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BASICS II Final Report

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 **BASICS II**



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BASICS II is a global child survival project funded by the Office of Health, Infectious Diseases, and Nutrition of the Bureau for Global Health of the U.S. Agency for International Development (USAID). BASICS II is conducted by the Partnership for Child Health Care, Inc., under contract no. HRN-C-00-99-00007-00. Partners are the Academy for Educational Development, John Snow, Inc., and Management Sciences for Health. Subcontractors include Emory University, The Johns Hopkins University, The Manoff Group, Inc., the Program for Appropriate Technology in Health, Save the Children Federation, Inc., and TSL.

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ACRONYMS

AIEPI	<i>Atención Integrada de las Enfermedades Prevalentes en la Infancia</i>
AIN	<i>Atención Integral a la Niñez</i>
AIN-C	<i>Atención Integral a la Niñez-Comunitario</i>
ANCI	African Nutrition Capacity Initiative
ARI	Acute Respiratory Infections
BASICS	Basic Support for Institutionalizing Child Survival Project (and BASICS II)
BCC	Behavior Change Communications
CA	Cooperating Agency
CAPA	Catchment Area Planning and Action
CBGP	Community-Based Growth Monitoring and Promotion
CDD	Control of Diarrheal Disease
C-IMCI	Community-Integrated Management of Childhood Illness
CORE	Child Survival Collaborations and Resources Group
CSP	Child Survival Partnership
DPT3	Diphtheria, Pertussis, and Tetanus
EBF	Exclusive Breastfeeding
ECOWAS	Economic Commission of West African States
ENA	Essential Nutrition Actions
EPI	Expanded Programme on Immunization
FANTA	Food and Nutrition Technical Assistance
FBO	Faith-Based Organization
FIC	Fully Immunized Child
GAVI	Global Alliance for Vaccines and Immunization
HCP	JHU/Health Communications Project
HealthCom	Communication and Marketing for Child Survival Project
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HKI	Helen Keller International
IADB	Inter-American Development Bank
IEC	Information-Education-Communication
IMCI	Integrated Management of Childhood Illness
INHP	Integrated Nutrition and Health Project
IYCF	Infant and Young Child Feeding
JHU	Johns Hopkins University
LAC	Latin America and Caribbean

MCH	Maternal and Child Health
MDG	Millennium Development Goal
MLM	Mid-Level Manager
MOH	Ministry of Health
NGO	Non-Governmental Organization
NIDs	National Immunization Days
OER	Operations and Evaluation Research
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PD/Hearth	Positive Deviance/Hearth
PMTCT	Prevention of Mother to Child Transmission
PRITECH	Technology for Primary Health Care Project
PRM	Performance and Results Monitoring
PRSP	Poverty Reduction Strategy Paper
PVO	Private Voluntary Organization
PY	Project Year
RBM	Roll Back Malaria
REACH	Technologies and Resources for Child Health Project
RED	Reaching Every District
SET	Strategic Experience Transfer
SNL	Saving Newborn Lives
SO	Strategic Objective
SPR	Short Program Review
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WAHO	West African Health Organization
WARO	West African Regional Office
WCARO	UNICEF/West and Central Africa Regional Office
WHO	World Health Organization
WHO/AFRO	WHO Regional Office for Africa
WHO/SEARO	WHO Regional Office for South East Asia

SUMMARY

This report covers the contract performance period of June 1999-December 2004 of the Basic Support for Institutionalizing Child Survival (BASICS) II Project. It documents the approach, results and lessons learned on increasing the uptake of child survival interventions. The Project was managed by the Partnership for Child Health Inc. This report is not exhaustive but highlights the main achievements during the five and one-half years of the project. Additional information is available in the annual Self Assessment Reports prepared by the Project for the U.S. Agency for International Development (USAID).

The **design** of the project involved providing technical support to countries to scale up proven interventions, and included a global technical leadership agenda to further the state of the art and facilitate transfer of experience to a larger number of countries through other organizations. The technical focus areas were immunization, community approaches for the reduction of childhood illnesses, nutrition, and neonatal health. The Project built on the lessons learned in BASICS I and focused on achieving scale.

By mid-2004, substantial **progress** was made in countries assisted by BASICS II in their capacity to plan and implement programs and in several coverage indicators. At the global level, nutrition was mainstreamed within child health, neonatal health interventions were operationalized at community level, community Integrated Management of Childhood Illness (IMCI) was designed and implemented in varied settings, treatment for pneumonia at community level was initiated in Africa, routine immunization programs were strengthened in the midst of polio eradication efforts, and several countries built stronger platforms for community-based child health programs.

Countries with a direct BASICS II presence were: Benin, Bolivia, DR Congo, Ecuador, El Salvador, Ghana, Guinea, Honduras, India, Madagascar, Mali, Nepal, Nicaragua, Nigeria, Senegal, Uganda, and Zambia. Over 65 sets of results in terms of increases in coverage or behavior change related to priority interventions were documented. The project also supported three regional programs for Asia, Africa, and Latin America and Caribbean (LAC). In collaboration with other global partners, the Project expanded the application of state-of-the-art approaches and tools in over 50 countries.

In addition to raising the coverage of specific interventions in direct presence countries, in the four technical areas the project made **progress** in advancing the field of child survival programming in the following ways:

- At country level: The capacity to design and implement large scale-programs in immunization, nutrition, community IMCI, and neonatal health was strengthened. Community-oriented programs were taken to scale; new approaches and tools were transferred across countries to better link communities with health services and to improve the quality of services; gaps and missing components in critical child survival services were filled; new partners were engaged and/or encouraged to coordinate their resources; and programs were streamlined and re-focused towards achieving results at scale.
- At regional level: Through regional institutions, the Project reached over 50 countries in Africa, Asia, and LAC with effective program approaches and tools to support community programs for common childhood illnesses, basic newborn care, essential nutrition actions, and routine immunization.

- At global level: The Project contributed to the development and operationalization of new child survival initiatives such as Reaching Every District (RED) for immunizing women and children, the Global Alliance for Vaccines and Immunization (GAVI), Injection Safety, Essential Nutrition Actions (ENA), Essential Newborn Care, the community component of Integrated Management of Childhood Illness (C-IMCI), Community-Based Growth Monitoring and Promotion (CBGP), and non-NIDs (National Immunization Days) vitamin A supplementation.

The Project **approach** related to the two main categories of activities can be summarized as follows:

- **Support to country programs to scale up proven child survival interventions**

In several countries, child survival interventions were already being implemented, often at scale. In these countries, the Project focused on increasing public health impact through building strategies for under-served and marginalized communities, such as C-IMCI in Bolivia, Ecuador, El Salvador, Honduras, and Nicaragua and reducing immunization drop-out rates in the DR Congo, Uganda, Guinea, Madagascar, Senegal, and India. Public health impact was enhanced also by addressing underlying risk factors such as malnutrition, such as with the *Atención Integral a la Niñez* (AIN) program in El Salvador, Honduras and Nicaragua, and with ENA in India, Nigeria, Senegal and Benin. Newborn health, a neglected technical area of rising concern, was given priority in Senegal, India, El Salvador, and Honduras.

In many countries, existing networks and program platforms that were not yet fully engaged in child survival programming were tapped for achieving scale and supported through capacity building. Examples include India (with CARE), Nepal (Village Development Committees and community health workers), Ghana (Ministry of Health (MOH)) and Uganda (MOH and non-governmental organizations (NGOs)).

In some countries, there were no primary health care platforms functioning at scale and therefore had to be built, such as with the Catchment Area Planning and Action (CAPA) committees in Nigeria; with a patchwork of the MOH, NGOs, and faith-based organizations (FBOs) in the DR Congo; and with the MOH and NGOs in Guinea, Mali, and Zambia.

- **Global and regional technical leadership activities to further the state of the art and expand the number of countries**

The state-of-the-art in programming for child survival was improved by the Project's selectively applying operational research frameworks and tools to areas that were considered by countries and global partners as key for advancing scale and impact. These included testing the feasibility of community distribution of cotrimoxazole for acute respiratory infections (ARI) in Senegal; demonstrating the effectiveness of an Essential Newborn Care package in Senegal and supporting CARE/India to do the same; demonstrating the effectiveness and impact of an integrated, community-based program focused on child growth in Honduras; improving immunization providers' communications and links with communities in Uganda; improving skills of patent medicine vendors for malaria treatment in Nigeria; evaluating private practitioners' prescribing and counseling practices in Uganda; synthesizing cross-country lessons in the application of causes of mortality studies to plan programs; and secondary analysis to demonstrate the contribution of tetanus to infant mortality in India.

Additionally, a number of senior technical staff from the Project provided feedback from field programs to global and regional forums where policy and resource decisions were being made. Emerging initiatives from global level were adapted and disseminated at the country level. Regional organizations were supported by the Project to expand the number of countries benefiting from new approaches, tools, and frameworks.

Lessons learned about the best use of technical assistance to expand child survival through a centrally managed “flagship” USAID project include the following. (Some of these were reiterated by the external assessment team (Pielemeier et al, 2003)):

- The Project developed and applied an effective framework for working at scale that focused on engaging partner organizations already present in project areas, and supporting their efforts by strengthening, focusing, or adding child health and nutrition activities.
- Some important constraints to reaching scale included the availability of non-USAID donor funding for child health. These have gradually dwindled, even in Africa where child mortality and morbidity remains very high, and within USAID the Africa Bureau’s resources for child survival also declined. USAID funds were limited, but the design assumed that other funding could be obtained from other donors and the private sector for major expansion efforts. Despite some BASICS II successes, this assumption has not been widely validated.
- Effective approaches were developed by the Project both for the delivery of integrated services aimed at addressing multiple causes of mortality and co-morbidities, and also for selective strengthening of key interventions within the context of comprehensive Maternal and Child Health (MCH) services. The Project found that both strategies could work with careful planning and attention to follow-up. However, integrated approaches are harder to implement and require a higher order of willingness to collaborate and compromise, and it takes time to form functioning linkages among technical domains. The short duration of BASICS II at field level made this difficult.
- The need for a consistent strategic vision within USAID among various missions and Bureaus and a plan with projected resources that could lead to desired outcomes would have helped BASICS II achieve more results within the project period.
- The expectation of meeting Strategic Objective (SO)-level results at national scale was unrealistic in light of start-up delays and prolonged planning. The contract ended when countries were beginning to implement more results-oriented programs; USAID and the countries lost out in momentum and the payoffs from these revised, more scaled up programs where investment had been carefully made.
- Many pre-requisites for achieving and maintaining scale include factors that are not under the direct control of a USAID project. These pro-scale conditions have not always been present in BASICS II countries and have threatened program expansion. The Project dealt with them in various ways.
- Learning from cross-country analysis of experiences is one of the main justifications for centrally managed projects. But systematic evaluations and analyses that have operational

value take time. Country programs did not become fully operational at scale until Project Years (PY) 3 and 4, and country and Mission interest in studies was not always high.

- Initially perceived as too rigid, the performance indicators of increases in coverage and scale helped several of the technical areas focus their strategies. Annual adjustments with the participation of national leaders in child health and nutrition would have helped program designs remain focused on priority issues in each country and technical area.
- Major transformations in the Project's lead technical arenas were taking place globally during 1999–2004. New global "initiatives" threatened to de-rail progress in the core elements of programming and systems strengthening. The technical leaders of the Project helped countries successfully navigate through these to maintain a focus on sustainable progress on the ground.
- The Project was able to contribute substantially more due to the combination of global leadership and country support functions. Continued USAID leadership in child health is best served by a leadership project that combines global technical leadership and cutting edge, but practical, application in the field.

The Project reached the majority of its public health performance targets and was widely acknowledged by partner organizations and countries as having contributed substantially to advancing the state-of-the-art in child health and nutrition. The majority of its direct public health impact came from DR Congo (immunization, vitamin A), Nigeria (breastfeeding and vitamin A), and India (nutrition and newborn care), illustrating the value of working in large countries and successfully engaging partners with a nationwide or very broad reach. Important activities with future payoffs included community-level newborn care, operational guidelines for the RED initiative in immunization, community-level management of malaria and ARI including the role of private medicine vendors, and working at scale with an ENA package.

Based on BASICS II's experience, areas where more effort would produce stronger child survival and nutrition results in future include: more strategic use of communications to reach the 42 countries with the largest number of childhood deaths with effective tools and technical support to expand a core set of priority interventions; gap analysis and a focus on critical missing operational elements needed for scale by country and technical intervention; transfer of experience from a small group of highly successful program sites to other countries through cross visits and dialogue; explicit strategies to build leadership in child survival programming in the 42 priority countries; and fostering interagency working groups at country and global levels for joint priority-setting, projections of future needs, and allocation of resources to assure that critical inputs for child survival are maintained. The value of performance monitoring on an annual basis to sustain momentum in reaching goals was validated. The need for focused, high coverage community approaches with explicit strategies to reach marginalized populations was highlighted. It was clear that systems support in the areas of performance and skills maintenance among frontline providers and their supervisors, supply and logistics systems, and information systems are critical, even for community-oriented programs.

The remainder of this report provides more details on the evolution of the Project, its approach and strategy, progress made, results, and lessons learned.

1. BACKGROUND

Context

The Project started in mid-1999; during the previous decade, progress in reducing infant and child mortality globally had slowed, and there had been little progress in the countries and regions with the highest levels of mortality. Disparities in mortality and health widened between the poor and the well off, between children in the less developed countries and the rest of the world, and within countries. Post-neonatal mortality continued its decline in several countries, but mortality during the newborn period increased as a proportion of the total. Malnutrition remained the major underlying cause of infant and child mortality. Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) became a major infant and child health concern in sub-Saharan Africa, principally in eastern and southern African countries and in some segments of populations in other countries.

The policy and resources context had also changed. Reorganization of the health sector occurred principally by decentralization, and several countries adopted broad sectoral approaches to financing. There was a tendency to follow either new, narrowly focused initiatives that bring substantial funding (e.g., polio eradication), or complex integrated, comprehensive service provision. These changes reduced the attention and resources being devoted to the evidence-based package of core child survival in many countries. The majority of countries currently do not have an overall child health policy and strategy.

USAID global and bilateral projects, including BASICS II, played a significant role in demonstrating to the global community that donor resources could make a substantial difference in expanding coverage and improving the quality of child health interventions in high mortality settings. Shortly after the Project started, the global community committed to the Millennium Development Goal (MDG) of reducing the mortality rate among children under five by two thirds by 2015. Since the establishment of this target, concerns have been raised that current levels of investment and implementation for child health activities are inadequate. In response to these concerns, a number of agencies with investments in child health have taken an interest in increasing the international focus on child survival. USAID's leadership and BASICS II were asked to participate in this alliance.

USAID Child Survival Programming

USAID's child survival approach began in 1982 with the adoption of a health assistance policy that moved away from support for primary health care systems to the implementation of focused, preventive and curative health interventions aimed at the principal causes of mortality and morbidity in less developed countries. The child survival strategy, adopted in 1986, specifically focused on the application of effective, low-cost technologies, principally immunization and oral rehydration therapy (ORT), as well as nutrition and child spacing.

An important factor in the success of child survival was the technical assistance provided by three global projects: the Technologies and Resources for Child Health (REACH) Project, focused on support for the Expanded Programme on Immunization (EPI) and to a lesser extent on ARI; the Technology for Primary Health Care (PRITECH) Project, focused on support of diarrheal disease control (CDD) programs and increased use of ORT; and the Communication

and Marketing for Child Survival (HealthCom) Project, focused on information-education-communication (IEC) support of child survival programs.

After almost a decade of providing vertical support to child survival programs, USAID identified the need to bring the key elements of such programs as well as the supply and demand aspects of child health and nutrition interventions together in a single global leadership and technical assistance project. The result was the Basic Support for Institutionalizing Child Survival (BASICS) Project, which began in 1993. By consolidating activities previously implemented under the three separate predecessor projects (REACH, PRITECH, and HealthCom), BASICS was expected to result in a more efficient use of human and financial resources and in a synergy of action with an increased capacity to take on new initiatives. A 1997 evaluation found BASICS to be highly successful and substantially contributing to USAID's global leadership and field implementation of child survival programs. However, in response to this evaluation and those of other key child survival projects, a new 10-year child health Results Package was written in 1998. The Results Package included a number of projects, with the "Flagship" (BASICS II) having a central role in developing state-of-the-art processes and tools in operationalizing child health and nutrition interventions and achieving scale.

The program vision for BASICS II was to move beyond small-scale activities to support a much broader implementation of a core package of child health interventions. The results of this program would be measured largely by improvements in coverage. Increased coverage was to be achieved by providing critical USAID technical and financial support and by obtaining other resources. The design had four novel features:

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

Approach and Strategy

BASICS II was designed to assist the Center for Population, Health and Nutrition (G/PHN, now the Bureau for Global Health), other Bureaus, and field Missions in increasing the use of child health and nutrition interventions at scale and advancing the state-of-the-art of global child survival programming. This goal was to be achieved through the following principal tasks:

- **Technical Leadership:** In close partnership with G/PHN, inform and influence global policy and program directions in key areas of child survival.
- **Regional/Global Initiatives:** Enter into partnerships with other USAID Bureaus and organizations for the development and implementation of regional or global initiatives related to the core interventions.
- **Country Programs:** Provide continuing technical assistance and support to child survival

programming in a limited number of selected countries with the intention of applying project resources strategically, with the greatest chance of transforming the way child health is done and achieving impact.

The Project's activities were organized around a limited number of key technical focus areas that corresponded to critical program needs and child survival technical priorities:

- Increased effectiveness and sustainability of child immunizations
- Integrated approaches to child health, later focused on community IMCI
- Incorporating nutrition into child survival activities
- Neonatal survival and health

In addition to the principal tasks, the BASICS II contract specified several technical support tasks:

- Operations and Evaluation Research (OER): Design, implement, analyze, disseminate, and apply the results of high-quality OER in support of the Project's objective and results.
- Strategic Experience Transfer (SET): Develop strategic approaches to documentation, analysis, and transfer of key expertise and experience for influencing policy and programming.
- Performance and Results Monitoring (PRM): Apply a systematic approach to monitoring progress, results, and quality of performance in all of the contract's functions.

To the greatest extent possible and in all areas of its work, BASICS II was also to seek to build capacity in developing country institutions and individuals and to build strategic partnerships with G/PHN, other Bureaus, Missions, other cooperating agencies (CAs), and other organizations.

The performance results or Strategic Objective (SO)-level results were specified by USAID as follows:

- Increased immunization coverage (fully immunized child) among high-risk infants and children with present EPI vaccines in at least 10 countries.
- Ninety percent measles coverage achieved through sustainable methods in six countries.
- Introduction and establishment of agreed-upon levels of coverage of new vaccines against major causes of morbidity/mortality of infants and children in four countries.
- ORT use increased by 50 percent or sustained at 80 percent or more of diarrhea episodes in at least 10 countries.

- Fifty percent increase in appropriate care seeking and treatment of ARI in at least 10 countries.
- Appropriate care seeking and treatment for children with febrile illness in malaria-endemic areas increased by 50 percent in at least five African countries.
- Significant increase in use by child caretakers of hand washing, food hygiene, and measures to maintain clean water at the household level in at least six countries.
- Increased use of insecticide-treated materials in malaria-endemic areas in at least five African countries.
- Breastfeeding at least 4 (amended to 6) months of age increased by 50 percent in five countries.
- Significant increase in appropriate child feeding (frequency, quantity, and/or quality of feeding) in five countries, and
- Adequate intake of vitamin A (and/or other specified micronutrients) achieved for 80 percent of children among populations identified as deficient in six countries.

There were no SOs for neonatal health or polio, but the Project achieved population-level results in several neonatal health care indicators and polio. The SO on hand washing and hygiene was dropped. For several indicators, the Project achieved more than the specified target and/or number of countries. In the three IMCI-related SOs, the number of countries was fewer. Overall, the Project exceeded the specified number of results.

In addition, the following intermediate results were specified.

- Fully operating integrated management of childhood illness (IMCI) and other integrated approaches. (The Project focused on the community component of IMCI.)
- Interventions to reduce neonatal morbidity and mortality. (On newborn care, the Project initiated large-scale programming in three countries and carried out a demonstration project in one country.)

Within the Project, BASICS II developed a plan for defining a clear vision and coherence in technical direction across country and global programs. Each TFA took the lead and managed the specified results as well as sought opportunities for advancing the global and regional agendas with other stakeholders. An investment strategy for the use of funds was developed to maximize payoffs for country SO-level results, for global technical leadership results, and for innovations and OER to support country programs. Each technical team developed Intermediate Results and Lines of Work to prioritize the work of country programs and global and regional activities. Annex A contains the Five-Year overviews of each TFA.

Based on ongoing dialogue with Missions and their country counterparts, the Project worked with varying levels of intensity to maximize coverage outcomes and contributions to the global state-of-the-art in child survival. The countries fell into the following categories:

- Implement a comprehensive package of multiple interventions and representative of

diverse settings with SO-level impact: Honduras, Nigeria, Senegal, India

- Achieve and document SO-level impacts in at least one technical area: Benin, DRC, El Salvador, Ghana, Guinea, Madagascar, Mali, Nepal, Nicaragua, Uganda
- Achieve learning about specific approaches: Ecuador, Zambia

Country “Results Teams” were formed with technical staff in the lead, and including representation from the field-based team, and from the various units at HQ (e.g. OER/PRM, SET, field programs, and finance and management). Each country team developed a project design using a simple Inputs, Process, Outputs, and Outcomes matrix that illustrated how the specific activities and inputs would lead to results. Each year’s work planning cycle involved reviewing and revising both the Technical Focus Area Five-Year Overviews and Country Designs. These tools were useful for planning PRM and SET functions as well.

2. PROGRESS MADE

This section describes the progress made in capacity building, improved policies and programming approaches, and strengthening the building blocks for child survival impacts in the future. Annex B provides an overview of the Project's contributions to USAID's Results package. Section 3 illustrates the type and magnitude of changes achieved at the population level in BASICS II supported countries during 1999-2004.

- **A number of country-level interventions were taken to scale at country level or across the majority of the country**

A "BASICS II Scale Framework" was developed, and country teams systematically identified and supported key organizations to scale up proven approaches. The emphasis was on community-level results and maintenance of quality. In some countries, comprehensive programs were scaled up, and in others selected technical interventions were scaled up. For example, in immunization, the RED approach was implemented in the DR Congo, Madagascar, Mali, and Senegal. For strengthening Essential Nutrition Actions (ENA) at scale, partner organizations working at national or state levels were supported in Benin, India, Madagascar, Nigeria, Senegal, and the DR Congo. CBGP was expanded in El Salvador, Nicaragua, Ghana, Honduras, and Zambia. Non-NIDs vitamin A supplementation reached high coverage using biannual distributions in the DR Congo, India, Nigeria, and Senegal. Measles control was undertaken in the DR Congo, Injection safety issues were advanced to national priority in Guinea, Mali, Senegal, and Uganda. Interventions to reduce neonatal morbidity and mortality were introduced and preparations for scaling up were undertaken in El Salvador, Honduras, India, and Senegal.

- **Host country capacity building for child health and nutrition programming was successful in several countries**

BASICS II used a range of training and non-training activities to strengthen institutional capacity aimed at accelerating scale and ensuring long-term sustainability for effective child health programs. Countries that benefited include Benin, Bolivia, DR Congo, Ecuador, El Salvador, Ghana, Guinea, Honduras, India, Madagascar, Mali, Nigeria, Senegal, Uganda, and Zambia. Several regional entities were strengthened in their capacity to support the expansion of child survival across more countries.

- **Behavior Change Communications (BCC) emerged as a critical component of scaled up child survival strategies**

BASICS II mainstreamed BCC in scaled up child survival strategies. The experience of designing and implementing communications packages at scale in LAC and African countries was disseminated to key partners. Project staff provided inputs to the Global STOP TB Program to help define the communication component used by their multi-agency partnership. A number of the rapid processes necessary for prioritizing high-impact behaviors were incorporated into a joint publication with the Pan American Health Organization (PAHO) and the Red Cross to guide LAC countries. They were disseminated to Central American countries in partnership with the Johns Hopkins University (JHU)/Health Communications Project (HCP). They were also

introduced region-wide in the context of peri/neonatal capacity building for LAC countries.

In several Project countries, such as Nigeria, El Salvador, Honduras, Guinea, and Senegal, BASICS II built the capacity of MOHs and partners in designing comprehensive communications strategies aimed at improving key emphasis behaviors. Countries participated in the development and production of full packages of child survival communications materials (posters, radio dramas, street theater, etc.), job-aids, and home health booklets for health workers and caregivers. The Project also supported community health worker and promoter training in the use of these materials, as well as training in the supervision of their use.

- **The Project contributed a number of new processes and frameworks to the practices of the four priority technical interventions**

Strategies and approaches developed by the Project were used by other countries and organizations beyond the countries of their emergence. For example:

- **Immunization:** BASICS II was instrumental in publishing *Immunization Essentials* – a monograph that captures the state-of-the-art of large-scale programming in routine immunization. It developed a new indicator for global tracking of country-level immunization coverage (diphtheria, pertussis, and tetanus (DPT3) coverage and measles coverage of >80% for each of the last three years) and widely disseminated regional maps by country. The World Health Organization's (WHO) Regional Office for Africa (WHO/AFRO) has now begun to use measles coverage of >80% for the past two years as one indicator of country readiness to introduce rubella vaccine. BASICS II finalized the WHO/AFRO Mid-Level Manager (MLM) Communication Module. A promising approach to reducing drop-out rates from Uganda involves a district-wide experience linking the peripheral health workers with the communities they serve using continuous adult learning principles.

BASICS II operationalized the RED approach in Uganda, Nepal, Senegal, and Madagascar—in most cases well before RED had been conceptualized at global levels. The BASICS II field experience in these countries influenced other countries and global partners on how to forge links between peripheral health workers and the communities they serve and how to introduce active monitoring at local levels for action. Madagascar's experience in district-level planning and community mobilization for immunization was adapted for other countries with the help of a multi-intervention (child and reproductive health) and multi-agency case study that was released in March 2004. Project experience on routine immunization data management, micro-planning, reporting, and supervision of performance of USAID-supported district and facility-level staff was transferred to global and regional immunization partners and representatives from African countries at several regional and inter-country technical exchange meetings. Also widely disseminated was a case study for effective functioning of interagency coordination committees for immunization.

- **Nutrition:** The Project supported West African Health Organization to finalize the three-year action plan of the African Nutrition Capacity Initiative (ANCI) and to participate in the development of the Nutrition Focal Points strategic plan. In the Asia-Near East region, support was provided to the WHO Regional Office for South East Asia (WHO/SEARO) in the development of ENA tools to facilitate ENA implementation. The Project also provided technical leadership and support for the alternative strategies for delivering vitamin A capsules through non-NIDs channels. The Positive Deviance/Hearth (PD/Hearth) experience

in Guinea and Mali has led to the replication of the approach in Senegal and Nigeria. In India, partnerships with bilateral organizations, NGOs, local government, the Forestry department, and various income-generating activities have increased the platforms to expand the promotion of ENA. Civil societies have also involved people from the community to start a "Malnutrition is Unacceptable Movement."

In CBGP, the development and implementation work done by BASICS II with the Health *Secretaría* in Honduras led to a region-wide sharing of experience with El Salvador, Guatemala, Nicaragua, and the Dominican Republic, which are replicating and adapting the strategy. With USAID support, this community strategy has also been transferred to Africa (Zambia, Ghana, and Mali). The experience has influenced other USAID (both global and bilateral), World Bank, Inter-American Development Bank (IADB), and NGO programs in countries such as Bolivia, Senegal, Madagascar, Uganda, Nicaragua, and Honduras.

- **Neonatal Health:** BASICS II provided technical support and input to a number of countries and organizations at global and regional levels to raise the importance of community-oriented programming and policies. The Project promoted the incorporation of newborn health into the Prevention of Mother to Child Transmission (PMTCT) of HIV/AIDS program through a number of USAID CAs and other organizations. Through three sets of regional activities BASICS II promoted best practices and strategies for newborn health to countries in Southeast Asia, LAC, and Africa. In the performance year, the Regional Southeast Asian Initiative advanced further with the development of regional guidelines in partnership with WHO/SEARO. In collaboration with partners, including PAHO, Child Survival Collaborations and Resources (CORE) Group and Saving Newborn Lives (SNL), BASICS II provided technical inputs targeted primarily for community-based interventions for improving newborn health in eight countries (Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Peru, and the Dominican Republic). At the request of WHO/AFRO, BASICS II also provided technical support on strategies for newborn health for their country staff at the regional (Anglophone and Francophone) meetings.
- **Community Approaches:** In El Salvador, all NGOs active in child health have adopted the *Atención Integral a la Niñez-Comunitario* (AIN-C) approach and are using the package of child health materials developed by BASICS II and the MOH. BASICS II has provided AIN-C and *Atención Integrada de las Enfermedades Prevalentes en la Infancia* (AIEPI) training for numerous NGOs in this country (Canadian Red Cross, FUSAL, CALMA, etc.) and has assisted the IADB in the training of health promoters for its project.

In West Africa, BASICS II collaborated with UNICEF/West and Central Africa Regional Office (WCARO) on the review of C-IMCI assessment and planning materials to be used at the district level, and on a planning exercise conducted in Guinea that involved two other countries (Cameroon, Mauritania). The Project also helped WHO/AFRO in the documentation of IMCI progress and best practices in Senegal, Madagascar, Niger, and the DR Congo. The Government of Benin and UNICEF-Benin are adopting the C-IMCI framework, guidelines, and materials from Senegal (developed with technical input from BASICS II) for the implementation of a community-based management of pneumonia.

- **Support to the Global Child Survival Partnership**

BASICS II worked in partnership with the USAID Global Health Bureau to establish the global Child Survival Partnership (CSP) and to improve the child survival focus in several priority countries. BASICS II contributed to achieving the following results:

- In **Ethiopia**, the Federal MOH created a national committee focusing on child survival and hosted the first High Level Visit of the CSP. The Federal MOH and Regional Health Bureaus held an inaugural national child survival conference and committed themselves to refine their new health sector strategy (Health Sector Development Plan III) to focus on child survival and community-level interventions having the greatest impact on child mortality. A link has been finally made between Ethiopia's child health strategy, Ethiopia's Country Status Report (developed by the World Bank and the Government of Ethiopia), and Ethiopia's Poverty Reduction Strategy. As a result of these efforts, there is now a renewed commitment to child health in Ethiopia by both the government and donors and a clear recommendation to double the government and donor investment in child survival programming in the future. This commitment can be seen in the Minister for Health's agreement to participate as the first Minister for Health on the global CSP Steering Committee.
- In **Cambodia**, the Secretary of State for Health in the MOH created a national Child Survival Task Force and, with donor support, conducted a comprehensive child survival situation analysis. Cambodia hosted the second ever High Level Visit of CSP members and, as part of that visit, conducted its first national child survival conference. Donors, including USAID, have agreed to review their assistance strategies in light of recommendations that came from the situation analysis and conference. As in Ethiopia, there is now a renewed donor and government commitment to child survival in Cambodia.
- In the **DR Congo**, child survival became a component of its Country Status Report that will lead to child survival becoming a component of an upcoming World Bank loan and will influence the content of DR Congo's Poverty Reduction Strategy Paper (PRSP).
- A draft Child Survival Scorecard was completed and field-tested. The Scorecard will be used in priority countries to monitor progress towards achievement of the child mortality MDG.
- A child survival assessment was done for **Iraq**. While not part of the CSP agenda at present, Iraq is one of the 42 priority countries. This assessment will form the foundation upon which child survival activities can be based when the CSP decides to focus there.
- The CSP overall structure and Secretariat has been defined and an interim Secretariat is being formed. While BASICS II did not participate as an entity in this process, it facilitated discussions that allowed CSP member to reach conclusions about structure and function.

- **Essential Nutrition Actions scaled up in Africa**

The West African Regional Office (WARO) team of BASICS II made a difference in the way nutrition programming is conducted in Sub Saharan Africa. The ENA approach developed in BASICS II has been adopted by countries, NGOs, and international organizations. As a key

partner to West African institutions and networks, the Project spearheaded a number of regional initiatives in nutrition. BASICS II supported WHO/AFRO and UNICEF in their efforts to move forward the Infant and Young Child Feeding (IYCF) global strategy in the region. BASICS II expanded access of African health professionals to implementing the IYCF strategy by using the ENA framework. Action plans were developed to accelerate implementation of the IYCF at country level in four countries (Burkina Faso, Côte d'Ivoire, Mali, and Senegal). Because of the Project's regional capacity and experience, the WAHO invited BASICS II to assist in the finalization of the three-year action plan on ANCI and to participate in the development of the strategic plan of the African nutrition network of implementing organizations. The Project also collaborated with the United Nations University.

BASICS II collaborated with regional partners (SARA, Helen Keller International (HKI), UNICEF, West African Health Organization (WAHO), AWARE-RH, UNICEF/WCARO) in Senegal, Mali, and Burkina Faso to support the umbrella mechanism of an NGOs network in capacity development for nutrition interventions (using ENA as the framework), and to develop a regional steering committee providing supervision and follow up to the NGOs. Three NGO workshops for capacity development using ENA tools and approaches were organized in collaboration with SARA and HKI for five countries; as a result, 70 NGOs and networks developed plans to integrate ENA tools and approaches in nutrition interventions. In Senegal, Côte d'Ivoire, Burkina Faso, and Mali, MOH staff and NGO representatives were apprised of and received generic nutrition modules based on ENA that were developed in collaboration with the SARA Project. BASICS II also supported 16 public health schools in Senegal, Guinea, Niger, and Cameroon to integrate ENA tools and approaches in their curricula. BASICS II also provided technical assistance in ENA to 23 trainers from 13 West and Central Africa Universities and food and technology postgraduate schools.

Two-thirds of the 15 countries in the Economic Commission of West African States (ECOWAS) adopted the ENA with HIV/AIDS intervention component. Four non-presence countries adopted ENA in their national programs, and the NGO network was evaluated and results presented at the 8th ECOWAS Nutrition Forum. WAHO and HKI are committed to support the dissemination of the evaluation report before the next forum. In collaboration with the Family Health International, BASICS II also developed and disseminated materials related to malaria and micronutrients to ten regional partners, six public health schools in four countries (Senegal, Benin, Cameroon, and Guinea), to Ministries of Health (Malaria and Nutrition programs), USAID Missions, and WHO and UNICEF offices in five countries (Senegal, Benin, Guinea, Mali, and the DR Congo). As a result, UNICEF/WCARO requested additional materials for their 24 countries.

- **Community-Based Growth Monitoring and Promotion was revitalized and taken to scale**

The CBGP approach was reborn as a platform for child health services delivery. Regional CBGP implementers met in Central America and exchanged experiences at a conference co-sponsored by BASICS II, Food and Nutrition Technical Assistance (FANTA), and NicaSalud. They reviewed experience from pilot programs and early expansion and discussed plans for national-level CBGP programming. In addition to NGO and international development agency representatives, the meeting drew high-level officials from governments implementing CBGP with BASICS II support, as well as from interested parties outside of the Project's focus countries (e.g., Guatemala and the Dominican Republic) and from international multilateral

agencies (the World Bank and IADB) and other potential donors and partners.

- **The private providers component of the global malaria initiative began to take shape through BASICS II**

The Project supported the Private Provider Task Force of the Roll Back Malaria (RBM) Malaria Case Management Working Group and other partners, particularly the Malaria Consortium, to move ahead with engaging informal drug sellers to improve community and home management of malaria.

- **Documentation of child health programs and approaches strengthened experience transfer**

BASICS II developed a documentation framework that was applied in Nepal, Madagascar, and the W. Africa Region. The AIN approach in Honduras and CARE's Integrated Nutrition and Health Project (INHP) were also documented to synthesize lessons learned. The IMCI Short Program Review (SPR) document for Nicaragua was finalized in late 2003. Along with other SPRs carried out in Honduras, El Salvador, and Bolivia, this document summarizes the process of IMCI implementation and identifies weaknesses that should be corrected in order to improve implementation of the strategy.

WARO collaborated in the documentation of the IMCI strategy in three Francophone countries (Madagascar, Niger, and Senegal), part of a larger effort by WHO/AFRO to document the IMCI experience in Africa. The documentation reports were presented at the WHO/AFRO's sub-regional meeting of IMCI focal persons in 2004. This documentation is the first region-wide attempt to collect, analyze, and use country experiences in the implementation of IMCI.

- **Accomplishments recognized in external assessment**

The accomplishments of the Project were recognized in an **external assessment report**, prepared in February 2003. It notes that at approximately 15 months before contract completion, the magnitude of results "are substantial." Other findings include the following:

- With reference to the Technical Focus Areas, "in immunization BASICS II has provided strong global leadership and country support in vaccine security, strengthening routine vaccination programs, improving vaccine safety, and encouraging the proper use of new vaccines. In nutrition, BASICS II has helped define and successfully implement a package of Essential Nutrition Actions, fostered an effective nutrition network of 20 countries in West/Central Africa, and established community-based growth monitoring as a platform for the delivery of community and household nutrition and health services. In neonatal health, BASICS II advocacy efforts and operations and evaluation research were needed and have been effective. In community IMCI, adoption in some countries has been hampered by a continuing controversy between the World Health Organization/Pan-American Health Organization and a USAID/private voluntary organization (PVO) coalition over the relative priority and sequencing of C-IMCI in relation to facility-focused IMCI and other approaches."

- Regarding the use of Flagship functions, the assessment reported, “in its support for field programs, most USAID Missions highly rate BASICS II field staff and its programs. In global leadership, the BASICS II immunization and nutrition leadership is internationally known and has worked closely with USAID staff to provide global leadership. Several African members of the African regional office (WARO) technical staff are highly respected and have provided effective regional leadership. Operations and evaluation research was not been effectively built into TFA [Technical Focus Area] agendas or BASICS II country programs. In Strategic Experience Transfer, as a separate entity from TFAs, BASICS II has struggled to define a role and to put it into operation. An effective program results monitoring system has been established that should provide valid measures of program results.”

3. RESULTS

The central objective of BASICS II was to support large-scale programs and demonstrate that they could produce public health impact. The Project made identifiable contributions to the sustained increase in the use of child survival intervention and documented increases in coverage and desirable household behaviors.

- **Increased immunization coverage among high-risk infants and children with present EPI vaccines in 11 countries**

Immunization coverage (% or number of children) increased as measured through DPT3 (diphtheria, pertussis, and tetanus) coverage or fully immunized children (FIC) in 11 countries: DR Congo, El Salvador, Ghana, Guinea, India, Mali, Madagascar, Nepal, Nicaragua, Senegal, and Uganda (see examples in Figures 1 and 2).

Figure 1: Mali—Trends in DPT3 Coverage Among Infants by 12 Months of Age, 1999–2003, 6 Regions

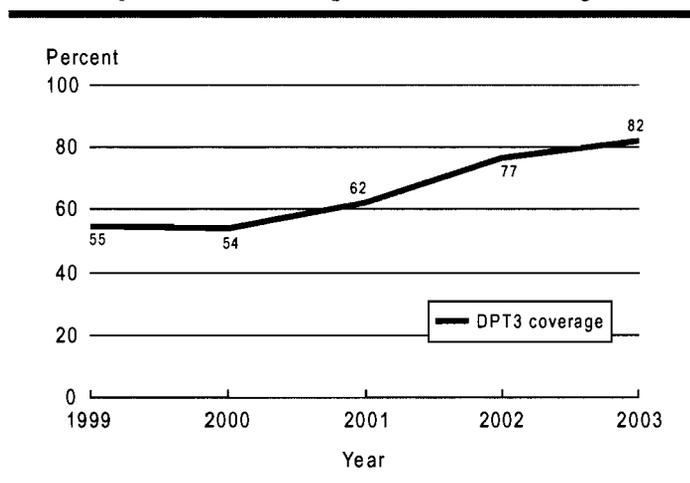
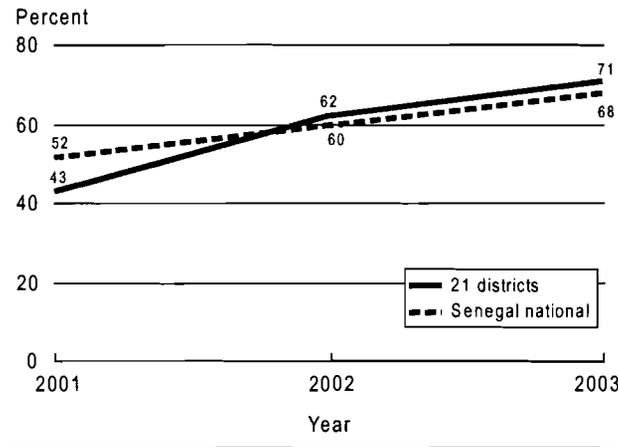


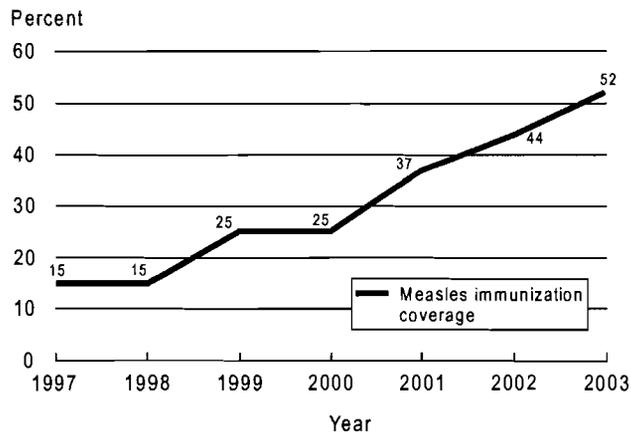
Figure 2: Senegal—Trends in DPT3 Coverage Among Infants by 12 Months of Age, 2001–2003, National and 21 Districts



- **Ninety percent measles coverage achieved through sustainable methods in 6 countries**

BASICS II has contributed to increased measles immunization coverage in six countries as documented in DR Congo, Guinea, Mali, Senegal, India, and Uganda (see example in Figure 3).

Figure 3: DR Congo—Trends in Measles Immunization Coverage, 1997–2003, National



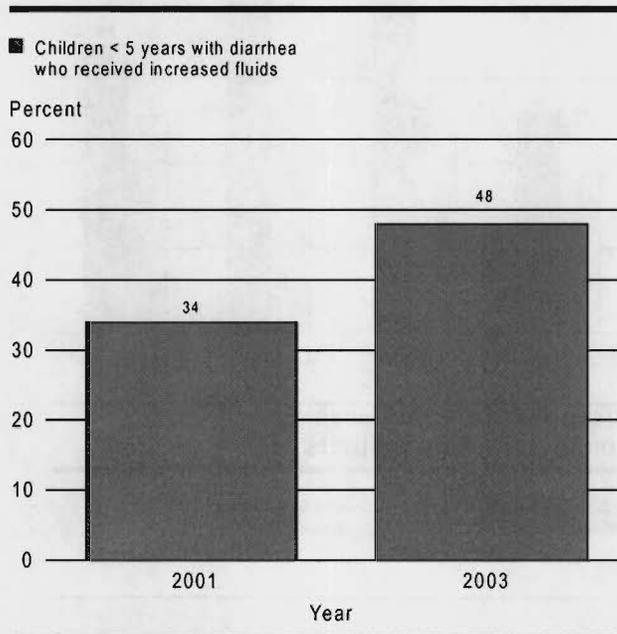
- **Introduction and establishment of agreed upon levels of coverage of new vaccines against major causes of morbidity/mortality of infants and children in 5 countries**

New vaccines were introduced with BASICS II assistance in five countries: the DR Congo, Senegal, Uganda, Mali, and Guinea.

- **ORT use increased by 50% or sustained at >80% of diarrhea episodes in 10 countries**

The Project contributed to substantially increased levels of oral rehydration therapy (ORT) use or maintained levels as measured in five countries: El Salvador, Ghana, Nicaragua, Senegal, and Uganda (Figure 4).

Figure 4: Uganda—Trends in Increased Fluids, 2001 and 2003, 5 Districts



- **Fifty percent increase in appropriate care-seeking and treatment of ARI in 10 countries**

The Project contributed to substantially increased care-seeking for ARI in six countries directly: Bolivia, El Salvador, Ghana, Honduras, Nicaragua, and Senegal (see examples in Figures 5 and 6).

Figure 5: El Salvador—Trends in Care-seeking for ARI, Among Children < 2 Years of Age, 2002 and 2003, 3 Departments

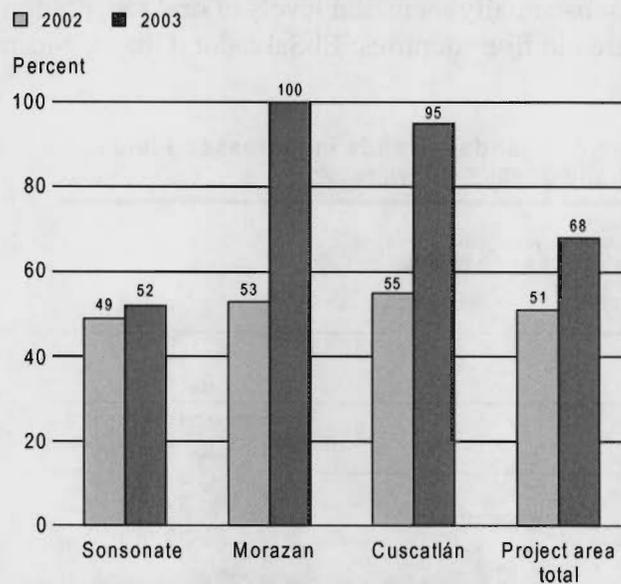
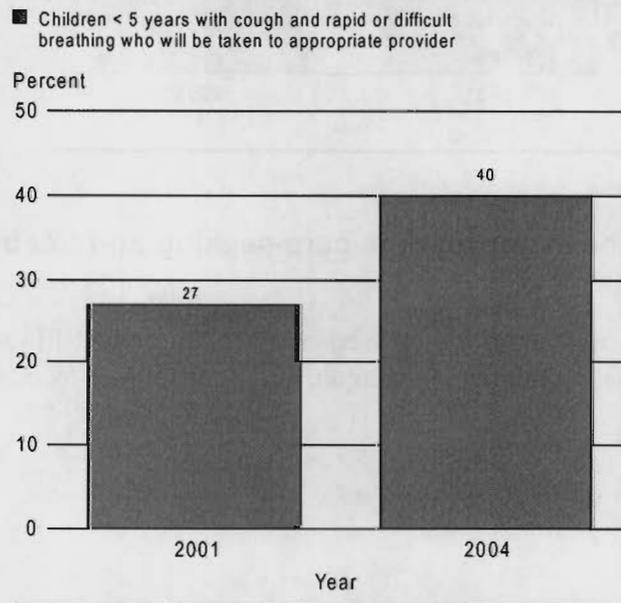


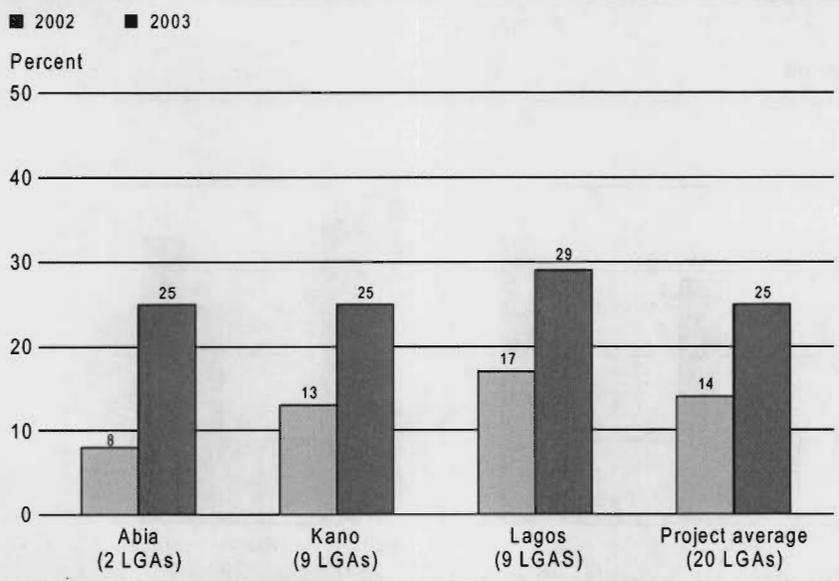
Figure 6: Ghana—Care-seeking and Treatment for ARI, 4 Districts



- **Appropriate care-seeking and treatment for children with febrile illness in malaria-endemic areas increased by 50% in at least 5 African countries**

Project inputs helped to substantially increase care seeking and treatment for febrile illnesses in Nigeria, Senegal, and Uganda (see Figure 7). In the DR Congo, progress was made in implementation.

Figure 7: Nigeria—Trends in Treatment of Febrile Illness, Children Treated with a Recommended Antimalarial Within 24 Hours, 2002 and 2003, Abia, Kano, and Lagos States (20 LGAs)



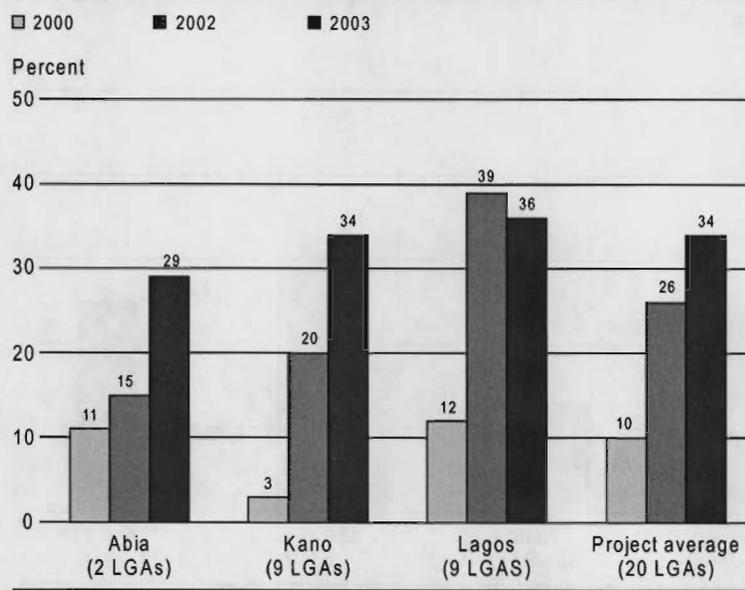
- **Increased use of insecticide-treated materials in malaria-endemic areas in at least 5 African countries**

BASICS II contributed to the increased use of insecticide treated bednets in four countries: Nigeria, Senegal, Uganda, and the DR Congo.

- **Prevalence of appropriate breastfeeding through at least four months of age increased by 50% in 6 countries**

The Project contributed to substantially increased rates of exclusive breastfeeding (EBF) of infants less than six months of age or maintained them at high levels in six countries: El Salvador, India, Nicaragua, Nigeria, Senegal, and Uganda (see the example in Figure 8).

Figure 8: Nigeria—Trends in Exclusive Breastfeeding Among Infants < 6 Months of Age, 2000–2003, Abia, Kano, and Lagos States (20 LGAs)



- **Significant increase in appropriate child feeding (frequency, quantity, and/or quality of feeding) in 5 countries**

BASICS II approaches demonstrated substantially increased rates of age-appropriate child feeding in five countries: El Salvador, Ghana, India, Nicaragua, and Uganda (see examples in Figures 9 and 10). In Senegal there is process-level evidence showing progress towards important changes in appropriate complementary feeding.

Figure 9: El Salvador—Trends in Appropriate Child Feeding by Age Group, 2002 and 2003, 3 Departments

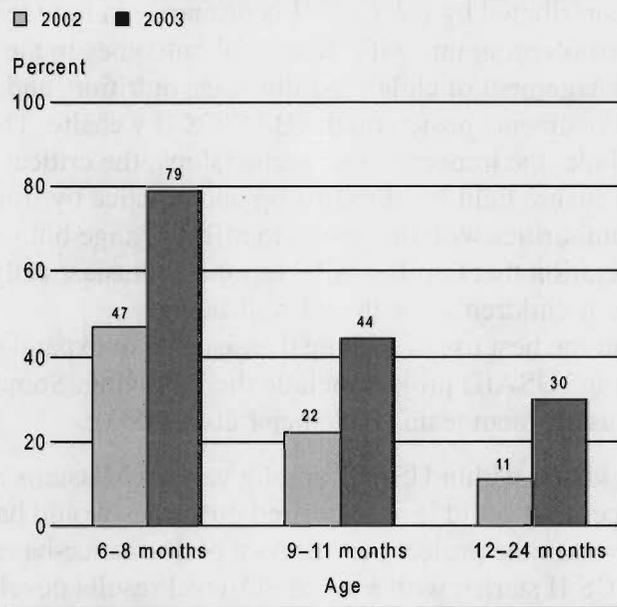
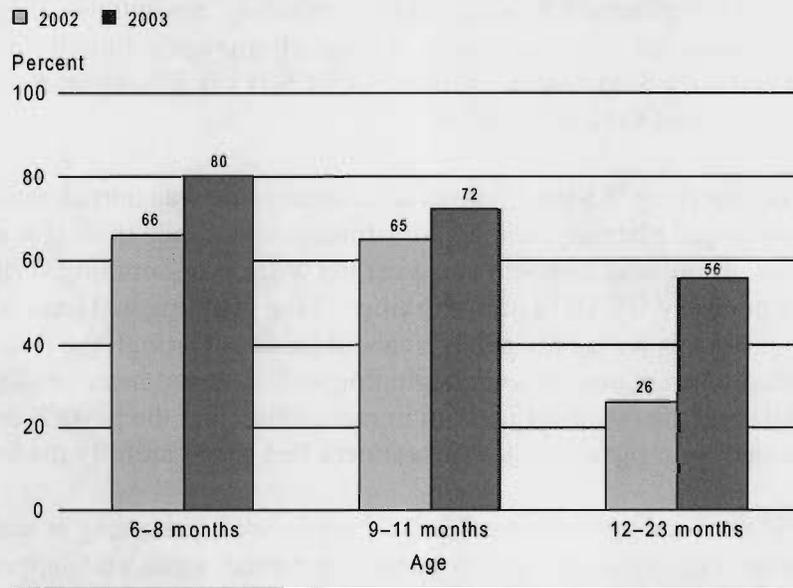


Figure 10: Nicaragua—Trends in Appropriate Child Feeding Practices, Infants 6-23 Months of Age, 2002 and 2003, PVO/NGO Partner Communities in 2 Departments



- **Adequate intake of vitamin A (and/or other specified micronutrients) achieved for 60% of children among populations identified as deficient in 6 countries**

BASICS II contributed to increased levels of vitamin A coverage or maintained high coverage in six countries: Benin, the DR Congo, India, Nigeria, Senegal, and Uganda.

4. LESSONS LEARNED

The new state-of-the-art contributed by BASICS II is primarily in how to operationalize large-scale child health and nutrition programs with successful outcomes in the areas of immunization, timely and appropriate management of childhood illnesses, nutrition, and neonatal health. The specifics are provided in documents posted on the BASICS II website. The universal lessons across technical areas include: the importance of partnerships; the critical need to go beyond policies and guidelines to ensure field-level follow up and practice by front-line health workers; the need to engage local authorities with the power to affect change but who often sit outside the health sector; and the reiteration that families will respond enthusiastically to any reasonable opportunity to improve their children's health and well-being.

Lessons learned about the best use of technical assistance to expand child survival through a centrally managed “flagship” USAID project include the following. Some of these were reiterated by the external assessment team (Pielemeier et al, 2003):

- A consistent strategic vision within USAID among various Missions and Bureaus, and a plan with projected resources that could lead to desired outcomes would have helped BASICS II achieve more results within the project period. As a performance-based contract with the Global Bureau, BASICS II started with a set of SO-level results developed centrally within USAID. However, a preponderance of field support funding led to a strong focus on meeting Mission needs and an effective but lower cost approach to global technical leadership. The USAID Missions did not always share the Global Bureau's vision and strategic direction. As BASICS II began, the USAID Missions had little knowledge about the results framework. Mission funds were programmed for systems strengthening, capacity building, and equipment in the traditional way—outside of a results framework. Initially designed as a 40% globally funded and 60% field funded project, BASICS II's field support funding in PY3, 4, and 5 was 76%, 72%, and 81%, respectively.
- The expectation of meeting SO-level results at national scale was unrealistic in light of start-up delays and prolonged planning, and no adjustments were made in the Project's duration to accommodate this. There was a one- to two-year lag when programming shifted to the results frameworks that underlay USAID's new thinking. These planning and (on the PCHC, Inc. side) leadership problems were only resolved about halfway through the five-year program. The contract ended when countries were beginning to implement more results-oriented programs; USAID and the countries lost out in momentum and the payoffs from these revised, more scaled-up programs where investment had been carefully made.
- The Project developed and applied an effective framework for working at scale that focused on engaging partner organizations already present in project areas, and supporting their efforts by strengthening, focusing, or adding child health and nutrition activities. The example of working with CARE in India illustrates this. With a modest budget and within a short period of time, the Project was able to support child health and nutrition interventions in a population of tens of millions. In the DR Congo, there was practically no movement in immunization indicators, and the Project-filled gaps that no other agency was addressing and helped an interagency coordinating committee in better allocation of resources, resulting in scaled up impact.

- Many prerequisites for achieving and maintaining scale include factors that are not under the direct control of a USAID project. These pro-scale conditions have not always been present in BASICS II countries, which threatened program expansion. The Project dealt with these factors in various ways. For example, the interventions in a country have to be tested and adapted to the satisfaction of the MOH, and the Project's SET function addressed this through documenting other country experiences and facilitating visits to other countries or meetings where these issues were discussed. Senior technical staff of the Project also maintained an ongoing dialogue with key stakeholders to gradually overcome barriers to change. The WARO team played a crucial role in overcoming these barriers in West Africa. Another prerequisite is that the MOH should provide strong program leadership and effective nationwide coordination. The Project often had to deal with changes in ministers and re-structured MOHs through alliances with other donors and strong district-level partnerships. (The role of the trust in and technical credibility of the Project field teams and in some countries of the USAID Mission was critical.) A reasonably effective health structure needs to be in place with trained staff, and the Project provided systems strengthening support, helped streamline interventions to fit local capacity, and identified local resources for additional support (e.g., NGOs). The Project also actively supported the use of interagency coordinating mechanisms for addressing many of these constraints.
- Some important constraints to reaching scale included the availability of non-USAID donor funding for child health. This type of funding has gradually dwindled, even in Africa where child mortality and morbidity remains very high. Within USAID, the Africa Bureau's resources for child survival also declined. Although USAID funds were limited, the design assumed that funding could be obtained from other donors and the private sector for major expansion efforts. Despite some BASICS II successes, this assumption has not been widely validated. Host country budgets remain stagnant and are allocated primarily for curative care and to pay salaries. Although child health interventions are relatively inexpensive, local cost funding is needed at the health post and clinic levels and to pay for supervisory visits to outlying villages where community-based programs need periodic monitoring and restocking. Health reform and government decentralization efforts offer new options for local cost financing, but processes and frameworks for tapping these specifically for child survival remain to be developed and used routinely.
- Learning from cross-country analysis of experiences is one of the main justifications for centrally managed projects. But systematic evaluations and analyses that have operational value take time. Country programs did not become fully operational at scale until PY 3 and 4 of the Project, and country and Mission interest in studies was not always high. In-country capacity was a limiting factor, and one that this Project was not geared up to address. However, the Project carried out several comprehensive studies, and critical assessments and analysis that highlighted important child survival issues.
- Initially perceived as too rigid, the performance indicators of increases in coverage and scale helped several of the technical areas focus their strategies. For example, nutrition programs with a tendency towards pilot projects were pushed to work at scale, neonatal interventions that have historically remained in facilities were encouraged to implement at community level, and C-IMCI was re-designed in the Project to focus on a few priority behaviors and

aimed to make a measurable difference in household behaviors at scale. However, in the immunization technical area, the emphasis of project performance indicators on coverage alone tended to reinforce historically ineffective practices including insufficient emphasis on quality and sustainability. Ideally, to achieve important child health results in the field, a flexible, adaptive approach is needed, with performance indicators designed to address locally relevant constraints to public health impact, and mindful of differences across technical areas. Annual adjustments with the participation of national leaders in child health and nutrition would have helped program designs remain focused on priority issues in each country and technical area.

- Effective approaches were developed by the Project both for the delivery of integrated services aimed at addressing multiple causes of mortality and co-morbidities, and for selective strengthening of key interventions within the context of comprehensive MCH services. Taking the lead from country-level needs assessments, the Project found that both strategies could work with careful planning and attention to follow-up. Integrated approaches are harder to implement and require a higher order of willingness to collaborate and compromise, and it takes time to form functioning linkages among technical domains. The short duration of BASICS II at the field level made this difficult.
- Major transformations in the Project's lead technical arenas were taking place globally during 1999–2004. New global “initiatives” threatened to de-rail progress in the core elements of programming and systems strengthening. The technical leaders of the Project helped countries successfully navigate through these to maintain a focus on sustainable progress on the ground. Immunization was dealing with polio eradication and the danger of falling routine immunization coverage while injection safety became a concern; neonatal health was gaining recognition as one of the most critical areas, but field experience with large-scale programs and program frameworks and tools was in short supply; the IMCI initiative underwent review and re-thinking, emerging with more modest strategies and recognizing the many alternatives for community-oriented programming to produce results; in nutrition, new concerns and priorities emerged (e.g., zinc and HIV/AIDS) while the package of the most cost-effective and proven six essential interventions was far from scaled up beyond a handful of countries.
- The Project was able to contribute substantially more due to the combination of global leadership and country support functions. Continued USAID leadership in child health is best served by a leadership project that combines global technical leadership and cutting edge, but practical, application in the field. BASICS II contributions to GAVI for immunizations and to operationalizing the global Infant and Young Child Feeding strategy are examples. Within countries, USAID Missions supported and encouraged the Project to engage in dialogue and policy discussions at the highest level. The Project's technical leadership was frequently invited to contribute in global forums, and closer teamwork between USAID and the Project would have been even more effective in bringing the funding and operational/technical insights to the table. Good examples of teamwork in global and regional forums are the Project Director's work with the USAID Global Health Bureau in establishing the global Child Survival Partnership (CSP) and taking initial steps in CSP focus country programming,

and the Asia Bureau and Project neonatal health team leader working with WHO/SEARO in inaugurating the Southeast Asia neonatal initiative.

- Based on BASICS II's experience, areas where more effort would produce stronger child survival and nutrition results in future include: more strategic use of communications to reach the 42 countries with the largest number of childhood deaths with effective tools and technical support to expand a core set of priority interventions; gap analysis and focus on critical missing operational elements needed for scale by country and technical intervention; transfer of experience from a small group of highly successful program sites to other countries through cross visits and dialogue; explicit strategies to build leadership in child survival programming in the 42 countries; and fostering interagency working groups at country and global levels for joint priority-setting, projections of future needs, and allocation of resources to assure that critical inputs for child survival are maintained. The value of performance monitoring on an annual basis to sustain momentum in reaching goals was validated. The need for focused, high coverage community approaches with explicit strategies to reach marginalized populations was highlighted. It was clear that systems support in the areas of performance and skills maintenance among front-line providers and their supervisors, supply and logistics systems, and information systems are critical even for community-oriented programs.

The Project reached the majority of its public health performance targets and exceeded them in several categories. The contributions made by BASICS II were widely acknowledged by other donors and countries as having advanced the state-of-the-art in child health and nutrition. The majority of its direct public health impact came from the DR Congo (immunization, vitamin A), Nigeria (breastfeeding and vitamin A), and India (nutrition and newborn care), illustrating the value of working in large countries with poor indicators and successfully engaging partners with a nationwide (or very broad) reach. Important activities with future payoffs included work in community-level newborn care, operational guidelines for the "reaching every district" initiative in immunization, community-level management of malaria and ARI including the role of private medicine vendors, and working at scale with a package of essential nutrition actions.

ANNEX A: Five Year Overviews of Technical Areas

ANNEX A.

1. Immunization Workplan — Five-Year Overview

This document is intended to illustrate the links among SO results, and IRs, Lines of Work (LOW), and among groups of activities in each successive year of the five-year plan for immunization. Details of the strategy are given in the BASICS II Strategic Plan (January 2000). Activities are itemized by year in the tables that follow.

SO Level Results	Intermediate Results (iR)	Lines of Work (LOW)
<p>Increased use of effective, improved, and sustainable child health interventions, specifically:</p> <p>SO 1 Increased immunization coverage (fully immunized child) among high-risk infants and children with present EPI vaccines in at least 10 countries.¹</p> <p>SO 2 90% measles immunization coverage achieved through sustainable methods in six countries.²</p> <p>SO 3 Introduction and establishment of agreed upon levels of coverage of new vaccines against major causes of morbidity/mortality of infants in four countries.</p> <p>Additionally:</p> <p>SO 6 Increased coverage of vitamin A in children at risk of vitamin A deficiency.³</p>	<p>IR 1: Routine immunization coverage increased sustainably through strengthening of systems (linked to IACH (C-IMCI) IR 3, Neonatal/Perinatal IR 1) in 10 countries.</p>	<p>1.1 Promote partnerships to leverage and coordinate support for strengthening immunization systems.</p> <p>1.2 Ensure the availability and use of services at the delivery points through improved planning and managing.</p> <p>1.3 Increase and sustain demand for immunizations.</p>
	<p>IR 2: Comprehensive approaches to disease control designed and implemented in four to six countries (linked to IACH (C-IMCI) IR 3, Neonatal/Perinatal IR 1, Nutrition IR 2).</p>	<p>2.1 Design, implement, and evaluate comprehensive strategies for long-term measles control and mortality reduction (possible countries: DR Congo, Nigeria, Mali, and Uganda).</p> <p>2.2 Design, implement, and evaluate innovative approaches to reduce neonatal tetanus.</p> <p>2.3 Eradicate poliomyelitis while strengthening routine immunization systems.</p>
	<p>IR 3: Underutilized and new vaccines introduced in four country programs.</p>	<p>3.1 Increase the use of underutilized vaccines and strengthen ability of routine system to incorporate new vaccines.</p>
	<p>IR 4: Quality of immunization services improved in two countries.</p>	<p>4.1 Ensure injection safety through comprehensive solutions.</p>

¹ Also supported by IACH (C-IMCI), Neonatal/Perinatal TFAs

² Also supported by IACH (C-IMCI) TFA

³ Support to Nutrition TFA

Activities for IR 1. Routine immunization coverage increased sustainably through strengthening of systems in 10 countries

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
1.1 Promote partnerships to leverage and coordinate support for strengthening immunization systems.	<p>Links made with key players (WHO, UNICEF, CDC, and World Bank) at the global, regional, and country levels and a technical role for BASICS II (HQ and WARO) established within new partnerships (GAVI, SIGN). The relationship between BASICS II and PATH/Gates CVP clarified regarding achievement of BASICS II contract results. Technical support provided to USAID to develop its immunization investment strategies. Technical collaboration with USAID CAs, bilaterals (Madagascar and Nepal), PVOs, and multi-lateral agencies initiated.</p>	<p>Concrete roles for BASICS II in GAVI activities at the global and regional levels established and carried out (see also IR 3). Specific modes of collaboration for immunization defined in identified countries between BASICS II and CVP/Abidjan, as well as with other CAs, PVOs, bilaterals, and multi-lateral agencies. In countries with long-term BASICS II immunization interventions, BASICS II HQ, regional, and country staff (1) participated actively in interagency coordinating committees; (2) assisted in development of multi-year plans; and (3) provided technical guidance on immunization within the context of health sector reform.</p>	<p>Local BASICS II staff continued to play an active role on ICCs and with BOOST implementation in countries with long-term interventions. Implementation of targeted joint activities with other players (CVP/Abidjan, bilaterals, CAs, and NGOs) expanded. Continued technical input to USAID and other partners provided, including technical assistance with USAID-wide and Afr/SD routine immunization strategies.</p>	<p>BASICS II maintained ongoing exchange of technical expertise that affects resource allocation and immunization plans, and reviewed experience in the operation of interagency coordinating committees. Refinements made, as needed, in approaches for coordinated support through multi-agency initiatives (e.g., GAVI, Global Fund for Children's Vaccine). If requested by USAID, BASICS II may assist in reviewing funding mechanisms to other donors.</p>	<p>In countries with BASICS II immunization interventions, coordinated, long-term strategies in place that support immunization in a manner consistent with public health goals and the local and national health care context. At the global level, coordinated long-term investor strategies, developed with input from BASICS II, implemented with sufficient resources to improve immunization in a sustainable way.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
1.2 Ensure the availability and use of services at the delivery points through improved planning and managing.	The staff visited selected countries to determine feasibility of involvement in strengthening routine immunizations (Guinea, Mali). MOH working groups established to plan and implement activities. Baseline information collected on coverage and on cold chain, supply, and monitoring systems; information analyzed with MOH; and problems and needs defined. Outline for district planning initiated on cold chain improvement and service access/utilization strategies (e.g., outreach). National MOH involved and future activities scaled up.	District planning continued, including implementation of cold chain improvement and strategies for service access/utilization. Key indicators and methods for health-facility monitoring defined in collaboration with MOHs. Staff assisted assessment and documentation of the activities and process to make adjustments and to facilitate future nationwide rollout. Refresher training on immunization principles and health facility monitoring initiated in coordination with other child survival training activities.	Lessons learned on the BASICS II approach for strengthening routine immunization presented at national, regional, and international meetings. The staff continued working with national and district colleagues to train, implement, assess, and document the strategies and process to strengthen routine immunization. Staff determined strategy with MOHs for geographical expansion of the approach to strengthen routine and improve collection and use of data at all levels in 10 countries.	Guidelines on how to implement the developed approach finalized. Planning with MOHs on geographical expansion completed and expansion initiated where appropriate. Post-intervention health facility assessments and coverage surveys conducted when appropriate.	Staff continued or initiated geographical expansion as needed. The BASICS II approach on strengthening immunization services was presented at regional and global meetings. Collection of post-intervention data (e.g., coverage) completed. Documentation on the process and the results finalized and distributed to other countries and partners.
1.3 Increase and sustain demand for immunizations.	Staff assessed IEC needs and developed and tested immunization IEC approaches, including polio-related initiatives, to improve KAP of caregivers and health workers in BASICS II countries (DR Congo, Ghana, Nigeria, and Senegal). IEC assessments conducted as part of EPI review in Guinea and Mali. In collaboration with partners, joint IEC initiatives implemented and evaluated (PEI lessons-learned assessments; communication for immunization training with countries; and guiding IEC strategy for WHO/AFRO immunization).	The staff used approaches and findings from PY1 to advocate for and support implementation of immunization CBC strategies sub-nationally (in Nigeria, DR Congo, and Ghana). These approaches were introduced to new countries (Mali, Guinea, Senegal, and Madagascar) and focused on missed opportunities and dropouts. The staff collaborated with MOH, WHO, UNICEF, USAID, CAs, and bilaterals to develop or revise, implement, and evaluate customized immunization CBC strategies and training approaches, using formal and informal channels.	BASICS II continued to support implementation and collaboration on CBC strategies and action plans, including process evaluation and monitoring to improve interventions. Staff shared experiences among countries and with other partners (e.g., WHO/AFRO, UNICEF, CVP, GAVI) and identified discernable changes in demand. Linkages among immunization communication network for Africa with GAVI Advocacy Task Force and other partners were strengthened.	Staff documented and disseminated tested immunization CBC approaches and strategies that could be applied to other countries by partners, as well as strengthened in-country technical ability to develop, coordinate, and manage CBC interventions themselves. Networks in place for improving CBC with routine immunization and new vaccine introduction.	In BASICS II countries, regionally and with partners (e.g., CHANGE and WHO/AFRO), CBC, advocacy, and social mobilization strategies sustained by national and/or ICC partners. Staff demonstrated improvement in KAP of health workers and caregivers regarding importance and need for routine immunization services in order to increase and sustain use of immunization services.

Activities for IR 2. Comprehensive approaches to disease control designed and implemented in four to six countries

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>2.1 Design, implement, and evaluate comprehensive strategies for long-term measles control and mortality reduction (possible countries: DR Congo, Mali, and Uganda).</p>	<p>BASICS II contributed to USAID strategies on measles control and vitamin A delivery with EPI. BASICS II forged partnerships with other agencies to develop medium- and long-term approaches for delivery of primary and supplementary doses of measles vaccine. Policies and strategies for measles control developed in DR Congo.</p>	<p>BASICS II worked with partners to develop national capacity to describe local measles epidemiology and develop joint systems for monitoring key information (e.g., age distribution, vaccination status of cases). In DR Congo, new measles policies and strategies were introduced including a monitoring and evaluation component. In other countries with long-term interventions (Uganda, Mali, and Nigeria), tailored strategies for reaching low-performing districts with primary doses were developed, including detailed plans for vitamin A administration with vaccination services.</p>	<p>BASICS II worked with national and sub-national MOH counterparts in at least seven countries to increase delivery of timely primary measles doses in low-performing districts (and vitamin A, as part of vaccination services). Strategies included active monitoring of epidemiologic data and conducting of outbreak investigations. A monitoring and evaluation component to measles control was implemented in DR Congo with ICC partners, and adapted for use in Senegal, Guinea, Mali, and Madagascar.</p>	<p>BASICS II continued to work with partners and countries to implement measles control strategies, documenting and sharing early results in DR Congo and other BASICS II countries with partners, other countries, and regional and global networks.</p>	<p>BASICS II documented and disseminated the process used and the results.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
2.2 Design, implement and evaluate innovative approaches to reduce neonatal tetanus (NNT) (also see IR 1).	Staff discussed plan for NNT elimination including policies and improved delivery strategies, such as school immunizations, and identified human and material resource requirements. Staff continued to advocate at the global level with UNICEF and WHO for the elimination of NNT. Resources were mobilized to develop a serologic measurement of anti-tetanus toxoid antibodies in women of childbearing age, to be used in conjunction with MICS surveys. BASICS II discussed with PATH the feasibility of developing a robust field assay for the measurement of anti tetanus antibodies.	BASICS II designed a comprehensive NNT control strategy in Uganda and Mali. With the MOH, staff planned and began implementation of a high-risk NNT approach in Uganda and Mali. This included OR on UNIJECT in Mali and use of primary schools for TT immunization in Uganda. A plan for NNT approaches in Mali was discussed to improve communications strategies for advocacy and behavior change. BASICS II conducted countrywide assessments of anti-tetanus antibody levels in women of childbearing age in several countries to validate the approach and to use data that will guide implementation.	Implementation of MNT action plans and implementation of country-level approaches continued in Mali, Uganda, and Madagascar.	BASICS III continued to assist MOHs and partners in implementation.	Country-based findings disseminated and experiences shared in design, implementation, social mobilization, operations, monitoring, and evaluation of approaches for eliminating NNT.
2.3 Eradicate poliomyelitis while strengthening routine immunization systems (also see IR 1).	BASICS II developed and disseminated through WHO and partners a checklist to improve the impact of PEI on EPI. In addition, technical guidance was provided for micro-planning, IEC/social mobilization, and improvement of ICC activities in BASICS II countries (e.g., Nigeria, DR Congo) in collaboration with international partners. The quality of NIDs and PEI activities were improved in Nigeria, Senegal, and DR Congo. The staff reviewed and provided recommendations on NGO/PVO proposals involving polio activities.	In BASICS II countries (e.g., Nigeria, DR Congo, Ghana, and Senegal), staff applied and tested the checklists, IEC/social mobilization initiatives and tools, micro-planning strategies, and tailored approaches to reach "zero" dose children to improve quality of NIDs and AFP surveillance. Staff also worked to build awareness of the importance of routine immunization with national and regional polio eradication activities.	BASICS II provided technical assistance to target the remaining "zero" dose children and/or problem areas at sub-national levels in Nigeria, DR Congo, and several other countries. Health staff were oriented toward use of micro-planning and routine data for monitoring and management in BASICS II countries. Technical assistance provided with external process evaluations of NIDs/PEI (Nigeria, DR Congo).	Experience from PYs 1-3 disseminated to international partners for use in other countries and for possible application to other vaccine-preventable diseases. Activities targeted to address routine immunization strategies.	BASICS II documented and disseminated actions for strengthening routine system components (in support of SO 1). National and international partners will apply and sustain approaches that build on PEI.

Activities for IR 3. Underutilized and new vaccines introduced into four country programs

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>3.1 Increase the use of underutilized vaccines and strengthen ability of routine system to incorporate new vaccines.</p>	<p>BASICS II participated in global formulation and piloting of assessment instruments (Armenia, Cambodia, Tanzania), prepared guidelines for proposals through GAVI to the Global Fund for Children's Vaccines, and prepared guidelines for fund disbursements. The staff contributed to the design of GAVI Task Forces and participated in overall vision/strategy for GAVI. WARO contributed to African GAVI initiatives.</p> <p>Staff advised Armenia Immunization 2000 (IA2K) Project on vaccine self-sufficiency for Armenia.</p>	<p>In a few BASICS II countries (e.g., Guinea, Uganda, Mali, DR Congo, Senegal), staff contributed to GAVI proposals by participating in five-year workplan preparation and assessments; defined policies, strategies, and management structures for incorporation of new vaccines; and provided operational and technical guidance and indicators for use of new Global Fund for Children's Vaccine and for "new" vaccine introduction. At global level, proposals from all eligible countries for GAVI were reviewed. Additionally, in collaboration with CHANGE, BASICS II designed and field-tested a rapid review of the GAVI process within countries.</p> <p>A vaccine revolving fund capitalized by the Armenia Diaspora group was created.</p>	<p>Ongoing technical assistance provided for the introduction of new vaccines and for monitoring their impact in several BASICS II countries. Procedures for GAVI revised and refined at global, regional, and country levels. BASICS II country staff participated in mid-term evaluations for GAVI. Based upon the rapid review results, BASICS II, in conjunction with CHANGE, made mid-course corrections and adjustments to GAVI messages and procedures.</p> <p>BASICS II assisted with strengthening of GAVI task forces with country and regional immunization programs.</p>	<p>BASICS II continued to support implementation and participate in documentation of GAVI experience at the global level and in BASICS II countries. The staff facilitated exchange of GAVI experience across countries, regions, programs, and partner agencies. Vaccine revolving fund continued.</p>	<p>Immunization coverage through the routine services for "new" vaccines approximated coverage for corresponding "traditional" antigens (e.g., hepatitis B in relation to DPT, Hib in relation to DPT, and yellow fever in relation to measles), in direct support of SO 3.</p>

Activities for IR 4. Quality of immunization services improved in at least two countries

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>4.1 Ensure injection safety through comprehensive solutions.</p>	<p>BASICS II established as a partner in SIGN and related efforts to improve injection safety. The Project took a leading role in the development of standardized approaches to problem definition, using multiple data-collection instruments (e.g., SIGN "toolbox," BASICS II household and health facility assessment tools, and the DMCI assessment tool).</p>	<p>In Guinea and Senegal, work began to develop local capacity for problem definition advocacy and for strategy design. BASICS II worked with a group of national counterparts, reviewed available information, and conducted additional formative research to design and begin implementation of a targeted set of interventions across health programs (e.g., IACH, immunization, nutrition). In other BASICS II countries (e.g., Nigeria, Mali), use of data on injection safety from household and facility assessments was discussed to identify actions to address specific problems. BASICS II adapted and applied interventions (e.g., network analysis, TIPS) through coordinated work with other CAs (e.g., CHANGE) and agencies. Operations research on such topics as medical waste management developed.</p>	<p>BASICS II continued to implement interventions for immunization safety in select BASIC II countries (e.g., Guinea). Methods for program monitoring instituted on a pilot basis. Operations research on waste management initiated to examine technical, managerial, behavioral, and cost considerations. BASICS II continued to play an active role in information exchange through SIGN, at global and Africa regional levels.</p>	<p>BASICS II continued work with SIGN and CAs to support implementation of interventions and collect preliminary data, and modifications to approaches were introduced as needed. Implications for policies, training, management, and costing/financing identified by BASICS II and local counterparts.</p>	<p>Effective approaches applied consistently across health program areas to reduce demand for injections and improve the safety of injections and medical waste management documented in at least one country. In multiple countries, increased capacity to recognize and define unsafe injections as a health problem, leading to a favorable policy environment and increased resource mobilization for ensuring safe injections.</p>

2. Nutrition Workplan — Five-Year Overview

This document is intended to illustrate the links among SO results, IRs, and Lines of Work (LOW), and among groups of activities in each successive year of the five-year plan for nutrition. Details of the strategy are given in the BASICS II Strategic Plan (January 2000). The strategy's main activities are identified by year in the tables that follow.

SO Level Results	Intermediate Results (IR)	Lines of Work (LOW)
<p>Sustained increase in the use of child survival interventions, specifically:</p> <p>SO 4 Significant increase in prevalence of exclusive breastfeeding (EBF) in infants < 6 months (or decline in EBF slowed)⁴.</p> <p>SO 5 Significant increase in appropriate child feeding (ACF).</p> <p>SO 6 Increased intake of vitamin A (and or other micronutrients) achieved in a substantial proportion of children in populations identified as deficient.⁵</p>	<p>IR 1: Community-based integrated health and nutrition approaches are demonstrated or scaled up (linked to IACH (C-IMCI) IR1, Neonatal/Perinatal IR1).</p>	<p>1.1 Identify, adapt and advocate approaches proven effective for increasing EBF, ACF, coverage of vitamin A (and other micronutrients), or use of combined health and nutrition interventions.</p> <p>1.2 Support scaling up of community-based integrated approaches proven effective for achieving SO-level results.</p>
	<p>IR 2: Health-systems capacity for improving child health through nutrition interventions are strengthened (linked to IMM IRs, IACH (C-IMCI) IR 2, Neonatal/Perinatal IR1).</p>	<p>2.1 Support effective policies and planning to achieve SO-level results.</p> <p>2.2 Strengthen capacity to implement and sustain scaled-up programs to achieve SO-level results.</p> <p>2.3 Strengthen monitoring and evaluation capacity for achieving SOs.</p>
	<p>IR 3: Use of strategies that focus on household behaviors is increased (linked to IACH (C-IMCI) IR 1 and Neonatal/Perinatal IR 1)</p>	<p>3.1 Facilitate use of approaches to identify effective household behavior change strategies to achieve SO-level results.</p> <p>3.2 Build capacity to design and implement scaled-up household behavior change and communication strategies to achieve SO-level results.</p>

⁴ Also supported by the IACH (C-IMCI) and Neonatal/Perinatal strategies. This result is modified from the original as follows: a) numerical targets will be specified for each country after baseline information is available, b) age group is modified to under 6 months to reflect USAID recommended policy; some countries will also report < 4 months.

⁵ Also supported by the IMM, IACH (C-IMCI), and Neonatal/Perinatal strategies.

Activities for IR 1. Community-based integrated health and nutrition approaches are demonstrated or scaled up

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>1.1 Identify, adapt, and advocate community-based approaches proven effective for EBF, ACF, vitamin A, and combined interventions (also see LOW 2.1).</p>	<p>Strategies and tools related to advocacy, social mobilization and implementation for selected approaches identified within a broader SET strategy; their adaptation, translation, or re-packaging was initiated. Partners identified, and agreements drafted with regional/global institutions. OER priorities identified based on global agreement regarding potential areas of public health impact and sustainability.</p>	<p>Emerging issues in community-based approaches continued to be identified, and plans for new tools, OER, policy dialogue identified. Use of advocacy tools expanded.</p>	<p>Selected tools and SET approaches assessed for effectiveness in bringing about change in community-based integrated health and nutrition programs. OER activities started implementation. Plans developed for engaging users of OER results. Preliminary lessons learned from OER shared with selected audiences.</p>	<p>Revised, improved SET guidelines developed and implemented for emerging new community-based approaches. Progress in OER for new approaches reviewed and adjustments made to assure use of results.</p>	<p>New community-based approaches demonstrated as effective, feasible, sustainable, and affordable. Lessons from BASICS II-supported activities began appearing in policies and programs aimed at addressing key nutrition problems. Lessons included not only technical aspects, but also process and scaling up vision.</p>
<p>1.2 Support scaling up of community-based approaches proven effective for SO-level results (also see LOWs 2.2, 3.2).</p>	<p>Scaling-up strategies for key country programs, and regional/global initiatives identified and integrated in country plans. New countries identified for future scaling up (e.g., PD/Hearth). Discussions on critical factors affecting the possibility of scaling up programs started. Existing activities related to combined interventions (e.g., AIN), and BF/ACF/vitamin A (e.g., MinPak-related programs) consolidated in preparation for expansion.</p>	<p>Agreements and MOUs drafted with partners. Political commitment and early local ownership of strategies achieved. Baseline measurements taken to document results. Program implementation began and constraints to scaling up addressed (e.g., systems support for community-based entities and supplies.).</p>	<p>Phased expansion supported directly in Honduras, Nigeria, and Senegal. Joint program reviews conducted at sites where BASICS II supports other partners as they scale up (e.g., Benin, India, and Uganda); assistance provided as needed to deal with constraints (e.g., logistics, staff skills).</p>	<p>Lessons from OER on existing and new community approaches to reduce malnutrition and micronutrient deficiencies incorporated during the process of consolidating and scaling up programs in key countries.</p>	<p>Improved breastfeeding, appropriate child feeding practices, vitamin A supplementation, and use of combined interventions documented in at least five countries (Benin, Senegal, Nigeria, El Salvador, Honduras). Additional countries and organizations following BASICS II-supported policies and program approaches.</p>

Activities for IR 2. Health systems capacity for improving child health through nutrition is strengthened

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
2.1 Support policies and planning to achieve SO level results (also see LOW 1.1).	Some country programs (e.g., Honduras, Senegal) set the policy and planning framework for scaling up. In other countries, and at the regional level in West Africa, networks were strengthened and tools packaged to enable country-level actions in policy and planning. In both scenarios partnering with country/regional decision makers was a priority.	More countries advanced to program implementation and established nutrition policies consistent with international guidelines.	Global and regional networks and organizations engaged in joint reviews of policy applications and address new needs in key countries. Global health events highlighted nutrition SO issues.	Lessons on new planning tools and advocacy supports transferred within and across regions. New partners engaged in policy development and advocacy.	Policy and planning led to development, implementation, and expansion of priority nutrition interventions in key countries.
2.2 Strengthen capacity to implement and sustain programs at scale (also see LOW 1.2, 3.2).	Several countries (e.g., Ecuador, Honduras, Nigeria, Senegal) put in place mechanisms for expanding coverage of services related to BASICS II SOs, as well as health staff with the capacity and tools to support this expansion. Lessons from scaling-up experiences (e.g., Madagascar, Vietnam) began to be documented. Selected tools from BASICS I (AIN tools, MinPak checklist, Nutrition Essentials, job aids) were adapted, translated, and repackaged to improve access by implementers and managers.	Based on in-country experiences (e.g. Madagascar, Vietnam) and using proven approaches, additional public and private health services, including NGOs, implemented nutrition activities. Systems support (e.g., supplies, training/supervision) strengthened to maintain a rapid pace of expansion.	Activities to strengthen systems focused on quality of service in expanded programs. Progress in scaling up reviewed, and steps taken to deal with remaining constraints. Program reviews conducted and plans made for broad transfer of experience and lessons learned, new tools, and approaches. Recurrent-cost financing of critical elements addressed.	In selected countries (e.g., Honduras, Nigeria, Senegal), SO-level results monitored, and exchanges of experiences across countries, regions, programs, and partner organizations were focused on process and best practices for successful scaling up.	Health systems implementing priority nutrition interventions within scaled-up programs in at least five countries (e.g., Benin, Senegal, Honduras, Nicaragua, El Salvador).
2.3 Strengthen monitoring and evaluation capacity.	Country programs started adapting tools and identifying options to strengthen their routine monitoring of nutrition activities in health services.	Assessments done of existing monitoring and evaluation capacity and systems. Integration of new tools in existing programs. Surveys of vitamin A coverage and reviews of quality of breastfeeding counseling increased.	Activity focus shifted to building capacity for using monitoring and evaluation information to improve services.	The use of surveys and routine monitoring to monitor SO level results emphasized.	Routine health monitoring and evaluation activities included priority nutrition indicators and methods and documentation of data utilization for decision making.

Activities for IR 3. Use of strategies that focus on household behaviors is increased

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
3.1 Facilitate use of approaches to identify effective household behavior change strategies.	Existing methods were used to identify locally appropriate feeding recommendations and the obstacles and motivations related to doing them (e.g., Nicaragua, Ghana). Indicator development started for monitoring child-feeding practices.	Capacity built for identifying strategies to encourage and overcome barriers to household adoption of improved child-feeding behaviors. Baseline studies conducted on household behaviors, appropriate feeding practices, and use of vitamin A.	The effectiveness of ongoing activities monitored, and the need for other approaches or further research in understanding household behaviors explored.	Experiences with approaches that encourage improved household behaviors shared. The impact of interventions on EBF, ACF, and vitamin A coverage was evaluated.	Approaches that facilitate adoption of improved household behaviors expanded to countries, NGOs, and other agencies.
3.2 Build capacity to implement household behavior change and communications activities at scale (see also LOWs 1.2, 2.2, 3.2).	Behavior change and communication strategies and materials and resources available to mobilize communities and promote key child health behaviors were reviewed. These reviews included feeding practices and the use of vitamin A. (e.g., Benin, Ecuador, Honduras). Strategies were initiated to strengthen ongoing BCC activities for scale-up.	Capacity built to design/revise/adapt and implement an effective behavior and communication strategy.	Process evaluation conducted. Implementation of BCC continued and incorporated lessons learned into planning as well as BCC.	Implementation of BCC activities continued to facilitate sharing of experiences among districts, NGOs, and other relevant agencies; initiated evaluation.	Capacity of MOHs, districts, and NGOs strengthened to achieve household behavior change in EBF, ACF, and use of vitamin A.

3. Community IMCI — Five-Year Overview

This document is intended to illustrate the links among SO results, IRs, and Lines of Work (LOW), and among groups of activities in each successive year of the five-year plan for nutrition. Details of the strategy are given in the BASICS II Strategic Plan (January 2000). Activities are itemized by year in the tables that follow.

SO Level Results	Intermediate Results (IR)	Lines of Work (LOW)
<p>SO 7: ORT use increased by 50 percent or sustained at 80 percent or greater of diarrhea episodes in at least eight countries.</p> <p>SO 8: 50 percent increase in appropriate care seeking and treatment of ARI in at least eight countries.</p>	<p>IR 1: Approaches to improve household and community health, nutrition and child development behaviors adapted, tested, and taken to scale in eight countries.</p>	<p>1.1 Advocate for community-level activities at global, regional, and country level within the public, private, and PVO sectors.</p> <p>1.2 Collaborate with countries in developing, implementing, expanding, and evaluating integrated community health strategies.</p>
<p>SO 9: Appropriate care seeking and treatment for children with febrile illness in malaria-endemic areas increased by 50 per cent in at least four African countries.</p> <p>SO 10: Significant increase in use by child care takers of handwashing, food hygiene, and measures to maintain clean water at the household level.</p>	<p>IR 2: Health system capacity to support integrated approaches to child health and nutrition improved in four countries.</p>	<p>2.1 Improve district-level availability, accessibility, and appropriate use of essential drugs (including malaria) in private and public sectors.</p> <p>2.2 Enhance district-level capacity to respond to referral system and compliance problems.</p> <p>2.3 Enhance national- and district-level management, supervision, and planning capacity for IMCI.</p>
<p>SO 11: Increased use of insecticide treated materials in malaria endemic areas in at least four African countries.</p>	<p>IR 3: Maintain and improve case management and preventive actions at first- and referral-level facilities in four countries.</p>	<p>3.1 Improve and maintain health provider case management skills at first contact venues.</p> <p>3.2 Enhance health provider capacity to manage severely ill children and sick neonates at first- and referral-level facilities.</p> <p>3.3 Advocate for and participate in modifications to the IMCI guidelines to include new or unrecognized threats to child health and nutrition, and improved preventive actions.</p>

Activities for IR 1. Approaches to improve household and community health, nutrition and child development behaviors adapted, tested, and taken to scale in ten countries.

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>1.1 Advocate for integrated community health activities at global, regional, and country level within the public, private, and PVO sectors.</p> <p>(Bolivia El Salvador Ghana Global Guinea Honduras LAC Regional Nicaragua Senegal Uganda WARO)</p>	<p>Worked with key partners (WHO, UNICEF, USAID, World Bank, CORE, SARA, and CHANGE) to identify advocacy strategies for integrated community approaches for child health. Supported CORE to mainstream and support HH/C-IMCI activities within HQ and field offices. Initiated national and district discussions in BASICS II countries for promotion of integrated community approaches to child health.</p>	<p>Leveraged resources to support greater USAID partner collaboration for C-IMCI.</p> <p>Developed C-IMCI implementation framework with CORE and disseminated to BASICS II and non-BASICS II countries (e.g., Eritrea, Mozambique, Guatemala). Disseminated C-IMCI framework to LAC IMCI Program Managers and NGO representatives from 8 countries. Influenced USAID to promote C-IMCI framework at SOTA for LAC PHN Officers. Proposed OR agenda for C-IMCI with JHU endorsed by CORE and partners, representing shift in research priorities to community level.</p> <p>Supported CORE to mainstream C-IMCI within member PVOs and to host malaria technical seminar for member PVOs.</p> <p>Collaborated with WB and partners to expand AIN from Honduras to El Salvador, Nicaragua, and Bolivia. Participated in WB design team to Senegal, and promoted focus on integrated IMCI and nutrition package.</p> <p>Implemented national and district C-IMCI advocacy activities.</p> <p>Proposed advocacy strategy to IAWG with SARA Project. Participated in global IAWG and IMCI/RBM meetings. Promoted C-IMCI in West Africa with UNICEF, WHO, and WAHO.</p>	<p>Leveraged resources to support greater USAID partner collaboration for C-IMCI.</p> <p>Advocated for C-IMCI with MOH and NGOs through regional workshops using C-IMCI Framework.</p> <p>Documented and disseminated lessons learned from Bamako initiative and its links to C-IMCI (community pharmacies) with WHO and UNICEF. Advocated community health through dissemination of results from 4 mortality studies conducted with TA by BASICS II. Promoted the integration of CBGP and curative care through documentation of approach in 3 Central American countries. Improved care seeking practices in LAC through collaboration with JHU and PAHO to document regional care seeking practices.</p> <p>Continued national and district strategies (e.g., for district managers, PVO networks) to increase support for C-IMCI, and to target high-impact behaviors, focusing on care seeking.</p> <p>Developed advocacy tools and materials (community component of the IMCI Costing Tool, TFA Package of Interventions) with key partners.</p>	<p>Dissemination events targeting key countries and resources held using documented success of implementation and expansion of community strategies.</p>	<p>Integrated community approaches for child health recognized as an integral element in national health strategies and reflected in national and district budgets in 8 countries.</p> <p>Community strategies promoting integrated approaches have measurably increased coverage for children under 5 in rural areas in 8 countries.</p> <p>The number of international agencies, national programs and NGOs supporting community strategies has increased.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>1.2 Collaborate with countries in developing, implementing, expanding, and evaluating integrated community approaches to child health strategies.</p> <p>(Bolivia Ecuador El Salvador Ghana Global Guatemala Guinea Honduras LAC Regional Madagascar Malawi Nicaragua Senegal Uganda WARO)</p>	<p>Developed joint plans and conceptual frameworks for expanding HH/C-IMCI and RBM implementation at global, regional, and country levels. Initiated development of appropriate assessment and communication tools for HH/C-IMCI, RBM, and AIN (e.g., C-IMCI Implementation Options Guide, Community Assessment Guide, Mother's Reminder Material Guidelines, HH/C-IMCI briefing package for consultants) with key partners. Provided technical guidance and briefings as needed to partners, such as PVO community (e.g., DIP reviews, proposal reviews) and WHO/AFRO on consultant HH/C-IMCI training.</p>	<p>Convened and/or supported meetings at global, regional and/or country level using C-IMCI framework to share implementation experience (Bolivia, Uganda, Ghana, Senegal, LAC Regional). Collaborated with MOH, NGOs, and other partners to introduce or expand C-IMCI activities in 8 countries (Benin, Bolivia, El Salvador, Ghana, Guinea, Honduras, Nicaragua, Senegal, Uganda).</p> <p>Completed integrated communications strategy (COMSAIN) in Honduras, and transferred to Nicaragua, El Salvador, Guatemala, Ecuador, and Senegal. Developed MRM in Nicaragua with HOPE and CHANGE and initiated development in Ghana and Malawi.</p> <p>Used existing data and/or conducted research on care seeking and home care practices and behaviors to guide development of C-IMCI strategies and demand generation strategies for ITMs in Senegal, Uganda, Ghana, and Guinea.</p> <p>Completed review of CHW incentives for retention and motivation of CHWs.</p> <p>Initiated development of guidelines and instruments for working at scale to achieve public health impact. Evaluated IMCI implementation and expansion in Ecuador.</p> <p>Began development of C-IMCI Consultant Briefing Package with WHO and SARA (WARO).</p>	<p>Documented and transferred lessons from AIN approach and integrated CBC strategies (COMSAIN) to other countries and regions. Disseminated lessons from Madagascar (with SARA and CHANGE).</p> <p>Promoted key family practices through integrated IEC strategies, (with JHU). Evaluated MRM in Nicaragua and completed in Ghana and Malawi.</p> <p>Developed training packages and counseling materials for CBAs. Improved community outreach skills of health providers in Uganda, Ghana, El Salvador, Nicaragua, and Honduras.</p> <p>Tested and expanded private sector vendor-to-vendor approaches with QAP in Uganda and Ghana.</p> <p>Participated with RBM partners in the launch of ITM campaigns and HBT initiatives in Uganda, Senegal, and Ghana.</p> <p>Hosted technical seminar to discuss CHW incentives and identify OR opportunities. Conducted review of past experience in training CHWs. Investigated OR to evaluate impact of PRA on CHW effectiveness.</p> <p>Used guidelines for working at scale in countries and with documentation efforts.</p> <p>Completed consultant briefing package (WARO).</p> <p>Strengthened PVO leadership Supported BHR/PVC and CORE for review of PVO applications, DIP reviews, and technical guidelines.</p>	<p>Continued to evaluate, document, disseminate, and promote use of equitable, sustainable, and scalable approaches to integrated community approaches to child health. Focused on national levels to strengthen PVO leadership roles for implementing C-IMCI. Involved additional partners at the country level to expand HH/C-IMCI efforts into additional areas, or to incorporate additional technical focus.</p>	<p>Partners have menu of integrated community child health approaches that integrate curative and preventive behaviors.</p> <p>Countries and partners using best practices to implement integrated community approaches to child health. PVOs providing leadership globally and in countries for scaling up the state-of-the-art in integrated community child health programs. Children in BASICS II target districts have improved access to quality care for ARI, DD, and malaria at the community level.</p>

Activities for IR 2. Health system capacity to support integrated approaches to child health and nutrition improved in five countries

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>2.1 Improve national- and district-level strategies to support the availability, accessibility, and appropriate use of IMCI essential drugs and ITMs in the community.</p> <p>(DRC Ghana Global Guinea LAC Regional Nigeria Senegal Uganda WARO)</p>	<p>Participated in discussions to incorporate the private and commercial sector into IMCI agendas of global, regional, and country partners. Explored private sector opportunities in BASICS II countries. Evaluated public health impact of commercial sector handwashing campaign in CA, and disseminated experience.</p>	<p>Developed partnerships with RPM and Netmark for improving availability, access, and use of essential drugs and ITMs.</p> <p>Developed capacity of national staff in West Africa to improve availability of essential drug supply through DMCI.</p> <p>Participated on national RBM Steering Committees in Senegal and Nigeria.</p> <p>Collaborated with partners to monitor chloroquine resistance in DR Congo.</p> <p>Documented handwashing campaign in Central America (funded by EHP, WB, UNICEF). Assessed feasibility of introducing PPP model for handwashing in Nigeria and Senegal.</p>	<p>Collaborated with Netmark to explore opportunities for targeting ITMs to most vulnerable populations in Senegal.</p> <p>Conducted assessment and drafted recommendations for improving drug use and availability in Senegal, with RPM.</p> <p>Conducted training for donors on DMCI to improve availability of drugs in Latin America (LAC Regional).</p> <p>DMCI surveys conducted by partners in 2 additional African countries.</p> <p>Used results of drug resistance study to influence revised national drug policy for antimalarials in DR Congo.</p> <p>Partners disseminated Central American handwashing campaign approach (EHP, WB, UNICEF).</p>	<p>Assessments of feasibility of use of drugs through PMVs and CHWs (Uganda, Nigeria, Senegal) conducted.</p>	<p>Lessons learned synthesized and disseminated.</p>
<p>2.2 Enhance district-level capacity to support referral of children with severe illness.</p> <p>(Ecuador Ghana Global Guinea WARO)</p>	<p>Completed OER study in Ecuador to document problems with referral care and systems (remaining costs paid by JHU). Developed simple tool to rapidly assess referral care systemic issues (global).</p>	<p>Completed documentation of referral study in Ecuador.</p> <p>Continued development of Rapid Referral Assessment Tool, originally developed in Ecuador, to assess referral constraints in other countries.</p>	<p>Disseminated Ecuador referral study findings through publication of journal article and other documentation.</p> <p>Incorporated results of WHO Multi-Centre Referral study into existing programs.</p> <p>Completed and field tested Rapid Referral Assessment Tool and assessed modifiable referral constraining factors (Ghana).</p> <p>Drafted white paper with CORE on PVO experiences with community level referral.</p> <p>Disseminated experience with adaptation of Guinea MURIGA approach for child survival (WARO).</p>	<p>Replicated rapid assessment of referral care in additional BASICS II countries. Continued support to interventions improving referral in selected countries. Disseminated interventions menu to improve community and facility referral.</p>	<p>Increased appropriate referral and treatment of children with severe pneumonia, dehydration, and febrile illness in selected BASICS II countries.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>2.4 Enhance national- and district-level management, supervision, and planning capacity for IMCI.</p> <p>(Bolivia El Salvador Ghana Global Honduras LAC Regional Nicaragua Nigeria Senegal WARO)</p>	<p>Developed/adapted tools for improving the planning and management of IMCI and health services (e.g., costing tool, COPE for child survival, IMCI Short Program Review).</p>	<p>Field-tested IMCI Costing Tool in 3 countries (Nepal, Nigeria, Honduras). CORE costing tool adapted for IMCI at the district level in Bolivia and incorporated by WB Project.</p> <p>Participated in evaluations of IMCI in Niger, and testing SPR in Nicaragua and applying it in Honduras, with PAHO.</p> <p>Drafted indicators for C-IMCI with IAWG on M&E.</p> <p>Supported systems strengthening activities in selected countries:</p> <p>Adaptation of COPE for child survival in West Africa with Engender Health.</p> <p>Adaptation of supervision models to incorporate IMCI /AIN (Ghana and Honduras).</p>	<p>Advocated for IMCI within PHR, as part of Health Sector Reform.</p> <p>Evaluated early IMCI implementation through application of SPR in 5 LAC countries (Bolivia, El Salvador, Honduras, Nicaragua, Peru), and 1 African country, with data incorporated into national expansion plans.</p> <p>Participated in IAWG for M&E.</p> <p>Supported systems activities in selected countries:</p> <p>Adapted supervision models to incorporate IMCI/AIN in Ghana, Honduras, El Salvador, and Senegal.</p> <p>Adapt HIS for IMCI/AIN in Honduras and El Salvador.</p>	<p>Supported countries to incorporate findings from SPR to increase scale of IMCI.</p> <p>IMCI included in HSR programs in selected BASICS II countries. Identified and documented issues and opportunities for institutionalizing the expansion of IMCI in selected countries.</p>	<p>Public and NGO partners scaled up IMCI in target countries.</p> <p>IMCI management tools incorporated into institutional strengthening efforts by other implementing partners.</p>

Activities for IR 3. Maintain and improve case management and preventive actions at first and referral level facilities in ten countries

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
3.1 Improve and maintain health provider case management skills at first contact venues. (Ghana LAC Regional Senegal)	TRAINING / ALTERNATIVES TO TRAINING / STRATEGIES FOR SCALE-UP				
	Existing alternative strategies and materials for IMCI training in LAC identified and reviewed. Helped develop IMCI IAWG strategies for private and commercial sector. Documented current health care seeking practices and the role of private practitioners (Nigeria, Senegal). Existing performance improvement/maintenance strategies identified/reviewed in collaboration with partners.	Drafted criteria and guidelines for the development and evaluation of alternative IMCI training strategies in LAC. Lessons learned from alternative training experiences captured and applied for Central America. Supported IMCI clinical skills training and materials adaptation in Ghana, DR Congo, and Senegal. Participated in development of WB toolkit for engaging private physicians in support of IMCI.	Evaluated alternative training approaches for IMCI clinical training in at least 3 LAC countries (Guatemala, El Salvador, Nicaragua). Shared lessons with partners in LAC and Africa. Develop protocol for evaluating alternative CHW training programs in LAC. Continued limited support for health worker training and follow-up technical assistance in Senegal, DRC, and Ghana. Conducted formative research in Senegal for improving case management of formal private providers.	Made results of evaluations available to partners in LAC and formally shared experience with Africa in a regional workshop. Continued limited support for health worker training. Monitored improvement of formal provider skills in Senegal.	At least 5 countries in LAC and 3 in Africa capable of evaluating their alternative IMCI training courses. At least 3 LAC countries and 2 Africa countries developed IMCI training approaches that allow them to sustain IMCI implementation with existing resources. Improved health worker performance in selected countries.
3.2 Enhance health provider capacity to manage severely ill children and sick neonates at first- and referral-level facilities.	Documented practices related to the severely ill child (including in the home) and the neonate in Bolivia. Participated in developing protocol for first 7-days as part of IMCI clinical management.	Adapted guidelines for severely ill and malnourished child in Bolivia. (See also Perinatal Framework).	Selected country activities are included in Peri/neonatal TFA.		
3.3 Advocate for and participate in modifications to the IMCI guidelines to include new or unrecognized threats to child health. (Global)	No activity in year 1.	Activity dropped			

4. Peri/Neonatal Workplan — Five-Year Overview

This document is intended to illustrate the links among SO results, IRs, and Lines of Work (LOW) and among groups of activities in each successive year of the five-year plan for neonatal health. Details of the strategy are given in the BASICS II Strategic Plan (January 2000). Activities are itemized by year in the tables that follow.

SO Level Results	Intermediate Results (IR)	Lines of Work (LOW)
<p>No SO-level results exist for the PN/NN TFA, but their activities support the following SOs:</p> <p>Sustained increase in the use of child survival interventions, specifically:</p> <p>SO 4: Significant increase in prevalence of exclusive breastfeeding (EBF) in infants under 6 months (or decline in EBF slowed).</p>	<p>IR 1 for Perinatal/Neonatal TFA: Interventions developed to reduce neonatal mortality and morbidity.</p>	<p>1.1 Design, implement and evaluate an essential newborn care package in a minimum of three sites.</p> <p>1.2 Strengthen and extend ability of health sector to address neonatal issues.</p>
	<p>Support Immunization TFA in MNT strategy: For maternal TT – OER dependent on the availability of UNIJECT (IMM IRs 1 and 2)</p>	<p>1.3 Strengthen the implementation of the package of activities aimed at reducing neonatal tetanus and sepsis.</p> <p>1.4 Improve the availability and use of quantitative and qualitative data on neonatal and perinatal morbidity and mortality.</p>
	<p>Support IACH (C-IMCI) TFA: IR 3: Maintain and improve case management and preventive actions at first- and referral-level activities in 10 countries.</p>	<p>1.5 Develop appropriate guidelines for care of the sick newborn.</p> <p>1.6 Explore and test interventions to improve survival of low-birth-weight neonates.</p> <p>1.7. Begin work involving specific infections relevant to neonatal health (determined by specific country needs).</p>

Activities for IR 1. Interventions developed to reduce neonatal morbidity and mortality

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
1.1 Design, implement, and evaluate the newborn care package including essential newborn care and additional support for vulnerable groups.	Potential sites explored: Senegal, Nigeria, El Salvador, Bangladesh. Advocacy carried out with the MOHs and potential partners	<p>Further site visits made to Bolivia, Senegal, and India. Three sites identified for the interventions:</p> <p>Senegal – Basic plan and strategy approved by the National Committee on Newborn Health (includes MOH), sites selected (Kebemer and Darou Mousty), and partners identified. Newborn component included in manual for trainers of <i>relais</i> in C-IMCI.</p> <p>El Salvador – Newborn health integrated into the health promoters' manual.</p> <p>India – a) Assisted CARE in planning the integration of neonatal health in their INHP II program to be initiated in eight states. (b) Provided technical support to ICMR and MOH for the development of the strategy for home based newborn care in six states.</p>	<p>Senegal – Newborn care programs commenced including, community mobilization, IEC program, and training of health workers and birth attendants. Tools and systems for monitoring and supervision developed. Because of the short duration of program, emphasis will be on process indicators.</p> <p>El Salvador – a) Training of health workers in the community (health promoters) and facility (health workers) supported and monitored. b) Information/data relevant to the development of the community assessment tool reviewed and draft for tool developed (TBD).</p> <p>India – Dependent on HQ travel access to the country. Continued to support CARE and ICMR/MOH.</p>	<p>Senegal – Program implementation continued and final evaluation commenced at end of PY 4.</p> <p>El Salvador – Training of CHWs, breastfeeding, and PNN monitoring in hospitals conducted.</p> <p>India – Implemented of community-based package.</p>	<p>Final evaluation completed. Interventions for newborn care that are cost-effective, feasible, and sustainable identified and those suitable for scaling up delineated. Information, including lessons learned, disseminated to National Committee on Newborn Health and relevant groups including local and national policy makers and stakeholders. Advocacy to improve policies relevant to newborn health carried out.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
<p>1.2 Strengthen and extend ability of health sector to address neonatal issues.</p>	<p>Advocacy - BASICS II reviewed existing approaches that have been field-tested (e.g., the Profiles approach used for nutrition) and, in collaboration with the CBC group and other partners, collection of existing neonatal data commenced.</p> <p>Materials/guidelines - Plans made to develop materials and training documents (in collaboration with other partners) in response to expressed needs from other agencies and implementers in the field, including a training manual on newborn care for basic health workers and a module on essential newborn care components.</p> <p>Regional approaches - Activities started in PY 2.</p>	<p>Advocacy - Advocacy tool not developed by BASICS with SARA because its targeted country, Nigeria, included only immunization and breastfeeding as country priorities. However, technical inputs were given in the development of the "Alive" model of the advocacy tool by SARA and SNL.</p> <p>Materials/guidelines - Training manual on normal pregnancy, childbirth and normal newborn care expanded to include more components of normal newborn care. Draft of evidence based guidelines revised.</p> <p>Regional approaches - Collaborated with international agencies such as PAHO, WHO, and WB to develop a regional approach not only for exchanging information but also for advocacy and promotion of options for newborn care in various countries in SE Asia and LAC.</p>	<p>Advocacy - Advocacy tool adapted for Senegal. Advocacy publication developed and disseminated with the Healthy Newborn Partnership.</p> <p>Materials/guidelines - Training manual and evidence-based neonatal module published and disseminated. Neonatal health incorporated in the community health worker's manual in Honduras.</p> <p>Regional approaches - Continued technical inputs to leverage and promote newborn care. More countries in the region included programs for neonatal care in their national policies.</p> <p>Regional workshop conducted for SE Asia and report and situation analysis published and disseminated.</p>	<p>Advocacy - Advocacy intervention continued and expanded.</p> <p>Materials/guidelines - Country staff utilized manual for training health workers. Some adapted it further to suitable local requirements.</p> <p>Regional approaches - Continued exchange of relevant technical information. Development of a system to facilitate this exchange explored with partners.</p>	<p>Advocacy - The burden and causes of neonatal mortality and morbidity recognized in more than one country, the key issues addressed in policies, and additional resources allocated to this area of child health.</p> <p>Materials/guidelines - Relevant new neonatal technical materials developed and tested in field situations in countries.</p> <p>Regional approaches - Technical information and lessons learned from individual country programs shared across countries.</p>
<p>1.3 Strengthen the implementation of the package of activities aimed at reducing neonatal tetanus and sepsis.</p>	<p>Link to LOW 1.1</p> <p>MNT Global initiative - BASICS II actively participated in technical advisory groups on clean birthing practices and maternal TT immunization (including the use of UNIJECT) as part of the global initiative for elimination of MNT by the year 2005.</p> <p>OR on UNIJECT - Opportunities to be reviewed in PY 2.</p>	<p>Link to LOW 1.1 - Activities supported clean delivery practices through training of health workers.</p> <p>MNT Global Initiative - Support provided in conjunction with the IMM TFA, to UNICEF and the global MNT initiative.</p> <p>OR on UNIJECT - Not conducted, as Uniject was not available for use in the countries where the PN/NN TFA was working.</p>	<p>Link to LOW 1.1</p> <p>MNT Global Initiative</p> <p>Activities continued.</p>	<p>Link to LOW 1.1</p> <p>MNT Global initiative</p> <p>Activities continued.</p>	<p>Link to LOW 1.1</p> <p>MNT Global Initiative</p> <p>Activities continued.</p>

Lines of Work (LOW)	Project Year 1	Project Year 2	Project Year 3	Project Year 4	Project Year 5
1.4 Improve the availability and use of quantitative and qualitative data on neonatal and perinatal morbidity and mortality.	BASICS II established contact with WHO to form a working group addressing PN/NN data issues.	Activity not carried out, as WHO did not initiate this activity.			
1.5 Develop appropriate guidelines for care of the sick newborn.	<p>Testing of community approaches for care of the sick newborn included in neonatal package tested in LOW 1.1.</p> <p>BASICS II participated in a WHO workshop with other technical experts to develop a protocol for determining the set of features that are most useful in identifying the sick young infants (< 60 days of age) who need referral to the facility.</p>	<p>See LOW 1.1</p> <p>In addition to technical inputs to WHO, collaborated with PAHO provide technical inputs on care of the newborn in LAC countries. Possible links with the IMCI strategy explored.</p>	<p>See LOW 1.1</p> <p>Collaborated with PAHO and Core Group activities.</p>	<p>See LOW 1.1</p> <p>Regional Workshop held in LAC.</p>	<p>See LOW 1.1</p> <p>Disseminated technical briefs in Spanish and French.</p>
1.6 LOW deleted.	Maternal malaria included in LOW 1.1				

ANNEX B: BASICS II Contributions to USAID's Results Package

During FY 2004, the project contributed to the following USAID Strategic Objectives:

- **SO 3 - Increased use of key child health and nutrition interventions (see details below and in the Annex)**
- **SO 5 - Increased use of effective interventions to reduce the threat of infectious diseases of major public health importance (see BASICS II SO5 Portfolio Review report FY04)**
- **SO 3 - Increased Use Of Key Child Health And Nutrition Interventions**

IR 3.1 - Increased immunization coverage and increased control of vaccine preventable diseases of children, leading to mortality reduction.

EOP Objective	Accomplishments and Progress to Date	Major Issues/Constraints
1. Improving the sustainable delivery of immunization services to all children in specified countries	<ul style="list-style-type: none"> ❑ Increased DPT3 coverage or fully immunized children (FIC) in 11 countries: DR Congo, El Salvador, Ghana, Guinea, India, Madagascar, Mali, Nepal, Nicaragua, Senegal, and Uganda ❑ Increased measles immunization coverage documented in six countries: DR Congo, Guinea, India, Mali, Senegal, Uganda ❑ Under-utilized vaccines introduced into the routine systems in DR Congo and Senegal. ❑ Processes strengthened: In Senegal, Mali, India, Madagascar and DR Congo, national consensus was forged on priority issues, strategies, and approaches through reviews, dialogue, demonstration, and interagency coordination mechanisms. New partners (e.g. CARE in India) and non-health sectors effectively engaged in routine immunization efforts. 	Reviews of low immunization levels in Nigeria and India identified the following concerns: <ul style="list-style-type: none"> ❑ Inadequate utilization of resources for vaccine supplies and logistics. ❑ Poor communications and engagement of community leaders to mitigate rumors/no faith in the value of immunizations. ❑ Need for more inter-sectoral collaboration.

EOP Objective	Accomplishments and Progress to Date	Major Issues/Constraints
2. Disease-specific efforts to reduce childhood morbidity and mortality	<ul style="list-style-type: none"> ❑ In DR Congo, measles control was strengthened within routine immunization strategies at the national level and integrated at provincial levels. ICC developed and disseminated technical guidelines for measles control, outbreak investigation, ensuring campaign quality, improving communication, and addressing injection safety and waste disposal. ❑ In Guinea, support given to national level and districts for intensified routine and campaign measles activities. ❑ In DR Congo and Senegal, routine polio coverage increased to sustain eradication efforts. Strategies and technical guidelines adapted and applied by other countries. 	Sustainability and displacement of routine services are concerns.
3. Global leadership and research into areas critical to immunization	<ul style="list-style-type: none"> ❑ Operationalized the RED approach in Uganda, Nepal, Senegal, and Madagascar; other countries and global partners improving links between peripheral health workers and communities, and active monitoring for decision-making introduced at local levels. ❑ Madagascar's experience in district-level planning and community mobilization for immunization adapted by other countries. ❑ <i>Immunization Essentials</i> (USAID) field guide published and providing countries around the world with technical, operationally sound information on vaccines and vaccine-preventable diseases, immunization program management, service delivery, etc. ❑ Project experience on routine immunization data management, micro-planning, reporting, and supervision of performance of district- and facility-level staff (supported by USAID) was transferred to global and regional immunization partners and representatives from African countries. ❑ Injection safety mainstreamed in national immunization strategies in Guinea, Mali, Senegal, and Uganda. ❑ Measles strategies improved (USAID, GAVI, WHO, Measles Partnership, countries). ❑ Developed a new indicator for global tracking of country-level immunization coverage. The WHO Regional Office for Africa (WHO/AFRO) began to use measles coverage of >80% for the past two years as one indicator of country readiness to introduce rubella vaccine. ❑ WHO/AFRO Mid-Level Manager (MLM) Communication Module available for region-wide use. ❑ Relevant approaches for routine immunization developed by CDC. ❑ Improved technical direction, approaches, and monitoring for routine immunization at WHO, UNICEF, Children's Vaccine Program (CVP), GAVI Secretariat, USAID missions and Bureaus, NGOs. ❑ The positive results of a study of TT-filled UNIJECT used to position Mali to receive these TT-filled auto-disable injection devices for use by community staff for routine services. 	

IR 3.2 - Effective approaches to reducing childhood diarrheal disease and pneumonia morbidity and mortality developed, promoted, and adopted

EOP Objective	Progress to Date	Accomplishments in Reporting Period	Major Issues/Constraints
1. Maintaining and/or increasing use of oral rehydration therapy (ORT)	Increased levels of oral rehydration therapy (ORT) use or maintained levels in five countries: El Salvador, Ghana, Nicaragua, Senegal, and Uganda.	ORT incorporated within comprehensive child health and nutrition strategies and approaches in LAC and Africa with a community focus, through regional partners.	At country level, within the area IMCI, malaria, and more recently pneumonia treatment and neonatal care, displaced attention on diarrhea management. Advocacy for ORT weakened since the mid-1990's.
2. Improving care-seeking, management, and appropriate antibiotic treatment of pneumonia	Substantially increased care seeking for acute respiratory infection (ARI) in six countries Bolivia, El Salvador, Ghana, Honduras, Nicaragua, and Senegal.	Initiated planning for the introduction of care seeking, management, and antibiotic treatment of pneumonia at community level in Benin and DR Congo.	National policies limit the use of antibiotics by lay workers. Decision-makers unaware of the ad hoc, widespread availability and use/misuse of antibiotics by trained/untrained providers. The need to address febrile illnesses (malaria and pneumonia in particular) jointly not adequately addressed.
3. Global leadership and research into areas critical to diarrheal disease/pneumonia control	<ul style="list-style-type: none"> ❑ Strengthened MOH focus on community-level interventions that address multiple causes of child mortality in order to fill gaps in fully operating IMCI and other integrated approaches (DR Congo, Ghana, Guinea, Honduras, Nicaragua, Nigeria, Senegal, and Uganda). ❑ Demonstrated the feasibility of community-based pneumonia treatment in Senegal. 	<ul style="list-style-type: none"> ❑ Following the regional NGO workshop on C-IMCI, four countries (Benin, Guinea, DR Congo, Senegal) organized national NGO workshops to disseminate the C-IMCI framework promoted with BASICS II support. By the end of 2003, nine countries had initiated C-IMCI implementation with partner organizations. A planning exercise was conducted in collaboration with UNICEF for Guinea, Cameroon, and Mauritania. ❑ National MOH in Senegal moved ahead with plans for national scaling up; and plans developed to transfer Senegal experience of community-based pneumonia treatment. ❑ Communications and behavior change tools and approaches widely disseminated for IMCI. 	Program success stories and tools for incorporating zinc in diarrheal disease management at large scale not widely available.

IR 3.3 - Increased utilization of key interventions to reduce malnutrition and its contribution to child morbidity and mortality

EOP Objective	Progress to Date	Accomplishments in Reporting Period	Major Issues/Constraints
1. Improved intake of vitamin A and other key micronutrients	Increased levels of vitamin A coverage achieved or maintained in five countries: DR Congo, Nigeria, Senegal, Uganda, and India.	Biannual distribution approach and tools incorporated within Essential Nutrition Actions strategy and disseminated in SE Asia (with WHO), and Africa region.	Streamlining the biannual child health and nutrition events with a package of catch-up services needs further work and advocacy. Countries overwhelmed with continuing polio NIDs.
2. Improved infant & young child feeding (IYCF) practices	<ul style="list-style-type: none"> ❑ Increased rates of exclusive breastfeeding (EBF) of infants under six months of age or maintained them at high levels in six countries: El Salvador, India, Nicaragua, Nigeria, Senegal, and Uganda. ❑ Increased rates of age-appropriate complementary feeding in five countries: El Salvador, Ghana, India, Nicaragua, and Uganda. 	ENA and AIN approaches demonstrated impact on infant & young child feeding practices at scale; tools and frameworks disseminated widely in LAC, Africa, and India.	Need to standardize global indicators for complementary feeding. Iron deficiency remains most widespread problem among children 6–24 months of age. There is a need for combined strategies to address anemia and growth in this age group.
3. Improved integration of food security, nutrition, and health programs	Nutrition integrated within national child health programs (and vice-versa) in LAC region using AIN approach (Honduras, El Salvador, and Nicaragua), and in India, Nigeria, DR Congo, and Senegal.	Tools and frameworks for operationalizing the integration of nutrition and child health widely distributed, and advocated.	Few systematic framework/guidelines/tools for linking food security with integrated child health and nutrition in populations at high risk of child mortality and malnutrition. Narrow focus of child survival often excludes food security concerns (e.g. no mention in <i>Lancet</i> series of 2003). There is a need for better intersectoral linkages in child survival strategies.
4. New and improved nutrition interventions and program approaches developed and introduced	<ul style="list-style-type: none"> ❑ Positive Deviance/Hearth approach incorporated within Essential Nutrition Actions in Nigeria (Kano) and Senegal. ❑ AIN incorporated essential newborn care in Honduras and identification/referral of sick children in Honduras, El Salvador and Nicaragua. 	Technical support provided to CARE/India-JHU operations research on impact of ENA on growth and anemia reduction in UP and AP states.	HIV AIDS not yet adequately addressed in ENA and AIN approaches. There is a need for more and better evidence on outcomes and public health impact of ENA and AIN.

IR 3.4 - Interventions with high impact on survival and health of newborns identified, developed, evaluated, and brought to scale

EOP Objective	Progress to Date	Accomplishments in Reporting Period	Major Issues/Constraints
<p>1. Effective interventions for neonatal health and survival implemented and expanded in USAID-assisted countries</p>	<ul style="list-style-type: none"> ❑ MOH and the Working Committee on Newborn Health in El Salvador improved the implementation of newborn health interventions both at the community and facility levels. At the community level, newborn health was incorporated into the C-IMCI strategy and training for the health promoters. ❑ In Honduras, community outreach for newborn care is now provided to women who deliver at home and at facilities. Postnatal visits teach mothers basic preventive newborn care and danger signs for care seeking. Messages relevant to newborn health were heard by households through the multi-media COMSAIN strategy. 	<p>CARE/India scaled up newborn care through training and supporting 300,000 community workers and service providers in 73 districts of India—covering a population of approximately 12 million. Surveys show improvements in the capacity of service providers and household knowledge and behaviors. The program has influenced government health systems, e.g. in one district in Rajasthan, Reproductive and Child Health (RCH) training sessions for traditional birth attendants (TBAs) have incorporated newborn care components.</p>	<p>Newborn care at peripheral health centers and by private providers not being addressed in India.</p>
<p>2. New or improved cost-effective interventions to promote neonatal survival and health developed and evaluated</p>	<ul style="list-style-type: none"> ❑ In El Salvador, evaluated the program to assess practices and availability of supplies. Early initiation of breastfeeding evaluated through better routine monitoring of process indicators. ❑ The positive results of a study of TT-filled UNIJECT are being used to position Mali to receive these TT-filled auto-disable injection devices for use by community staff for routine services. ❑ In Honduras, the MCH monitoring tool was expanded to include key components of essential newborn care. ❑ An evaluation of selected districts in India demonstrated improvements in newborn care at the household level on a large scale in CARE/India's INHP II project. 	<ul style="list-style-type: none"> ❑ In Senegal, MOH evaluated improvements in household and service quality indicators; substantial increases resulted after training and follow-up supervision of community-based and health facility workers, and engagement of community groups. ❑ In India, CARE and JHU evaluated the INHP II intervention program in Barabanki district of UP, and found improvements in process indicators. 	<p>Lack of basic training of health staff in Senegal and other countries in essential newborn health likely to delay rapid scaling up. Supervision and follow up found to be critical in improving essential newborn care will require external support to support MOH efforts.</p>

IR 3.5 - Health system performance in the sustainable delivery of child survival services increased (activities should be linked to improvement of child health/nutrition outcomes)

EOP Objective	Progress to Date	Accomplishments	Major Issues / Constraints
<p>1. Improved policies, organization of services, and management for child survival increased</p>	<ul style="list-style-type: none"> ❑ DR Congo: BASICS II was a key technical advisor in the Immunization ICC, and Nutrition and Malaria Task Forces, providing input to MOH and partner health strategies, multi-year plans, and annual work-plans. Tools and frameworks are being adapted and used by partners nationwide. ❑ El Salvador: Newborn health strategies and policies defined; activities were incorporated into the workplan for MOH's Newborn Care Division. ❑ Ghana: MOH and its Nutrition Unit identified CBGP as a component of their child health strategy. In immunization, BASICS II helped revitalize the ICC and form the Communication Standing Committee (CSC), and developed a national plan for communication to improve demand for immunization and to reduce the drop out rate. ❑ Guinea: MOH staff developed improved injection safety and vaccination management policies and strategies. ❑ Honduras: The Ministry improved their national AIN program by addressing health needs such as neonatal health and anemia control. ❑ Madagascar: BASICS II was a leading contributor to the ICC, sanctioned and participated by the MOH. Notably measles and neonatal tetanus. ENA and communications oriented C-IMCI approaches documented by BASICS II have become national strategies. ❑ Nepal: HMG Nepal incorporated close ties between health facility staff and community organizations as part of the national health strategy and established active monitoring by health workers. ❑ Nigeria: In areas of nutrition, immunization, malaria, and polio initiatives, the Project worked closely with national, state, and LGA representatives to promote and support national policies in child health. To strengthen the focus of nationwide nutrition efforts, BASICS II provided critical technical input to developing an ENA framework with the FMOH and its partners for national guidelines and plans, including the National Nutrition Plan of Action; a joint workplan for vitamin A supplementation; and national guidelines for prevention and control of micronutrient deficiency, for infant & young child feeding, for. PD/Hearth; and for infant & young child feeding for children with HIV/AIDS ❑ Senegal: MOH accepted the recommendation to expand community-based treatment for pneumonia nationwide. Essential newborn care with a large community component was adopted as a national strategy to reduce infant mortality. In immunization, approaches for RED, improving measles control, and data quality were adopted by the ICC for nationwide use. In nutrition, PAIN (ENA in Senegal) was adopted as the national nutrition strategy and is an entry point for community identification of and care seeking for childhood illnesses. Using PROFILES, BASICS II supported policy advocacy. ❑ Uganda: BASICS II worked in tandem with Uganda National Expanded Programme on Immunization (UNEPI) on the design, testing, and adaptation of the community approach to immunization called CPSSD. 		<p>Continuity and follow up of policy initiatives is critical, but uncertain due to changes in donor funding and technical support. There is a vacuum in leadership for child survival at national level and no clear vision or plan for securing financial resources and the collaboration of other sectors that are necessary to achieve scale.</p>

EOP Objective	Progress to Date	Accomplishments	Major Issues / Constraints
2. Health workers deliver child health services of higher quality	Substantial increase in trained, motivated and skilled health workers in DR Congo, El Salvador, Guinea, Honduras, India, Nigeria, Senegal, and Uganda.	In Senegal, India, and El Salvador, innovative approaches developed to maintain the benefits of in-service training.	Supervision and follow up are key constraints.
3. Commodities including drugs, vaccines, and supplies are available and appropriately used for child health services	In Senegal (cotrimoxazole) and Nigeria (antimalarials), new approaches to improve the utilization of drugs were developed and tested.	Participated in interagency committees and task forces to review the situation of drugs, vaccines, and supplies for child survival and nutrition interventions and to develop action plans.	The role of private providers and pharmacists needs further elaboration.
4. Financing for child survival services is increased and used more effectively	Support provided to the global Child Survival Partnership to raise awareness in key countries about the current situation and need for greater investments.		
5. Information for child survival services is available and appropriately used by policymakers, managers, and consumers	<ul style="list-style-type: none"> <li data-bbox="347 1005 818 1215">❑ Routine information systems and rapid surveys were improved and demonstrated to MOH and NGOs in India, Senegal, El Salvador, Nepal, Uganda, and Nigeria as key elements for strengthening health services. <li data-bbox="347 1236 818 1446">❑ Comprehensive evaluations conducted to generate information on key policy issues such as pneumonia treatment in Senegal, newborn care in Senegal and India, essential nutrition actions in India, and others. 		