

# CONCERN worldwide

## Child Survival Programming in Concern Worldwide: Lessons Learned from Over a Decade of Work July 2010



Mothers and children in Concern's working area in Bangladesh. Source: Concern Worldwide

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## 1. BACKGROUND

### ***1.1 Review of Concern's Child Survival Health Grants Programs***

In 2007/2008 Concern's Child Survival (CS) advisor, in conjunction with field teams, reviewed Concern's Child Survival Health Grants Program (CSHGP) to elicit lessons learned in order to improve the quality of current and new Child Survival Programs. An internal advisory team was formed and multiple internal documents reviewed. A peer-based analysis and categorization of findings was used to consolidate the lessons and chart out key issues for the future. The document arising from this work has been summarized and updated here to include the additional lessons learned from the evaluation of the 10 year child survival program in Bangladesh, almost 10 years of programming in Rwanda, and the experiences of more recent programs in Burundi and Niger and a recent application from Malawi.<sup>1</sup> This document provides an overview of USAID's CSHGP, a summary of the review findings, and an outline of the key lessons learned. The original, more detailed document is also available at the same site on the intranet.

### ***1.2 Overview of USAID's Child Survival Program***

USAID has funded and supported CSHGPs<sup>2</sup> since 1985, with the purpose of contributing to sustained improvements in child survival and health outcomes by supporting the innovations of U.S. based, non-governmental organizations and their in-country partners in reaching vulnerable populations. The CS community is credited for making a significant contribution to the reduction of global child mortality during its first 25 years. The CSHGP targets evidence-based, low cost sustainable interventions aimed directly at the leading causes of childhood death. Programs are community centered with a focus on social/community mobilization, behavior change promotion, capacity building and breaking down access barriers to health services (through strategies such as community case management and awareness raising around appropriate health seeking). While referral care at hospitals is considered, Child Survival Programs (CSPs) largely involve front-line health centers and dispensaries as well as volunteer community health workers and the populations that they serve. Technical interventions that can be implemented include immunization, infant and young child feeding, vitamin A and micronutrients, prevention and treatment of malaria, pneumonia case management, control of diarrheal disease, maternal and newborn care, and HIV & AIDS. Many current CSPs are implemented under the Community-Integrated Management of Childhood Illness (C-IMCI) framework and thus include as many as five of the specified technical interventions.

In general, there is an annual call for applications to which an organization may submit one application, provided the organization will not have more than five CSPs if the grant is awarded. Each application is scored and only those over a certain predetermined score are considered for an award. Somewhat unique among grants, there is a long design phase as shown in figure 1

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<http://intranet/Programmes/Health/Maternal%20Child%20Health/Forms/AllItems.aspx?RootFolder=%2fProgrammes%2fHealth%2fMaternal%20Child%20Health%2fChild%20Survival%20Programs%2fLessons%20learned%20from%20over%20a%20Decade%20of%20Work&FolderCTID=&View=%7bDFF851BE%2d1828%2d4AE9%2d973A%2dC7ECE1F7180D%7d>

<sup>2</sup> [http://www.usaid.gov/our\\_work/global\\_health/home/Funding/cs\\_grants/cs\\_index.html](http://www.usaid.gov/our_work/global_health/home/Funding/cs_grants/cs_index.html)

which includes six months for baseline formative research and culminates in the submission of a Detailed Implementation Plan (DIP). Annual reporting is required in years one, two and four, and a detailed mid-term and final evaluation must be conducted by an external evaluator in years three and five respectively. CSHGPs are highly competitive, but once funded they are awarded for four or five years. The US dollar value of these grants varies from 1.5 million to 1.75 million over the grant period of four to five years. There is a matching fund requirement from the NGO for a minimum of 25% of the awarded funding amount. Funds are channeled under cooperative agreements that allow significant autonomy in decision making and flexibility in budgeting. Generally only one application is permitted per year per organization.

Information and technical support are provided to grantees through the CORE group<sup>3</sup> and the Maternal and Child Health Integrated Program Team (MCHIP)<sup>4</sup>. The program has developed many tools, such as survey instruments, to facilitate the monitoring and evaluation components. Technical and administrative support for the CSPs is provided from the Concern New York office.

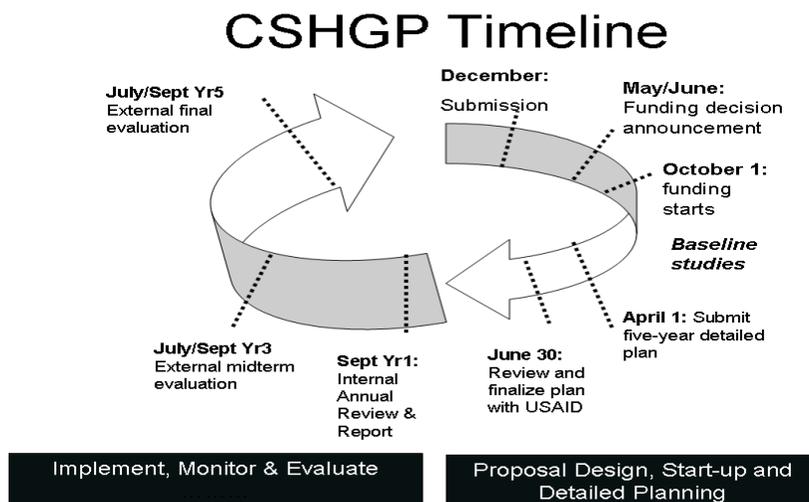


Figure 1: CSHGP Project Cycle Management\*

\*This diagram reflects the traditional CSHGP Timeline, but in recent years (since 2007) the cycle has been delayed with the Request for Applications (RFA) being issued as late as December or January.

### 1.3 Concern's Child Survival Programs

The CSHGP fits clearly with Concern's identity, vision, mission, and core values, as it focuses on the reduction of infant, child and maternal mortality (MDGs 4 &5), vulnerable populations, capacity building, community mobilization, and sustainability. Concern first applied for a child survival grant in 1996. While this application was unsuccessful, subsequently eight of nine applications have been successful (overall success rate 80%) (Table 1). The two unfunded applications were found to be particularly weak in partnering with other health actors on the

<sup>3</sup> <http://www.coregroup.org/> As Concern is a member of the CORE group all Concern staff have access to materials provided by CORE.

<sup>4</sup> <http://www.mchip.net/>

ground, program approaches, technical interventions and management. The total cost of our CSPs to date is over 20 million USD, with 65% of funds coming from USAID.

**Table 1: Concern’s Child Survival Application Timeline, Results and Budget (USD)**

Year	Country	Grant category	Score	USAID funding	Concern funding (budgeted)	Total funding
1996	Haiti	Entry	Not provided	n/a	n/a	n/a
1997	Bangladesh	Entry	Not provided	298,217	125,077	423,294
1999	Bangladesh	Standard	Not provided	1,330,109	335,531	1,665,640
2000	Rwanda	Standard	87/100	1,298,491	555,752	1,854,243
2001	Ethiopia	Standard	68/100	n/a	n/a	n/a
2003	Bangladesh	Extension	94/100	1,500,000	693,657	2,193,657
2004	Haiti	Standard	98/100	1,500,000	908,779	2,408,779
2005	Rwanda	Extension	92/100	4,000,000	1,705,416	5,705,416
2007	Burundi	Innovation	Not provided	1,600,000	1,200,000	2,800,000
2008	Niger	Innovation	Not provided	1,750,000	1,790,117	3,540,177
2010	Malawi	Innovation	Pending	n/a	n/a	n/a
<b>Total</b>				<b>13,276,817</b>	<b>7,314,329</b>	<b>20,591,206</b>

\* Malawi applied for a CSP grant in early 2010. It is anticipated that notification on the outcome of the grant will be received in June or July of 2010.

At the end of 2009 Concern had a portfolio of four CSPs serving approximately 1.1 million direct beneficiaries (children <5 years of age and women of reproductive age; Niger 156,000, Haiti 85,000, Burundi 95,000 and Rwanda 747,000). Bangladesh finished a 10 year program in 2009. Evaluations and subsequent replication phases of our CSPs have demonstrated that, at a very low cost, Concern has achieved significant improvements, not only in health outcomes and subsequent averted mortality, but also in terms of empowered communities, more capable local health systems, and better quality services.

## 2. REVIEW FINDINGS

Many achievements have been documented in externally led CSP evaluations.

- Programs have been effective in advocating for changes in national **policy** and guidelines affecting service delivery (e.g. community treatment of malaria, pneumonia, and diarrhea in Rwanda);
- Evaluations of our two replication phases (in Bangladesh and Rwanda) have shown that approaches developed in limited geographic areas can be rolled out at **scale** increasing the reach of our programs.
- Programs have demonstrated dramatic increases (more than doubling in many cases) in women’s and children’s **access** to health information and services.
- New ways of measuring **equity** were developed to objectively assess and demonstrate the ability of Concerns CSP to reach the poorest and most vulnerable groups.
- The **sustainability** assessment of the first five years of the CSP in Bangladesh found that with no further inputs by Concern, basic operations and health indicators were

maintained. However, critical gaps were identified in some areas (e.g. human resources and management).

Arguably, CSPs are one of the lowest-cost, highest-impact approaches to achieving MDG 4. The average annual cost per woman of reproductive age and child under-five is \$2.63 across Concern’s four current programs. Using the Bellagio Lives Saved Calculator, we can estimate the number of under-five year old child lives saved, and cost per life saved, as a result of the coverage gained by our interventions (Table 2). These calculations demonstrate that while the initial cost per life saved is high, once the program is scaled up during the replication phase, the cost-effectiveness improves dramatically (e.g. Rwanda and Bangladesh). Programs implemented in countries with lower mortality rates (e.g. Bangladesh) tend to cost more per life saved. In addition, our interventions reduce morbidity and have wider social effects, such as increased community capacity and confidence. However, even though the cost per life saved is relatively low, particularly in programs that have scaled up, few developing countries could afford the costs without external assistance.

**Table 2: Child lives saved and costs (USD) by project, Concern Worldwide 2000-2010**

Project	Period	Number of lives saved	Cost per life saved
Bangladesh I:	2000-04	334	\$3600
Bangladesh II:	2004-09	1,155*	\$1732*
Rwanda I:	2001-06	747	\$2482
Rwanda II:	2006-11	14,311*	\$478*
Haiti	2005-10	719*	\$3350*
Burundi	2008-2012	not yet calculated	not yet calculated
Niger	2009-2013	not yet calculated	not yet calculated
<b>Total</b>	<b>2000-2010</b>	<b>17,266**</b>	<b>Avg. \$2,328</b>

*\*numbers and costs estimated based on presumption of reaching target levels on health indicators and expenditures in line with funded budget.*

*\*\*numbers exclude Niger & Burundi Projects*



Mother and Child in Chittagong, Bangladesh. Source: Concern Worldwide

### 3. LESSONS LEARNED

Fifteen lessons learned are presented across three areas: Program Design, Approaches, and Monitoring & Evaluation. Challenges encountered are discussed briefly throughout.

#### **3.1 PROGRAM DESIGN**

CSHGP are about getting proven interventions to the people who need them most, while providing the technical support needed to encourage innovation. Rather than delivering interventions ourselves, we assess the context, analyze the stakeholders, and develop a partnership model where we organize a multitude of diverse actors to make a health system work with the communities. Concern operates as a catalyst, opposed to the exclusive implementer or change agent. It can be argued that CSPs are 10% technical and 90% management, given the multitude of operational issues that project teams face trying to realize implementation plans. A significant amount of time is dedicated to program design, baseline research and establishing a detailed workplan. Even before the application stage, countries that are considering a CSP require extensive pre-planning and forward thinking. Factors to consider include the level of government support, human resource issues, needs of the beneficiaries, security issues, and how a CSP fits in with the overall Concern country strategic plan.

*“The participation of government counterparts in surveys can enable transformative change as local decision makers and policy influencers see firsthand the issues on the ground and believe it.”*

#### **Lesson Learned 1: Ownership and engagement by all partners**

Despite challenge in complexity of information and issues, it is essential for the Global Health Advisor, country office and staff, Government and other partners to take full ownership of project design decisions collectively from the very beginning. This collective ownership can be encouraged through the following practices:

- Include national and local Government from the start.
- Use stakeholder workshops to analyze findings (e.g. using a participatory work group style).
- Use team building, consultations and reflection workshops for staff who may be employed after the initial design phase.
- Explain and disseminate the key concepts and documents to relevant health and local authorities.
- Negotiate clear primary roles and responsibilities of each party.
- Development concise MoUs and revisit the agreement on a regular basis with senior management.
- Ensure that project workplan is also included in National or District MOH work plans.
- Build informal relationships i.e. friendships.
- Hold regular review sessions for refreshers and discussions. As the concept is quite new (no infrastructure, no transfers of cash) it does take time for others to see the value of the capacity building approach.

*“Demystify Child Survival Programs for the rest of your staff – lots of acronyms and large documents that mean staff feel a little intimidated or just switch off. All staff, including support staff, need to be on board.”*

### **Lesson Learned 2: Realistic and flexible funding**

Historically, Concern has contributed 30% additional funding to the total cost of its CSPs, exceeding the minimum 25% match requirement to USAID funds. Our higher costs are not necessarily a reflection of inefficiency, but rather the larger scale of our programs and the willingness of the organization to bring additional resources to bear, mitigating major input gaps that could limit project effectiveness (e.g. procurement of mosquito nets, vehicles, sanitation hardware, and capacity building of MOH staff). It cannot be assumed that the USAID grant amount and minimum 25% match requirement is always adequate, so it is essential to be realistic about the funding it will take to implement project interventions in a specific country context for success and sustainability.

Inevitably, empowering healthcare providers and communities in a participatory way raises expectations, and requests may be made that are beyond the scope of the CSP. Some flexibility, within well-set limits and procedures, allows the organization to address urgent needs and requests that have not been planned into the project. This can be done by:

- Clustering with other Concern and partner programs;
- Increasing Concern matching funds to meet unexpected needs, while keeping in mind that project interventions must remain focused enough to keep the overall project manageable.

### **Lesson Learned 3: Ensure quality programming**

Ensure quality programming through:

- Keeping the design simple with fewer technical strategies, rather than the full package of CS interventions.
- Designing the program based on solid and participatory formative research, and identifying the gaps between what the desired health practices are, compared to people’s realities.
- Focusing on strategies that promote access to health services and that challenge social norms has been most successful in achieving behavioral change. The BEHAVE framework has been particularly useful in all projects to help local teams address determinants of behavioral change rather than default health education.

### **Lesson Learned 4: Child Survival Technical Support**

CSPs are somewhat unique in that an advisor and health programme officer are based in Concern’s New York office and are dedicated only to supporting the CSPs. Strong and consistent technical and grant management support both motivates the implementing team and improves the quality and documentation of the program. An absence of a strong Technical Advisor has been shown to diminish program quality, specifically in report writing and development of

implementation strategies specific to CS. This position also serves as a vital link between the global child survival community to share promising practices emerging from Concern's projects, but also transfers external evidence, tools and experiences back to the organization.

Communication and support to and from the field and Dublin office can be enhanced by:

- Frequent field visits for regular face-to-face contact.
- A good flow of communications with finance regional directors and desk officers.
- Share learning and dissemination of experience.
- Good documentation of project results and challenges.

### **Lesson Learned 5: External facilitator**

An external facilitator/consultant is recommended to help to write the initial application and occasionally the DIP if warranted. USAID has very specific requirements as to how the application is written, thus using someone (e.g. a consultant) with a track record in successful CS applications is recommended. They also bring the best global and organizational practices into the design from the beginning and ensure that the focus fulfils the core CSHGP tenants. It is important that a field anticipates the costs involved in this process, as the application costs are borne by Concern. Some problems have been encountered when staff, inexperienced with the USAID style, technical requirements, and the details of the CSHGP, has written documents for USAID. It is essential, however, that the writing process is done in close collaboration with the Concern program team, otherwise ownership of the program becomes an issue, which has been experienced in the past.

### **Lesson Learned 6: Demands for incentives**

Government staff and other partners may have experience in receiving various incentives (e.g. per diems) to participate in trainings or take on certain roles and responsibilities (e.g. salary top-ups). This has led to demands on Concern to provide the same incentives. Strategies to deal with this have included:

- Careful consideration of these factors during the design phase.
- Being mindful of expectations given the shortage of public personnel.
- Negotiating an agreed policy that everyone sticks to and that is revisited as necessary.
- Regular reviews and supportive senior country management.

*“Initially hard to promote partnership without any financial involvement ... pressure for hardware and cash by partners.”*



Bukora Health Center Rwanda. Source: Concern Worldwide

### **3.2. APPROACH**

Our approach is facilitative, empowering to both civil society and local government, and builds on existing resources, policies, guidelines, and social capital. Our programs are designed to function without continuous input from Concern. Ultimately, the goal is for communities to act with autonomy, assuming responsibility for their health such as adopting behaviors which will lead to long lasting, sustainable outcomes. Achieving this requires attention to national partnerships, minimizing direct involvement in implementation, and sharing decision-making. Sustainability requires strong buy-in from the government at the beginning and throughout the program. The program also needs to consider how changing factors in the external environment affect results, and that improvements in health are unlikely to be attributed to CSP investment alone.

#### **Lesson Learned 7: Successful capacity building requires a major effort**

Although working fully within government structures and catalyzing social change has been very successful (e.g. Bangladesh), it has required major effort from Concern staff. The following strategies have helped to achieve successful programs:

- Plan sustainability from the start by using the CS Sustainability Assessment Framework.
- Regularly cross-check Concern's role to ensure that we are working as a catalyst and not as a replacement for ongoing service delivery.
- Be diplomatic and patient, as dealing with the complexity of the socio-political mobilization approach can be time consuming and frustrating.
- Remain apolitical.
- Work to build up partnership, trust and mutually beneficial relationships between health providers and community members, as this relationship is not always a natural fit.
- Although demanding, both in terms of time and management, detailed consultation with other stakeholders helps to leverage resources, ensure collaboration and avoid duplication.

*“Given the more fragile social fabric in the poor urban neighborhood we work with in Port-au-Prince, it is absolutely key to work with local organizations to access the population in an efficient way.”*

### **Lesson Learned 8: Identify vulnerable populations**

Even when a program achieves high coverage, there remains a small segment of the population that is at a higher risk of mortality, illness and poverty. Work with local partners to rigorously identify the most vulnerable (socially and economically) populations and develop feasible social protection mechanisms and strategies to enhance their access to project interventions (e.g. Ward Health Committees in Bangladesh and insurance exemptions in Rwanda for the extreme poor).

### **Lesson Learned 9. Motivating volunteers is achievable.**

Many CSP activities are performed by voluntary community based health actors, particularly around behavior change communication (BCC). BCC is a mechanism to create long last change- and it can be highly effective given that once a behavior (i.e. hand washing or breastfeeding) is changed, it is sustainable in that it doesn't require continual input and the learned behavior can be passed on. In the urban context, working with youth volunteers has been particularly successful, when they have some free time in the evenings and weekends and they receive social access that they would not normally gain otherwise. In some areas, where payment of community health promoters has become the norm by organizations other than Concern (e.g. in Haiti), successful community-based volunteers programs are more difficult. Supportive leadership and regular supervision from the community and the health system are critical to motivating and retaining volunteers. Workloads must be kept realistic and frequent refresher training, conducted by local trainers (trained by Concern's Training of Trainers approach), is necessary. It is best if volunteers can be assigned a particular zone or area near to their home to reduce the amount of time devoted to outreach activities while maximizing their efforts. Furthermore, providing small incentives such as t-shirts and identification badges has proven to not only motivate volunteers but distinguish them within their communities. The ability to rehabilitate sick and malnourished children has proven to be one of the most motivating factors for satisfied volunteers.

Community volunteers have proven to be a vital link during an emergency. In the case of Haiti, volunteers were the first responders with intimate knowledge of their community following the tragic earthquake which claimed hundreds of thousands of lives. They were able to actively assist Concern throughout the various phases of the emergency response, including assisting with registering families, distributions, referrals and delivering key health and hygiene messages.

### **Lesson Learned 10: Capacity building approach requires different staff skills**

The capacity building approach requires skills beyond the realms of traditional health programming skill sets. This approach has proved challenging to our staff, who now require skills in advocacy, social change, facilitation, research, and data interpretation. We have had some success building up these skills through in-house training, exposure/exchange visits and supporting staff to complete public health course work, but it remains a challenging area,

particularly as many programs experience a high turnover of staff (often when they begin to show promise). We have found that the CSP itself affords a living classroom to staff curious enough to gain experiential learning. Outsourcing of some functions such as quality assurance and M&E strengthening has been mixed; it proves good for rolling things out quickly, but poor in terms of integration into the project team's thinking and operations. We should consider evaluating the benefits of exposure visits between different fields.

*“Exploring the learning and comparing it with other municipalities played a vital role in understanding the context by the politicians in Bangladesh.”*

### **3.3. MONITORING AND EVALUATION**

At the heart of all CSPs is a well documented baseline situation report, internal annual progress reports, midterm and final evaluations. Combined, these components provide evidence of the effectiveness of our programming and have enabled replication.

#### **Lesson Learned 11. Use project monitoring and evaluation plans from the beginning**

The use of streamlined and focused project monitoring and evaluation plans from the start of the program that cover all levels of the log frame or strategic framework ensures effectiveness of our programming. However, in reality there have been big gaps in the ability of our staff and counterparts to fully operationalize these plans, due to limited skills in some key competencies. The program emphasizes identifying a focal point for M&E within the project staff and a MoH counterpart. However, often this role falls on the manager, who may be the only one that has the competency to ensure quality of the monitoring and evaluation system.

#### **Lessons Learned 12: Reporting**

Child Survival Reporting is very specific and always involves a participatory approach. In the absence of a technical backstop, reports tend to be of lower quality and difficult to produce. Recent experience has shown that the quality of reports improve with greater field-level involvement and support. Annual reports should not be generated from headquarters level, but should be generated from the field, during an annual review workshop that reflects on the achievements and challenges of the past year and serves as a planning forum for the coming year. It is also very important that all reports are generated early, and given wide distribution within the agency for comments and clarification, to avoid last-minute, poor quality submissions.

#### **Lesson Learned 13. Engage, Review, Adjust**

Child Survival documents are not set in stone, and preparation of annual plans allows engagement, review, and adjustment. Regular, participatory analysis and workplan modifications empower program implementers and maximize project success.

*“We found the DIP was seen as a stone tablet and thus inflexible. Get the clear message across that the DIP is a five year plan BUT that modifications are done in the subsequent annual plans.”*

*So much counts on the quality of the annual review process and the development of the next year's work plan."*

#### **Lesson Learned 14: Externally-led Evaluations have helped us grow**

Participatory, externally-led evaluations have helped us to grow. CSPs require an external evaluator at the midterm and final evaluations, who holds considerable autonomy in terms of conclusions and recommendations. In order for him/her to be effective, local stakeholders need to be active and participatory members of the evaluation team. A national co-evaluator can ensure that the review is relevant to the national situation and audience. Project staff should not fear evaluations, but see them as a great opportunity to seriously review what's working and what's not, and to propose substantial changes.

Consultants are often unable to assess the supporting management system issues adequately, as many have not managed field programs recently and evaluation periods tend to be short due to costs. We have found that having the country office teams complete an internal review of the management section of the guidelines works fairly well.

#### **Lesson Learned 15: Influence on Country Office Programming**

The presence of a CSHGP in a country program has had a positive influence on the overall country programming. Staff gains included capacity, built with new technical tools and skills particularly in monitoring and evaluation, as well as behavior change strategic design. This has been particularly true for other health project staff. We have had only limited success in bringing the learning from CSPs to health programs in other countries, and this is an area to improve.



Mother & Child in Haiti. Source: Concern Worldwide

## **4. CONCLUSION**

Overall, Concern's CSPs have been highly successful at impact, replication and sustainability levels. Despite our successes and what we have learned, there are critical challenges and shortcomings that require organization consideration and influence decisions about programming recommendations from the CS program experience. These include perceived complexity, tight

timeframes to achieve ambitious target and results within a within a five-year program, human resources, technical support from an affiliate office, and limitations of our national and global contribution.

Our scale-up approach has predominantly been about branching-out (e.g. expanding to more geographic areas) rather than transformation/integration into national systems. We have not been able to effectively manage a national roll-out of successful approaches. We need therefore to consider why our programmes have little domestic traction to date; are the lessons we learn relevant for national implementation, and have government plans been given sufficient prominence? We need to strengthen our ability to convene and catalyze a diversity of quality actors in addition to government, and develop our own management capacity for partnerships, logistics and staffing. We also need to do better holistic contextual analysis and application of a broader livelihoods approach to meet the real underlying causes of poor health in target communities. Concern has yet to develop experience in applying the CS model in lower-capacity, emergency settings, although with the program just getting underway in Niger, there will be several lessons to learn. What is clear is that our current model requires some type of health infrastructure with which to integrate. It may be necessary in some contexts to invest in human resources and infrastructure, which often falls outside the CSHGP mandate.

Within Concern we must continue to learn from our experiences implementing CSPs, and work to apply this learning in other programs, particularly the strong monitoring and evaluation framework associated with CSPs. A new feature of the more recent CSPs is the requirement to have an innovations and operational research component, which is intended to increase the emphasis on innovations within the CSHGP portfolio. It will be important that we apply any learning from this research, and integrate cross organizational learning from other programs such as Innovations for Maternal, Newborn and Child Health (iMNCH), to other Concern programs.

We must endeavor to ensure that the impacts from the programs are sustainable. The Bangladesh 5 years sustainability assessment had several positives, but did demonstrate that some activities were not sustained, leading to a plateau in health outcomes. Commitment to funding by governments will help sustainability. Concern should continue to use various platforms to encourage African countries to meet their commitments under the 2001 Abuja Declaration to allocate at least 15% of national budgets to health every year.



Children in Haiti. Source: Concern Worldwide