USAID/PVC Matching Grant Evaluation Series:

Partnership and Livelihood Security

Matching Grant No. FAO-0158-A-00-6051-00 between

CARE USA and USAID/PVC

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FINAL REPORT

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ACRONYMS

AOP	Annual Operating Plan
API	Annual Project Information
BHR	Bureau of Humanitarian Relief
CA	Cooperative Agreement
CBO	Community-based Organization
CO	Country Office
DFID	Department for International Development
DIP	Detailed Implementation Plan
DME	Design, Monitoring and Evaluation
EA/ME	East Africa/Middle East
FFP	Food for Peace
FY	Fiscal Year
HLS	Household Livelihood Security
HQ	Headquarters
IEI	Impact Evaluation Initiative
ISA	Institutional Support Assistance
LRSP	Long Range Strategic Plan
M&E	Monitoring and evaluation
MER	Monitoring, Evaluation and Reporting
MG	Matching Grant
MOU	Memorandum of Understanding
NGO	Non-governmental organization
PACD	Project Activity Completion Date
PHLS	Partnership and Household Livelihood Security
PIMES	Program Impact Monitoring and Evaluation System
PL-480	Public Law 480
PVC	Private Voluntary Cooperation
PVO	Private Voluntary Organization (usually U.S.)
RBA	Results-based Approaches
UN	United Nations
USAID	United States Agency for International Development

EVALUATION IDENTIFICATION SHEET

PVO name	CARE USA
Matching Grant Title	Partnership and Household Livelihood Security
Cooperative agreement number	FAO-0158-A-00-6051-00
Amount of Grant	$3.8 million
Period of Grant	October 1, 1996 through September 30, 2001
Any (cost/no cost) extensions?	Yes – two-year extension from October 1, 1999 through September 30, 2001
Current status of MG	Completed
USAID/PVC Grant Officer (s)	Martin Hewitt
Technical area of grant	Institutional strengthening
Date of the evaluation	December 2001
Countries of program activity	Peru, Bolivia, Mali, Tanzania
Country programs evaluated	Peru and Tanzania
Evaluation Team Members (organization)	CARE and MSI

1.0 EXECUTIVE SUMMARY

1.1 Overview

USAID/BHR/PVC awarded a $2,400,000 Matching Grant (MG) to CARE/USA for the three-year period from October 1, 1996 to September 30, 1999. As recommended in a February 1999 "final" evaluation report, the grant was subsequently extended for an additional two years, to September 30, 2001, with a total budget of $3,800,000, to be matched by CARE. MSI was contracted by PVC to conduct this summative evaluation, which was carried out between late September and early December 2001 by a team comprised of two MSI specialists and one CARE representative. Team members reviewed relevant documents and interviewed key informants at CARE headquarters in Atlanta and in Peru, as well as interested USAID officials and representatives of partner organizations.

This grant supported CARE's *Partnership and Household Livelihood Security (PHLS)* program which, broadly defined, sought to institutionalize within CARE the concepts and methodologies of three major programming initiatives: i) Partnership; ii) the Household Livelihood Security (HLS) framework; and iii) Design, Monitoring and Evaluation (DME). As stated in the February 1999 evaluation report: "The PHLS cooperative agreement was structured to be a *capacity building project* (a primary focus of the PVC Matching Grant Program), rather than a direct *impact* project." The models developed in the four pilot countries selected were to be documented and disseminated throughout the CARE system. Activities were carried out by a newly created PHLS Unit at CARE headquarters in Atlanta and in the pilot countries: Mali, Tanzania, Peru and Bolivia.

Through the institutionalization of PHLS, CARE sought to shift from a purely sectoral orientation to a more holistic focus on the complete set of household livelihood security needs, as identified in the HLS framework. Partnership with other institutions (NGOs, CBOs, government) were to provide not only a means to implement activities addressing more than one of these needs simultaneously, but also to strengthen the capacity of partners to deliver relevant services effectively, efficiently and sustainably.

Because the DIPs approved by USAID/PVC did not provide for the measurement of impact-level accomplishments, particularly household-level impact, and since many targets were non-specific, with results described almost exclusively at the output level, it was not possible to determine the precise degree of "success" or ultimate impact achieved as a direct result of the PHLS grant. Nevertheless, the elements of the DIPs for which there are specific indicators and targets were found to have been implemented successfully.

The first three of the four major hypotheses on which this MG was based appear to have been valid: *i) that focusing in a holistic manner on a comprehensive set of securities at the household level would improve project impact; ii) that working with partners would increase program coverage and sustainability, while also increasing their capacity to deliver relevant services efficiently and effectively; iii) that the incorporation of DME systems to track changes, particularly at the household level, would permit COs to measure impact and improve programming.* However, the fourth hypothesis (*that the four pilot countries would produce*

models to be disseminated by the PHLS Unit throughout CARE and among partners and colleagues) proved to be too limited, in that the creation and testing of models was not based solely on activities in those four countries.

The activities supported by this grant facilitated the introduction of PHLS as an organization-wide programming framework (a first, which is an accomplishment in an of itself), and contributed significantly to what appears to be an historic change in CARE's basic programming philosophy. Rather than concentrating on the effects of poverty, the organization has decided to pursue "rights-based approaches" (RBA) aimed at exploring and resolving its underlying causes. This implies CARE's entry into areas such as policy analysis and advocacy. The experience accumulated by virtue of efforts to institutionalize PHLS as an organization-wide programming framework is expected to help inform the process of addressing and operationalizing RBA in the future.

Finally, it should be noted that CARE USA is one of ten independent, national organizations that make up CARE International (CI), which manages programs in over 60 countries. Based on grant-supported experience, the organization has been successful in transferring PHLS concepts to CI, thus broadening the ramifications of these activities beyond the 36 countries in which CARE USA works.

1.2 Key conclusions and recommendations

As described in the various sections of this report, the key conclusions drawn by evaluators from the findings outlined, and the recommendations that were formulated on the basis of those conclusions include the following:

Conclusions:

- PHLS approaches have been successfully institutionalized within CARE and have contributed to changing the way the organization addresses poverty alleviation. The incorporation of rights-based approaches into its philosophy is CARE's next big programming challenge. The process supported by this grant provides significant insights to help guide that effort.

- DIPs were prepared in accordance with USAID requirements but, once approved, did not provide significant guidance for management of the grant, nor was that required by PVC. In sum, DIPs were not used for on-going performance measurement or reporting.

- Since impact indicators were developed only for measuring change at the household level and not at the level of higher goals and objectives, it is not possible to measure precisely the impact of the overall matching grant, particularly with regard to changes in the institutional capacity of CARE and its partners.

- PVC's requirement that grantees specify at the outset the specific "pilot" countries in which activities are to be funded, even when the objective is institution-wide, limits the grantee's

ability to create or enhance field-based incentives or to take best advantage of opportunities while minimizing obstacles.

- Given that both ISAs and MGs are aimed at strengthening grantee institutions, to maximize results while creating greater efficiencies from the grantee's perspective, it would be helpful for PVC and FFP to seek to align grant requirements and procedures more closely.

Recommendations:

1. PVC should improve the format for and provide a results framework to be used by all MG recipients for the preparation of DIPs. The framework/matrix should call for indicators that measure performance at all levels in terms of quality, quantity and time, as well as specific PACD (project activity completion date) targets related to those indicators.

2. CARE should develop, test, and make available to all country offices tools for measuring multi-sectoral impact within the household and for tracking results at levels beyond the household, as well as indicators for measuring changes in the institutional capacity of CARE offices and of partner organizations.

3. CARE should document and disseminate within the organization and to other PVOs overall lessons learned and new insights resulting from the PHLS grant.

4. To increase the effectiveness of MGs aimed at strengthening the capacity of entire organizations or institutionalizing new approaches, USAID/PVC should consider eliminating the requirement that grantees specify at the outset the specific countries in which they will pilot grant-related activities or allocate funding.

5. PVC should explore with FFP the possibility of more closely aligning ISA and MG requirements and procedures, the goal being to achieve greater synergy and the broadest development impact possible, which is in everyone's interest.

1.3 Acknowledgements

Members of the evaluation team wish to express our deep appreciation for the confidence placed in us and for giving us this opportunity to work with USAID and CARE on such an interesting assignment.

Our special thanks go to the staff of CARE Atlanta and CARE Peru for the spirit of cooperation with which they received our requests for information and facilitated our work. Likewise, we are grateful to all the Peruvian government officials, CARE partners and USAID/Peru officials who shared their time, knowledge and opinions with us. Each of the individuals contacted made a significant contribution to the overall results recorded here. We thank them all.

2.0 EVALUATION METHODOLOGY AND TEAM COMPOSITION

Approach:

The overall approach to this evaluation was participatory. The three-member team included two MSI staff members, and one from CARE. The methodology employed consisted of document review, interviews with key informants and focus groups and frequent discussions among team members to confirm findings, conclusions and recommendations. Evaluation tasks were undertaken during the following four major phases:

Phase One:

- Preparatory work in Washington - Half-day Team Planning Meeting with CARE and USAID officials (September 24) and document review at MSI headquarters (October 22-24); interview with the USAID/BHR/PVC CTO (November 7).

Phase Two:

- Visit to Atlanta - Team Leader traveled to CARE headquarters to interview key staff and collect additional documents (October 25-26).

Phase Three:

- Field visit to CARE Peru - The full team traveled to Lima and two members also visited Ayacucho; further review of key documents and interviews with CARE staff and consultants, government officials, partner organizations, and USAID officials (November 13-21).

Phase Four:

- Preparation/submission of draft report (November 26-December 17).
- Incorporation of USAID and CARE comments, and production of final report.

The original plan was for evaluators to travel to Tanzania from October 31 to November 8. That trip, together with the visit to Peru, would have provided an opportunity for data collection in two of the four pilot countries involved in this grant. However, due to tightened travel restrictions resulting from the September 11 tragedy, it was not possible to obtain country clearance from USAID/Tanzania. Thus, key CARE personnel in that country were later interviewed by telephone from MSI/Washington.

As indicated in the various sections of this report, data were verified through the review of key documents (see ***Annex A*** for a complete list) and interviews with relevant individuals and groups (***Annex B*** provides a list of persons contacted). Findings are based on the information collected, while conclusions and recommendations are the opinions and contributions offered by the evaluation team.

Report Format:

It should be noted that the team was asked to use a pre-determined format for the preparation of this report. That is because this is one of a set of some 12 final evaluations of Matching Grants

for which MSI was contracted by USAID/PVC. Therefore, to facilitate possible future study at the level of the overall PVC grant program, it was determined that all reports would employ the same sections and sequence. Non-applicable sections are marked simply "N/A."

Team Composition:
Based on the Scope of Work (see ***Annex C***) , the evaluation team was comprised of the following members:

- **Joan Goodin**, MSI Senior Associate, served as Team Leader. Ms. Goodin has led a number of USAID evaluations, and is a specialist in the field of civil society. Last year, also under contract to PVC, she prepared a Case Study of the impact of PVC Matching Grants on CARE. That effort provided an opportunity to develop a basic understanding of the issues involved in this final evaluation.

- **Ky Johnson**, MSI Program Associate, was also selected for this team. Mr. Johnson has experience in qualitative and quantitative assessment, broad exposure to USAID programming, and has lived and worked in a number of developing countries.

- **Michael Rewald** of the Program Division was selected by CARE to serve on this team. Mr. Rewald has been with CARE for over ten years, holding high-level positions in a number of CARE's country offices. He also served as Acting Director of the PHLS Unit at CARE headquarters for a year, and is well versed in the various aspects of the grant under review.

3.0 MATCHING GRANT BACKGROUND

3.1 Historical & technical context

USAID/BHR/PVC awarded a $2,400,000 Matching Grant (MG) to CARE/USA for the three-year period from October 1, 1996 to September 30, 1999. The grant was subsequently extended for an additional two years, to September 30, 2001, with a total budget of $3,800,000, to be matched by CARE. This MG supported CARE's *Partnership and Household Livelihood Security (PHLS)* program which, broadly defined, sought to institutionalize within CARE, including its 36 Country Offices (COs), the concepts and methodologies of three major programming initiatives: i) Partnership; ii) the Household Livelihood Security (HLS) framework; and iii) Design, Monitoring and Evaluation (DME). PHLS was structured to be a "capacity building project," rather than a "direct impact" project, and the models developed in the four pilot countries selected were to be documented and disseminated throughout the CARE system. Activities were carried out by a newly created PHLS Unit at CARE headquarters in Atlanta (HQ) and in the pilot countries: Mali, Tanzania, Peru and Bolivia. Several key positions at CARE headquarters and in each of the four pilot countries were funded through the grant.

CARE proposed to use different approaches in each of the four pilot countries, thus producing "models" for dissemination throughout the organization. Bolivia was to work with established, formal non-governmental organizations; Peru with sector-based partnerships; Mali with beneficiary-owned organizations; and Tanzania with local organizations and indirect service

delivery. The PHLS Unit at HQ and its coordinators in each of the four pilot COs were expected to develop and test new approaches to promote Partnership, HLS and DME in those countries; to institutionalize these approaches in their countries' programming; and then, based on lessons learned in the pilots, to disseminate and promote these strategies throughout the rest of the CARE system.

Through the institutionalization of PHLS, CARE sought to shift from a purely sectoral orientation in development work to a more holistic focus on the complete set of household livelihood security needs. While these include many basic needs as traditionally defined, they also include higher-order needs, such as environmental protection and building social capital and participation in civil society. Partnership with other institutions (NGOs, CBOs, government) were to provide not only a means to implement activities addressing more than one of these needs simultaneously, but also to promote the sustainability of these interventions.

PHLS became the intellectual underpinning for CARE's development efforts as the organization restructured itself both at headquarters and in the field to reflect its new vision. This restructuring stressed not only cost efficiencies through streamlining operations and forging strategic partnerships, but also the achievement of greater impact for less cost by promoting synergy between various sectoral interventions.

The concept of Household Livelihood Security was officially adopted by CARE in 1994, based on the concept of food security as articulated by USAID through the food aid program (PL-480 Title II). With HLS, food security was broadened to encompass other basic household securities, such as nutrition, health, economic, education, habitat, environment, and so forth. These are diagnosed through rapid, participatory assessments conducted in areas selected by CARE for long-term involvement. Once the exact nature of these household insecurities is known, key, leverage-point interventions are designed and funding sought from one or a number of donors. Baseline studies and effective monitoring and evaluation systems are then incorporated in these poverty-reduction efforts from the design stage.

As an integral part of this initiative, CARE undertook to promote program quality, effectiveness and impact. Using HLS as the conceptual framework, and promoting partnerships with local institutions, CARE sought to use this MG to clarify its definitions of impact and what is required to plan for, achieve and evaluate impact on the lives of its intended beneficiaries. Thus, an important purpose of the work undertaken was to significantly strengthen the capacity of CARE staff and partners to design, monitor and evaluate all that they do in the four pilot countries and wherever CARE works.

3.2 Project goals and objectives

Given that the original three-year grant was extended for two additional years, the initial goal was later re-stated. For phase I (1996-1999), the MG included the following goals and objectives.

TABLE 3.2: PROJECT HIERARCHY OF OBJECTIVES [*]

Goals:	1. To enhance CARE's capacity to improve Household Livelihood Security of more than 18 million poor families on various points of relief to development continuum; and 2. To enhance CARE's sectoral programs at the community level through strengthened local partners.
Objective 1:	To operationalize the concepts of Household Livelihood Security CARE-wide through an effective and locally appropriate M&E approach, and to disseminate lessons learned to CARE COs, colleagues.
Objective 2:	To build CARE's ability to partner with local organizations and capacity of partners to deliver relevant services efficiently, effectively and sustainably.

For the phase II extension (2000-2001), grant elements were to be made "more truly cross-cutting while strengthening the three key elements of the 'PHLS approach'." In particular, while work in the four pilot countries was to continue, the dissemination of those models was to "be intensified during the extended phase of this grant." The overall goal of this phase was stated as follows:

> "Based on the HLS framework improve the analysis, design, monitoring & evaluation of CARE programs, especially those implemented with partners, in order to achieve demonstrable impact on the households of target communities."

The matrix included as ***Annex D*** presents a re-configured and more detailed picture of the goals, objectives, indicators, targets, and accomplishments included in the two DIPs, which cover the entire five-year period.

4.0 PURPOSE OF THE EVALUATION

The prime purpose of this final evaluation is to fulfill the requirements of USAID/BHR/PVC's Matching Grant Program, which will use this information to assess how well the MG met its objectives and to assist in the review of any follow-on proposals presented by CARE. In addition, together with other MG assessments, this evaluation is to assist PVC in:

- determining patterns and emerging issues across all MG funded programs;
- identifying the technical support needs for grantees;
- shaping new MG RFAs;
- developing internal and external documents to demonstrate the effectiveness of the MG program; and
- sharing lessons learned with the entire PVO community.

PVC will use the information outlined in the Scope of Work (see ***Annex* C**) in its annual Results Report and in USAID's annual report to Congress.

[*] From the 1996-1997 Detailed Implementation Plan (DIP), submitted to USAID/PVC in March 1997.

The second purpose of this evaluation is to help CARE assess, articulate and learn from its experience in implementing the MG-funded PHLS initiative over the past five years. Though technically a *summative* evaluation (in the sense that the MG is finished), it can actually be seen as a *formative* evaluation in that CARE has stated its intention to continue promoting Partnerships, Household Livelihood Security, and enhanced program Design, Monitoring and Evaluation throughout the organization. Thus, the lessons learned from this experience can help guide CARE into the future.

5.0 PROGRAM IMPLEMENTATION EVALUATION QUESTIONS

5.1 The Detailed Implementation Plan

5.1.1 MEETING DIP TARGETS AND DATA ACCURACY

Findings:

(a) As shown in *Annex D,* at the Objective level, seven of the 15 indicators (47%) included in the two DIPs were non-specific in terms of PACD targets. At the Activity level, nine of the 34 indicators (26%) were non-specific.

(b) The "Accomplishment" column included in *Annex D* provides information on the achievements realized under the grant. As shown, nearly all of the eight Objective-level and 25 Activity-level targets specifically described in the DIPs appear to have been met. The majority of these targets involved activities in the four pilot countries or all CARE COs, or were one-time events or publications. The large volume of reports, publications and other materials produced under this grant, plus interviews with key informants, made it possible to verify this finding.

(c) Because change occurs ever-more rapidly at all levels of society, it is highly unlikely that the implementation plans designed by MG awardees for three to five year periods will lead to maximum results over the longer term unless periodically updated.

Conclusions:

(a) CARE has regularly documented and maintained records of grant-related activities.

(b) The overall purpose and higher-level objectives included in project DIPs constitute a framework for monitoring progress, and should remain constant over time. However, it is important to review changing local/national circumstances on a regular basis (say, annually), and to revise specific lower-level activities (inputs) in order to maximize new opportunities or avoid emerging problems. Because DIPs were never reviewed/updated to reflect changing circumstances, they do not reflect the most effective use of MG funds, nor are they effective management tools.

Recommendation:

(a) PVC should consider providing for the periodic review and possible revision of DIPs in order that the activities funded may maximize emerging opportunities or overcome unexpected obstacles.

5.1.2 QUALITY OF DIP AND DEGREE OF SUCCESS IN IMPLEMENTATION

Findings:

(a) As stated in various project documents and in the February 1999 evaluation report, "The PHLS cooperative agreement was structured to be a *capacity building project* (a primary focus of the PVC Matching Grant Program), rather than a direct *impact* project."

(b) As shown in *Annex D*, no measurement of impact-level accomplishments, particularly at the household level, was envisioned in the DIPs approved by PVC. Results are described almost exclusively at the output level and, as discussed above, for a good number of objectives and activities, no measurable indicators or specific PACD targets were stipulated.

(c) It was reported that the format and matrix used by CARE for the preparation of the phase I DIP had been provided by, and was a requirement of, PVC. The phase II DIP was completely narrative, with no matrix or results framework. While both DIPs were based on the general terms of the CA, the format used did not require specific, measurable performance indicators.

Conclusions:

(a) Given that neither DIP included measurable indicators, and that many targets are non-specific, it is not possible to determine the precise degree of "success" in quantitative terms. Nevertheless, the elements of the DIPs for which there are specific indicators and targets were implemented successfully.

(b) DIPs were prepared in accordance with USAID requirements but, once approved, did not provide significant guidance for management of the grant, nor was that required by PVC. In sum, DIPs were not used for on-going performance measurement or reporting.

Recommendations:

(a) PVC should improve the format for and provide a results framework to be used by all MG recipients for the preparation of DIPs. The framework/matrix should call for indicators that measure performance at all levels in terms of quality, quantity and time, as well as specific PACD targets related to those indicators.

(b) PVC should require that the results frameworks contained in the DIPs be used as the basis on which grantees prepare their Annual Reports. Thus, progress could be reported in relation to the objectives stated in the framework, and measured in accordance with approved indicators.

(c) Grantees should use the new, improved DIP as a management tool for continually tracking progress against specific, measurable results, revising it as needed, rather than preparing this document merely as a PVC requirement.

5.1.3 FAMILIARITY WITH DIP AND DESIGN

Findings:

(a) Staff of the PHLS Unit and other key personnel at CARE headquarters as well as in pilot COs exhibited familiarity with the underlying principles of the DIPs and the general areas covered. It was found that there is broad awareness at various levels of the organization of the three major aspects of the MG – Partnership, HLS and M&E. There is also an understanding that the grant supported activities at headquarters and in the four pilot countries. While it was found that DIPs were not used as a management tool, or that they served as a "living document" to be consulted on a regular basis, the logic of their overall design appears to have been fully understood.

(b) The DIPs were found to underestimate the organization-wide mandate of the PHLS Unit at HQ and to overestimate the importance of the four pilot countries in terms of reaching MG objectives. While those pilots were to provide "models" for dissemination throughout CARE, the PHLS Unit spread its net far more widely within and outside of the organization, and did not depend solely on pilot COs for testing and documenting ideas and lessons in order to institutionalize PHLS concepts.

5.1.4 MAJOR SUCCESSES AND SHORTFALLS IN IMPLEMENTATION

Highlights of implementation experience, based on review of the DIPs and other documents, as well as interviews with key informants, are summarized in the table below.

TABLE 5.1.4:MAJOR SUCCESSES AND SHORTCOMINGS IN IMPLEMENTATION

Implementation Experience at a Glance	
Major Successes	**Major Shortcomings/Constraints**
PHLS concepts institutionalized within CARE	Difficulties in retrofitting PHLS within existing projects
CARE's basic program philosophy changed from direct service provider to indirect service delivery through partners	Lack of performance indicators for measuring capacity-building within CARE and in partner organizations
CARE COs assessed their capacity to monitor and evaluate projects and developed plans to strengthen that capacity	Lack of buy-in in some COs by CARE staff, who see PHLS as a separate project, rather than as a holistic, cross-cutting approach
PHLS opened the door to new projects and entry into new areas without antagonizing others	Failure to develop, document and disseminate PHLS "models" among pilot COs and within CARE
CARE was motivated to expand PHLS concepts to "rights-based approaches" (RBA), representing a further advance on the relief-to-development continuum	Difficulty in finding qualified staff in a good number of countries, especially in DME

5.1.5 IMPACT RESULTS

Findings:

(a) In the absence of impact indicators against which to measure grant performance (either at the household level or at the higher organizational level), for purposes of this evaluation, organization-wide results appear to have been accomplished, as reflected in the recently adopted CARE Strategic Plan for FY2002-2006. That Plan states: "Over the past five years, the household livelihood security framework has enabled CARE USA to develop expertise in cross-sector analysis of underlying causes of poverty and in identification of critical leverage points that increase the impact of programming. Household livelihood security, enhanced by rights-based approaches to programming, will continue to be our guiding conceptual framework… We will also invest further in helping country offices explore and integrate efforts in advocacy, partnership, civil society and gender equity and diversity… We must continue to strengthen design, monitoring and evaluation systems, particularly as rights-based approaches are implemented."

(b) As discussed in Section 7.4, efforts to measure impact concentrated on the household level through indicators designed around the eight components of livelihood security contained in the HLS framework.

(c) Ironically, though project documents and the prior evaluation report emphasize that PHLS was a *capacity-building*, rather than direct impact activity, indicators to measure performance at that level were never developed. Neither changes in the capacity of CARE, nor that of its partners, have been regularly tracked. Indeed, various key informants asserted that the development and application of capacity-building measures was a high priority for the future. (A start was made when all COs were asked to assess their DME capacity, providing a baseline for measuring future DME trends within CARE.)

Conclusion:

(a) CARE senior management have demonstrated their commitment to institutionalizing PHLS concepts within the organization.

(b) Since impact indicators were not developed for measuring change at the level of higher goals and objectives, it is not possible to measure precisely the impact of the overall matching grant, particularly with regard to changes in the capacity of CARE and its partners. However, evidence strongly suggests that change has occurred within CARE as a result of this grant.

5.2 Assessment of project model and hypotheses

5.2.1 PROJECT HYPOTHESES ARTICULATED IN CA

Findings:

(a) The four major hypotheses on which this MG was based were: *i) that focusing in a holistic manner on a comprehensive set of securities (beyond food security) at the household level would improve project impact; ii) that working with partners would increase program coverage and sustainability, while also increasing their capacity to deliver relevant services efficiently and effectively; iii) that the incorporation of DME systems to track changes, particularly at the household level, would permit COs to*

measure impact and improve programming; and iv) that the four pilot countries would produce models to be disseminated by the PHLS Unit throughout CARE and among partners and colleagues.

(b) Before discussing these hypotheses, it is important to appreciate their overall effect on CARE as a development organization. It was found that the application of the HLS framework and the concept of partnership have contributed to what appears to be an historic change in CARE's identify and the way it works. This relates to the organization's decision to pursue ***Rights Based Approaches*** **(RBA)**, the ramifications of which are enormous since they involve moving into the areas of advocacy and policy reform (a further advance along the relief-to-development continuum). CARE's 2002-2006 Strategic Plan notes that this decision was made after a period of research, analysis and experimentation during the previous plan period, and lists as Strategic Direction 1: "Adopt Rights-based Approaches to Achieve Greater Impact on Poverty and Social Injustice." The plan states that, "rights-based approaches will enrich and not replace the HLS framework," noting that these approaches "demand that CARE… work to eliminate practices that violate the social, cultural, economic, civil and political rights of people in poor communities. They also demand that we try to change policies and attitudes that perpetuate such practices."

The momentum generated by PHLS for moving on to RBA was clearly evident in the field. A key informant at CARE Peru asserted: "PHLS is a powerful tool to identify needs, but is simply a first step; it remains at the level of symptoms. To complete the picture, we need to find out about the causes. It needs to be combined with RBA - behind every unsatisfied need there's an unfulfilled right." CARE Tanzania reported: "New concepts such as gender, benefit harm analysis, and RBA are building on the HLS framework, moving beyond the household to the issues happening at the context that affect the same households; the need for policy analysis and advocacy has become more prominent and CARE Tanzania projects are increasingly looking at how policies can be made to benefit the poor… It becomes obvious that CARE has to focus on demystifying these new concepts, equipping itself and its partners with capacity to engage in policy debates and dialogue and thus operationalize RBA within the HLS framework." The Tanzania Country Director reported that to pursue this new direction the CO is currently recruiting candidates for a new position: Policy & Information Coordinator. The plan is to pay for this new position with the CO's own resources, eventually shifting this cost to project budgets. Other staff in that CO expressed a strong sense of urgency noting that, due to the rapid pace of change there and their PHLS experience, CARE is now "in a good position to take a leadership role, working with others," adding that "Tanzania is moving faster than what Atlanta is doing regarding RBA," and underscoring the urgent need for guidelines to *operationalize* this new concept, not just materials dealing with it on a conceptual or intellectual level.

(c) **Hypothesis 1; HLS**: The first hypothesis involved the application of the household livelihood security framework to the design and execution of projects in targeted geographic areas, generally selected because of the high incidence of poverty. CARE officially adopted HLS (defined as "adequate and sustainable access to income and other resources to enable households to meet basic needs") as a programming framework in

1994. Applying this concept in specific locations requires significant changes in the way COs work. This engendered resistance on the part of officials in some COs, while others (including Bolivia and Tanzania) initially saw PHLS as a separate project, rather than as an overarching, holistic approach. Geographic targeting was a shift away from projects addressing specific technical sectors (i.e., agriculture, water, health, small enterprise, food security, etc.) scattered in different locations. The clustering of various sector projects in the same area was aimed at affecting the same set of households and was found to have produced greater coordination and synergy among technical teams. CARE Peru reported that clustering had also led to greater cost effectiveness, particularly with regard to equipment and transportation costs, since the staff of different projects could travel together to the same location. Finance and administration managers there explained that PHLS had led to the re-assignment of all vehicles to the CO, de-linking them from specific projects. Thus, no single project "owns" the vehicles; they are now subject to use by all staff members on an as-needed basis. It was also reported that administrative costs had been reduced because PHLS had led to the establishment of regional sub-offices in targeted "economic corridors" (areas also targeted by the GOP and by USAID/Peru), with space and equipment shared by all personnel, rather than each project maintaining its own logistical arrangements. This, plus the CO's decentralization plan, had led to a 40% reduction in support staff in 1998, and a savings of 13% for regional office overhead.

In sum, as observed in CARE Peru, when a CO embraces HLS as a "holistic" approach, this does not always mean that individual projects are multi-sectoral. It may mean that sector projects are clustered in the same area and, by targeting the same set of poor households, greater overall impact is expected. Meanwhile, the HLS Unit at CARE headquarters reported that "many projects worldwide… have used the HLS approach to craft a multisectoral approach within a single project."

Once the geographic area is selected, an **HLS assessment** is conducted to determine the relative levels and types of household insecurity among the targeted population. These assessments, known variously as "Rapid Livelihood Security Assessments" (RLSAs) or "diagnostic studies," were found to be the cornerstone of the PHLS process, though they differ widely in terms of duration, cost, depth and scope. They generally involve the collection of data from targeted households, as well as the use of available secondary data. Results are analyzed and leverage points are identified for the design of potential projects. During the life of the MG, 11 RLSAs were conducted in the four pilot countries, while assessments were also carried out in 22 other countries (*Annex B* provides a list). They are conducted for various reasons. CARE staff often referred to assessments as planning tools, emphasizing that, while HLS approaches can be easily applied to new projects, it is extremely difficult to retrofit them into existing activities, especially since that would imply donor approval for necessary adjustments. One criticism expressed by a number of interviewees was that assessments are "too expensive." However, that view implies that there is only one way to do an assessment, while it was found that they run the gamut from limited samplings in small communities to region-wide efforts. A weakness of the assessment process mentioned by various interviewees at HQ and in the field relates to the use of the data collected. It was generally felt that the emphasis is

placed on the collection process, while too little attention is given to the analysis and interpretation of the information collected. It was also felt that in many cases an overabundance of information is gathered, which only complicates subsequent analysis.

CARE Tanzania reported that, because that office was newly established as a permanent CO shortly before the PHLS grant began, the RLSA conducted in Dar Es Salaam (the first such assessment in an urban area) had resulted in great visibility and credibility, putting it "on the map." With MG funding, that CO conducted three RSLAs (two urban and one rural), and is now preparing a fourth using its own resources. It has reported that, thanks to this greater recognition, the number of CARE projects increased from seven when the PHLS grant began to the current portfolio of 18, six of which were designed on the basis of recommendations from two of the HLS assessments, and that the funding base has been greatly diversified among different donors. One lesson reported by that CO is that "HLS diagnosis should not be necessarily elaborate, but rather should look into the nature and type of programming opportunities envisaged and consider use of existing data, [leading] to the selection and use of simple and cost effective sampling methodologies."

(d) **Hypothesis 2; Partnership:** This hypothesis envisioned the advantages of working with partners of various types and at different stages of the project cycle for the purpose of increasing coverage and impact in terms of poverty reduction. Partnership is defined by CARE as "a set of principles involving trust and mutualism." The MG was to provide for a Partnership Coordinator at HQ and in the four pilot countries. However, this component was weakened by staff turnover at all offices, and compounded by resistance to these positions on the part of some senior regional managers. The initiative began in 1996 with the appointment of a Coordinator in Atlanta, who conducted a review of existing CO partnerships. This led to the formulation of Partnership Guidelines and a policy paper in 1997. However, during the following 18 months the position was vacant at HQ, and staff turnover occurred in the field. It was not until the final two years of the MG that another person was brought on by the PHLS Unit as the Partnership Coordinator to serve until the end of the grant. He conducted a three-part study, and in 2001 the following documents were published: *Partnership Principles – What We Have Learned About Partnering and Institutional Capacity Building; Promising Practices – A Case Study of Partnership Practices and Issues; and Partnership Recommendations.* Another recent study, *Financial, HR and Administrative Aspects of Partnerships,* examines the more practical aspects of this issue and offers recommendations as to how the organization can change its systems to facilitate partnerships more effectively. The April 2001 report of a CARE partnership workshop held in the UK describes the Partnership Principles and Key Behaviors that had been adopted, and states: "The nature of the relationship depends on the degree to which the principles are implemented, rather than on the relationship's structure."

It was found that the HLS assessment process motivated COs to identify and involve partners in their work. Though some assessments are done by CARE staff, it appears that in most cases, once the CO determines the area to be targeted, the public and private organizations working there are identified and invited to participate in data collection,

analysis and planning tasks. For this purpose, COs provide orientation or even formal training. The expectation is that partners will also be involved in providing the services found to be needed, whether as CARE sub-grantees or through separate projects in their own areas of technical expertise, thus enhancing coverage and impact. In Peru and Tanzania, for inexperienced or weaker local partners, the CO often provides financial management training for sub-grantees or assists them in drafting project proposals and identifying potential donors. Thus, it seems clear that the capacity of partner organizations is strengthened, though this aspect of the process is not measured or reported. This finding was supported by anecdotal information indicating that a number of partners have used this experience to carry out their own assessments in other areas and have received funding for the resultant projects. The application of assessment experience has also been reported in connection with academic studies and presentations at public events.

The Long Range Strategic Plans of all four pilot COs and of CARE USA include partnership as the fundamental element. An important underlying concept as articulated in above-mentioned report and echoed by staff in HQ, Peru and Tanzania is that: " CARE will increasingly shift from a service delivery mode to one of *facilitation and capacity building.* CARE's role will be to establish and nurture coalitions among public, private and civil society stakeholders whose programs influence the structural causes of poverty in society." As explained in CARE Tanzania's Final Progress Report, "Partnership has been institutionalized in all new project design and implementation and even existing projects have evolved over time from direct service delivery to indirect service delivery through partners." That CO estimates that between 75% and 90% of its services are now delivered through partner organizations – of which they count over 40 district/municipal councils, 420 CSOs, three private companies, and 354 primary schools. CARE Peru also reports progress in the transition to indirect service delivery, and has identified four types of partnerships, designed for: i) local development; ii) advocacy; iii) joint venture; and iv) complementary expertise. These involve a large number of central, regional and local government bodies, the private sector, NGOs, CBOs, and multi-institutional networks. (See Section 6.1 for information on the number of partnerships reported CARE-wide.)

(e) **Hypothesis 3; DME:** The importance attached to this component of the PHLS grant was clearly evident during interviews at HQ and in the field and in the documents reviewed. Evidence includes the fact that, once the MG was completed, the Program Division decided to continue the DME Coordinator position using unrestricted funds. As discussed in Sections 5.1.5 and 7.4, DME efforts were linked primarily to the application of the HLS framework and indicators to measure impact at the household level. While the DME Coordinator at HQ began some five years ago, efforts appear to have been slowed by the complexity of DME concepts and by difficulties in finding and retaining personnel with relevant skills in the four pilot countries. A first step was the self-assessment of DME capacity by all COs and the development of plans to strengthen it. In general, key DME tasks include the collection of baseline data in conjunction with HLS assessments and subsequent project design, the development of logframes, and the monitoring and reporting of performance. Final evaluations, it was found, are generally conducted by outside consultants. A DME Capacity Assessment Toolkit and HLS Impact Guidelines

were published by the PHLS Unit in February 2000, while a Design Manual is available in draft, and a Baseline and Evaluation Guide is still being developed.

It was found that a conundrum cited in the February 1999 PHLS evaluation report remains unresolved: "The principal contradiction in the conceptual framework of HLS is that most interventions remain sectorally focused and community oriented, and multi-sectoral household focus only becomes a reality in impact measurement. Clustering of projects in the same geographic area is not the same as focusing these projects on the same households." This has significant implications for the monitoring and reporting process. The indicators provided in the HLS framework for measuring the various kinds of household securities are used in the design of assessment tools and for the collection of data from households within the target area. However, project M&E systems are generally designed to measure change at the broader community level – as is required by most donors. Therefore, it was found that no data are available to confirm the number of households affected, nor the degree of intra-household impact achieved.

Key informants at HQ reported that, of the four pilot countries, Mali is the most advanced in the area of DME, which also coincides with the 1999 evaluation report. It was noted that currently Mali has two staff members for this component, and that it has also strengthened its capacity in the area of partnership. However, the HLS component remains weak.

CARE Tanzania also has two DME staffers at present, has created a DME task force and has introduced and trained "M&E Point Persons" in each project, whose responsibilities include the identification of DME capacity needs of field staff and partners. The DME assessment report of the EA/ME region states: "Tanzania has been a leader in DME in the region, being the first CO to complete its capacity assessment, and to hold a CO-wide workshop to review the assessment, revisit all project log-frames, and to devise a strategy that includes a program area baseline survey." That CO reports that it "has been able to enhance the DM&E skills of partners to the extent that they have managed to diversity their funding base through improved quality of project design and reports." Concerned about the need to measure cumulative impact above the level of individual projects, that Office is now in the process of developing a Programme Impact Monitoring and Evaluation System (PIMES) to capture and account for impact at the higher multi-sector program level.

To emphasize the need to learn from experience, CARE Peru changed the job title from DME to "Evaluation & Learning Coordinator," and also has a "Research & Learning Specialist." Under the MG, the Coordinator position was funded 25% by PHLS and 75% by the Title II program. Now, 40% comes from Title II, 20% is covered by projects, and 40% from CARE. Noting that it is difficult to build DME into on-going projects, the official policy of that CO mandates that all new projects start with baselines and have an M&E system. It has developed a comprehensive, three-day DME training workshop for project staff, as well as an M&E self-training module on the CO's Intranet, which reaches all staff. The design of Peru's three large, new programs included a DME coordinator; reportedly, the current challenge is to identify common indicators among projects for

each major sector. CARE Peru has not yet provided DME training for partner organizations, but envisions doing so in the future.

The regional DME Capacity Assessment report states that at CARE Bolivia "there is no formal DME team… and projects lack detailed M&E plans. The practical and theoretical links between project design, implementation, monitoring, evaluation and the intended impact are weak." The report also notes that diagnostics "are often focused within a predetermined sector and do not use an HLS approach… M&E is perceived as something required for purposes external to the project… project staff had little formal instruction or practical training on how they could make use of the various DME concepts and tools to strengthen their project and to contribute to its impact."

Unfortunately, tools and indicators for measuring change in the area of capacity building have not been developed. CARE staff indicated that this shortcoming has been recognized and that a joint study (with the American Red Cross) was recently commissioned and is to provide recommendations concerning this issue. It seems clear that the HLS assessment process in and of itself produces increased capacity on the part of CARE staff and among partners. In Peru, for instance, a five-day workshop is held prior to carrying out an assessment, and workshops are held upon completion of the process in order to analyze the data and plan next steps. It would have been possible to measure organizational change as a result of that process, for example, by administering a simple pre- and post-assessment survey among all participants. In short, it was found that, while capacity-building has almost certainly occurred within CARE offices and partner organizations as a result of the HLS process, it is not possible to verify that finding since there was no provision for measuring or reporting on that aspect of the grant.

(f) **Hypothesis 4; Pilot Country Models:** This hypothesis was based on the notion that the four countries would produce PHLS models, which would then be disseminated CARE-wide by the PHLS Unit in order to achieve the institutionalization envisioned. It was found that for a number of reasons this did not happen. First, given the complexity of the PHLS approach, and the interplay among its three major components, plus the enormous differences that exist between country contexts, no concrete "models" emerged. Second, the PHLS Unit wisely took a broader approach to institutionalization. Information, assessments and case studies of various aspects of CO operations were solicited across the board – not just from the four pilots. In addition, to help spread the word, PHLS staff participated in many organization-wide gatherings and regional meetings and workshops. The bulk of the input gathered for the various manuals and guidelines published by the Unit came from many COs, not just from the four pilots.

While there is no concrete evidence for this finding, it seems very likely that, because it had been pre-determined that a good proportion of MG funds be allocated to only four pilot countries chosen up front, it is likely that the PHLS Unit was unable to maximize other opportunities as they arose. Under this grant, only 38% of total funding was used by HQ, while 62% was allocated to pilot countries (Bolivia, 15%; Mali 16%; Peru 15%; and Tanzania 16%).

Conclusions:

(a) The first three hypotheses (use of the HLS framework, working with partners, and the incorporation of DME systems) were fully tested in all pilot countries, as well as by many of CARE's 32 other country offices. The testing of the fourth hypothesis (institutionalization of PHLS based on models produced by the four pilot countries) was the responsibility of the PHLS Unit at HQ, and does not appear to have been feasible.

(b) Because the MG established no system for measuring these hypotheses, no objective data are available to specify the degree of accomplishment. However, the anecdotal information found leads to the conclusion that the first three hypotheses were correct, while the fourth was not.

(d) The HLS assessment process has increased CARE's credibility as a development actor in some countries and opened the door to new programmatic areas and donors. It also contributed to the adoption of RBA as an official programmatic approach.

(e) Working with partners has increased coverage in the four pilot countries, but it is too early to measure the sustainability of partner-sponsored efforts, particularly since the strengthening of their overall organizational capacity was not directly addressed.

(f) While a good foundation has been laid for the incorporation of effective DME systems throughout the organization, much is yet to be done, particularly in the areas of higher-level objectives and indicators for measuring capacity building efforts, both internally and externally.

(g) PVC's requirement that grantees specify at the outset the specific "pilot" countries in which activities are to be funded, even when the objective is institution-wide, limits the grantee's ability to create or enhance field-based incentives or to take best advantage of opportunities while minimizing obstacles.

Recommendation:

(a) To increase the effectiveness of MGs aimed at strengthening the capacity of entire organizations or institutionalizing new approaches, USAID/PVC should consider eliminating the requirement that grantees identify at the outset the specific countries in which they will pilot grant-related activities or allocate funding.

5.2.2 REPLICATION AND SCALE-UP OF APPROACHES IN PROJECT AREA OR ELSEWHERE

(a) Evidence was found in Peru and Tanzania to indicate that the application of the HLS framework has been replicated in a variety of settings. In both countries, PHLS approaches spread beyond the areas originally targeted, triggering new project initiatives. While no concrete data were found on the breadth of replication within the organization as a whole, the global report on HLS assessments indicates that as many as 23 COs have engaged in these efforts. The evidence found indicates that PHLS activities have been replicated far beyond the four pilot countries involved in the grant.

(b) Evidence of significant scale-up activity was also found in Peru. One change stimulated by PHLS activities concerns that country's five-year Title II Food Security program (a $23 million grant that until its recent completion represented 26% of the total budget). In 1999, the CO proposed and USAID approved an amendment, adding $1.5 million for a fourth grant component - a two-year local management initiative (September 1999-2001) called FOGEL, carried out in four departments of the country. FOGEL's objective was to

build the capacity of municipal governments to work in a concerted effort with local organizations to achieve food security in the 11 economic sub-corridors targeted. (The FOGEL grant document includes a logframe which provides indicators for measuring local government strengthening.) A final evaluation just completed by a seasoned external consultant concluded that FOGEL "constitutes one of the most complex and successful experiences seen [in Latin America] for strengthening the management capacity of different municipalities and of facilitating the formation of spaces for coordination led by those municipalities." Success was built around the HLS assessment approach, which had culminated in the creation of multi-sectoral "*Mesas de Concertación*" (Coordination Councils) in 67 municipalities, 46 of which were found to be totally or nearly consolidated. The evaluation report states: "Framed within CARE's holistic approach, FOGEL was marked by its multi-sector character and by the importance of partnership as a source of synergy and complementarity... The project worked with 70 agreements with municipalities… and carried out 40 partnerships with NGOs and eight with different private institutions." Some 50 strategic plans had been formulated by the *Mesas*, and it was found that the $400,000 provided by CARE in small grants had leveraged over $1.5 million for local projects – many with municipal funds.

Building on this model for strengthening local government and public-private coordination, CARE Peru responded to three RFAs from the USAID Mission; one for a new five-year Alternative Development project ($23 million), and two for five-year projects under the Peru-Ecuador border program ($14 million and $1.5 million). All three bids involved HLS approaches and partner organizations, and all were successful. These new activities have now been launched and represent a significant percentage of the COs current portfolio. In addition, CARE Peru was awarded a grant by DFID for a three-year civil society program to start in April 2002 (reported to be a scaling-up of the FOGEL model at the regional level).

Conclusions:

(a) While it is not possible to quantify the degree of replication and scale-up of PHLS that has occurred throughout CARE, it is clear that the approaches supported by the MG have permeated the system and have been incorporated into country programming in all regions.

Recommendation:

(a) CARE should develop case studies of significant new initiatives stimulated by the success of PHLS approaches, such as that found in Peru, and disseminate these throughout the organization and beyond.

5.3 Advocacy under the project

5.3.1 ADVOCACY ACTIVITIES AND IMPACT

Findings:

(a) Since advocacy was not among the objectives of the PHLS grant, no data were collected in this area. However, anecdotal information was found to indicate that some advocacy activity at the local level had been stimulated by PHLS initiatives. For example, in Peru

the FOGEL component of the Title II project (discussed above) had led to a coordinated, public-private effort in one area to press regional leaders for increased resources to support various parts of the strategic plan drawn up by the multi-sectoral *Mesa de Concertación*.

(b) At the organizational level, it was found that PHLS had contributed significantly to the adoption of rights-based (rather than needs-based) approaches (RBA). The institutionalization of RBA concepts will inevitably involve CARE in areas such as policy analysis, advocacy, negotiation and policy change. To study the organization's approach to this new challenge, an RBA Reference Group has been created at HQ and is now exploring ways in which organization-wide implementation might be pursued. It was suggested by one CARE official that the process employed for incorporating PHLS into the system, including the mistakes made along the way, itself constitutes a model for the institutionalization of RBA. One issue under study is when and under what circumstances CARE should engage in "direct" advocacy rather than through others, as it has on several occasions, such as the effort to achieve peace in Sudan.

Conclusions:

(a) PHLS has laid the foundation for CARE to move more squarely into the field of advocacy aimed at affecting the causes of poverty, rather than concentrating only on its effects.

5.3.2 PARTNER/PVO ROLES IN ADVOCACY (SEE FORGOING SECTION)

5.4 Implementation Lessons Learned

Findings:

(a) An enormous volume of studies and documents and a good number of tools and methodologies related to the three components of the MG were produced or further developed during the PHLS grant. These include, for example, the two-volume HLS Manual published in English, French and Spanish in 2001 and sent free of charge to the four pilot countries and all other Title II countries (it was made available to other COs at a cost of $350). The various papers concerning HLS, partnership and DME mentioned in foregoing sections of this report were also developed under the grant (see materials listed in the bibliography attached to this report for a more complete listing). A PHLS web site was also launched, and is currently being tested and refined.

(b) Based on the opinions registered by a number of CARE representatives, both at HQ and in the field, efforts to institutionalize PHLS appear to have produced two key lessons. First, because insufficient input was solicited from throughout the organization at an early stage, HLS was seen to be a "top-down" initiative whose "owner" was a single individual at HQ, thus engendering considerable resistance, if not resentment, in some quarters. Second, the early materials distributed to explain HLS dealt with it on a conceptual or intellectual level, rather than providing operational guidance for its implementation. Various interviewees expressed a hope that this will be avoided in connection with efforts to institutionalize RBA.

(c) A number of interviewees underscored the failure to disseminate information and lessons learned concerning PHLS throughout the organization on an on-going basis. While various new developments and initiatives were described in field reports and observed by

evaluators on the ground, they are not generally documented (or translated) and distributed throughout the system by way of providing technical assistance or guidance. Noting the lack of attention to dissemination, one of the recommendations of the 1999 evaluation stated: "All examples of successful coordination between CARE projects or between CARE and other donor projects need to be documented and studied. It is the role of the Atlanta PHLS Unit to galvanize and inform this process."

(d) A comprehensive set of lessons learned from the PHLS process was developed in a recent workshop by key members of CARE's senior staff. Results are included in a September 2001 draft paper titled *"The Institutionalization of Household Livelihood Security in CARE: A Global Review,"* which states that it is hoped that learnings from this process will help inform efforts to institutionalize RBA. Highlights from the paper are as follows:

<u>What Worked Well in Institutionalizing HLS</u>

- The introduction of HLS was supported by a large pool of resources (Title II and the PHLS Grant).
- Key people in CARE/USA were supportive of the livelihood approach.
- A number of cases were accumulated before there was visibility of the approach.
- There was an attempt to have a number of people to provide technical assistance as demand for the approach increased.
- CARE trained a cadre of TA from the beginning both within and outside the organization to insure that demand could be met.
- There were venues for people to vent their issues regarding implementation.
- The livelihood framework was adapted to different settings and COs.
- HLS was woven into various levels of planning (project design, regional planning, LRSPs).
- Commitment to the approach was sustained through political transitions (changes in senior management).
- Supportive technical materials were developed.
- Donors began to buy into the approach (particularly DFID).
- It was important to embrace dissention.
- HLS was evolutionary and kept incorporating learnings.

<u>What did not Work Well in Institutionalizing HLS</u>

- The TA was seen as Headquarters-driven.
- The HLS model was made overly complicated.
- There were too many think pieces introduced at once.
- The approach was introduced as if there was a rigid sequential plan.
- The HLS Assessment was seen as the beginning and end of the approach.
- Simplified messages in bite-sized pieces should have gone out sooner.
- The application of HLS in emergency settings was not made clear.
- People were not always aware that the institutionalization process required vetting and testing the approach.
- The conceptual models became an enterprise in and of themselves.
- The focus on taking HLS concepts to the design and planning level came too late.

- There is a need to stay in front of learning needs -- don't try to roll out the approach so comprehensively.
- More horizontal learning could have been done.
- People must know up front that the approach is not fully evolved.
- If the Country Director did not like the approach, it did not get institutionalized.
- HLS papers were academic and English-centric -- there was a need for simpler materials for multiple audiences.
- The HLS model and approach was made to look like a huge thing that had to be swallowed whole -- it might have been better to introduce it incrementally.

Conclusions:

(a) While some case studies and lessons learned have been collected, the dissemination within CARE of information on new "models" or field-based experiences related to grant-supported activities has been weak.

Recommendation:

(a) CARE should document and disseminate within the organization and to other PVOs overall lessons learned and new insights resulting from the PHLS grant.

6.0 PARTNERSHIP QUESTIONS

6.1 Analysis of Partnership Schemes

Findings:

(a) It was found that, during the five years of the PHLS grant, CARE has made significant progress in working with and through partners, particularly in terms of the number of partnerships recorded. Because organization-wide partnership numbers have only recently been tracked, comparative data over the life of the grant are not available. However, based on the FY 2001 Annual Performance Indicators (API) report, which includes information from all COs, some 27,858 partnerships existed among the 36 COs, up from 23,816 in FY 2000. A vast majority of these were with local governments (13,446) and CBOs (10,139). Many involved informal working relationships (particularly with village governments and CBOs), while only 3,488 (12.5%) had formal, written agreements, most in the form of MoUs. If the 4,273 partnerships with organizations other than village governments and CBOs are considered, then the percentage with formal agreements increases to 81.6%.

(b) As discussed in Section 5.2.1, partners benefited from PHLS approaches by participating in activities stimulated by the grant, particularly HLS assessments and project coordination. Though the original idea was that each pilot country would focus on developing partnerships with different types of organizations, this was found not to be the case. Because the identification of appropriate partners is a function of local context, all countries work with a broad array of partners, from national, regional and local governments to community groups and formal NGOs. Private sector relationships were explored in all pilot COs, but success was mixed.

(c) The manner in which partners were selected varied from one country to another, with each CO establishing its own guidelines and selection criteria. Building on the experiences of the COs, at the end of the grant period the PHLS Unit did develop a *"Partner Selection Tool"* to provide general guidance in this area.
(d) Given the wide variety and nature of relationships described by COs as "partnerships," it is not possible to pinpoint the precise level of involvement of CARE's partners in project activities. API data indicate that 77% of the resources in projects that CARE implements with or through partners is managed by the partners. It is also reported that 29.1% of the partners have been involved in project M&E. However, direct contact with donors by partners is not the norm, with only 1.2% of CARE's partners being involved in donor relations.
(e) One concrete indication that the concept of partnership has become institutionalized in the organization is the fact that CARE's 2002-2006 Strategic Plan states that the Strategic Direction related to Constituency Building will build on lessons gathered in the area of partnerships.
(f) Institutional capacity building within partner organizations is included as a component of many CARE projects. However, while the organization is now exploring how best to measure these efforts, systems have not yet been developed to monitor and evaluate these efforts.

Conclusions:

(a) The PHLS grant allowed CARE to experiment with and stimulate different types of partnerships and, based on these experiences, the organization has begun to clarify its thinking about how best to interact with other organizations committed to poverty reduction. The documents produced under the grant clearly demonstrate that CARE's approach to partnership has matured in recent years.
(b) Partnership is very context specific, and organization-wide guidelines need to be broad enough to allow for local adaptation.
(c) While the concept of partnership is now institutionalized within CARE and most projects work with or through partners, understanding the organization-wide ramifications of this approach and operationalizing it are still at an early stage.
(d) Efforts to build the organizational capacity of partners are also at an incipient stage and will take some time to develop and document. This will become increasingly important as RBA moves forward.

Recommendations:

(a) CARE HQ should collect partnership information from all offices on a regular basis, analyzing relationship types, the role of partner organizations, the results expected and those achieved through this approach to programming.
(b) CARE should formulate and incorporate into the programming process specific measures for addressing and tracking changes in the institutional capacity of partner organizations.

6.2 Measuring Institutional Capacity

Findings:

(a) As previously discussed, though it appears that the institutional capacity of CARE and its partner organizations was enhanced through PHLS activities, efforts were not made to capture this information or measure the degree to which change may have occurred.

6.3 Constraints to Partnership

Findings:

(a) A number of local partners were interviewed in Peru and were universally positive about their relationship with CARE. This included representatives of a central government ministry and a UN agency in Lima, as well as several mayors, other municipal officials and local CBOs and NGOs in Ayacucho. Only one report was heard of a partnership that had gotten off to a rocky start. This involved a budget-related misunderstanding between CARE Peru and a sub-grantee involved in a newly-funded program in that country. However, those difficulties appear to have been amicably resolved.

6.4 Information Technology – N/A

6.5 Use of local networks and service organizations – N/A

7.0 PROGRAM MANAGEMENT

7.1 Strategic Approach and Program Planning

Findings:

(a) The PHLS grant was not intended to improve CARE's ability to plan strategically, though it has influenced the content of the Long Range Strategic Plans (LRSPs) developed both at HQ and by country offices. The CARE USA Strategic Plan for 2002-2006 is replete with references to PHLS concepts and calls for future activities based on those concepts. HQ personnel includes a full-time Strategic Planning and Analysis Coordinator who reports directly to the president, as well as liaison positions in both the Program Division and the External Relations Division.

(b) The LRSP adopted by CARE Peru for FY 2001-2005 contains references to the three major PHLS components. It states, for example, "the need to define a role and organizational structure appropriate for the future and to consolidate the transition from a centralized, assistance-oriented program to one that incorporates the concepts and participatory methods of the PHLS approach." It also states: "CARE Peru coordinates projects with partner organizations to the fullest extent possible to maximize efficiency, effectiveness and productivity… We will replace our current system to monitor progress towards organizational objectives with a comprehensive monitoring system."

7.2 Country Initiatives

Findings:

(a) Based on observations and interviews with both CARE and USAID personnel in Peru, it seems clear that the relationship is marked by mutual respect and a high degree of communication and coordination. Both financial and progress reports related to locally-funded projects are filed in a timely manner, and it appears that lessons learned are shared on an on-going basis.

7.3 Conflict Management – N/A

7.4 Monitoring and Evaluation

Findings:

(a) A priority objective in the CARE Program Division's FY 99 Annual Operating Plan (AOP) was the development of guidelines and standards for measuring impact in CARE projects. To achieve this, an "Impact Evaluation Initiative" (IEI) was established with an IEI Working Group comprised of some 24 individuals representing nine COs, HQ offices and specialized consultants. The objective of IEI was "to offer a structure of norms and practices that will help programmers design 'at impact,' and a menu of indicators and tools that facilitate a common language and methodology for impact measurement across CARE." Nine projects that showed exemplary potential for achieving and measuring impact were identified by Regional Managers, and a case study was written on each. They were from COs in: Bangladesh, Egypt, El Salvador, Honduras, Lesotho, Mali, Nepal, Peru and Uganda. The culmination of the IEI initiative was a workshop held in Atlanta in April 1999, where case studies were presented and next steps were formulated. By October of that year, the Senior Vice President for Program transmitted to all COs a set of documents resulting from that effort, including the nine case studies, an Impact Evaluation Checklist, a Menu of Standard Indicators for HLS Impact, and a DME Capacity Assessment Toolkit. Following a period of testing and feedback, in February 2000 those materials were published in a document titled "CARE Impact Guidelines," which was transmitted to all COs.

(b) As noted in that publication, using the DME Capacity Assessment Toolkit, all COs were asked to "conduct self-assessments of their capacity to do effective program and project diagnosis and design, establish and implement useful monitoring systems, and organize good quality evaluations," using the HLS framework. These assessments, which aimed at identifying areas of strength and weakness, were then to be used by COs to develop strategies and plans for strengthening specific aspects of their DME capacities.

(c) In August 2001, a Global Synthesis Report on DME capacity assessments was drafted. Based on results received from 23 COs covering 186 projects, findings included:

- 20% of projects were based on full HLS Assessment;
- 84% had logframes;
- 73% had household level impact as their final goal;
- 36% were reported as having detailed M&E plans;
- 80% were reported as having some form of a baseline; however, only
- 43% had baselines that included a quantitative survey;

- 57% measured indicators of impact;
- 72% included indicators of effect;
- 63% have ways to disaggregate beneficiaries by gender;
- 66% had reports that meet the needs of donors;
- 38% had adequate DME training during the past two years;
- 65% had plans for future training in DME.

(d) As indicated in the February 1999 PHLS evaluation report, it was hoped that a monitoring and evaluation reporting (MER) system would be functional in the four pilot countries by September of that year. This was to facilitate the tracking of multi-sectoral impacts and the maintenance of a permanent database. However, the system was judged unsatisfactory by those offices, and is operating in only a few CARE countries. Thus, no comprehensive information is available on the impact of CARE programming. CARE Peru reported that it is in the process of creating its own software for tracking multi-sectoral impact.

(e) Since 1993, CARE has collected information annually from all COs on basic issues related to the organization's mission, such as the number of people reached. This is done through Annual Project Information reports (APIs). Data from the most recent API report indicate that CARE had reached a total of 45.6 million "Net Direct Beneficiaries," and 190 million "Indirect Beneficiaries." However, data are not collected on the number of households reached, nor it is possible to relate this information directly to PHLS activities.

(f) In February 2001, CARE produced "The MEGA Evaluation: A Review of Findings and Methodological Lessons from CARE Final Evaluations, 1994-2000," based on an examination of 104 evaluation reports. This produced a CARE-wide view of what can be learned from project/program evaluations, as well as a critique of the methodologies used. It was reported that both the CARE Board and the CI Program Working Group have deemed this a significant instrument and process for synthesizing lessons learned from evaluations, and have asked that it be repeated annually.

Conclusions:

(a) The DME Capacity Assessment Toolkit developed by the PHLS Unit had a positive effect on the degree of attention given to this important component of the grant, and stimulated efforts by COs to better understand their own capacity and plan for strengthening it.

(b) The CARE Impact Guidelines published under this grant provide indicators and guidance for measuring change in the level of security at the household level, but do not address the overall impact of multi-sectoral activities, nor the strengthening of organizational capacity within CARE or among partner organizations.

(c) The absence of a baseline and subsequent data with which to measure the overall results of the activities undertaken through this grant makes it impossible to gauge the precise degree of achievement attained and mitigates against efficient program management.

Recommendations:

(a) CARE should develop, test, and make available to all COs tools for measuring multi-sectoral impact within the household and for tracking results at levels beyond the household.

(b) CARE should also develop approaches and tools for addressing and measuring changes in institutional capacity both internally and among partner organizations as an important component of the development process.
(c) Once new tools for measuring impact and capacity-building efforts are available, the PHLS Unit should work with Regional Management Units to identify and train a cadre of persons in the use of these tools.

7.5 Overall Management

Findings:

(a) The grant was managed by the PHLS Unit at CARE Atlanta, which also manages an Institutional Support Assistance (ISA) grant from USAID/BHR/FFP. The five-year ISA grant covers the period from FY 1999 to 2003, and provides approximately $1M per year "to refine food and household livelihood security (FS/HLS) conceptual models for Title II programs; strengthen and develop tools and methods to diagnose, design and monitor program impact; develop the capacity of CARE staff and partners to program and manage Title II resources; and identify opportunities to sustain the FS/HLS program."
(b) The four positions in the PHLS Unit were funded by a combination of resources from the PVC/MG and the FFP/ISA, and the objectives and activities carried out under these grants were complementary. Both grants have supported the HLS approach. Since the completion of the PVC grant, both the PHLS Unit Director and the HLS Coordinator are paid through a combination of ISA and unrestricted funds; the DME Coordinator is now funded totally with unrestricted funds; and the position of Partnership Coordinator has been discontinued.
(c) Under the ISA grant, all funds are awarded for use by headquarters, which is free to identify the most appropriate activities and opportunities for building institutional capacity. There is no requirement that pilot countries be stipulated in the grant, though a good portion of ISA funding is used in the field. In general, ISA requirements are narrower than those for the PVC grant, since they are tied to food security and nutrition and may only be used in rural areas. Thus, it was reported that, while more geographically restrictive, the PVC grant allows for greater programmatic creativity. It was also felt that PVC's current requirement that 50% of MG funds go to field activities represents a considerable constraint when attempting to achieve institution-wide objectives.
(d) The formats and matrices used by PVC and FFP for MG and ISA grant proposals are substantially different. The matrix used for ISAs provides a clearer picture of project goals, strategic objectives and intermediate results, though indicators remain primarily at the output level.

Conclusions:

(a) PHLS Unit managers of the PVC MG have been effective in the use of grant funds in coordination with resources made available through the FFP ISA, and in dovetailing the activities undertaken through the two grants.
(c) Given that both ISAs and MGs are aimed at strengthening grantee institutions, to maximize results while creating greater efficiencies from the grantee's perspective, it

would be helpful for PVC and FFP to seek to align more closely grant requirements and procedures.

Recommendation:

(a) PVC should explore with FFP the possibility of more closely aligning ISA and MG requirements and procedures, the goal being to achieve greater synergy and the broadest development impact possible, which is in everyone's interest.

7.6 Sustainability

Findings:

(a) Since the fundamental purpose of this grant was to institutionalize the concepts related to PHLS on a CARE-wide basis, the question of sustainability is a function of whether or not that was achieved.

(b) As discussed earlier, it is clear from the documents reviewed, the interviews conducted and general observation that PHLS concepts have indeed been institutionalized and will be sustained by the organization as major programming principles.

7.6.1 OVERALL SUSTAINABILITY SURVEY – N/A

7.7 Financial Management

7.7.1 EFFECTIVENESS OF FINANCIAL MANAGEMENT

Findings:

(a) Judging from interviews with USAID officials in Washington and in the field, and with relevant CARE representatives, grant finances appear to have been well managed, and have presented no difficulties.

7.7.2 LEVERAGING OTHER DONOR FUNDS

Findings:

(a) Project records indicate that CARE has more than matched the amount provided by this grant.

(b) It was also found that PHLS approaches served to open the door to funding from other donors, including DFID which for some time expressed resistance to the notion of multi-sectoral programming targeting households.

7.7.3 COST EFFECTIVENESS OF TECHNICAL APPROACH

Findings:

(a) While it is not possible to quantify the magnitude of change brought about by the application of PHLS, the cost effectiveness of this technical approach is directly linked to the challenge of institutionalizing any new concept within an organization as large as CARE. In that sense it may be said that the $3.8 million provided by the MG over five

years contributed significantly to changing the way a PVO with a balance sheet of over $370 million operates.

7.7.4 REPERCUSSIONS OF "MATCHING" REQUIREMENT ON PROGRAM

Findings:

(a) The matching requirement was found to have virtually no repercussions in terms of the program funded.

7.8 CARE's Information Management

Findings:

(a) According to CARE and USAID interviewees, both progress and financial reports are submitted in a timely fashion.
(b) Based on written exchanges and interviews at HQ and in the field, communication between country offices and headquarters runs smoothly. The overall atmosphere was found to be one of mutual respect and support.
(c) CARE has developed "lessons learned" at various intervals and with respect to the major components of the grant. (See Section 5.4 for a summary of global lessons learned.)
(d) An effort was made to provide a MER system for the four pilot countries to record grant-related data. However, that system was deemed unsatisfactory by the COs involved, and is not in operation in those countries.

7.9 Logistics – N/A

7.10 Project Supervision

Findings:

(a) It was found that there had been significant turn-over among staff of the PHLS Unit in Atlanta and in the pilot countries. Current staff appear to possess appropriate management and technical skills, as required by their respective positions.

7.10 USAID Management

Findings:

(a) From all reports, USAID's oversight and backstopping of this grant has been timely and productive. The PVC CTO knows CARE well, and has made a number of field trips to observe program activities. He was also a member of the team that conducted the 1999 "final" evaluation of the original three-year grant, recommending that it be extended for an additional two years.

8.0 OVERALL CONCLUSIONS

Taken together, the findings identified through the evaluation process lead to the following overall conclusions:

- PHLS approaches have been successfully institutionalized within CARE and have contributed to changing the way the organization addresses poverty alleviation.

- This grant also strengthened CARE USA's ability to win support for the incorporation of PHLS concepts in the policies and programs of CARE International (CI), a confederation of 10 separately registered and governed member organizations working together to end poverty and respond to emergencies around the world. CI members are Australia, Austria, Canada, Denmark, France, Germany, Japan, Norway, the United Kingdom and the United States. Different CI members are assigned lead roles in managing programs in over 60 countries in which CARE operates, though other members also contribute. Therefore, the ramifications of grant-related activities go beyond the 36 countries in which CARE USA works.

- The incorporation of rights-based approaches into its philosophy is CARE's next big programming challenge. The process supported by this grant to institutionalize PHLS concepts within CARE provides significant insights to help guide that effort.

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Annex B: List of Persons Contacted

Name	Organization & Title
Segundo Dávila	CARE Peru (Ayacucho), Regional Director
Rosa Torres	CARE Peru (Ayacucho), Zonal Chief
Beatriz Becerra	CARE Peru (Ayacucho), Zonal Chief
Epifanio Bace	CARE Peru (Ayacucho), Civil Society Advisor
Guido Gutierrez	CARE Peru (Ayacucho), Income Generator Advisor
Julio Salcedo	CARE Peru (Ayacucho), Representative
Health Promoter	CARE Peru (Ayacucho), Health Promoter in Pampachacra
Irma Ramos	CARE Peru (Lima), Coordinator Multisectoral Population Project
Ricardo Furman	CARE Peru (Lima), Coordinator Learning and Evaluation
Raúl Ho	CARE Peru (Lima), Rural Management and Environment
Jenny Menacho	CARE Peru (Lima), Training Unit – Human Resources
Gladys Soto	CARE Peru (Lima), Finance Manager
José Aquino	CARE Peru (Lima), Administration and Human Resources Manager / Coordinator of National Emergencies
Carlos Cárdenas	CARE Peru (Lima), Country Director
Carlos Mora	CARE Peru (Lima), Program Director – Northern Border Program
Marusia Ruiz Caro	CARE Peru (Lima), Advisor to Director of Programming
Gustavo D'Angelo	CARE Peru (Lima), Assistant Country Director / Director of Programming
Isabel Hurtado	CARE Peru (Lima), Learning and Research Specialist
Josefa Rojas	CARE Peru (Lima), Manager of Local Development / Coordinator of Title II Programs
Artemio Pérez	CARE Peru (Lima), Institutional Strengthening / Alternative Development Program
Geoffrey Chege	CARE Tanzania, Country Director
Josephine Ulimwengu	CARE Tanzania, Dar es Salam Area Coordinator
Isam Ghanim	CARE USA (Atlanta), Director of Progam Assessment and Development
Patrick Carey	CARE USA (Atlanta), Senior Vice President
Milo Stanojevich	CARE USA (Atlanta), Chief of Staff
Colin Beckwith	CARE USA (Atlanta), Deputy Regional Director for Latin America & Caribbean
Jeanne Downen	CARE USA (Atlanta), Director – Partnership and Household Livelihood Security
Jim Rugh	CARE USA (Atlanta), Coordinator – Program Design, Monitoring and Evaluation
Jane Benbow	CARE USA (Atlanta), Director of Basic & Girls Education
Eric Dupree-Walker	CARE USA (Atlanta), Strategic Planning and Analysis Coordinator
Kevin Fitzcharles	CARE USA (Atlanta), Director of Contracts & Grants
Miriam Choy	USAID (Peru), Office of Strategic Planning and Results
Kristin Langlykke	USAID (Peru), Coordinator of FIS Project, Office of Health, Population and Nutrition
Luis Seminario	USAID (Peru), Public Health Assessor, Office of Health, Population and Nutrition

Martin Hewitt	USAID (Washington, DC) BHR/PVC CTO
Tim Frankenberger	Consultant to CARE
Victor Bacini	Ministry of Health (Peru), Director of CLAS (Local Health Committees)
Peregrina Morgan	UNICEF, Education Coordinator (Peru)
Eduardo Ballón	DESCO Consultant / FOGEL Evaluator (Peru)
Head of Association	Head of Farmers Association in Luricocha District (Peru)
Mayor	Mayor of Luricocha District (Peru) / Chief of Concertation Board
Mayor	Mayor of Huanta Province (Peru) / Chief of Concertation Board
70 persons	Representatives of Huanta Concertation Board (Peru): Education, Business, Human Rights, Health areas, etc.
12 persons	Representatives of CARE Peru (Ayacucho) partner organizations: handicraft network, tourism network, Mayor of Iguaín, Ministry of Health, Ministry of Education, Ministry of Agriculture, various local NGOs.

Annex C

STATEMENT OF WORK

USAID / PVC
MATCHING GRANTS FINAL EVALUATION OF CARE'S PARTNERSHIP & HOUSEHOLD LIVELIHOOD SECURITY PROGRAM (PHLS)

RE-DRAFTED BY JIM RUGH 10-1-01
BASED ON TEAM PLANNING MEETING 9-24-01

MATCHING GRANTS PROGRAM
OFFICE OF PRIVATE AND VOLUNTARY COOPERATION
BUREAU FOR HUMANITARIAN RESPONSE
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

EVALUATION SCOPE OF WORK
CARE's PHLS Matching Grant

Introduction: "Evaluation is a relatively structured, analytical effort undertaken selectively to answer specific management questions regarding USAID-funded assistance programs or activities." (USAID ADS chapter 202.4). An evaluation scope of work (SOW) is a plan for conducting an evaluation. A good SOW provides clear directions to the evaluation team.

PVC uses information from the evaluation of the programs it funds as part of a yearly results reporting process. In order to get more consistent information across all Matching Grants (MG) funded programs a standard evaluation format is used. The questions in this evaluation SOW template are the questions that PVC is asking in all programs. The PVO and their local partners will need to review this template and add sections or questions that reflect their specific information needs. [Original template wording in CG Times font. CARE-specific sections are inserted using Arial font.]

ELEMENTS IN THE SOW

I. PROGRAM IDENTIFICATION

PVO name
Cooperative agreement number
Date of the evaluation
Country programs evaluated

II. PROGRAM BACKGROUND

Include the following information:

- Provide basic information on the program that will be evaluated

  Include a short statement on:
  - History of the program
  - Current implementation status
  - Local Partners

- Provide Program Planning Matrix, logframe or the section from the program design that lists:
  - Objective
  - Indicators
  - Data from baseline studies or description of the status of the intervention at the beginning of the project.

  Indicate what information and data are available for the external evaluator. PVC already sent a document that will give you an excellent idea of the documents that should be assembled and preparation needed prior to an evaluation.
- Include documentation of any changes that have taken place since the initiation of the program.

III. PURPOSE OF THE EVALUATION

This section should contain two components --- (1) identify the evaluation audience and (2) establish a set of evaluation questions that are relevant to each audience.
Outline the information needs of the evaluation audience (PVC, the PVO and local partners), and how each partner will use this information.

- Who wants the evaluation information,
- What do they want to know,
- What will the information be used for,
- When will it be needed, and
- How accurate must the information be?

The second objective for this evaluation is to help CARE to assess, articulate and learn from experience in implementing the MG-funded PHLS initiative over the past five years. Though technically a *summative* evaluation (in the sense that the MG is finished), it can actually be seen as a *formative* evaluation in the sense that CARE will continue to promote Partnerships, Household Livelihood Security, and enhanced program Design, Monitoring and Evaluation. Thus the lessons learned from this experience can be very informative in helping CARE know how to continue into the future.

IV. THE EVALUATION QUESTIONS

- PVC EVALUATION QUESTIONS.

The following are a set of questions that the MG division is asking in all evaluations. These questions relate to the objectives of the MG division and PVC's strategic plan. The evaluator or evaluation team will assess the following program and institutional questions, provide evidence, criteria for judgment and cite data sources. The evaluator(s) will assess both headquarters and the country-level programs.

The PVO will need to tailor the SOW to reflect their own and their local partners information needs by adding questions into each section, or adding additional sections if needed.

A. Program Implementation

1. Assess progress towards each major objective

- Based on the logframe/program planning matrix, or statement of program purpose from the proposal, determine if the program objectives have been met, partially met or were unattained. This is the single most important element the evaluation must document and discuss. In addition to the discussion of project results in the text of the evaluation, this information should also be put into matrix format. List each objective, and key outcomes at the effects and/or impact level. In the text:

  - Identify major successes and constraints in achieving objectives and

unanticipated effects.

As part of this discussion comment on the PVO and their local partners' capacity to do program monitoring and evaluation. Note any constraints that prevented the PVO from measuring achievement of program objectives. If the program does not have "baseline" and end-of-project data from which judgements can be made about the achievement of project objectives, this should be noted. (A more detailed discussion of monitoring and evaluation should be covered in Section III B of the report)

- Identify if the project had a detailed implementation plan and the familiarity of field staff with the project design, implementation plan and monitoring and evaluation plan and data.

- Assess effectiveness of models, approaches or assumption that underlie the project. Has the approach been scaled-up in the project area or replicated elsewhere in country or in other countries?

- Has the PVO engaged in program or policy advocacy? What was the focus of the advocacy and effects

- Discuss what the PVO and local partners have "learned" implementing this project. Identify if these "lessons learned" have been applied elsewhere (other projects or countries)

2. Assess the status of partnership(s) with NGOs, community based organizations or local level (or national) government.

- Include a chart that:

  - Categorizes local level partners. Are the partners: NGOs, affiliates of the PVO, private or commercial groups, cooperatives, community-based organizations, regional or local governments or intermediate service organizations?
  - Identify the type of mechanism employed with each partner, i.e. MOU, sub-grant, contract.
  - Outline the roles, responsibilities and decision-making responsibilities of the partners.
  - Identify the fiscal autonomy and amount of grant funds directly managed in past year.

- Assess the process that the PVO used to build and maintain local partnerships.

- Does the PVO have a partnership policy and approach to assess potential partners?
- Did the PVO do a formal assessment of local partner capacity and develop plans to build their capacity?
- Document change in local partner capacity.
- What were the major constraints to effective partnerships?
- Has the project increased the local partners' access to information technology? How?

- Assess the local level partners' satisfaction with the partnership with CARE.

- Assess the PVO and their local partners' involvement in local networks or with intermediate service organizations.

- What effect did participation in networks or service organizations have on the operational or technical capacity of the local partner? What would make it more effective? Cite the major implementation lessons learned and recommendations

B. Management Capacity/Institutional Strengthening

The objective of the MG is to build PVO headquarters and field organizational and technical capacity. This section of the evaluation should assess change in the PVOs operational and management capacity (organization, structure or quality of planning and management) as a result of PVC grant.

- Strategic Approach and Program Planning
  Have changes occurred in PVO headquarters capacity to:

  - manage the planning process --- program renewal, strategy integration, project design;
  - address over-arching program issues of replicability, scale-up, sustainability,
  - Use performance data to forecast emerging trends and develop strategic plans?

- Country Level Initiatives

  Identify and assess (if relevant), PVO contributions in the following areas:

  - PVO cooperation and coordination with the USAID mission and other development partner programs including natl./local government agencies;
  - PVO advocacy activities: issues, goals, partners and results (Has the PVO used project data for advocacy with the public sector or consistently shared lessons learned with other PVOs in country or with non-partner NGOs?);
  - If the country or program area has a history of violent conflict, other man-made/natural disasters, or food insecurity:

(a) PVO activities in conflict prevention, mitigation, resolution or post-conflict transition
(b) PVO's contingency plan to ensure the safety of program staff and program continuity.

- Monitoring and Evaluation

Has the project implemented a process and put into place a sustainable system to monitor project performance and collect results (effects or impact) data? Provide evidence that the project:

- Established results oriented objectives and valid indicators for the technical intervention and capacity building components in the project; collected valid baseline data, and made realistic plans to collect end-of-project data and analyze differences; analyzed performance data and used findings to manage the project. Since this is a final evaluation, has the PVO acted on recommendations from the mid-term evaluation?
- Improved the knowledge and skills of field staff on how to measure performance and analyze data.
- Transferred monitoring and evaluation skills to local partners?
  - What changes have occurred in the capacity of the local partners to measure program performance and impact?
  - Have local partners increased M&E in their own activities (non-PVC-funded programs) as a result of skills gained through this project?
  - What would accelerate the capacity of the local partners to document performance?

Determine if the PVO has used the MG to develop a sustainable capacity at headquarters and in the field offices to monitor project performance and measure effects and impact. Has the PVO headquarters:

- fostered analysis and self evaluation in country programs, or conducted quantitative or qualitative analysis to refine interventions;
- conducted periodic review of performance data by project personnel and taken actions as a result of review;
- institutionalized performance monitoring and impact evaluation systems developed with MG funds into other non-PVC grant funded programs, and;

What were the biggest constraints to improving project monitoring and evaluation and what are the recommendations for PVC and the PVO?

- Sustainability

- Does the project have a system for addressing financial or operational sustainability?
- Does the project have a business plan?
- Describe the program elements, financial or operational, that are intended

to be sustained (objectives); the means for judging if the sustainability objectives have been achieved (indicators); and sustainability achievements and prospects for post-grant sustainability.

- Identify if the project has any cost-recovery mechanisms, i.e., local level financing or approaches to generate resources to support project operations. Describe the achievements of these mechanisms and provide an estimate of the magnitude of the system, for example, provide a ratio of costs recovered to operational expenses.

▪ OTHER MANAGEMENT SYSTEMS

Financial Management

- Are adequate financial monitoring systems in place?
- Has the program leveraged additional resources (beyond the match)?
- How cost-effective is the technical approach?

Information Management

- Comment on the utility and timeliness of PVOs required reports.
- Has the PVO developed, disseminated and used "lessons learned" from the project?
- Information Technology

Logistics

- Comment on the adequacy and timeliness of PVOs material inputs.

▪ Supervision/HRD

- Assess if there were sufficient staff with the appropriate technical and management skills to oversee program activity at both headquarters and in the field program

▪ USAID Management

Comment on USAIDs oversight and backstopping of this cooperative agreement.

CITE THE MAJOR MANAGEMENT LESSONS LEARNED AND RECOMMENDATIONS

V. EVALUATION METHODOLDOGY

Give a brief description of the evaluation methodology use.
- *Evaluation approach*
- *Methodology and instruments*
- *Criteria used for judgement, data source, and data analysis.*

A. Approach

The PVO's program was developed and funded prior to the Agency's emphasis on results-oriented program designs and the development of PVC's Strategic Plan. The data from all PVC-funded programs is critical to PVC's ability to report on achievements against the Office's Strategic Plan. Until all current PVC-funded programs have made the transition to a more results-oriented project plans, it will be necessary for the evaluator to conduct a *team-planning meeting* with the PVO and local partners to:

- refine and consolidate the purpose-level objectives and outputs into a set of results-oriented objectives; and
- Agree upon a set of appropriate indicators against which the evaluation will assess the achievement of project results outlined in the SOW and will be judged. And where necessary, identify criteria for judgement. (See above list of questions.)

B. Methodology

The Evaluation Team will:

- explain the appropriateness of using the data collection approaches;
- document data sources (data constraints, quality, etc.); and
- Provide, a copy (electronic or paper) of all primary data collected and analysis performed.

VI. TEAM COMPOSITION AND PARTICIPATION

INSTRUCTIONS:
Based on tasks outlined and the emphasis of each evaluation section determine skills needed and who will participate in the evaluation team ---- PVO, NGO and AID staff. Outline:
- *Roles and responsibility of team leader and members*
- *Language requirements*
- *Technical expertise, or country experience*
- *Evaluation methods and data collection expertise*

VII. SCHEDULE

INSTRUCTIONS:
Determine:
- *Time needed at headquarters*
- *Time needed in the field*
- *Time necessary for report writing*

VIII. REPORTING AND DISSEMINATION REQUIREMENTS

INSTRUCTIONS:
- *This SOW will serve as the outline of the report*
- *Delivery schedule*
- *Review/revision policy*

Annex D: Detailed Implementation Plan Tables

DIP for Phase I: Submitted to USAID/PVC in March 1997, covers the original three-year grant period, 1996-1999. The information included in this Table is based on the matrix provided as an annex to the DIP.

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Goals: 1. To enhance CARE's capacity to improve HLS of more than 18 million poor families on various points of relief to development continuum; and 2. To enhance CARE's sectoral programs at the community level through strengthened local partners.						
Objective 1: To operationalize the concepts of HLS CARE-wide through an effective and locally appropriate M&E approach, and to disseminate lessons learned to CARE COs, colleagues						
	Project designs address HLS in integrated problem analysis	Non-specific	Integrated project designs have been followed in Tanzania (Mwanza Livelihood Project and urban project); Title II projects in Bolivia and Peru; and PDRT in Mali; Livelihood projects have been designed and implemented in more than 20 CARE COs	Yes	Not all COs follow the same approach. Some have designed multi-sector projects while others have had sector projects that have been designed holistically. Both approaches are appropriate	Yes
	Rapid Livelihood Security Assessment (RLSA) conducted in all new program areas	No # of COs specified	RLSAs have been conducted in Tanzania (3), Peru (5), Bolivia (2), and Mali (1). RLSAs have also been conducted in India, Nepal, Ethiopia, Honduras, Guatemala, El Salvador, Nicaragua, Haiti, Mozambique, Zambia, Malawi, Zimbabwe, Sudan, Angola, Kenya, Somalia, Togo, Uganda, Sri Lanka, Madagascar, South Africa, Lesotho	Partially	Not all of the RLSAs have been successful. The approach has improved over time. In some cases, there was not adequate planning for the survey. In other cases, information was not well applied. The main weakness was how to translate the information into appropriate follow-up design.	Partially
	Baselines carried out will reflect statistically valid cross-sectoral M&E information and analysis	No # specified; Analysis in Year 3	Mali, Tanzania, Peru, Bolivia. Cross-sectoral baselines also carried out in Bangladesh, Nepal, Malawi, Madagascar, Kenya, Honduras, Guatemala	Partially	The baselines that have been carried out are of differential quality. They have improved over time. No overall analysis done.	Partially

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
	Long Range Strategic Plan (LRSP) of 4 pilot countries reflect household livelihood perspective	4 pilot countries	All 4 pilot country LRSPs use HLS as the framework. LRSPs that have been written in the 5 years all have HLS and partnerships reflected in them. The regional LRSPs for Latin America, Southern and West Africa, and East Africa also have HLS embedded into the plans. The CARE Program Division LRSP incorporates HLS, as does the CARE USA LRSP. The CARE USA LRSP manual addresses HLS as an organizing principle.	Partially	In the past, the LRSPs tried to use HLS as an umbrella concept to gather all projects under one roof rather than use the framework in a strategic way. Currently, the framework is being used in a much more strategic way to improve targeting and focus programming.	Yes
	Analysis of M&E systems in CARE COs	Analysis of all COs	DME Capacity Assessments conducted in 4 PHLS Pilots and subsequently in almost all CARE USA-led COs.	Yes (See "DME CA Synthesis Report")	The reports reveal that a great deal of work needs to be done to build capacity in the country offices. It has become recognized that new staff with the necessary skills need to be hired.	Yes
ACTIVITIES FOR OBJECTIVE 1						
HLS training provided to CARE CO staff & NGO partners	No indicator	Non-specific	A cadre of trainers including CARE staff, consultants, and staff from CRS, Technoserve and World Vision were trained to provide technical guidance in HLS assessments and program design. In addition to these formal trainings, PHLS staff participated in multiple international forums (DFID, ODI, WFP, FAO, Intl Famine Center, Ireland; IFPRI, Society for Applied Anthropology; Amer. Anthropology Assoc., Tulane, Tufts, Baylor, Brown, Emory and Harvard Universities, Univ. of Arizona, Peace Corps, World Bank; World Food Summit; World Food Prize annual meeting, ICRW, etc.	Yes. (Training manuals have been developed for East Africa, and Asia. A CD-ROM of all PHLS training and conceptual materials provided to all trainers.)	Although the quality of the trainers was not uniform, most assessments were done in a consistent manner. In COs where the consultants were inexperienced, the quality of the assessments and project designs were not very good. Quality control is an issue that needs constant attention. The content of the training needs to be continually updated.	Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
HLS Conference in Asia	Conference Reports	1 Conference held	India 1/98.	Yes. (See conference report.)	The conference identified many of the issues that need to be addressed to further operationalize HLS, such as decision trees for when assessments are needed, appropriate sampling for RLSAs, and how to do cross-sectoral problem analysis.	Yes
Define HLS Tools and Guidelines for Program Manual	HLS Program Manual published	Manual completed	Manual sent gratis to pilot COs and Title II countries; available to other COs for $350	Yes. (See 2-binder set of overheads.)	This manual needs to be updated as more experience comes in. It is hard to have a generic manual that fits all the different contexts that CARE works in.	Yes
HLS Workshop in Latin America (LA)	Proceedings from HLS workshop	Workshop held	3 LA Technical Committee workshops held on HLS. The Technical Committee was comprised of CARE staff from 8 Latin American COs.	Yes. (See reports)	These LA workshops provided an excellent forum for exchanging ideas and experience. The major problem was that different people attended different workshops so some of the same ground was covered repeatedly.	Yes
Participate in at least 2 RLSAs: Asia, E/W Africa	RLSA reports for 2 pilot countries	Participation in RLSAs in Mali and Tanzania	Tanzania (Yes); Mali (with consultant); Peru and Bolivia (helped plan the assessment). As noted above, PHLS staff participated in numerous RLSAs worldwide supported by the grant.	Partially. (See Tanzania Dar es Salaam Urban LSA report.)	In addition to the RLSA, Mali did multi-sectoral baselines on existing clusters of projects.	Yes
On-going portfolio analysis to identify sectoral best practices	Annual project reports, 4 CO offices	Analysis completed for 4 COs	Annual meetings of pilot countries held to capture lessons learned from each of the pilots to share with other country offices.	Partially. (See reports.)	Most pilots were stronger in one area than another. For example, the work in Peru on assessments was good; the work on DM&E in Mali was good; the urban work in Tanzania was good; Bolivia fostered strong municipal government partnerships.	Partially

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Develop case studies on implementation of HLS	4 HLS case studies	Non-specific	Peru developed lessons learned document. Documents developed for the other three pilots	Partially. (See reports.)	HLS work was much more developed in Peru and Tanzania than in Bolivia and Mali. This was primarily because of Senior management support.	Partially
Evaluate performance of M&E systems in COs	M&E Survey Reports	Evaluation completed for all COs	DME Capacity Assessments completed in almost all USA-led COs	Yes. (See "DME CA Global Synthesis" report.)	Considerable difference exists across the COs with regards to DM&E capacity. Much more work needs to be done.	Yes
Objective 2: To build CARE's ability to partner with local organizations and capacity of partners to deliver relevant services efficiently, effectively and sustainably						
	Review & synthesis of existing partnership tools	Review & Synthesis completed	API tool to measure CO partnerships worldwide 1996; Partnership Guidelines 1997; Partnership Policy 1997; 3-part Partnership Study, consisting of a bibliographic reference guide; Lessons Learned, and Recommendations for the Future, 2001; Partnership Field Guide, 2001.	Yes		Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
	Incorporation of lessons learned into future project design	Non-specific	Each pilot did partnership reviews and partnership guidelines; each incorporated partnership objectives into CO long-range strategic plans; several new projects partnership focused, such as urban project in Tanzania, Bolivia and Peru's Title II projects, and Mali's civil society strengthening activities.	Yes. (see Annual reports; LRSPs, project proposals.)	The first project coordinator in Tanzania in experienced. The partnership coordinator in Bolivia left halfway through the project. In Mali the national staff partnership coordinator was transferred to CARE Ghana. In CARE HQ, there was a 1 1/2 year gap in the Partnership Coordinator and some people in regional senior management were opposed to filling the position again. Staff turnover in COs and HQ has been a problem. The Partnership consultant did very strong work the last two years. At present there is no permanent partnership post at HQ	Yes
	Effective use of partnership strategy and tools in diagnostic activities by 4 pilot countries	Not defined	Partnership assessments have been done in almost all project designs worldwide.	Partially	CARE is still learning how to develop mutual partnerships, especially with local NGOs, where it must strike a balance between partnering, mentoring, and overseeing contractual obligations. The accountability required of grantees in most USAID projects makes flexible partnerships difficult at times.	Yes
	LRSPs of 4 pilot countries includes partnership perspective	4 LRSPs completed	All 4 LRSPs do have a partnership component. The majority of CARE USA COs have a partnership objective in their LRSPs. The partnership component has been incorporated into the CARE USA LRSP manual.	Yes	Variance due to changes in staffing, particularly national staff. See above.	Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
	Creation of Learning Environment for Partnership in CARE	Not defined	Workshop for CARE International offices and COs held in UK to update the concept of partnership, to get agreement on partnership principles, and to accumulate important case studies that can be used to disseminate lessons learned. Partnership Coordinator participated in CARE-wide forums such as CARE USA LRSP and meetings of the CARE Board of Directors.	Partially		Yes
ACTIVITIES FOR OBJECTIVE 2						
Incorporate guideline questions into new LRSPs	LRSPs	# of LRSPs unspecified	See above	Partially		Yes
Test tools in COs with existing LRSPs		Non-specific	See above	No		Partially
Conduct local lessons learned workshop	Workshop Proceedings	One workshop conducted	UK workshop - see above	Yes		Yes
Organize / Deliver Partnership Conferences in Asia, S/W Africa, and Latin America	Conference reports; Organizational Development Report (Spanish & French)	4 Conferences conducted	Asia conference held in Sri Lanka, 1997; S/W Africa held in Senegal, 1998; Latin America held in Atlanta, 1998	Yes	Valuable for sharing lessons learned and motivating staff; however, CARE has learned that individual conferences require substantial support and follow-up to achieve learning objectives.	Yes
CO Staff training in partnership	4 CO cross visits/year; Training Reports	12 CO cross visits carried out	2 cross visits between Bolivia and Peru; 1 between Bolivia and Mali; 1 between Mali and Peru;	Yes. (See annual PHLS grant reports.)	Not necessary to have as many cross visits as anticipated since PHLS Atlanta instituted annual meeting of pilot countries. All pilots visited and shared annual lessons in Mali, Bolivia, and Atlanta.	No

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Testing and dissemination of new tools & methodologies	Not specified	Non-specific	See above - Review and Synthesis of Existing Tools. All tools tested in pilots and disseminated CARE-wide.	Yes		Yes
Refinement of partnership web site	Not specified	Refined partnership web site operating	Part of PHLS web site which has been established	Yes. (See <http://www.kcenter.com/phls/>)	First partnership website, Linking Partners, established 1997. However, PHLS unit did not have adequate staff to maintain, so website became dormant in 1998. Now included in new PHLS website along with HLS and DME.	Partially
Develop CO self-assessment tools for partnership progress	Not specified	Tools developed	Partnership Manual 1997 included tools. New API measurement tool developed in 2000. Updated tools issued 2001.	Yes		Yes
Produce/disseminate partnership case studies	4 partnership case studies/year	12 case studies	Mali, Tanzania, Bolivia, Peru in Phase I. Somalia, Egypt, Bangladesh, Madagascar, Zambia, Ethiopia, Mozambique, Nepal in Phase II.	Yes. (See report, "Promising Practices: A Case Study Review of Partnership Lessons and Issues".)		Yes
Review policy guidelines	Partnership Strategy document; Revised Policy Guidelines	Guidelines reviewed	See above - 1977 documents	Yes		Yes
Assess key information needs by region	Not specified	Assessment completed for each region	Done through regional Partnership Workshops	Yes. (See workshop reports.)		Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Hire and promote staff with partnership skills	Adjusted staff project profiles	Non-specific	Each pilot and HQ hired partnership coordinator, but not all posts retained	Partially	Pilots and other COs realized that specific relationship-building skills were needed for successful partnerships.	Partially

DIP for Phase II: Submitted to USAID/PVC in February 1999, covering the two-year grant extension period, FY2000-FY2001. The information in this Table is based on the commitments described in the narrative of the DIP, which did not include a matrix similar to the one annexed to the first DIP.

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Goal: Based on the HLS framework, improve the analysis, design, monitoring & evaluation of CARE programs, especially those implemented with partners, in order to achieve demonstrable impact on the households of target communities.						
Objective 1: To make grant elements more truly cross-cutting while strengthening the three key elements of the "PHLS approach:"						
	Tools and guidelines developed or refined on problem analysis, evaluations/baselines, project design/redesign, partner selection, multi-sectoral programming, selection criteria for geographical areas, and HLS assessments	Tools and guidelines completed	a) Baseline & Evaluation Manual still being developed. Design Manual available in draft. MER guidelines developed and still being refined. Impact Evaluation Initiative guidelines developed. b) 6 short papers on Operationalizing HLS were written and disseminated; a paper on problem analysis was written and disseminated; HLS assessments guidelines disseminated for rural and urban contexts; HLS training and facilitation manual c) Partnership tools developed - see 3- part study previously mentioned.	Partially	a) Difficult to finalize some DME documents because of need to incorporate continually evolving concepts and approaches. Final DME products, though delayed, will be high quality and fit current CARE needs.	Partially
Activities for Objective 1						
Provide format to capture case studies	Format developed to document lessons learned and HLS program implementation in 4 pilot countries	Format provided	Outline for LL documents developed in conjunction with LARMU	Yes		Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Document lessons learned on HLS operationalization in the field	Case studies carried out in pilot countries	4 case studies provided by pilot countries	Peru developed LL document. Lessons learned documents generated for other three countries and the evolution of HLS for CARE	Partially	Not all countries were incorporating HLS in its entirety due to the reluctance of some senior management to accept the new conceptual approach.	Partially
Objective 2: To spread to other COs the approaches taken by the 4 pilot countries.						
	Solid models developed in the 4 pilot countries that serve to spread PHLS approaches to other COs	4 case studies completed, including principles, tools, and guidelines for HLS program implementation.	A synthesis document was written that tried to capture the lessons learned	See "Operationalizing HLS" and other lessons learned documents	It was felt that the 4 pilots represented the cross section of the types of COs that exist in CARE. Because the quality of staff varies, the level of institutionalization will vary as well. Peru is the best example of a well-integrated PHLS approach.	No
ACTIVITIES FOR OBJECTIVE 2						
Continue and intensify the dissemination of models from the 4 pilot countries	No indicator	Non-specific	"Models" not developed in the 4 pilot countries. Some dissemination of lessons learned		PHLS Unit did note depend only on information form pilot countries.	Partially
Objective 3: To institutionalize partnership as a way of working within CARE.						
	Not specified	Institutionalization of partnership accomplished	Partnership is central to CARE's vision ("a partner of choice") and a main theme in CARE USA's 2002 – 2006 LRSP (one of the 3 strategic directions is constituency building, which builds on the work done in partnership).	Yes. (CARE International LRSP; CARE USA LRSP; all CO LRSPs.)	Partnership has been integrated as a core principle of CARE programs.	Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Activities for Objective 3						
Document the common conceptual approaches used among the 4 pilots to build consensus on definitions of the types and functions of partner relationships	Documentation emphasizes the link between HLS and partnership and distinguishes between partnerships to improve household needs attainment and efforts aimed at building social capital	Documentation completed	The conceptual development of partnership concepts has evolved considerably over the last 2 years, and is well documented in the last 5 documents produced by the Partnership Coordinator. In addition, a Partnership Field Guide was recently developed.	Yes. (See "Promising Practices, "Partnership Concepts", "Partnership Recommendations" and Partnership Field Guide".)	This activity is not confined to/dependent upon the 4 pilot countries.	Yes
Identify staff skills needed to implement the different types of partnership activities	Issues encountered by pilot countries in staff training for partnership documented, including conflict resolution strategies and negotiation skills	Issues documented	Consensus was reached at the meeting in the UK on the common principles of partnering. These principles will require different types of staff skills than currently exist in many CARE COs. CARE is presently reviewing core competencies for all staff and the partnership perspective is being considered as part of that review.	Yes	What is needed is a staff review in each CO in relation to the principles.	Yes
Identify, test and disseminate new organizational development approaches and tools for building partnership skills among staff	Not specified	New OD approaches & tools disseminated	See above. Also, CARE has recently completed a study looking at how CARE can change its systems to become a better partner.	Yes. (See "Financial, HR and Administrative aspects of Partnerships. ")	Program Department is working with Finance, Administration and HR Departments to implement recommendations in the study.	Partially

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Disseminate lessons learned about indicators and methodologies for measuring progress in capacity building, institutional development and partnership	Indicators identified and methodologies developed for measuring progress in capacity building, institutional development and partnership, and tested in the 4 pilot countries	Lessons learned re these indicators & methodologies disseminated to all COs	CARE participated extensively in NGO forums in Washington DC that discussed capacity-building measures. CARE and ARC commissioned a joint study on Organizational Development (with one case study from CARE and one from ARC), and three papers were produced – OD Funneling Tool, Literature Review and Partners Selection Tool.	Yes	The PHLS grant contributed to building institutional capacity. Unfortunately, that was not measured. CARE realized shortly after the grant began that it did not know enough to build capacity in local partners. CARE is in a better position now, after all it has learned, to build and measure capacity in partners.	No
Objective 4: To strengthen Design, Monitoring & Evaluation (D+M&E) in the 4 pilot countries, as well as CARE-wide using an HLS perspective						
	Tools and procedures developed and promoted, including templates for TORs to support M&E efforts, and project information systems	Non-specific	MEGA evaluation report recommendations regarding evaluation TORs	Yes	More detailed evaluation TOR templates will be part of forthcoming Baseline & Evaluation Guide	Partly

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Activities for Objective 4						
Develop case studies of projects showing the elements required to measure impact, and share with other CARE countries and partner international NGOs	Not specified	No specific # of case studies produced or shared with other COs; no # of partner int'l. NGOs specified for dissemination.	9 case studies completed in 1999 as part of Impact Evaluation Initiative (IEI). Widely disseminated and read throughout CARE (and beyond).	Yes		Yes
Conduct D+M&E needs assessments in each pilot country	Current capacities assessed and determination made about what is required to develop a D+M&E strategy and comprehensive system	4 D+M&E needs assessments conducted	Begun 6/99 in Tanzania; 2/00 Bolivia; 9/00 Mali; 12/00 Peru.	Yes		Yes
Each pilot country identifies or hires a person responsible for leadership of D+M&E at the country level	Person identified in each pilot country	D+M&E person in place in 4 pilot countries	Yes in Peru, Mali and Tanzania. No unique DME specialist in Bolivia.	Yes		75%
Develop a cadre of D+M&E trainers	Not specified	Cadre of D+M&E trainers developed	Selected consultants given TOT right after IEI workshop 5/99	Yes		Yes

OBJECTIVE /ACTIVITY	INDICATOR	PACD TARGET	ACCOMPLISHMENT	Data Verified?	Explanation for Variance	Target Met?
Adapt the M&E approach used in Mali to enhance the M&E standards in the 3 other pilot countries	M&E capacity in Tanzania, Bolivia and Peru strengthened	Mali approach adapted and M&E standards in the other 3 countries enhanced	M&E systems strengthened in Peru and Tanzania; not so in Bolivia	Yes		75%
Enhance the M&E capacities of CARE and its partners	Methods used in the 4 pilot countries shared with other COs	Non-specific	Important part of DME Capacity Assessments in all Cos was Capacity Enhancement; each CO developed strategies for long-term further capacity development	Yes	The IEI + DME Capacity Assessment + DME Strategies have proven to be the most successful strategy for enhancing DME capacity in CARE. Not dependent upon the 4 pilot countries	Yes