, and communities. By preventing closely spaced births or births to very young mothers, infant, child, and maternal mortality can be reduced. Closely spaced pregnancies increase the chances of women having low birth weight babies, the competition for limited resources between siblings, and the risk of transmission of infectious diseases. Babies born less than two years after the previous child are twice as likely to die in the first year of life as those born after an interval of at least two years. Even if

these infants survive the first year, they are 1.5 times more likely to die before the age of five than children whose births were spaced at least two years apart.

Areas for Support

PVOs are in an ideal position to promote the use of child spacing. Although some programs are promoting it, the CSGP as a whole seems to be less involved in this intervention than it has been in the past. PVOs are currently promoting child spacing by integrating this activity into maternal and child health activities and creating linkages between the communities they work in and facility-based programs. PVOs can support community-based providers who can make spacing methods more readily available.

STI, HIV, and AIDS

Final Evaluation Review Results

Only three PVOs reviewed spent at least 10 percent of their effort on STI- or HIV/AIDS-related activities. One had a comprehensive approach to sexually transmitted infections and documented the implementation of appropriate STI treatments. Most activities for STIs and HIV/AIDS focused on knowledge and behavior-change communication, most commonly promoting access to and use of condoms. However, AIDS interventions are still weak. There is little baseline or final data available to judge results or impact.

STI, HIV, and AIDS

Number of PVOs	"Criteria" or "Standard"
17	Number of PVOs under review
3	STI and HIV—general—reference to STIs and HIV/AIDS
2	Condoms—introduce, promote, or provide adequate and appropriate access to and use of low-cost, high-quality condoms (male and or female)
1	STI—treatment—introduce, promote, or provide adequate and appropriate treatment for STIs (preferably using the syndromic approach), ensuring a reliable and affordable supply of appropriate drugs
	Home-based care
	Orphans
0	Integration into service contact—any contact between women and the health system (for example, family planning, child care) before, during, and after pregnancy should be used as an opportunity for primary prevention, STD case-finding, and treatment of symptomatic cases

Discussion

In most developing countries, the AIDS epidemic is still on the rise, and we are only beginning to understand its impact on adults and children in the population. Some PVOs work in countries where one third of the women visiting clinics for antenatal care are infected with the AIDS virus.

How this will affect child survival and mortality and thus the Child Survival Grants Program is not yet fully known.

Areas for Support

PVOs could further expand their activities to address such issues as mother-to-child transmission and the community's capacity to absorb AIDS orphans. In current projects, relatively little effort is directed to mitigating the impact of the AIDS epidemic. In their child survival programs, most PVOs have traditionally limited their activities to increasing AIDS awareness and behavior-change communication and promoting access to and use of condoms. PVOs may need to start addressing orphans and vulnerable children, people living with AIDS, home care, and treatment.

MONITORING AND EVALUATION

Monitoring and evaluation is an essential component of any health program. It encompasses many activities including baseline assessments; setting goals, objectives, and indicators; and midterm and final evaluations. Ideally this information is collected and analyzed in order to improve program performance. As described in the December 2000 Child Survival Grants Program Technical Reference Materials (TRMs), "M&E provides the information that program managers and stakeholders need to determine whether they are achieving results and moving toward a health impact."

Building on this definition, this section outlines findings from recent CSGP documents from the perspective of M&E as a tool for continuous learning and continuous improvement. This perspective emphasizes not only the collection of the information but also the use of the information for program management. By using the information to determine where the program or project is working well and where it is not, managers are able to continuously improve service delivery. This dynamic programming, in turn, helps to improve the nutrition and health status of the ultimate beneficiaries.

The focus of this approach, which has also been called the Learning Process Approach,[11] is how to obtain and then use information for a good decisionmaking information system. It includes both qualitative and quantitative information and involves many different sources—from field staff to beneficiaries and people with outside experience in other projects. It involves an open exchange of ideas and participation by a wide variety of people with an interest in improving health and service delivery.

The learning process also involves actively developing new approaches to flexible, dynamic programming. For example, projects can pilot new activities in several communities or health facilities to understand how they might work best and what the results might be. Managers can also become involved in carrying out operations or action research by trying different implementation strategies in different subproject areas. Managers can compare results and resources expended to achieve those results.

The experiences of CSGP grantees in different aspects of this comprehensive approach to M&E is outlined below, focusing on the following areas:

- **Systematic Collection of Data**—Systematic collection is the base of a strong M&E system, ensuring that any project management decisions or conclusions about project outcomes and impact are based on valid and timely measures. Are the sampling designs used by projects in the present portfolio appropriate? How have grantees triangulated quantitative and qualitative data to inform planning and decisionmaking? How have partners and communities been involved in data collection?

[11] The Learning Process Approach has been briefly described in chapter II of the *Participatory Program Evaluation Manual* by Judi Aubel (http://www.childsurvival.com/documents/csts.cfm#aubeleng). The emphasis is on dynamic programming and an analysis of both what is working and what might work better. For example, an important question about training might be, "Is training being carried out on schedule?" After that question has been answered, the next step is to ask, "Is this training making a difference? Is the service delivery improved? Are the under-fives healthier?"

- **Using Data for Decisionmaking**—Data collected should be useful to management for continuous learning and improvement. Are projects collecting the data they need to inform the direction of their strategies, and are they doing so in such a manner that the data can be used for these purposes in a timely manner? Do projects use M&E data to occasionally step back and not focus only on the planned activities and short-term results but also to reevaluate the whole strategy? For example, if a project is focusing on Village Health Committees or Revolving Drug Funds, it is important to assess whether these mechanisms continue to be the most practical and cost-effective means to improve the health status of children. Are they worth the resources and effort that they entail? Are there other ways to better use available resources to obtain the desired results?

- **Measuring Results of Program Impact**—Data collected should help demonstrate whether projects have achieved their project objectives. Can projects document how improved health status may be related to their project interventions? What has been the effect, beyond the PVC-funded project, of M&E systems developed?

- **Opportunities for M&E Capacity-Building**—Opportunities exist throughout the child survival project cycle to develop or strengthen the monitoring and evaluation capacity of PVO staff and local partners. In the context of continuous learning, are PVO staff gaining the skills and knowledge necessary to monitor and evaluate their own projects? Is this capacity being carried over to the level of the PVO and local partners?

Information Management and Use in the CSGP

Systematic collection of data includes baseline, midterm, and final KPC surveys; ongoing lot quality assurance sampling; midterm and final evaluations (including participatory evaluations); health facility assessments; and qualitative research. This information can be used by the project in many ways, sometimes productively, and other times not.

The review of documents demonstrates that a great deal of data, especially on inputs and outputs (activities including training) is being routinely collected at the project level. In addition, some outcome information is tracked starting with community health volunteers and reported up the line, mainly to project data depositories.

In this review of child survival project approaches to monitoring and evaluation systems, we first discuss ways PVOs have collected data systematically. We then explore how this information may have been used for planning and decisionmaking.

Systematic Collection of Data

KPC Surveys

Child survival projects routinely collect baseline and end-of-project (EOP) data on health practices of mothers randomly selected from the population of the entire program area. They then use this information to establish targets for objectives at the ultimate beneficiary level: children under five and their mothers.

Seventeen projects that were completed in 2000 carried out baseline data collection using a KPC 30-cluster sample survey. The survey provides population-level estimates of health-related behaviors of mothers of children under the age of two for the child survival program areas. The baseline information was used to establish program targets. Projects (with the exception of Population Services International (PSI)/India, a social-marketing project focusing on ORS distribution) then repeated the small-sample survey at the end of the project using a similar methodology.

Several projects modified the "generic" approach to the KPC survey to make it more useful for project management and planning. The Cooperative for Assistance and Relief Everywhere (CARE) included a comparison group during the end-of-project data collection in both Peru and Mozambique. Several projects modified the "generic" approach to the KPC survey to make it more useful for project management and planning. CARE included a comparison group during the end-of-project data collection in both Peru and Mozambique. Collecting data within a project area allows project managers to compare health behaviors at the beginning of the project and at the end. Collecting data in areas where the project had not been implementing its community health activities enabled CARE managers to compare project indicators with indicators from similar areas that had not been affected by project interventions.

Six projects distinguished important subdivisions within the project areas and are sampling from each subdivision area to track differential results or make comparisons. Subdivisions include new areas for project interventions, areas where activities were previously carried out, areas with high access to primary health services, and peripheral areas with lower access to primary health services.

An example of a project that collects data representative of subprogram units is the Adventist Development and Relief Agency (ADRA) (CS XI follow-on) project in Honduras. This project focused on marginal urban communities of Tegucigalpa and reported data separately for the communities located southeast of the city (included in the project) and a newly added project area in the western part of the city. Separate baselines, targets, and end-of-project estimates were provided in the final evaluation for these two project areas.

Helen Keller Worldwide (HKW)/Niger identified three different cultural and ecological zones and conducted baseline and final surveys for each zone. They also developed DIP objectives specific to each zone. Then data were reported for communities with different levels of access: villages that had a Village Animation Committee and villages further away that did not.

In the case of World Vision (WV)/Zambia, the EOP KPC sample included two districts that had been handed off to the Ministry of Health (MOH) at midterm. However, no comparison of results from these districts with those still receiving project support was included in the evaluation report.

The Africare follow-on project in Malawi reported that they collaborated with the district MOH to carry out the baseline survey. A large sample of 900 mothers in three Traditional Authority areas was interviewed. However, the data for those three areas was combined in the initial report. This masked any differences between the area where the project had already been working and the two newly added areas.

PLAN projects in Nepal and Ghana state in their third annual reports that they have developed KPC questionnaires for periodic surveys based on lot quality assurance sampling (LQAS) of different supervision areas of the project.

Five projects (Africare/Malawi, PLAN/Burkina Faso, International Relief Committee (IRC)/Rwanda, CARE/Kenya, HKW/Niger) are collecting data from expanded samples using 60 or more clusters, whereas one project (Catholic Relief Services [CRS] and a El Salvador) is maximizing efforts by parallel sampling, drawing or selecting one sample of mothers of children under the age of one year and a second sample of mothers of children 12 to 23 months from each cluster.

Lot Quality Assurance Sampling

LQAS is an industrial quality-control sampling procedure that uses small sample sizes and random-sampling techniques from distinct "lots" or strata to minimize the data collection effort. This sampling procedure has been adapted to determine whether a certain expected proportion of a target population in a community or supervision area has incorporated new knowledge of practices. The sampling technique could indicate, for example, whether in the given sample at least 50 percent of women know at least two modern contraceptive methods or whether less than 20 percent of women know at least two modern contraceptive methods. Equally, the sample could indicate that 70 percent of mothers with children under two years of age know how to prepare and use ORT or less than 40 percent of mothers with children under two years of age know how to prepare and use ORT. For vaccination, LQAS could distinguish areas where 80 percent of children were properly vaccinated from areas where less than 50 percent were vaccinated. In brief, LQAS detects communities or supervision areas that are at the ends of a distribution of coverage, namely, whether coverage is adequate or unacceptably low.

"For project monitoring and carrying out day-to-day management decisionmaking, this type of quality control information is what is needed because it shows the communities with the lowest quality project implementation that need particular attention. They need attention because these are the supervision areas in which children are at the highest risk of health problems."[12]

Participatory Evaluations

Child Survival projects are required to conduct midterm and final evaluations with guidance from an external facilitator or evaluator. These events provide important opportunities for developing M&E capacity and "learning organization" skills with project stakeholders, especially with the project staff and staff of the local partners who are working to improve child and maternal health at the local level.

Participatory evaluation involves strengthening critical thinking and sharing concerns and suggestions. In its fullest execution, the participatory evaluation approach involves the stakeholders in the design of evaluation questions and the development of interview questions, data gathering (including qualitative data from key informants and focus groups), and the review of quantitative data from routine information systems and surveys.

Many projects use the *Participatory Project Evaluation Manual* by Judi Aubel as a guide for performing their evaluations. The manual has been translated into French and Spanish and is posted on the CSTS Web site. CSTS has used this manual in workshops on participatory evaluation in July and August of 1999 (Bolivia and Haiti) and May 2000 (Senegal).

[12] PLAN/Nepal, CS XIII Year Three Annual Report, p. 26.

Eight[13] of the 17 project final evaluation documents reviewed for the year 2000 indicate that a participatory approach was adopted. Many of the project and partner staff were involved in designing and carrying out those evaluations, not only participating as information providers, interviewers, or interviewees. As a result of the participatory methodology, stakeholders from the final evaluations from Project HOPE in Peru, Helen Keller Worldwide in Niger, World Vision in Cambodia and Zambia, International Eye Foundation (IEF)/Christian Children's Fund (CCF) in Ethiopia, Save the Children (SC)/Mozambique, CARE/Haiti, and World Relief (WR) in Nicaragua—had a clear understanding of what the program had achieved.

A review of the 12 available CS XIV midterm evaluations (three were missing at the time of the review) and one CS XIII Midterm evaluation (MTE) (HOPE/Haiti) from 1999 indicated that all but one project, a social-marketing project, had employed a participatory approach to the process. Most of the projects involved partners as evaluation team members in addition to their own project staff.

Projects approach participatory evaluation in different ways. At least one project (PLAN/Senegal) engaged an evaluation facilitator for a five-week period to carry out a complete in-service training in a participatory evaluation process and the use of qualitative data. Most projects attempted to compress the evaluation process into two weeks. Some organizations, however, carried out training with the project/partner evaluation team in participatory methodology on their own during a two-and-a-half-to four-day period before the arrival of the outside consultant who would facilitate the evaluation. When there is a challenge of language with the local staff using a language different from that of the facilitator, this approach would seem to be particularly useful.

For example, to start the midterm evaluation process, Save the Children's regional health advisor went to Tajikistan to work with the evaluation team (made up of SC project staff and MOH staff) to train them in participatory methodology in an intense four-day training course. The team then began data collection in the presence of the trainer, which furthered the capacity-building process among the evaluation team. Thus, the MTE was not only an assessment of the project to date, but it contributed to the project's goals of increasing the skills of SC staff and MOH staff as well.

Different data collection methodologies were used during the Tajikistan MTE, so that the results from each could be triangulated. Several data collection tools were designed including interview field guides, focus group field guides, observation checklists, and a competency questionnaire. The team selected a sample and collected data. Each day of the evaluation, team members met and compiled notes. The participatory program evaluation methodology was followed so that the project team could participate and feel they owned the results of the midterm review. It was believed that using this methodology increased the credibility of the results in the eyes of the project team, so that they would be more likely to accept and carry out the recommendations.

In addition to building capacity of their own project and partner staff, there is some evidence that PVOs may be introducing some consultants to this participatory approach. PVOs are requesting that consultants empower local staff by developing an inclusive process. Consultants are also being asked to provide in-service training in identifying issues key to project success and to design both evaluation questions and data collection instruments. Collecting, analyzing, and interpreting the information is done after this training. The last step is to develop an action plan to improve project management for results.

[13] Project HOPE/Peru, HKW/Niger, World Vision in Cambodia and Zambia, IEF/CCF in Ethiopia, SC/Mozambique, CARE/Haiti, and World Relief/Nicaragua

The HKW/Niger final evaluation included conclusions about the participatory evaluation methodology. "Based on feedback from HKW staff and partners, several conclusions were formulated regarding the participatory methodology used in the evaluation. The involvement of program implementers and partners, in all phases of the evaluation process, had several beneficial effects: it ensured that the evaluation responded to the main concerns and expectations of all participant groups; it contributed to their feeling of ownership of the evaluation results; it increased the relevance and feasibility of the lessons developed based on the results; and it increased the knowledge and skills related to program evaluation of those who participated in it."[14]

Health Facility Assessments

As described in the December 2000 PVO Child Survival Grants Program Technical Reference Materials, health facility surveys focus on outpatient services at first-level and referral facilities. Measures of health workers' clinical performance for the management of key child-health problems are collected as gauges of the quality of care. They can then be used to monitor improvements in clinical practice. Assessments also look at the availability of essential drugs, vaccines, supplies, and equipment. Availability of vehicles, health education materials, and the infrastructure of the facility are also used as measures of the quality of care.

In reviewing the CS XV DIPs, a number of projects are carrying out health facility assessments to provide a baseline for improving the quality of service. Examples of projects conducting HFAs at baseline include CARE and SC/Nepal, IEF/Bolivia, and HOPE/Uzbekistan and HOPE/Malawi.

Qualitative Research

Many projects report carrying out qualitative studies with focus group discussions (FGDs). Sometimes the local staff is involved, but without technical assistance, they do not appropriately analyze or make the best use of the information collected. One midterm, for instance, reported that the project carried out a qualitative assessment of cultural, practical, and knowledge barriers to successful, exclusive breastfeeding. But the external evaluator concluded that despite the project staff's good intentions, the results of the study were of little real value to the project.

This is primarily caused by the lack of professional guidance in the use of focus group discussions, particularly in the analysis of the data. For example, the study was mistakenly used to determine the level of exclusive breastfeeding and used percentages to represent results, which is not a valid way to reflect FGD findings. Furthermore, although FGDs were conducted with different target audiences, the report of the findings combines these groups' responses, thereby losing the benefit of separate discussions. Finally, the findings from the survey did not serve to inform the choice of health messages.

Program Data Used for Decisionmaking

In addition to small-sample survey capacity, projects are expected to develop useful monitoring systems. These systems typically focus on processes or activities—the monitoring of inputs to outputs such as the number of community health volunteers trained and the number of health education sessions conducted by the volunteers. In Nicaragua, World Relief project staff met

[14] HKW/Niger, CS XI Final Evaluation, December 2000.

monthly in each of the project areas to review past activities and plan for the next month. They used their health information system to identify areas that needed attention and to guide them in meeting their implementation targets such as numbers of *Brigadistas* trained, *casas bases* organized, and so on. An especially important part of their planning was to meet monthly with the staff at the local health posts to plan supervision trips and program interventions, such as vaccination campaigns, on the basis of health information system data.

Few projects describe periodic examination and reporting on progress toward results—for example, outcomes and results such as change in nutritional status and practices to improve the health of children under five. When inputs and outputs are linked to the adoption of health-related practices, a useful chain of results is developed. For example, the IEF/CCF Ethiopia project management reported that various actions were taken based on the routine reporting system (monitoring data for quarterly and annual planning). One such major action was organizing and launching campaigns on immunizations where they found coverage to be very low.

Some projects develop disease surveillance systems and mortality tracking through social and verbal autopsies. Others include routine growth monitoring. However, data from these monitoring systems are most often not used for reporting project results.

For some projects, it would be logical to collect data to monitor inputs, outputs, outcomes, and short-term results for separate implementation units. This would allow managers to individually track these communities, supervision areas, and health center catchment areas, to better allocate resources to attain project objectives in all geographic areas covered. Several projects indicate that they display data graphically, and periodically discuss and use information from monitoring systems to improve their project's performance.

Routinely collecting and using enough, but not too much, information that is useful in improving project management for results is a pervasive challenge. One question to keep in mind when both planning and analyzing information systems comes from the evaluation of World Vision's child survival program in Ballia, India: "Is the juice worth the squeeze?"[15]

In many cases, there is an overambitious data collection effort. One midterm evaluation indicates that an outstanding feature of the project is that health data is collected from multiple sources, analyzed, and used at the community level of the village health committees (VHC), community leaders, and health facilities in planning activities and for decisionmaking. On the other hand, the VHC members are overwhelmed by the number of different registers used to collect data, some of which represent a duplication of effort. The data management obstacle is exacerbated by illiteracy among VHC members. Not all data is reported back every month as planned because of the amount of data and the busy schedule of the principals involved.

Community-based Data Collection and Use

Child survival programs most often target communities, and many projects collect data for monitoring inputs outputs and short-term progress toward results *at the community level*. Community volunteers gather information in the form of community registers or data from growth monitoring.

[15] World Vision/India, CS XV Midterm Evaluation, 2000.

The community health volunteers may use this information to identify cases that need to be followed up.

Several projects identified how information was used for project management. For example, the community-monitoring system developed by CARE in Peru focuses the work of volunteers to provide counseling to pregnant women. Volunteers using information from this system can concentrate monthly home visits on households with pregnant women and women of reproductive age. With this monitoring and reporting system, volunteers were motivated to provide key information to mothers on maternal health.

World Relief/Nicaragua used an innovative approach to conduct rapid local surveys to monitor progress on their measurable objectives during the final two years of the project. The team used key questions from the KPC survey that related directly to the measurable objectives to create its own survey. Each subproject area carried out a survey and used the information to make adjustments in its implementation activities.

A review of all of the brief accounts of monitoring systems in CS documents shows that a lot of data is being collected. One can find references to the community health worker data collectors using some of this information to follow-up on needs such as immunizations or antenatal care, but it is more difficult to find examples of communities as a whole using the information to take actions to improve their well-being.

In Cambodia, three child survival projects (Partners for Development [PFD], WR, WV) organized a community-based monitoring and evaluation workshop in November 2000 with participation from 16 other organizations working in the country. The workshop was intended to provide a forum for the exchange of ideas and experiences related to community-based monitoring and evaluation. Organizations discussed the types of information collected by village health workers, how the information is used, and how the community-based health information system is connected to the health-center-based system. Among the reasons participants cited for monitoring program activities were the following:

- Identification of geographical and programmatic problem areas
- Verification of the success of different strategies
- Tracking of program progress
- Motivation of volunteers and program staff
- Competition between volunteers
- Advocacy with local or national officials
- Mobilization of community support or action.

Participants suggested that data such as project activities, project outputs, a few project outcomes, and quality and effectiveness of services should be monitored by health projects using community-based volunteers.

In response to the question "What percentage of information gathered by your project's health information system is really useful?," some participants indicated that all the information was useful,

but others stated that perhaps 20 to 30 percent of the data was useful. Much of the rest of the information collected did not help in making programmatic decisions.[16]

Health Workers' Performance

In addition to measuring knowledge, practices, and coverage of mothers and caretakers of children under the age of two, some projects are tracking improvements in quality of care provided by facility- and community-based workers.

CARE/Kenya has reported two evaluations of the quality of IMCI case management by community health workers. All CHWs received an initial three-week training in IMCI. The following year, the clinical skills of 100 randomly selected CHWs were evaluated and the findings were used to guide the development of a curriculum for a one-week refresher training course that was conducted in the fall and the following spring. A second evaluation of case management skills was carried out the next year as well. A representative sample of 120 currently active CHWs who received initial and refresher training were selected by systematic random sampling (the sampling frame was ordered by sublocation). CHWs were brought to the Siaya district hospital, where they stayed overnight and performed case management; they were then returned to their residence.

The clinical officer from the district MOH and the project training officer were the gold standard for evaluating the CHWs, since they managed the cases of children seen at the sick-child outpatient clinic and at the pediatric inpatient ward. The study found that eight to 12 months after refresher training, CHWs had maintained most of their clinical skills, with notable improvements in the treatment of children with malaria and the counseling of caretakers of all sick children. However, there was a decline in appropriate referrals made by CHWs.

PLAN/Ghana has developed a "support visit" form for supervising community health workers. The form is based on the supervisor's observations of CHWs' case management of sick children. In addition, the supervisors review data on family planning activities and attributes of the facility, including records and stocks of drugs and commodities.

Measuring Results of Program Impact

In addition to providing information for program planning and decisionmaking, information can also provide estimates of progress toward results. These progress estimates include data from growth-monitoring sessions, vital statistics (pregnancies, births, deaths), estimations of immunization coverage, and other project objectives at the beneficiary level based on periodic KPC surveys. Some midterm evaluations and third annual reports include data on progress toward results, but projects mainly depend on end-of-project KPC surveys to report on results by making comparisons with targets established from baseline coverage estimates.

[16] Northeast Cambodia Child Survival Program, *Community-Based Monitoring and Evaluation Workshop Report*, Phnom Penh, Cambodia, December 2000. <PFD.Cambodia@BigPond.com.kh>

Performance Index

One attempt to calculate the success or effectiveness of a child survival project—the degree to which results have been achieved in terms of improved child health—is to calculate a performance index (PI). The performance index describes the proportion of the gap in coverage closed during the life of the project for key practices and behaviors that contribute to improved nutritional status and child health. This information is averaged across projects, giving each project the same weight. The results are further stabilized by calculating a three-year mean for the Child Survival Grants Program as a whole.

The performance index is determined by calculating the difference between the baseline value and the final evaluation value for an indicator related to a behavioral objective. This gain (or loss) is then divided by the difference of 100 minus the baseline value. The PI is how much has been accomplished (percent change) divided by how much change is possible.

The performance index has been calculated by USAID/BHR/PVC since 1994 to measure gap closure by child survival programs for three indicators: child immunization, maternal tetanus immunization, and exclusive breastfeeding. This information is averaged over three-year periods and is reported in the R4 report.

Table 1 shows the child survival performance index by year and intervention.

Child Survival Projects Evaluated—Year 2000
Table 1: Child Survival Performance Index by Year and Intervention

Performance Index (Percentage of coverage gap closed)	1994	1995	1996	Baseline 3-Year Mean	1997	1998	1999	1997-1999 3-Year Mean	2000	1998-2000 3-Year Mean
Child Immunization[17]	35%	30%	41%	35%	27%	28%	46%	34%	14%	29%
Maternal Tetanus Immunization[18]	11%	13%	15%	13%	17%	29%	58%	35%	35%	41%
Exclusive Breastfeeding[19]	20%	37%	33%	30%	38%	31%	24%	31%	14%	23%

[17] percentage of children age 12 to 23 months who are fully vaccinated
[18] percentage of mothers of children age 0 to 23 months who received at least two tetanus toxoid injections before the birth of their youngest child
[19] percentage of infants age 0 to 5 months exclusively breastfed

Child Survival Performance Index for Projects Evaluated—Year 2000

Funding Cycle	Baseline KPC			Final KPC			Performance Index (percentage of coverage gap closed)		
	Imm	TT	BF	Imm	TT	BF	Imm	TT	BF
CS Cycle XI									
El Salvador/CRS	45.0	21.0	17.4	61.4	54.4	21.1	29.8	42.3	*4.5*
Honduras/ADRA[20]	72.8	34.5	50.0	74.9	58.3	28.7	7.7	36.3	-42.6
Indonesia/PCI	26.8	37.1		34.2	42.9		10.1	9.2	
Niger/HKW[21]									
Uganda/AMREF[22]	38.0	74.0	47.0	43.0	82.0	47.0	8.0	30.8	0.0
CS Cycle XII									
Cambodia/WV	93.0	60.5		96.3	96.4		47.1	90.9	
Ethiopia/IEF/CCF	15.5		17.7	22.6		68.0	8.4		61.1
Haiti/CARE		43.0			65.3			39.1	
Haiti/ADRA	8.0		7.0	65.0	70.7	15.0	62.0	67.4	8.6
India/CRS	13.0	10.0		46.0	44.0		37.9	37.8	
Mozambique/CARE	NA	NA		41.9	20.1				
Mozambique/SC	14.0	5.0	1.0	30.0	30.0	6.5[23]	18.6	26.3	5.6
Nicaragua/CRS		37.0	17.0		41.0	44.1		6.3	32.6
Nicaragua/WR	69.0	18.0	9.0	71.0	49.0	28.0	6.5	37.8	20.9
Peru/CARE		60.0	46.4		79.0	64.0		47.5	32.8
Peru/HOPE	60.0		[24]	51.0		68.5	-22.5		
Zambia/WV	80.0	64.0		70.0	57.0		-50.0	-19.4	
CS XIII									
India/PSI (97-00)									
						Year 2000 Performance Index	13.6	34.8	13.7

Demonstrating change by calculating a performance index with the KPC small-sample survey data has some caveats because of the precision of population estimates.

In addition to statistical considerations, it is important to consider that project focus has changed since the inception of the CSGP. In earlier years, most projects targeted immunization and exclusive breastfeeding. It is now more common for projects to focus on interventions, for example, malaria, PCM, and AIDS, which are not included in the PI. The results of these projects will not be captured because the indicators these projects affect are not included in the performance index.

The performance index calculation merits reevaluation. Small changes from baseline to final sample estimates may indicate that there was no real change at the population level and therefore no measurable gap closure.

For example, Project HOPE in Peru estimated immunization coverage at 60 percent at baseline and 51 percent at end of project. The true coverage rate in the entire population (which we do not know but estimate at 60 percent at baseline) has a 95 percent chance of being within 10 percent of the

[20] ADRA/Honduras: Average of separate data sets for San Francisco and Flor del Campo marginal urban communities southeast of Tegucigalpa and Nueva Suyapa, a newly added project area in the western part of the city

[21] Neither HKW/Niger nor PSI/India reported on any of these three objectives/indicators.

[22] AMREF/Uganda: Average of separate data sets for four subcounties

[23] SC/Mozambique estimated exclusive breastfeeding through age one month as reaching 24 percent at EOP.

[24] HOPE/Peru estimated 0 percent exclusive breastfeeding at baseline using a different methodology, which is not comparable with the final KPC estimates.

estimate (in this case between 50 percent and 70 percent). The EOP estimate of 51 percent falls within the confidence interval of the baseline estimate, which means there is no statistical difference or measurable change. At the end of project the true coverage rate in the entire population (estimated at 51 percent) has a 95 percent chance of being within ±10 percent of the sample estimate (in this case between 41 percent and 61 percent). The measurement technique employed is not precise enough to conclude that there was actually an eight percentage point change in the population that translates into a performance index of –22.5 percent.

It is questionable whether the PI should be calculated or reported for these projects with no statistically significant measure of change. As an alternative while waiting for a better index, we could consider assigning a 0 gap closure to projects that have small changes (for example, less than 10 percent if the sample size and method are unknown or yield statistically insignificant changes when confidence limits are calculated).

For mothers' TT vaccination, four projects ending in 2000 report very small changes and nine projects report changes greater than 10 percent. The average performance index on mothers' TT vaccination for the 13 projects is 34.8 percent. Of the four projects that reported on exclusive breastfeeding, the PI ranged from a high gap closure of 61.1 percent to a low of less than 10 percent. One project reported a decrease in exclusive breastfeeding. This project worked in the marginal areas of a large urban center where women were engaged in many different activities outside of the home. This may have affected the a decline in exclusive breastfeeding.

If CSTS and BHR/PVC were to keep performance indexes for projects ending in 2000 only where a change greater than 10 percent is reported (the shaded cells in the table), the performance index for complete immunization coverage would be calculated for four projects: CRS/El Salvador with a performance index of 29.8 percent, ADRA/Haiti with a performance index of 62 percent, CRS/India with a performance index of 62 percent, and SC/Mozambique with a performance index of 18.6 percent. The eight other child survival projects that reported data for complete immunization show change of less than 10 percent. Given the margin of error associated with 30-cluster sampling design, this is not considered a statistically significant change, and a zero change would be assigned to these projects.

An alternative to changing the index would be to change the measurement tool. The level of measurement precision of the KPC using a 30-cluster sample to estimate population parameters needs to be considered. A sample size of 30 clusters of 10 households is sufficient to provide an estimate with ±3 percent to ±10 percent precision for a coverage rate and can establish, with reasonable confidence (determined by the α value traditionally set at 5 percent), whether an objective has been met. When the sample size is reduced by using a subset of observations—for example, measuring exclusive breastfeeding of children to about six months by using only the zero- to five-month age group or complete immunization of 12- to 23-month-olds—the problem is exacerbated.

However, if population census data are available—for example, for a community unit—it would be straightforward to actually measure complete immunization coverage at several points in time by using records kept in the community and to calculate the performance index or gap closure moving toward 100 percent coverage.

If the PI is retained as an indicator of the effectiveness of CSGP service delivery, BHR could also consider giving a greater weight to projects spending more effort on measured activities, (for

example, vaccination activities) or those covering a bigger population. As it stands, a project spending 15 percent of its efforts, covering a population of 40,000 children, and increasing vaccination coverage from 20 to 40 percent (gap closure of 25 percent) is assigned the same value as a project spending 5 percent of its effort on vaccination, covering 1,000 children, and declining in coverage from 40 percent to 25 percent (gap closure –25 percent).

In addition to concerns about measuring significant change in a project area population, the limited focus of the PI on three critical behaviors limits its utility. Although immunization, maternal TT, and exclusive breastfeeding were previously a focus of the majority of CS projects, now there is more diversity in project interventions. For example, two projects doing final evaluations in 2000 included none of these three indicators.

In recognition of the diversity of child health interventions targeted by PVOs, the CORE Monitoring and Evaluation Working Group (MEWG) has developed an updated list of critical life-saving behaviors and practices. The CORE MEWG KPC Task Force has reviewed and revised the KPC developed by the Johns Hopkins University's Child Survival Support Program (JHU CSSP). Thirteen key indicators have been identified to provide information on critical, life-saving household behaviors and care-seeking patterns. These Rapid CATCH (Core Assessment Tool on Child Health) indicators can provide a basis for comparison among CS projects. The CORE MEWG strongly suggests that PVOs include all the Rapid CATCH questions in their KPC survey (see www.childsurvival.com/KPC2000.cfm).

Effects of M&E Systems Beyond CS Program

The monitoring and evaluation systems developed by the PVOs funded in the Child Survival Grants Program have had effects beyond the child survival programs themselves. Many organizations work extensively with local government, NGO, or community partners, and there is evidence that M&E capacity is being transferred to those partners as a result of the child survival grants.

For example, at the level of the health facility and district, CARE/Peru's census-based community monitoring is used to improve appropriate health care as well as document the work of community volunteers. The project has developed a community information system and helped Ministry of Health facilities install and learn to use Epi Info software to track monthly reports submitted by health promoters. The MOH health providers use this information to plan extramural visits.

The regional health department in La Libertad indicates they are planning to expand the CARE-initiated community-monitoring model to at least three other provinces in the department, specifically to address the problem of maternal mortality.

Project information has been used within CARE and USAID in Peru to support expansion of project strategies to other programs. The MOH is now using project information to disseminate project strategies to other MOH programs and other regional health departments.

The World Vision project in Zambia strengthened the use of the MOH health management information system (HMIS) data for decisionmaking by displaying results graphically; some indicators were even posted on office walls. In the words of one Gwembe Valley District Health Management Team (DHMT) staff member, "In the past, we would just collect data from reports

and send it to the Central Board of Health, where it would go to the archives. Now we can see for ourselves the areas where we need to make changes."[25]

> The desired M&E outcome at all levels is that people routinely use information for decisionmaking, to improve and on occasion to reevaluate and realign their priority objectives.

On a larger scale, many other projects, including Mission-funded child survival projects, Title II food aid projects with health and nutrition programming, and projects funded by other donors, have adopted the use of the KPC 30-cluster sample surveys to measure objectives and report results using the child survival program model.

Opportunities for M&E Capacity Building

Besides the M&E systems that have been transferred to local partners, further opportunities exist throughout the child survival project cycle to develop or strengthen the monitoring and evaluation capacity of PVOs and local partners, including local NGO and MOH counterparts. There is also the opportunity to work with local communities to improve their routine use of information for problem solving and to develop community competence for improving the well-being of their community members in terms of nutrition and health.

Considering the desired M&E outcome posited in the box above, examples of M&E capacity-building objectives might include the following:

- Project staff and local partners receive training in small-sample survey design, data collection, and analysis including graphic presentation and use of information for program design.
- Project staff and local partners use their skills by participating in baseline and end-of-project surveys with both quantitative and qualitative data.
- Project stakeholders develop ownership and integral understanding of project-generated data as well as relevant secondary data and studies.
- Project data are incorporated and used as part of the organization's health portfolio review to share lessons learned and improve the PVO's ability to work with partners to provide effective, continuing service delivery to benefit children under the age of five.

The first two objectives may be attained by involving the key project stakeholders (project staff and local partners) in the design of formative qualitative research and baseline surveys including the KPC (but also any organizational, health facility, or community assessments). Using this information to develop the DIP would be the next step. An integral part of project planning is developing an M&E plan and an HMIS system that emphasizes selectively collecting data that are conscientiously used to improve service delivery and project results.

[25] World Vision/Zambia, CS XII Final Evaluation, December 2000.

Midterm evaluations provide another major opportunity for project staff, partners, and headquarters support staff to review the project managerial and technical inputs, outputs, and progress toward results. This activity is a chance to demystify evaluations by including local stakeholders, project staff, and partners in the actual process of designing and carrying out the progress review. It becomes much easier to design and carry out qualitative data collection to better understand strengths and to develop suggestions for improvement in a "learning organization" context. This can happen only when the external team leader understands his or her role to be that of an educator and facilitator of this process, rather than an external expert who is on an inspection tour.

The end-of-project survey and final evaluation again provide important opportunities for strengthening M&E skills of project and partner staff in small-sample survey design, data collection, analysis, and interpretation of behaviors and practices adopted by mothers and caretakers of infants and young children. The final evaluation may also involve the project stakeholders in investigating the project's capacity-building outcomes that have aimed at sustaining high-quality and extended-coverage service delivery. Additional project outcomes may increase local competence in terms of broader maternal and child health (MCH) knowledge, monitoring of quality of care and health workers' performance, and organizational structures developed at the community level.

Small-sample survey implementation also provides an opportunity to build capacity within the PVO. It appears that while several PVOs have in-house capacity to design, carry out, and analyze small-sample surveys, the majority of organizations call on outside consultants to implement the surveys. Whereas one entry-level PVO has conscientiously focused on including its MOH partner in the design and implementation of the baseline survey, others are missing the opportunity to strengthen the capacity of their local partners and project staff in designing and carrying out applied quantitative research activities.

IRC/Rwanda with its entry-level grant clearly targeted strengthening the capacity of the MOH regional and district partners. The project engaged a consultant who worked with the stakeholders and trained the team in all facets of questionnaire design, data collection, and analysis. The MOH staff carried out the survey, including the analysis, with the assistance of IRC and the consultant facilitator.[26]

Several PVOs reported that they collaborated with the district MOH to carry out the baseline survey, including senior district MOH officers as well as project field health supervisors. In another project, the district MOH provided logistical support. It is not clear, however, whether the district MOH benefited from this experience in data analysis and use for action planning or whether participation was mainly limited to data collection activities.

Unfortunately, it is difficult to discern what type of capacity strengthening may have taken place because the final evaluation documents do not describe it. The majority of the other CS XV DIPs do not include KPC reports that provide detail about who designed and carried out the KPC baseline survey. Thus, it is not clear whether there is capacity in the PVO at either the headquarters or field project level to do a KPC without outside assistance from a consultant. Whether or how the local partner organization was involved in the study was not discussed either.

[26] *CS Connections* forthcoming issue.

The opportunity to build M&E capacity to design, implement, analyze, and use small-sample survey data for project planning and management is not being documented if it is actually happening. This may be a major missed opportunity for projects to highlight the M&E capacity they are building or strengthening with their own project staff and, at least sometimes, with their local partners to design, implement, analyze, and use small-sample surveys.

Although many of the final evaluations presented data for baseline and EOP objectives, many of them did not include a complete KPC survey report for the EOP survey. This should include details on methodology, with information on who was involved in designing, carrying out, and analyzing the survey; at what time fieldwork was conducted; and with what sampling design, including sample sizes for each indicator. Please see "How to Write a Survey Report" at www.childsurvival.com/kpc2000.

CAPACITY STRENGTHENING

Introduction

USAID/BHR/PVC's Child Survival Grants Program encourages grantees to build capacity not only at the level of the mothers and children who directly benefit from their programs but also at organizational levels where increased capacity will contribute to the overall quality and sustainability of health interventions. Within the context of the CSGP, these organizational levels include local governmental, nongovernmental, private, and community partners and the PVO grantee organization itself. This section outlines current trends in capacity-building activities among recent and present grantees, focusing on the efforts targeted to the PVO grantee and its local partners.

Final evaluations for CS XII grantees (projects ending in 2000) were reviewed to provide a snapshot of the range of capacity-building activities that are reported by PVC's Child Survival grantees. These findings are presented in section II below.

Key trends in capacity building across PVC's Child Survival Portfolio were identified through review of CS XIV midterm evaluations and CS XVI funded applications. These trends, discussed in sections III and IV below, are related specifically to 1) PVO institution strengthening, yielding increased capacity in the PVO grantee itself, and 2) strengthening of local partners, particularly as it relates to the roles of PVOs in strengthening decentralized health systems.

An Overview of PVO Activities in Primary Capacity Areas

Final evaluations for projects ending in 2000 report a wide range of capacity-building activities targeting community-level organizations; government, private-sector, and NGO partners; the grantee staff implementing the actual project; and the PVO grantee organization itself. These activities, as illustrated in the Capacity Building Intervention Matrix, touch on the following capacity areas: use and knowledge of technical skills, organizational learning, management practices and governance, financial resource management, human resource management, administrative infrastructure and procedures, and civil society/partnership development. Each of these areas, with illustrative examples from final evaluation reports, is further discussed below.

Use and Management of Technical Knowledge and Skills—This capacity area relates to the degree to which project staff, partners, and beneficiaries possess the requisite knowledge and skills in the key child survival interventions: immunization, nutrition and micronutrients, breastfeeding promotion, control of diarrheal disease, pneumonia case management, control of malaria, maternal and newborn care, child spacing, STI and HIV/AIDS prevention, and Integrated Management of Childhood Illnesses.

This has traditionally been the primary area in which CS grantees focus their capacity-building efforts, and all CS XII grantees reported activities in this area. World Vision/Cambodia, for example, reported that "local partners had increased their ability to train, plan, implement, and monitor their ongoing activities in the health centers, and greatly increased their knowledge and involvement in community health activities through . . . training, mentoring, and cross-visits" facilitated by the project. IEF/Ethiopia reported "improved capacities of 10 health facilities,

including the zonal hospital in Debre Birhan, to conduct EPI, diarrheal case management, and other health activities."

Management Practices and Governance—This area relates to the project management skills that often must be balanced with intervention-specific technical knowledge and skills in order to implement a successful program. This area also relates to the overall management/governance structure of the organization, be it a grantee, local partner, or community-based organization that may be an indirect beneficiary of the program. Six grantees from CS XII reported activities that could be classified in this capacity area. CARE/Mozambique's final evaluation reflected a range of management-related lessons learned that might benefit future grantees, including the following:

- Pay closer attention to the qualifications of the candidates for project manager. Ability to learn the language and previous management experience, as well as excellent interpersonal skills and a broad technical background, are essential.

- Arrange adequate orientation for new project managers; they should arrive at the project site familiar with personnel, resource and financial policies, and disciplinary measures. Do not expect the new manager to learn the policies from the procedure manual.

- Anticipate that even the most qualified manager will need support from the headquarters and country office. Ensure that the backstop personnel understand the language and the context and have relevant experience as well.

- Allow the manager to dedicate his or her time to managing the CS XII project (attending to fieldwork and visiting with [partners] more often), by ensuring that tasks related to logistics and procurement are performed in a timely manner by the appropriate personnel.

- Develop a more efficient system for providing timely finance reports to the project managers.

- Communicate with project managers in a clear, concise, and more streamlined manner about staff movement between offices, especially when the same facilities are used by several projects.

- Encourage project managers to coordinate with and share resources among sister projects (reproductive health, agriculture, and microcredit) as much as possible at the province, district, and community levels to overcome problems in logistics, procurement, monitoring, and supervision.

- Encourage managers of all [sister] projects to hold a staff meeting (inviting staff from all three projects) at least every three months to discuss the coordination of fieldwork for enhanced sustainability.

Organizational Learning—This area pertains to the evolution of the learning capacity of the organization itself. Organizational learning is seen when organizations make adjustments to their programs based on data collected from the field and document their findings and the new and innovative strategies that have emerged from those adjustments. Specific systems or processes are often set up to facilitate the integration of learning into the organization's management decisions. These organizations routinely recognize the interdependence of the host PVO, its partners, and the beneficiary community and involve all three components in addressing project challenges and

making key decisions. Seven of 14 CS XII grantees reported activities related to organizational learning.

World Vision/Zambia reported that "lessons learned from the CSP have built ADP [Area Development Program, a regional organizational unit of World Vision] capacity to work in partnership with the local MOH. This represents a shift in health programming from building health clinics to involvement in health development programs and will contribute to building sustainable programs in the future."

World Relief reported that it will continue to communicate lessons learned to the broader development community through participation in CORE, presentations at the Global Health Council, and its organizational newsletter, *Community of Caring*. The most recent issue of *Community of Caring* featured highlights from the Nicaragua child survival project final evaluation and was disseminated to World Relief partners in more than 10 countries.

Financial Resource Management—This area includes all capacity areas that deal with how an organization manages its finances, including the availability of funds for planned activities, the status of financial management and accounting systems, the accuracy of financial data, budgeting, and other relevant financial issues. Three grantees reported activities related to building capacity in financial resource management.

World Vision/Cambodia's final evaluation reported that the organization's "financial management, budgeting, and accountability seem excellent," and that "World Vision staff financial skills have been developed through training, so that they have very good budgeting skills, can accurately estimate costs and elaborate budgets for future programming, and carry out audits. World Vision/US has developed a grant management certification program which stresses finance and compliance issues. World Vision/Cambodia has five staff who have completed the program and successfully passed the exam. Three of these staff have direct working relationships with this project."

Project HOPE (Peru) reported that "the monitoring of financial aspects has assisted HOPE to identify weaknesses in their system, and motivated the development of a complementary tool for financial control, which has been used in other HOPE programs. Project HOPE is continuing to improve the financial system to better serve the needs of CS and other programs."

Human Resource Management—This category includes capacity areas specifically related to staff development, deployment, recruitment, and compensation; performance appraisal; opportunities for advancement; grievance and conflict management processes; administrative personnel practices; supervision; allocation of tasks; and other areas related to the management of an organization's human resources. Four CS XII grantees reported capacity-building activities in this area.

CARE/Peru reported that its Project Enlace—which has been integrated into the Ministry of Health—could be credited with strengthening the capacity of human resources in the DISA (Regional Health Department Office), UTES (Territorial Health Unit), and health facilities through various program management activities. For example, Enlace included MOH staff from all three of these levels in meetings and activities for the following:

- Development of Enlace's overall operational plans
- Development of micronetwork operational plans in each micronetwork

- Presentation and discussion of annual progress reports
- Evaluation planning, implementation of evaluations, and presentation of evaluation results.

Administrative Infrastructure and Procedures—There are a range of administrative procedures that affect an organization's capacity to efficiently implement and support its programs, ranging from the ability to procure supplies and equipment, to the administrative support necessary for producing reports and other key correspondence, to the capacity to contract with consultants for specific tasks, to the ability to manage logistics at the local level. Two CS XII grantees reported capacity-building activities related to this area.

World Relief/Nicaragua reported that the "project team and World Relief/Nicaragua should be commended for managing logistics so well in a very difficult working environment. The *casas base* never lacked for supplies, refrigerators were delivered on time and vitamin A capsules were always available. Once the promoters were supplied with motorcycles in the Rio San Juan area, they were able to make supervision visits much more effectively."

Civil Society/Partnership Development—Through their partnerships at the community and MOH levels, Child Survival grantees are making important contributions to the social infrastructure that forms the basis for civil societies. In its final evaluation, CARE/Mozambique reported a number of community-based management systems that contributed to civil-society development including the establishment of a community referral system to identify early danger signs of childhood illness and the establishment of an emergency transport system including SOS alert flags, bicycle ambulances, and plans for medical emergencies. Five CS XII grantees reported capacity-building activities that could be classified in this area.

In Peru, CARE used the "strategy of forming and strengthening Health Promoter Associations (APROMSAs) that will greatly increase the level of sustainability of volunteers. As the project nears its end, it is clear that the APROMSAs and the MOH have gained the necessary skills and credibility in their communities to elaborate annual operating plans, including supervision of activities that allow for generating funds. This allows for complete self-sufficiency of the Health Promoter Associations, which in turn leads to better-developed communities, active health promoters, and satisfied MOH personnel."

PVO Institutional Strengthening

At the level of the PVO grantee, institutional strengthening efforts can be observed in two ways: 1) through postproject analysis of how the CSGP has built organizational capacity and 2) through evidence of increased attention to strategic capacity development based on formal baseline capacity assessments at both the PVO and PVO Health Division levels.

Postgrant Assessment of Capacity Development

Projects ending in 1999 reported capacity development primarily at the level of their project team in the field, citing increases in technical knowledge and skills, increased understanding of sustainability issues, and increased skills in project management. Only one of 18 projects (5 percent) in this cohort

reported any capacity development attributable to the Child Survival Grants Program at the level of the PVO headquarters.[27]

Seven of 14 projects (50 percent) ending in 2000 reported increases in capacity at the level of the PVO headquarters based on postproject evaluation. These grantees reported capacity development in a wide range of areas, from increased technical knowledge and skills, to organizational learning, to financial and human resource management, to partnership and civil-society development.

CARE/Peru's CS XII final evaluation, which is outlined on the page that follows, summarized the overall effect of the CS grant on CARE as an organization. Project HOPE reported specific capacity gains in the areas of organizational learning and financial resource management, while World Vision reported on the effect of its experience with the CSGP on its regional health efforts in Southeast Asia for multiple donors.

These experiences are outlined in text boxes on the pages that follow.

Building PVO Capacity—The Impact of a CS Grant on the Grantee Organization

Judiann McNulty, deputy director of CARE USA, states, ***"This [CS XII] grant has allowed us to implement possibly our most effective, sustainable CS project ever. By having a flexible DIP and focusing on strategy rather than specific technical interventions, we were able to innovate and perfect as the project was implemented. We have been able to work in an environment that allowed us to refine our approaches to working through the MOH, learning how to take advantage of what motivates them, in order to garner their support for community health (extramural) at all levels—local, district, regional, and national. Through this grant, we have also learned how to make a complex design work with minimal staffing. In sum, this project has 'pushed us to the maximum' in a good way—taking us to a much higher level in Child Survival programming."***

According to the project's final evaluation, the experience gained through the PVO Child Survival Grants Program funding of Enlace has provided CARE with innovations and strategies that CARE will be able to apply to future community health projects. ***"In subsequent projects,"*** explains Dr. McNulty, ***"we are using the same strategy of working through the Ministry (as opposed to simply in partnership); we are focusing more on sustainability using the concepts learned; and we are replicating the strategy of organizing community volunteers in Nepal, Tanzania, and Nicaragua. Most important, we have developed an overall children's health strategic plan, which focuses on taking strategies developed in district-level projects such as this to national scale. We have accomplished this through Enlace in Peru, and we now know we can do it elsewhere."***

—CARE Peru/CS XII Final Evaluation

Increased Attention to Strategic Capacity Development

Strategic capacity development implies that a PVO has systematically identified its capacity strengths and weaknesses and has developed strategies for building on those strengths and addressing those weaknesses in order to implement more effective grants. To date, PVO reports on their own organizational development through the child survival grants program have been primarily retrospective in nature—at the end of a grant, a PVO reflects on organizational changes that it sees as resulting from the grant. Beginning in 1999, however, there has emerged a trend toward more

[27] Child Survival Technical Support Project. *1998-1999 Child Survival Grants Program Review.* September 25, 2000.

strategic capacity development efforts in the health arena on the part of PVOs receiving child survival grants.

Five of the 26 PVOs (19 percent) currently funded to implement CS programs have participated in USAID/BHR/PVC's Discussion Oriented Strengths Assessment (DOSA) initiative for the purpose of assessing their overall organizational capacity. But since 1999, seven of those PVOs have conducted more specific capacity assessments targeted to their health divisions in an effort to enhance the quality of child survival and other health programs. Six more are scheduled to participate in an assessment focused on their health division early in 2001, which means that 50 percent of Child Survival grantee PVOs will have assessed the capacity of their health functions by the end of this year. The primary tools utilized at this level have been the Health Package Assessment Tool developed by NGO Networks for Health and CSTS's Institutional Strengths Assessment Tool (ISA), which CSTS began piloting in November 2000.

The general trends that seem to have emerged from these assessments has been a need to focus attention on issues related to operations research, information sharing and organizational learning, and development of technical capacity in the field.

Although it is too early to report aggregate data from PVO experiences with the ISA (pilot testing will continue through May 2001), ADRA and PLAN reports on their experiences with the Networks tool are outlined in text boxes below.

Adventist Development and Relief Agency—Organizational Assessment

In October 1999, ADRA undertook an institutional assessment as a part of the NGO Networks for Health project. This assessment utilized a tool developed by PACT, Inc., and looked at five areas, including staffing, organizational learning and knowledge sharing, partnering and professional outreach, organizational commitment to the technical package, and general management. The tool measures the organization's sense both of capacity and consensus on capacity. ADRA was judged strongest in organizational commitment to the technical package and partnering and professional outreach. ADRA scored lowest in organizational learning and knowledge sharing. The findings validate what ADRA had already identified as a part of last year's CS submissions—the need for creating a learning culture within the organization. ADRA coupled these findings with a review of the Capacity Building Matrix developed by CSTS and presented at the RFA workshop in September 1999. During discussions, group consensus focused on the need to be more intentional in management and backstopping in order to achieve the intended goals and objectives of the proposed programs. From the two assessments, ADRA has determined that its key areas of focus during the next four years should be strategic management and organizational learning. ADRA believes that the development of a strategic-management system that documents, analyzes, and projects, rather than fixing and reacting, will enable an organizational-learning environment.

Source: Funded CS XVI application, Haiti

PLAN International—Organizational Capacity Assessment

In the Spring of 1999, PLAN participated in the PVO/NGO Networks for Health organizational stock-taking, initiative conducted by Education Development Center and PACT, Inc., aimed at assessing its commitment and capacity to plan, implement, and evaluate CS/RH/FP/HIV services. Both the country and headquarters assessment teams identified CS/RH/FP/HIV as an institutionwide program priority receiving increasing attention and resources. Assessment findings showed that PLAN has a strong institutional commitment to continuous quality in health programs and new ideas are being well marketed both internally to policymakers and externally to constituents around the world. PLAN's strong commitment to the health package was one of the strongest findings of the assessment. This assessment also showed PLAN's weaknesses in technical-skills performance and operational research. Given these findings, PLAN has become committed to making program quality an important performance evaluation criterion at all levels. The quantity and quality of program technical advisors will be increased from community through headquarters levels as more operations research (OR) opportunities are developed. As a key member of the PVO/NGO Networks for Health consortium, a member of the CORE group, and a capacity-building task force member with the Child Survival Technical Support group in Washington, DC, PLAN is committed to continuing to utilize lessons learned to influence its health programs and partners and to effectively reach millions around the world.

Source: funded Child Survival XVI Application, Cameroon

Strengthening Local Partners

CSGP grantee efforts to build capacity in their local partners are evident in the increased attention to strategic capacity development and their increased roles in supporting the development of decentralized health systems.

Increased Attention to Strategic Capacity Development

Increased attention to strategic capacity development is evident at the local-partner level as well. Whereas only one of 14 CS XII grantees (projects ending in 2000) (7 percent) measured local-partner capacity at baseline and final, 10 of 16 projects (62 percent) scheduled to end in 2004 have planned for strategic-partner capacity building based on baseline and final capacity assessments. Grantees are implementing a range of baseline assessment tools at the local-partner level, ranging from adapted Appreciative Inquiry Techniques to Organizational Capacity Assessment (OCA)-based approaches (OCA is a capacity assessment methodology developed by PACT) to the application of the Management Sciences for Health (MSH)-developed Management Development Assessment (MDA) tool or the Managing for Organizational Sustainability Tool (MOST). Other PVOs, such as Counterpart International and Project Concern International, have developed their own capacity assessment tools to be applied at the local-partner level. One PVO reported having developed a rapid organizational assessment survey that it conducted to gain a snapshot of local-partner capacity before submitting its application for funding.

The experience of Concern Worldwide International in adapting appreciative inquiry techniques to conduct baseline capacity assessments of two health municipalities in Bangladesh is outlined below, along with CARE's experience demonstrating large increases in management capacity among eight health center partners in Haiti.

Assessment of Saidpur and Parbatipur Municipality Health Departments Through Appreciative Inquiry

Concern Worldwide International adapted appreciative inquiry techniques to conduct baseline institutional assessments of Saidpur and Parbatipur Municipality Health Departments and to develop capacity-building plans for a 4-year PVC-funded child survival project in Bangladesh. The baseline assessment was carried out in October 1999.

Concern's organizational development unit applied principles from the GEM Initiative's intensive appreciative inquiry program to develop a capacity assessment tool with indicators for 11 components of capacity (continuity, human resource development, committed leadership, management culture, community participation, results, shared values, innovation, information resources, learning, and networking). Drawing on models from *Partnering to Build and Measure Organizational Capacity: Lessons From NGOs Around the World*—a Christian World Relief Committee publication funded by BHR in 1997—Concern developed measurement scales based in the local context of Bangladeshi culture to facilitate understanding of the capacity assessment process. The result has been a participatory and inclusive process that is both sensitive to the culture of local government and suited to the institutional awareness of municipality staff.

The Health Institution Capacity Assessment Process (HICAP) process was designed to drive Concern's overall efforts to strengthen the municipality's capacity to deliver specific child survival activities of good quality that will improve the health status of mothers and children in Saidpur and Parbatipur and that can be sustained within Municipal and Ministry of Health and Family Welfare (MOHFW) resources. Specifically, the project aims to—

- Increase EPI coverage from 43 percent to 60 percent in Saidpur and from 49 percent to 65 percent in Parbatipur
- Ensure that 85 percent of children aged 12 to 23 months have received a minimum of two vitamin A doses
- Increase antenatal coverage by 58 percent in Saidpur and by 61 percent in Parbatipur, to reach 70 percent coverage in each location
- Increase the percentage of deliveries assisted by trained personnel from 52 percent to 65 percent in Saidpur and from 36 percent to 55 percent in Parbatipur.

RICHES 2000 (CARE/Haiti)—Attaining Increased Capacity in Local Partners

In March 1997, RICHES 2000 contracted with Association d'Oeuvres Sanitaires Privés (AOPS), a USAID-funded umbrella organization that provides technical support to PVOs working in Haiti, to conduct a management capacity assessment. AOPS used a tool developed by the HS-2004 project to establish a baseline management capacity for eight participating [health center partner] institutions. The assessment examined institutional capacity in the areas of organization; population and health indicators; planning; human resources; information systems; stock management; financial management; and information, education, and communication (IEC).

Based on the assessment findings, AOPS assisted the project in designing and conducting a variety of management training sessions. These included management training and equipment assistance to improve capacity while simultaneously stimulating the demand for appropriate health services and the ability of health institutions to supply the required services on a lasting basis. This training led to the development of microprojects in the form of annual action plans with key priorities and activities to be carried out by the institutions.

In July 2000, the project repeated the management assessment survey. The overall baseline capacity of 19 percent increased to 45 percent. This represents an increase of 131 percent. The largest gains in capacity were in the areas of planning, human resources, financial management, and stock management. For example, within the planning component, most of the capacity gains came from a significant increase in the setting and monitoring of objectives.

Table 2 shows the increase in overall management capacity for each of the eight health institutions. The baseline capacities ranged from 16 percent at Bon-bon to 25 percent at Dame-Marie, with an average of 19 percent. The final survey capacities ranged from 38 percent at Anse d' Hainault to 51 percent at Dame-Marie and Abricots, with an average of 45 percent. The overall increase in capacity was 131 percent.

Table 2: Institutional Capacity by Health Center

	Moron	Cham-bellan	Dame-Marie	Irois	Anse d' Hainault	Bon-bon	Abri-cots	Roseaux	Average
Total 1999	47	56	70	53	50	45	50	64	54
Total 2000	115	121	143	141	107	110	143	127	126
% 1997	17%	20%	25%	19%	18%	16%	18%	23%	19%
% 2000	41%	43%	51%	50%	38%	39%	51%	45%	45%
Improvement	145%	116%	104%	166%	114%	144%	186%	98%	131%

The assessment also compared the management capacity of the eight health centers by development stage. According to the scaling system of the original assessment methodology, all eight health centers were classified in the startup development stage. The second assessment in July 2000 found that six health centers had progressed to the second stage of development while two others had progressed into the third growth stage.

—Adapted from CARE/Haiti CS XII Final Evaluation

Role of Child Survival Grantees in Supporting Strengthening of Decentralized Health Systems

USAID/BHR/PVC-funded Child Survival grantees have evolved in recent years from providing direct services to communities to being key players in strengthening decentralized health systems around the world. The growing efforts of CS grantees in supporting decentralized health systems are a natural extension of their longstanding efforts to develop community-based health infrastructure. A sample of CS projects from cycles XVI and XII show that nearly 93 percent of the grantees dedicated some of their project resources to building community infrastructure, including village health committees, community pharmacies, mothers' groups, anti-AIDS youth clubs, establishing networks of trained birth attendants and community health workers, and other structures designed to mobilize communities to manage their health care needs.

At the same time, PVOs are beginning to work more directly with decentralized health systems that have been established to serve the same communities where grass-roots health infrastructure has been taking root. An analysis of recent evaluations and planned activities reveals that the percentage of grants that focus on strengthening local health systems, as opposed to providing direct services to communities, has increased from 50 percent (projects ending in 1999), to 54 percent (projects ending in 2000), to 74 percent (projects ending in 2003). Over the same period, the percentage of programs whose efforts have been based on a formal baseline assessment of health system capacity has increased from 12.5 percent (projects ending in 1999), to 23 percent (projects ending in 2000), to 74 percent (projects ending in 2003).

- In child survival projects that ended in 1999 (CS XI), two of 16 grantees completed a baseline facility assessment or other capacity assessment of district or regional health facilities. Eight of the sixteen reported some level of capacity strengthening of district health systems.

- In child survival projects that ended in 2000, three of 13 grantees completed a baseline facility assessment or other capacity assessment of district or regional health facilities. Seven of the 13 reported some level of capacity strengthening of district health systems.

- In child survival projects scheduled to end in 2003, 14 of 19 grantees are planning to complete a health facility or baseline capacity assessment at the district level, and the same number have planned activities designed to strengthen these health systems.

In addition to the example above on Concern Worldwide's efforts to support the health municipalities in Bangladesh, CARE's experiences in Peru and Mozambique are outlined below to illustrate PVO efforts to support decentralized health systems.

CARE Peru

From the beginning of the funding period, CARE implemented its Enlace child survival project in Peru (CS XII) through the MOH. The Enlace project was not intended to be self-sustaining as a project after the end of four-year funding cycle. Rather, the project was designed and implemented to be absorbed into MOH operations by MOH personnel. Enlace provided technical assistance at all levels of the health system so that the project would in effect be "owned" by the MOH at the end of the project. Enlace worked jointly with the MOH beginning with baseline data collection and initial planning activities.

According to Dr. Henry Rebasa, director general of the Regional Health Department Office in La Libertad, Enlace was instrumental in strengthening the institutional relationship between the MOH, community health promoters, and local political structures such as the municipalities. He also recognized the institutional strengthening aspect of helping the MOH, especially health professionals in health facilities, to understand that increased productivity in services can result from increased community health work.

For Territorial Health Unit Eight (UTES-8), Enlace's work to develop a model of community health in Otuzco-Julcán was key to strengthening the health care system of the entire zone. One MOH official stated that community work was critical for the achievements in health care coverage in the mountains of Peru.

To sustain what the project achieved and institutionalize it within the local system, the UTES director signed a Directorial Resolution, which formalized all the elements of the Enlace project within UTES-8. This included specifying responsibilities of health facilities in continuing to support the training, supervision, monitoring, and supply of health promoters, as well as the organizational structures and information systems set up by Enlace.

—CARE/Peru, CS XII Final Evaluation

Capacity Intervention table

Capacity-Building Interventions: Areas and Institutions Targeted

As Reported in CS XII Child Survival Final Evaluations (projects beginning in 1996 and ending in 2000)

Health System Units / Capacity Areas	PVO Grantee				Other Intermediaries			Private Sector			Government			Communities		
	US HQ	HQ CS Unit	Field Office	CS Project Team	PVOs (Int'l/ US)	Local NGO	Net-work	Media	Business	Health Care Wkrs	Nat'l MOH	District Health System	Health Facility /Staff	Health CBOs	Other CBOs	HWs
Use of Technical Knowledge and Skills	4[28]		1	5		3				2		4	4		5	5
Organizational Learning	4		1	1							2	3				
Management Practices & Governance	1			2		1					1	2			2	
Financial Resource Management	1			1		2										
Human Resource Management	2			2		1					1					
Administrative Infrastructure and Procedures						1									1	
Civil Society/Partnership Development	2			1							1	1			1	

[28] Numbers represent the number of different evaluation documents that mention a capacity-building activity within a given "box." For example, four different final evaluations mentioned capacity-building activities related to the use of technical knowledge and skills at the U.S. headquarters level. Summing the numbers by row or column ***does not yield*** the number of different programs that mentioned capacity-building activities in a primary capacity area or within a given capacity level.

CARE/Mozambique

CARE's Child Survival XII project in Mozambique worked closely with the MOH to enhance the MOH's institutional and performance capabilities. This was done through training of health personnel and provision of materials and equipment.

The performance capabilities of personnel of the Ministry of Health were enhanced through a combination of supervision and monitoring of individual performance at the health unit. A review of supervision forms from October 1999 to June 2000 demonstrated that in general, elementary nurses made improvements in their working environment, especially regarding workplace hygiene (a critical factor in most health units). The nurses also continued to meet the minimum requirements for work and workplace organization, including maintaining regular hours, proper management of drug supplies, and practicing triage for urgent cases.

CARE/Mozambique provided training-of-trainer courses for maternal and child health nurses and modeled supervision to the district-level MOH. Because the project has established a foundation for the transfer of knowledge, health facilities strengthening, attention to health worker quality, and training will be sustained.

—CARE/Mozambique, CS XII Final Evaluation

SUSTAINABILITY

The issue of sustainability has been emphasized, in one form or another, since the outset of the Child Survival Grants Program in 1985. Beginning with the earliest cohorts of funded projects, grantees have been required to report on the prospects for sustainability in their projects. Analyses of final evaluation documents have been periodically conducted to assess sustainability of CS projects, and BHR/PVC has fine-tuned the language in its evaluation guidelines each year to reflect the current thinking in sustainability. The past several years have seen expanded attention to this issue within the child survival PVO community, which has resulted in an emerging PVO-driven framework for examining sustainability in the child survival context.

This section describes important developments in the current thinking about sustainability in child survival programs and PVO progress toward sustainable service delivery since CSTS' 1998-1999 program review.

Since March 2000, the following developments have advanced the state-of-the-art thinking in sustainability for child survival and other primary-health-care programs:

- The CORE/CSTS Sustainability Initiative—a one-year research effort that analyzed both the literature and the experience of more than 30 PVOs in the child survival community.
- The Child Survival Sustainability Assessment Framework (CSSA)—a framework for systematically planning and monitoring a project's progress toward sustainability; this tool has emerged from the Sustainability Initiative.

> **Sustainability in CS programs can be defined as a contribution to the development of conditions enabling individuals, communities, and local organizations to express their potential, improve local functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure resources (financial, human, technical, informational) in order for local stakeholders to negotiate their respective roles in the pursuit of health, wellness, and development beyond a project intervention.**
>
> —CORE/CSTS Sustainability Initiative, September 2001

The suggested definition of sustainability highlighted above has emerged from the CORE/CSTS Sustainability Initiative and represents one view of how this issue might be envisioned for child survival projects. This definition also provides a context for examining the progress of grantees toward sustainable health interventions. Progress can be described in terms of results reported in final evaluations and improved approaches to sustainability in grant applications submitted to the CSGP.

The CORE-CSTS Sustainability Initiative

The developments in sustainability thinking outlined above can be traced to the March 2000 Sustainability Dialogue Meeting.[29] This one-day event featured presentations on the CS agenda for the future, in particular the challenge of child wellness, definitions and models of sustainability in health care programs, and a report on a CORE-sponsored "Sustainability Review of BHR/PVC-funded Child Survival Projects in Bangladesh and Bolivia from 1985-1997" (an abstract from this report is included in the text box below).

The presentations led to discussions and recommendations on how to improve sustainability design in CS projects. The dialogue initiated at the meeting continued afterward and resulted in recommendations for more research on project sustainability. However, a consistently identified limitation for advancing the research agenda was the lack of a shared and accepted reference or framework to orient research questions and be inclusive of the vast array of issues and approaches faced by PVOs in planning for durability.

> The sustainability of child survival projects reviewed in both countries was found to be strong, with many project activities continuing as long as 10 years after BHR/PVC funding had ceased. The capacity built through the child survival process resulted in PVOs beginning activities in new countries, a new NGO being created, and strengthened monitoring and evaluation and other activities within both PVOs receiving grants and other PVOs/NGOs throughout the two countries. In addition, lessons learned became institutionalized as part of national policies and strategies within each country's Ministry of Health. Community organizations continued to meet and volunteer health workers continued to work in the former project areas of six of the 13 PVOs/NGOs. Some PVOs demonstrated, by means of community surveys, sustained impact in communities from two to more than four years after PVO-initiated activities had been discontinued. National policies and the relative stability and economic development of the country were found to affect the pattern of sustainability in each country with more organizations continuing service delivery after BHR/PVC funding ended in Bangladesh and stronger examples of increased technical and managerial capacity in Bolivia. Through the PROCOSI (Programa de Coordinación en Salud Integral) Network, PVOs/NGOs were better able to disseminate lessons learned to nongrant recipients and to the MOH.
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> *—Abstract from the executive summary—Seims, La Rue, "A Sustainability Review of BHR/PVC-Funded Child Survival Projects in Bangladesh and Bolivia from 1985-1997: What's Left After All These Years?"—The CORE Group, April 28, 2000.*

One outcome of the Sustainability Dialogue Meeting was the CORE-CSTS Sustainability Initiative, a one-year research effort that has sought to answer the question:

"Can a common framework be developed, allowing for the expression of diversity, yet allowing PVOs to assess performance on sustainability, share lessons, and have a leading role in the sustainability agenda?"

This effort has explored the organizing concepts and recognized factors of sustainability for CS and PHC programs through a review of the literature, interviews of key informants, and questionnaire surveys. More than 30 PVOs in the CSGP have participated in the Initiative and have contributed time, expertise, and project information. A document review has taken place, including both the literature and project documents. Experienced managers in the CORE Group have been

[29] The report from the Sustainability Dialogue Meeting can be downloaded at (http://www.childsurvival.com/documents/workshops.cfm)

interviewed. This has produced a 1,000-page narrative used for textual content analysis. A survey of critical issues about sustainability was addressed to individual technical PVO backstop staff in the CSGP community and received participation from 50 PVO practitioners, a high level of participation considering the size of our professional community. A second survey was addressed to projects coming under evaluation in the coming year. Most of the data analysis has been done, and preliminary results were presented in spring 2001 at the CORE Members Meeting and to CS grantees in Senegal and Egypt, as well as to project representatives from Cambodia.[30]

The study has led to the development of a tool for evaluation and planning—the CS Sustainability Assessment—which has been presented along with the preliminary results and has received critical and positive feedback from field projects. Further development and refinement of the CSSA will take place through collaboration with PVOs and field implementation. The CSSA integrates not only the participatory research conducted with PVO practitioners/experts but also state-of-the-art thinking on sustainability assessment from the field of sustainable development.

Key Lessons from the CSTS Sustainability Initiative[31]

The initiative's main purpose was not to develop a laundry list of indicators and strategies for sustainability in the absence of a clear conceptual road map; instead, it was to develop such a conceptual (then programmatic) road map based on the collective expertise of the CSGP PVOs. An underlying assumption of the study was that models and indicators for sustainability are best developed through a process of dialogue fully respectful of local development realities.

The key lessons learned from the Sustainability Initiative to date include the following:

- There is no one linear model but a number of approaches to achieve sustainable results. A final sustained impact is the result of complex and multidimensional interplay.

- Capacity building is a focus, but sustainability depends on many other factors. This has been found to be particularly relevant in terms of strategic intermediary results at the level of a project. For example, improvements in social cohesion or community competence play an important part in the PVO sustainability strategy.

Changing the dependency profile of local organizations is another important element, whether it relates to financial viability, organizational linkages and relationships for support, advocacy, access to information and technical assistance, accountability, or other such factors. Other process factors are recognized by many PVOs as contributing heavily to end-of-project sustainability, whether it be the style of management and partnership provided by the project (a "way to do business") or personal factors such as leadership, commitment, attitude of staff within project and partner organizations. These elements seem to intervene not only as processes in the delivery of quality and effective interventions but also as proximal factors that condition the ability of local systems to sustain either the intervention itself or its impact through local mechanisms.

[30] Although the surveys themselves were designed exclusively for this research study, a number of PVOs, including World Vision and IEF, have reported utilizing the survey questions to assist them in organizing their thinking about sustainability in PHC and other development projects they are implementing.

[31] A comprehensive report on the research findings from the Sustainability Initiative and corresponding Child Survival Sustainability Assessment is projected for CSTS publication in winter 2002.

There are also strong external factors that influence sustainability in a project, many of which are outside of the reach of PVOs, although some can be targeted through advocacy (for example, policies). Whether amenable to being influenced by PVO projects or not, progress on these external conditions, or lack thereof, is a crucial part of assessing the prospect of sustainability in CS interventions.

- **Sustainable results, particularly positive results, can often not be reliably predicted, even with attention to design**. When observed, they seem to be due to successful local negotiations, supported by favorable conditions, which the intervention has supported, but not necessarily controlled. PVO participants in the study agreed that issues related to local institutionalization and local financing are important contributing factors to sustainability, but they gave greater collective weight to issues related to such things as building functionality, creating opportunities, developing relations and interdependency, or creating an enabling environment.

- **The Sustainability Assessment is not linear**. The study results suggest the need for a contextual evaluation approach, requiring attention to processes, to stages of progress, to a project's contribution to the bigger picture, and to the enabling conditions it advances, more than trying to directly attribute sustainable results to program inputs in a linear model. The vision of a bigger picture, particularly in terms of development, would probably lead many PVOs to reject a model of sustainability in which the capacity built within a local partner would be too narrowly activity focused and would not consider a broader view of the local partner's mission. PVO respondents support this position whether the local partner be a District Health Team, a local NGO, or a rural community.

Main Features of the CS Sustainability Assessment

The lessons outlined above have served as the foundation for the Child Survival Sustainability Assessment tool. The CSSA tool proposes both a *framework*—which allows a systematic approach to the shared dimensions of evaluation on which progress can be measured—and a *process* for a participatory sustainability assessment with communities and local partners. This systematic approach allows for 1) framing a vision and defining consistent goals for sustainability along dimensions shared by all projects, 2) locally identifying the relevant issues within those dimensions, 3) selecting and/or defining locally meaningful indicators, and 4) basing decisionmaking on a comprehensive assessment and examination of the identified issues.

The process and the framework require—from the outset—an agreement of all local stakeholders on a systems perspective of the conditions for sustainable health progress in the zone of intervention. The CSSA tool guides further planning based on the results of the assessment. It also affords PVOs a tool for cross-learning and benchmarking between their various interventions, opening the door for more advances in sustainability studies. Finally, it seeks to integrate the various assessment tools used by child survival programs, as opposed to adding a new measurement tool.

The Child Survival Sustainability Assessment Framework

The CS Sustainability Assessment framework offers a systematic approach to the selection of issues to be assessed and from which project objectives will be identified. These issues fit within three

main dimensions relevant to the different types of CS projects. The three dimensions, which are outlined below, are related to the primary goals of a project; the local organizational capacity that supports these primary goals; and the community, social, and ecological systems in which a project evolves.

Progress along these three dimensions represents an improvement of the local conditions necessary for lasting health progress and impact. Depending on the local context and the nature of the project, the interplay between these dimensions and the issues that are relevant within each dimension will vary, as will the relative importance of specific issues and dimensions to others. The tool is designed to allow projects to revise, adapt, and improve the definition/selection of issues over the life of the project and to revise, adapt, and improve the definition/selection of the corresponding indicators of progress on these issues as learning takes place. The essential element of validity of the framework is that progress along these dimensions—as defined through locally meaningful indicators—should describe an improvement in the conditions under which durability has an increasing prospect, while lack of progress along these dimensions indicates a decreasing prospect for durable health impact.

The three primary dimensions of the Sustainability Framework are described below:

1. ***Primary goals of the project.*** These elements are generally already part of a project evaluation at different stages:

   - The first element is the population's *health status* (or proxies such as immunization coverage) where the project's effectiveness will be measured.

   - The second element includes issues in the *health services performance* and the *intervention approach* that will influence the durability of any health improvement, such as quality, equity, project fit, level of partnership, community participation, and so on.

2. ***Local organizational capacity and viability.*** Identification of the relevant local organizations is part of the assessment process discussed in the next section:

   - The first element is the *organizational capacity* that the local partners need to maintain performance.

   - The second element is the *organizational viability*, or the profile of dependency of the key local partner. Dependency relates not only to financial viability but also to the other essential types of support on which an organization may depend to continue serving its mission.

3. ***Community and social ecological systems in which the project evolves.***

   - The first element includes *social cohesion* and *community competence*.

   - The second element includes a number of issues within the *environment* of the project in the largest sense: national policies, the economic and political environment, and the environmental and human development situation. These issues are frequently, but not always, outside of a project's scope of intervention. They may, however, be relevant to a

sustainability assessment within a CS project because they indicate important transitional stages of development that PVOs cannot ignore.

The CS Sustainability Assessment Process

For each element within the three dimensions, the framework suggests issues that a given project may want to include in its assessment as it builds a coherent picture of how sustainability ought to be addressed in its context.

The CS Sustainability Assessment framework suggests a six-stage process[32] to define and assess progress toward sustainable health in the region of intervention of CS projects. Stages one through four are designed to go from the general to the specific by helping users articulate their vision of sustainability in the local context and from there to defining indicators in the different dimensions of the framework. Stages five and six are used to combine indicators into performance indexes for the specific dimensions, then into aggregated performance indexes to assess performance, identify priorities, and make decisions.

The six suggested stages are as follows:

1. Define the system to be assessed and its goals
2. Identify elements and objectives
3. Choose indicators and performance criteria (standards)[33]
4. Measure and map the indicators
5. Combine the indicators and map the indices
6. Review results and propose programmatic intervention or policies.

One of the strengths of this process is that it has been used successfully with communities and local partners in a participatory process familiar to most PVOs. The CSSA does not offer directives or ready-made indicators for project sustainability, but it supports the systematic development of a project "dashboard" of sustainability. Like the dashboard in a car, which summarizes the status of all the major mechanical systems that are essential to ensuring that the car continues to run smoothly, sustainability dashboard provides the project manager with an overview of the major systems and issues that might affect the long-term continuation of the health benefits being promoted. And just as a failure in any one mechanical system might result in the car's ceasing to function, changes in the status of any of the systems on the sustainability dashboard might affect the long-term continuation of health benefits or other project impacts.

As specific tools are used to measure specific issues (health status, organizational capacity, community capacity, and so on), they provide elements of information, which fit within a comprehensive and unified framework. By examining progress or stagnation on the different dimensions, project managers are equipped with an evaluation tool—just like a dashboard revealing where the critical intervention is needed—to guide their decision and to communicate with their peers.

[32] This process has been adapted from the work of the International Union for the Conservation of Nature (IUCN) in the field of sustainable development. See reference to the Community Level Sustainability Assessment by Najam.
[33] Performance criteria, or benchmarks, refer to progress along an indicator and are preferable to dichotomous indicators, which give no information on progress between two stages.

Sustainability Findings of the 2001 Program Review

PVO Progress Toward Sustainability

The trends observed in past years through the application, DIP, or program review processes have been essential to launching the efforts discussed in the previous sections. Similarly, the Sustainability Initiative and the CSSA Framework are beginning to shape the way PVOs assess and report on sustainability as they adapt the tools and key concepts from the research findings that have been integrated into the Child Survival Grants Program Guidelines.

Evidence From Evaluation Reports

CSTS's 1998-1999 Program Review suggested that PVOs were laying the groundwork for sustainability. They placed a lot of effort on training, for both technical and management issues. Developing individual skills in technical and management issues is, of course, a first step toward sustainability. Beyond this, financial viability and institutional capacity were also addressed through a variety of other strategies: creation of local NGOs, building coalitions of service providers, maintenance of the PVO in country without CSGP funding, leadership development, and so on.

For projects in the CS XII cohort (evaluated in 2000), evaluation documents address a wide range of sustainability issues, such as institutionalization; strengthening quality of services; demand for service; cost recovery; and issues of financial sustainability, leadership, and accountability development. Eleven CS XII final evaluation documents, as well as two CS XI projects, were available for this review.

This cohort of projects exhibits a stronger element of partnership in their design than in the past. Working through community health workers is a typical way for child survival projects to operate. But PVOs now work with and through local partners to support the child survival projects. The District Health Management Team was actively engaged as a partner in 11 out of 13 projects to improve quality of care at the facility level and/or provide support for and supervision of the CHWs. Community-based organizations (CBOs), sometimes through CHW associations, were systematically involved in the selection and support of the CHWs. Half of the projects also included some level of partnership with a local NGO.

Partnership has gone beyond the sometimes token collaboration of the old projects. PVOs are moving toward more genuine capacity-building partnerships and moving away from direct implementation of services. Much of what they do is about improving contacts and linkages between the traditional service providers (under the DHMT) and the community stakeholders (first of all, the CHWs and CBOs), such as health committees.

Although partnership is desirable for sustainability, it also opens the door to specific constraints and challenges, from creating dependency on the capacity of the partner to negotiating biases of financial expectation frequently encountered in nascent collaborative efforts. In spite of this, eight projects out of 13 in the CS XII cohort had particularly positive lessons about partnership. Individual capacity building in technical areas, in management skills, and in monitoring and evaluation among partner organizations' staff was the first beneficial element of partnership. The next level of partnership achievement was the building of trust and the development of more constructive and

productive professional values. Transmitting the child survival strategic vision for the long run is also an achievement of partnership that resulted from the development of respect, goodwill, and commitment. World Relief/Nicaragua links these elements to achieving high immunization rates at the district level.

The shift from direct-service implementation to partnership in intervention design and implementation is even clearer in more recent projects, some of which are going forward with institutional strengthening and pulling out of implementation altogether. These more recent projects also demonstrate an increased emphasis on capacity assessment for themselves and their partners. The trends will need careful monitoring to observe their benefits and limitations and to provide projects with the appropriate lessons, guidelines, and tools to support or advise the changing nature of their effort.

Examining Progress Through the CSSA Framework

Although the CSSA tool is still in its final stages of development, it does offer a lens through which we might examine the progress toward sustainability of grantees whose projects ended in September 2000. It is important to note that since the CSSA tool was in development at the time most of these evaluations were written, grantees did not necessarily utilize the tool to frame their evaluation findings in terms of sustainability. The degree to which sustainability outcomes are clearly articulated varies across projects, which makes it difficult to quantify trends in grantee progress toward sustainability.

Nevertheless, CS XII final evaluation documents suggest that almost all the projects achieved some amount of progress in more than one dimension of evaluation of the CSSA and most achieved some element of progress in all dimensions. Progress was achieved through establishing locally appropriate strategies to achieve valuable health goals; building capacity and viability in local organizational partners; and improving community, social, and environmental systems.

Outlined below are highlights of progress drawn from final evaluation documents:

- CARE/Mozambique's evaluation identifies the need to improve selection mechanisms for health council members, seeks to develop ongoing training of district nurses, and seeks to integrate the lessons of the child survival project into two of its other projects. Although these objectives have not yet been reached, it is noticeable that projects are now tackling this level of questions that are directly related to sustainability. In terms of results, however, progress is observed on the motivation and professional attitudes of health personnel, leading to improved quality of care. The project evaluator notes that "In addition to the behavior changes described above, the project has been successful in motivating health personnel to gain more knowledge and apply that knowledge in their work. Health personnel have come to appreciate their colleagues who assisted them in improving the quality of their work. Twenty-two health posts that received equipment and materials have enhanced their capacity to serve their clientele."

- HOPE/Peru monitored progress toward sustainability in terms of 190 community committees being organized, having regular meetings, and implementing health activities in at least 96 communities. This demonstrates attention paid to assessing not only the existence of the committees but also the *functionality* of the community structures. The functionality of the

structures are expected to play a role in maintaining the elements of the intervention over time. HOPE also achieved an improvement of the relationship and collaboration between health staff and communities and saw the establishment of associations of health promoters (in this case, breastfeeding counselors). No one has yet described the ideal sustainable project, but these results suggest an increased prospect for achieving durable health improvement, or in other words, an *ability* for the local system to *sustain* the benefits of the initial intervention.

- PCI in Indonesia has addressed the sustainability of their maternal and newborn care intervention by recognizing that access and use of services are constrained by the attitudes of men and religious/community leaders on these issues. PCI is coaching a local NGO in the skills required to communicate on culturally sensitive topics with these key audiences. This approach is likely to be both more effective and more sustainable than one led solely by PCI. Although it is true that projects rarely effectively and systematically monitor how much progress is being made toward sustainability, it is important to observe and note that relevant issues are addressed in a strategic, more than incidental, manner through such a project.

- CARE/Peru used its participatory working style to overcome traditional mistrust between the nonprofit and private sectors on one end and the public sector on the other. The evaluator of the project concludes that CARE has not only increased the institutional capacity of the local MOH partner but has also increased the buy-in of the partner on the project itself. Change-sensitive indicators are still needed to demonstrate progressive institutionalization, but we can recognize that lack of buy-in from the partner would be a sure predictor of nonsustainability.

  CARE also works with associations of community health volunteers and was able to train them in the organization of fundraising activities, in raising modest membership fees, and in securing the coalition of associations (macronetworks) from the marginal revenues of the associations themselves (micronetworks).

- CARE/Haiti discovered the added challenges of moving from direct-service provision to institutional strengthening. By using microplanning, both a development of the local capacity of its partner and an increase in the sense of ownership were observed. These positive indicators for sustainability were directly related to client satisfaction and an increase in the prevalence of contraceptive use. It is important to recognize that the project was working in a hard geographical area with a weak community-based distribution system.

- Save the Children in Mozambique described important approaches and achievements for sustainability in its evaluation: use of appropriate technologies (bicycle ambulances) to improve referrals, improving communication mechanisms between key players (thus moving away from dependence on the project alone toward local interdependencies vital for the future), influencing national policy (vitamin A distribution), building local capacity in management of a community-based information system and systematic supervision, developing community-dependent incentive systems for CHWs, and partnering with the Mozambique Department of Education for literacy work linked to the CS activities. SC also identifies a series of threats to sustainability in its program in terms of dependencies for cold chain maintenance, recruitment of nurses for its mobile brigades, lack of ownership of budget responsibilities by health staff, and lack of support for distribution of modern contraceptives by the health district. Although the narrative of the evaluation needs to be probed somewhat to extract all the information

related to sustainability, it does allow for the development of an understanding of the critical issues and the transitional stage reached toward sustainability.

- ADRA/Haiti has built sustainability elements in its project by using community-marketing channels for contraceptive distributions; improving access to services; building capacity and leadership in health committees; and strengthening information, supervision, and referral systems. It increases the viability of the intervention by diversifying sources of funding and sources of supply. Even though—in addition to engagement from the MOH—some of the new sources (Pan-American Health Organization [PAHO]/World Health Organization [WHO], PSI) are external (international), they seem to be reasonable sources of diversification given the situation of the country. The evaluation also suggests a sense of the community acceptance of the project (demonstrated by active participation, mobilization and enrollment) and of its limitations (support, but lack of proactivity, critical engagement, and initiative).

Improved Approaches to Sustainability in Grant Applications Submitted to the CSGP

In response to recommendations from the March 2000 Sustainability Dialogue, BHR/PVC took a number of measures to more intensely focus the attention of potential applicants on this issue:

- The section on sustainability in the CSGP Technical Reference Materials was substantially revised.

- The length of new and mentoring grants was extended from four years to five, and three-year "costed extensions" replaced four-year "follow-on grants." These actions were designed to provide PVOs one additional year in their base grants to build the foundations for sustainable interventions and to ensure that any additions to the base grant were planned with sustainability in mind.

One potential result of these efforts can be observed in the trends in CSGP application scores over the past two years. Beginning with CS XVI applications (submitted in December 1999), the CSGP has systematically tracked trends in scores for each evaluation criteria of applications received. With the exception of "description of the PVO applicant," sustainability was the only evaluation criteria for which scores have increased for each of the three major grant categories (entry, new, costed extension) over the past two years. The average increase was 4.6 points on a 10-point scale over the two-year period.

Conclusions on Sustainability in the CSGP

This year's program review shows encouraging trends in terms of the prospects for sustainability of PVC-funded child survival programs. This is especially encouraging given the environment in which child survival programs operate. The reasons that justify implementing a child survival program in the first place are related to poor socioeconomic conditions, which projects cannot alter on their own and which heavily condition the sustainability of their efforts. Even given their efforts and achievements, the projects can still be questioned about the sustainability of their achievements—because of design factors but even more because of external factors often out of their control, such

as provincial-level vaccine stock-outs for district-level projects working in partnership, slow cultural change (even at the MOH decisionmaking level) on issues affecting project effectiveness, poor local human resource practices in local institutional partners, catastrophes and geographical factors, and so on.

The attention given to this area in the Child Survival RFA and corresponding program guidelines has contributed to an overall improvement in the approach to sustainability outlined in applications over the past two years; detailed implementation plans are demonstrating more sophisticated approaches to sustainability than in the past, which holds promise for positive results when those projects end in three to four years.

So far, however, guidelines have been more helpful in suggesting better documentation of sustainability plans than in providing measurement tools and programmatic direction. There is still frequently a disconnect between even the best thinking about sustainability in the project documents and the M&E plans that provide the information to guide management decisions. This disconnect only increases as implementation gets under way. Midterm evaluations rarely lead to any strategic program reorientations based on the initial sustainability rationale of the project. Beyond the increased focus on measuring capacity in child survival projects (see the Capacity section of this document), as a collective CS community, we have had almost no available tools to guide evaluation, information, and decisions about our concerns for sustainability. Current models are neither operationalized nor applicable to the programmatic diversity of CS interventions. The evaluator of the CARE/Haiti project seems to underline this need in her statement: "The absence of a structured phase-out strategy as part of the sustainability plan made it difficult to assess the level at which some project activities would be continued."

The collaborative development of the CSSA with the PVO community constitutes the beginning of a shared framework for approaching the issue of sustainability. This development holds promise for newly starting and future projects.

Across the Child Survival Portfolio, there is also evidence of critical and strategic thinking about sustainability factors in almost all projects to some extent:

- In achieving progress on crucial health conditions and community-based health care services
- In their intervention approaches (appropriate technologies, partnership, leadership building, community participation)
- In building local capacity (technical skills, management skills, functionality of community associations, management of health district operations)
- In increasing the long-term viability of community associations and the relationships between key local stakeholders (thus increasing the prospect that flexible adjustments can be made with time in order to sustain intervention components) in developing public-private partnerships
- In increasing community support for health workers at the cultural and organizational level, in increasing the ownership and institutionalization of more effective supervision and quality of care with health districts, and in demonstrating increased client satisfaction for services

- In advocating policy change and in linking their health intervention with environmental and agricultural interventions.

In short, this year's projects have developed many conditions, mechanisms, capacities, and linkages that are not only supportive of, but also necessary for, sustainability. The efforts placed on these elements certainly increase the prospect that many of the projects' achievements will be maintained.

RECOMMENDATIONS

CSTS has identified several areas in which PVOs involved in the Child Survival Grants Program can grow and develop. In addressing these areas, we have formulated the following recommendations:

Technical Areas

Preventive Caretaker Behavior

- In the area of malaria prevention, PVOs need more experience in how best to introduce and/or promote the appropriate use of insecticide-treated materials such as bednets. Partnering with the private sector should be encouraged.

- Where possible, PVOs should be encouraged to take on the challenge of introducing proven diarrhea prevention activities to decrease the incidence of diarrheal diseases.

- Especially in areas where EPI coverage is below national or World Health Organization goals, PVOs should consider including EPI activities in their programs and adopt a comprehensive approach to immunization. PVO and local-partner organizations would enable implementation of EPI programs that ensure quality and safety and include a surveillance component.

Illness Recognition, Care-Seeking, and Access to Quality Care

- PVOs should continue playing a leading role in defining and introducing community IMCI both in their target area and on a global level.

- If it is possible in the project context, PVO programs should be encouraged to make every effort to ensure that the target population has proper access to trained providers through negotiation with local health authorities.

- PVOs should be further encouraged to play a role in promoting the introduction of health facilities that serve their target area. Simple health facility assessment tools should be developed, and their use should be encouraged and documented.

- As a stand-alone, disease-specific intervention, pneumonia case management should only be promoted in settings where Integrated Management of Childhood Illnesses has not yet been introduced. PVOs should be encouraged to document and promote proper recognition, care-seeking, and treatment for ARI, including counseling. This can be done as part of the IMCI strategy. Successes in negotiations with local health authorities that ensure access to quality first-line providers—such as new regulations allowing village health workers to administer appropriate first-line antibiotics—should be documented and replicated where possible.

- Programs could be improved if PVOs could expand their involvement in the promotion of proper recognition, care-seeking, and treatment (including counseling) for all diarrhea cases

(not only acute watery) as part of the IMCI strategy at all levels (household, community, and health facility).

- The PVO programs could be strengthened if they used IMCI to better participate in or provide support for effective training in malaria case management, supervision of health workers (including CBD agents, shopkeepers, and pharmacists), and assurance of an adequate supply of the antimalarial drugs of first choice.

- All maternal and newborn care programs in malaria-endemic areas should be strengthened to include a malaria component.

- Another area for potential growth is the provision of and accessibility to quality emergency obstetric care. In addition, promotion of early detection and management of pregnancy-related problems such as anemia, pre-eclampsia, malaria, and STIs should be addressed, as well as promotion of deliveries by skilled birth attendants, improved care of the mother during the postpartum period, and improved care of the newborn.

Nutrition

- An area for potential PVO growth is a comprehensive approach to the problem of malnutrition. The efforts underway to document successes and to measure the effect of programs on nutritional status should receive further encouragement and support.

STIs and HIV/AIDS

- Some PVOs are addressing the AIDS epidemic and its effect on child survival. AIDS-related activities, including people living with AIDS, home-based care, and work with AIDS orphans and vulnerable children need to be documented to ensure funding for these activities in the future.

General Technical Approach

- PVOs should consider developing a comprehensive approach to child health.

We have now come to understand better what leads to childhood deaths and have the know-how and technology to avoid those deaths. The conceptual framework, "The Pathway to Survival," is one outline that may be useful to PVOs in helping to conceptualize the development, monitoring, and evaluation of child survival programs. The framework was adopted and adapted and illustrates the interactions of wellness and illness with care inside the home and care outside the home. A third dimension, the community, has now been added (see the CSTS publication "Reaching Communities for Child Health and Nutrition: A Framework for Household and Community IMCI"). The "pathway" or framework forces thinking in terms of comprehensive behavioral and health systems interventions.

PVOs have traditionally worked with the "wellness" or the preventive side in the community and the "inside the home" components of the pathway. Ministries of health traditionally work on the

"outside of the home" side. Few PVO projects have adopted a comprehensive approach encompassing each aspect of the framework, and suggesting that they do so could be demanding too much. However, PVOs could define and develop a minimum package of activities for child survival or each technical component. By keeping the framework in mind while developing a minimum package, each of the quadrants can be addressed in some way. The application of this concept would enable maximization of results for effort and funds expended.

A minimum package of activities would be most useful and accepted if written by the PVOs themselves. The CORE Malaria Working Group has suggested a minimum package for malaria interventions. Other working groups could develop minimum packages for various technical areas. After the framework, the package would deal with preventive measures (inside and outside the home), as well as with sickness recognition, care-seeking, and provision of quality care (inside and outside the home).

For malaria, the proposed minimum package includes the following elements:

- The "wellness—inside the home" quadrant suggests that programs "improve malaria prevention and appropriate treatment in pregnant women."

- The "wellness—outside the home" quadrant advocates the "promotion of appropriate communitywide (especially children and pregnant women) use of insecticide-treated materials (nets and others) for prevention of malaria" and the "promotion of other simple and effective environmental approaches to malaria control."

- The "illness—inside the home" and "illness—outside the home" quadrants follow the IMCI strategy of "improving malaria recognition and appropriate case management in infants."

Monitoring and Evaluation

Information Management and Use

- Projects that have not yet experienced a participatory evaluation are encouraged to make use of the method as a means to encourage local ownership by stakeholders and increase interest in sustaining high-caliber service delivery. A manual describing how to use the method is available on the CSTS Web site in English, Spanish, and French.

- Examples of how HFAs are used to improve quality of care need to be compiled. Projects could use the assessments as a basis for selecting continuing education topics. Exercises and activities on these topics could be made a part of regularly scheduled staff meetings.

- Projects may be advised to connect with outside experts, such as local universities, or through interns from U.S.-based institutions or cooperating agencies to access assistance to design, implement, and analyze applied research activities and strengthen local capacities in applied research.

Community-based Data Collection and Use

- More attention is needed to developing lean, useful monitoring systems and graphic and innovative presentations, so local users can routinely incorporate this information in decisionmaking to improve health- and nutrition-related service delivery. Additional focus on using community-gathered data for tracking community behavioral change, such as feeding behavior and recognition of danger signs or care-seeking, would contribute to fine-tuning strategies to improve child health.

- Additional case studies of monitoring systems illustrating how data are used by local decisionmakers are needed.

- Attention to the development and adoption of useful nutrition and health surveillance systems by local communities may be advanced through symposia on "Community-Based Data Collection and Use" similar to the meeting organized in Cambodia to share lessons and focus attention on collecting only information that is useful and used.

- Improvement in health workers' performance deserves additional monitoring. In addition to technical skills and knowledge, the ability to provide counseling and mobilize or empower communities is important.

Measuring the Results of Program Impact

- The sampling design and sample size of KPC surveys needs to be given more attention. Alternative sampling strategies including parallel sampling need to be disseminated. Data need to be reported with the design effect attributable to cluster sampling and with the size of the sample for each indicator. An observed difference should be reported with the confidence interval.

  The decision to make a before-and-after comparison must be made at the beginning of the program, and the sample size of the baseline survey must be calculated appropriately. To statistically demonstrate a difference between the baseline and end-of-project estimates, larger samples or different sampling designs are needed, thus reducing the two levels of imprecision. Small changes at the population level cannot be detected using the 30-cluster (n=300) sampling techniques commonly used by child survival projects.

- Since the KPC 2000+ with Rapid CATCH has been developed with sampling options and a field guide, additional training of PVO headquarters and field staff, in conjunction with local partners and regional training institutions, is needed. Training could be used to update and strengthen the capacity of all stakeholders to design, implement, analyze, and use data from small-sample surveys adapted to their project context. It could also strengthen capacity to establish a baseline and then estimate program results in terms of population-level nutrition and health practices by caretakers of infants and children under five.

- The utility of the Rapid CATCH key indicators to track critical life-saving behaviors for infants and children needs to be widely discussed and incorporated into child health information systems.

Opportunities for M&E Capacity Building

- Measures of capacity-strengthening indicators of health workers and health facility systems leading to increased quality of care need to be developed and tracked.

- Regional capacity to support projects to develop local staff and partners' ability to carry out and use data from small-sample surveys should be inventoried. Ideally, regional training in conjunction with established institutions could be organized for new project grantees based on the revised KPC 2000+ and different sampling options. The emphasis would be on understanding survey data and how to use the information for management improvement.

- Although the main use of baseline data for the entire population of the project area is to develop objective targets to be reached by the end of the project, we recommend that PVOs place more emphasis on developing the ability to disaggregate data to meaningful sets. This includes collecting and reporting data for strata—geographical subprogram units, as well as data for different subgroups of beneficiaries (girls versus boys, for example) and their caretakers (literate versus illiterate, young versus old, indigenous versus other ethnic groups, isolated marginal groups versus those with high centrality along a road or near a market, and so on.). PVOs can also mine population data with simple cross-tabulations to look for differences that could be useful for informing project strategies.

  For example, HKW/Niger identified three different cultural and ecological zones and conducted baseline and final surveys for each zone. They also developed DIP objectives specific to each zone. Then data were reported for communities with different levels of access: villages with a Village Animation Committee and villages further away that did not have one.

- PVOs should consider involving their local partners and other stakeholders in carrying out and analyzing baseline and EOP population survey data to increase M&E capacity. This will ideally lead to increased ownership in jointly selected objective targets and adoption of a management-for-results perspective.

- Reports of baseline and other KPC surveys should be crafted using the October 2000 guidelines on "Writing the KPC Survey Report," which is posted on the Web with the KPC 2000+ survey modules. These guidelines include a section on "Process and Partnership Building," where projects are encouraged to discuss partnership and capacity-building activities as they relate to the KPC process.

- Participatory evaluation approaches should be adopted wherever possible for midterm and, where appropriate, final evaluation activities.

- Grantees should seek to foster a learning process approach to M&E that is rooted in continuous learning and continuous improvement. The focus of this approach should be how to systematically collect and utilize information for planning, monitoring, and decisionmaking in an ongoing manner. It includes both qualitative and quantitative information and involves many different sources—from field staff to beneficiaries and persons with outside experience in other projects. It involves an open exchange of ideas and participation by a wide variety of persons with an interest in improving health and service delivery. It emphasizes the

involvement of stakeholders at all levels in periodic reflection on project or health system strategies to reach improved health outcomes.

Capacity Strengthening

CS XII final evaluations offer some clear examples of how capacity building has occurred at various system levels through the Child Survival Grants Program. Recent applications and DIPs suggest that even stronger data will be available on capacity-building outcomes of projects that will end in the years to come. The recommendations below are offered for the purposes of further strengthening the capacity development efforts of CSGP grantees:

- In projects that are working at the health facility level or working with newly decentralized health systems, PVOs seem to be well positioned to play an important role in strengthening that health system. This recommendation is intended to encourage projects that will soon be conducting midterm or final evaluations to examine the role of the project in strengthening decentralized health systems.

- Anecdotal evidence from PVO documents suggests that Child Survival Grants may have spill-over effects on civil-society development by helping to build problem-solving skills at the community level, developing community-based development associations, enhancing community response to conflict or disaster, and so on. It is recommended that projects that will soon be conducting midterm or final evaluations examine the role of project activities in contributing to civil-society development.

- There is emerging evidence from this program review that PVOs are rapidly gaining capacity in developing, selecting, and conducting organizational assessments with their local partners and even for their own PVO organizations. It is recommended that PVOs ensure that these capacity assessment processes are presented and used as tools for building partner relations or strengthening working relationships in the PVO itself, as opposed to top-down, expert-driven assessments.

- This program review points to increased attention to strategic capacity development—the systematic identification of organizational strengths and weaknesses and the development of strategies that build on those strengths and address the weaknesses for the purpose of achieving project results. It is recommended that CS grantees continue to undertake this systematic approach to capacity development and that they seek opportunities to document and share their lessons learned with the variety of tools that they have used.

- The increased availability of data on organizational capacity should better position PVOs to develop appropriate strategies for preparing their organizations and local partners to implement effective, sustainable health interventions at the community level. However, there is little data on the relationship between enhanced capacity, enhanced service delivery, and improved health outcomes. It is recommended that PVOs explore opportunities for comparing data from multiple sources to draw conclusions about the impact of capacity development on improved health outcomes.

- It is recommended that PVOs, in their new programs, consider approaching capacity development activities through the window of sustainability. This would be accomplished by

first asking, "What capacities need to be in place and for whom for our project's health interventions to be sustainable at the end of the project?" The capacities identified in response to this question would then be the basis for the program's capacity development plan.

Sustainability

- It is recommended that new grantees undertake a more systematic approach to project planning that incorporates sustainability issues from the earliest stages of planning. PVOs in the Child Survival Grants Program today are faced with the challenges of working in the most difficult environments, building the capacities of local partners who themselves may have few resources for working in those environments over the long term, and measuring and reporting on a limited number of indicators that can be used for management decisionmaking and to demonstrate project results. It is important that the issue of sustainability not assume a role that is perceived to be parallel to project results and capacity building, but one that is in fact integrated with these and other factors. To date, there has been no common framework or evidence of a shared understanding of sustainability among the PVO community.

- It is recommended that PVOs seek to use formal assessment tools to gauge progress toward sustainability. Final evaluations reviewed for this report suggest that for many Child Survival Programs, sustainability, if measured at all, is examined during the final evaluation of the project. Midterms for CS XIV suggest that some PVOs are beginning to examine progress toward their sustainability objectives after two years of the project. There is still a great need for better assessment tools to gauge progress. Any assessment tool must look at the multiple dimensions that sustainability planning requires.

- Crucial pieces that are still missing for most if not all of these projects is a preimplementation description of the following:

  - ✓ What the realistic vision of sustainability for the project was

  - ✓ How the different levels addressed by the project were expected to interplay in pursuing this vision

  - ✓ The indicators of progress—not just the descriptors of presence/absence of key recognized factors such as community participation—that could inform the project about the *extent* to which it has achieved its objectives at the different levels on which sustainability is being pursued.

- The tools and approaches need to be shared and critically reviewed by peers and field use. This is the case not only for the CSSA but also for specific tools or adaptations used by individual PVOs. Much like the effort around Community IMCI, sustainability is not a place where learning will take place in isolation. PVOs should increase their leadership in defining, planning for, and measuring progress toward sustainability.

CONCLUSIONS

It is now generally accepted that progress has been made in the health of general populations and that childhood mortality in developing countries has declined over the past few decades. It is also unmistakable that the gains are not made on an equitable basis. Not only have the rich become richer, but in many instances the poor have become poorer. Poorer populations have not profited equally from the gains made; in some "forgotten" areas of the world, childhood mortality has even increased.

PVO programs involve populations that are frequently not reached by other means. They play a crucial role in enabling mothers, households, and communities to improve their health. Today, as health systems have become decentralized to the district and community level, CS grantees are playing an important role in bridging the gap between communities and newly established health systems designed to serve them.

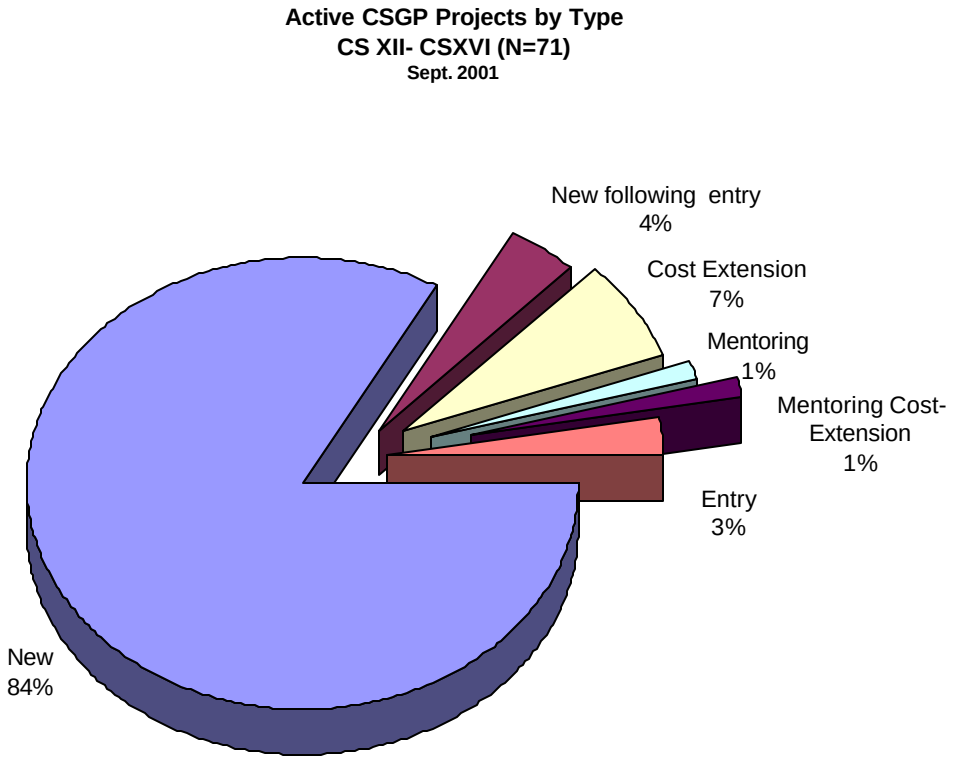
The strength of the PVOs is their work with communities situated at the end of the road both physically and economically. Innovation, and consistent work at the community level, are two other hallmarks of the PVOs in the Child Survival Grants Program. This is true especially in the areas of social mobilization, behavior change, and other grassroots-level activities. Hearth is just one example of a community-based approach that leaves long-term results. Innovations such as Project HOPE's use of fortified cocoa also promise to leave widespread, lasting effects.

PVOs are placing increasing emphasis on issues such as sustainability and capacity building. DIPs and applications show that PVOs have begun to systematically measure capacity development, both within their own organizations and among their organizational partners. PVOs have also taken on an increased role in strengthening decentralized health systems by means of capacity development activities.

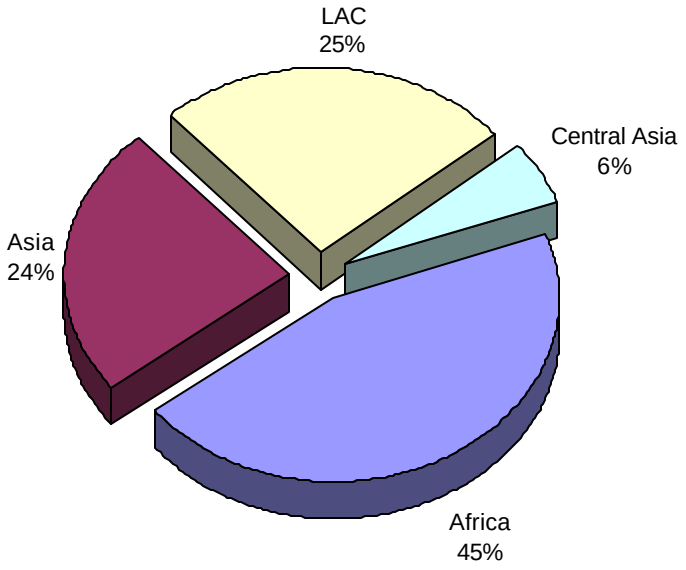
Projects in the present CS portfolio have developed many conditions, mechanisms, capacities, and linkages that are necessary to ensure sustained health benefits at the community level.

Organizations that have received grants from the Child Survival Grants Program are now committed to focusing on the unfinished agenda of improving child health globally. Having played a key role in defining a framework for HH/C-IMCI, the organizations can place emphasis on promoting household behaviors not dependent on the performance of health systems, while building the capacity of the formal health system to reach underserved populations better.

CHILD SURVIVAL GRANTS PROGRAM PROJECT LOCATIONS AND INTERVENTIONS



Active CSGP Projects by Region
CS XII - CS XVI (N=71)
Sept. 2001



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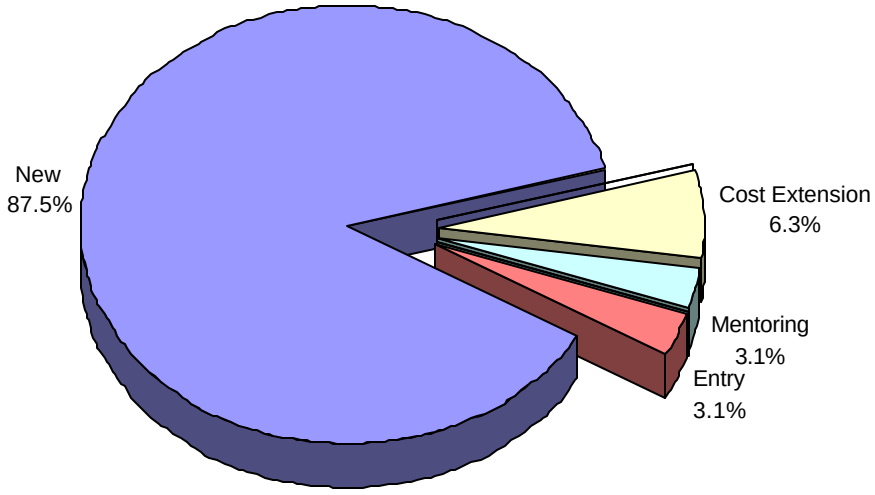

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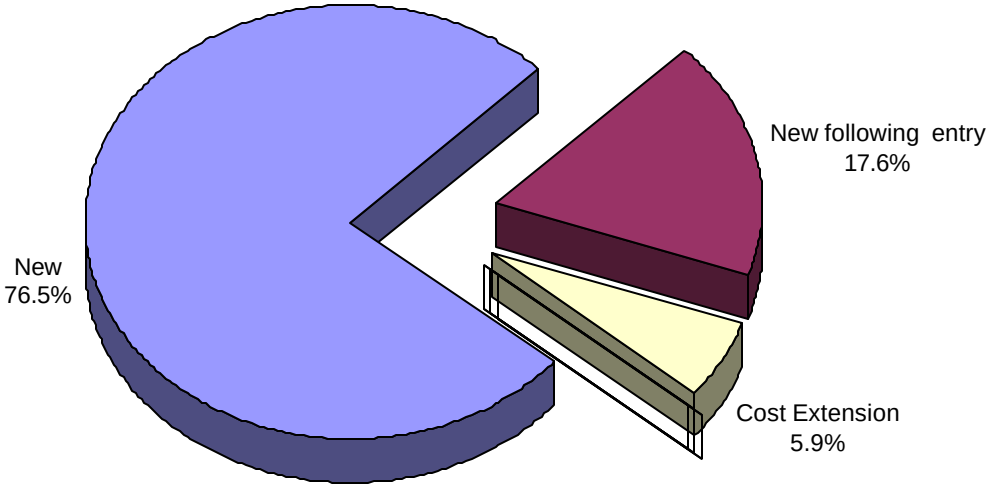

Active CSGP Projects
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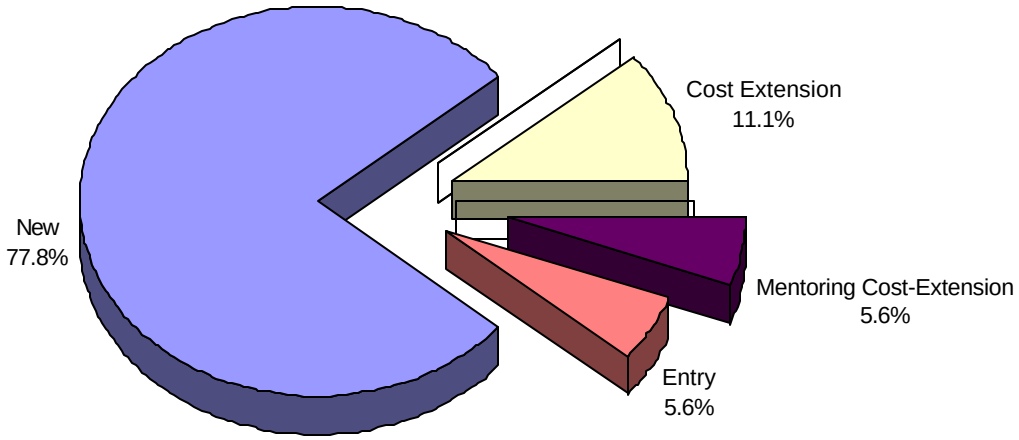
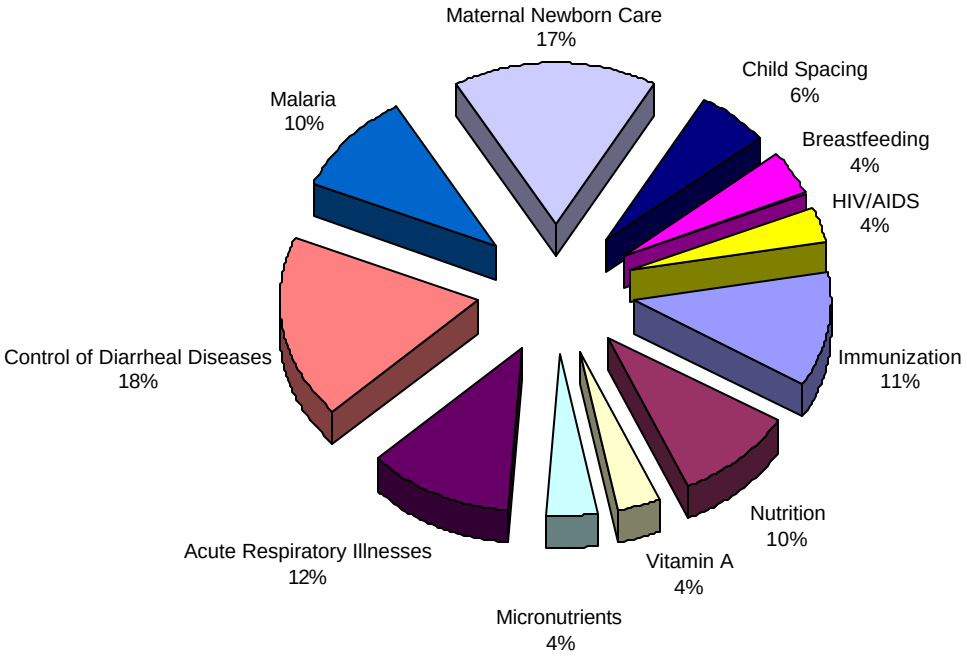
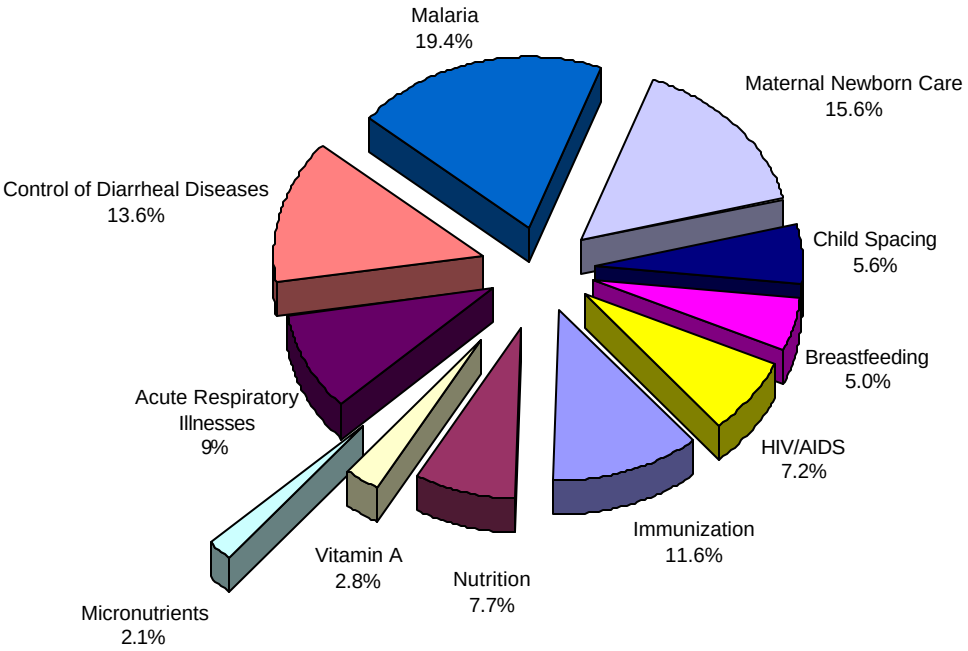


Composite Intervention Mix for Active CSGP Projects
All Countries
Sept. 2001



Composite Intervention Mix for Active CSGP Projects
AFRICA
Sept. 2001



Composite Intervention Mix for Active CSGP Projects
Asia/Near East
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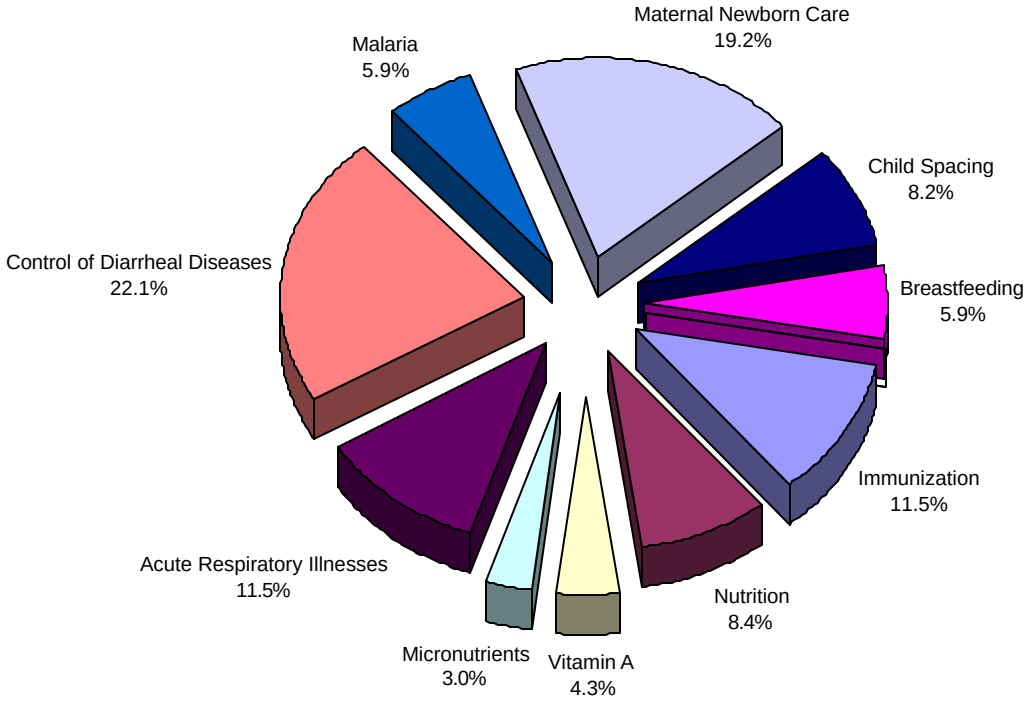

Composite Intervention Mix for Active CSGP Projects
Latin America/Caribbean
Sept. 2001