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CHILD SURVIVAL AND HEALTH GRANTS PROGRAM: Pearls of learning from 8 recent Final Evaluations

Eight U.S. Agency for International Development (USAID) International Non-Governmental Organization (iNGO) partners through the CSHGP recently submitted final project evaluations. These partners include: Center for Human Services (CHS), ChildFund International, Aga Khan Foundation (AKF), HealthRight International, Concern Worldwide, Curamericas, Medical Teams International (MTI), and CARE. These evaluations draw on a broad range of quantitative and qualitative project data (including monitoring and evaluation systems, with baseline and endline surveys; ongoing process documentation; operations research; and mid-term evaluations) to generate learning and recommendations for governments, local civil society, other in-country stakeholders, iNGOs, and USAID. The evaluations can be found at individual links provided below or at the following link: [CSHGP Final Evaluations](#).

CENTER FOR HUMAN SERVICES, ECUADOR (2009-2013)

Nancy Sloan, Evaluator

Evidence for a network of care model produced by Center for Human Services influenced a decision by the Ministry of Health (MOH) for national expansion in Ecuador.

The evidence generated by the Center for Human Services for its innovative “Essential Obstetric and Neonatal Care” (EONC) network model influenced a decision by the MOH for country-wide expansion, including a dedicated budget and staffing. Inequities in health persist in Ecuador with significant disadvantage among rural, less educated and Indigenous groups who primarily receive maternal and newborn health care from traditional birth attendants, traditional healers and family members. In this context, the EONC network model coordinated community- and facility-based services (both public and private) to promote service delivery along the continuum of care, and facilitated quality improvement by supporting parish health teams (including TBAs and facility providers) as well as district and provincial hospitals quality improvement teams to monitor and improve the quality of care, including cultural appropriateness. This

network led to improved behaviors for improving maternal and newborn health (including exclusive breastfeeding and recognition of postpartum and newborn danger signs, and increased postpartum visits within 2 days of birth), and improved quality of care. In the final months of the project, CHS provided technical support to the MOH and updated maternal, newborn and child health (MNCH) quality standards, created a tool for quality management, and created an EONC toolbox with more than 60 tools (now being distributed nationwide). Project staff that provided this support are now employees of the MOH. The project was also recently highlighted in Spain’s main newspaper, El Pais – for this Spanish language article and pictures please see the following link: [El Pais article on CHS Ecuador](#). The final evaluation (including the operations research report) is available at the following link: [CHS Ecuador Final Evaluation](#)



A pregnant woman is transported in a “chacana” by the rural doctor and her neighbors, Photo by Mario Chavez, CHS Ecuador

CHILDFUND INTERNATIONAL, HONDURAS (2009-2013)

Ramiro Llanque Torrez, Evaluator

Achieving greater health equity for women and children in Francisco Morazan Sur, Honduras.

Honduras is poised to improve its national health system and maternal and child outcomes by 2015; however, despite a clear intention by the Government of Honduras to include communities, equitable coverage of health services has not been achieved. To respond to this need ChildFund set up UCOS, a unique community based model, to improve health equity among rural, low-income beneficiaries in remote communities. As a result of project activities, child mortality in high burden communities decreased from 33 per 1,000 live births in 2009 to 27 per 1,000 live births in 2012. Ninety-four percent of those who benefited from the UCOS were in the lowest socio-economic quintiles, and yet by the end of the project these communities enjoyed higher child survival rates than that of the department or national level. The UCOS, or health post, is staffed by an array of community volunteers including trained traditional birth attendants, growth promotion monitors, and community

health volunteers. ChildFund is now in the process of expanding the model to 25 additional communities in the Department of Santa Barbara as it offers a low-cost, policy-responsive service delivery model that meets the needs of high burden populations. Results of a costing study conducted on the UCOS found that when families found solutions to a child health problem at the community level UCOS, they saved from USD \$6.03 to USD \$70.24 (as opposed to visiting a rural health post or hospital, respectively). Similarly, the costing study found that resources could be “saved” by the government as a result of strengthening medical attention at the community level - from USD \$6.07 at a rural health post to USD \$33.13 at a hospital (per visit averted). The draft of the final evaluation (including the operations research report and costing study report) is available at the following link: [ChildFund Honduras Final Evaluation](#)



Project and field staff at Hatillo UCOS.

Photo by ChildFund

AGA KHAN FOUNDATION, PAKISTAN (2008-2013) Sohail Amjad, Evaluator

In collaboration with the Aga Khan Development Network (AKDN) agencies and the Khyber Pakhtunkhwa (KPK) provincial and Chitral district governments, the Aga Khan Foundation (AKF) developed a public-private model to increase access to and demand for skilled care at the community level.

Global “progress has been much slower, and inequities in coverage much wider, for skilled attendant at birth and other interventions that require a strong health system. New approaches are needed that improve the quality of services, bring services closer to home and expand access to essential care.”¹ While Pakistan has had reductions in maternal mortality and increased the skilled birth attendance (SBA) indicator to 40%, progress has been slow and is not on track to meet MDGs 4 and 5. Approximately 30,000 women continue to die annually of pregnancy and childbirth related causes in the KPK province, and 85% of deliveries take place at home. In the high altitude and geographically remote Chitral district of KPK province, AKF, in collaboration with the AKDN agencies and the Ministry of Health, responded to the call to prevent maternal deaths and improved skilled attendance at birth from 33% to 82% and skilled care across a continuum of care² from 1% to 23% in areas of greatest need within a 5 year period. An innovative intervention package included improved training and deployment of community midwives, referral mechanisms, behavior change interventions including male involvement, and community engagement and empowerment through village health committees (VHCs) and community savings schemes. Through training and an additional facility-based practicum, the project built CMW skills and confidence and bolstered relationships between community and facility health providers.

The project fostered CMW linkages with community members and other community health workers through VHCs, and assured service quality by establishing a supportive supervision system. Community Based Savings Groups (CBSG) were introduced and were found to hold promise for increasing utilization of skilled care, as women who were associated with CBSGs were four times more likely to access skilled care across a continuum of care. Referral mechanisms were strengthened as an outcome of connections fostered among community health workers and between community and facility level providers – women were both referred to the CMW by other community health workers and referred on time to secondary facilities (supported in some cases by the VHC for transport). A significant recommendation from the evaluation to the provincial government is to utilize the project model to strengthen the community health workforce, in particular CMWs, and to extend AKF’s technical assistance to the government to adequately support and monitor the CMWs after the project ends. Deployment of CMWs is currently the only strategy to promote skilled deliveries in rural Pakistan, and thus the evaluation recommends that the government also allocate sufficient funds to monitor CMWs and develop effective mechanisms to provide supervision. At a recent dissemination event, representatives from the KPK department of health committed to retaining the 28 CMWs deployed by the project. The draft evaluation includes two operations research study reports, one focusing on the utilization and retention of CMWs and the other funded by DFID and AUSAID’s Research and Advocacy Fund in KPK on the role of CBSGs in increasing utilization. The draft evaluation is available at the following link: [Aga Khan Foundation Pakistan Final Evaluation](#)



Photo by AKF Pakistan

¹ <http://www.countdown2015mnch.org/countdown-highlights>
² A minimum of one antenatal care (ANC) visits, skilled attendance at birth, and at least 1 postnatal care (PNC) visit within 2 days of delivery.

HEALTH RIGHT INTERNATIONAL, NEPAL (2009-2013)

Chitra Gurung, Evaluator

In Nepal, HealthRight improved the continuum of care through a new, integrated model of maternal and newborn care in facilities and communities.

HealthRight implemented the community based newborn care package in Arghakhanchi and Kapilvastu districts of Nepal, which contributed to improved knowledge and behaviors, such as an increase in immediate drying and wrapping of newborns in each district from 63% to 79% and 33% to 72% respectively, and an increase in four or more antenatal care visits in each district from 36% to 71% and 29% to 51% respectively. HealthRight also introduced and conducted operations research on a Maternal and Newborn Care Quality Improvement (MNC-QI) process in facilities. The targeted facilities showed improvements in quality indicators with an aggregate score of 80% or higher on the 12 MNC-QI tools implemented by the end of the project (nine tools on improving maternal newborn service delivery and three on improving skilled birth attendance training sites). The USAID

Nepal Health for Life bilateral project will adapt HealthRight's Quality Improvement model in modified version to support the Nepal Department of Health Services to institutionalize a nationwide system for quality improvement. HealthRight also built the capacity of Health Facility Management Committees, working with Village Development Committees (VDCs) to appropriately oversee and allocate local resources (human resources and cash), leading to improved health facility performance. The Health Facility Management Committee strengthening program has been scaled up by the District Health Office to additional VDCs in one of the project districts and by USAID Nepal's bilateral Health for Life in additional districts (14). The final evaluation (including the operations research report) is available at the following link: [HealthRight Nepal Final Evaluation](#)



Focus group discussion with FCHVs in Khilji VDC, Arghakhanchi. Photo by HealthRight.

CONCERN WORLDWIDE, BURUNDI (2008-2013)

Bonnie Kittle, Evaluator

In Burundi, Concern Worldwide effectively extended the reach of the health system's Community Health Workers (CHWs)

Concern Worldwide integrated a Care Group approach of women volunteers to extend the reach of CHWs and to achieve improvements in key child health and nutrition behaviors. This research is very relevant to the global health community because the traditional Care Group approach (facilitated by iNGOs) has been proven to be effective in reducing child malnutrition rates, and is currently being employed as a behavior change strategy in more than 20 countries. The OR study tested whether an integrated Care Group model, organized through the the health system and led by MOH-supported CHWs, was as effective as the traditional (iNGO-facilitated) Care Group model when comparing 40 key child health and nutrition knowledge and practice indicators. For example, in both intervention groups,

mothers' knowledge of when to begin complementary feeding showed significant increases from baseline to endline (from 75% to 90% in the integrated Care Group model and from 69% to 86% in the traditional Care Group model). This suggests that the MOH-supported CHW in the integrated Care Group model were just as effective in training and supervising their Care Groups as compared to the iNGO-paid Promoters in the traditional Care Group model. Further discussions are underway with the Department of Community Health to consider integrating Care Groups into the health system more widely. The final evaluation (including the operations research report) is available at the following link:

[Concern Worldwide Burundi Final Evaluation](#)



A Care Group Volunteer conducts a home visit. Photo by Adele Fox, Concern Worldwide.

CURAMERICAS, LIBERIA (2008-2013)

Jean Capps, Evaluator

Community generated and owned data combined with mobile rural health teams supported by Curamericas Global significantly improved immunization coverage in rural Liberia

In rural Nimba County Liberia, Curamericas Global implemented an approach built on their innovative Census-Based Impact Oriented (CBIO) methodology, mobile Primary Health Care Teams, and targeted behavior change communication (BCC) based on initial barrier analysis and implemented using the Care Group model. Curamericas mobilized the community using the CBIO methodology by conducting a participatory data collection and monitoring process to allow tracking of service use (or lack of use) over time utilizing community registers, while the mobile health team approach brought

services directly to the community along with targeted BCC. These combined approaches resulted in improvements in multiple health behavior and coverage indicators, for example, vaccination coverage – by the end of the project, household survey results found significant improvements indicating that 97% of children (12-23 months) had received measles and PENTA 3 vaccinations. This model and associated results will be shared by key in-country partners with the county health team. The final evaluation is available at the following link: [Curamericas Liberia Final Evaluation](#)



*Project staff conducting focus group discussion with Trained Traditional Midwives.
Photo by Jean Capps.*

MEDICAL TEAMS INTERNATIONAL, UGANDA (2009-2013)

Sue Leonard, Evaluator

Medical Teams International Uganda achieved improved health practices and quality of care by strengthening the relationship between community systems and the district health system.

MTI built the capacity of community health systems structures (Village Health Teams, mother's groups, Parish Development Committees, Health Unit Management Committees, and health facilities) to collaborate to promote key family health and child development practices, referrals, and community case management. Household and community level practices improved significantly as did health provider quality of care indicators. Maternal and child health service delivery and management at the health facility and health promotion at community levels also

dramatically improved. Survey findings indicate more women are delivering with skilled attendants (from 35% at baseline to 84% at endline) and women with 4 or more antenatal care visits has also increased (from 35% to 58%), reinforcing comments in the focus groups about the improved attitudes of health providers. District and local government structures are assuming responsibility for continuing the interventions. The final evaluation is available at the following link:

[Medical Teams International Uganda Final Evaluation](#)



*ECD Peer Educator Tonny Anyang of Apua Parish teaches a mother about baby cues.
Photo by MTI.*

CARE, INDIA (2008-2013)

Ambarish Dutta, Evaluator

Improved linkages between private providers, community volunteers, TB and HIV programs, and local self-government systems supported the national tuberculosis control program to improve TB testing, treatment, and patient support.

Gaps in the national tuberculosis control program (RNTCP) in West Bengal included low case detection, barriers to accessing to facility Directly Observed Treatment (DOTS) (including distance, migration of patients), weak coordination between TB and HIV programs, and general lack of awareness of TB. In order to bridge these gaps, CARE employed the following major strategies: 1) engagement of rural health practitioners (private providers) to ensure early referral of TB suspects to RNTCP; 2) involvement of community volunteers for identification of suspects and provision of DOTS; 3) creating linkages between local self-government systems (PRI) for access to social welfare schemes and 4) encouraging coordination between TB-HIV programs through sensitization of both sets of staff . Referral of patients from private providers had previously been a contentious issue

- this is perhaps the first time in West Bengal that this resistance was overcome and these referred TB suspects were directly tested with sputum microscopy by the RNTCP thus creating an opportunity in future for more referrals from other providers outside the government system. The community volunteers played an important role to intensify the treatment compliance of the retreatment patients - the default rate for re-treatment patients in one project area has dropped to zero in the last few project quarters due to intensified support. District-level policy-issuing bodies for PRIs in a few districts have designed a standard framework for support to the TB patients. Finally, the project also raised counselling and testing of TB patients for HIV in some districts to 70%. The final evaluation is available at the following link: [CARE India Final Evaluation](#)



*PRI Pradhan giving food to TB patient.
Photo by Soumen Pandey.*