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CHILD SURVIVAL GRANTS PROGRAM REVIEW

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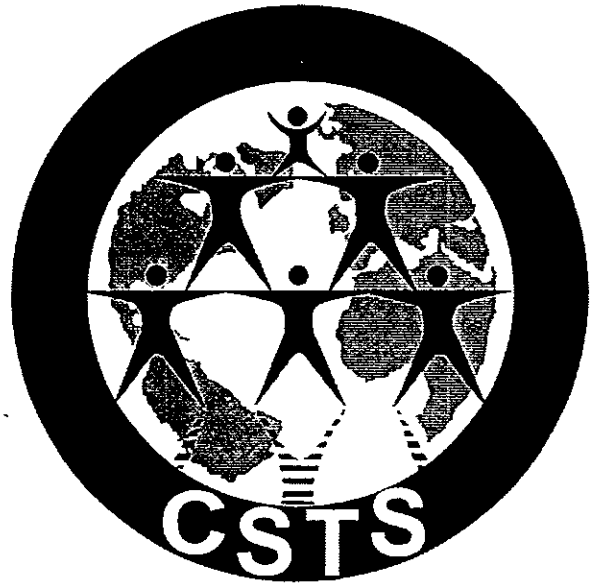

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B

TABLE OF CONTENTS

c

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

ADRA	Adventist Development and Relief Agency
AFP	Acute Flacid Paralysis
ARHC	Andean Rural Health Care
ARI	Acute Respiratory Infection
ASACO	Associations de Santé Communautaire
BASICS	Basic Support for Institutionalizing Child Survival
BHR	Bureau of Humanitarian Response
CA	Cooperating Agency
CBD	Community-based Distribution
CBO	Community-based Organization
CORE	Child Survival Collaborations and Resource Group
CDD	Control of Diarrheal Disease
CSGP	Child Survival Grants Program
CSSP	Child Survival Support Project
CSTS	Child Survival Technical Support Project
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
Hib	Haemophilus influenzae type b
HKI	Helen Keller International
HIS	Health Information System
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Result
ITM	Insecticide-treated Materials
KPC	Knowledge, Practices, and Coverage
LAM	Lactational Amenorrhea Method
LGU	Local Government Unit
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MNC	Maternal and Newborn Care
MOH	Ministry of Health

NID	National Immunization Day
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PCM	Pneumonia Case Management
PLG	Program Learning Group
PLAN	PLAN International
PVC	Office of Private and Voluntary Cooperation
PVO	Private Voluntary Organization
RFA	Request for Application
RHF	Recommended Home Fluids
RHU	Rural Health Unit
SOTA	State of the Art
STI	Sexually Transmitted Infection
TT	Tetanus Toxoid
VHC	Village Health Committee
VHW	Volunteer Health Worker
VVM	Vaccine Vial Monitor
WRC	World Relief Corporation
WVI	World Vision International

1998 - 1999
CHILD SURVIVAL GRANTS PROGRAM REVIEW

I. INTRODUCTION

OVERVIEW OF STUDY

Since 1985, the U.S. Agency for International Development, Bureau of Humanitarian Response, Office of Private and Voluntary Cooperation has funded U.S.-based private and voluntary organizations (PVOs) to implement child survival programs in countries with high degrees of infant and child mortality. As of April 2000, the portfolio of projects supported by BHR/PVC's Child Survival Grants Program (CSGP) included 75 projects implemented by 26 PVOs in 36 countries.

Since 1998, the Child Survival Technical Support Project (CSTS) has provided assistance designed to impact the overall quality of the CSGP portfolio of projects. This assistance addresses an array of technical intervention areas, incorporates a variety of monitoring and evaluation approaches, and seeks to build capacity at multiple levels of intervention.

CSTS, as part of its results package, developed this report to outline a review of the portfolio of active projects funded by the CSGP as of January 2000. To ensure a representation of projects from different stages of the grant cycle in the present portfolio, CSTS analyzed a variety of PVO project documents:

- 18 final evaluations completed by the CSGP grantees in 1998 and 1999
- Funded applications for CS-XV (1999-2003)
- Applications submitted for CS-XVI (2000-2004) funding
- A selection of Mid-term evaluations of CS-XIII projects (1997-2001)
- Detailed Implementation Plans (DIPs) submitted for CS-XIV (1998-2002).

A number of tools were applied in analyzing these documents, including a State of the Art Checklist for Child Survival Interventions, and statistical analysis of baseline and final KPC data. CSTS staff performed a content analysis of M&E, capacity building, and sustainability data presented in evaluations, mid-terms, and applications. The specific methodological approach to this study is outlined in the next section of this report.

The review of the grants program portfolio is presented in Chapter II in four major analytical sections. The first section provides an overview of the grants program. It examines types of projects,

regional dispersion of projects, cost per beneficiary, and overall intervention mixes for active projects. The Technical Interventions section discusses nine intervention areas, and how these areas are addressed by the organizations participating in the BHR/PVC Child Survival Grants Program. The third section of the review discusses the monitoring and evaluation aspects of projects in the CSGP portfolio. Capacity strengthening, including capacity building, partnership, and sustainability issues, is addressed in the fourth section.

In looking at the results of this review, it is important to note that the Child Survival Grants Program is evolving in a changing environment. Some of the factors in this changing environment are listed below:

- USAID is placing increased emphasis on managing for *results* and using a results framework to facilitate planning for sustainable, cost-effective service delivery.

- Health systems have devolved and, with decentralization, there is a need for strengthening health management systems at the district and municipal levels.

- Health service delivery strategies are emphasizing greater integration of services, in contrast to vertical programming.

- PVOs are moving from direct service delivery and PVO-oriented projects—sometimes with parallel systems—to working with local partners and providing coaching, mentoring, and capacity strengthening for local actors and systems that provide sustained service delivery.

Against this background, the Child Survival Technical Support Project (CSTS) reviewed the portfolio of child survival (CS) projects to identify strengths, challenges, and growth areas. Section III of this document offers specific recommendations based on the review.

KEY FINDINGS OF PVO PROGRAM STRENGTHS

Within the constantly changing, challenging environment in which they operate, PVO child survival projects have been able to demonstrate success in several areas. Outlined below are PVO strengths as identified in the analysis.

- Important gains in all child survival technical areas have been demonstrated by CSGP projects. Comparisons between the baseline and final evaluations show high levels of change in child immunization, maternal tetanus immunization, and exclusive breastfeeding.

- Although historically there has been a lack of baseline data on partner capacities to contribute to CS programs, there is evidence that grantees are beginning to explore tools and strategies for collecting this level of data.

- There is evidence that PVO grantee capacities are built through the experience of implementing CS programs; however, systems for reporting on this capacity building still need to be developed.

- There is evidence across the portfolio of child survival projects that sustainability is being addressed in the areas of individual behaviors, financial viability of services, and development of institutional capacities in partners.

- The PVOs perform well in harnessing community involvement and participation to increase immunization coverage, and introducing or strengthening efforts to reach the "difficult to reach."

- Where PVOs have opted to support immunization, coverage rates have generally increased. In some project areas, rates have more than doubled.

- Several PVOs are introducing and documenting innovative ways to introduce and/or to promote growth-monitoring programs that not only identify children with problems, but also implement corrective measures. Some have spearheaded cost-effective nutritional rehabilitation models, such as the Hearth method.

- PVOs are successful in promoting proper care-seeking behavior for Acute Respiratory Infection, including early recognition of danger signs, compliance with prescribed treatment, and knowledge of the location of competent providers.

- PVOs implementing current child survival projects are committed to the Roll Back Malaria initiative. Their strengths are in improving access to quality providers and promoting proper care-seeking behavior. The latter includes early recognition of and care seeking for fever, compliance with the prescribed treatment, and knowledge of the location of a competent provider in cases of severe disease.

- The PVOs are strong on promoting preventive care, such as iron supplementation and tetanus vaccination for pregnant women.

METHODOLOGY

Several types of documents were analyzed for this Program Review. Documents examined included Final Evaluations, Mid-term evaluations, Detailed Implementation Plans (DIPs), and applications written in response to the CSGP FY2000 RFA.

An in-depth review of the final evaluations of projects completed in 1998 and 1999 was carried out. Final evaluation documents from 18 child survival grants projects finishing in 1998 and 1999 were analyzed for strengths and potential for improved performance. Five of the projects were in the CS-X grant cycle and 13 were in the CS-XI grant cycle. Six additional projects from the CS-XI grant cycle have received no-cost extensions and will be submitting Final evaluations in 2000. Of the 18 projects reviewed, 11 have finished their PVC grant funding, while seven have been awarded follow-on CS-XV grants.

CSTS used a general checklist developed by the Office of Private and Voluntary Cooperation (PVC) for measuring PVO capacity (see Attachment C). Other tools included 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 Knowledge, Practice, and Coverage (KPC) indicators at the baseline and final to construct the performance index.

A general review was then carried out for the 75 projects currently receiving funding. Data from the CSTS child survival project database were utilized to describe the universe of current projects. General trends were determined from Mid-term evaluations of CS-XIII projects, Detailed Implementation Plans for CS-XIV, and funded applications for CS-XV, as well as applications for CS-XVI funding.

CSTS conducted a content analysis of the Mid-term evaluations and DIPs, with special emphasis on monitoring and evaluation, capacity building, and sustainability trends. Applications were viewed strictly through the lens of the SOTA checklist.

II. REVIEW OF THE CHILD SURVIVAL GRANTS PROGRAM PORTFOLIO

OVERVIEW OF CURRENT PORTFOLIO

As of September 2000, the USAID Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC) funds 75 child survival grants in 36 countries. These projects are implemented by 26 PVOs and their non-governmental and Ministry of Health (MOH) partners. The current projects include those initiated between 1995 (CS-XI) and 1999 (CS-XV). This analysis of the grants includes five projects from CSXI, which had received extensions into the year 2000. As can be seen in Table 1, subsequent cycles show an increasing number of projects funded each year. Over the last four cycles, the trend in the type of projects funded has remained relatively consistent, with the majority of projects being either new or follow-on grants, with a slight decline in the number of entry grants.

The five cycle categories include entry, follow-on, mentoring, new, and new following entry. *Entry grants* are those awarded to PVOs that have never received a competitively awarded BHR/PVC-funded PVO Child Survival Cooperative Agreement, but that do have some experience in implementing community health programs in developing countries. *Follow on programs* are those proposed to further develop an existing program where the PVO has implemented a BHR/PVC-funded PVO Child Survival program. *Mentoring grants* involve a partnership between two U.S.-based PVOs, in which a more experienced PVO mentors the lesser-experienced PVO. Those programs implemented by an experienced PVO in an area where they have not previously carried out child survival programming are considered *new grants*. Entry grants which are funded for a four-year cycle after having successfully written a DIP for the project site are classed as *new following entry*.

Types of Projects

Table 1 Number of Active BHR/PVC Child Survival Projects by Project Type and Cycle

	Type of Child Survival Project					
Child Survival Cycle	Entry	Follow-on	Mentoring	New	New following entry	Total
CS-XI	0	4	0	1	0	5
CS-XII	0	4	0	10	0	14
CS-XIII	4	5	1	7	0	17
CS-XIV	2	5	0	11	0	18
CS-XV	2	6	0	12	1	21
Total	8	24	1	41	1	75

Analysis of Projects by Region

The Africa Region and the Asia/Near East Region have shown a steady increase in the number of funded child survival projects: 31 are currently operating in Africa, and 20 in the Asia/Near East region (Table 2). A general downward trend for funding in the Latin America/Caribbean Region was reversed in the last funding cycle. There are only two projects in the Europe/Eurasia Region.

Table 2 Number of Active BHR/PVC Child Survival Projects by Region and Cycle

Child Survival Cycle	Africa	Asia/ Near East	Europe/ Eurasia	Latin America/ Caribbean	Total
CS-XI	1	2		2	5
CS-XII	5	2		7	14
CS-XIII	6	4		7	17
CS-XIV	8	6	1	2	17
CS-XV	11	6	1	4	22
Total	31	20	2	22	75

The Latin America/Caribbean Region and the Africa Region show the highest proportion of follow-on grants (41 percent and 35 percent, respectively). Differences between regions regarding project-type mix are small, although the Latin America/Caribbean Region has a much smaller proportion of entry grants than the other two major regions. The two projects currently funded in the Europe/Eurasia Region— Tajikistan (CS-XIV) and Uzbekistan (CS-XV)— are new projects.

Cost Per Beneficiary

In this analysis, most financial information for current projects comes from DIPs. Financial information for projects funded under CS-XV, however, was sparse because it came from project applications. Thus, only 56 active projects can confidently be used to compute cost-per-beneficiary statistics. For the purpose of this analysis, *beneficiaries* include children less than five years of age and women of reproductive age in the targeted project areas. Projected births over the course of the project were not included as beneficiaries. The cost per beneficiary was calculated on a *cost per beneficiary per year* basis.

It has not been possible to more thoroughly examine the factors affecting cost-effectiveness for the various projects and results due to the differences between projects. For example, the number of beneficiaries in the CS-X and CS-XI projects varied from 16,100 in Nepal (Save the Children) to more than a million in the Philippines (Helen Keller International, HKI). The types of interventions also varied substantially as well. HKI was working to reactivate poorly functioning or nonfunctioning nutrition committees at provincial and municipal levels in eight provinces. Their goal was to develop an integrated intersectorial view of nutrition aimed at improving the nutritional status of the entire population. Save the Children, on the other hand, worked with 14 of 61 remote village-development committees in Nuwakot district, a hilly section of the central development region northwest of the capital Kathmandu. The project sought to maintain immunization coverage

levels, teach the signs and symptoms of illness, increase care-seeking for acute respiratory infection/pneumonia case management (ARI/PCM), encourage appropriate care for control of diarrheal diseases (CDD), and promote vitamin A supplementation. Additionally, Save the Children worked in the areas of maternal and newborn care, child spacing, and HIV/AIDS.

Another factor causing the large differences in cost per beneficiary among projects (as seen in Table 3) is the variation in the definition of what constitutes a beneficiary. Is a beneficiary defined only as a direct recipient of a project intervention, or can a beneficiary also be a tangential recipient of the benefits of the program's presence? This difference is clearly illustrated by projects in the three major regions. For example, in the Latin America/Caribbean Region, cost per beneficiary ranges from $3.78 (Project Hope/Nicaragua's Follow-on project) to $68.64 (Christian Children's Fund/Guatemala's New project). Table 3 shows the high, low, and average cost per beneficiary per year by region.

Table 3 Costs Per Beneficiary Per Year by Region for Active Child Survival Projects

	Cost Per Beneficiary Per Year		
Region	High	Low	Average
Africa	$45.54	$0.32	$7.35
Asia/N.E.	$22.09	$0.58	$7.60
L.A./Caribbean	$68.64	$3.78	$15.78
Europe/Eurasia	$7.09	$7.09	$7.09

Intervention Mix

The current portfolio of child survival grants is defined by nine intervention categories. Starting with CS-XV, a category was added for breastfeeding. In the earlier cycles breastfeeding (as an intervention) was included under "maternal and newborn care," "nutrition and micronutrients," "child spacing," or "other." Graphs in Appendix A show the intervention mix for all current CS projects and for current projects in the four regions. It should be noted that the proportion of "other" interventions is slightly inflated due to incomplete information on the intervention mix from CS-XV grant applications.

TECHNICAL INTERVENTIONS: FINAL EVALUATION REVIEWS AND ACTIVE PROJECTS

As part of the program review, 18 Final evaluation reports for CSGP projects were reviewed and the child survival technical interventions of the PVOs were assessed based on a State of the Art Interventions (SOTA) checklist. Based on this review of Final evaluations, this section outlines

where the Child Survival Grants Program stands and where it might go in the future in terms of child survival technical interventions.

The SOTA checklist used in this assessment reflected the suggestions made in The Technical Reference Materials that accompany the DIP guidelines each year. By listing the most crucial components of any given intervention, the list 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 is clear why certain components are or are not part of the PVO's approach to the intervention.

The *minimum package of activities* concept has a role in this context. *Minimum package of activities* for child survival refers to a set of the most highly effective approaches to certain health-care issues which all PVOs involved in that technical area should consider addressing, regardless of PVO size or project scope. There has not yet been a minimum package developed for most technical areas. Such a package could link the technical reference materials with the SOTA checklist, and the application of this concept in the technical areas would enable maximization of results for effort and funds expended.

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 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, as they were deemed to have too little effort dedicated to the intervention to be reviewed.

Nine project intervention areas were reviewed for this analysis. These 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; as well as the Integrated Management of Childhood Illness strategy.

Immunization

Final Evaluation Review Results

Fifteen PVOs were involved in some type of immunization activity; however, only 12 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. Where sufficient data were available, it was estimated that as a result of the efforts of the intervening PVOs, an additional 43,000 children were immunized in a timely manner (an increase of over 40 percent) at year four of the CS-XV project cycle. In areas where coverage goals were not reached, the cause was usually outside of the PVO's control, such as a vaccine shortage in the country. PVOs scored high in introducing new and innovative ways to reach underserved and difficult to reach populations and in involving the community or community members in efforts to increase coverage (see Example # 1 below). One PVO (PATH/Indonesia)

was instrumental in introducing new vaccines (such as Hepatitis B) and new technologies in its area of intervention.

> **Example 1**
>
> *Community Approaches to Immunization - CARE/Niger*
>
> When gas prices doubled during the second year of the project, and as the community began to see the benefits of the immunization sessions, several communities either collected funds to pay for the nurse's gas or sent an ox/donkey cart to bring the vaccines and the nurse to the village to conduct the immunizations. During the period between November 1998 and July 1999, 42 communities participated in organizing at least one vaccination session in their community. It appears that these communities are sufficiently motivated to continue organizing vaccination sessions.

Discussion

From the final evaluation reports it was not always clear if the PVOs were involved in assuring vaccine quality. While 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 improved quality of immunization.

While child immunization is widely regarded as one of the most cost-effective interventions for reducing child morbidity and mortality, immunization rates over the past few years have stagnated in some countries and in a few instances even dropped. It is now clear that the World Health Organization (WHO) goal of achieving national coverage rates of at least 90 percent for all vaccines by the year 2000 will not be reached in most developing countries. Although this high level of coverage may not be reached on a country level, PVOs and their local partners should adopt the WHO goal of 90 percent coverage for children in their intervention areas, thereby contributing to vaccination coverage in the countries concerned.

Immunization has not received the attention it merits: only 19 out of 44 PVOs that responded to the latest CSGP request for applications include immunization in their proposed package of interventions. Some PVOs noted low coverage by the country's Expanded Program on Immunization (EPI) but still opted not to include EPI activities. They provided no rationale for this decision. PVOs that did include immunization in their intervention package spent only a small portion of their effort on these activities. Even fewer PVOs adopted a comprehensive approach to immunization.

An analysis of the Final evaluations show that few PVOs promoted the inclusion of vitamin A distribution in EPI activities or participated in polio-eradication activities (e.g., national immunization days and acute flacid paralysis (AFP) surveillance). With new funds available to the PVO community to strengthen involvement in polio eradication, this situation will probably change.

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."

Areas for Support

Some major areas that are not always addressed and thus still need strengthening are the following:

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

Nutrition, Micronutrients, Vitamin A, and Breastfeeding

Final Evaluation Review Results

Sixteen of the 18 PVOs reviewed spent 10 percent or more of their effort on nutrition-related activities. This is in line with the general acceptance that malnutrition is the major factor contributing to infant and child mortality. Nutrition is also the technical area with the greatest number of possible interventions. The PVOs that spent more effort on nutrition tended to include more interventions. Promotion of breastfeeding and appropriate introduction of weaning foods—probably the single most cost-effective way to improve the nutritional status of infants—was adopted almost universally by PVOs as a strategy to improve infant nutrition. However, since exclusive breastfeeding up to six months was not always the measured indicator or objective, it is likely that promotion of breastfeeding and appropriate infant feeding was related to local MOH policy.

Eleven PVOs promoted regular vitamin A distribution to children and/or cultivation and consumption of vitamin-A-rich foods. Only three PVOs promoted vitamin A distribution to mothers in the first weeks after delivery. Likewise, few PVOs promoted use of iodized salt, and there is little evidence that any PVOs participated in the promotion of adequate nutritional management of the sick child.

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

Discussion

It is widely accepted that malnutrition contributes to more than half of all under-five deaths. Thus, the vast majority of PVOs have implemented nutrition-related activities. In current CS grants, nutrition receives the highest 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. As a result, few PVOs are able to document the impact of their nutrition activities.

The Hearth Nutrition Model, an innovative and cost-effective approach to rehabilitation of the malnourished child, was developed by the PVO community and is being replicated at some project sites. Several PVOs are introducing and documenting innovative ways to introduce and/or to promote growth-monitoring programs that not only identify children with problems, but also implement corrective measures.

Areas for Support

The PVO community has three main foci in the area of nutrition: 1) promoting breastfeeding; 2) promoting increased vitamin A intake (by supporting vitamin A supplementation and consumption of vitamin-A-rich foods); and 3) promoting utilization of appropriate weaning foods. However, even after reference materials were made available, not all PVOs that submitted a proposal last year were adhering to the new guidelines supporting exclusive breastfeeding up to the age of six months. Additionally, few PVOs promote vitamin A supplementation during pregnancy, during the early postpartum period, or as part of the treatment protocols of sick children (e.g., when the child has measles).

Few PVOs participate in promoting the use of iodized salt or promoting micro-enterprises for local fortification of salt. Likewise, few PVOs promote or introduce innovative approaches in order to increase iron intake among pregnant women.

Control of Diarrheal Disease

Final Evaluation Review Results

Sixteen of the projects reviewed spent 10 percent or more of their effort on the control of diarrheal diseases. Almost all (14) of these promoted the use of appropriate oral rehydration and appropriate feeding practices during diarrheal episodes. According to the final evaluation reports, nine PVOs for which there is sufficient data contributed to an additional 27,000 children receiving appropriate diarrheal treatment when they had a simple case of diarrhea. Baseline data showed that an average of 41 percent (ranging from 17 percent to 83 percent) of children received oral rehydration therapy (ORT) during their last episode of diarrhea, whereas during the final evaluation an average of 71 percent (ranging from 28 percent to 84 percent) had received this potentially life-saving fluid. In one project (HOPE & CARE/Honduras), the use of ORT to treat diarrhea in young children increased from 17 percent to 75 percent.

Discussion

It is estimated that in developing countries over two million children die yearly from diarrheal diseases. Interventions to reduce this cause-specific mortality are usually "low-tech." Therefore, control of diarrheal disease is a popular intervention among PVOs, and diarrheal diseases receive more attention than immunization. However, with new diarrheal vaccines in the pipeline, immunization could well play a role in the future control of diarrheal disease. It is important, therefore, for PVOs to have strong immunization programs in place.

Areas for Support

Most PVOs have directed their efforts toward the promotion of the early use of ORS or appropriate recommended home fluids (RHF) to treat or prevent dehydration associated with diarrhea, and the promotion of appropriate feeding practices during and after diarrheal episodes. Few PVOs have taken on the challenge of introducing proven activities to decrease the incidence of diarrheal disease (prevention), such as the promotion of appropriate hand-washing practices.

It is hoped and expected that, as more PVOs get actively involved in the IMCI strategy, they will become more involved in the 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

Six of the 18 PVOs reviewed spent at least 10 percent of their effort on improving pneumonia case management (PCM). All six included community actions among their activities to improve care-seeking behavior of mothers with sick children. Four PVOs also contributed to improving the quality of care children received from health care providers. One, CARE/Kenya, was outstanding in its approach. The project offered easy access to quality care after convincing the MOH to allow the use of antibiotics—and thus proper treatment of children with pneumonia—by trained primary health care workers in the community.

Discussion

Pneumonia case management gets less attention than diarrheal disease control. However, pneumonia-specific interventions should be promoted only in settings where integrated management of childhood illnesses (IMCI) has not been introduced. With the advent of IMCI, PCM should become part of that strategy.

Example 2

Volunteer PCM – World Relief/Honduras

The records of all of the volunteers who do pneumonia case management show that there have been no deaths due to pneumonia since they began. One volunteer has treated over 100 suspected cases in the last three years, with no deaths.

In anticipation of the full acceptance of or large-scale introduction of IMCI in all countries with active PVOs, the PVO community is addressing PCM primarily in terms of demand. PVOs are successful in promoting proper care-seeking behavior, including early recognition of danger signs, compliance with prescribed treatment, and knowledge of the location of competent providers.

Malaria

Final Evaluation Review Results

Six PVOs included malaria as one of their priority interventions. Four promoted the use of insecticide-treated bednets (insecticide-treated materials (ITM)). One PVO included the provision of quality care, including proper (differential) diagnosis, classification, treatment, and referral of children with fever. Four PVOs assured proper access to quality care, and four promoted proper care seeking. Two PVOs included malaria treatment and prevention in the antenatal care program in their intervention area.

Discussion

Malaria, still a major cause of deaths among infants and young children, has typically received little attention and is an area that has needed to be strengthened. According to WHO's Roll Back Malaria program statistics, there are some 300 million cases of malaria each year worldwide. About one million of these cases will be fatal. Most of these malarial deaths are among children under five in Africa, where one in four childhood deaths is caused by malaria. Children continue to die either because they do not sleep under insecticide-treated bednets, or because they lack access to proper care and life-saving drugs.

PVOs implementing current child survival projects are committed to the Roll Back Malaria effort. Their strengths are in improving access to quality providers and promoting proper care-seeking behavior. The latter includes early recognition of and care seeking for fever, compliance with the prescribed treatment, and knowledge of the location of a competent provider in cases of severe disease.

Areas for Support

To strengthen the gains and successes made to date, still more effort needs to be put into improving appropriate malaria recognition and case management at all levels of health care providers. This means improving on all the aspects of quality of care, such as appropriate assessment and

differential diagnosis, classification, treatment (and/or referral), and counseling. The PVO should participate in or provide support for effective training in Malaria Case Management, supervision of health workers (including Community-based Distribution (CBD) agents, shopkeepers, and pharmacists), and assurance of an adequate supply of the anti-malarial drugs of first choice.

PVOs have been active in the area of malaria prevention, but should focus on or strengthen their efforts to introduce and/or promote the appropriate use of insecticide-treated materials (ITM) such as bednets by women and children, including re-treatment. It is not known how sustainable bednet interventions are, but experience indicates that partnering with the private sector would be beneficial in this area.

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, but in the evaluations reviewed, only one PVO, CARE/Kenya, was rated as state of the art in IMCI, i.e., participated in defining and introducing community IMCI.

Maternal and Newborn Care

Final Evaluation Review Results

Thirteen projects included maternal and newborn care (MNC) in their interventions. Nine promoted improved care during delivery and six promoted the early recognition of danger signs during pregnancy, but only two promoted emergency obstetrical care. Little attention was paid to improving postpartum care for the mother or care for the newborn child.

The PVOs were strong on promoting preventive care: 10 PVOs promoted preventive interventions such as iron supplementation and tetanus vaccination for pregnant women. Eight participated in child spacing programs.

Discussion

After nutrition, maternal and newborn care has been the intervention receiving the highest level of effort in current child survival grants, representing 17 percent of the total intervention mix across active projects. Forty-three percent of grant seekers (19 out of 44) in the CS-XVI grant cycle included MNC in their application. While newborn care is still largely unexplored territory in child survival, it is potentially the area in which the greatest progress can be made in reducing child mortality.

Areas for Support

It is now generally accepted that to reduce maternal mortality, 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 by the mother, persons in her immediate environment, and first-line providers of antenatal care, of the danger signs during pregnancy— bleeding, convulsions, pallor, swollen extremities, labored breathing, fever, and headache. Few PVOs are actively promoting early detection and management of pregnancy-related problems such as anemia, pre-eclampsia, increased susceptibility to malaria, and STIs.

PVOs have focused on improving preventive measures during antenatal care and care during normal deliveries. It is time to also promote improved care of the mother during the postpartum period and improved care of the newborn.

Child Spacing

Final Evaluation Review Results

Ten PVOs spent 10 percent or more of their effort on child spacing, resulting in an estimated 65,000 additional women practicing modern contraceptive methods.

Discussion

It was generally accepted after the Cairo conference that child spacing should be an integral part of maternal and child health programs. Many PVOs now promote child spacing activities and delay of first pregnancy. In their programs most of them assure a reliable and adequate supply of an appropriate range of contraceptive methods that are easily available to the target population, mostly through CBD agents. Many still need to integrate child spacing into antenatal and postnatal services.

STI, HIV and AIDS

Final Evaluation Review Results

Seven PVOs spent at least 10 percent of their effort on STI/HIV/AIDS-related activities. Five PVOs participated in activities involving condom distribution. Only one had a comprehensive approach to sexually transmitted infections (STI), and documented the implementation of appropriate STI treatments.

Most activities in the STI/HIV/AIDS area focused on knowledge and behavior change communication, most commonly promoting access to and use of condoms. However, the area of AIDS interventions is still weak. There is little baseline or final data available to judge results or impact.

Discussion

In most developing countries the AIDS epidemic is still on the rise, and its impact on adults and children in the population is not yet fully understood. Some PVOs work in countries where one-third of the women consulting for antenatal care are infected with the AIDS virus. How this will affect child survival and mortality is not known.

Areas for Support

PVOs will need to expand their activities to address such issues as mother-to-child transmission and the community's capacity to absorb AIDS orphans. However, in current programs and in new applications, little effort is directed to mitigating the AIDS epidemic. In their child survival programs, most PVOs have limited their activities to increasing AIDS awareness, behavior change communication, and promoting access to and use of condoms.

One needs to keep in mind when looking at this data that many vital AIDS intervention activities, such as work with school-aged children and commercial sex workers, cannot be done using child survival funds. From the documents reviewed it is not known if the PVO community is accessing funds for AIDS prevention from other sources, or what interventions they are using if they are procuring such funds. Linkages with other HIV/AIDS programming does not come through in the child survival project documents.

Integrated Management of Childhood Illness

Final Evaluation Review Results

While Integrated Management of Childhood Illness (IMCI) is considered the strategy of the future and will most likely replace vertical CDD and PCM interventions, review of this strategy will have to wait for future grant cycles. During the 1995-99 cycle, only one PVO was active and innovative in introducing community IMCI.

> Example 2
>
> *CIMCI – CARE/Kenya*
>
> CARE's project in Siaya applies components of both IMCI and the Bamako Initiative. IMCI charts and training materials have been adapted for community health workers. They are based on IMCI guidelines for managing cough or difficult breathing, fever and diarrhea, for counseling mothers on home care and when to return to the community health worker for care, as well as when to take the child promptly to the clinic.

Discussion

IMCI was mentioned earlier in the sections on immunization, CDD, PCM, and malaria. It was not mentioned in the section on nutrition, but nutrition of the sick child and nutritional counseling play a role in IMCI algorithms and strategy. Also, in countries with high AIDS prevalence, IMCI is adapted to meet local needs.

Whereas few PVOs have been actively involved in developing or adapting IMCI algorithms, some PVOs have played a role in promoting the introduction of IMCI in the health facilities that serve their target area. The new role for the PVOs is to participate in defining and introducing community IMCI both in their target area and on a global level.

Logically, the next step for the Office of Private and Voluntary Cooperation is to consider advocating that PVOs group disease-specific interventions such as CDD, PCM and malaria into the IMCI strategy for approaching these problems.

MONITORING AND EVALUATION

This section discusses findings from a systematic review of Final evaluations from CS-X and CS-XI grantees, followed by observations from PVC's present portfolio of active Child Survival Grants.

All of PVC's programs require grantees to include monitoring and evaluation (M&E) plans as part of their applications. The Child Survival program specifies that grantees collect baseline and final data, thereby assuring that achievements are quantifiable. The CS program also requires Midterm evaluations, which focus on program implementation issues, while the Final evaluations typically compare baseline and final survey data.[1]

> "In the PVO Child Survival Program, monitoring and evaluation provide program managers, local partners and USAID with: a clear understanding of how the PVO program is functioning; evidence of results that have been achieved, and the importance of these achievements to the design and implementation of future programs. The final evaluation is focused on several aspects including assessing if the program met the stated goals and objectives and the effectiveness of the technical approach."[2]

In light of PVC's evaluation guidance, this Program Review sought to determine the extent to which results have been achieved, and the extent to which M&E systems and approaches truly do provide program managers and local partners with a clear understanding of how the program is functioning.

PVC's Strategic Objective is "Increased capacity of PVC's PVO partners to achieve sustainable service delivery." Intermediate Result (IR) 1.2 focuses on upgrading PVO grantee planning and administrative systems including monitoring and evaluation systems. Strategic Objective 1.6 relates to increased capacity of local partners. PVC developed a Grant Evaluation Score Sheet which aims to measure progress of PVOs towards these objectives (see Attachment C).

Review of Final Evaluations

Five CS-X projects and 13 CS-XI project final evaluations were reviewed using the PVC FY 2000 R4 Grant Evaluation Score Sheet. Projects were coded on eight indicators of M&E Capacity when information was available. Indicators one through six are measures of PVC's IR 1.2 and indicators seven and eight are measures of SO 1.6. Each indicator was scored on a five-point scale with a rating of five as excellent and one being unacceptable. (See Table 4).

All project evaluations presented evidence of technical baseline data for children under two years of age at the population level. They also presented end-of-project follow-up data to examine whether program objectives were attained in terms of improved child survival health practices and knowledge of selected healthy child and maternal care behaviors by mothers (indicators one and three). From the information presented in the evaluation reports, it was difficult to score these indicators on a five- point scale. A number of factors were taken into consideration, including whether the project was measuring what it was actually doing, if indicators were appropriately stated and calculated, whether targets were set which could be detected using a small sample survey, whether the design

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[1] PVC Monitoring and Evaluation Needs Assessment Draft 11/15/98.

[2] USAID/BHR/PVC PVO Child Survival Grants Program CS-XI, 1995-*1999 Guidelines For Final Evaluation*

effect was taken into account for cluster sampling, and whether the interpretation of the findings was correct.

Other indicators were even more difficult to score on the basis of the limited information reported in the Final evaluation documents. For example, in order to assess whether or not an M&E system is fully functional, CSTS sought evidence of information being routinely collected and reported as well as the information being used for decision-making. This is similar to indicator five – Use of M&E data as a project management tool.

Only one project, CARE/Niger, mentioned that their M&E system was being implemented by another non-PVC program elsewhere –a reproductive health project in another part of the country.

In terms of the trend in scores for the indicators for IR 1.2, CS-XI projects on average scored slightly higher than CS-X projects indicating strengthened M&E systems, or better reporting, in the later cohort of projects.

Indicators seven and eight aim to measure sustainable and operational M&E systems of local non-governmental organizations and MOH partners and communities. While the CS projects themselves show evidence of developing working M&E systems, there is less evidence of projects building the capacity of local NGO and MOH partners (or communities) to develop their own monitoring systems to use information for decision-making. Scores for these two indicators were noticeably lower than for indicators one through five.

Table 4 – M&E System Capacity Scores

		INDICATORS							
Project CS Cycles	**X & XI**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
CS Cycle X	X								
Ethiopia – Africare	X	2	2	2	2	2		3	2
Indonesia- PATH	X	3	4	3	4	3		3	3
Malawi- Int. Eye Foundation	X	4	4	3	3	2		3	3
Philippines - HKI	X	4		4		3			
Senegal-World Vision	X	4	3	4	3	3			3
Mean Score		**3.4**	**2.6**	**3.2**	**2.4**	**2.6**		**1.8**	**2.2**
CS Cycle XI	XI								
Bangladesh- CARE	XI	4		4	4	4		3	3
Honduras-Hope/CARE	XI	4	3	4	3				
Honduras-World Relief	XI	4	4	5	4	4		2	3
India-PLAN	XI	3	3	4	3	3			2
Kenya-CARE	XI	4	4	4	3	3			
Malawi-Africare	XI	4	2	3	2	2		2	2
Mali-Save the Child	XI	4	3	4	3	4		2.5	3
Mozambique-World Relief	XI	4	5	5	5	5		3.5	4
Nepal-Save the Children	XI	3	4	4	4	3		3	3
Niger - CARE	XI	4	3	4	3	4	3		
South Africa- World Vision	XI	4	3	4	3	3		3	3
Yemen - ADRA	XI	3	2	3	3	3			2
Zambia - ADRA	XI	4	3	4	3	3		2	2
Mean Score		**3.8**	**3.0**	**4.0**	**3.3**	**3.0**	**0.2**	**1.6**	**2.0**

Capacity Indicators	
	1) Evidence of baseline data (of objectives from proposal/DIP. Technical interventions or organizational capacity building)
	2) M&E system fully functional/put in place
	3) Follow-up data collection to demonstrate that programs objectives have been met.
	4) Evidence of consistent monitoring of program performance during CA implementation
	5) Use of M&E Data as project management tool.
	6) Evidence that PVC supported M&E system has been implemented in other non-PVC grant programs elsewhere
	7) Program operations (of local partners & NGOs) independent of PVO TA (sustainable & operational)
	8) Evidence of community, facility or other local-level M&E capacity
Scoring Key	**Excellent = 5** Comprehensive and complete, meeting or exceeding all requirements
	Good = 4 Meeting or exceeding most or all requirements, may have some excellent aspects
	Acceptable with minor changes = 3 Generally meeting requirements, with minor or easily correctable omissions
	Acceptable with major changes = 2 Meeting some requirements, but with negative aspects
	Unacceptable = 1 With gross omissions, failing to understand issues or requirements
	NA = not applicable

Child Survival Performance Index

One way of evaluating the success of a child survival project— the degree to which results have been achieved— is to calculate a performance index. The performance index describes the proportion of the problem eliminated by the program.[3] It illustrates gap closure—the percentage of coverage achieved compared with what could maximally be achieved. The performance index is calculated across projects from baseline and final population estimates to measure gap closure by the CS program for three key indicators: child immunization, maternal tetanus immunization, and exclusive breastfeeding.

In practical terms, the performance index is the difference between the baseline value and the final evaluation results for an indicator, divided by the difference of 100 minus the baseline value. Or more simply put, it is how much has been accomplished (percent change) divided by how much change is possible. If the baseline is 80 percent coverage for immunization, for example, then the maximum a project can achieve is 100-80 percent, which is 20 percent. If the project has achieved coverage of 90 percent at the end of project, the performance index would be 10 percent divided by 20 percent, i.e., the performance index is 50 percent.

Child survival projects continue to achieve approximately a third of the possible gap closure in the areas of child immunization, maternal tetanus immunization, and exclusive breastfeeding. The increased gap closure in maternal TT may reflect the greater availability of maternal health cards, as well as increased use of antenatal health services.

Table 5 shows the Child Survival Performance Index by year and intervention. Three-year means were calculated to stabilize distributions.

Table 5 Child Survival Performance Index by Year and Intervention

	Performance Index							
Intervention	1994	1995	1996	**Baseline 1994-96 3-Year Mean**	1997	1998	1999	**1997-1999 3-Year Mean**
Child immunization	35%	30%	41%	**35%**	27%	28%	46%	**34%**
Maternal tetanus immunization	11%	13%	15%	**13%**	17%	29%	58%	**35%**
Exclusive breastfeeding	20%	37%	33%	**30%**	38%	26%	24%	**29%**

Note: The *performance index* is the percentage of the gap closed as a result of program performance.

3 Mohr, Lawrence B. *Impact Analysis for Program Evaluation*, 2nd Edition. Sage Publications: Newbury Park, pp. 5, 1995. (quoted in 1997 R4)

Table 6 shows the Child Survival Performance Index for CS-X and -XI by project for immunization, maternal tetanus toxoid, and breastfeeding.

Table 6 Child Survival Performance Index for CS-X and CS-XI Cycles

	CS Cycle	Baseline KPC						Final KPC						Performance Index		
Project	X/XI	Imm	Imm	TT	TT	BF	BF	Imm	Imm	TT	TT	BF	BF	Imm	TT	BF
CS Cycle X		%	SS	%	SS	%	SS	%	SS	%	SS	%	SS			
Ethiopia - Africare	X	16	122	7.3	122	N/A	N/A	19	157	19	300	N/A	N/A	**3.4**	**12.9**	***N/R***
Indonesia-PATH(Sumbawa)	X	11	N/A	15	391	42	59	84	N/A	79	N/A	54	N/A	**82.0**	**75.3**	N/R
Indonesia-PATH (Mataram)	X	56	N/A	13	N/A	67	N/A	76	N/A	29	N/A	69	N/A	**45.5**	**18.4**	N/R
Malawi- Int. Eye Foundation	X	83	259	47	600	21	125	87	241	78	291	64	83	**23.5**	**58.5**	**54.4**
Philippines - HKI	X	N/A	N/A	N/A	N/A	56.7	513	N/A	N/A	N/A	N/A	63.1	544	**N/R**	**N/R**	**14.8**
Senegal-World Vision	X	61	294	52	445	3	44	56	150	42	300	11	44	**-12.5**	**-19.8**	**8.2**
CS-X Performance Index														**28.4**	**29.1**	**25.8**
CS Cycle XI																
Bangladesh- CARE	XI	22	113	41	300	30	44	91	110	86	300	14	N/A	**88.5**	**76.3**	**N/R**
Honduras- Hope/CARE (U)	XI	75	N/A	56	N/A	21	N/A	87	N/A	71	N/A	42	N/A	N/R	34.1	26.6
Honduras-Hope/CARE ('R)	XI	72	N/A	58	N/A	37	N/A	82	N/A	65	N/A	35	N/A	N/R	16.7	-3.2
Honduras-World Relief	XI	68	136	47	296	19	79	87	147	80	300	44	82	**59.4**	**62.3**	**30.9**
India-PLAN	XI	N/A	N/A	30	210	N/A	N/A	N/A	N/A	95	415	N/A	N/A	**N/A**	**92.9**	**N/A**
Kenya-CARE	XI	N/A	N/A	33	81	2	45	N/A	N/A	99	N/A	30	N/A	**N/A**	**98.5**	**28.6**
Malawi-Africare	XI	N/A	149	94	234	36	45	N/A	N/A	N/A	N/A	49	43	**N/A**	**N/A**	**20.3**
Mali-Save the Child	XI	31	88	47	240	N/A	N/A	47	136	71	300	72	58	**23.7**	**44.5**	**N/A**
Mozambique-World Relief	XI	37	N/A	37	N/A	16	N/A	93	N/A	82	N/A	55	N/A	**88.9**	**71.4**	**46.4**
Nepal-Save the Children	XI	29	108	28	N/A	58	47	28	N/A	N/A	N/A	N/A	N/A	**-1.0**	**N/A**	**N/A**
Niger - CARE	XI	12	97	36	287	N/A	79	52	108	81	300	N/A	N/A	**45.5**	**70.3**	**N/A**
South Africa- World Vision	XI	54	101	32	297	37	65	91	107	69	300	48	75	79.8	N/R	17.6
Yemen - ADRA	XI	9.6	135	70	20	37	46	4.9	162	74	34	11	38	**-5.2**	**11.7**	**-42.1**
Zambia-ADRA	XI	78	145	73	138	2	45	N/A	133	60	130	87	45	**N/A**	N/R	**86.4**
CS-XI Performance Index														**46.1**	**57.9**	**23.5**

N/A: Not available
N/R: Not relevant as the project does not have the indicator in its objectives
SS: Sample Size
Imm: Child immunization; TT: Maternal tetanus toxoid; BF: Breastfeeding

Cycle X Projects

Of the five CS-X projects reviewed, Path/Indonesia presented data separately for two regions. Markedly different performance indexes are observed for child immunization and maternal tetanus toxoid (TT). Twenty-six villages in Sumbawa received initial project support in the first quarter of 1996; an additional 23 villages in Sumbawa began project activities in April 1997. Project activities began in Mataram in 1995 under an AusAID-funded project and continued under the USAID-funded project. The baseline data for immunization coverage are higher for Mataram (56 percent) than Sumbawa (11 percent). An 82 percent gap closure for child immunization was achieved in Sumbawa compared with 46 percent in Mataram. While baselines for maternal TT were low in both regions (15 percent for Sumbawa and 13 percent for Mataram), a much larger gap closure was estimated for Sumbawa (75 percent) compared with Mataram (18 percent). This analysis illustrates the usefulness of being able to compare subareas within a project site.

Cycle XI Projects

CSTS analyzed 13 projects in the CS-XI cycle. The Honduras HOPE/CARE project provided information separately for urban and rural areas. The urban areas had higher performance in maternal TT and breastfeeding than the rural areas. The performance index of key indicators for some projects could not be calculated, as these projects did not include that particular objective in their project. HOPE/CARE Honduras was excluded for child immunization; Africare/South Africa and ADRA/Zambia were excluded for maternal TT; and CARE/Bangladesh was excluded for exclusive breastfeeding.

Sampling Issues and Adaptations of the KPC Methodology

While the Performance Index may provide a useful conceptual framework for describing trends in key child survival program indicators, it is important to recognize a number of sampling issues that also emerged from the analysis of CS-X and CS-XI Final Evaluations.

All 18 projects collected baseline data for technical interventions, most often using indicators identified and diffused by the Child Survival Support Project (CSSP).[4] Objectives and indicators were posited by all projects, and end-of-project data were collected that generally allowed estimation of whether objectives were attained.

Seventeen of the 18 projects used small-sample 30-cluster KPC surveys. The original KPC methodology, which collects data from approximately 300 mothers of children under the age of two, was designed to estimate population values within a *confidence limit* of 10 percent and a *confidence level* of 95 percent. While the sample size of the 30-cluster methodology for the KPC was designed for sub-samples (e.g., children age 12-23 months for immunization), the sub-sample for exclusive breastfeeding in children less than four months was between 45 and 70 in the majority of the projects reviewed. However, not all of the projects reported the sub-sample size for each of the indicators. In addition, most of the projects did not report the confidence intervals of the various statistics relating to key indicators at baseline and final survey. This led the evaluators to discuss the

[4] PVO Child Survival Technical Report, Vol. 3, No. 3, April 1993

key indicator values observed through the KPC as absolute values rather than as estimates within a range of probability of the true population value. Thus, where a project observed small differences between baseline and final surveys and concluded that the project had shown an increase, statistical analysis often showed that these differences were not statistically significant. Cluster sampling design effect—the potential bias and added imprecision that comes from sampling groups rather than individuals—was often discussed in relation to confidence limits (the margin of error) in the analysis of findings.

One project (HKI/Philippines) invested in large sample surveys of more than 3,000 respondents to collect data on nutritional status. Multivariate regression analysis was used to estimate the impact of the project on the behavioral indicators independent of other factors, including improvements in socioeconomic status and level of education. Data were analyzed to compare behaviors of those who participated in the project with behaviors of those who did not participate. Mothers who resided in municipalities where the project had provided capacity building interventions where compared with those who lived in other areas, and mothers who attended mothers' classes were compared with those who did not attend. The logistical regression analysis provides statistical support for the conclusion that the project activities did have a favorable impact on mothers giving infants colostrum, children receiving vitamin A capsules, children being weighed in the past 12 months, and mothers' basic knowledge of vitamin A. No measurable impact was found regarding several other project objectives.

Use of Data for Decision-Making at the Project Level

Several projects reported periodic routine meetings with volunteer health workers and project staff to report information and discuss issues. WRC/Mozambique employs a quarterly monitoring system based on rapid assessment surveys using KPC survey questions to monitor project indicators. Every quarter, one group from each of the 19 animators is randomly chosen and assigned to another animator-trainer who conducts home surveys with all the families in that group. The resulting database of almost 2,000 interviews is analyzed and reported project-wide to chart progress on objectives. This monitoring system provides a rapid identification of progress and problems every three months, serves as a performance monitoring tool for individual animator-trainers, encourages project staff to strive for continuous program improvements, and provides feedback to the community for motivation and discussion.

The Role of Local Partners in Monitoring and Evaluation

The PVC Guidelines underscore that evaluations are joint activities, and truly effective learning experiences involve all partners. A participatory process for carrying out the final evaluation was described by ADRA/Yemen. As this project has a follow-on grant, this evaluation methodology is particularly useful for monitoring and evaluation capacity building with project staff and Ministry of Health partners. The primary purpose of the evaluation was to address the issues of effectiveness, sustainability, and lessons learned. Five main variables were selected for field study: health workers, health supervisors, cost sharing, the drug revolving fund program, health facility committees, and women's groups. The evaluation team was divided into groups, each of which focused on a specific variable and developed its own evaluation tools (i.e., surveys, focus group discussion guides, tables, questionnaires, interviews, etc.). These instruments were discussed and modified by the team; field visits were coordinated; and lessons learned were formulated to share widely.

Monitoring and Evaluation Activities of Current Projects

CSTS reviewed DIPs from fourteen CS-XIV projects, as well as additional project documents for a number of current CS projects in other cohorts to achieve an understanding of M&E strengths and challenges. Outlines below are observations related to several key themes that emerged from this analysis.

Results Framework: Objectives and Indicators

As used by USAID, the Results Framework is a way of identifying critical results and interrelated changes which are necessary to accomplish an objective. It shows the cause and effect linkages which have been used to design the PVO's strategy (*see Results-Oriented Assistance: A USAID Sourcebook*). All child survival projects funded under the Child Survival Grants Program identify technical objectives and results-level indicators, and the majority of the 75 current projects are learning to use the Results Framework language.

Although there is not a required core set of technical indicators for results in the child survival intervention areas, most projects utilize the indicators developed in conjunction with Johns Hopkins University, which can be collected by the Knowledge, Practices and Coverage small-sample survey. A set of recommended practice and coverage indicators was included as an appendix to the RFA Guidelines for CS-XII, funded in 1996. CS-XII projects will be carrying out final evaluations this year. No indicators were suggested for new intervention areas including malaria and STI/HIV/AIDS. Projects working in these areas have derived indicators from other sources.

Using the Results Framework allows the PVOs to posit a chain of results ranging from PVO capacity strengthening, to outcomes in terms of increases in local-partner service-delivery capability, to improvements at the beneficiary level. While all projects specify objectives and indicators for improved health practices in the child survival intervention areas, project documents most often do not not explicitly state how they plan to arrive at these results with objectives, indicators, and milestones for the intermediate-level results (outcomes).

Involvement of Local Partners in Monitoring and Evaluation

Child survival projects most often collect baseline data using a KPC survey instrument, as previously discussed. A second KPC survey is usually carried out at the end of the project cycle to estimate whether the technical health promotion objectives have been attained. Some projects also do a KPC survey for the Mid-term evaluation.

This small-sample survey methodology is cost effective and provides an opportunity to engage project stakeholders, including local partners, in the process of conducting a field survey and discussing health practices with mothers in their homes. It is also an opportunity to provide in-service training for project and local partner staff in monitoring and evaluation and in survey data collection, analysis, and interpretation. From the project documents, however, it seems that not all projects use this opportunity to involve local actors and develop their capacity in the area of survey research. The baseline and end-of-project surveys, as well as mid-term surveys in some instances, are carried out by outside contractors or consultants. This includes instrument design, data collection, data processing and analysis, and report generation.

Many projects do indicate that they involve local partners and stakeholders in the process of selecting the priority health interventions and setting objective targets based on the KPC baseline data. Those projects which do involve the MOH in data collection have a unique opportunity to compare MOH and KPC data and to discuss any discrepancies there may be. This often takes place during a DIP workshop.

Unfortunately, in some cases there is little local-partner involvement, understanding, or ownership of the data collection process. If MOH staff have not been involved in data collection the project runs the risk of weakening or damaging partner relations in instances where KPC data is significantly different from the Ministry of Health data. Local partners may become alienated if their Health Information System (HIS) estimates are not corroborated by the KPC survey results. This is sometimes the case with immunization coverage, since the KPC survey typically depends on card verification for vaccination information (rather than mother's reports). As a result, estimates of immunization coverage from the KPC survey are often lower than those of the MOH.

The degree to which projects are contributing to the development of local partners' M&E skills is not clear from the limited discussions found in project documents. These skills, which could be developed even at the community level, include monitoring and the use of data for project implementation and strengthening service delivery. The assistance projects render to the existing MOH information systems—to improve data collection, reporting, and utilization—is not well described. Likewise, the degree to which CS projects contribute to institutionalization of useful, practical monitoring of health status at the district, municipal, community, or local service-provision-unit levels is unclear. Plans or expectations of the current data collectors and users for sustaining any of these monitoring systems are nebulous.

Baseline and End-of-project Data: Adaptations of the KPC to Local Context

Although generally the standard KPC questions and methodology have been employed with few changes, there is some evidence that projects carefully adapt the standard KPC questions to the local context and develop additional indicators and questions to measure what they are doing. There are some notable cases in which PVOs have innovated. For example, CCF/Angola collected information on all children under five years, and PLAN sometimes uses four questionnaires and samples: mothers of children under 12 months, mothers of children one to two years, women of reproductive age, and men.

Example 3

Adapting Tools - MDCI/South Africa

In the KPC protocols, it is the mother who is questioned regarding knowledge and practices. Because grandmothers are taking care of many children, MCDI adapted the survey to measure the knowledge and practice of the "caregiver." The results of the KPC survey may thus better reflect actual household knowledge and practices.

If the project has used other sources of data to triangulate the results of their small-sample survey, this process should be detailed in the project documents. Mention of the use of health facility service-delivery statistics from the MOH is very limited in project documentation, however. The triangulation of data using multiple indicators from the small-sample surveys conducted by the project with other sources of information including Demographic and Health Surveys (DHS) and MICS surveys is very rarely discussed either. As a couple of countries, notably Malawi and Mali, are now planning DHS surveys that will provide data at the district level, these new surveys will be more useful for comparisons and validation of project-level data sets.

On-Going Monitoring Systems

PLAN/Nepal has experimented with KPC questions and LQAS (Lot Quality Assurance Sampling) for periodic monitoring of a random sample of the population and comparison of the service provision sub-units within the project area. A few additional projects, such as those of WRC, describe monitoring plans for data collection and utilization during the project. The monitoring plans can be used to assess progress towards achievement of technical objectives in the different health intervention areas. The vast majority of projects, however, do not describe the use of any on-going monitoring system, and do not report results until the end of the project.

Although most projects work with communities or other subdistrict service provision units, there are very few monitoring systems described in documents that track inputs, outputs, outcomes, and results for these PVO program units. Such a monitoring system would allow a project to better track its activities and resulting progress toward objectives. A monitoring system that could distinguish outcomes and results for its subunits would foster operations research and studies of comparative impacts. Currently, there is little discussion of follow up to training or IEC activities to estimate how these activities may have influenced or changed systems or practices.

While some projects discuss community surveillance systems, roster, or other census-based systems, rarely is there information on how this data is incorporated into or used by the larger MOH system. If monitoring data are actually used by local systems for planning, improved service delivery, and tracking of results, it is not sufficiently documented.

The Role of Mid-term and Final Evaluations

Projects often report carrying out qualitative research during the proposal development stage and, to a lesser extent, related to the DIP; however, a major opportunity for capacity development in design, collection, and use of qualitative data for project staff and local partners should be during the mid-term evaluation. Unless a mid-project KPC survey has been carried out, there is usually little quantitative data reported in the Mid-term evaluation document outside of process indicators such as the number of persons trained. This lack of quantitative information often results from not having a functioning HIS or monitoring system in place to track objectives.

While some CS projects identify the evaluations as important learning opportunities for staff and partners and consciously embrace a participatory evaluation methodology, the majority of the CS projects appear to limit participation of local partners and staff as part of the evaluation team. This conclusion was reached on the basis of team member listings and the limited discussion of the

evaluation methodology. A classic expert-driven evaluation approach appears to continue to be the norm for project Mid-term evaluations as well as final evaluations.

Final evaluations present another excellent opportunity for strengthening the capacity of local partners and other stakeholders in data utilization and critical thinking. Usually, a final population estimate is derived from a small-sample survey and provides the main data source for measuring attainment of objectives.

Increasingly, projects are retrospectively describing additional project achievements in terms of innovative approaches, partnership building, and capacity strengthening, but without strategic planning of these outcomes and results and without concomitant indicators of these objectives.

The mid-term evaluation is an excellent opportunity to include the local partners in the process of identifying the research questions, the means of information gathering, the construction of data collection instruments, and the gathering, organizing, and interpreting of data. Together with project staff, the local partners and other stakeholders can identify and document project strengths and successes, and arrive at lessons learned. With understanding and ownership of this evaluation process, the team is in an excellent position to lead the development of an action plan to improve the project implementation and to seek results in terms of increased service delivery and improved health practices.

Measuring Post-Project Sustainability

Currently, there is no generalized strategy for measuring post-project sustainability of service delivery or population-level results. Several projects have carried out KPC surveys after the PVC-funded projects ended, but the findings from these studies are not yet widely disseminated.

This lack of longitudinal tracking underlines the desirability of setting up easy-to-maintain monitoring systems that continuously provide valid, reliable, and useful data on service delivery and health practices during and after the project. The objective of longitudinal data for service-provision subunits maintained by the local partners might prove to be more useful than small-sample KPC surveys at the beginning and end of projects, which are dependent on external expertise and funding.

CSGP guidelines currently stress the project's responsibility to monitor implementation of activities and to measure results. There is little mention of developing monitoring and evaluation capacity at the local level, including strengthening the ability of communities, health service providers, and MOH district managers to routinely utilize information to monitor their own activities, health coverage levels, and the health status of the population. However, the utilization of information at the local level is hypothesized to be a key building block to the sustainability of gains achieved. In addition, the capacity to produce and utilize useful information is fundamental to increasing the ability of local organizations and communities to be better planners, problem solvers, and innovators.

CAPACITY STRENGTHENING

In its strategic plan the Office of Private and Voluntary Cooperation (PVC) has long emphasized the importance of building local partnerships, planning for sustainability, and building capacity in each of the programs it sponsors. The Child Survival Grants Program (CSGP) has sought to emphasize these same areas, and has continually adapted and fine-tuned its program over time to best support the development of PVO capacity to carry out successful projects in the field.

A useful analysis of the present state of capacity building among CSGP grantees must address not only the activities being carried out by grantees, but also the trends in program guidance that these grantees have received. This analysis of the present state of the CSGP incorporates an analysis of the CSGP Program Guidelines beginning with Cycle CS-XII; final evaluations from CS X and XI; CS-XIII Mid-term evaluations; CS-XIV Detailed Implementation Plans; and recently submitted applications for CS-XV.

Review of CSGP Program Guidelines

It is important to review the portfolio of active and recently concluded projects within the context of the evaluation guidance provided to those grantees. Prior to the RFA for FY98 (Grant Cycle CS XIV), guidelines referenced the areas of partnership, capacity building, and sustainability in general terms—and these concepts were woven throughout the guidance. RFA guidelines for CS-XII grantees, for example, referenced these areas in sections on program priorities and review criteria. DIP guidelines for this same cohort asked grantees to outline their sustainability plan, but did not ask them to discuss partnership issues or capacity building strategies in depth.

The CSGP Request for Applications (RFA) for FY98 (Grant Cycle CS-XIV) was the first to include specific sections dedicated to partnership and capacity building. The inclusions of specific sections on these areas in the RFA suggests an increased emphasis on the part of the CSGP on ensuring that applicants directly address these issues. CS-XIII grantees were asked to respond specifically to capacity building and partnership issues beginning with their Mid-term evaluations.

Our review of grantee documents for this report reveals that the CSGP Program Guidelines have not been the singular guiding force for the programs—there is evidence of capacity building even in projects that were not required to develop formal capacity indicators. However, we have also concluded from this review of the program that there is an increased focus on capacity-building issues in more recent Mid-term evaluations, DIPs, and applications that have responded to specific requests for information in the CSGP Program Guidelines. Even with this increased focus on the part of grantees, this review revealed that there has not been any systematic reporting on capacity building activities or results based on baseline and final capacity data. This section of the review offers general observations of trends in capacity building since CS-X, based on a capacity matrix developed by CSTS in its review of existing capacity assessment tools in January 1999 (see Attachment D), as well as observations from discussions with PVO representatives in the development of the Institutional Strengths Assessment Methodology.

Final Evaluation Review Results

The purpose of the Child Survival Grants Program is to provide U.S. PVOs with funding to improve their capacity and that of their developing country partners to deliver child survival (CS) services.

In reviewing the 18 projects which completed Final evaluations, it was found that the principal training and technical assistance interventions provided through the projects were related to improving the technical CS competencies of local partners. Included in this capacity-building category were case management and supervisory skills (see Attachment D).

The principal targets of project capacity-building interventions (17 of 18 projects) were communities— community-based organizations (CBOs) and community volunteer health workers. CBOs included village and community health committees, as well as women's and youth organizations, literacy groups, and micro and small enterprises. A wide range of health workers were targeted for training, including village, community, and primary health workers, traditional birth attendants and native healers, revolving drug fund volunteers, health assistants, animators and promoters, etc. Most were responsible to the committees concerned and several of them worked out of local-level health facilities (e. g., health posts, village pharmacies).

Most projects featured behavioral change strategies that went beyond information, education, and communication (IEC). Animator-trainers, facilitators, and promoters— many of them volunteers— were targeted for training by the projects. Institutional bases for these change agents provided support and supervision. CBOs such as health committees were the principal community organizations involved, along with government staff from health facilities and the concerned PVO.

Ministries of Health were next most involved in the projects as partners and as the beneficiaries of project capacity-building assistance. The primary targets included health services at the local government level (district, commune, municipality), as well as fixed government health facilities and their health workers. Health facility workers included primarily outreach and supervisory personnel such as nurses, health surveillance assistants and child survival or Mother Child Health promoters and trainers. At the district or local government level, the members of District Health Management Teams and the principal reference health facilities were key targets of the projects.

Two of the 18 projects involved participation by indigenous NGOs (as distinct from CBOs) and one project involved a private sector organization.

At the PVO level, the principal recipients of project capacity-building assistance were the project teams formed to manage the CS grants. A small number of in-country PVO program staff benefited from project training. There were only three cases in which headquarters personnel were involved in upgrading skills; this was primarily in the area of performance monitoring. In most cases, the projects were discrete management units dependent on the CS (or other project) grant for their continuation.

Sustainability was frequently addressed in relation to community-based organizations (both health and non-health oriented) and government, including district teams and health facility workers. This normally included a focus on cost-recovery/fee-for-service schemes and income-generating projects.

It was noted that several projects cited the importance of literacy programs for their capacity-building strategies. Literacy was closely linked to empowerment of women, particularly in terms of increasing participation in health care decision-making and implementation.

There were virtually no projects that had satisfactorily addressed the problem of sustainability of health services and functions by the end of the grant period. It appears that the principal strategy

used to deal with the issue was to continue project interventions, including capacity building, in the follow-on projects. However, there were a number of examples that showed promise by linking capacity building to sustained service delivery (see Attachment E).

Capacity Building Activities of Current Projects

Among current CS projects, capacity-building outcomes are being reported at both the PVO headquarters level and the field-based project level in a variety of capacity areas. The primary focus of capacity-building activities has been on building technical knowledge and skills at the community level— i.e., among beneficiaries and health workers. There are a few cases of projects before CS-XII which have tied capacity-building outcomes to specific objectives set at the beginning of the project. However, it is only since CS-XIV, with the development of capacity-building indicators, that projects were encouraged to implement effective capacity-building approaches. Therefore, much of the information on capacity building presented below is not tied to any specific capacity-building plan and much of it is anecdotal— i.e., information learned through conversations and interactions with grantees— and was not formally reported in the documents submitted to PVC.

Capacity Building at the PVO Headquarters Level

PVOs are involved in building capacity at the headquarters levels through the Child Survival Grants Program (CSGP). The first CSGP cohort to formally include discussion of "strengthening the PVO organization" in their Mid-term evaluations was the CS-XIII grantees. Examples of capacity building at the PVO headquarters level include:

- Creation of a Health Department within the PVO organization
- Increased contacts with universities and other NGOs in the health arena
- Increased awareness on the part of non-health staff in the PVO regarding important health-related issues that may impact their own projects. (One PVO Health Officer sponsored brown-bag lunches for non-health staff in her organization)
- Establishment of a Child Survival Team within the headquarters organization
- Cross-training of technical backstop staff in budgeting, contracting, and other administrative areas to provide better support to CS grants
- Expansion of the PVO's capabilities to work with specific populations (e.g., Project HOPE working with agricultural employers and indigenous migrant workers)
- Technical training for headquarters backstop staff, primarily through attending workshops sponsored by the CORE Group, CSTS, BASICS, and other cooperating agencies
- Participation in the CORE Group—in genera cited as a capacity-building activity for headquarters staff
- Placement of project staff at regional levels in some of the larger PVOs (highlighted as an example of how field staff were given opportunities to broaden their knowledge and experience)

Capacity Building at the Field Level

CS-XIII Mid-term evaluations and CS-XIV DIPs suggest that the most common capacity-building activities take place at the community level and are targeted to building technical knowledge and skills in beneficiary populations, volunteers, or district health workers. Building partner capacity usually involves training partner staff in specific technical areas, or including partner staff in the implementation of baseline surveys.

Capacity-building approaches that target institutional systems—as opposed to individual beneficiaries or health workers—are less common, but there is evidence that CSGP grantees are beginning to include these approaches in their programs. The most common institutional system targeted is the health facility, with specific capacity-building activities tied to the outcomes of a health facility assessment. Other examples of approaches to strengthening a partner's institutional systems are outlined below:

- In Guatemala, Project HOPE has created an alliance between the Ministry of Health, Social Security Facilities, Anacafe health centers, and 14 NGO facilities, to develop more effective health service delivery.

- In Peru, Esperanca has assisted its local PVO partner to develop an efficient logistical supply system for its projects, and to improve its financial management system.

There is some evidence of PVOs instituting systems that promote organizational learning among local partners, such as Esperança's monthly "technical meetings for solving problems" for partner PVO supervisors. Save's "Program Learning Group" in Nepal and World Vision's "Regional Area Development Team" meetings are other examples of organizational learning strategies that facilitate the sharing of lessons learned across project sites.

Challenges

One challenge is the development of strong capacity-building indicators. As the evaluation guidance has grown more specific, applicants and grantees have responded by crafting measurable indicators that they will use to track capacity-building activities over the course of their projects. While many of the CS-XIII Mid-term evaluations began with the preface that "although we included no formal capacity-building indicators in our DIP... " CS-XIV grantees and CS-XV applicants have been required to include such indicators.

An examination of the indicators that have been developed suggests that many PVOs are continuing to focus their capacity-building activities on training only, while others are attempting to build systems-level capacities in their partner organizations.

Other organizations have recognized the critical link between defining capacity-building indicators and building strong partnerships. These organizations have not proposed any formal capacity-building indicators in their DIPs, but have outlined a process by which they will work together with their partners to identify mutually agreed upon capacity-building indicators during the first year of the project. This approach recognizes the time and effort required to build relationships with partner organizations before addressing the issue of how the program might strengthen a partner's capacity. This concept may have implications for the focus of the RFA in future years.

Only one of 17 grantees in Cycle CS-XIII (Africare/Benin) mentioned that it had conducted baseline capacity assessments— other than Health Facility Assessments— with its local partners. CS-XIV grantees began to explore more creative approaches to gaining baseline data, including partnerships with indigenous capacity-assessment NGOs (HOPE/Malawi) and Appreciative Inquiry techniques (ADRA/Madagascar).

Partnership

In the present portfolio of CSGP grantees, the most common local partners are communities, district-level health offices, and Ministries of Health. Local NGOs are the next-most frequent partners, and there are a few grantees partnering with private sector organizations. A review of CS-XIII Mid-term evaluations suggests that while the majority of partnerships are in place and functioning, there is a broad range in the relative health of these partnerships. For example, one mid-term evaluation states that "the project staff have developed an excellent working relationship with the Ministry of Health. While the quality of the relationships vary from health center to health center, in all cases the staff have a good working relationship. The relationships with the MOH at the Department (State) level are excellent. A strong bond of mutual respect and trust exists on both sides. This is one of the few projects in this evaluator's experience where there is an excellent working relationship with the MOH."

Another notes that "the work with the MOH has taken a while to develop, as creation of this partnership and trust requires time and repeated contacts. The addition of the relatively new training coordinator, a former MOH staff, has allowed the partnership to become more robust, and may allow greater collaboration than was planned ... "

Yet another states that "The MOH's role is crucial to the sustainability of project activities. Much [of the] human resources needed for project implementation come[s] from the MOH. However, even though subdistrict health staffs complain of work overload due to inadequate numbers of health workers at post, [there are] more critical issues of poor time management, a perennially low morale among health workers, and [an] inadequate logistics support system. There is also the initial wrong perception by subdistrict health staff that [The CSGP grantee] owns the project and therefore they should be paid for any extra work done [on] the project. In its short life, the project has witnessed the transfer of some critical health staff, particularly at the district level out of the project area, when they are just beginning to seriously get involved with project activities. These challenges are being addressed arduously by the project ... "

Challenges

The challenges faced by CSGP grantees in the partnership arena are critically linked to the capacity-building issues outlined above. Some grantees appear to enter into agreements with their local partners without clearly indicating how the issue of capacity building will be addressed. In many cases, local NGO partners with specific areas of expertise actually contribute to the overall capacity of the PVO project team, or to the capacity of another member of the partner team. In the future it will be important for applicants and grantees to clearly identify which partners will build capacity and which partners will have their capacity built through the project.

Those PVOs that have established partnerships with private-sector organizations seem to have been able to do so based on having developed a reputation for excellence in a given country and having

become well respected in terms of health care delivery. For example, Project HOPE in Malawi was able to capitalize on its quality work on the tea estates in the north to attract Press Agriculture as a private-sector partner for its current project in the Kusungu. PLAN International is well recognized at the household level in Ghana, which facilitated its attractiveness as a partner to the Ministry of Health there.

Additionally, CSTS has received feedback directly from PVO representatives in the field. The following are the most important challenges identified:

- **Identifying Good Partners.** While the Ministry of Health or an MOH District subunit is usually a key partner for grantees, PVO representatives have voiced their concerns about identifying good local non-MOH partners. Some have instituted RFA processes of their own to weed out undesirable partners, but a number have still found themselves in bad partnerships even though they have performed what they felt was due diligence in the selection processes. The primary reasons for these mismatches have been related to differences in core philosophies and inadequate financial resources.

- **Building Good Working Relationships with Partners.** The complexity of CS projects and issues of ownership, funding, and accountability often create tension between PVOs and their partners. The added component of assessing partner capacity can easily set up an us/them mentality between PVOs and their partners. The challenge for CSGP grantees is to maintain a good working relationship with their partners in the midst of these variables.

Sustainability

The present state of sustainability as it relates to projects funded through the CSGP is probably best captured through an examination of the key sustainability questions that emerged from CSTS/CORE's recently sponsored "Sustainability Dialogue." This event, held on March 20, 2000, was attended by representatives from the PVO community, USAID/BHR/PVC, the BASICS II Project, and CSTS. It focused on the issue of post-project sustainability. While a number of useful tools and ideas were presented, the event also raised a number of key issues that PVOs struggle with in terms of sustainability of their programs. These include:

- The need for a common language for talking about sustainability. As one participant noted, "sustainability is not something you look for at the end of the project, it's what you plan for at the beginning. Sustainable health behaviors are what you should see at the end of the project."

- There is an absence of specific tools/frameworks that could be used in planning for sustainability and measuring whether any project activities actually proved sustainable.

- The double-edged sword of identifying a common set of "sustainability indicators." As one participant said, "the danger of developing one set of indicators is that people will actually use them!" (at the expense, perhaps, of other external variables that may argue for different indicators).

- The need to define the role of PVOs in the context of project sustainability. On the one hand, sustainability is defined as a U.S.-based PVO establishing a country office that is able to provide services to indigenous populations over an extended period of years with funding from multiple

donors. The competing view is the idea that the local U.S.-based PVO entity should be temporary and constantly working to transfer all of its expertise to local institutions.

These issues are reinforced by the approaches to sustainability outlined in the applications, DIPs, and Mid-term evaluations of the active CSGP grantees. A few PVOs have laid out comprehensive definitions of sustainability within which their programs are planned. Most PVOs simply define sustainability in the context of the specific project they are implementing.

There are PVOs that quote their beneficiaries as saying "we hope PVO X never leaves this area" and noting their long-term commitment to be in the host country. Others may maintain a host-country presence, but work to build local infrastructure in the regions they work in and then move on to other regions.

Overall, however, the present portfolio of projects is attempting to address sustainability issues at multiple levels, including individual knowledge and behaviors, financial viability of services, and development of institutional capacities in partners.

It is also important to note the interrelationships between capacity building and sustainability. Many of the capacity building activities discussed above have been implemented toward the goal of building the strengths of local individuals and institutions to carry out project activities when funding ends.

Training is a common activity that is linked to sustainability outcomes—building skills and knowledge of beneficiaries or district health workers so that they can continue practices in the long term. However, other strategies that PVOs are undertaking address the systems that need to be in place to continue service provision when the project ends. These strategies include:

- Creation of a new local NGO that can continue the project when the CSGP grant expires
- Building local coalitions of service providers
- Guaranteeing that the grantee PVO will maintain a presence in the country, regardless of whether it receives CSGP funding for additional work
- Providing board development and leadership development assistance to local partners

The review of final evaluations from CS-X and CS-XI suggested that most had not put sufficient sustainable systems in place to provide for continuation of the project without additional external funding. PVOs therefore applied for follow-on grants.

CS-XIII mid-term evaluations reflect some hope of achieving a level of sustainability in specific areas. For example:

- In Bolivia, Andean Rural Health Care (ARHC) has sought to build financial sustainability for its program through developing contracts with both municipal and regional authorities to financially support the health care system. At the Mid-term evaluation, ARHC had already reached three of its end-of-project sustainability goals related to increased municipal support, increased regional support, and increased sales (service fees).

- In Guatemala, Project HOPE's Mid-term evaluation indicated it was making good progress in implementing the sustainability strategy outlined in the DIP. Specifically, 130 coffee estates have joined the program and committed to supporting a health unit on their estates; strong collaborative relationships have developed among the partner organizations; and departmental committees have taken over much of the management of the program.

- In Ghana, PLAN International's Mid-term evaluation reported that project-trained CORP (Community Owned Resource Persons) volunteers are optimistic that the communities can generate or mobilize adequate finances to support the CS activities at the end of the project. The major source of optimism is the Community Health Fund, a revolving fund initiative of the CS project. The volunteers have received adequate technical training, and are confident that with refresher courses shortly before the end of the project, they will be able to carry on the tasks of providing quality services.

In the Philippines, an unexpected outcome reported by World Vision has been cost-sharing and in-kind resource sharing by all eight partner municipalities for project activities. This resulted from a series of coordination and orientation meetings with Local Government Units (LGUs) and Rural Health Units (RHUs). This has led to more municipalities being willing to negotiate cost sharing on a "per-activity" basis, and has increased ownership of the project activities by local partners.

III. SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

In looking at the Child Survival Grants Program through the lens of project documents from recently concluded projects and current ongoing projects, several trends were observed related to the strengths of the PVO programs, as well as the challenges facing these organizations.

PVOs have traditionally been quite strong in harnessing community involvement to better deliver health care components such as immunization. There is evidence of innovative programming in growth monitoring and programs to implement corrective measures when growth monitoring indicates a need for it. PVOs are generally quite strong on promoting preventive care, and their programs involve populations that are frequently difficult to reach by other means.

In addition to the strengths of the program identified in the introduction to this review, 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 INTERVENTIONS

- There has not yet been a minimum package of activities developed for most technical areas. 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 working groups should be encouraged to develop minimum packages for various technical areas.

- 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. Strengthened PVO and local-partner organizations would enable implementation of EPI programs that assure quality and safety and include a surveillance component.

- One area for potential PVO growth is a comprehensive approach to the problem of malnutrition. Efforts under way to document successes and to measure the impact of programs on nutritional status should receive further encouragement and support.

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

- Programs could be improved if PVOs could expand their involvement in the promotion of proper recognition, care seeking, and treatment (including counseling) for diarrhea cases, as part of the IMCI strategy at all levels (household, community, and health facility level).

- As a stand-alone, disease-specific intervention, Pneumonia Case Management should only be promoted in settings where Integrated Management of Childhood Illness (IMCI) has not yet been introduced. PVOs should be encouraged to document and expand their involvement in the

promotion of proper recognition of and care seeking and treatment (including counseling) for ARI, as part of the IMCI strategy. Successes in negotiations with local health authorities that assure access to quality first-line providers— such as new regulations allowing Volunteer Health Workers (VHW) to administer appropriate first-line antibiotics— should be documented and replicated where possible.

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

- Programs could be improved if PVOs could participate more actively in providing effective training in pneumonia case management; provide supervision of trained health workers; and assure that an adequate supply of antibiotics is available at all levels.

- The PVO community could be strengthened if it 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 anti-malarial drugs of first choice.

- 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 (ITM) such as bednets. Partnering with the private sector should be encouraged.

- 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 improved care of the mother during the postpartum period and improved care of the newborn.

- Some PVOs are addressing the AIDS epidemic and its impact on child survival. AIDS-related activities and work with AIDS orphans and vulnerable children needs to be documented to assure funding for these activities in the future.

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

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

- PVC should consider grouping the disease-specific interventions such as CDD and PCM (and eventually malaria) into the IMCI category when reviewing the request for application.

- All Maternal and Newborn Care (MNC) programs in malaria endemic areas should be strengthened to include a malaria component.

MONITORING AND EVALUATION

- CSGP Guidelines should include a general model and examples of the Results Framework linking capacity-building objectives and indicators to results at the beneficiary-population level. PVOs and their local partners should be encouraged to diagram the chain of results as a key planning tool. Objectives and indicators should be linked to this chain, which would be presented in the project documents.

- Projects should be encouraged to develop yearly targets, or at least milestones, for capacity-building immediate results (IR), and to create graphic representations to show the baselines, targets, and yearly progress for each objective.

- Documentation of indicators for technical interventions which are routinely measured at baseline and end of project are generally adequate, but sample size and confidence intervals should be reported for key indicators.

- In addition to baseline and end-of-project surveys, the importance of using routine monitoring data to continuously revise program design and to model critical thinking should be emphasized.

- Partnership would be strengthened if PVOs would take the opportunity to involve local partners on the evaluation teams for mid-terms and finals. Local partners can be involved in the process of identifying the research questions, the means of information gathering, the construction of data collection instruments, and the gathering, organizing, and interpreting of data.

- Capacity building by local project staff and other stakeholders in the area of monitoring and evaluation should be highlighted as a strategy to improve local problem-solving and sustainability of health management. The use of data for rational planning and decision making should receive special attention.

- It would be desirable to develop options to enable PVOs to revisit project sites after PVC funding has ended to measure the continuance of process outcomes such as organizational learning, SOTA for technical interventions, quality of care, and levels of sustained service delivery. In addition, community norms as well as community empowerment to take greater responsibility and control of their health could be measured.

- The use of other sources of demographic information to triangulate the results of the KPC small-sample surveys should be highly encouraged in the program guidelines. This practice would help to either validate or place the information gathered during the KPC in the proper perspective.

CAPACITY BUILDING

The general recommendation of CSTS is that the Child Survival Grants Program continue to emphasize the importance of partnerships, capacity building, and planning for sustainability in its funded projects, and that it provide its grantees access to assistance that further enhances their efforts in these arenas. Specifically, we offer the following recommendations:

- CSGP Program Guidelines should be examined as a package to ensure that there is consistency between the guidelines issued for the RFA, DIP, First Annual Report, Mid-term, and Final Evaluation. This will help to emphasize the importance of planning for capacity building and sustainability at the outset, and continuing to monitor developments in these areas over the course of the project. These guidelines should continue to emphasize the importance of planning for sustainability and capacity development in collaboration with local partners, and the need for collecting baseline data on capacity so that capacity development can be effectively measured over the life of the project.

- CSTS and the CORE Group should collaborate in the development of a conceptual framework for planning for and measuring the sustainability of project activities. Such a framework could provide CSGP PVOs with a common language for discussing and presenting sustainability issues, and could lead to grantees providing more consistent data on sustainability in their reports to PVC. The process of developing this framework should be inclusive of the PVO community and other key thinkers on sustainability, so that the process itself becomes a learning tool for participants.

- Further guidance is necessary to CSGP grantees in assessing how their Child Survival grants contribute to strengthening the capacities of their PVO organization. The Institutional Strength Assessment Methodology under development by CSTS should assist in addressing this recommendation. However, it is also recommended that the existing examples of how PVOs have strengthened their capacity through the Child Survival Program be documented and disseminated to the CS PVO community to begin to create greater awareness of the potential benefits of capacity building at this level.

- The issue of how to form good partnerships should be given greater attention. This analysis suggests that there is considerable variation in the relative health of existing partnerships among active grantees. Examples of successful partnerships should be documented and disseminated widely to the Child Survival PVO community; brown-bag discussions or short workshops could be held on this issue to help grantees focus on how to develop a strong working relationship with their local partners.

- PVOs should be encouraged to more closely link proposed technical results (e.g., increased immunization coverage) with capacity building strategies and sustainability plans. In other words, if a project desires to achieve sustained immunization coverage, which capacities need to be built in individuals and in systems over the course of the project? At present, applications and DIPS offer few links between these three variables, and final reports do not discuss these connections.

CONCLUSIONS

PVOs are working in and adapting to a changing environment. Their roles, strengths, and the challenges they face are evolving as they move from various models of direct service delivery to strategies that seek to build the capacities of their partners, so that those partners become responsible for sustained service delivery. Whereas PVOs have traditionally been viewed as organizations with strong ties and experience at the community level, many today are expanding that base of expertise to create bridges between these same communities and newly created health infrastructure designed to serve them. Most work in close collaboration with MOH and District-

level partners; others have forged relationships with WHO, UNICEF, and other multi- and bi-lateral organizations.

In this environment, there are a range of strategies that PVOs are implementing around the world. Some CS projects focus on one specific technical area and seek to bring about policy changes that will impact larger target populations. Others focus on a restricted goegraphical area and, by relying on vast numbers of community volunteers, offer a more comprhensive mix of interventions. Still others provide no direct services to the community, but work exclusively through their partners to reach their target populations.

One of the strengths of PVC's Child Survival Grants Program is that it allows for this diversity of approaches and strategies that can be targeted to local realities. This review was conducted to examine common themes related to technical interventions, monitoring and evaluation, capacity strengthening, partnership, and sustainability. It also illuminates the successes and challenges of recently concluded and presently active child survival programs funded through USAID/BHR/PVC. It is hoped that the findings and recommendations outlined here will provide useful insights to both the PVO community and to PVC's Child Survival Grants Program, ultimately resulting in Child Survival Projects that are more effective and yield even more impressive results than have already been demonstrated.

ATTACHMENT A

Overview of CSGP Project Statistics

Figure 1 Number of BHR/PVO Child Survival Projects by Project Type and Cycle (N=75)

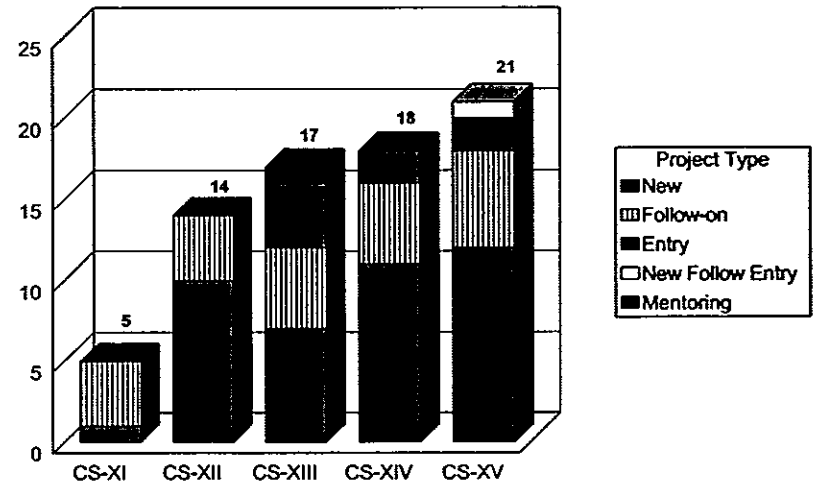


Figure 2 Currently Active BHR/PVO Child Survival Projects, by Project Type, CS-XI to CX-XV (N=75)

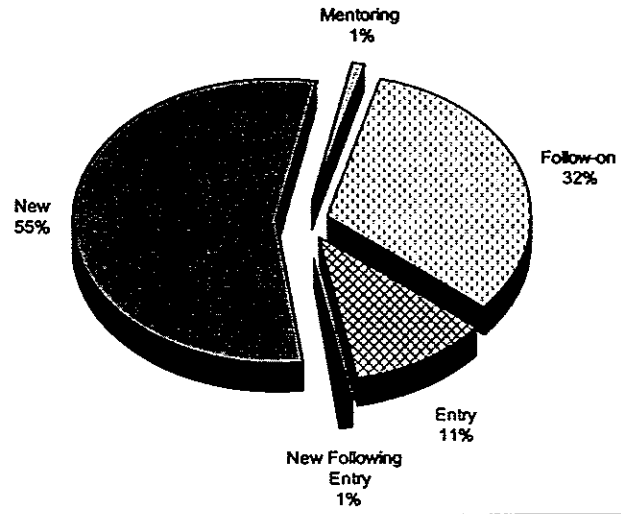


Figure 3 Number of Active BHR/PVC Child Survival Projects by Region and Cycle (N=75)

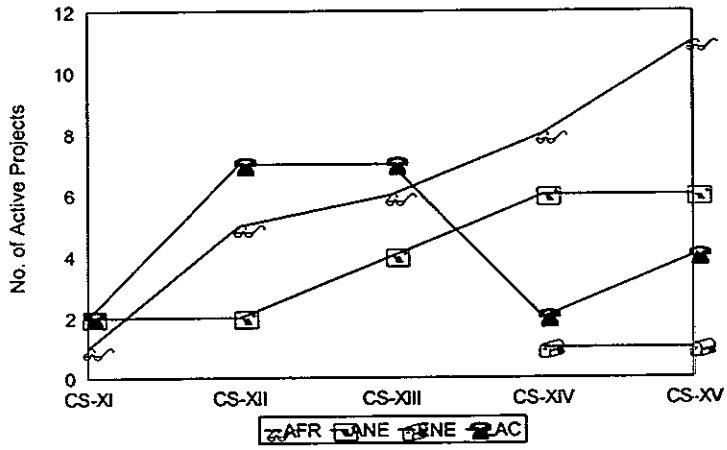


Figure 4 Currently Active BHR/PVC Child Survival Projects by Region (N=75)

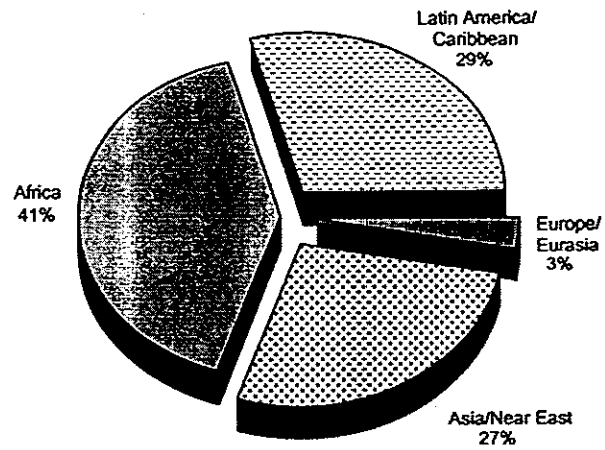


Figure 5 Currently Active BHR/PVC Child Survival Projects by Region and Project Type

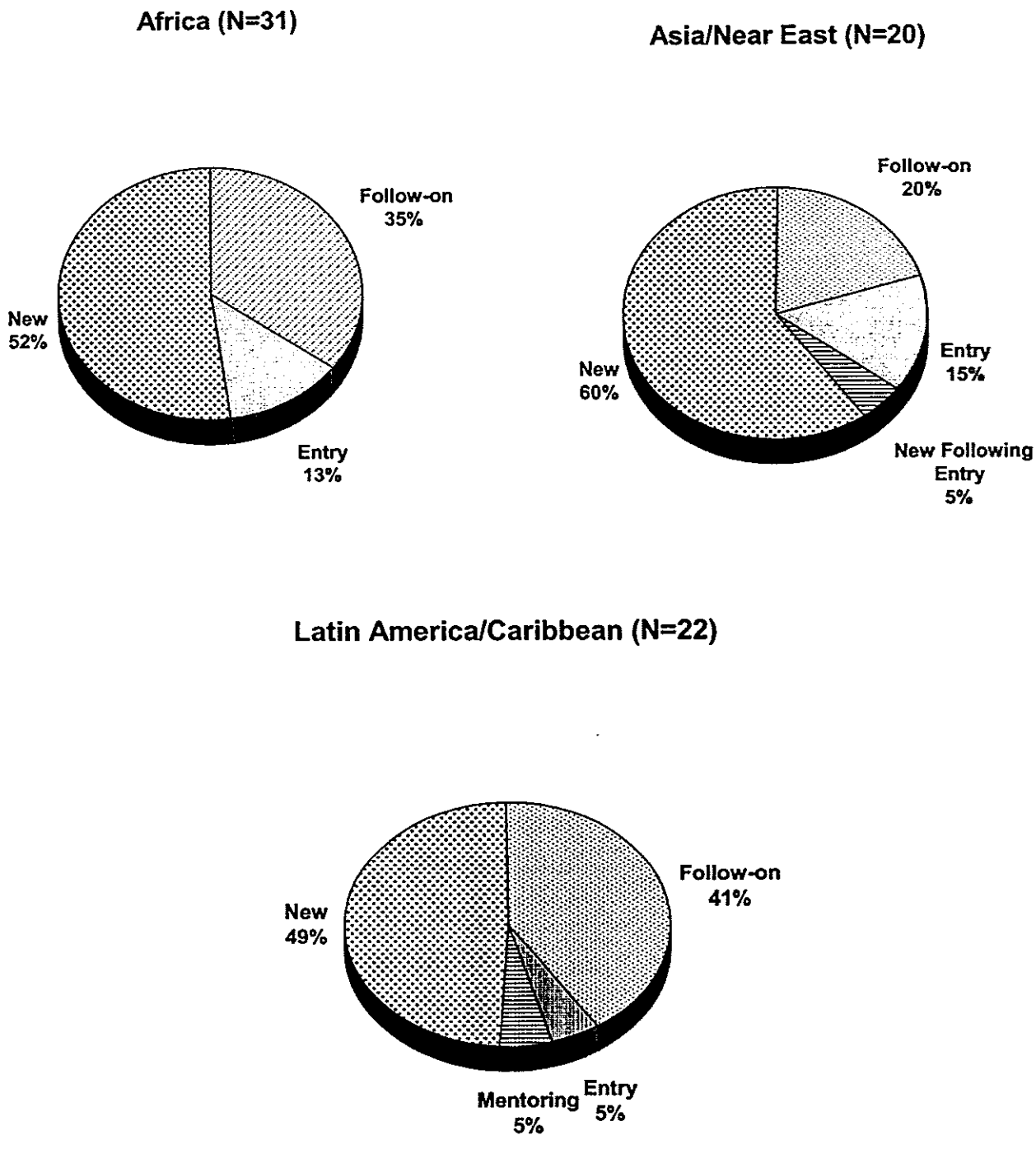


Figure 6 Average Cost Per Beneficiary Per Year (dollars) by Region

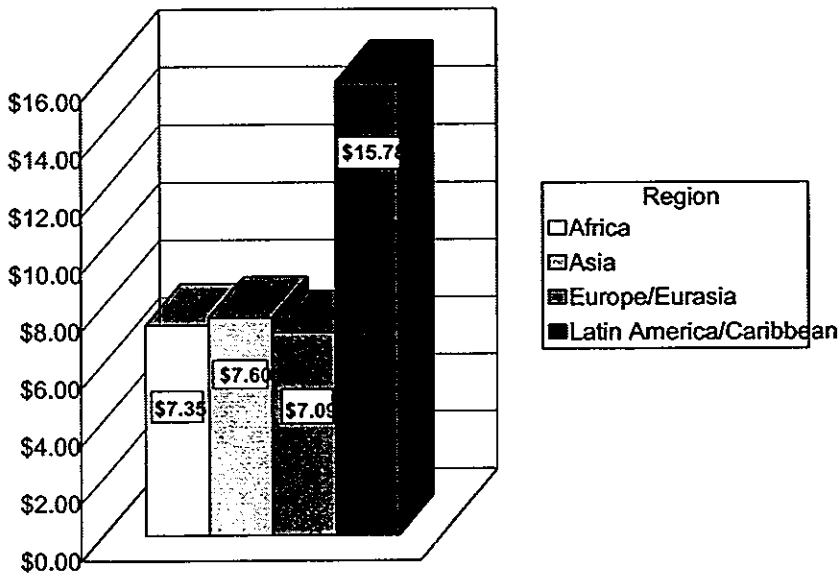


Figure 7 Composite Intervention Mix for All Active BHR/PVC Child Survival Projects

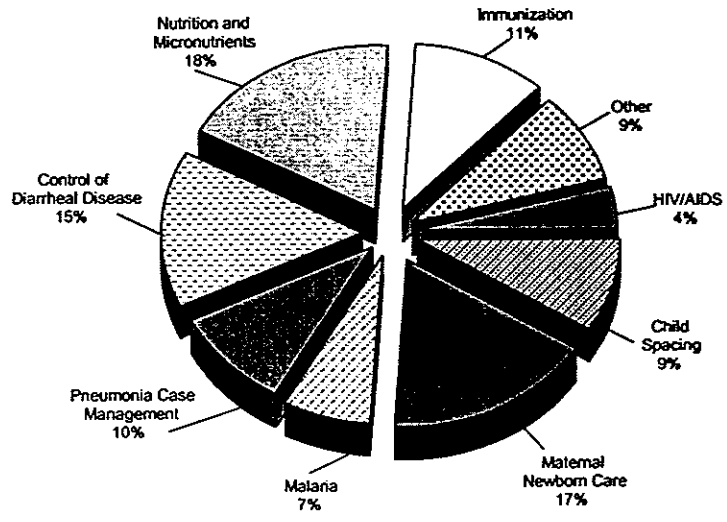


Figure 8 Composite Intervention Mix for BHR/PVC Child Survival Projects: Africa

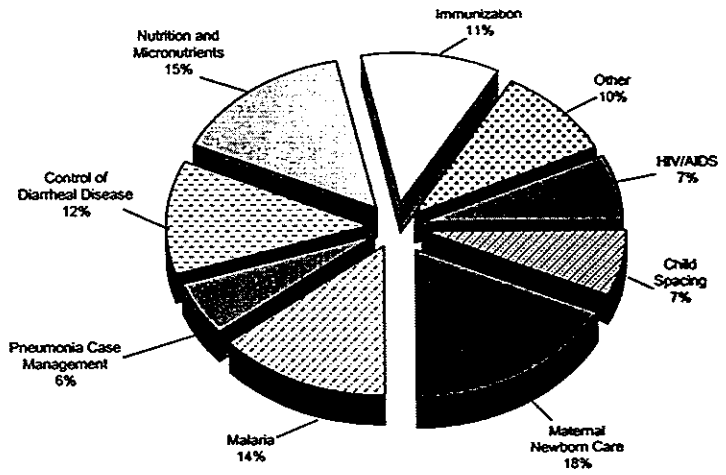


Figure 9 Composite Intervention Mix for Active BHR/PVC Child Survival Projects: Europe/Eurasia

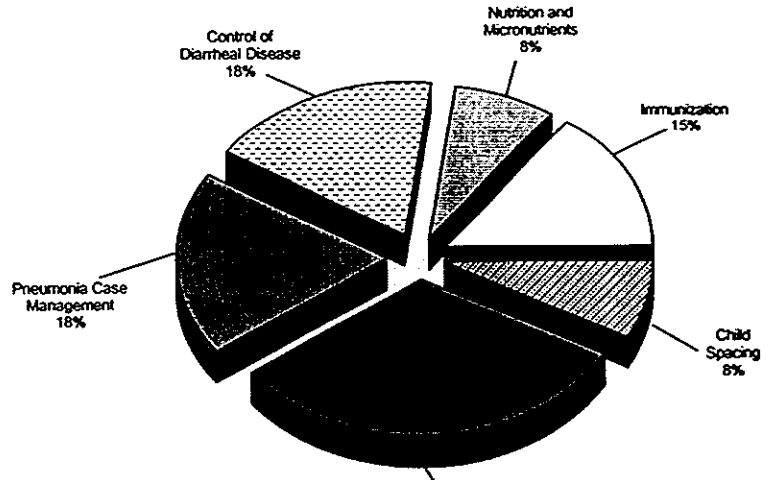


Figure 10 Composite Intervention Mix for Active BHR/PVC Child Survival Projects: Latin America/Caribbean

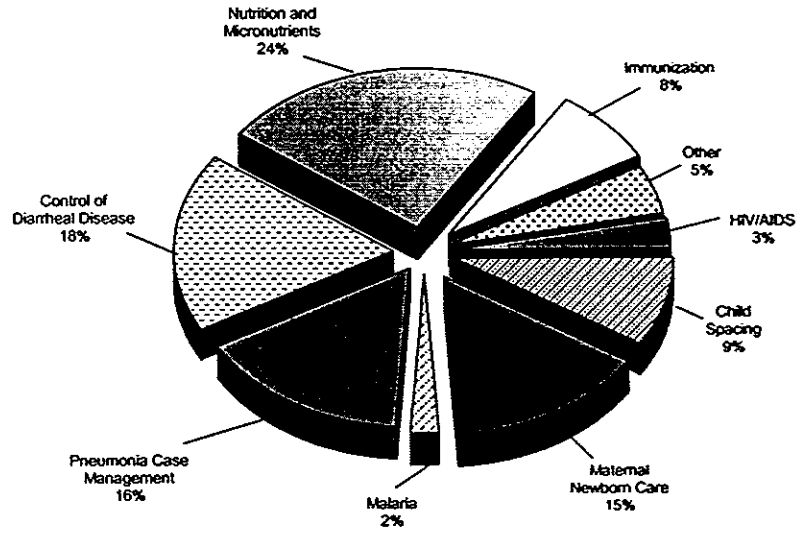
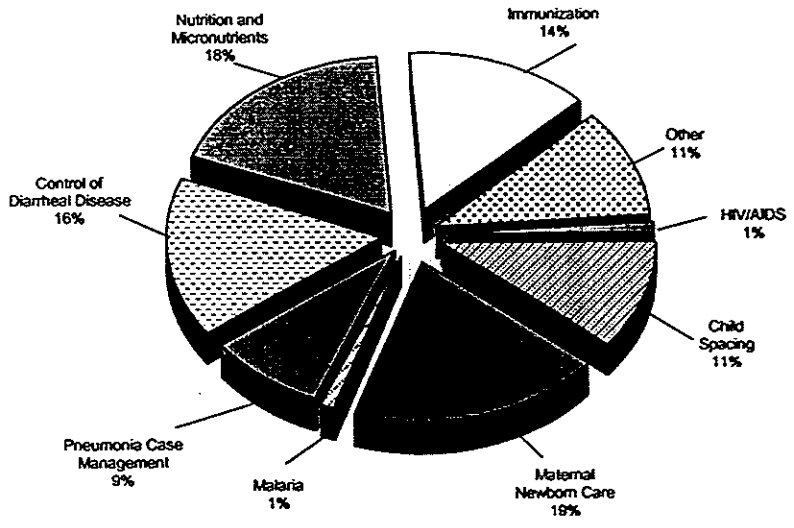


Figure 11 Composite Intervention Mix for Active BHR/PVC Child Survival Projects: Asia/Near East



ATTACHMENT B

SOTA Checklist for Technical Interventions in the PVO Child Survival Grants Program

1. *Immunization*

For grants where Immunization is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduction or strengthening of approaches to reduce "missed opportunities." (Integrated into programs such as Integrated Management of Childhood Illness (IMCI) or community-based activities such as Community-based Distribution (CBD).
- Introduction or strengthening of approaches to reach the "difficult to reach."
- Cold chain monitoring and strengthening, including the use of Vaccine Vial Monitors (VVM).
- Activities to ensure injection safety (auto-destruct syringes; disposal of sharps)
- Introduction of "new" vaccines (Hepatitis B, Hib)
- Inclusion of vitamin A distribution in the EPI activities.
- Participate in polio eradication activities (e.g., National Immunization Days, Acute Flacid Paralysis (AFP) surveillance)
- Participate in surveillance activities (AFP and others).
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - New approaches to reach women or girls to increase TT coverage.
  - Community involvement and/or participation to increase coverage.

2. *Nutrition, micronutrients, vitamin A and breastfeeding*

For grants where nutrition is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduction of the minimum package of nutrition activities (Minpack)
- Introduction or strengthening of one or more components of Minpack

Promotion of exclusive breastfeeding until six months

- Introduce 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 (and breastfeeding techniques).
- Introduce or promote breastfeeding support groups.
- Support the baby-friendly hospital initiative.
- Introduce a practical approach to breastfeeding in a high HIV/AIDS-prevalence situation.
- Introduce or promote the Lactational Amenorrhea Method (LAM).

Appropriate complementary feeding from six months and continued breastfeeding to 24 months

- Promote breastfeeding up to 24 months.

- Develop or promote utilization of appropriate weaning foods for children six months of age.

Nutritional management of the sick child

- Participation in the development or promotion of the Integrated Management of Childhood Illness (IMCI) nutrition toolbox.

Vitamin A (supplementation/fortification/foods) for women, infants, and children

- Introduce or promote vitamin A supplementation for pregnant women or supplementation within the first eight weeks postpartum.
- Introduce or promote regular (every 4 to 6 months) vitamin A distribution (as part of EPI, polio eradication effort, CBD, growth monitoring, or any other known or innovative program).
- Introduce or promote vitamin A supplementation into treatment protocols of targeted diseases such as measles.
- Introduce or promote gardening and consumption of vitamin-A-rich foods.

Iron and folate supplementation during pregnancy

- Introduce or promote innovative approaches to increase iron intake (compliance–supply-counseling) by pregnant women.

Consumption of iodized salt

- Promote the consumption of iodized salt and/or introduce/promote micro-enterprise for local fortification of salt.
- Introduce innovative approaches to iodine supplementation.
- Introduction, promotion or scaling up of the Hearth Nutrition Model.
- Introduce and document innovative ways to introduce or promote rational growth monitoring programs that not only identify "problem children," but also include corrective actions.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and/or participation to increase coverage.

3. *Control of Diarrheal Disease*

For grants in which control of diarrheal disease is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduce or promote proven activities to decrease the incidence of diarrheal diseases (prevention), e.g., the promotion of appropriate hand-washing practices.
- Introduce or promote the early use of ORS packets (oral rehydration salts) and/or the use of appropriate recommended home fluids (RHF) in cases of diarrhea.
- Introduce or promote appropriate feeding practices (continuation of breastfeeding, frequent small feedings, catch-up feeding) in cases of diarrhea.
- Introduce or promote proper recognition and care seeking for serious diarrhea cases (dehydration, dysentery, chronic/persistent diarrhea) at the household level.
- Introduce or promote proper case management and counseling for diarrheal diseases among health workers at all levels.

- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

4. *Pneumonia Case Management*

For grants where pneumonia case management is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Approach focused on standard Pneumonia Case Management (PCM), including three components: quality of care, access, and demand.
- *Quality of care* is defined as appropriate assessment, classification, treatment (and/or referral), and counseling. The PVO should participate in or provide effective support for training in PCM and supervision of trained health workers, and assure an adequate supply of antibiotics.
- *Access* to a quality provider: the PVO should assure that the target population has proper access to the provider (e.g., one hour travel maximum).
- *Demand* is defined as proper care-seeking behavior, including early recognition of danger signs, compliance with prescribed treatment, and knowledge of location of provider.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

5. *Malaria*

For grants where control of malaria is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduce, provide, or promote malaria recognition and case management at appropriate levels.
- Approach focuses on standard Malaria Case Management (MCM), including three components: quality of care, access, and demand.
- Quality of care is defined as appropriate assessment and differential diagnosis (especially pneumonia), classification, treatment (and/or referral) and counseling. The PVO should participate in or provide support for effective training in MCM, supervision of health workers (including CBD agents, shopkeepers, and pharmacists), and assure an adequate supply of the anti-malarial drug of first choice.
- Access to a quality provider: the PVO should assure that the target population has proper access to the provider (e.g., one hour travel maximum).
- Demand is defined as proper care seeking behavior, including early recognition and care seeking for fever, compliance with prescribed treatment and knowledge of location of provider in case of severe disease.
- Introduce and/or promote antenatal prevention and treatment of malaria.
- Introduce and/or promote the appropriate use by women and children of Insecticide-Treated Materials (ITM) or bednets, including retreating of ITMs.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

6. Maternal/Newborn Care

For grants where Maternal and Newborn Care (MNC) is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduce or promote emergency obstetrical care. This is a MUST and needs to address care-seeking behavior, access to care, and quality of care.
- Introduce or promote recognition by the mother, persons in her immediate environment, and first-line providers of antenatal care, of danger signs (bleeding, convulsions, pallor, swollen extremities, labored breathing, fever, and headache.
- Introduce or promote early detection and management of pregnancy-related problems such as anemia, pre-eclampsia, malaria, and STIs)
- Introduce or promote improved care during normal delivery (three cleans, recognition of danger signs in mother and baby, reducing unsafe/harmful practices, immediate breastfeeding, newborn care).
- Introduce or promote improved quality of postpartum care.
- Introduce or promote improved quality of newborn care.
- Introduce or promote preventive care such as immunization (TT) and micronutrients (Iron/Folate).
- Introduce or promote healthy behaviors and provide community support (reducing workload, rest, nutrition, supplements, prophylaxis, treatments, referral)
- Participate in or introduce programs that promote delay of first pregnancy, child spacing, and family planning.
- Integrate child spacing, maternal health (care, nutrition, prevention), and newborn care.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

7. Child Spacing

For grants where child spacing is 10 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduce or promote child spacing activities, including an adequate and reliable supply of an appropriate range of contraceptive methods that are easily available to the target population, and appropriate counseling by competent staff.
- Integration of child spacing with antenatal and postnatal services.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

8. STI/HIV/AIDS

For grants where STI/HIV/AIDS prevention is 20 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Introduce, promote, or provide adequate and appropriate behavior-change communication services.

- Introduce, promote, or provide adequate and appropriate access to and use of low-cost, high-quality condoms (male and or female).
- Introduce, promote or provide adequate and appropriate treatment for STIs (preferably using the syndromic approach), assuring a reliable and affordable supply of appropriate drugs.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

9. Integrated Management of Childhood Illness

For grants where Integrated Management of Childhood Illness (IMCI) is 20 percent or more of the effort, does or did the PVO participate in or contribute to one or more of the following activities?

- Participate in or promote the introduction of IMCI in health facilities that serve the target area, including strengthening the health system (in planning, supervision, drug and other supply management, M&E, and personnel management).
- Participate in defining and introducing "community IMCI" in the target area.
- Any new or innovative activities or successes?
  - Approaches to increase coverage (general population or the unreachable/underserved).
  - Community involvement and or participation to increase coverage.

ATTACHMENT C

PVC FY 2000 Grant Evaluation Score Sheet

Program Identification					
Name of PVO:	PVC Division (check one)	MG	CS	Coops	
HQ location:					
Countries (insert all):					
Type of Evaluation:		Mid-term	Final		
Type of Agreement:		new	follow-on	extension	
Cooperative Agreement # & Implementation Date:					
Scorer:					

	Capacity Area	Changes taken place (indicators)	IR 3			IR 1.2	SO level 1.1		SO level 1.6
			LNGO	Local govt	Business		Organ'l	Technical	
1	**M&E SYSTEM**					Score from 1 to 5			
		1) Evidence of baseline data of technical nature.							
		2) M&E system fully functional/put in place							
		3) Follow-up data collection to demonstrate that programs objectives have been met.							
		4) Evidence of consistent monitoring of program performance during CA implementation							
		5) Use of M&E Data as project management tool.							
		6) Evidence that PVC supported M&E system has been implemented in other non-PVC grant programs elsewhere							
		7) Program operations independent of PVO TA (sust & oper)							

		8) Evidence of community, facility or other local-level M & E capacity	
	Scoring key for IR 1.2 only	**Excellent = 5** Comprehensive and complete, meeting or exceeding all requirements	
		Good = 4 Meeting or exceeding most or all requirements, may have some excellent aspects	
		Acceptable with minor changes = 3 Generally meeting requirements, with minor or easily correctable omissions	
		Acceptable with major changes = 2 Meeting some requirements, but with negative aspects	
		Unacceptable = 1 With gross omissions, failing to understand issues or requirements	
	Technical Capacity:		
		1) Built SOTA technical capacity	
		2) Improved technical expertise for existing staff or new staff (T)	
		2) Improve quality of program planning & design	
		3) Expanding into new service areas or increased coverage (T)	
2	**Strategic Management:**		
		1) Develop board of directors	
		2) Bd of Directors contributes to strategic planning	
		3) Improved system of governance	
		4) Sustainability: business plan	
		5) Sustainability: recovery of substantial operating costs	
		6) Sustainability: diversified funding sources (includes fundraising)	

		7) Sustainability: programs with local financial input, ie, income generation, fundraising, or volunteer contributions from community							
		8) Sustainability: Approaches to genearte non-financial resources (eg., time, equipment, space, land, etc.)							
		9) Establish business linkages							
3	**Organizational Learning:**								
		1) Organizational capacity assessment (external or internal) done							
		2) Have ongoing evaluations inform organizational learning & operations & research?							
4	**Financial Resource Management:**								
		1) Transfer of Resources to local partner: monetary							
		2) Transfer of Resources to local partner: in-kind (eg, capital equipment)							
		3) Transfer of Resources to local partner: TA/training							
		4) Generates accurate and timely financial reports							
		5) Cost containment							
		6) Upgrading procurement practices							
5	**External Partnerships & Relations**								
		1) Strategic partnerships with local partners (local NGOs or govt)							
		2) Strategic partnerships with private business(es)							

		3) Network participation			
		4) Well-defined consistent effort to influence policy (national & local levels)			
		5) Information sharing			
		6) Assessed & addressed capacity needs of NGO partners			
6	**Human Resource Development**				
		1) Staff development			
		2) Regular staff training			
		3) HR practices help to retain staff			
		4) Evidence of organization adding & paying salaries of new staff position(s) as specified in DIP.			
7	**Civil Society:**	1) Building client groups/organizations			
		2) Building policy advocacy			

ATTACHMENT D

Primary Capacity Areas[1]

1. *Introduction*

In early 1999, the Child Survival Technical Support Project identified and reviewed 16 instruments (tools) that were developed between 1995 and 1999 to assess organizational capacity. The purpose of this review was not to assess the value of each of these tools; rather, it was to identify the range of approaches that have been utilized at different organizational levels, and to identify common areas of capacity that have been examined across each of these levels. The review of the 16 capacity-assessment tools yielded a total of 55 separate capacity areas. Capacity areas were identified by reviewing a specific tool, and determining the general categories in which capacity was being assessed. The 55 capacity areas were then grouped into broader categories by cross-referencing specific questions addressed under each area and looking for commonalties. This process resulted in the identification of six *primary capacity areas*, which accommodate all of the 55 capacity areas originally identified. In July 1999, input from a team of PVO representatives was incorporated into the descriptions of these areas. A brief overview of the six primary capacity areas is presented below.

2. *Primary Capacity Areas*

Strategic Management Practices— Strategic management practices are the series of activities that are carried out to ensure that programs reach planned and measurable performance goals within defined budget parameters. Organizations with strong capacity in this area feature a clearly articulated organizational vision, mission, and governance structure that guide management practices, program direction, and task implementation. This area includes an organization's capacity in the areas of teamwork, leadership, delegation of authority, decision-making structures, management/administration of supplies, and internal operations.

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 which 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. Projects that exhibit strong capacities in the area of organizational learning have created environments where staff, partners, and community members feel comfortable expressing their opinions, even when they know those opinions may not be widely shared by other members of the group.

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, breast- feeding promotion, control of diarrheal disease, pneumonia case management, control of malaria, maternal and newborn care, child spacing, STI/HIV/AIDS prevention, and Integrated Child Survival

[1] This paper is adapted from the primary capacity areas identified through CSTS' Institutional Strength Assessment Development Process. More information on this process can be found at http://www/macroint.com/csts/forum.

Programs and IMCI. This area further relates to how well these individuals manage and use their knowledge and skills. At an organizational level, this capacity area is illustrated by how effectively the organization utilizes and manages the knowledge and skills of its staff.

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. Organizations with strong capacities in this area regularly use established procedures to maintain revenue and expenses in balance; make accurate financial projections; include financial contingency measures that prevent operational disruptions; modify expenditures on a timely basis to account for revenue shortfalls; and disburse funds in a timely manner.

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. Organizations with strong capacities in human resource management routinely offer staff training that directly contributes to the achievement of the organization's priorities; provide opportunities for staff growth and development; and proactively address the issue of staff turnover.

Sustainability— This capacity area includes activities related to financial sustainability (a project's ability to continue under alternative funding sources when its original grant expires) and strategic partnering practices (aligning with a local partner whose capacity can be built to the extent that it can eventually assume both financial and technical responsibility for the project); environmental sustainability (nature of a project's impact on the environment); political fit of the project into the host-government's vision; and cultural sustainability (how an organization's practices fit within the values, beliefs, and practices of the countries it works in). Sustainability also includes the extent to which a project has developed the capacity to address project outcomes unrelated to the original child survival interventions planned (for example, as the rate of child survival goes up, the need for schools may increase— how does the project facilitate the development of education systems in a community it has served through a child survival grant?)

Capacity Building Interventions: Areas and Institutions Targeted

(As Reported in Child Survival Final Evaluations (CS X ending in 1998 & CS XI ending in 1999)

Health System Units / Capacity Areas	PVO Grantee				Other Intermediaries			Private Sector			Government Ministry of Health			Communities		
	US HQ	HQ CS Unit	Field Office HQ	CS Project Team	PVOs (Int'l/ US)	Local NGO	Net-work	Media	Busi-ness	Health Care Worker	Nat'l MOH	District Health System	Health Facility/ Staff	Health CBOs	Other CBOs	HWs
Strategic Management Practices				10		1	2				2	9	4	10	2	3
Organizational Learning				6		1	2							4		
Technical Knowledge and Skills				18	2	3	7			1	2	12	16	10	4	17
Financial Resource Management				11		1	2		1	1	1	2	8	5	1	4
Human Resource Management				8		1	3					3	5	5		
Sustainability				16	2	3	3		1	1	2	6	3	11	2	9
External Partnerships	1		1	16	4	3	4		1		2	8	4	10	4	5

ATTACHMENT E

Examples of Projects Linking Capacity Building and Enhanced Service Delivery

The following examples, gleaned from a review of 18 child survival grantee projects, demonstrate instances where there is a clear connection between the capacity-building efforts of PVOs and enhanced service delivery of their government and community partners, or increased organizational effectiveness.

Save the Children/Mali: This project contributed to the increased effectiveness of Village Health Committees (VHCs) in their role of mobilizing communities to participate in the broader decentralized health care system in two ways. One way is through exchanges with other VHCs to discuss common problems and the approaches undertaken to address them. The second way is through their involvement in local decision-making. This includes participation in a range of public forums alongside other health system actors, including national Ministry of Health personnel, communal (local government) health authorities, donors, and board members from community health centers.

The Save/Mali project demonstrated the importance of functional literacy programs as perhaps the most fundamental of all capacity-building interventions geared to increasing the effectiveness of local community organizations and health care workers. Not only does the ability to read and write enhance the skills and knowledge of these front-line, primary health care actors, but it also empowers them to address and solve problems that have plagued their communities for decades.

Save the Children/Nepal: In 1997, as a result of child survival successes in Nepal and elsewhere, Save's headquarters created a Program Learning Group (PLG), which brought together the organization's field and home-office health staff. The PLG was augmented by recognized health experts, including those from USAID and other cooperating agencies. The PLG was designed to serve as a mechanism for broadening the impact of Save's Child Survival Grants Programs through the dissemination of lessons learned and best practices, both within the organization and to organization partners. The PLG complemented its efforts by promoting staff exchanges between country programs, through the creation of regional health advisor positions and by sharing the results of program and project evaluations.

CASP-Plan/India: This child survival project trained women to take on the lead role in community-level health education and the promotion of corresponding changes in health behavior. Specifically, the project chose women who were both poor and socially isolated. The Empowerment of Women Health Guide was accomplished through a deliberate and sequenced program of training using adult learning techniques. The Health Guide program started with functional literacy and basic health education training, then moved to the delivery of group health education sessions. From there the program provided training on

how to conduct preliminary antenatal exams (including history taking), general health exams, and follow-up postnatal care.

WRC/Honduras: This CS project showed the importance of local (municipal) government support of community-based health care workers and their grassroots organizations. The financial contributions that municipal governments made to support local health workers not only provided the resources to continue their training, but gave legitimacy to their roles and functions in the broader health care system. The lesson for community-based organizations is that there is a political as well as health incentive for municipal governments to support their efforts—i.e., gaining voter favor.

WRC/Mozambique: The Care Group structure promoted by the project transformed behavior change from an individual decision to a social movement. Care Groups have become a well-accepted and sustainable community institution. They were the principal reason for the project's success. Sustainability of the structure depended on internal cohesion and solidarity, not external incentives. The model was a major service delivery innovation for several reasons:

- It built on an existing social organization, i.e., the village block structure of 10 homes.
- It promoted and reinforced traditional African values of solidarity and social support.
- It used traditional education methodologies (e.g., song, drama, and dance) to convey messages.
- It created a critical mass of volunteers in each village for community-wide behavioral change.
- The 10 households composing the block were a realistic and appropriate number of units for a volunteer to cover.
- Because of the model's strong community roots, there were no problems with volunteer payment.
-

World Vision/South Africa: The following is the mission statement of the KwaZulu-Natal Department of Health with whom World Vision collaborated on the project:

> "To develop a sustainable, coordinated, integrated and comprehensive health system at all levels, based on the Primary Health Care Approach through the District Health System."

The World Vision Child Health Project assisted in the development and strengthening of the newly established District Health System. The system was based on the notion of a *shared governance* model in which all health care actors— whether government, nongovernmental, or private— were able to participate as legitimate partners in the creation and implementation of health care policy. World Vision chose to support this model and the concerned actors instead of creating its own service delivery capacity.

Project HOPE/Honduras: The Regional Committee for Inter-Institutional Coordination for Child Survival, created by the Ministry of Health in the project area, became a forum in which PVOs, government, and NGOs shared child survival best practices and then were

encouraged to incorporate them into their own programs. Project HOPE helped to strengthen this committee, which built capacity through the transfer of knowledge and best practices, thereby leading to more effective service delivery.

ADRA/Yemen: ADRA worked with an informal network of women's groups and helped to organize them into formal organizations that now play a major role in disseminating health education messages, reinforcing corresponding changes in health behavior, and promoting empowerment through literacy programs and small-enterprise-development activities. This project demonstrates 1) the importance of working with and through existing community-based structures rather than creating them, 2) the effectiveness of matching health results with economic opportunity, and 3) the importance of literacy and economic welfare to women's empowerment.

CARE/Bangladesh: The project demonstrated to the community that sustainable, quality-outreach child survival services were dependent on community involvement, participation, and support. Equally important was the realization that the community's right to quality services is directly related to its obligation to participate in the planning and implementation of those services. The important lesson here is that building the capacity of both government and community health workers is closely linked to the quality and sustainability of child survival services.

HKI/Philippines: This project took the view that a more political approach to influencing local government decision-making was required. Program planners concluded that "nutritionists must learn to speak a different, more 'political language.'" Thus, the program combined nutrition education—such as a 'Mayor's Nutrition Kit' for newly elected officials—and child survival best practices with advocacy to achieve desired health policy change. The lesson learned is that developing the political capacity of PVOs and NGOs is perhaps the most effective advocacy tool in dealing with governments that may be skeptical of opening decision-making to those in the private sphere.

World Vision/Senegal: Evaluators noted that the success of this project was largely attributable to the fact that women played a leading role in the management of community child survival interventions. This led to an overall feeling of empowerment at the community level as well as among the individual women who participated—a finding similar to that found in other CS-X and CS-XI evaluations. The project also reinforced findings from several other evaluations that emphasis on literacy must be a fundamental component of any capacity-building strategy, particularly in terms of strengthening a community's ability to identify, prioritize, and solve collective problems in health as well as in other social and economic areas.

WRC/Mozambique—Training Camps: All the trainers of trainers (TOT), together with their supervisors and health educators, came together to camp for a week. Camps rotated from one animator's region to the next and became an important event for the community. Each morning at the TOT camp, animators learned technical information about the intervention and how best to train the Care Groups. Each afternoon, the animators

practiced the training techniques with the Care Groups and discussed what worked and what did not.

Save/Nepal: Although the project referred patients to MOH health service facilities, the quality of care at these facilities remained low, and lack of female staff hindered the achievement of the maternal and newborn care objectives.

Female Community Health Volunteers were trained in standard case management of acute ARI in children, including oral antibiotics for pneumonia. This training increased their skills, job satisfaction, motivation, and credibility in their communities.