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Progress Toward Results: A Report for the Child Survival and Health Grants Program

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Cover photo taken by Michel Pacque during a visit to the ADRA Guinea project.

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CSTS+
ORC Macro
Suite 800
11785 Beltsville Drive
Calverton, Maryland 20705

(301) 572-0823
Email: csts@orcmacro.com
Internet: www.childsurvival.com

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Acronyms and Abbreviations

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
AKF	Aga Khan Foundation
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCI	Behavior Change Interventions
BHR	Bureau for Humanitarian Response
CA	Cooperating Agency
CDD	Control of Diarrheal Disease
CHERG	Child Health Epidemiology Resources Group
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Childhood Illnesses
CORE	Child Survival Collaborations and Resources Group
CPI	Counterpart International
CRS	Catholic Relief Services
CSHGP	Child Survival and Health Grants Program
CSTS	Child Survival Technical Support
CWI	Concern Worldwide
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DOW	Doctors of the World
EBF	Exclusive Breastfeeding

Acronyms and Abbreviations

EPI	Expanded Program on Immunization
FE	Final Evaluation
FOCAS	Foundation of Compassionate American Samaritans
FY	Fiscal Year
HFA	Health Facility Assessment
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HQ	Headquarters
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment (for malaria)
ITN	Insecticide-Treated Nets
KPC	Knowledge, Practice and Coverage [Survey]
LQAS	Lot Quality Assurance Sampling
MC	Mercy Corps
M&E	Monitoring and Evaluation
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
MTCT	Mother-to-Child Transmission
MTE	Midterm Evaluation
NGO	Non-governmental Organization
OR	Operations Research
ORT	Oral Rehydration Therapy

Acronyms and Abbreviations

PAHO	Pan American Health Organization
PCI	Project Concern International
PMTCT	Prevention of Mother-to-Child Transmission
PR	Program Result
PSI	Population Services International
PVC	Office of Private and Voluntary Cooperation
PVO	Private Voluntary Organization
RBM	Roll Back Malaria
RFA	Request for Applications
SC	Save the Children USA
TRM	Technical Reference Materials
TT	Tetanus Toxoid
U5MR	Under-Five Mortality Rate
USAID	United States Agency for International Development
VA	Vitamin A
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WRC	World Relief Corporation
WV	World Vision USA
WRA	Women of Reproductive Age

Introduction

Since 1985, USAID's Child Survival and Health Grants Program (CSHGP) has reached more than 102,000,000 children under five and women of reproductive age with proven public health interventions. Managed through the Agency's Bureau for Global Health, Office of Health, Infectious Disease and Nutrition (GH/HIDN), Division of Nutrition, the CSHGP has supported more than 386 projects implemented by 46 private voluntary organizations (PVOs) in 60 countries over the past 20 years.

As of September 1, 2005, the CSHGP's active portfolio of grants included 67 projects implemented by 32 PVOs in collaboration with local Ministry of Health (MOH) and nongovernmental organization (NGO) partners in 39 countries. These projects presently reach over 23,000,000 beneficiaries at the household level. Total U.S. Agency for International Development (USAID) funding for these projects is \$98,771,655, with an additional PVO match of \$42,221,946 (or about 43% of the amount provided by USAID).

This report describes the progress toward the CSHGP's program results during fiscal year 2005. It draws heavily from the results of 22 grantee final evaluation reports, highlights important new strategic initiatives of the CSHGP, and presents important achievements of the Child Survival and Health Network Program (implemented by the CORE Group¹) and the Child Survival Technical Support Plus Project (CSTS+)—two of the CSHGP's primary collaborating partners.

Highlights of Results from CSHGP Grantees

CSHGP Projects Save Lives: Based on analysis using the same methodology applied in the 2003/2005 Lancet series on child survival and neonatal health, recently completed projects reduced child mortality by more than 13%, with many achieving reduction in mortality of more than 25%. Seven of 13 projects to which a "lives saved" calculation was applied reduced U5MR by 16-34%, with the top three of these projects each saving between 1000 and 3300 lives.

CSHGP Grantees Significantly Improve Health Status: Grantees increased coverage in eight life-saving intervention areas by an average of 25%. The indicators demonstrating the highest average gains included Vitamin A (+42%); ITN Use (+35%); exclusive breastfeeding up to 6 months (+35%); and maternal TT immunization (+34%). The full report describes the achievements of some projects that showed even more impressive results in their project areas.

¹ This program will be referred to as the CORE Group throughout this report.

CSHGP Projects Raise Coverage above National Levels: CSHGP Grantees tend to choose implementation sites where coverage is significantly lower than the national average, and then raise coverage to levels above the national average by the end of their projects. Counting either the current project baseline or the original project baseline in the case of cost extension projects, for vaccination coverage and ORT use, projects' baseline levels of coverage were worse than national average 92% of the time for vaccinations and 90% of the time for ORT use; they ended better than national average 75% and 80%, respectively.

CSHGP Grantees Improve Quality of Health Services: Eighty-six percent of projects reviewed (n = 22) targeted health facilities for capacity-building activities focused on improving quality or access; 90% of these reached or exceeded their targets. Grantees focused on training health center staff, improving supervision systems for health workers, and improving supply chain management. Eighty-one percent of the projects reviewed utilized the World Health Organization (WHO)-developed Integrated Management of Childhood Illness (IMCI) strategy.

CSHGP grantees are making important contributions to national efforts to bring proven interventions to scale—through strategic partnering to expand coverage, several of the projects reviewed for this report demonstrated important contributions to national efforts to bring proven interventions to scale. The full report outlines examples of grantee participation in bringing IMCI to scale in Cameroon, expanding IMCI coverage in Bolivia, and bringing Malaria treatment to scale in Rwanda. CSHGP grantees and the CORE Group were also involved in activities that lay the groundwork for potential future efforts to scale up interventions through participating in national policy discussions, informing regional strategies, and aligning their activities with Mission priorities.

Important New Strategic Initiatives from the CSHGP Team

In fiscal year (FY) 05, the CSHGP strengthened its contributions to USAID priorities in Child Survival and Health through the activities described below.

Agreements in place with Key Implementing Partners: In addition to supporting 15 new grantees in FY05, the CSHGP also put in place a five-year cooperative agreement with the CORE Group for the Child Survival and Health Network Program, and a 5-year contract with ORC Macro for the Child Survival Technical Support Plus (CSTS+) project. These two agreements position the CSHGP to ensure technical excellence and quality programming for its grantees; provide leadership in defining NGO contributions to impact, scale, sustainability, and equity in child survival and health; and raise the visibility of the PVO community as an important partner in global health for USAID Missions and other donors. In FY05, the CSHGP, the CORE Group, and CSTS+ have worked together to ensure that Program's activities remain supportive of the global health and strategic priorities of the agency.

A New CSHGP Results Framework: With support from CSTS+ and input from the CORE Group and USAID stakeholders, the CSHGP drafted a new results framework that centers around improved health status of vulnerable populations; increased scale of health interventions; and increased contribution of the CSHGP to global capacity and leadership for child survival and health. The performance management plan to support this Results Framework will be finalized in early FY06 and serve as an anchor for the CSHGP's programmatic directions and annual reporting process.

The CSHGP New Partner Initiative: Through support from CSTS+, the CSHGP designed this program to proactively identify potential new grantee partners. These are organizations that have not previously worked with USAID, but add value to the overall portfolio of CSH grants. In FY05, 12 potential new partners applied; four of these were awarded CSH grants to begin in October 2005; and 30 potential new partners were identified who may apply in FY06. Three new partner organizations also joined the CORE Group in FY05.

Increased Attention to Scale: To maximize the program's future contributions to scale the CSHGP included a program result related to "increased scale of health interventions," thereby establishing a mechanism of accountability for itself in terms of reporting annually to the Bureau for Global Health.

In parallel to the PMP development process, the CSHGP revised its annual Request for Applications, integrating language and guidance in all grant categories to describe clearly the expectations for successful applicants regarding contributions to scale. Guidance for the Program's Expanded Impact Category was updated to ensure that successful applicants in this category would make significant contributions to national-level efforts to bring proven interventions to scale.

The newly awarded Child Survival and Health Network Program includes a program result of "increased PVO collaborations at country-level to scale up interventions." This result will drive the CORE Group's efforts in this area over the next 5 years, and the CORE Group's FY05 activities focused on expanding options for such collaboration among its members. The CORE Group also advanced the thinking on potential PVO contributions to scale through the development of a working paper entitled *Scale and Scaling Up: A CORE Group Background Paper on Scaling up Maternal, Newborn and Child Health Services*.

Contributions to Global Capacity and Leadership in Health: The CORE Group supported the development of practical tools that are designed to facilitate expansion and adoption of approaches that have been shown to demonstrably improve the effectiveness, sustainability, equity or scale of child health outcomes and could be expanded and adopted across the child survival community. The approaches are outlined in greater detail in the full report; they include Helen Keller International's Integration of Vitamin A Supplementation Into Community-Directed Treatment with Ivermectin; World Relief's

Care Groups; Save The Children's Partnership Defined Quality (PDQ); Food For The Hungry's Barrier Analysis; Curamericas' Census-Based, Impact-Oriented Methodology; and Catholic Relief Services' Framework for an Integrated Community Approach to Obstetric and Neonatal Emergencies.

Conclusions and Recommendations

USAID's Child Survival and Health Grants Program is making a significant proven impact on child survival and health worldwide, using effective and sustainable community-based approaches. The program also has great promise for contributing to scale at national level in the countries in which its projects operate and, through the CORE Group and its members, plays a leadership role in representing the NGO community at the national and international levels.

This section summarizes the recommendations that are discussed in further detail in the full report. Recommendations in this report relate to enhanced data quality, focus of the program's technical interventions, increased contributions to scale, and increased visibility of the program.

ENHANCED DATA QUALITY

The CSHGP has long been known for the rigor it requires of its projects—with technical review and approval of detailed implementation plans, requirements for establishing measurable indicators at baseline and measuring progress on those indicators at final evaluation (as a minimum), and CSHGP approval of a PVO-identified midterm and final evaluator for each program. The Knowledge, Practice and Coverage (KPC) survey has long been the standard tool used by grantees for their population-level baseline studies. In 2000, the introduction of the Rapid Core Assessment Tool for Child Health (CATCH)—a subset of the indicators in the KPC tool—established a common set of standard indicators across the CSHGP portfolio. The projects reviewed in this report reflect the first set of CSHGP projects for which most CATCH indicators were collected at both baseline and final evaluations.

Recommendation 1: The CSHGP should consider modifying its list of standard indicators to fully incorporate measures of the proven life-saving interventions in the Lancet Series and to mirror recent updates to DHS indicators.

Recommendation 2: The CSHGP should provide guidance across its portfolio of projects on collecting commonly accepted indicators of health services quality, while allowing grantees the flexibility to use indicators that are relevant to their project settings.

FOCUS OF TECHNICAL INTERVENTIONS

This report illustrates the broad range of technical interventions in which grantees have achieved results, as well as the evolution of technical focus of the program since 1985. This evolution demonstrates the CSHGP's flexibility in quickly adapting to emerging knowledge in technical areas; this year's report suggests that present and future grantees reexamine the focus of their maternal and newborn care interventions.

Recommendation 3: Since the Millennium Development Goal for child survival cannot be met without a substantial reduction in neonatal mortality, CSHGP project efforts need to maintain and even increase their focus on the newborn.

INCREASED CONTRIBUTIONS TO SCALE

As noted in this report, the CSHGP has incorporated a focus on scale into its program in FY05. The recommendations below are identified as the next steps in the process for ensuring that the results of the program's scale-related efforts maximize the strengths of the PVO and NGO community, while supporting USAID's strategic direction in this area.

Recommendation 4: The CSHGP should work with its partners to position itself to address barriers to scale that may exist at the community, district, regional, or national levels. In so doing, the CSHGP should consider defining its contribution to scale in the context of the impact equation (*Impact is a function of effectiveness, efficiency, scale, equity, and sustainability*).

Recommendation 5: The CSHGP, through the CORE Group, should continue to advance the knowledge about community-based delivery mechanisms that hold promise for going to scale, along with those that represent the "best" in community-based health development.

VISIBILITY OF THE PROGRAM

Increased visibility of the program has been identified as part of the vision for the CSHGP team, to facilitate access of the larger child survival and health community to the rich achievements, approaches, and lessons learned from the program. The recommendations below are intended to promote strategically the visibility of the program.

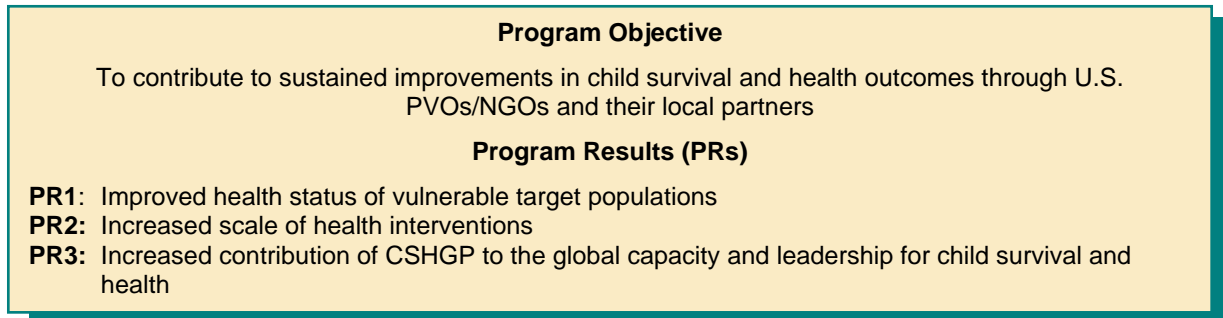
Recommendation 6: The CSHGP, the CORE Group, and PVO Grantees should consider the application of the Lives Saved Analysis from this report, as well as other strategies that have proven feasible for community-based programs, to enhance the visibility of PVO contributions to child health.

Recommendation 7: The CSHGP should encourage its grantees to document more clearly their contributions toward addressing equity in their projects.

About this Report

This report describes the progress toward results during fiscal year (FY) 2005 for the U.S. Agency for International Development's (USAID's) Child Survival and Health Grants Program (CSHGP). It seeks to synthesize the achievements of the program's three components—its portfolio of grantees, the Child Survival and Health Network Program, and the Child Survival Technical Support Plus (CSTS+) project to demonstrate progress towards the CSHGP's Program Objective and Program Results (Figure 1).

Figure 1: CSHGP Program Objective and Results



This chapter provides an overview of the CSHGP and its three components. It also presents a historical background of the program, highlights new directions for the program, and summarizes the data sources and methods used to synthesize the data in this report.

Chapter 2 describes progress towards the CSHGP's overall Program Objective, focusing on an analysis of lives saved through recently completed grants, and prospects for sustained improvements in child survival and health outcomes.

Chapter 3 describes results achieved in terms of improved health status of vulnerable populations—highlighting grantee achievements related to increased knowledge and improved health practices and coverage; improved quality and availability of services; and increased capacities of communities and local partners.

Chapter 4 highlights strategic initiatives undertaken in FY05 by the CSHGP to define its contributions to scale and presents evidence of activities recently undertaken by the CORE Group, and grantees whose projects recently ended have made important contributions that have laid the groundwork for present efforts to bring proven interventions to scale in some countries.

Chapter 5 describes important contributions, through the CORE Group and CSTS+ to Global Health Capacity and Leadership—focusing on products and activities that have expanded learning and practice beyond the CSHGP and its grantees.

Chapter 6 offers recommendations that might serve as the starting point for dialogue about future directions for the CSHGP, its grantees, and the larger CSH community.

The information in this report is presented to inform USAID’s Annual Child Survival and Health Programs Fund Progress Report, as well as the annual portfolio review meetings that take place within USAID’s Bureau for Global Health. This report will also inform implementation of present and future grantee efforts in child survival and related health programs by highlighting the major accomplishments of the most recently concluded group of CSHGP-funded projects.

The report presents much information about diverse projects around the world; it also invites dialogue about how best to transform this information into recommendations for the CSHGP and for grantees.

An Overview of the Child Survival and Health Grants Program (CSHGP)

The Child Survival and Health Grants Program (CSHGP) is managed by USAID, Bureau for Global Health, Office of Health, Infectious Disease and Nutrition (GH/HIDN), Division of Nutrition. It consists of three components, each of which contributes to its program objective and results:

- A Portfolio of Grantees: CSHGP grantees are U.S. Private Voluntary Organizations (PVOs) and Non-Governmental Organizations (NGOs) that work through local partners to address child survival and health issues worldwide. As of September 1, 2005, the active portfolio included 67 projects implemented by 30 PVOs in 38 countries. Total USAID funding for these projects is \$98,771,655, with an additional PVO match of \$42,221,946 (or about 43% of the amount provided by USAID).
- The Child Survival and Health Network Program, a 5-year cooperative agreement with the CORE Group, supports CSHGP to achieve the following results:
 - Increase annual PVO membership in the Child Survival and Health Network to access an increased beneficiary population.
 - Increase PVO collaboration at country level to scale up proven public health interventions for effective and sustainable programs.
 - Increase PVO collaboration with global health alliances and initiatives to enhance, contribute, and promote community-level best practices.
 - Improve PVO capacity to improve quality and access to health care services at community and district levels.

- Improve PVO capacity to improve key family and community practices to address public health issues in communities.
- The Child Survival Technical Support Plus project (CSTS+), a five-year contract with ORC Macro, provides an array of technical support services to USAID's CSHGP team and its partners, including grantees, potential grantees, the CORE Group, the PRH Office's PVO/NGO Flexible Fund Program, other GH Offices, and Missions. CSTS+ activities seek to leverage inputs from each of these partners to enhance the contributions of PVOs and their local partners to sustained improvements in child survival and health outcomes. CSTS+ also supports the CSHGP in tracking the progress of its portfolio of grants, maintaining project information on all historical projects, and serving as a technical resource to the CORE Group and its working groups.

Child Survival and Health Grants—A Historical Perspective

Since its inception as the Child Survival Grants Program in 1985, the program has supported more than 386 projects implemented by 46 PVOs in 60 countries and reaching more than 102,200,000 beneficiaries. The intervention mix of CSHGP grantees has evolved over the years as new health priorities have emerged. Figure 2 illustrates changes to the overall level of effort dedicated to specific interventions since 1985. Historically, the program has evolved to reflect emerging health issues and changing health priorities in the developing world. Immunization, nutrition, and control of diarrheal disease were the focus of interventions in the early years of the program, but the intervention mix has evolved to include a more diverse array of interventions with activities focused at household, community, health facility, and district levels.

Today, some funded grants included family planning and tuberculosis interventions, expanding not only the focus but also the targets of the interventions beyond children under 5 years and women of reproductive age. The CSHGP's contribution to current directions and trends in USAID's Office of Health, Infectious Disease, and Nutrition includes rolling out zinc for prevention and treatment of diarrheal disease, addressing water sanitation at points of use, post-partum care, particularly active management of the third stage of labor, neonatal health, and community-case management of pneumonia.

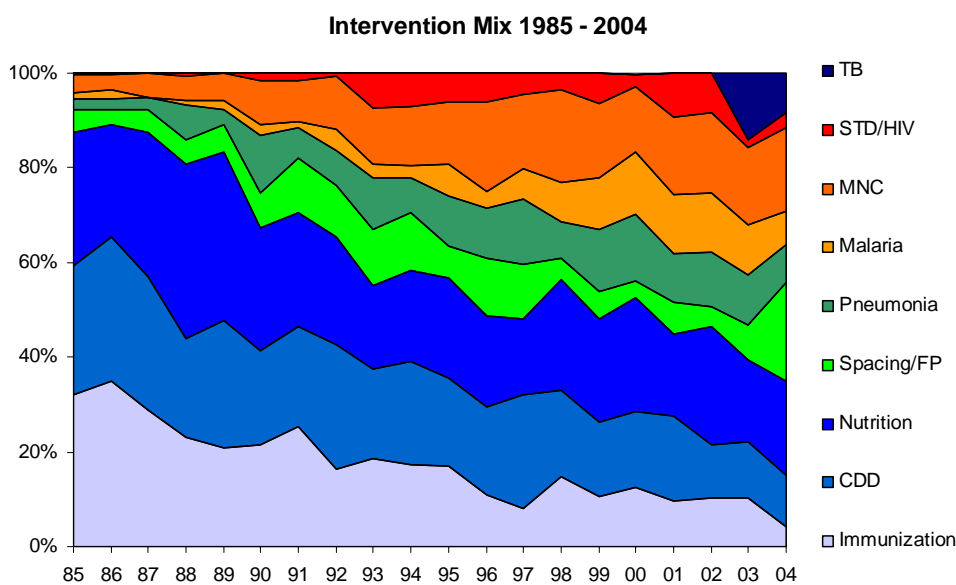
CSHGP grants are funded annually through a competitive process and currently range in duration from 4 to 5 years. The CSHGP funds projects in a number of categories. Standard grants are funded for up to \$1.5 million to contribute to improved child survival and health outcomes at the district/multidistrict level. Under this category, organizations may also apply for projects that expand a previous standard grant to additional geographic areas or add interventions in the same project area of a successful project. Expanded impact projects are funded for up to \$4 million for programs that make significant contributions to the

bringing proven interventions to scale. Entry/New Partner grants are funded for up to \$1.25 million to build the Agency’s base of implementing partners by focusing on U.S.-based PVOs and NGOs not previously funded through USAID’s Global Health Bureau. The CSHGP also funds programs that for which 100% of the level of effort is dedicated to Tuberculosis Control or Family Planning, each at up to \$1.5 million per award.

Figure 2: Historical Intervention Mix (Portfolio Level of Effort)

Current projects reach 24,792,770 beneficiaries, including 11,103,202 children under age 5 and 13,689,568 women of reproductive age. One of the projects, Population Services International/India, reaches 11,946,844 total beneficiaries, mainly through social marketing efforts. Tuberculosis control projects reach an average of just over 5,900 TB patients per project. In terms of coverage, the 41 standard and 5 entry/new partner grants are similar in scope, covering 46,000 children under 5 on average; cost extension grants cover about 50% more beneficiaries on average; and the expanded impact grants are on average about six times the size of a current standard grant.

The current portfolio of projects is distributed regionally among Africa (46%), Asia/Near East (27%), Latin America (15%), and Europe and Eurasia (12%). A matrix of all active projects, by country and intervention mix, is included in Appendix E.



IMPORTANT NEW STRATEGIC INITIATIVES FROM THE CSHGP TEAM

In FY05, the CSHGP strengthened its program’s contributions to Agency priorities in Child Survival and Health through the activities described below.

Agreements In Place with Key Implementing Partners: In addition to supporting 15 new grantees in FY05, the CSHGP also put in place a five-year cooperative agreement with the CORE Group for the Child Survival and Health Network Program, and a five-year contract with ORC Macro for the Child Survival Technical Support Plus (CSTS+) project. These two agreements position the CSHGP to ensure technical excellence and quality programming for its grantees; provide leadership in defining NGO contributions to impact, scale,

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sustainability, and equity in child survival and health; and raise the visibility of the PVO community as an important partner in global health for USAID Missions and other donors. In FY05, the CSHGP, the CORE Group, and CSTS+ have worked together to ensure that the Program's activities remain supportive of the global health and strategic priorities of the Agency.

A New CSHGP Results Framework: With support from CSTS+ and input from the CORE Group and USAID stakeholders the CSHGP drafted a new results framework that centers around improved health status of vulnerable populations, increased scale of health interventions, and increased contribution of the CSHGP to global capacity and leadership for child survival and health. The performance management plan to support this Results Framework will be finalized in early FY06 and will serve as an anchor for the CSHGP's programmatic directions and annual reporting process.

The CSHGP New Partner Initiative: Through support from CSTS+, the CSHGP established this program designed to identify proactively potential new grantee partners who have not previously worked with USAID but could add value to the overall portfolio of CSH grants.

CSHGP Expands Its Program to New Partners

In FY05, 12 potential new partners applied. Four of these were awarded CSH grants to begin in October 2005, and 30 potential new partners were identified who may apply in FY06.

Increased Attention to Scale: To maximize the program's future contributions to scale, the CSHGP included a program result related to "increased scale of health interventions," thereby establishing a mechanism of accountability for itself in terms of reporting annually to the Bureau for Global Health.

In parallel to the PMP development process, the CSHGP revised its annual Request for Applications, integrating language and guidance in all grant categories to describe clearly the expectations for successful applicants regarding contributions to scale. Guidance for the Program's Expanded Impact Category was updated to ensure that successful applicants in this category would make significant contributions to national-level efforts to bring proven interventions to scale.

The newly awarded Child Survival and Health Network Program includes a program result of "increased PVO collaborations at country-level to scale up interventions." This result will drive the CORE Group's efforts in this area over the next five years, and the CORE Group's FY05 activities focused on expanding options for such collaboration among its members. The CORE Group also advanced the thinking on potential PVO contributions

to scale through the development of a working paper entitled *Scale and Scaling Up: A CORE Group Background Paper on Scaling up Maternal, Newborn and Child Health Services*.

Summary of Methods Used in the Analyses for This Report

The results presented in this report are drawn primarily from grantee final evaluation reports from 22 projects. Table one (tables located at the end of this section) illustrates the mix of interventions for each of these projects, and table two provides more detailed information for each project including project area, beneficiaries, grant category, duration of project, and total funding (including USAID funding and PVO Match). The regional distribution of the 22 projects reviewed for this report reveals that 32% of projects were in Africa, 32% in Asia/Near East, 27% in Latin America, and 9% in Europe and Eurasia.

CSHGP projects set measurable objectives and estimate results in improved health practices for the target populations of infants and children. They conduct baseline and end-of-project surveys, using the standardized Knowledge, Practices, and Coverage (KPC) tool to collect population-level data for a concise set of key indicators that were selected to measure progress toward objectives set at the inception of the project. Final evaluation reports are developed by an evaluation team, which typically includes project staff and local stakeholders and is facilitated by an external team leader selected by the PVO and approved by the CSHGP.

The Rapid Core Assessment Tool for Child Health (CATCH) is a subset of the KPC survey and features 13 standard indicators that are collected by all CSHGP projects. Much of the population-level data presented in this report is derived from CATCH indicators. A list of CATCH indicators is included as Appendix B.

The availability of Rapid CATCH data facilitated the application of a “lives saved” analysis driven by the formula for lives saved that was the basis for calculations in the recent Lancet series. For those activities for which no CATCH data was available, grantee final evaluation documents often showed evidence of relevant measures. Table 3 illustrates relationships between the CSHGP intervention areas, Bellagio study lives-saving interventions, KPC indicators used to calculate lives saved for CSHGP grantees, and the extent to which the KPC indicators mirrored DHS indicators that were largely used to make calculations for the Lancet Series.

The lives saved analysis was based on 13 CSHGP projects that were completed in 12 of the countries used for the Lancet calculations, including Bangladesh, Cambodia, Cameroon, Ethiopia, Ghana, India Indonesia, Malawi, Mozambique, Philippines, Yemen, and Zambia. A complete description of the methods used to calculate lives saved is included in Appendix A.

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Grantee final evaluation reports were also analyzed to report on the portfolio's contributions to improved quality of services and the development of capacity in local partners—including the capacity of the local MOH, community structures, and NGO partners.

Additional information describing the current portfolio and activities of the past year was adapted from the CORE Group's Annual Report and data generated from their activities, as well as results from CSTS+ activities.

CHAPTER 1: Introduction

Table 1: Intervention Mix for Projects Reviewed

PVO-Country	Immunization	Nutrition	Vitamin A	Micro Nutrients	Pneumonia Case Management	Control of Diarrheal Disease	Control Of Malaria	Maternal And Newborn Care	CHD Spa	Breastfeeding	HIV
ADRA Yemen	15%	5%	5%	5%		10%	25%	20%	10%	5%	
ADRA Zambia	10%	15%	5%			10%	30%	15%		5%	10%
WV Indonesia	30%		10%		5%	20%	35%				
ADRA Haiti	15%	15%	5%	5%	20%	15%		10%	5%	5%	5%
Africare Ethiopia	40%					40%					20%
AKF Tajikistan	8%	17%		33%	7%	7%		7%	7%	7%	7%
CARE Peru		30%			20%	20%		30%			
CPI India	20%	25%			30%	25%					
CPI Uzbekistan					45%	35%				20%	
CRS Philippines	15%			15%	25%	25%				20%	
CWI Bangladesh	20%	10%	14%		10%	10%		36%			
HOPE Peru		35%			15%	15%	5%		5%	25%	
PFD Cambodia	25%	35%				25%				15%	
PLAN Cameroon	20%	25%				20%	35%				
PSI Rwanda							100%				
SC Bolivia	20%	30%			30%	20%					
SC Mozambique	15%				15%	10%	15%	30%	15%		
WRC Malawi		15%	5%	5%	15%		15%	15%	15%		15%
WV Cambodia	15%	5%	15%	10%	15%	15%		5%	15%	5%	
FOCAS Haiti	10%	25%			20%	10%		10%	25%		
MC Honduras		25%						40%	30%	5%	
PCI Ghana		5%	3%	2%	20%	20%	25%	20%		5%	

CHAPTER 1: Introduction

Table 2: Profile Information on Grantees Reviewed for This Report

Country	PVO	Region(s)	Number of Beneficiaries		Grant Category	Duration of Project (years)	Amount of Funding	
			WRA	Children			USAID	PVO
Bangladesh	CWI	Saidpur and Parbatipur Municipalities	47,338	26,275	New Entry	4	\$994,578	\$335,531
Bolivia	SC	Huanuni, Challapata, and Eucaliptus Districts	0	13,500	Standard	4	\$1,000,000	\$1,000,000
Cambodia	PFD	Chhlong and Snoul Operational Districts	27,049	14,456	New Entry	4	\$1,000,000	\$439,816
Cambodia	WV	Kean Svay Operational District	93,460	79,964	Cost XT	4	\$699,987	\$292,802
Cameroon	PLAN	Bertoua, Doume, and Nguelemendouka Districts	48,568	37,907	Standard	4	\$1,000,000	\$366,778
Ethiopia	Africare	Gambella	31,265	26,798	Standard	4	\$999,942	\$370,416
Ghana	PCI	Wassa West and Wassa Amenfi Districts	36,826	36,826	Standard	4	\$1,199,132	\$756,278
Haiti	ADRA	Diquini and adjacent neighborhoods	50,768	19,168	Cost XT	3	\$692,198	\$727,809
Haiti	FOCAS	Pétion-Ville	23,275	14,401	Cost XT	3	\$1,910,806	\$875,001
Honduras	MC	Two health districts in Comayagua Province	56,132	41,718	Cost XT	2	\$500,000	\$166,666
India	CPI	Danilimda, Behrampura, Raikhad, Raipur, Jamalpur and Dariyapur Municipal Wards	53,216	32,963	Standard	4	\$987,120	\$833,000
Indonesia	WV	Two subdistricts (Mandor and Sengah Temila) of the Landak District	67,822	48,439	Standard	5	\$999,712	\$309,384
Malawi	WRC	Ekwendeni, Embangweni, and David Gordon Memorial Hospital in Rumphi District	32,185	36,732	Standard	4	\$999,997	\$333,334
Mozambique	SC	Nacala-a-Velha and Memba Districts, and referral hospitals in Nacala Porto and Monapo.	130,788	94,648	Cost XT	3	\$700,000	\$233,000
Peru	CARE	Twelve districts of JF Sanchez Carrion Province and three districts in the Cajabamba Province	44,457	22,659	Standard	5	\$1,000,000	\$333,333
Peru	HOPE	Region San Martin	53,040	26,586	Cost XT	3	\$700,000	\$233,869

CHAPTER 1: Introduction

Table 2: Profile Information on Grantees Reviewed for This Report (contd.)

Philippines	CRS	Maguindanao	23,520	13,048	Standard	5	\$999,592	\$606,473
Rwanda	PSI	Entire country	1,195,654	986,414	Standard	3	\$999,920	\$570,000
Tajikistan	AKF	Gorno-Badakhshan Autonomous Oblast	49,880	13,193	Standard	4	\$930,800	\$354,300
Uzbekistan	CPI	Nukus and Taktakupir rayons	31,110	13,720	Standard	4	\$998,182	507,481
Yemen	ADRA	Khokha, Hais, Jebel Ras Districts	44,620	34,232	Standard	5	\$999,798	\$440,544
Zambia	ADRA	Chipata and Chadiza Districts	164,146	96,404	Standard	5	\$999,957	\$333,675
TOTALS:			2,305,119	1,730,051			\$21,311,721	\$10,419,490

Table 3: A Comparison of Indicators and Data Sources for CSHGP Bellagio Lives Saved Analysis

CSHGP Intervention Area	Bellagio Study Group Evidence-Based Activity	Indicator	Rapid CATCH?	KPC Module	KPC question(s) for construction of indicator	Lancet/DHS indicator?
Immunization	Measles vaccination	Measles vaccination coverage based on maternal report	YES	RC	15	YES
Nutrition and Micronutrients	Vitamin A supplementation	Vitamin A coverage in last 6 months	NO	Immuniz.	1	YES
	Complementary feeding	Complementary feeding rate	YES	RC	13	YES
Pneumonia Case Management	Antibiotics for pneumonia	ARI care seeking	NO	ARI	1,2,9,10	YES
Control of Diarrheal Disease	Hand washing	Maternal hand washing behavior	YES	RC	26	YES (but KPC is more stringent)
	Sanitation (latrine use)	Coverage by an improved toilet facility	NO	Watt/San	21,23	YES
	Clean water	Coverage by an improved source for drinking water	NO	Wat/San	1,2	YES
	ORT use	ORT use during a diarrheal episode	NO	Diarrhea	2	YES
Control of Malaria	ITN use	Child bed net use	YES	RC	18,19	YES
	Antimalarial use	Health facility care seeking for fever	NO	Malaria	2,4,5,8,9	YES
	Intermittent Presumptive Treatment (IPT)	Malaria prophylaxis during pregnancy	NO	Malaria	1 (submodule A)	YES
Maternal and Newborn Care	Tetanus toxoid (TT) vaccination	Tetanus toxoid coverage x 2 in last pregnancy	YES	RC	8,9	YES
	Effective Antenatal Care	Prenatal care coverage	NO	PNC	2	YES
	Clean delivery	Skilled delivery assistance at last birth	YES	RC	10	YES
Breastfeeding Promotion	Exclusive breastfeeding 0-5 months	Exclusive breastfeeding (0-5 month olds)	YES	RC	13	YES

CHAPTER 2: Progress toward the CSHGP's Program Objective

Introduction

The CSHGP's Program Objective is to contribute to sustained improvements in child survival and health outcomes through PVOs and their local partners. The primary measure of progress toward this objective is "number of lives saved," which is described in this chapter through the estimated impact on mortality of recently concluded projects. A brief discussion of sustainability is included at the end of this chapter, to provide a context for the other key results that are presented throughout the report.

Specific improvements in health status, quality of health services, and capacity of local partners and communities are presented in Chapter 3 of this report.

Results—CSHGP Projects Save Lives²

Thirteen projects analyzed are estimated to have saved the lives of 9,688 children under five. Of the 13 projects, five achieved mortality reductions of at least 25% or saved at least 1,000 lives. The three projects with the largest number of lives saved accounted for 6,358 lives saved between them.

Although the analysis was applied to a small group of projects, it raises interesting questions about the relationship between impact and coverage, suggests that mortality reduction can be accomplished with a range of intervention mixes, and supports the notion that greater mortality reduction can be accomplished in countries where mortality rates are highest. Table 4 presents beneficiaries, under-five mortality rates, lives saved, and percentage mortality reduction for the five projects that saved at least 1,000 lives or achieved at least a 25% mortality reduction.

Table 5 presents the results of these five projects in terms of the change in coverage achieved in the life saving interventions analyzed. The following key points emerge from these tables:

² Note: Further analysis of lives saved data was presented at the Countdown to 2015 Conference in London in December 2005. The poster presented at this meeting is included in Appendix F of this report.

CHAPTER 2: Progress Toward the CSHGP's Program Objective

Table 4: Five Projects That Reduced Mortality by 25% or Saved More Than 1,000 Lives

Project Center	Beneficiary Population (U5)	U5MR (per 1,000)	Lives Saved	% Mortality Reduction
World Vision/Cambodia	79,964	124.4	3,230	34%
World Relief/Malawi	36,732	188.5	2,059	29%
PLAN/Cameroon	37,907	143.6	1,069	21%
Counterpart International/India	32,963	94.7	686	25%
Partners for Development/Cambodia	14,456	124.4	498	29%

Table 5: Percent Indicator Improvement in Five Projects that Reduced Mortality by 25% or Saved More Than 1,000 Lives

	Comp. Feeding	Vitamin A	ARI	ORS	Hand washing	ITN	IPT	Treat Malaria	Maternal TT	EBF
World Vision/Cambodia		66.0%	74.0%	47.0%					73.0%	36.0%
World Relief/Malawi			36.0%			51.7%	30.7%	38.4%		48.8%
PLAN/Cameroon	10.6%	16.6%			28.0%				8.8%	37.9%
Counterpart International/India	13.3%		42.6%	46.0%	65.9%				18.5%	15.8%
Partners for Development/Cambodia				62.6%					52.0%	66.0%

Does the Lancet Calculation Underestimate the Impact of the CSHGP Projects?

This analysis gives an estimate of the number of lives saved. As a validity check, the model was run on the World Relief Mozambique project included in last year's Results Review. This project showed a *directly measured* 62% reduction in U5MR. The model only predicted a 33% mortality drop (a 47% underestimation). There are several reasons why the model may tend to systematically *underestimate* the mortality reduction experienced by the projects. These are outlined in detail in Appendix A, but the two most important are the following:

- Only data constructed in the most rigorous manner were used (beyond the requirements of the grants). This meant that data for construction of the indicators necessary for the calculations were missing for 23 of 124 (19%) occurrences of these high impact interventions.
- National-level mortality data were used. Project sites almost certainly experienced higher rates of mortality, given that their health statistics were significantly worse than the national average in key health services variables.

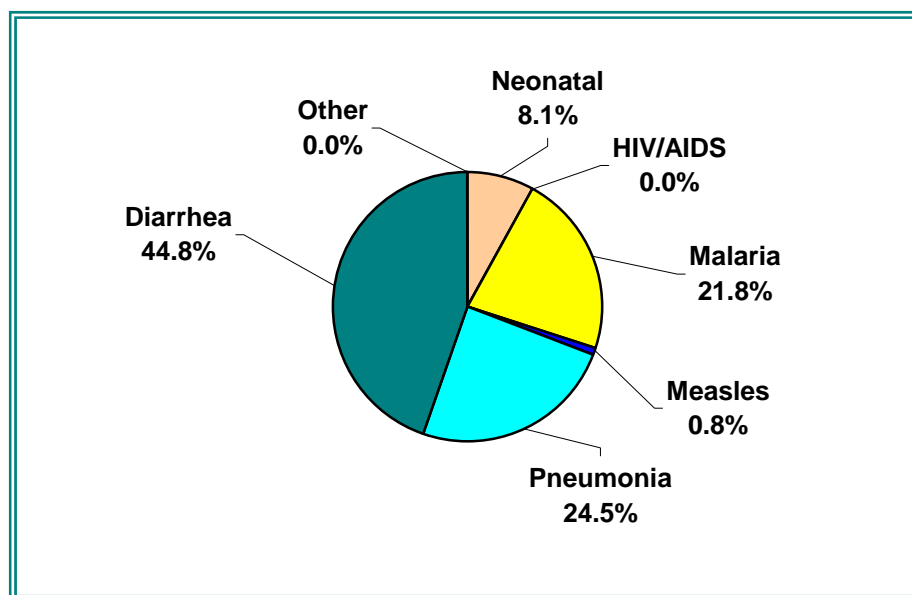
CHAPTER 2: Progress Toward the CSHGP's Program Objective

- Only one of these projects covered almost two times the average number of beneficiaries (WV/Cambodia had 80,000 child beneficiaries), while one covered *significantly less than* the average number of beneficiaries for the projects under review (Partners for Development/Cambodia had 14,000 versus an average of 44,500 U5 beneficiaries).
- The three projects that saved more than 1,000 were implemented in high mortality countries, with U5MRs ranging from 124 to 189 per 1,000.
- When placed in the context of Table 2 (presented in the previous section), which outlines the intervention mix for all projects reviewed for this report, one finds that the intervention mix for these five projects ranged from fewer than the average number of interventions (4) to almost the maximum number possible (9).
- Four of the five projects in the above table improved at least 5 of the 15 Lancet indicators, and usually by very substantial margins (see Table 5). These projects had a very balanced approach, in terms of addressing issues of demand creation and health service quality improvement (e.g., pneumonia and malaria care seeking); increasing access (e.g., vitamin A and maternal tetanus immunization coverage); and improving household behaviors (e.g., ORS and ITN use), though most of their effect was attributable to improving household behaviors.

Figure 3: Distribution of Lives Saved by Cause of Death (as % of lives saved)

Figure 3 shows the distribution of the 9,688 estimated lives saved, by cause of death.

Almost half of all lives saved were from prevention of deaths by diarrhea. Most of the rest



of the lives saved were split evenly between malaria and pneumonia. A much smaller proportion of the lives saved (8%) was due to improvement of the situation of neonatal causes. Predicted drop in mortality from HIV/AIDS in the 13 projects analyzed was not calculated because CSHGP

grantees do not measure the indicator used by the Bellagio group—purchase of nevaraprine.

CHAPTER 2: Progress Toward the CSHGP's Program Objective

How much does it cost to save a life? CSHGP Grantees Demonstrate the Hidden Costs...

The Bellagio Group recently expanded on their lives saved calculations by estimating the cost of universal coverage for these interventions to show that these proven interventions are also cost-effective. They estimated the cost of delivering an effective package of interventions to be about \$1.23 per beneficiary, an average of \$887 per child life saved. The Bellagio calculations were done from the perspective of service delivery of interventions already scaled-up to universal coverage; it included such line items as the cost of commodities and salaries.

CSHGP Projects, as illustrated in this report, tend to work at a smaller scale, and their project costs often do not include the items used as inputs for the Bellagio calculations. They do include, however, important costs that were not included in the Bellagio calculations and were related to capacity building, community building, and health system strengthening. An analysis of the 13 projects to which the lives saved calculation was applied suggests that USAID invests less than \$5.00 per beneficiary to support these projects. This translates into a cost of just over \$1,000 per life saved. If one focuses on the three projects that demonstrated the highest impact, the results are even more striking. Their collective cost was only \$425 per life saved. This is especially poignant when compared with the costs of implementing single vertical interventions like a measles vaccination campaign, which alone can cost more than \$1,200 per life saved in a high mortality region of South Africa (Uzicanin 2004).

While certainly not directly comparable to the Bellagio calculations, CSHGP projects may demonstrate some of the hidden costs related to health systems strengthening and community building that are not taken into account in other calculations and illustrate the strategic niche that PVOs can play in the delivery of live saving interventions.

The lives saved calculations described in the previous section illustrates that the PVO grantees are having a positive impact on the child survival and health outcomes in the countries where they work. But to what extent will the improvements in these outcomes be sustained?

This question will perhaps be best answered 3-5 years from now, through an examination of what has actually continued in the project area. One of the grantees reviewed for this report, Concern Worldwide, has integrated just such a study into a follow-on project it was awarded to expand its work in northern Bangladesh to seven additional municipalities. The two municipalities from the original CSHGP project will serve as learning centers for the new municipalities. To continue monitoring the sustainability of the work it began in Saidpur and Parbatipur, two post-intervention sustainability assessments will be held (+3 years, +5 years), in these areas.

Sustainability is a contribution to the development of conditions enabling individuals, communities, and local organizations to reach their potential. This includes improving local functionality, developing mutual relationships of support and accountability, and decreasing dependency on insecure resources (financial, human, technical, informational), for local stakeholders to negotiate their respective roles in the pursuit of health, wellness, and development beyond a project intervention.

The individuals, communities, and local organizations constitute a *local system* with their environment. It is ultimately their coordinated social interactions and efforts, based on the understanding of their own health and development that will lead to lasting health impact.

—CSTS+/CORE Sustainability Initiative

CHAPTER 2: Progress Toward the CSHGP's Program Objective

While Concern has positioned itself to measure actual sustainability in its original project areas, it is important to note that all projects reviewed for this report established sustainability plans or objectives at the outset and reported on the progress of these efforts at the end of the grant period.

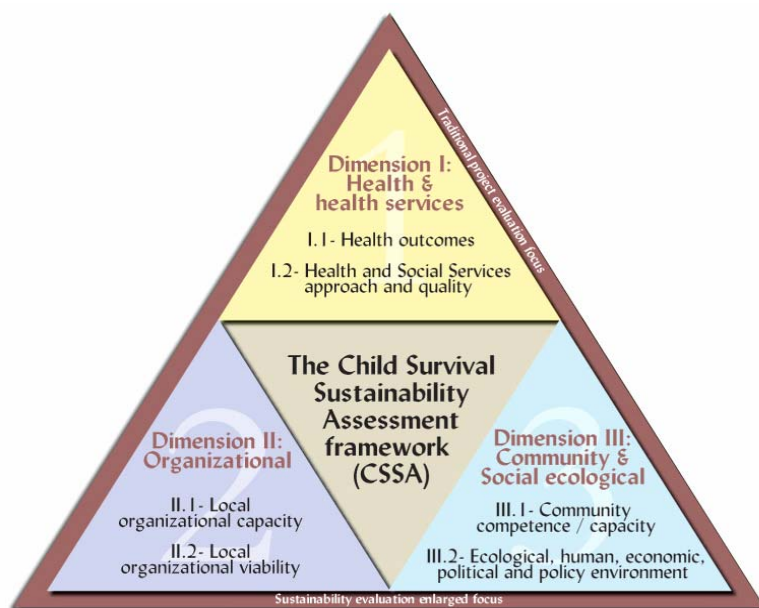
Grantees progress toward sustainability fell into the following broad categories:

- Promoting maintenance of behaviors at the community level;
- Creating or enhancing supportive structures within the community;
- Creating and strengthening links between communities and permanent institutions like the ministries of health and local health facilities;
- Establishing local NGO partners and building their capacity to support continuing child survival activities.

These categories are consistent with a Sustainability Framework developed in recent years through a collaborative effort between CSTS+, CSHGP grantees, and the CORE Group.

The framework, outlined in Figure 4, suggests that to ensure the best opportunity for sustained health outcomes beyond the life of a project, grantees must address the complex inter-relationships between improved health status, quality of health services, capacity and viability of local organizations, community capacity, and factors in the socio-ecological and political environment.

Figure 4: CSSA Framework



Dimension I: Health and Health Services

Component 1: Health Status
Component 2: Health Services
Capacity

Dimension II: Local Organization

Component 3: Local Organizational
Capacity
Component 4: Local Organizational
Viability

Dimension III: Community and Social Environment

Component 5: Community Capacity
Component 6: Enabling
Environment

CHAPTER 2: Progress Toward the CSHGP's Program Objective

The next chapter of this report describes grantees' progress in each of the dimensions of the sustainability framework, focusing on improved health outcomes, improved quality of health services, and capacity building of communities and local partners. The examples presented about building local capacity, when viewed in light of the progress in improved health outcomes and quality of health services, suggest that this cohort of grantees has made important progress toward sustained health outcomes in their project areas.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

Introduction

The results of the lives saved analysis shows the magnitude of the impact that CSHGP projects have on saving the lives of their child beneficiaries. This section expands the analysis of portfolio-level results beyond the 13 grantees examined in the lives saved calculation, drawing on the achievements of 22 recently concluded projects to demonstrate that 1) grantees work with vulnerable populations; 2) grantees improve health outcomes in for the populations they serve; 3) grantees improve the quality and availability of health services; and 4) grantees build the capacity of their local partners and the communities in which they work.

CSHGP Grantees Work with Vulnerable Populations

Grantees tend to work in geographic areas that receive poor health services and consequently have poor health status in comparison with the national averages in the countries where their projects operate. A comparison of grantee baseline and final data with DHS data on two key indicators—ORT usage and immunization coverage—illustrates this point. These two indicators were chosen because there were data for the largest number of projects from the group of 22 that submitted final evaluations and because there were data that were the most comparable to DHS data that had been collected nationwide at or near the time of the project baseline KPC surveys.

The data presented in Figures 5 and 6 show that baseline levels of coverage were below national average 92% of the time for immunization coverage, and 90% of the time for ORT, but improved to levels above national average 75% and 80% of the time, respectively.

For vaccination coverage³—

- Eight of twelve projects started at or below national average, and seven of these raised immunization coverage to levels above the national average by the end of the project.
- Of the four projects that did not start below the national average, three were cost extensions that were building on at least 4 years of previous activities; each of these succeeded in maintaining or increasing immunization coverage at or above their baseline measures.
- The only non-cost extension project that started above national average was Africare/Ethiopia, whose baseline full vaccination coverage rate was near national level and still very poor (19.4% vs. 14.3%).

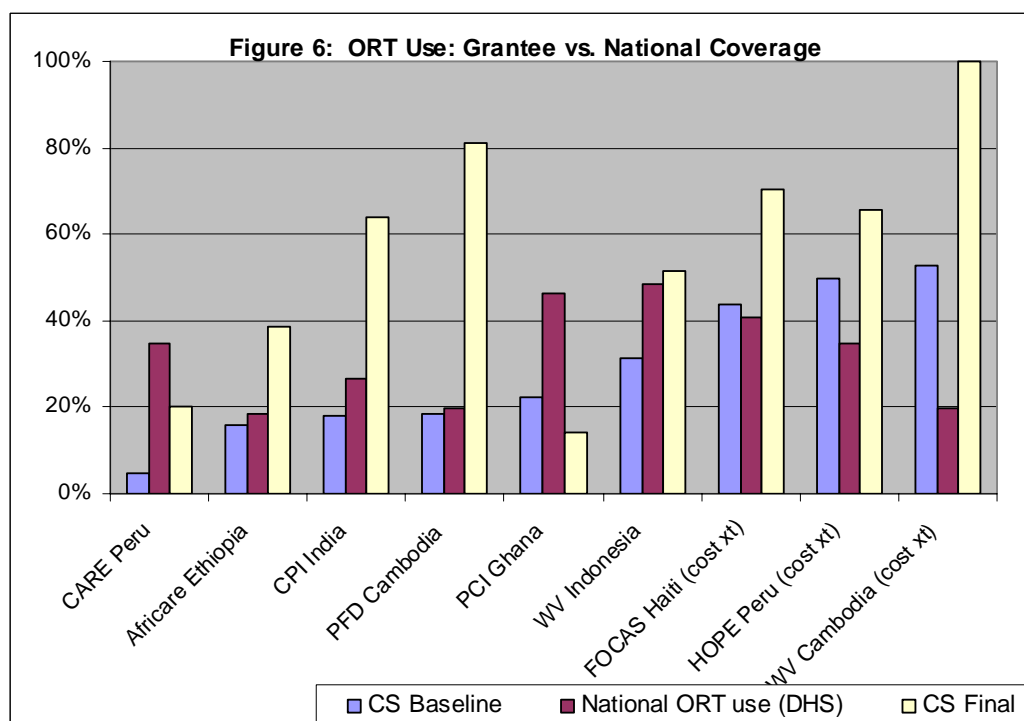
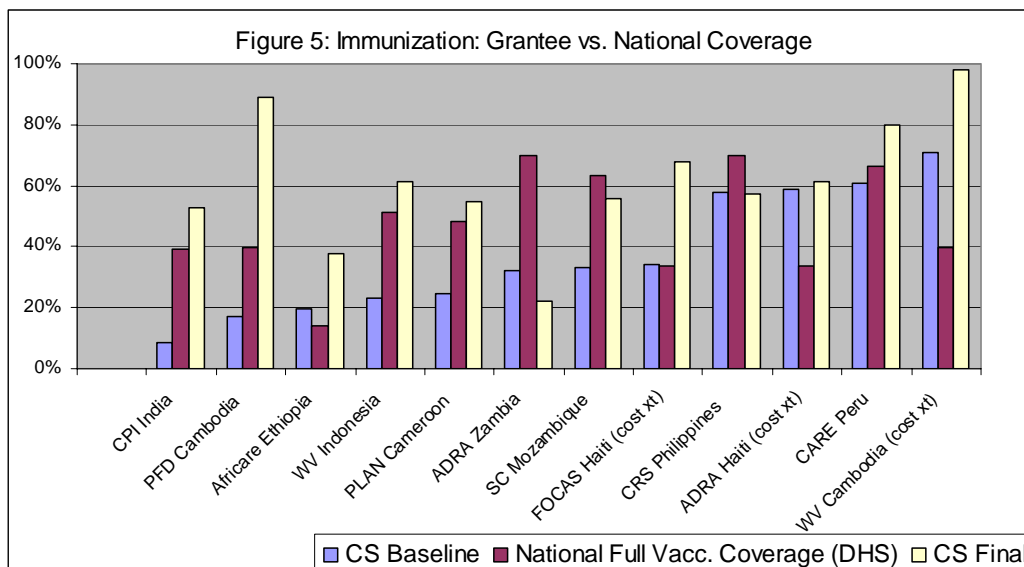
³ The CSHGP measure for immunization coverage relies on card confirmation; the DHS measure relies on mothers' recall.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

For ORT Use

Six of the nine projects reporting baseline and final data on ORT use began at levels below the national average, and five of these improved coverage to levels above the national average by the end of the project.

- Each of the eight grantees that achieved improvements in coverage over the life of their projects showed an increase of 15% or more.



CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

GRANTEES ADDRESS GEOGRAPHICAL INEQUITY

Project HOPE's experience in Peru offers a dramatic example of the sorts of disadvantaged project areas in which grantees often work. HOPE is the only PVO presently working in health education in the Huallaga Valley Region of Peru's Amazon Basin, where years of political, social, and economic upheaval, together with geographic isolation from Peru's urban centers have conspired to create an environment in which health and general living conditions are grim: rates of infant and under-five mortality are higher than the national average and extreme poverty and low levels of education persist. The citizens have suffered hardship because they live in a zone known for illegal coca growing and guerrilla fighting over the past 20 years. Despite this area being a priority for the regional MOH, access to health facilities remains difficult due to cultural barriers and limited community involvement. Using the C-IMCI strategy and strengthening the linkages between the CHWs and the health facilities, HOPE/Peru overcame these all but insurmountable challenges to effect important health gains in its target region. Reductions in the prevalence of chronic and global malnutrition in children 6 to 35 months from 55.4% to 36.8% and the increase in the prevalence of exclusive breastfeeding from 61% to 85.5% are the most notable successes. The program has also maintained 134 mother support groups for breastfeeding (GALME) in 162 rural communities, which promote active feeding practices during illness in addition to exclusive breastfeeding.

GRANTEES ADDRESS ISSUES OF SOCIAL INEQUITY

Within the project areas, grantees also work with poor and marginalized groups. When equity is considered within health interventions and outcomes, it is often from an economic perspective, but the identity of marginalized groups can be specific to the local context. They may in fact be the poor, but they may also be the lower caste, women, or ethnic or religious minorities. Natural disasters, and recovery from them, often provoke existing, though sometimes hidden, differences among groups of people. Inequity in access and treatment becomes apparent in and are exacerbated by these situations. The experience of the CPI/India project is instructive in terms of the impact that a community-based project can have on social determinants of equity. This project worked in Gujarat State with members of both the Hindu and the Muslim communities. These are not communities that have traditionally worked well together, and there had been recent incidents of violence among the groups. In the aftermath of a recent massive earthquake, the project discovered that one of its approaches, the Hearth Model, which reduces severe malnutrition, acted as a catalyst for community cooperation and built trust among participants of both faiths—trust in each other and trust in the services provided. The outcome: CPI's complementary feeding indicator improved by 13.3%, a remarkable achievement in a post-disaster environment.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

GRANTEES ADDRESS GENDER INEQUITY

Women around the world often experience unequal treatment and access to health services. A human rights violation in itself, this inequity also affects children of both sexes who are cared for by a woman who cannot make decisions about seeking health care on her own, who has little knowledge of good health practices, or whose opinion is not counted in the design and implementation of services. The ADRA/Yemen project sought to include women in the implementation and supervision of its project. This gave women an opportunity at societal participation that was not available to them through other means. Women responded very positively, becoming effective agents of positive change in their communities. The outcome: Household health behaviors like ORT use and exclusive breastfeeding increased by 20% and 14%, respectively.

Results: Improved Health Outcomes

Table 6 summarizes coverage improvements for the most important evidence-based interventions/activities that were identified through the Lancet Series. Grantees included in this analysis had both included the activity in their projects and collected complete baseline and final coverage data. (Note: each project worked on a subset of the interventions and not all of these had complete data for the analysis). The number of projects working on an intervention ranges from one project for intermittent presumptive treatment (IPT) for malaria and effective antenatal care to 10 projects for ORS use at last diarrheal episode. An average of five projects were included per indicator.

The third column in the table shows the number of projects that were successful at increasing coverage, and the fourth column shows the average increase in coverage among grantees *who were successful in increasing coverage*.

For 7 of the 15 indicators—antenatal care, exclusive breastfeeding, IPT, prompt malaria treatment, hand washing, clean water coverage, and sanitation coverage—every project that had the activity and the required information showed success at improving the indicator. In six of the remaining eight indicators, grantees were successful in improving the indicator at least 70% of the time. For ITN use and clean home delivery, grantees achieved large coverage improvements when successful, but tended to be successful closer to 60% of the time.

It is not just the fact that the indicators improved that is impressive, but the magnitude of the improvement. As can be seen in the last column of the table, average improvements were typically 30%, and even 40% or more. Ten of the activities gave *average* increases in coverage that ranged from 30% (hand washing, clean home delivery) up to 43% (Maternal TT).

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

Table 6: Coverage Improvements for the Most Important Evidence-Based Interventions/Activities in the 22 Recently Completed Projects

Evidence-Based Intervention/Activity	Number of projects with intervention and complete data	Number of projects successful at increasing coverage	Average increase in coverage among those successful
Measles vaccination	7	6	25%
Vitamin A supplementation	6	5	34%
Complementary feeding, 6-9 months	6	3	12%
Antibiotics for pneumonia	8	6	32%
Hand washing	3	3	30%
Sanitation (latrine coverage)	2	2	18%
Clean water	2	2	30%
ORT use	10	8	30%
ITN use	5	3	35%
Prompt antimalarials	3	3	23%
IPT x 1 or more	1	1	31%
TT x 2	10	7	43%
Effective antenatal care	1	1	6%
Clean home delivery	3	2	30%
Exclusive breastfeeding, 0-5 months	8	8	31%

Some projects had even much larger increases in key indicators.

- HOPE/Peru raised pneumonia care seeking from 22% to 79%.
- World Vision/Cambodia improved the pneumonia care seeking from 26% to 100% and raised Vitamin A coverage from 26% to 92.0%. This project also saw an increase in exclusive breastfeeding, from 7% to 43%—
- WV Indonesia saw an increase in Maternal Tetanus Toxoid immunization from 0.8% to 85.3%.
- ADRA Yemen raised the coverage of measles vaccination from 12% to 60%.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

- WRC Malawi saw an increase in all three evidence-based indicators for the control of malaria. ITN use increased 51% (9% to 60%); intermittent presumptive treatment increased by 30% (31% to 60%); and prompt care-seeking behavior increased from 35% at the beginning of the project to 74% at the final evaluation.
- CPI's projects in India and Uzbekistan made significant increases in the prevalence of hand washing and ORS use. In India, there was a 65% increase in hand washing at key times (9% to 75%), and in Uzbekistan ORS use increased from 0% to 76%.

Results: Improved Quality and Availability of Health Services

Eighty-six percent of projects reviewed identified capacity-building objectives targeted to health facilities, with a focus on improving quality at those sites. Nearly half of the projects reviewed targeted the MOH at the district or provincial level with a similar focus. Table 7 summarizes the number of projects with capacity building targets at these levels, as well as the percentage of those projects that met their targets.

Table 7: Summary of Capacity-Building Efforts to Improve Health Service Quality

Partner	Number (%) projects with capacity-building target	Number (%) projects that reached capacity-building target
MOH District/Provincial	10 (45%)	9 (90%)
Health Facilities	19 (86%)	14 (74%)

Final evaluation reports indicate that grantees invested project resources in training health center staff, improving supervision systems for health workers, and improving supply chain management. Specific indicators identified by grantees varied, and it was not possible to identify a group of standard indicators that could be used for portfolio-level analysis in this report. Highlights of grantee accomplishments are outlined below:

- In Cameroon, PLAN's project increased from 36.3% to 69.4% the percentage of cases seen at health facilities where the health facility staff completed correctly all the counseling tasks.
- In the Philippines, CRS achieved improved the percentage of health facilities storing vaccines at appropriate temperature, from 30% at baseline to 80% by end of the project. This project also raised the percentage of health facilities with a functioning ORT corner based on WHO standards, from 8% at baseline to 100% at the end of the project.
- In Yemen, ADRA raised the percentage of health workers following standard case management for diarrhea treatment from 10% to 40%.
- Several projects also provided technical and logistical support for existing, although under funded, health facility plans and activities. For example, Africare/Ethiopia provided technical and logistic support, which included fuel, ORS and ORT material purchase, and cold chain and motorbike maintenance.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

Almost all the recently completed projects (18 of 22) used the WHO-developed Integrated Management of Community Illness (IMCI) strategy, which integrates community health education for behavior change with increasing access to and quality of health services. Grantees in some cases were actually on the leading edge of the curve for adoption of the model. In Cameroon, for example, PLAN's IMCI intervention preceded the government rollout of IMCI by two years and directly supported the MOH community outreach policy aimed at empowering communities to improve local health resources and to increase access to health services.

Other projects helped to operationalize and refine the IMCI strategy mandated by the national MOH. In Honduras, Mercy Corps used to great success the Honduran Ministry of Health's version of IMCI (known as AIN-C), which also incorporates monthly growth monitoring and promotion. The percentage of children under two weighed in the last six months rose from 17% to 95%. With regular attendance by the majority of families with small children, these monthly monitoring visits could then be used as a platform for delivering important health messages for prevention and treatment of the most common illnesses.

For IMCI to work effectively, there needs to be a link between communities and their health centers, and there should be concomitant improvement in facility-based health services as well. The CPI / Uzbekistan, ADRA / Haiti, World Vision / Indonesia, and ADRA / Zambia projects all incorporated activities to improve health worker performance. For instance, the Indonesia project increased the percentage of health centers that had an adequate cold chain for vaccines from 20% to 100%. In Uzbekistan, the proper case management for diarrhea and pneumonia increased dramatically through training and strengthening of the supervisory capacity of health center staff.

Grantee efforts to improve quality and availability of health services extended beyond health facilities, focusing also on the capacities of the communities being served. These efforts are outlined further below.

Results: Increased Capacity of Communities and Local Partners

Grantee accomplishments related to improved health outcomes and improved quality and access to services are supported by a strong base of work in building the community infrastructure necessary to support the health system. All projects reviewed for this report worked to build the capacities of the communities they served, through strengthening community governance structures, building capacity of local non-governmental organizations, building bridges between community-based and facility-based providers, and building the capacity of communities to use health information to make decisions about managing their health needs.

CHAPTER 3: Contributions to the Improved Health Status of Vulnerable Populations (PR1)

STRENGTHENING HEALTH-RELATED GOVERNMENTAL STRUCTURES

In Bangladesh, Municipality and Ward Health Committees are required at the community level according to a government circular dated 28 November 1995, although in reality such committees are almost non-existent.

As a result of Concern's CSHGP grant, Saidpur and Parbatipur Municipalities are two of the very few municipalities nationwide to have functional ward health committees—with 24 committees functioning between the two municipalities, and a number of them almost ready to function independently with little input from Concern. This ward level committee includes the respective ward commissioners (male and female), ward secretary, NGO representative, a social worker from the community, a community health volunteer, a representative from the private service providers, EPI workers from the ward, *thana* level health staff working in the ward, and distinguished persons residing in the ward.

The Ward Health committees have become the successful focal point for community mobilization, and have been a major contributor to significantly raising immunization and Vitamin A coverage and in maintaining the achieved rates. These committees are playing a critical role through—

- Selecting, supporting, and supervising community health volunteers;
- Supporting and supervising traditional birth attendants, who have been trained in clean, safe delivery and referring women with danger signs during delivery and postpartum period to health facilities;
- Organizing community-level health promotion events.

In Cameroon, PLAN built the technical and management capacity of Health Area Committees in 27 health areas of Bertoua, Doume and Nguelemendouka health districts. As a result of the project activities, the of health areas with joint village plans for addressing health issues rose from zero to all 27 areas by the end of the project. The percentage of health area committees reporting up-to-date financial records increased from 20% at baseline to 100% by the end of the project.

BUILDING CAPACITY OF LOCAL NON-GOVERNMENTAL ORGANIZATIONS

With the help of ADRA, in the four years of its existence, the Al Mustaqbal Association (AMA) has made serious strides to becoming an important contributor to the improved health of the people of Yemen. As early as a year into their existence, they had taken important steps to ensuring their financial stability by writing winning proposals. Currently, they are engaged with many international donor agencies e.g. Oxfam, GTZ. The AMA has carried out extensive health education in three districts on immunization, nutrition, maternal and newborn care, malaria, and diarrheal disease. They have also

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initiated many health-related activities such as conducting KAP research and becoming the first maker and distributor of bed nets in Yemen.

ADRA focused its attention on building up the capacity of the AMA, which had formed with the help of ADRA. While many of its staff worked with ADRA in the past and had valuable experience, ADRA felt that more was needed to introduce a model NGO to the project area as well as to the country of Yemen. To this end, ADRA invested in training and improving institutional capacity and infrastructure for AMA. Trainings in management, program implementation and evaluation and accountability to the community and donors were held, as well as training of key staff in accounting and data management. The AMA worked in partnership with ADRA/Yemen to implement the CS XV Project and to encourage the sustainability of health education interventions through the local institutions. Currently AMA carries out most of the health education activities previously managed by ADRA.

Save the Children's project in Bolivia, which is described in greater detail below, strengthened the capacity of a major local NGO partner, APROSAR, to provide CB-IMCI and to apply, document, and expand SECI and Hearth/Positive Deviance strategies to communities outside the *Wawa Sana* project area. APROSAR also strengthened its capacity to implement other communication strategies (materials development, improved educational methods, and use of radio programming). Finally, APROSAR increased and diversified its funding sources from nearly total dependence on USAID funding at the start of CS-16 to only 25% today.

BUILDING BRIDGES BETWEEN COMMUNITY- AND FACILITY-BASED PROVIDERS

In Cambodia, the MOH delivers outreach services (e.g. vitamin A distribution, immunizations) through mobile outreach teams. The Ministry of Rural Development (MRD) also has mandated that there be Village Health Volunteers (VHVs) who perform home visits for health education. In the wake of the devastation wreaked by the Khmer Rouge regime, community structures are very weak in much of the country. Additionally, the activities of VHVs and MOH outreach teams have often been less than optimally coordinated.

At the completion of PFD's project in Chhlong and Snoul Operational Districts, there were 410 well-trained, supported, and motivated behavior change agents that have continued their work since the PFD activities were completed.

Realizing that behavior change depends as much on the message and the messenger, PFD's approach to changing behavior in Cambodia focused on establishing a knowledgeable and motivated group of Village Health Volunteers (VHVs) that would become agents of change within their communities. PFD's intimate knowledge of the community allowed them to initiate a VHV selection process that ensured that the VHVs would have the respect and

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support of key role players in the community as well as the health centers. Health center staff was appointed as VHV supervisors, which established a direct link (and thus established credibility for the VHVs) between the VHVs and the health center. This served to motivate and support VHVs in their work. Intensive training to increase technical knowledge and to affect behavior change in the VHVs took place. This last point is important, as noted in the final evaluation, because the most effective messages of behavior change come from a VHV who has already changed his/her behavior.

In Malawi, World Relief has adapted the CARE Group model that it has applied successfully in Mozambique. Care Groups (CGs) are a *saturation model* of community volunteers that achieve *universal coverage* for households with U5 children and women of reproductive age. Every household is reached twice a month. CG volunteers train and support mothers at the household level to adopt healthy behaviors, such as basic hygiene and sanitation practices and prevention of common childhood illnesses by using low-cost and culturally appropriate measures like ITNs, ORT, etc. They also promote appropriate and prompt care-seeking behavior, and mobilize communities to increase demand for vital MOH prevention services like immunization. Volunteers in turn receive regular supportive supervision from paid WR staff. The role of the WR staff is gradually replaced by MOH staff, making the structure sustainable. This project increased from 8.5% to 60% the percentage of WRA and children U5 sleeping under a bed net; increased from 3% to 76 % the percentage of pregnant women receiving Iron Folate; and increased from 36% to over 95% (95.4%) the percentage of women exclusively breastfeeding infants from 0 to 6 months old.

Through CGs, community-based health information systems are established and maintained, strengthening the MOH's reach to the community in a sustainable manner. CG volunteers collect vital events data from women in the households they visit, and pass this information on to project staff who share the information with the MOH, community, and other stakeholders. Data collected are used to influence decisions at the community and district levels. In addition, routine surveillance data collected informs project and MOH of disease outbreaks, allowing for timely interventions.

AKF's project in Tajikistan emphasized training of PHC staff with the same messages and content as the community volunteers. This assured consistency between the different service providers and improved case management at the health center level (e.g., emphasis on exclusive breastfeeding, ORS treatment for diarrhea, and complementary feeding for growth faltering).

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BUILDING THE CAPACITY OF COMMUNITIES TO MANAGE INFORMATION FOR DECISION-MAKING

Save the Children's experience in Bolivia offers another example of strengthening community structures for service delivery. In the midst of a rapidly changing, complex sociopolitical and cultural context in rural Bolivia, in three districts of Oruro, the Save the Children project *Wawa Sana* ("Healthy Child") project was highly successful, having achieved or surpassed nearly all of its objectives, in large part due to the Community Epidemiology Surveillance System (SECI) Methodology's powerful ability to mobilize communities.

Key accomplishments included—

- Pentavalent-3 vaccine coverage increased from 32% to 85% in infants.⁴
- Acute respiratory infections treated by health services and Promoters increased 224% from 2001 through 2003 in CS-16 intervention areas.⁵
- Families increased their children's fluid intake during diarrheal diseases from 21% at the start of the program to 54% at final evaluation.⁶

Keys to Success—lessons learned from FOCAS/Haiti

FOCAS's program manager identified five keys to success that all involved strengthening multi-functional community-based delivery mechanisms:

- 1) Integrated approach—both prevention measures (e.g., immunization, family planning, nutrition, MNC) and treatment (e.g., pneumonia, diarrhea)
- 2) Community outreach—maximizing coverage through an annual census, community-based health posts, and house-to-house visitation
- 3) Beneficiary education and informed participation—education of family caretakers through mothers clubs, nutrition clubs, community events, leadership meetings, and one-on-one counseling
- 4) Documented supervision—follow-up through quality improvement checklists, onsite spot-checks, use of pre-tests and post-tests in education and training efforts

Training—both primary and ongoing refresher training for staff and community workers (e.g., Traditional Birth Attendants)

- Most CS-16 communities now place health at or near the top of their agenda in sharp contrast to prior to *Wawa Sana* when health was low or absent completely.
- Municipalities, communities, and health service providers learned to share and analyze community health information to set priorities, plan, act, and evaluate progress resulting in stronger working relationships.

⁴ KPC surveys, baseline (2000) and final (2004), based on verified registration on child health card.

⁵ Bolivia National Health Information System (SNIS) data.

⁶ KPC surveys, baseline (2000) and final (2004).

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- At least 15 other NGOs and government health services throughout Bolivia have adopted and adapted *Wawa Sana's* SECI methodology.

SECI is seen as a very effective strategy for community mobilization as well as an important tool in promoting the sustainability of the health intervention. Using this methodology and health care data collected on simple forms and community maps, community health care promoters and service providers are able to obtain information on the health conditions relevant to the community. Communities and health workers are then able to devise strategies and objectives for the health priorities in their community and make decisions about how best to achieve agreed upon objectives. As a mobilization aid, this tool puts the information for decision making into the hands of the people. It also effectively puts into practice the Bolivian “Law of Popular Participation.” This last example illustrates the power of putting information into the hands of community members in a form that is understandable to them. This is a strong motivator for positive social and behavioral change.

In Haiti, FOCAS worked with local NGOs to increase the capacity of the local community to collect and use census-based health information to improve health status.

Through a mentoring partnership formed with Curamericas (formerly Andean Rural Health Care), FOCAS implemented the CBIO methodology with its local NGO partners, Mission Evangelique Internationale (MEI), and Oeuvre de Bienfaisance et de Développement Communautaire (OBDC). This approach, pioneered by Curamericas,⁷ resulted in a community-based, community-oriented child survival program that utilized home visitation through resident Community Health Agents (CHAs) to collect and use vital health information for more than 100,000 Haitians. Most significantly, this approach allows a program to monitor direct changes in mortality. CHAs register family members in their communities and go door-to-door to provide a “personal prompt” for mothers and children to attend nearby assemblies or to use health center services. With community volunteers, they organize regular monthly “rally posts” for activities such as growth monitoring/counseling (GMC) and immunization, as well as for health education on, for example, oral rehydration therapy and other specific interventions. The efforts have had very positive impact on several health outcomes as noted below.

- Decline in under-five death rates (U5MR)—OBDC: Decline of 31% in 4 years (from 68/1000 to 47/1000); MEI: Decline of 65% in 4 years (from 188/1000 to 66/1000).
- Steady decline in malnutrition rates revealed in ongoing growth monitoring data.
- Proportion of children weighed six times in last 12 months has increased dramatically—OBDC: Baseline was 11%, 2003: 81%; MEI Baseline was 32%, 2003: 92%.

⁷ Shanklin, D and Sillan D. The Census-Based, Impact Oriented Methodology: A Resource Guide for Equitable and Effective Primary Health Care. Curamericas, Raleigh, North Carolina, April 2005.

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- Proportion of children breast fed within one hour after birth has increased—OBDC baseline (1998) was 52%; EOP was 70%; MEI baseline (98) 57%; EOP (03) was 73%.
- Oral Rehydration Therapy: 85% (MEI); 91% (OBDC) of mothers fed more liquids during diarrhea; and about 3/4 included ORT.
- More than 2/3 of children are fully immunized before their first birthday: MEI: 67%; OBDC: 70%; vaccination “dropout rate” has declined.

CHAPTER 4: Contributions to Increased Scale of Health Interventions (PR 2)

Introduction

In FY05, the CSHGP undertook strategic efforts to position itself for making important contributions to the implementation of proven interventions at scale. These efforts included the integration of a program result related to scale in the CSHGP's new Performance Management Plan; the revision of the CSHGP's annual request for applications to generate more programs designed to work at scale; and the inclusion of a scale-related result in the CSHGP's new cooperative agreement with the CORE Group.

While these efforts are designed to ensure that future initiatives supported by the CSHGP will make important contributions to scale, it is also notable that the cohort of grantees reviewed for this report demonstrated some important achievements related to scaling up interventions during the lifecycles of their projects.

This section outlines the CSHGP's strategic initiatives related to scale in FY05 and contributions of recently concluded CSHGP grants and the CORE Group Network Agreement, which can serve as building blocks for future CSHGP efforts.

CSHGP Strategic Initiatives to Enhance Contributions to Scale

The CSHGP's efforts to position itself for maximizing its contributions to scale are framed in the context of two definitions that have emerged in recent years. In 2001, Achieving Impact on Child Health at Scale (Mary Taylor, BASICS II) described scale as *"widespread achievement of impact at affordable cost,"* noting that *"increased impact requires effectiveness (quality), sustainability (continuity, ownership) and equity (reaching the hardest to reach, usually the poor.)"* USAID's FY2004 Child Survival and Health Programs Fund Progress Report describes a framework for tracking the development of the agency's health interventions in which one stage includes interventions being *"scaled up to the national level (covering half or more of a country and achieving good coverage at reasonable cost)."*

In FY05, the CSHGP laid the groundwork for ensuring strong results related to scale in the years ahead, through the activities described below:

INCLUSION OF SCALE IN THE CSHGP'S PERFORMANCE MANAGEMENT PLAN

By including a program result related to "increased scale of health interventions," the CSHGP has established a mechanism of accountability for itself in terms of reporting annually to the Bureau for Global Health. Through a collaborative process that included key stakeholders in the Bureau for Global Health, representatives from the PVO

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community, and the CORE Group, the CSHGP established the following subprogram results⁸ that will define its own reporting on scale in future years:

- Increased population reached through the use of strategic partnerships and networks
- Improved health systems and policies that support effective health programs and services in government and private sectors
- Improved collaboration with USAID missions.

REVISIONS TO CSHGP REQUEST FOR APPLICATIONS TO STRENGTHEN DESIGN OF SCALE PROJECTS

In parallel to the PMP development process, the CSHGP revised its annual Request for Applications, integrating language and guidance in all grant categories to describe clearly the expectations for successful applicants regarding contributions to scale. Across all categories, applicants are now encouraged to demonstrate stronger collaboration with USAID Missions through linking their projects with Mission-funded implementing partners and aligning project indicators with Mission indicators. Applicants in the Standard Category are explicitly required to demonstrate how their program will lay the groundwork for future scale-up at the national level.

Guidance for the Program's Expanded Impact Category was updated to ensure that successful applicants in this category would make significant contributions to national-level efforts to bring proven interventions to scale. A summary of the updated guidance for this grant category is included in the text box below.

Supporting Scale through the CORE Group Network Agreement

The PVO Network Agreement put in place with the CORE Group in FY05 includes a program result of increased PVO collaboration at country level to scale up proven public health interventions for effective and sustainable programs. This result will drive the CORE Group's efforts in this area over the next five years, and the CORE Group's FY05 activities focused on expanding options for such collaboration among its members. The CORE Group also advanced the thinking on potential PVO contributions to scale through the development of a working paper entitled *Scale and Scaling Up: A CORE Group Background Paper on Scaling up Maternal, Newborn and Child Health Services*. The thinking in this paper both informed and was informed by the CSHGP's Performance Management Plan development and RFA revision processes, and was used to help organize panel presentations made at the CORE Group's Spring Members Meeting and the CSHGP's annual Mini-University event.

⁸ All subresults are defined to occur at the national level or at a significant subnational level.

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A Vision for Scale—Guidelines for Applicants in the CSHGP’s Expanded Impact Category (FY06 CSHGP Request for Applications)

(Note: Expanded Impact projects may be funded for 5 years, with up to \$2.5 million for single PVO and up to \$4 million for multi-PVO programs)

Purpose and Scope: To contribute to the expansion of proven child survival and health interventions and approaches at the national or significant sub-national level. The intention of this expanded impact category is to support PVO applicants to collaborate closely with Ministries of Health and their key donor and implementation partners to design and implement a child survival and health program that contributes to the achievement of widespread impact. This program can be a scaled-up version of a PVO program successfully applied in smaller settings, or the extension of a national MOH (or donor partner) program already in place.

Essential Elements

- Improve access to and utilization of proven maternal, newborn and child survival interventions to the greatest extent possible within the resources available by leveraging other MOH, donor, and implementation partner resources.
- Work in close coordination with the MOH and support MOH priorities; MOH ownership and “mainstreaming” of interventions are key elements of the program.
- Complement and support USAID Mission priorities and strategies.
- Coordinate with a variety of partners at the national and sub-national level on the design and implementation of the program.
- Include a community component that represents and links with community needs and strengthens community structures (e.g., encourage community participation and representation, support community mobilization activities, build community capacity, work with existing community networks or groups; meaningfully engage community with the health system).

SUPPORTING LINKAGES BETWEEN CSHGP GRANTEES AND USAID MISSION PROGRAMS TO FACILITATE SCALING UP

As USAID Missions work at the national level to support efforts at scale, CSHGP grantees can play an integral role in contributing to the Mission’s objectives. In FY05, several Missions saw the value of centrally funded projects, adding funds to those projects or continuing to support them when CSHGP funding expired.

Partners for Development, whose project in Cambodia ended in 2004, receives ongoing financial support from the Mission to continue project activities and maintains an active role among a PVO consortium for child survival that has formed there.

World Relief’s Care Group model, which has been highlighted in multiple settings and was a focus of the CORE Group’s Diffusion Efforts, receives Mission support to continue activities and reach more communities throughout Mozambique in conjunction with the CSHGP-funded Expanded Impact Project that began in October 2004. World Relief also received one year of “bridge” funds from the Mission to keep project activities going between CSHGP grants.

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Concern Worldwide’s Expanded Impact in Bangladesh, which will expand its previous CSHGP project from two to nine Municipalities in Northern Bangladesh, also receives Mission support and is being monitored as a potential model for urban health programs in Bangladesh.

EXAMPLES OF GRANTEE AND THE CORE GROUP’S EFFORTS TO CONTRIBUTE TO SCALING UP

The Strategic initiatives outlined above will facilitate opportunities for documenting future results of programs operating at scale, and learning about the processes involved in scaling up (e.g., efforts to bring more quality benefits to more people over a wider geographical area more quickly, more equitably, and more lastingly).⁹

However, a review of recently concluded CSHGP grants and ongoing activities of the CORE Group suggest that the groundwork for scale is already being laid in many settings, and in some cases has taken hold at a national or significant sub-national level.

PLAN’s CSHGP project played an important role in bringing IMCI to scale in Cameroon. The project’s successful pilot of the IMCI approach preceded the government rollout of IMCI and directly supported the MOH community outreach policy aimed to empower communities to improve local health resources and to increase access to health services. The government rollout of IMCI began in 2002, with the intention by the MOH and PLAN (and UNICEF, WHO, HKI, PSI and others) to scale up IMCI throughout the entire country based on the results of this project (as well as the other two pilot districts carried out by UNICEF and WHO). In FY05, PLAN submitted a successful application to the CSHGP to implement an Expanded Impact Program with Heller Keller International and Population Services International with a primary goal to accelerate the scale-up of IMCI and Roll Back Malaria in Cameroon.

In Rwanda, CSHGP Grantees and the CORE Group teamed to help bring malaria treatment to scale. Malaria is the leading cause of morbidity and mortality in Rwanda, accounting for 43% of all deaths and 40% of health center visits. But use of health facilities is low, and many children with malaria end up dying at home, without proper treatment. To bridge this gap in treatment, the National Integrated Malaria Control Program in 2004 teamed with the three CORE Group PVOs who are implementing CSHGP projects to launch a pilot program for community-based distribution of antimalarial medication in five districts.

The ongoing initiative—funded by the CORE Group, USAID/Rwanda, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM)—aims to educate parents to identify danger signs associated with malarial fever and treat the illness with help from a nearby

⁹ This definition of “scaling up” is from the International Institute for Rural Reconstruction; is also used by the United Nations Development Program.

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community drug distributor, within hours of onset, when the chances of saving a child's life are at their highest. Parents are advised to seek help at a health center for more complicated cases.

While the Rwandan government provides program oversight, the PVOs (International Rescue Committee, World Relief and Concern Worldwide) and their local partners implement and monitor drug distribution efforts. Community health workers, chosen by communities and trained by health districts and their PVO partners, are responsible for distributing the drugs.

As of April 2005, program results were promising. In the initiative's first five months, more than 85% of children in five districts were treated within 24 hours of onset of fever. World Relief trained 329 local drug distributors and reported no deaths among children receiving treatment through these distributors. From November 2004 to February 2005 in Kibilizi District, Concern Worldwide reported that cases of children successfully treated for fever in the community rose from zero to 795.

The International Rescue Committee (IRC) reported that, as of May 2005, 280 community distributors in Kirehe District were treating more than 3,000 cases of childhood fever per month.

The CORE Group supported PROCOSI, a network of NGOs in Bolivia, to increase collaborative efforts around C-IMCI. PROCOSI had a representational relationship with the Bolivian government on behalf of the NGO community. PROCOSI achieved several key results, including creating and maintaining a database and maps on the state of implementation of C-IMCI by NGOs. A recent report stated that 26 NGOs are developing the IMCI strategy in 161 municipalities, covering 51% of the 314 municipalities in the country. PROCOSI also worked with other national stakeholders to develop process indicators for C-IMCI implementation to measure progress on community health agent implementation of epidemiological surveillance, home visits, and communication for behavior change.

One way NGOs can achieve greater scale of proven public health interventions is by combining their efforts in a specific country and coordinating planning, implementation and evaluation. In Nepal, the CORE Group expanded on a strong collaborative base built by the Polio Partners Project to support expansion of C-IMCI through NGOs. With support from the CORE Group, CARE, ADRA, Save the Children, and World Vision developed a strategy to expand community-based IMCI in six districts in Nepal.

CHAPTER 5: The CSHGP Contributes to Global Health Capacity and Leadership for Child Survival and Health (PR 3)

Introduction

Although this is a new program result for the CSHGP, which was adopted toward the end of the fiscal year, this report describes several examples of activities implemented by program partners over the past year, as well as a few examples from the 22 projects reviewed for this report that contribute to Global Capacity and Leadership in Health. Contributions are defined through three main areas: increased technical excellence, improved recognition and visibility of PVO work in health, and increased capacity of new partners of the CSHGP to implement effective health programs.

Increased Technical Excellence

Since its inception, the CSHGP has developed, tested, and disseminated a wide range of technical resources to support its grantees in implementing high-quality health programs. These resources range from the Knowledge, Practices and Coverage Survey Tool, which guides collection of population-based data for baseline and final evaluations, to the CSHGP Technical Reference Materials, which provide grantees with a quick reference to the most up-to-date technical and program management guidance for their programs. Internet-based resources, training curricula, and U.S. and field-based learning events are also included in the range of strategies that the CSHGP supports to foster technical excellence in its implementing partners.

In FY05, the CSHGP sponsored many events to train PVO staff, facilitate information sharing among grantees and program partners, and promote excellence in child survival programming. More than 1,560 participants attended CSHGP-sponsored technical or programmatic training events in seven countries. These included 12 seminars (a few hours long) on new and emerging technical health issues, 15 skill-building workshops (2-10 day training events) on important technical and crosscutting methodologies, and seven partners' meetings to share information and develop plans and activities among partners. In addition, the CORE Group and CSTS+ provided technical assistance to CSHGP grantees and PVO networks. Events were held throughout the year in several different locations to maximize attendance from various organizations. Participants in these events included CSHGP grantees, USAID Washington technical staff, USAID Mission representatives, PVOs and NGOs, and other stakeholders from the governmental and private sectors. A set of tools was developed and widely disseminated to complement some of the important training of trainers' events so that the skills could then be widely disseminated within the

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organizations and their partners. A table of CSHGP-sponsored events is included in Appendix B.

Through the CORE Group, additional technical resources were developed to support specific strategies and approaches that have shown promise at a small scale, but that need further testing to determine their replicability across the portfolio and at a larger scale. In FY05, The CORE Group held a competitive process to select and support the approaches that demonstrably improved the effectiveness, sustainability, equity or scale of child health outcomes and could be expanded and adopted across the child survival community. These documented innovations, outlined in detail below, form a new coterie of “best practices” in community-based child survival programming.

Helen Keller International: The Integration of Vitamin A Supplementation into Community-Directed Treatment with Ivermectin

HKI staff throughout Africa saw CDTI as an opportunity to enhance delivery of Vitamin A supplement in their project areas. Their efforts in implementing this approach in six states in Nigeria and one district in Cameroon showed, among other things, that Vitamin A coverage could be widely increased. In Cameroon, vitamin A supplement coverage was 77% among children 6-59 months and 90% among women post-partum, and Ivermectin coverage increased from 70.3% to 74%. Reaching women post-partum by other mechanisms in Cameroon had not achieved more than 20% coverage nationally.

Based on this experience, they produced a “How to Guide” in both English and French that details costing, training, and logistics and management information system, and they conducted dissemination workshops in Nigeria, Cameroon, and the Democratic Republic of the Congo to train other NGOs and partners in the approach.

World Relief: Care Groups

WRC developed a guide that covers the evidence base for the Care Group model, offers criteria to assist project managers in determining the feasibility of using this approach within their own programs, and provides a step-by-step guide for starting and sustaining Care Groups.

World Relief pioneered the Care Group model as part of its Vurhonga (I and II) child survival projects in Mozambique (1995-2003). As a result of this model, by the end of Vurhonga I, the number of children between 12 and 23 months that are up-to-date on their immunizations increased from 37% to 93%; the number of children that are exclusively breast fed increased from 16% to 55%; and the number of mothers who seek treatment within 24 hours for their children who have fevers increased from 11% to 85%. Care Group volunteers provide peer support, develop a strong commitment to health activities, and find creative solutions to challenges by working together as a group.

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Save the Children: Partnership Defined Quality (PDQ)

Partnership Defined Quality (PDQ) is a methodology to unite equitably community members with providers to define quality; identify and prioritize problems; and create solutions to strengthen the quality, access, and use of services that improve the health status for all. Save the Children piloted the approach in Pakistan, Uganda, Rwanda, Azerbaijan, the West Bank, Georgia, and Ethiopia and developed an implementation guide with step-by-step instructions for field use. Though the CORE Group's support, Save the Children developed a training supplement to the guide that enables facilitators to conduct a PDQ training designed to equip participants with all the skills necessary to adapt and implement PDQ in their programs.

Based on operations research conducted in Nepal, PDQ sites showed a significant improvement relative to control sites in the number of sick children presenting for care ($p < 0.005$); the PDQ intervention was associated with an increase in utilization by adults ($p < 0.005$); and the improvements in visits by ongoing OC users in PDQ facilities was greater than that in the control sites.

Food for the Hungry: Barrier Analysis

Barrier analysis is a social and behavioral change tool that helps program managers identify barriers to behavior change that (if adopted) would have a significant positive impact on the health, nutrition, or wellbeing of targeted groups (e.g., preschool children) in a project area. The tool has been used in Haiti, Kenya, Mozambique, Ethiopia, and Bolivia to discover key barriers to behavior change regarding breastfeeding, other nutritional practices, latrine use, agricultural practices, HIV/AIDS behaviors, and other intervention areas. A training guide and curriculum was formalized and used to train other PVOs in Kenya and Washington, DC in the approach, including 53 participants from 31 organizations.

Curamericas: Census-Based, Impact-Oriented Methodology

Curamericas developed and tested a model of health service delivery called the Census-Based, Impact-Oriented (CBIO) approach in Bolivia, Guatemala, Haiti and Mexico. The CBIO approach is a community-based primary health care model that allows local health care staff to better understand and treat more effectively the most common causes of sickness and death within their communities. Because of its unique approach to measuring community health, the CBIO methodology provides a basis to measure accurately health service outcomes and impacts, including mortality reduction.

Evidence of the effectiveness of this approach is seen in the 31% mortality reduction in the project area on an NGO using this methodology in Haiti, where the NGO also saw greater-than-15% increase in the proportion of children breast fed within an hour after birth; more

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than two-thirds of children fully immunized before their first birthdays; and more than 30% increase in the proportion of women using a modern contraceptive method.

A manual was created to gauge the appropriateness of the strategy in specific program areas and to guide program implementation. Greater than 60% increases in the number of children weighed in the last 6 months.

CRS: Framework for Integrated Community Approach to Obstetric and Neonatal Emergencies

Through a grant from CSHGP, CRS Honduras implemented a safe motherhood program aimed at decreasing maternal and neonatal mortality in rural settings with limited access to care by strengthening the management skills of traditional birth attendants (TBAs). CRS's approach was based on the "life saving skills" methodology developed by the American College for Nurses and Midwives. Two of the major accomplishments attributed to the project include that 17% of all pregnancies in the project area were identified with some complication or danger sign that required and resulted in a referral, and that institutional births, a proxy for the global indicator of increased births with a birth attendant, increased from 16 to 23%.

The CORE Group provided support to CRS to disseminate several products arising from the project. These projects are available in both English and Spanish and include a TBA manual, a training plan for TBAs and maternal health aides, and facilitators' guides for training TBAs and community emergency transport committees.

Improved Recognition and Visibility of PVO Work in Global Health

The CSHGP worked to improve the recognition and visibility of PVO work in health through project documentation, publication of journal articles, and presentations at global fora. Twenty-nine technical documents were produced and disseminated on key child survival and health technical issues.

In FY05, the CORE Group documented the following projects:

- MIHV and ADRA's family planning program in Uganda focusing on experiences partnering with communities and district health teams;
- American Red Cross' programs integrating a measles campaign with a bed net, Vitamin A and Mebendazole campaign in Zambia;
- MIHV's work improving malaria case management in Ugandan communities;
- World Relief's lessons learned from Mozambique on community-based solutions for effective malaria control;
- Doctors of the World's implementation of a national tuberculosis control program in minority communities in Kosovo;

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- Project Hope's work with TB control in Kazakhstan and Tajikistan;
- Multiple NGO's approaches to promoting insecticide-treated bed nets in Tanzania and promoting home-based treatment of malarial fever in Uganda.

The CORE Group published journal articles in *Global HealthLink* (on management of malarial fever in Uganda); *Eurohealth* (on TB control in Kosovo); and the U.S. State Department's *E-Journal* (on community-based distribution of anti-malarial medication in Rwanda).

The CORE Group presentations to global health fora in FY 05 included a presentation at the American Public Health Association Conference on the Roll Back Malaria movement and its integration with C-IMCI, and a presentation by Minnesota International Health Volunteers at the Global Health Council Conference on community-based partnerships to improve family planning in Uganda. Additionally, the CORE Group members Concern Worldwide and International Rescue Committee presented their work with the CSSA tool at the Global Health Council Conference, with support from CSTS+. CORE Group member World Vision also presented their work with the CSSA and transformational development. Finally, CORE Group member ADRA presented information from their project in Cambodia at this conference.

INCREASED CAPACITY OF NEW PARTNERS

In FY05, the CSHGP established a New Partners Initiative to reach out to organizations that have not previously worked with USAID but could add value to the overall portfolio of CSH grants. The program was designed to proactively identify potential new grantee partners. In FY05, 12 potential new partners applied for funding, four of these were awarded CSH grants to begin in October 2005, and 30 potential new partners were identified who may apply in FY06. Three new partner organizations joined the CORE Group during this time as well.

The strategic approach that the CSHGP has taken to supporting new partner organizations holds promise for ensuring that both USAID and these organizations benefit from the experience. While those benefits will become clearer as new partners begin full implementation in the coming years, the experience of several grantees analyzed for this report provide some insights into potential future outcomes. Testimonials about the impact of the CSHGP on Concern Worldwide, FOCAS, and Partners for Development are included in Appendix C. For each of these organizations, the CSHGP grant that was analyzed for this report was their first experience working with USAID's Global Health Bureau.

CHAPTER 6: Recommendations

Introduction

USAID's Child Survival and Health Grants Program is making significant proven impact on child survival and health worldwide using effective and sustainable community-based approaches. The program also has great promise for contributing to scale at national level in the countries in which its projects operate and, through the CORE Group and its members, play a leadership role in representing NGO community at the national and international levels.

This section presents recommendations based on the information presented in this report. The recommendations in this report relate to enhanced data quality, focus of the program's technical interventions, increased contributions to scale, and increased visibility of the program.

Enhanced Data Quality

The CSHGP has long been known for the rigor it requires of its projects: with technical review and approval of detailed implementation plans, requirements for establishing measurable indicators at baseline and measuring progress on those indicator at final evaluation (as a minimum), and CSHGP approval of a PVO-identified midterm and final evaluator for each program. The Knowledge, Practice and Coverage (KPC) survey has long been the standard tool used by grantees for their population-level baseline studies. In 2000, the introduction of the Rapid Core Assessment Tool for Child Health (CATCH)—a subset of the indicators in the KPC tool—established a common set of standard indicators across the CSHGP portfolio. The projects reviewed in this report reflect the first set of CSHGP projects for which most CATCH indicators were collected at both baseline and final evaluation.

Recommendation 1: The CSHGP should consider modifying its list of standard indicators to fully incorporate measures of the proven life-saving interventions in the Lancet Series, and to mirror recent updates to DHS indicators.

The analysis presented in this report, which was based on indicators linked to proven child survival interventions noted in the Lancet Series, also coincides with recent updates to key DHS survey modules. The analyses presented here were constrained by the fact that not all of the grantees collected information that could be used in the calculation. To bring the Rapid CATCH in line with the Lancet and new DHS indicators, the standardization of the following indicators would strengthen the CSHGP's ability to report on the overall contributions of its portfolio of grantees:

- Use of ORT/ORS. There is presently an indicator for increased *food/fluids for last illness episode*. However, ORT use is reported by DHS, MICS, and most MOHs. It is a well-known indicator and may be more useful.
- Pneumonia Care Seeking. There is no specific indicator among the Rapid CATCH for ARI. Since several questions are needed for the construction of this indicator, the CSHGP should further discuss with its partners the potential burden to grantees. However, this indicator would prove useful for strengthening the lives saved calculation.
- Vaccine coverage by card only and hand washing at all appropriate times. These two indicators are a bit more stringent than is standard. The more commonly reported versions of these are—vaccine coverage by mother’s report or card and various hand-washing indicators that are not quite as strict as the one included in the RC. The CSHGP should consider whether the present indicators are acceptable proxies for these more stringent definitions.
- Vitamin A—Coverage with vitamin A is such an effective intervention that an indicator ought to be included in the Rapid CATCH.

Recommendation 2: The CSHGP should provide guidance across its portfolio of projects on collecting commonly accepted indicators of health services quality, while allowing grantees the flexibility to use indicators that are relevant to their project settings.

This report illustrates important contributions that CSHGP grantees have made to improve the quality of health services at the facility level. However, it was difficult to identify common indicators for health services quality across the projects reviewed because there were no common indicators for quality. It is recommended that the CSHGP, the CORE Group, and CSTS+ work to identify a small set of health services quality indicators that could be recommended for all grantees to track whether their activities are related to these indicators.

Focus of Technical Interventions

This report illustrates the broad range of technical interventions in which grantees have achieved results, and illustrates the evolution of technical focus of the program since 1985. This evolution demonstrates the CSHGP’s flexibility in quickly adapting to emerging knowledge in technical areas, and this year’s report suggests that present and future grantees reexamine the focus of their maternal and newborn care interventions.

Recommendation 3: Since the Millennium Development Goal for child survival cannot be met without a substantial reduction in neonatal mortality, the CSHGP project efforts need to maintain and even increase their focus on the newborn.

The estimated lives saved calculation shows that in the projects under review, a modest (4%) reduction in neonatal deaths was achieved. From the 2005 lancet series on Neonatal

Survival, we know however, that *of the 130 million babies born every year, about 4 million die during the neonatal period*,¹⁰ close to 40% of all child deaths or an estimated 450 newborn deaths every hour, mainly from preventable causes. It is thus reasonable that we recommend that the CSHGP and its grantees pay more attention to the neonatal period. As illustrated in previous progress reports, PVOs have consistently increased their efforts in maternal and neonatal health and have contributed to an increase in the coverage of antenatal care in their intervention areas, as documented by a dependable increase of tetanus toxoid (TT) coverage. Neonatal tetanus, which is easily preventable accounts however only for a small proportion ($\approx 7\%$) of all neonatal deaths, and the three main causes of neonatal death remain underweight (preterm) births, infections and asphyxia.

Most (about 60%) current CSHGP projects have a maternal and newborn health component, which is now, after the nutrition-related interventions, the intervention category which draws the most LOE in the portfolio. The types of activities grantees presently undertake focus on the promotion of antenatal care; recognition of danger signs by families and communities; promotion of clean deliveries during home births; promotion of births attended by skilled providers; postpartum care of the mother and the newborn; birth preparedness including the promotion of birth plans with the prevision of emergency transport; and in some projects, the promotion of home-based life saving skills.

To increase the impact of the program, projects seeking to intervene in settings with very high neonatal mortality should be given priority for support, and PVOs should scale up their successful activities at the community level as well as in health facilities. PVOs should ensure that they maintain gains made during antenatal care while increasing their focus on the delivery and the postpartum periods.

Increased Contributions to Scale

As noted in this report, the CSHGP has incorporated a focus on scale into its program in FY05. The recommendations below are identified as the next steps in the process for ensuring that the results of the program's scale-related efforts maximize the strengths of the PVO and NGO community, while also supporting USAID's strategic direction in this area.

Recommendation 4: The CSHGP should work with its partners to position itself to address barriers to scale that may exist at the community, district, regional, or national levels. In so doing, the CSHGP should consider defining its contribution to scale in the context of the impact equation (*Impact is a function of effectiveness, efficiency, scale, equity, and sustainability*).

As outlined earlier in this report, scale has been defined as widespread impact, and impact has been defined as a function of equity, sustainability, effectiveness, and efficiency. As the

¹⁰ Neonatal Survival 1-4 million neonatal deaths: When? Where? Why? Lancet. 2005, May 28-Jun 3; 365(9474):1845.

CSHGP works to define its role in agency-wide efforts to focus on scale, the impact equation may serve as a useful framework for focusing the discussion on the specific role that its grantees can play, and the balance between contributing to scale and contributing to other factors that influence impact.

CSHGP Grantees have demonstrated that they can achieve high mortality reduction at small scale, that they have the capacity to participate in national-level mainstreaming efforts, and that they can partner strategically with other stakeholders to make important contributions to the scale-up of proven interventions. There is evidence that grantees are addressing equity issues where they work, although documentation of that could be improved. Through the CSSA Framework, they are systematically addressing sustainability issues.

Using the impact equation as a point of departure might inform discussions of the appropriate guidance to provide grantees for documenting their contributions to scale.

Recommendation 5: The CSHGP, through the CORE Group, should continue to advance the knowledge about community-based delivery mechanisms that hold promise for going to scale, along with those that represent the “best” in community-based health development.

As illustrated by the estimated lives saved calculation, CSHGP projects hold promise to be highly effective with high impact. Many projects reviewed for this report substantially improved four, five, six, even seven key indicators known to have high impact on child survival.

While the projects under review for this report covered between 1-6% of the national child population, new guidelines for Expanded Impact grants could yield programs that cover a significant portion of children nationwide. CSHGP grantees, by working at the community level, are therefore uniquely positioned to answer some of the difficult questions raised by the Bellagio Child Survival Study Group in terms of delivering effective and equitable child health programming at scale. Further documentation of the feasibility of such mechanisms as CARE Groups, networks of village health committees, and community mutuelles might be further explored. CSHGP grantees should be encouraged to document the mechanics of the delivery mechanisms that are working at scale in their future programs, and the CORE Group should be encouraged to further document effective community-based delivery mechanisms, including those that might be taken to scale.

Visibility of the Program

Increased visibility of the program has been identified as part of the vision for the CSHGP team, to facilitate access of the larger child survival and health community to the rich

achievements, approaches, and lessons learned from the program. The recommendations below are intended to promote strategically the visibility of the program.

Recommendation 6: The CSHGP, The CORE Group, and PVO Grantees should consider the application of the Lives Saved Analysis from this report, as well as other strategies that have proven feasible for community-based programs, to enhance the visibility of PVO contributions to child health.

The templates used to calculate the predicted lives saved in this report could be powerful tools for the PVO community in better documenting their impact and raising the visibility of their efforts. As illustrated in this report, predicted mortality drops are large (16-34% for the projects in the top half), and the analysis applied to these projects is most likely an *underestimate of impact*—because it uses optimistic national mortality figures, does not include incomplete data on proven indicators, and does not include other indicators that almost certainly have substantial positive effects. In fact, as a validation check, the model was run on the World Relief Mozambique project (Vurhonga I) that ended last year. This project registered a directly measured 62% decline in U5MR, while the lives saved analysis estimated only a 33% decline.

It is recommended that the CSHGP further explore the strategies applied by World Relief and others to measure impact, and that it also explore potential partnerships with the CHERG (from the Bellagio Study Group) to make these formulas and supporting data widely available. Skills training in these methods for CSHGP grantees could be integrated into the CORE Group Spring Meeting, CSHGP Mini-University, or other events that are widely attended by grantees.

Recommendation 7: The CSHGP should encourage its grantees to document more clearly their contributions toward addressing equity in their projects.

CSHGP grantees often work in remote areas at the community level, where inequities often have the greatest impact. Therefore, they are uniquely positioned to inform the global learning agenda regarding equity issues in health programs from a community-based perspective.

Presently, project data can be used to demonstrate that grantees work in underserved regions in which their projects operate, but only anecdotal evidence is available at present to demonstrate how these projects address the broad range of equity issues. While this report includes examples from three PVOs addressing geographic, religious or ethnic, and gender equity issues, the evaluation reports reviewed suggest that few grantees formally assess equity to determine their project sites or measure equity issues over the life of the project.

CHAPTER 6: Recommendations

The Bellagio Study Group raised the question of equity (Vicotra, et. al., Child Survival 4) as an important dimension for those concerned with scaling up child health interventions. While different strategies for measuring equity at the project level (e.g., wealth quintile analysis) may be explored in the future, the complexity of equity issues suggests that it will be difficult to implement a full set of tools that can measure socioeconomic, gender, ethnic/cultural, and other forms of equity simultaneously. It is recommended that as a first step, grantees seek to document not only what they did to address equity issues in their communities, but also how they did it. Grantees should be encouraged to document more explicitly equity issues and strategies they have implemented through the results highlight page that is required in their evaluation reports.

Appendix A: Methodology for Lives Saved Analysis

Because of the novel nature of the analysis of lives saved, the method used for this calculation is highlighted here.

The use of the KPC tool has ensured that grantees collect quality information about the health outcomes of their projects. However, because grantees appropriately tailor questionnaires and indicators to project strategies and activities to fit the conditions and needs of their specific project area, the information collected is not always completely comparable from one project to another. For instance, immunization standards in the countries of the Former Soviet Union dictate that a child be vaccinated for measles at 12-15 months of age. This differs from EPI standards in many other countries with projects in the portfolio. Consequently, the standard EPI indicator of “full vaccine coverage (including measles vaccine) by 12 months of completed age” gives a false impression of poor coverage in places like Uzbekistan and Tajikistan. Even given these complications, indicators were consistently defined and analyzed. This consistency promoted by the use of the KPC allowed an analysis of impact for the first time this year, which is reported in Chapter 3 as the Lives Saved calculation, using a methodology developed by the Child Health Epidemiology Reference Group (CHERG). This is the same methodology used for the calculations in the landmark 2003 Lancet Child Survival series (see References).

Fourteen of the 22 projects could be analyzed using the CHERG data sheets. The PSI/Rwanda project was not included in the analysis because attribution of results to this national level project is difficult; so 13 projects were included in the lives saved analysis (see Table 8).

Table 8: Thirteen Projects Included in the Lives Saved Analysis

Country	PVO
Bangladesh	Concern Worldwide
Cambodia	World Vision
Cambodia	Partners for Development
Cameroon	PLAN
Ethiopia	Africare
Ghana	Project Concern International
India	Counterpart International
Indonesia	World Vision
Malawi	World Relief
Mozambique	Save the Children
Philippines	Catholic Relief Services
Yemen	Adventist Development and Relief Agency
Zambia	Adventist Development and Relief Agency

There are presently 13 different intervention areas eligible for CSHGP funding. Two of these intervention areas—tuberculosis and family planning—have been added in recent years. In the group of projects analyzed, there were only eleven possible intervention areas. There were multiple projects with activities in every one of these intervention areas; however, three of the intervention areas, HIV/AIDS, Micronutrients, and Child Spacing, did not have activities that were included in the lives saved calculation. This was because the only evidence for lifesaving interventions in two of these areas (prevention of mother-to-child transmission through nevirapine and replacement feeding; zinc supplementation) have come since these projects started. The Bellagio Group did not feel that child spacing had enough *causal* evidence linked to it to include any indicator (Saul Morris, personal communication). The other eight intervention areas each had at least one evidence-based activity associated with it, with standard indicators.

Calculation of Lives Saved by 13 Recently Completed Projects Using method developed by the Child Health Epidemiology Reference Group for 2003 Lancet Child Survival Series (for full description, see Child Survival 2 reference)

- Seven diseases/conditions are known to account for the large majority of child mortality worldwide. These are diarrhea, pneumonia, measles, malaria, malnutrition, HIV/AIDS, and neonatal causes. All these conditions are covered by CSHGP intervention areas.
- Fifteen evidence-based activities outlined in the Lancet articles were supported by CSHGP in this group of projects. Any one project implemented from 1 to 10 of these activities.
- Standard and comparable indicators were selected from the KPC survey to measure coverage rates for the 15 evidence-based activities.
- Where available, the values of these standard indicators were identified from project documentation at baseline and end of project for the 13 projects in the countries analyzed by the Bellagio Group (minus PSI / Rwanda). The only indicators included in the calculation were those that had a statistically significant improvement (generally $\geq 4.0\%$ for the 300 respondent KPC survey). Data were missing for 19% of evidence-based activities.
- In the few instances when there was a negative change in a coverage level, this was not counted as lives lost, but simply treated as if there had been no change. This was done because it is highly unlikely that worsening coverage is attributable to the project, but rather is due to influences outside their control.
- The lives saved for each intervention is a product of the *baseline number of deaths* estimated for that cause (using national level epidemiological data compiled by CHERG multiplied by the estimated midterm under-five population from project data) multiplied by that intervention's *effectiveness* (extracted from the literature reviewed by CHERG) multiplied by the *change in coverage* (from KPC data collected by the project at baseline and end of project).
- For Water/Sanitation/Hygiene, the CHERG data (which used Esry's 1985 meta-analysis) were updated and the intervention effect levels from the 2005 Fewtrell meta-analysis were used instead.
- The number of lives saved was summed from numbers estimated from all the interventions implemented by each project and analyzed as the number of lives saved from each of the seven diseases/conditions; by each activity; by each project; and collectively for the group of 21 projects.
- The model also takes account of the effects of malnutrition on mortality and the fact that some interventions have effects on multiple conditions (e.g., vitamin A has effects on both measles and pneumonia); and avoids "double counts" (i.e. one child might receive more than one lifesaving intervention, but is only counted as being saved once).

See Table 9 for the intervention areas and the evidence-based activities and indicators associated with them for which there was activity by at least one grantee.¹¹ Therefore, not all grantee activities were included in the calculation, even some that almost certainly do reduce mortality. Other activities were not included for certain projects simply because there was not enough information available.

¹¹ For a full description of the methodology, see the Child Survival 2 article in the references.

Table 9: Evidence-Based Activities Identified by the Bellagio Group and Used in the Lives Saved Calculation

CSHGP Intervention Area	Evidence-Based Life Saving Activity/Activities
Immunization	Measles immunization
Nutrition	Complementary feeding for 6-9 month olds
Vitamin A Supplementation	Vitamin A supplementation
ARI	Treatment of pneumonia with antibiotics (prompt care seeking to an appropriate provider was used as a proxy)
Diarrhea NOTE: Used Fewtrell 2005 meta-analysis rather than the Esry 198 article used by CHERG	Hand washing Oral rehydration salts or recommended home fluids Water purification Sanitation provision
Malaria	Insecticide Treated Nets (ITNs) Intermittent Presumptive Treatment (IPT) for pregnant women Prompt treatment of child malaria case (prompt care seeking to an appropriate provider was used as a proxy)
Maternal-Neonatal Care	Maternal tetanus immunization Effective antenatal care Skilled birth attendance
Breastfeeding	Exclusive breastfeeding, 0-5 months

Finally, Table 10 gives an analysis of reasons why the calculations of lives saved could be either overestimates or underestimates. Taking account of each of these factors and its probable magnitude, the overall effect is most likely to be underestimation, perhaps rather significant underestimation. As evidence of this, a WRC / Mozambique project was reviewed in last year's Annual Results Review that *directly measured deaths* in the project area and recorded a 62% drop in U5MR. The model only predicted a 33% drop in mortality.

Table 10: Summary of Possible Inaccuracies in Lives Saved Estimate

Factor	Does this cause the calculation to be an overestimate or underestimate?	Comments
Use national child mortality figures	underestimate	Project sites are generally in higher than average mortality environments, but the national figures are the most reliable estimates.
Missing data to do coverage calculations	underestimate	19% of the time that an intervention was done, there is not sufficient data available from the projects.
Do not count activities that probably are life saving but for which there is not sufficient information	underestimate	None of the 7 Micronutrient (non-vitamin A) interventions nor the 9 child spacing activities was counted.
Mathematical model assumes that the increase from baseline to final coverage was immediate rather than a slow rise	overestimate	This effect is probably not as large as one might imagine. One of the projects has midterm coverage data, showing a rather substantial rise from baseline for a majority of its key indicators so the rise may well be quite steep for these projects.
Data from literature on intervention effectiveness is from tightly controlled trials, and “real world” projects may not achieve these levels of effectiveness	overestimate	Again, this overestimate is probably small, as most of the projects are in relatively small areas with relatively close supervisory systems

Appendix B: The CSHGP Increases Capacity of New Partners to Implement Effective Health Programs

Over the past 20 years, the CSHGP has continuously sought to reach out to and include new partners in the program, although this has evolved into a more deliberate effort in recent years. In FY05, the CSHGP defined a “New Partner Initiative.” The result of this initiative is that 3-4 awards (25% of total funding available) are made to new partners in each grant cycle. The Entry/New Partner category has quickly become competitive; about 12 applications were received in FY05, and at least that number is expected again in FY06. A “new partner” is defined as an organization that has never received development funds from the Global Bureau or its predecessor offices. Four new partners were funded in FY05 and 04, and one new partner was funded in the previous year. The New Partner Initiative represents a conscientious effort on the part of the program to expand its partnership base. New partners advance the program by contributing new ideas and innovative methods of working with populations.

The New Partner Advisor, supported by CSTS+, conducted a situational analysis that identified barriers to new partners joining the program and made recommendations for removing them. As a result, potential new partners have greater accessibility to the program than ever before. The program builds the capacity of new partners through its program cycle, which guarantees a certain level of quality in programming. In addition, new partners must include an organizational capacity-building component in their projects.

Throughout the first year of the initiative, the New Partner Advisor contacted more than 30 organizations to assess their interest in and eligibility for the CSHGP. It is anticipated that many of these organizations will apply for a grant in the next FY. Because of the capacity building nature of the CSHGP, which provides thorough and constructive feedback even to unsuccessful applicants, it was discovered that the organizations most likely to apply to the CSHGP were those who had applied, unsuccessfully, in the past. This will create a cohort of more experienced applicants and ultimately increase competition in and the quality of proposals funded under the Entry/New Partner category.

Among the recently completed projects, there were three organizations new to the program (the new partner initiative began subsequent to their awards), though one was implementing a cost-extension grant. Including that cost-extension, two of the three new partners have received second grants from the program. Their experiences are illustrative of what can be expected from new partners. More information about how the CSHGP built these organizations’ capacities is included below.

CONCERN WORLDWIDE

Concern’s first CS project was implemented in Saidpur and Parbatipur Municipalities in Bangladesh. In submitting their final evaluation, Concern’s Child Survival and Health

Advisor acknowledged that, with this first grant, they “truly valued [the] opportunity to learn and grow. Greater exposure to practitioners, tools, and guidance has influenced not only our health programs in Bangladesh, but globally.”

CWI’s U.S. office is very active in the CORE Group and participates on several working groups, including IMCI, Social Behavior Change, HIV/AIDS, and Nutrition. CWI’s U.S.-based health specialist was elected to the CORE Group’s Board of Directors mid-2003. CWI has also worked closely with CSTS+ to measure the project’s potential for sustainability and in testing the beta version of the electronic sustainability database. Involvement with both the CORE Group and CSTS has enabled CWI, as a newcomer to the CSHGP, to benefit from the collective experience of participants and gain needed technical assistance. This has strengthened CWI’s institutional capacity around the world. CWI also benefited from hiring a health specialist who had experience with the CSHGP and field projects. CWI has been awarded two additional CS projects since beginning the project in Bangladesh, and was recently awarded a cost extension to the CS project in Bangladesh.

FOCAS HAITI

This grant supported a mentoring partnership between Curamericas, an experienced CS grantee, and FOCAS, a new partner. The original project ended in 2000, and a cost extension application was successful. The second phase of the project ended in 2003. The final evaluation of the second phase concluded that the CSHGP is to be commended for supporting this mentorship program. The extensive training offered by the experienced partner brought excellent supervision, monitoring, and evaluation to the project. Participation in the CSHGP has built FOCAS’s capacity to implement community-based primary health care programs. The organization’s financial accountability procedures improved. FOCAS has increased its board development activities at both headquarters and field level. FOCAS conducted an organization-wide assessment to fulfill the grant’s capacity-building requirements. This resulted in the organization reviewing and revising its vision and mission statements. FOCAS is also a member of the CORE Group.

PARTNERS FOR DEVELOPMENT

PFD believes that the CS grant contributed to institutional development within the organization by professionalizing human resources management and financial management. PFD designed and disseminated a project manager’s manual specifically for CS projects. In addition, the CS project has contributed to a better understanding of the best approaches to CS program design and implementation. The high standard of knowledge and expertise, as well as tools and models, gained through the CS project has been applied to other PFD programs. The CSHGP’s regular reporting requirements contributed to the organization’s capacity to monitor continuously their work and to institutionalize monitoring tools for community assessments, including LQAS and KPC surveys. PFD

believes that participation in the CSHGP, in addition to raising programmatic standards, has helped it to evolve into a learning organization. The USAID Mission continues to fund PFD CS activities, even after the centrally funded grant has ended. PFD is a member of the CORE Group.

New partners recognize that they have a lot to learn from and to contribute to the CSHGP. Some of the greatest challenges stem from the rigorous reporting requirements of the program. The New Partner Advisor attempts to guide new partners through the first year of project implementation to ensure the quality of documentation.

Appendix C: Rapid CATCH Indicators

PRIORITY CHILD HEALTH INDICATORS

Sentinel Measure of Child Health and Well-being

1. Percentage of children age 0–23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Prevention of Illness/Death

Percentage of children age 0–23 months who were born at least 24 months after the previous surviving child

Percentage of children age 0–23 months whose births were attended by skilled health personnel

Percentage of mothers with children age 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Percentage of children age 0–5 months who were exclusively breastfed during the last 24 hours

Percentage of children age 6–9 months who received breast milk and complementary foods during the last 24 hours

Percentage of children age 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Percentage of children age 12–23 months who received a measles vaccine

Percentage of children age 0–23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night

Percentage of mothers with children age 0–23 months who cite at least two known ways of reducing the risk of HIV infection

11. Percentage of mothers with children age 0–23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Management/Treatment of Illness

12. Percentage of mothers of children age 0–23 months who know at least two signs of childhood illness that indicate the need for treatment

13. Percentage of sick children age 0–23 months who received increased fluids and continued feeding during an illness in the past two weeks

Appendix D: Profile Matrices of Active CSHGP Projects (As of September 1, 2005)

Table 11: Current CSHGP Project Funding

PVO-Country-Cycle	Year	Type	Funding		
			USAID	PVOMatch	Total
CARE Nepal CS XIX	2003-2007	Expanded Impact	\$2,500,000	\$833,378	\$3,333,378
SC Mali CS XX	2004-2009	Expanded Impact	\$5,000,000	\$1,666,667	\$6,666,667
WRC Mozambique CS XX	2004-2009	Expanded Impact	\$2,500,000	\$833,333	\$3,333,333
WV India CS XIX	2003-2008	Expanded Impact	\$2,499,771	\$945,422	\$3,445,193
ADRA Nepal CS XX	2004-2009	Expanded Impact/FP	\$2,461,334	\$864,003	\$3,325,337
Africare Uganda CS XIX	2003-2008	Cost XT	\$1,299,999	\$383,880	\$1,683,879
CARE Nicaragua CS XVIII	2002-2007	Cost XT	\$2,243,251	\$749,559	\$2,992,810
CCF Senegal CS XVIII	2002-2006	Cost XT	\$1,250,000	\$454,445	\$1,704,445
CPI India CS XX	2004-2009	Cost XT	\$1,499,923	\$1,314,595	\$2,814,518
CWI Bangladesh CS XX	2004-2009	Cost XT	\$1,500,000	\$693,657	\$2,193,657
HAI Mozambique CS XVIII	2002-2007	Cost XT	\$1,250,000	\$750,425	\$2,000,425
HOPE Guatemala CS XVII	2001-2005	Cost XT	\$1,249,931	\$1,252,884	\$2,502,815
HOPE Uzbekistan CS XIX	2003-2007	Cost XT	\$1,299,851	\$434,958	\$1,734,809
MCDI Madagascar CS XVIII	2002-2006	Cost XT	\$1,229,843	\$460,099	\$1,689,942
MCDI South Africa CS XVII	2001-2005	Cost XT	\$1,194,824	\$409,026	\$1,603,850
PLAN Nepal CS XVII	2001-2006	Cost XT	\$1,132,342	\$377,622	\$1,509,964
SC Ethiopia CS XVII	2001-2006	Cost XT	\$1,250,000	\$416,750	\$1,666,750
SC Guinea CS XVIII	2002-2006	Cost XT	\$1,400,000	\$416,675	\$1,816,675
SC Tajikistan CS XVIII	2002-2007	Cost XT	\$1,250,000	\$333,300	\$1,583,300

Table 12: Current CSHGP Project Intervention Mixes

PVO-Country-Cycle	Year	Type	Intervention Mix														
			Immuni- zation	Nutri- tion	Vita- min A	Micro- nutri- ents	ARI	CDD	Malaria	MNC	Child Spac- ing	BF	HIV	FP/RH	TB		
CARE Nepal CS XIX	2003-2007	Expanded Impact		35%			35%	30%									
SC Mali CS XX	2004-2009	Expanded Impact					10%	10%	17%		13%			50%			
WRC Mozambique CS XX	2004-2009	Expanded Impact	10%	20%			10%	20%	20%				5%	15%			
WV India CS XIX	2003-2008	Expanded Impact	40%	3%	4%	3%							20%		30%		
ADRA Nepal CS XX	2004-2009	Expanded Impact/FP													100%		
Africare Uganda CS XIX	2003-2008	Cost XT	25%	15%				10%	35%					15%			
CARE Nicaragua CS XVIII	2002-2007	Cost XT		20%			10%	10%			50%		10%				
CCF Senegal CS XVIII	2002-2006	Cost XT	10%	10%	5%	10%	15%	15%	15%		15%		5%				
CPI India CS XX	2004-2009	Cost XT	10%	20%			25%	25%			20%						
CWI Bangladesh CS XX	2004-2009	Cost XT		20%			25%	15%			40%						
HAI Mozambique CS XVIII	2002-2007	Cost XT							35%		25%			40%			
HOPE Guatemala CS XVII	2001-2005	Cost XT	5%	10%	3%	2%	15%	10%	5%		20%		5%	10%			
HOPE Uzbekistan CS XIX	2003-2007	Cost XT		10%			10%	10%			30%		10%		30%		
MCDI Madagascar CS	2002-	Cost XT	20%				15%	15%	15%		20%		15%				

Table 12: Current CSHGP Project Intervention Mixes (cont.)

PVO-Country-Cycle	Year	Type	Intervention Mix															
			Immuni- zation	Nutri- tion	Vita- min A	Micro- nutri- ents	ARI	CDD	Malaria	MNC	Child Spac- ing	BF	HIV	FP/RH	TB			
XVIII	2006																	
MCDI South Africa CS XVII	2001-2005	Cost XT	15%					20%	20%			15%				30%		
PLAN Nepal CS XVII	2001-2006	Cost XT						15%	30%			30%	25%					
SC Ethiopia CS XVII	2001-2006	Cost XT	15%					15%	10%		10%	20%				30%		
SC Guinea CS XVIII	2002-2006	Cost XT	10%	15%	5%	10%						40%				20%		
SC Tajikistan CS XVIII	2002-2007	Cost XT	15%	15%	1%	4%		15%	15%		15%	30%			5%			
WRC Cambodia CS XVIII	2002-2007	Cost XT	35%	20%		15%		15%	15%									
ACTS Georgia CS XX	2004-2009	Entry/New Partner		15%				15%	25%			25%			20%			

Table 12: Current CSHGP Project Intervention Mixes (cont.)

PVO-Country-Cycle	Year	Type	Intervention Mix												
			Immunization	Nutrition	Vitamin A	Micro-nutrients	ARI	CDD	Malaria	MNC	Child Spacing	BF	HIV	FP/RH	TB
CRWRC Bangladesh CS XX	2004-2009	Entry/New Partner	10%	25%	5%	15%	10%	10%		15%		5%	5%		
GHA Haiti CS XX	2004-2009	Entry/New Partner	15%			10%				40%		10%	15%		
IRC Rwanda CS XVII	2001-2005	Entry/New Partner		20%			10%	20%	30%		20%				
ADRA Cambodia CS XVII	2001-2006	Standard	10%	10%	5%	5%			35%	20%	10%	5%			
ADRA Guinea CS XVI	2000-2005	Standard	20%	15%	3%	2%				15%	35%	10%			
ADRA Madagascar CS XIX	2003-2007	Standard	15%	15%			5%	10%	15%	25%	15%				
ADRA Nicaragua CS XVII	2001-2006	Standard	10%	15%			15%	15%	20%	5%	5%	15%			
Africare Senegal CS XIX	2003-2008	Standard		10%		10%		10%	20%	50%					
AKF India CS XIX	2003-2008	Standard	5%	9%		9%	12%	12%	40%	5%	3%	5%			
ARC Cambodia CS XX	2004-2008	Standard	15%	15%	10%		10%	10%	10%	20%					
CARE Ethiopia CS XVIII	2002-2007	Standard	20%	35%			25%	20%							
CARE Mozambique CS XVII	2001-2006	Standard	10%	20%	5%	5%			45%		15%				
CARE Sierra Leone CS XIX	2003-2008	Standard	15%	10%		10%			35%	30%					
CRS Cambodia CS XVII	2001-2006	Standard	20%				25%	25%	30%						

Table 12: Current CSHGP Project Intervention Mixes (cont.)

PVO-Country-Cycle	Year	Type	Intervention Mix														
			Immunization	Nutrition	Vitamin A	Micro-nutrients	ARI	CDD	Malaria	MNC	Child Spacing	BF	HIV	FP/RH	TB		
CRS Kenya CS XVIII	2002-2007	Standard		25%	5%		25%		30%						15%		
Curamericas Bolivia CS XVIII	2002-2007	Standard	10%	25%			20%	20%			25%						
Curamericas Guatemala CS XVIII	2002-2007	Standard	10%	20%			15%	10%			25%	10%	10%				
CWI Rwanda CS XVII	2001-2006	Standard		22%					22%		22%				34%		
HAI East Timor CS XX	2004-2008	Standard									100%						
HHF Haiti CS XX	2004-2009	Standard									60%	20%	20%				
HKI Niger CS XX	2004-2009	Standard		20%	20%	20%			10%	20%				10%			
HOPE Haiti CS XVII	2001-2006	Standard	15%	10%	2%	3%	10%	15%			15%	10%	15%	5%			
HOPE Kyrgyzstan CS XVIII	2002-2006	Standard	5%	15%			10%	10%			30%	10%	10%	10%			
HOPE Nicaragua CS XVIII	2002-2007	Standard	7%	13%			10%	15%			30%	10%	10%	5%			

Table 12: Current CSHGP Project Intervention Mixes (cont.)

PVO-Country-Cycle	Year	Type	Intervention Mix															
			Immuni- zation	Nutri- tion	Vita- min A	Micro- nutri- ents	ARI	CDD	Malaria	MNC	Child Spac- ing	BF	HIV	FP/RH	TB			
XVIII	2006																	
MCDI South Africa CS XVII	2001-2005	Cost XT	15%					20%	20%			15%				30%		
PLAN Nepal CS XVII	2001-2006	Cost XT						15%	30%			30%		25%				
SC Ethiopia CS XVII	2001-2006	Cost XT	15%					15%	10%		10%	20%				30%		
SC Guinea CS XVIII	2002-2006	Cost XT	10%	15%	5%	10%						40%				20%		
SC Tajikistan CS XVIII	2002-2007	Cost XT	15%	15%	1%	4%		15%	15%		15%	30%			5%			
WRC Cambodia CS XVIII	2002-2007	Cost XT	35%	20%		15%		15%	15%									
ACTS Georgia CS XX	2004-2009	Entry/New Partner		15%				15%	25%			25%			20%			

Table 12: Current CSHGP Project Intervention Mixes (cont.)

PVO-Country-Cycle	Year	Type	Intervention Mix												
			Immunization	Nutrition	Vitamin A	Micro-nutrients	ARI	CDD	Malaria	MNC	Child Spacing	BF	HIV	FP/RH	TB
CRWRC Bangladesh CS XX	2004-2009	Entry/New Partner	10%	25%	5%	15%	10%	10%		15%		5%			
GHA Haiti CS XX	2004-2009	Entry/New Partner	15%			10%				40%		10%			
IRC Rwanda CS XVII	2001-2005	Entry/New Partner		20%			10%	20%		30%		20%			
ADRA Cambodia CS XVII	2001-2006	Standard	10%	10%	5%	5%				35%	20%	10%			5%
ADRA Guinea CS XVI	2000-2005	Standard	20%	15%	3%	2%				15%		10%			
ADRA Madagascar CS XIX	2003-2007	Standard	15%	15%			5%	10%	15%	25%	15%				
ADRA Nicaragua CS XVII	2001-2006	Standard	10%	15%			15%	15%		20%	5%	5%			15%
Africare Senegal CS XIX	2003-2008	Standard		10%		10%		10%	20%	50%					
AKF India CS XIX	2003-2008	Standard	5%	9%		9%	12%	12%		40%	5%	3%			5%
ARC Cambodia CS XX	2004-2008	Standard	15%	15%	10%		10%	10%	10%	10%		20%			
CARE Ethiopia CS XVIII	2002-2007	Standard	20%	35%			25%	20%							
CARE Mozambique CS XVII	2001-2006	Standard	10%	20%	5%	5%			45%			15%			
CARE Sierra Leone CS XIX	2003-2008	Standard	15%	10%		10%			35%						
CRS Cambodia CS XVII	2001-2006	Standard	20%				25%	25%		30%					

Table 13: Current CSHGP Project Beneficiaries

PVO-Country-Cycle	Year	Type	Beneficiaries						
			Infants	Ch 12-23	Ch 0-23	Ch 24-59	Ch 0-59	Wm 15-49	TB Cases
CARE Nepal CS XIX	2003-2007	Expanded Impact	31,388	30,321	61,709	84,805	146,514	36,280	
SC Mali CS XX	2004-2009	Expanded Impact			116,121	116,121	232,242	417,182	
WRC Mozambique CS XX	2004-2009	Expanded Impact			38,635		38,635	63,122	
WV India CS XIX	2003-2008	Expanded Impact	304,240	289,028		540,027	1,133,295	1,609,280	
ADRA Nepal CS XX	2004-2009	Expanded Impact/FP						213,309	
Africare Uganda CS XIX	2003-2008	Cost XT	12,028	12,028		15,124	39,180	42,911	
CARE Nicaragua CS XVIII	2002-2007	Cost XT					60,150	58,052	
CCF Senegal CS XVIII	2002-2006	Cost XT					32,454	39,317	
CPI India CS XX	2004-2009	Cost XT	21,763	21,763	43,526	65,289	108,815	91,519	
CWI Bangladesh CS XX	2004-2009	Cost XT	18,875	18,875	37,751	56,627	94,378	225,102	
HAI Mozambique CS XVIII	2002-2007	Cost XT	115,000	19,400		58,200	192,600	600,000	
HOPE Guatemala CS XVII	2001-2005	Cost XT	32,863	34,008		95,433	162,304	171,959	
HOPE Uzbekistan CS XIX	2003-2007	Cost XT					36,716		
MCDI Madagascar CS XVIII	2002-2006	Cost XT						81,510	
MCDI South Africa CS XVII	2001-2005	Cost XT					29,829	78,829	
PLAN Nepal CS XVII	2001-2006	Cost XT					78,870	110,418	
SC Ethiopia CS XVII	2001-2006	Cost XT	6,100				25,800	31,700	
SC Guinea CS XVIII	2002-2006	Cost XT	17,080	17,080		51,242	85,402	106,753	

Table 13: Current CSHGP Project Beneficiaries (cont.)

PVO-Country-Cycle	Year	Type	Beneficiaries							
			Infants	Ch 12-23	Ch 0-23	Ch 24-59	Ch 0-59	Wm 15-49	TB Cases	
SC Tajikistan CS XVIII	2002-2007	Cost XT	7,500					36,000	60,000	
WRC Cambodia CS XVIII	2002-2007	Cost XT				20,344		20,344	46,128	
ACTS Georgia CS XX	2004-2009	Entry/New Partner	6,765	6,802	13,567	24,428		37,995	144,649	
ARC Albania CS XIX	2003-2008	Entry/New Partner	3,760	3,714		12,476		19,950	55,417	
CRWRC Bangladesh CS XX	2004-2009	Entry/New Partner			5,072			5,072	11,468	
GHA Haiti CS XX	2004-2009	Entry/New Partner	5,580					5,580	31,447	
IRC Rwanda CS XVII	2001-2005	Entry/New Partner						110,000	160,000	

Table 13: Current CSHGP Project Beneficiaries (cont.)

PVO-Country-Cycle	Year	Type	Infants	Beneficiaries						
				Ch 12-23	Ch 0-23	Ch 24-59	Ch 0-59	Wm 15-49	TB Cases	
ADRA Cambodia CS XVII	2001-2006	Standard	3,463	1,236	4,699	11,623	16,322	22,545		
ADRA Guinea CS XVI	2000-2005	Standard	2,709	3,387	6,096	8,128	14,224	55,530		
ADRA Madagascar CS XIX	2003-2007	Standard				72,335	72,335	90,735		
ADRA Nicaragua CS XVII	2001-2006	Standard	843	882	1,725	2,530	10,212	9,133		
Africare Senegal CS XIX	2003-2008	Standard			40,995		40,995	45,556		
AKF India CS XIX	2003-2008	Standard	1,611	1,678		1,778	5,067	20,685		
ARC Cambodia CS XX	2004-2008	Standard	6,362	6,238	12,600	17,966	30,566	48,521		
CARE Ethiopia CS XVIII	2002-2007	Standard	7,311	7,062	14,373	21,620	35,993	71,909		
CARE Mozambique CS XVII	2001-2006	Standard	9,900	9,450	19,350	28,649	47,999	60,087		
CARE Sierra Leone CS XIX	2003-2008	Standard	4,517	3,877	8,394	9,921	18,315	51,491		
CRS Cambodia CS XVII	2001-2006	Standard					19,368	36,491		
CRS Kenya CS XVIII	2002-2007	Standard					17,960	42,805		
Curamericas Bolivia CS XVIII	2002-2007	Standard	2,068	2,251		7,168	11,487	22,725		
Curamericas Guatemala CS XVIII	2002-2007	Standard	1,952	2,403	4,355	7,457	11,812	14,293		
CWI Rwanda CS XVII	2001-2006	Standard	6,998				34,839	33,469		
HAI East Timor CS XX	2004-2008	Standard	20,000				20,000	100,000		
HHF Haiti CS XX	2004-2009	Standard					25,755	37,776		
HKI Niger CS XX	2004-2009	Standard	15,494	14,835	30,329		30,329	79,068		

Table 13: Current CSHGP Project Beneficiaries (cont.)

PVO-Country-Cycle	Year	Type	Beneficiaries							
			Infants	Ch 12-23	Ch 0-23	Ch 24-59	Ch 0-59	Wm 15-49	TB Cases	
HOPE Haiti CS XVII	2001-2006	Standard	4,922					16,517	23,665	
HOPE Kyrgyzstan CS XVIII	2002-2006	Standard	4,853	5,794				30,000	53,618	
HOPE Nicaragua CS XVIII	2002-2007	Standard	8,101	8,149	16,250	43,781		60,031	70,827	
IEF Malawi CS XVIII	2002-2006	Standard						33,000	45,000	
IRC DR Congo CS XVIII	2002-2007	Standard			14,600	14,600		29,200	35,000	
IRC Sierra Leone CS XIX	2003-2008	Standard	3,500	3,300		9,500		16,300	21,200	
MC Azerbaijan CS XVII	2001-2006	Standard	2,597	2,597		7,761		12,955	38,535	
MC Tajikistan CS XX	2004-2008	Standard	3,814	8,632	12,446	16,340		28,786	50,787	
MCDI Benin CS XIX	2003-2007	Standard	13,242	13,242		39,724		66,208	74,918	
PCI Indonesia CS XIX	2003-2007	Standard						10,732	9,251	
PCI Zambia CS XVIII	2002-2007	Standard	5,193	5,193		15,580		25,966	28,561	
PLAN Kenya CS XX	2004-2009	Standard	9,270	9,270	18,540	27,814		46,354	64,381	

Table 13: Current CSHGP Project Beneficiaries (cont.)

PVO-Country-Cycle	Year	Type	Beneficiaries									
			Infants	Ch 0-23	Ch 24-59	Ch 0-59	Wm 15-49	TB Cases				
PSI Cameroon CS XVIII	2002-2005	Standard				641,800	855,733					
PSI India CS XVIII	2002-2005	Standard				5,546,749	6,400,095					
SAWSO South Africa CS XVIII	2002-2007	Standard				27,242	37,816					
SC Afghanistan CS XIX	2003-2008	Standard	24,840	17,610	81,750	124,200	155,800					
SC Vietnam CS XVIII	2002-2007	Standard	2,450	2,896	8,585	13,931	20,897					
WRC Rwanda CS XVII	2001-2006	Standard				24,021	34,066					
WV Kenya CS XVII	2001-2006	Standard				46,620	39,988					
DOW Romania CS XIX	2003-2006	Mentoring/TB										
MCDI South Africa CS XX	2004-2008	Standard/TB	16,400			16,400				9,000		
PATH Ukraine CS XIX	2003-2006	Standard/TB									11,660	
PCI Mexico CS XX	2004-2008	Standard/TB									1,190	

Appendix E: Poster Presented at the "Countdown to 2015" Conference. London, Dec. 2006



13 USAID-Supported NGO Projects Saved 10,000 Lives in 4 Years: Applying the Bellagio Study Group Methodology to Real Project Data

Jim Ricca, ORC Macro and Saul Morris, London School of Hygiene and Tropical Medicine

BACKGROUND

USAID's Child Survival and Health Grants Program (CSHGP) has supported US NGOs since 1985 to work on district-wide community-centered child survival projects. The current portfolio includes 71 maternal child health projects in 40 countries implemented by 36 NGOs in collaboration with local MOH and NGO partners. These projects presently reach over 23,000,000 beneficiaries (WRA and children U5) at the household level. Projects typically run 4-5 years with a median of 34,000 under five beneficiaries. The average annual USAID investment per project is \$200,000. The average annual NGO contribution per project is an additional \$67,000, giving a total average annual budget per project of \$267,000.

METHODS

The Bellagio Study Group methodology developed for the 2003 Lancet child survival and 2005 neonatal survival articles was used to estimate the number of lives of children under five saved during project periods. The needed information was abstracted from documentation for the thirteen projects that submitted their final reports in the last year: beneficiary data and baseline/final coverage levels for each of 15 Bellagio Group evidence-based child survival interventions. This information was supplemented with national level DHS data to estimate baseline numbers of births and child deaths in the project areas.

FINDINGS

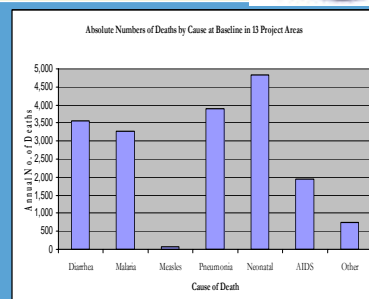
For \$12.6 million USAID investment (\$18.2 million total), these 13 projects are estimated to have saved 9,688 lives during their 3-5 year project periods (4.2y avg.). They are estimated to have reduced child mortality by an average of 13% (range 0.1 - 34%) at a cost of \$1,235 per life saved. Four projects achieved mortality reductions of more than 25%. Each of the top three projects is estimated to have saved over 1,000 lives; costing \$1.43, \$3.95, and \$4.84 per beneficiary; and \$217, \$486, and \$935 per life saved (USAID cost). Assuming comparable levels of mortality reduction, it is predicted that the current portfolio of 71 USAID-supported NGO maternal and child health projects will collectively prevent 77,000-100,000 child deaths during their 4-5 year project periods.

CONCLUSIONS

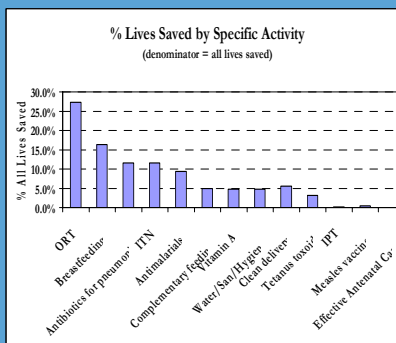
The Bellagio Study Group estimated the impact that would be achieved by scaling up about 30 neonatal/child survival interventions of known effectiveness. Applying this same methodology to 13 actual USAID-supported NGO projects that implemented 15 of these interventions we demonstrate that these NGOs achieved impressive impact at low cost when implementing these evidence-based interventions through integrated community-based delivery mechanisms.

POLICY IMPLICATIONS

Evidence is lacking on effectiveness and cost-effectiveness of delivery mechanisms to supply needed child survival interventions, especially at the community level. USAID-supported NGO projects may have some answers that are worth more in-depth analysis.



Summary of Increases in Coverage	Meas vacc.	Vit. A suppl.	Comp feed.	Abx pneum	Hand wash	Sanit.	Clean water	ORT use	ITN use	Anti-malar	IPT	TT x 2	Effect. ANC	Clean deliv	EBF
# projects implementing and with complete data	7	6	6	8	3	2	2	10	5	3	1	10	1	3	8
% projects successful at increasing coverage	86%	83%	50%	75%	100%	100%	100%	80%	60%	100%	100%	70%	100%	67%	100%
Avg. change in coverage among those successful	25%	34%	12%	32%	30%	18%	30%	30%	35%	23%	31%	43%	6%	30%	31%



Project	SUMMARY OF LIVES SAVED BY PROJECT		
	Life of Project (3-5 years) Predicted Lives Saved	% Predicted Mortality Reduction	USAID Cost per Life Saved
Cambodia 2	3,230	34%	\$217
Malawi	2,059	29%	\$486
Cameroon	1,069	21%	\$935
India	686	25%	\$1,439
Mozambique	601	5%	\$1,165
Cambodia 1	498	29%	\$2,008
Yemen	475	9%	\$2,105
Ethiopia	423	9%	\$2,364
Indonesia	237	9%	\$4,218
Bangladesh	163	8%	\$6,102
Ghana	136	4%	\$8,817
Philippines	92	16%	\$10,865
Zambia	19	0.1%	\$52,629
TOTALS	9,688	13%	\$1,235

The Lancet 2003 Child Survival Series

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