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Evaluation of Health-related programmes of three Co-financing Agencies

A joint evaluation of the programmes of Cordaid, ICCO and Plan Netherlands in the Democratic Republic of Congo, Nepal and Zambia in the period 2002-2004

Synthesis report

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Preface

An external programme evaluation of Cordaid's, ICCO's and Plan Netherlands' Health-related programmes for the period 2002-2004, was carried out between September and December 2004 by the HLSP (former IHSD) institute based in London.
All three Co-Financing Agencies (CFAs) commissioned the study and ICCO was the leading agency. This synthesis report is based on three country reports about the CFAs support to partner organisations in DRC Congo, Nepal and Zambia.
The aim of the evaluation was to gain insight into the contribution of the CFAs and their partner organisations to the improvement of sustainable use of, access to and control over health related services for the poorer sections of the population, with a special emphasis on women and youth.

This study is the third in a series of MBN programme evaluations 2003-2006. An External Evaluation Reference Group (ERG) assesses the quality of process and results of these evaluation studies of the MBN. In annex 1 their assessment of this study can be found.

According to the three CFAs the study contributes significantly to their policies and practices in the field of health, gender and rights based approaches. We value the way the researchers have demonstrated the richness and diversity of experiences of partner organisations and field offices supported in the different contexts, as well as pointing out the weaker points of our policies and practice. This study provides new insights as well as confirmations of our own analysis and understandings. The evaluation has prompted all CFAs to sharpen or revise health-related policies.

Cordaid, ICCO and Plan Netherlands give follow up on the key issues emerging from this study in several ways. In the first place there will be a joint learning session with CFA staff and other stakeholders on the finance of health systems. Furthermore tailor-made follow up agendas specific for each of our organisations are designed. Themes on the agenda's, amongst others, will be the dialogue with our partners, the ways to improve the use of baseline data and information and the participation of beneficiaries.

Cordaid will continue its support to organisational development capacities, will emphasize the improvement of the access to health services and the strenghtening ot the demand side, and will continue the strenthening of church umbrella organisations in health, especially on the issue of advocacy.
On the basis of the evaluation ICCO has completed its health policy. The aim of this policy is to improve access of vulnerable people to better quality basic health care services in general, and more specific to sexual and reproductive health care services. ICCO's specific challenge is to improve the clarity of health-related policies and strategies together with our partners.
Plan Netherlands seeks to promote an integrated approach towards reducing child, adolescent and maternal morbidity and mortality, to promote the combination of home/ community based and clinic- based interventions, to develop and implement strategies to reach the most marginalized children, adolescents and women.

We sincerely thank all the partner organisations, researchers and colleagues for their energy and commitment to this evaluation. We are particularly grateful to the evaluation team and to the coordination group (Mariecke van der Glas (ICCO), Dieneke de Groot (ICCO) , Rens Rutten (Cordaid) en Lis Ostergaard (Plan Netherlands) and the MBN secretariat for their hard work and willingness to coordinate this learning initiative.

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The team that carryied out this evaluation was led by Cindy Carlson, in cooperation with Janneke Roos. The country case study team leaders were Bonani Bukaka (Democratic Republic of Congo), Raghav Raj Regmi (Nepal) and Kwibisa Liywalii (Zambia).

Special thanks goes to the other team members, to the many individuals working in the CFAs and their partner organisations, and to all those who generously gave of their time and insights to inform this evaluation. The evaluation team trusts that the findings will prove useful to them, as well as to the wider international community.

About the HLSP Institute

The Institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health and address HIV and AIDS. It is part of HLSP, a professional services firm specialising in the health sector both in the UK and globally.

The HLSP Institute was formerly known as Institute for Health Sector Development (until April 2005)

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Table of Contents

Acronyms

BDOMs	Diocesan Medical Offices (DRC)
BNMT	British Nepal Medical Trust
BOAD	Ecumenical Development Office (DRC)
CBRS	Community Based Rehabilitation Service (Nepal)
CBOs	Community-Based Organisation
CCDN	Centre for Community Development (Nepal)
CCJDP	Catholic Committee for Justice, Development and Peace (Zambia)
CDEs	Classified Daily Employees
CFAs	Co-Financing Agencies
CFP	Co-Funding Programme
CHAZ	Church Health Association of Zambia
CME	Centre Medical Ecumenique (DRC)
CPD	Continuing Professional Development
CSO	Civil Society Organisation
CSPR	Civil Society for Poverty Reduction (Zambia)
CVICT	Centre for Victims of Torture (Nepal)
DDC	District Development Committee
DRC	Democratic Republic of Congo
DHMT	District Health Management Team
DOTS	Directly Observed Treatment (for TB)
EC	European Commission
ECCDs	Early Childhood Care and Development Centres
EDP	European Development Programme
ESP	School for Public Health (Kinshasa, DRC)
HCC	Health Centre Committee
ICCO	Interchurch Organisation for Development Co-operation
IEC	Information, Education and Communication
IPASC	Institute Pan-Africaine de Sante Communautaire (DRC)
HCCs	Health Centre Committees
LNGOs	Local Non-Governmental Organisations
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOH	Ministry of Health
NHCs	Neighbourhood Health Committees
NGOs	Non-Governmental Organisations
ODA	Overseas Development Assistance
PHC	Primary Health Care
PRSPs	Poverty Reduction Strategy Papers
RBA	Rights-based Approach
RH/MCH	Reproductive Health/Maternal Child Health
SNV	Dutch Volunteer Organisation
SPS	Service Promotion Sanitaire (DRC)
SSS	Sakriya Sewa Samaj (Nepal)
SWAp	Sector Wide Approach
UMN	United Missions of Nepal
VDCs	Village Development Committees
WOREC	Women's Rehabilitation Centre (Nepal)
YUHP	Yala Urban Health Programme (Nepal)

1 Executive Summary

1.1 Background and context

The HLSP Institute[1] was commissioned by three of the Dutch Co-Financing Agencies (CFAs) – Cordaid, ICCO and Plan Netherlands – to undertake an evaluation of their health sector programme in 2004 as part of their joint institutional learning programme and to improve their accountability. The evaluation used a case study methodology, making an in-depth assessment of these CFA health-related programmes in three countries: Democratic Republic of Congo (DRC), Nepal and Zambia. The evaluation team comprised two international consultants, who coordinated all components of the evaluation exercise, and three national research teams. The evaluation questions, developed by the CFAs, were:

1 Which visions, strategies and activities do partner organisations have to improve access to, use of and control over basic health services by potential users?

2 What are the qualitative and quantitative results of these programmes and for whom do they improve sustainable access to, use of and control over basic health (related) services?

3 To what extent do (complementary) partnerships, participation in networks and/or alliances contribute to better performance of the partner organisations and the health system in general?

4 With what results do (complementary) partnerships, participation in networks and/or alliances contribute to a better performance of the partner organisations and the health system in general?

5 What is the added-value, in terms of results and partnership aspects, of the CFAs' support for the partner organisations and their programmes?

The three countries have poor socio-economic indicators and weak health systems that struggle to provide adequate services for their populations. All feature at the low end of the UNDP's Human Development Index, with the majority of the population in each country living below the World Bank's absolute poverty line of US$1 per day. Large parts of the population in all three countries are highly dependent on external aid in order to maintain a basic standard of living.

All three countries face major development challenges. Although enjoying political stability, Zambia is facing continuing food security difficulties, exacerbated by its severe HIV/AIDS epidemic. Two of the countries (DRC and Nepal) are experiencing on-going conflict, which has had a critical impact on people's livelihoods and personal security, as well as severely disrupting public service delivery. The dynamics of conflict have

[1] Known as the Institute for Health Sector Development, IHSD, until April 2005.

had the dual effect of making people both more vulnerable and also less easy to reach through development assistance.

Each of the three CFA organisations evaluated in this report has responded to the challenges presented by the national contexts in a variety of ways. The results and analysis in this report are presented with these contextual issues in mind.

In terms of their overall strategies, Plan Netherlands works through Plan field offices to fund programmes providing community health and development activities, mainly through its Early Childhood Care and Development Centres in Nepal and through district-based programmes in Zambia, often working closely with government providers. ICCO and Cordaid work with a wide range of both international and national non-government partners, both faith-based and secular. The role of non-state providers in each of the countries studied is of vital importance to the health of communities. The support of the three CFAs to many of these providers represents a significant contribution to the health sector (see summary table of partners).

Summary table: CFA partner participants in the evaluation

DRC	Nepal	Zambia
Cordaid Bureau Diocesan d'Oeuvre Medicale (BDOM) Kinshasa, Kananga and Bukavu Ecole de Sante Publique (ESP) Comite National Feme et Development (CONAFED) SPS (Cordaid assistance discontinued) Centre Olame	*ICCO* United Ministries of Nepal (UMN) • Yala Urban Health Project (YUPH) • Centre for Community Development (CCDN) – Makwanpur • Sakriya Sewa Samaj (SSS) British Nepal Medical Trust (BNMT) Centre for Victims of Torture (CVICT) WOREC (Women's Rehabilitation Centre) Community Based Rehabilitation Services (CBRS)	*Cordaid* Catholic Centre for Justice, Development and Peace (CCJDP) Christian Health Association of Zambia (CHAZ) Civil Society for Poverty Reduction (CSPR) Diocese of Ndola Diocese of Mpika Diocese of Mansa
DRC	**Nepal**	**Zambia**
ICCO Bureau Oecumenique d'Appui au Developpement (BOAD) Centre Medicale Ecumenique (CME) Beni ELIMU Institut Panafricain de Sante Communitaire (IPASC)	*Plan* Early Childhood Care and Development Centres (ECCDs) Evaluated projects in • Makwanpur • Kathmandu	*Plan* Evaluated district health and development projects in • Mazubika • Chibombo

1.2 Findings, conclusions and recommendations

1.2.1 Health-related visions, strategies and activities

Respondents in all three countries, including the government, stakeholders or beneficiaries, were highly appreciative of the health-related work of the CFA partner organisations or Plan programmes in their areas. Their absence would leave a gaping hole in health-related services, especially where partner organisations work in remote areas of the country.

The visions, strategies and activities of all CFA partners evaluated favour access to, use of and control over health services by the poor, as set out in their mission statements.

Broadly, strategies adopted by CFA partners fall into two categories: those engaged in service delivery and training; and those undertaking policy advocacy and influencing activities through networking and coalition development, research activities, capacity building, information exchange and lobbying of policy makers. However, all CFA partners are involved to a greater or lesser extent with advocacy activities, in terms of influencing policy and implementation agendas for pro-poor health and development. All the CFAs emphasise local capacity building as part of their development strategy, whether their partners are working within a complex humanitarian crisis or a more stable development situation.

Key strategies are summarised below.

Service provision: The CFA contribution by Cordaid and ICCO supports service provision by the very influential non-state sector (mostly faith-based organisations or local NGOs such as the Yala Urban Health Project in Nepal). Plan is engaged in direct operational projects, often in support of local government staff and structures (such as Plan's district-based activities in Zambia and Nepal, through the ECCD programme).

In the DRC, the faith-based organisations supported by ICCO and Cordaid provide essential health services in about half of the country, and have been able to maintain their operations remarkably effectively in the face of the considerable challenges imposed by conflict. In Nepal, the BNMT is the major provider of health services in the eastern part of the country. In Zambia, Cordaid supports partners in the faith-based sector, which overall is responsible for about 40% of health services, and also contributes to CHAZ, the umbrella organisation for all faith-based providers.

CFA partners are reaching out to highly marginalised groups whose access to services would otherwise be very limited. Targeted beneficiaries of the more specialised service delivery NGOs include survivors of violence and torture (eg CVICT in Nepal), women (eg WOREC in Nepal and Centre Olame in DRC), disabled people (e.g. CBRS in Nepal), people living with HIV/AIDS (Ndola Diocese, Zambia) and the very poor in low income urban areas (YUHP in Nepal). In general, however, the impact of these NGOs tends to be localised and as yet there has been limited success in building support for scaling up proven new approaches.

YUHP is a notable exception to this. It is providing basic primary health care services to the urban poor, factory workers, migrants and internally displaced persons, mainly women and children, in Kathmandu's municipal area. The project has supported the building of the municipality's institutional capacity to take over its functions, and has created participatory structures and community-based health programmes that are effectively transferring to the authorities. In so doing, YUHP has effectively contributed to developing new policy and strategy for urban health care in Nepal.

Coordination and collaboration with government: The majority of service delivery partner organisations are working in coordination with government agencies, where they complement and strengthen government services such as Plan's ECCD centres, BNMT, and YUHP in urban primary health care in Nepal. Alternatively, they provide services under contract to, or in partnership with the government in areas where the public sector is not established, for example through faith-based sectors in Zambia and DRC. The training programmes supported through organisations such as ESP and IPASC

in DRC, and through the dioceses in Zambia, were also seen to fit well with national priorities and programmes.

These strategies are seeing results in terms of influencing or contributing to government policy development (e.g. the work of Centre Olame in DRC, YUHP and Plan in Nepal and Ndola Diocese's HIV/AIDS work in Zambia). In Nepal, Plan's approach to community health and development through the ECCD programme in collaboration with government has resulted in a nationally owned plan for scaling up. ECCDs have been included in the national poverty reduction strategy, although Plan could be advocating more strongly to ensure that ECCD standards are maintained in rollout plans, such as maintaining the nutrition components that benefit children of low-income households.

Networking and advocacy: CFA support also benefits several smaller but potentially influential NGOs, and networking or umbrella organisations, which are engaged in policy advocacy on key priorities such as pro-poor policy implementation and monitoring (e.g. CSPR and CCJDP, Zambia) and gender equity (CONAFED in DRC, and WOREC in Nepal). These organisations are having some success. For example, CCJDP and CSPR in Zambia have worked effectively with community-based organisations that form parts of their network, while also providing much needed capacity building of community groups. Kinshasa-based CONAFED in the DRC is a network of women's organisations active in all provinces. CONAFED is reported to have contributed to the increase in number of women parliamentarians, the participation of women in the political negotiations as part of the intra-Congolese dialogue at Sun City in South Africa, and raising gender as an issue for NGO networks.

However, the evaluators consistently found that capacity limitations, including in strategic planning and policy-advocacy, affected these organisations' ability to deliver more far-reaching results. Partnerships are not always encouraging the scaling up of successful activities of their members, nor acting as vehicles for spreading innovative practices. In the DRC, different BDOMs appear to have highly divergent strategies for addressing similar problems and are not engaging in significant cross-organisational learning. CHAZ, while effectively representing member interests in Zambia, is not contributing greatly to sharing lessons learnt or innovations. Innovative practices in some Plan project communities are not being transmitted to other Plan areas in Nepal.

Several of the service delivery NGOs are also engaged in partnerships and coalitions for advocacy purposes. Centre Olame is part of local partnerships such as the 'Coalition to fight against rape and violence against women' and the 'Network for action on human rights in Kivu' (RADHOSKI). Actions in defending girls and women's rights are commended by local authorities. However, specific policies targeting the protection of women from violence are lacking in DRC. Wider use of lessons learned from Centre Olame's success in working with violated and traumatised women could provide valuable evidence for advocating and implementing such policies in a context affected by conflict.

Community participation in development: This is emphasised by partners in their strategies, either by facilitating community management of project activities (e.g. the Early Childhood Care and Development Centres for Plan) or through engaging community members in various actions (e.g. health promotion and home-based care by community groups in DRC or Zambia). In the countries in conflict, DRC and Nepal, programmes supported by the CFAs lend a sense of normalcy to very abnormal lives, by

bringing communities together to work for their own improvement, while also providing much-needed services. In Nepal, active community engagement was found to be an important element in keeping programmes running, as the insurgents do not interfere with organisations seen as responding to the expressed needs of communities. There are significant local differences: in Zambia, as with DRC, community involvement in health management committees was highly variable between the dioceses. This in turn affects the degree to which community members engage in other actions for improving their health and health services.

A promising example of effective participation in DRC is the performance-based contracting (l'approche contractuelle), which is applied by BDOM Bukavu and recently introduced in Kananga. Apart from rendering services more effective, an important added value of this approach is that it offers great potential to increase community participation in managing health services.

However, it is also the case that few of the service providers have explicit objectives concerning beneficiary control over basic health-related services, and tend to see this as being mediated more through existing national policies that promote some form of community health management committees. Furthermore, there is currently no means of monitoring the involvement of poorer sections of the community, although Plan has specific objectives for strengthening the voice of children and young people. Anecdotal evidence indicates that the people who are better off in most communities are those who participate in community committees.

Governance arrangements in partnership and umbrella groups do not always support full participation. For example, WOREC in Nepal is active as an advocacy and capacity-building organisation and in providing services through local bodies. However, there is little indication from reports and interviews that the local community organisations have much input into the strategic direction of WOREC.

There are also some wider organisational issues that limit the effectiveness of the CFA partner strategies described above.

The evaluation team found that, overall, the CFA partner organisations rarely have strategic plans that set out SMART objectives and indicators to help them monitor whether their visions, overall strategies and activities are in fact achieving their purpose. Few of the service delivery organisations have explicit objectives to improve or monitor beneficiary access to or control over basic health-related services, particularly by the poorer groups.

Although some have set service delivery targets, the overall strategic objectives and implications for required capacity to deliver them are not always clear, and reporting tends to be input and output focused. In the main, it is difficult to demonstrate that their organisational visions are leading to outcomes and impact. There are two main exceptions. Plan's programmes, such as the ECCDs, have measurable indicators used to assess programme progress against objectives. BNMT, a long-established INGO, has a strategic plan for its service delivery objectives, with baseline data established in 2003.

For those NGOs, umbrella organisations and networks undertaking advocacy activities, an additional challenge lies in the need to develop measurable and achievable capacity-building and advocacy strategies. Planning and monitoring these kinds of strategies is

recognised as difficult – this is not just an issue affecting CFAs and their partners, but is a challenging one for many northern and southern NGOs.

Specific issues include the need for a baseline (e.g. mapping existing policy barriers and targets, possible allies, adversaries; and assessing stakeholder views and analysis). An advocacy strategy needs to set out achievable objectives, using proxy and intermediate indicators that measure progress along the impact chain. These might include informed media coverage that uses the organisation's research, gaining other NGOs' support, developing alliances, recognition by policy makers and elected officials – these are all steps along the path to introducing, implementing and monitoring new policy.

For example, it was noted by the evaluation team that in order for CONAFED to make a real change in the position of women, the organisation must identify its strategic priorities, build strategic alliances with donors and powerful national stakeholders (for example the BDOMs and NGO coordination body, CNONG), and build up managerial capacity inside their own organisation and networks.

The need for partner strategies is also linked to a broader strategic issue – that of each CFA's overarching global and national goals. Of the three CFAs, only Plan Netherlands has clear country strategies, linked to Plan's global policies. Neither ICCO nor Cordaid have as transparent or explicit a link between their global policies on health and the partners and programmes they support in countries. Consequently there is some disconnection between what Cordaid and ICCO aspire to support and what health-related activities are actually being implemented in countries through their partners.

This does not imply that ICCO or Cordaid should become operational organisations. However, the development of country strategic frameworks, through a process that involves dialogue with the partners themselves, would help to guide partner relations in future and create more explicit connections between ICCO and Cordaid policy and activities implemented by partners.

Given the challenging country contexts, it must be recognised that the service delivery organisations tend to focus on the key priorities of meeting people's practical rather than strategic needs, whether living in the conflict-affected areas of Eastern and Central DRC, and of Nepal, or working with communities in Zambia experiencing the triple threat of poverty, food insecurity and HIV/AIDS. However, this also creates the challenge for the CFAs of how to best influence and work with their partners and field staff to develop and implement newer CFA policy on gender equity and rights-based approaches.

Understanding and ownership of rights-based approaches amongst service delivery partners tend to be poorly developed. As all the CFAs are increasingly advocating for shifting to a rights-based approach in the work they fund, the question of how beneficiaries can influence the partner organisations themselves needs to be addressed more explicitly, as well as the problems of engaging more socially marginalised groups within communities.

Plan is the most effective at bridging this policy-implementation gap, perhaps not surprisingly, as it can facilitate greater understanding through its staff structure down to community level. However, Plan could also do more to strengthen staff capacity to challenge societal norms where those norms lead to the continued marginalisation of

certain groups. For example, the evaluation found that young people remain excluded from local development committees (Zambia) and dalit ('low caste') women are prohibited from being involved in certain activities (Nepal).

Cordaid and ICCO's ways of working give greater ownership to local/national organisations, and therefore require more investment in communicating and negotiating with partners to build commitment to gender and rights-based policies. Negotiating strategies for improving gender equity and challenging norms that disadvantage women is especially needed in some Catholic institutions supported by Cordaid, where some inconsistency was found in both DRC and Zambia. Women's participation in health committees and management structures remains poor in some dioceses, and many of their sexual and reproductive health needs were not or could not be met. There are, however, positive examples to draw on, such as the Family Action Programme in BDOM Bukavu, which concretely addresses gender concerns. It provides support to couples on issues such as sexual and reproductive health, responsible parenting and prevention of violence against women, and it strengthens women's decision-making power. This indeed adds value to the services provided.

More thought also needs to be given to how best to encourage 'rights-based approaches' in conflict/post-conflict situations. This evaluation found that in the highly sensitised contexts of Nepal and Eastern DRC, more nuanced approaches are required. The DRC and Nepal governments are not able to fulfil their obligations to citizens claiming their 'right to health'. In the case of Nepal local government staff themselves feel that their involvement in service delivery could compromise effective provision of much-needed health services. Rather than approaching rights-based approaches from a 'duty versus claim' dichotomy, partner organisations could be looking at other demand-side approaches that help build community confidence to claim their right to health from a wide variety of duty holders.

Recommendations for improving health-related visions, strategies and activities

All CFAs

- More concerted support needs to be given to partners (government and non-governmental) in organisational development capacities such as strategic planning to help them operationalise their goals, and assess their achievements. Expertise for doing this exists in all three countries studied in this evaluation, and specific funding could be given by CFAs to buy in this support.
- In-country workshops should be held to work with partners (ICCO and Cordaid) and staff (Plan) on how to understand and adapt CFA core policies on gender and rights-based approaches (RBA). RBA in particular needs specific attention in Nepal and DRC, and the CFAs should look at how to strengthen their partners to build community confidence and demand-side strategies. These could include for example, strengthening community management of partner health facilities and exploring the value of voucher-for-service schemes that target poor and marginalised groups.

Cordaid and ICCO

- National frameworks should set out each CFA's priorities and strategic directions in terms of pro-poor development and target groups, and draw out coherent links between its policy and the expected results of its support to existing partners, as negotiated with them. This latter point, of defining the CFA's niche with the partners is particularly important, given the fact that the CFAs are only one among several

donors for some partners. It would also indicate the kinds of inputs (financial, capacity building, support to advocacy etc.) that partners could expect from CFAs. Such a framework would create a clear thread that draws an explicit line from global policies and strategies to the local adaptation and implementation of those policies as agreed with partners.
- As part of their organisational development programme, ICCO and Cordaid should continue to support internal organisational and partnership assessment exercises such as the one employed during this evaluation, to help their partners evaluate their own development needs.

Cordaid
- Given the importance of Cordaid's global gender policy, the CFA needs to negotiate more robustly with its Catholic partners to ensure a much more meaningful involvement of women within diocesan structures. It should build on models of strong female leadership in the Catholic church in other countries and explore how these can be adapted with its partners who work to more male-dominated models. As mentioned above there are examples of good practice in the case study countries to draw upon. However, the evaluation also found that Cordaid in particular needs to consider how it collaborates with Catholic-run health service providers that are not open to focusing on women's participation in decision making and that will not engage in effective delivery of sexual and reproductive health services in countries with high maternal mortality and escalating rates of sexually transmitted infections and HIV. Where church partners prove particularly resistant over time, Cordaid should as a last resort consider reducing or withdrawing support altogether.

Plan
- As part of developing rights-based approaches, Plan should develop a programme of support to its own staff, many of whom come from their programme communities, to build understanding of the dynamics of social exclusion and ways in which to challenge social norms.

1.2.2 Quantitative and qualitative impact of health-related services

The evaluation coordinators have not been able to reach a definitive conclusion about the health impact in quantitative terms of CFA partners. In all three countries CFA partners were on track with meeting their annual activity targets, where they existed. However, quantitative impact is particularly difficult to assess amongst Cordaid and ICCO partners, due to a lack of quantitative indicators, poor population data, no baseline information and poor monitoring data. Plan has a more developed monitoring and evaluation system, which has allowed the evaluators to review progress over time.

All partners and projects supported by the three CFAs are providing health-related services that otherwise would not exist at all, or to a very limited extent in all three countries. The community outreach programmes of the CFA partners are particularly effective in reaching people with primary health care and health promotion activities, where they would otherwise not be reached. For example, the Zambian AIDS home visit programme run by Ndola Diocese is especially effective in bringing care to people who would otherwise receive no care at all. Similarly, the YUHP programme in Nepal is bringing health care to people in poor, migrant communities who would otherwise have to fend for themselves in the private sector.

A concerted effort now needs to be made to assist organisations to develop health-related indicators where appropriate, and to improve their own monitoring systems. New health information systems do not necessarily need to be created to address this, as national systems already exist and can be better applied by CFA partners. As the main barriers to the widespread use of the health management information systems concern logistics and capacity issues, the partners need more support to introduce and use existing national systems. They also need to consider what other data they need to collect on a routine basis in order to measure achievement of organisational and programmatic objectives, especially with regards to how well they are meeting the needs of poor people.

A further problem that is impacting on quantitative results amongst Cordaid partners is the reluctance by some of the Catholic institutions to provide comprehensive sexual and reproductive health services. Significant service-delivery gaps were found where Catholic diocesan health services have a limited sexual and reproductive health programme, particularly where these health services are the only service providers available. In both DRC and Zambia, where there are both high rates of maternal morbidity and mortality and where communities are heavily affected by the HIV and AIDS epidemic, sexual and reproductive health programmes are vital for preventing illness and death.

From a qualitative perspective, health services provided by CFA partners are widely appreciated by government stakeholders and beneficiaries. These services are considered to be of higher quality than alternative (public) services. In general the quality of care provided by different partners can be considered to be technically good or very good. Quality is determined by factors such as the quality (and presence) of qualified staff, staff attitudes to patients, and levels of material, drugs and equipment available to diagnose and treat patients appropriately. All services evaluated rated well in terms of material, drugs and equipment in health units. Even where state-run health services operate fairly close by faith-based facilities supported by CFAs (as seen in parts of Zambia), the faith-based facilities are better able to diagnose and treat patients due to having more qualified staff and a better stock of medicines.

There remain, however, serious challenges to service quality in all three countries. The conflict and weak state structures in DRC and Nepal mean there are severe problems with recruiting and retaining qualified staff in partner health units. Zambia also faces serious problems with retaining staff in remote health units, whether in the state or non-state sector, with its problems further compounded by the loss of many trained staff to AIDS. The CFAs are working with partners to improve the situation with regards to staff retention, for example, supporting incentive schemes and providing trained volunteers.

New trends in contracting health services between the state and non-state sectors provide opportunities for Cordaid and ICCO's partners to review their relationship with the state sector as well as for shaping national health policy. This will also require more alignment with nationally agreed quality assurance standards and health monitoring system requirements. While acknowledging the very real challenges facing districts and dioceses, the long-term sustainability of health services is dependent on their working closer together. This may require a more open and transparent approach by some partners. Similar issues arise where Plan runs health clinics or schools on behalf of the government.

Community-based activities are filling a real public health need and benefit poor and non-poor alike. For many beneficiaries, though, user fee charges continue to be a significant barrier to their ability to use health services, even where costs have been reduced. The CFAs are not, at present, working with partners or developing policy-influencing strategies for reducing the damaging effects of user fees, other than supporting small-scale activities with limited reach. Section 8 explores some of the mitigating strategies in more detail.

Across all countries, financial sustainability of partner activities is extremely weak, and will continue to be so for the foreseeable future. This is not surprising in such aid-dependent countries, nor in countries such as DRC and Nepal, which have to contend with conflict and the threat of conflict. Sustainability of programme activities, especially those that are community based, appears to be more certain in those programmes that actively engage community members, that encourage self-help initiatives and that build community capacity to carry on beyond the life of the project. Examples of programmes that have high prospects for longer-term sustainability through community mobilisation include BOAD's work, ELIMU's literacy programme and the various home-based/community-based care initiatives supported by CFAs. Stronger governance arrangements that increase accountability by moving from a staff- to stakeholder-based model would also improve chances for sustainability, for example as developed by CBRS in Nepal.

Sustainability can also be better assured by integrating programme activities into government systems, as is being done with Plan's programmes and YUHP, set up by UMN in Kathmandu. However, as can be seen with government plans to expand the ECCD programme in Nepal, public resource constraints may limit the government's capacity to implement programmes to the standard set by non-state providers.

Recommendations on improving quantitative and qualitative impact of health-related services

All CFAs

- All CFAs should continue to work with and strengthen their community-based programmes, as these are having the greatest effect on the health of poor people, and have the greatest likelihood for sustainability (e.g. Mama and Papa Bongisa, Kinshasa Diocese; Ndola Diocese's AIDS home-based care; Plan's outreach work in Zambia and Nepal).
- All the CFAs need to reconsider their own and their partners' strategies that depend on user charges for services they support. User fees are a deterrent to the use of services by poor people and appear to contradict the CFAs' own pro-poor policies; yet they also provide much-needed resources to maintain services at local level. A first step should be to hold a policy forum that includes staff of the CFAs, representatives of their partners/field staff and leading researchers to help frame how the CFAs can respond to this and how they can support or influence national policy development in either eliminating user fees or creating social safety nets for those who cannot afford them.
- Training should be provided to CFA partners (governmental and non-governmental) in the collection and use of routine health data to help develop an evidence base with regards to health outcomes and ensure it is well linked to the national health management information system.

Cordaid and ICCO

- In order to measure the health impact of CFA support, national strategic frameworks should include objectives with measurable indicators that reflect the aggregate results of their partners' own strategic plans and targets. CFA partners also need capacity building to help them with developing capacity in this area. This will greatly support partner M&E activities, and facilitate future evaluations of health-related programmes.
- Sustainability of health-related services remains a key concern for ICCO and Cordaid partners. ICCO and Cordaid should work with their service delivery partners on improving the prospects of longer-term sustainability of their activities, through designing handover strategies, creating more transparent links with government services by making better use of contracting arrangements and building on models of good practice for community involvement identified in this, and other, evaluations. ICCO and Cordaid should also continue to encourage their partners to seek ways of diversifying their funding base.
- ICCO and Cordaid should examine the model of community capacity building employed by Plan and discuss with partners if and how this model could be adapted into their community-based work.

Cordaid

- Cordaid needs to give serious consideration to how it can support filling the gap left by its partners in family planning and other reproductive health services. One suggestion is that where the Cordaid (Catholic) partner is the sole service provider Cordaid should also fund an alternative non-Catholic partner to ensure these services are accessible, or that it use its influence to persuade another donor to provide support in this area. At the same time Cordaid should embark on a programme to facilitate greater cross-learning between the Catholic organisations it supports and negotiate more emphatically for attention to be given to sexual and reproductive health within the organisations it supports.
- Health reforms leading to decentralisation have created a new set of dynamics that Cordaid's partners in Zambia have not fully incorporated into their own thinking. Cordaid and its partners also need to reflect on how to build a more transparent and trusting relationship with government line agencies in Zambia, including being more open about financial flows.

Plan

- Plan programmes should consider exploring the UMN experience in Nepal to see whether they can further institutionalise their programmes by setting up and supporting a local NGO, which would then carry on the main areas of Plan's activities.

1.2.3 Issues concerning extent and impact of partnerships and networks

Partnership and networking has had an overall positive impact on the work of the partner organisations. The partnerships supported through CFA funding are making a meaningful contribution to local and national policies on health for poor people. The more established networks, such as CHAZ, CCJDP and CPRS in Zambia and CONAFED in DRC are ensuring dialogue both within the networks themselves as well as with national bodies and other stakeholders. It was reported that building of coalitions with other organisations resulted in generation of a greater voice. Several examples of effective approaches have been given in previous sections of this summary.

Many of the networks and partnerships evaluated also have strong elements of capacity building of members and community organisations as key strategies for enhancing the work of their networks. The following examples illustrate the importance of capacity building for improving the performance of partners:

- CONAFED has developed and runs training modules for members in raising awareness of gender issues and supporting the mobilisation of women.
- ELIMU has developed literacy training modules and management training programmes for community-based women's groups, which directly benefits the performance of these groups when applied to their income-generating activities and other areas of work.
- Plan's programmes in both Nepal and Zambia have worked closely with and supported the training of local government counterparts, leading to improved performance in such areas as Integrated Management of Child Infections.
- BNMT's collaborative work with government staff has built government capacity to plan and manage TB programmes.
- CCJDP and CSPR, through training programmes aimed at members of their own networks, have built the capacity and confidence of community-based organisations to monitor and hold to account government officials.

However, as mentioned above, networking and advocacy organisations also need support in developing strategic plans, objectives and indicators that will help them to set targets and monitor their progress in achieving the purpose of their partnerships or advocacy campaigns. Much of the impact of partnerships and networks reported in this evaluation is anecdotal, and needs better data to back up the stories of improvements provided to the research teams.

The evaluation also found that there is some confusion as to how the terms 'partnerships and networks' are being used. In some cases, those organisations designated as a network are in fact large local NGOs that provide a conduit for funding to community-based organisations (e.g. WOREC in Nepal and BOAD in DRC). These are therefore not partnership or network organisations where members are supported by a secretariat. However, such large NGOs do provide important umbrella functions, such as capacity building, for community organisations that would be difficult to achieve otherwise, and therefore enable much greater reach into poor communities.

Although some efforts have been made, Cordaid and ICCO have not yet been able to build effective links between their partners and relevant networks in the countries they work in, nor are they playing a role in bringing together like-minded organisations within countries, which would have the potential for creating greater synergies. This could allow them to scale up innovative practice beyond the scope of their projects. This has resulted in some degree of 'atomisation' of programmes within countries, with little sense of an overall, coherent health strategy that works towards improved population health.

For example, the dioceses in both Zambia and DRC operate similar structures and within similar systems. However some have been more innovative and responsive to community need than others, and yet there seems to be little sharing or spread of good, innovative practice. Another example was found with the organisations that had branched off from UMN projects in Nepal, where again, there appeared to be little sharing of good practice (for example, in terms of governance), which could

help organisations to improve their performance. Plan could also create stronger links between its various project teams, and between these teams and local/national networks.

Recommendations for strengthening partnerships/networks

Cordaid and ICCO

- Networking and advocacy partners need particular support in developing ways of measuring the outcomes of their less tangible activities. The strength and results of partnerships can be assessed within the partnerships themselves, using validated tools, one of which was introduced in this evaluation. Cordaid and ICCO should also support advocacy partners to develop measurable targets and key indicators that will help them to benchmark progress towards reaching their advocacy objectives.
- Once partnerships and networks have undertaken a more robust assessment of their partnerships, Cordaid and ICCO should support these organisations to build on their members' strengths so that they become more influential. At present, many of the partnerships and networks supported are not creating the synergistic effect expected from organisations working together.
- Cordaid and ICCO already provide some South-South networking opportunities for partners and these could be continued and expanded to include a cross section of both organisations' partners where appropriate. Innovative work done by partners on gender-based violence should be a key area of expansion as some of the organisations working in this area remain small and isolated.
- In the DRC, Cordaid and ICCO should work together with their faith-based partners and other donors to develop a national faith-based health association that can advocate on behalf of faith-based health service providers as well as provide a framework for quality assurance of health services. It may be helpful to involve CHAZ, to draw on its experience as an effective umbrella organisation in Zambia.

1.2.4 Issues concerning CFA value added

The CFAs are bringing added value to the work of their partners, primarily through flexible and consistent funding and support for capacity building. While there is much overlap between the policies of the CFAs, each also has unique elements to its approach. Assessment is limited by the lack of identified added value in CFA strategy, in terms of, for example, capacity building and human resource development, global North-South advocacy, promoting innovation and facilitating linkages and information exchange.

Examples include Cordaid's support to strengthening BDOMs and provider partners in Zambia in building up their managerial competences, which is contributing to making the organisations more efficient and effective, and broadening their funding base. Respondents in DRC felt that the presence of a local office for Cordaid facilitates interaction between Cordaid and its partners, enhances their participation in donor coordination, and facilitates advocacy for improved legislation and policy making at the national level. Cordaid's technical assistants are also filling in human resource gaps in hospitals and clinics where it is very difficult to recruit and retain staff, while Cordaid is also providing packages of training and incentives to national staff.

ICCO has a very flexible approach to its funding, allowing it to build partnerships with civil society institutions, while also maintaining links into faith-based organisations which are critical health service providers in many countries. ICCO's approach opens opportunities to small organisations that are usually below the international development radar. An observed significant added value of ICCO's support is that it

enabled partners to adopt and maintain a more holistic approach, which does not address health in isolation but as an integral aspect of development. It was felt that the importance given to community capacity building was very valuable though extremely challenging in war-stricken areas. Support rendered by ICCO is strengthening civil society in Eastern Congo in terms of providing specialised services as with CME, increasing training capacity for community health and creating enabling environments (IPASC), and networking with grassroots organisations (BOAD and ELIMU).

Plan's work in country brings a more 'hands on' approach to community (and civil society) capacity building through its community facilitators and through facilitating training for health facility staff. Plan Netherlands' contribution is to provide active support for this work, and to promote the child-centred approach.

Numerous areas of effective innovation were also identified by this evaluation, for example, in Plan's programmes for early childhood care, in the organisations supporting women who experienced sexual violence (Cordaid-DRC and ICCO-Nepal), in institutionalising new approaches with government and influencing policies on urban primary health care (ICCO-Nepal), AIDS outreach and care in Zambia (Cordaid) and performance-based contracting in the DRC (Cordaid).

Some of the partner organisations visited have been involved in a number of capacity-building workshops in Zambia and DRC. ICCO has also organised regional level sharing meetings for some of its partners, and partners have been enabled to attend regional conferences. Some North-South networking is taking place at the global level. However, no formal or informal networking and coordination among CFA (mainly ICCO) service delivery partners have taken place in Nepal. Networking activities in general are weak among all NGOs. While the conflict situation may explain some of this, the fact that this evaluation was able to conduct two workshops with health-related partners during particularly tense periods shows that it is possible to facilitate greater networking.

Many partners reflected on the fact that, at least as far as Cordaid and ICCO are concerned, they were aware that Netherlands-based programme officers were overstretched with the number of countries and organisations they cover. Also, frequent changes in staffing within these key link posts made communication very difficult, especially regarding any dialogue on organisational strategic changes. To many partners, new policy directions outlined in the various CFA policy documents were perceived as more of a 'whim' of individual programme officers, rather than representing important changes with implications for the partnership.

This evaluation has found that added value could be strengthened. As many of the partner organisations funded by the Cordaid and ICCO also receive funding from multiple other donors, these two CFAs need to reconsider the niche they can fill to increase the added value of their support in line with their global policy objectives. The evaluation team identified a number of areas in which the CFAs could strengthen their added value, related primarily to supporting partners' institutional development, such as strategic planning, financial management, M&E and communication mechanisms. Given their long-standing relationships with their partners, the CFAs also have unique opportunities with which to challenge prevailing norms that continue to exclude women and marginalised groups and, especially within the Catholic missions, challenging conservative attitudes to sexual and reproductive health and women's participation.

Recommendations for strengthening added value

All CFAs

- As an initial step CFAs should support cross-learning opportunities that bring together partners in single countries or regionally to share experiences and discuss good practice. These could be done at a sectoral level, though much of the good practice observed during the evaluation has cross-sectoral application. This should include making more deliberate efforts to link partners involved in running networks for advocacy-related work and service delivery partners.
- CFAs should also develop strategies to strengthen the voice of their southern partners in the North, working with partners to agree on priority issues for advocacy by CFA policy units.

Cordaid and ICCO

- Both Cordaid and ICCO need to elaborate more explicit links, through strategic planning processes, between their global policies related to access to health and basic services and the programmes they support in countries. These links must delineate how the CFAs are adding value to partners' programmes, including:
  - Challenging prevailing social and organisational norms relating to gender, as well as paternalistic attitudes of some partners towards communities they work with.
  - Developing mechanisms for cross-learning between partner organisations to ensure the spread of good innovation and promote stronger coherence. This is particularly important in DRC and Nepal, where normal coordination mechanisms are weak or non-existent and need developing. This could start with an exploration with partners of what coordination mechanism would best suit their needs and could extend to non-CFA partners in time.
- CFAs should strive for greater stability of programme officers to allow for more consistent and longer-term contacts between partner organisations and the relevant CFA. Where this is unlikely, or hard to control, the CFAs need to develop a more consistent communication strategy with partners that allows them to engage more in dialogue with the CFA organisation concerned.

Plan

- Plan should encourage greater cross-learning between staff working on different projects, as innovations are not being spread effectively across each country's programme.
- Plan staff should be provided with further training and support to challenge social norms within the CSOs they work with that exclude particular groups, and to use their prominent role in the communities to advocate more directly for the rights and needs of the most vulnerable.

2 Introduction and Background

2.1 Background and purpose of the evaluation

This report summarises the key findings of the evaluation of the health component of three of the Dutch Co-Financing Agencies: Cordaid, ICCO and Plan Netherlands. The evaluation used a case study approach, with three country programmes selected by the three CFAs: DR Congo, Nepal and Zambia. The evaluation was commissioned by the three Co-Financing Agencies to contribute to the wider, ongoing Co-Financing Programme evaluation (2003-2006), which includes studies undertaken on six additional themes. ICCO had lead responsibility for coordinating the health component evaluation.

Cordaid, ICCO and Plan Netherlands agreed to commission a programme evaluation to gain better insight into the results of their support of health (related) activities for poverty reduction and to learn from their practice. The evaluation is seen in relation to the ongoing evaluation efforts related to the CFP (Co-Funding Programme) that have been undertaken since 1980. Based on a review of the results of previous evaluations and changing organisational policies, the three organisations decided the present evaluation must give attention to both direct service delivery and to civil society building aspects of the CFA-supported interventions in the health sector.

This report summarises the results of the three country evaluations and analyses these in relation to the stated polices of the three CFAs as well as the key variables used within this evaluation. Please see Appendix 2 for the Terms of Reference for the evaluation, and appendices 2 through 4 for the detailed evaluation reports in see separate country reports for the detailed evaluation reports.

2.2 National contexts

The three countries selected for inclusion in the evaluation, Democratic Republic of Congo (DRC), Nepal and Zambia, all feature in the low end of the UNDP's Human Development Index, with the majority of the population in each country living below the World Bank's absolute poverty line of US$1 per day. Two of the countries (DRC and Nepal) are experiencing ongoing conflict, which has had a critical impact on people's livelihoods and personal security, as well as severely disrupted public service delivery. Although enjoying political stability, Zambia is facing the triple threat of poverty, continuing food security difficulties, and the exacerbating effect of its severe HIV/AIDS epidemic. While large parts of the population in all three countries are highly dependent on external aid in order to maintain a basic standard of living, the dynamics of conflict have had the dual effect of making people both more vulnerable and also less easy to reach through development assistance.

The tendency in conflict situations (and often in highly aid-dependent communities) is to import technical assistance and invalidate local experience and expertise. The imperative to deliver assistance tends to overrule the importance of continuing to build on local capacity and to support local coping strategies. Each of the three CFAs

evaluated in this report have responded to the challenges that the national contexts present them in a variety of ways. All emphasise local capacity building as part of their development strategy, whether their partners are working within a complex humanitarian crisis or a more stable development situation. The results and analysis in this report are presented with these contextual issues in mind.

2.3 Health-related services

Health systems are made up of a variety of actors, institutions, funding and service delivery mechanisms. The fundamental system features of health service delivery are how it is provided and how it is financed. In all three countries that took part in this evaluation, the health systems are made up of a combination of state and non-state providers. In terms of health-related services for poor people, the main providers are the state, NGOs and faith-based organisations. However, the countries also have a significant informal private sector made up of traditional healers, as well as 'brief case' or 'quack' doctors who are unqualified individuals with ready access to drugs. These informal providers often give much better access to treatment for poorer and more remote communities than the more formal health services can. The formal for-profit private sector in all three countries caters primarily for the wealthier (urban-based) elite, who can pay for the more specialist services offered.

Historically, faith-based clinics and NGO clinics were set up in remote areas of countries, with an ethos of service to marginalised communities. With their direct connections to external sources of funding and arguably better management, faith-based and NGO clinics have been seen as better resourced and more able to cater for the users of their services than government services. However, government-run services are seen as the backbone of the health system, and the populations of most countries consider that governments have a duty to ensure access to basic health care for all, a duty that cannot be imposed on non-state providers by communities themselves. Government services have tended to be very poorly resourced and understaffed. Both government and faith-based clinics have substantial reach across the three countries studied here.

In Zambia and Nepal, efforts have been made to coordinate and regulate services across the state and non-state divide through reforms to the health sector. Memorandums of understanding guide the relationship between the state and faith-based organisations in both these countries. Such efforts are at a very early stage in the DRC, where government policy and influence in the health sector has been extremely weak for the last 30 years. In the DRC an EC funded programme has introduced government contracting whereby non-state providers enter into a performance-based contract with the government to deliver an agreed set of services. Contracting has gained increasing interest amongst the donor community as a means of supporting government regulation and coordination of the health system in weak states, while recognising that non-state organisations are better placed to deliver services and programmes.

In all three countries health services are funded through government budgets, donor funds and charges to users. Very limited social insurance schemes exist in the three countries, and these tend to be geared to urban and better-off populations. All countries have exemption policies aimed at ensuring that the poorest and most vulnerable parts of the population are not charged for services. In no country are these exemption policies adhered to or implemented consistently. This situation mirrors findings from

more in-depth research, which indicate that user fee exemption strategies are simply not implemented and are often abused.[2] Some small-scale efforts have been put in place to make health care more affordable to poor people in urban and rural areas, primarily through non-governmental projects. These have included 'associations mutuelles' (which are member based and act as local insurance schemes), cash transfer schemes (where money is given to poor families to help pay for school fees and health care costs, usually through social services) and barter systems (where the equivalent of fees are paid through commodities, such as maize or other locally produced goods).

2.4 Evaluation aim and questions

The aim of this evaluation is to: gain insight into the contribution of the CFAs and their partner organisations to the improvement of sustainable use of, access to and control over health-related services for the poorer sections of the population, with a special emphasis on women and youth.

Questions to be answered by this evaluation are provided below, with sub-questions/ areas of enquiry:

- Which visions, strategies and activities do partner organisations have to improve access to, use of and control over basic health (related) services by (potential) users in the programmes funded entirely or partially by the CFAs?

- What are the qualitative and quantitative results of these programmes and for whom do they improve sustainable access to, use of and control over basic health (related) services?

- To what extent do (complementary) partnerships, participation in networks and/or alliances contribute to better performance of the partner organisations and the health system in general?

- With what results do (complementary) partnerships, participation in networks and / or alliances contribute to a better performance of the partner organisations and the health system in general?

- What is the added value, in terms of partnerships and results, of the CFAs' support for the partner organisations and their programmes?

The above questions were answered using an analytical framework that includes six variables that the evaluation team considered to be core to the questions that needed answering. As this evaluation seeks to understand both outcomes and processes, the variables to be assessed are as follows: Impact/effectiveness, Quality, Coherence, Participation, Sustainability, Added value. As stated in the Technical Proposal (p. 9, annexe), 'Programme outcomes are delivered or mediated through a number of processes or outputs, including direct service provision to poor communities, civil society building through development of alliances and networks, citizen and client

[2] Creese AL (1991) User charges for health care: a review of recent experience. *Health Policy and Planning* 6: 309-319; Gilson L (1997) The lessons of user fee experience in Africa. *Health Policy and Planning* 12: 273-285.

voice and policy-advocacy activities, often undertaken by the intermediary partner organisations. Investments/inputs to these processes by the CFAs are the key strategies of a) working in partnership with a number of groups in each country and b) facilitation of organisational development or capacity building'.

3 Methodology of Evaluation

3.1 Overview

The methodology is based on well-tested case study methods used in similar styles of research. Both Marsden et al. (1994) and Roche (1999) either reviewed or used the case study approach as a means of evaluating the impact of development assistance. The methodology in this study is based on the learning and best practice advice outlined by both groups of authors. Standardisation of data collection was assured through use of a common framework across all three countries (see TORs in Appendix 2) and common data collection tools (see below).

As outlined above, the evaluation examined the CFA programmes in three different countries: Democratic Republic of Congo, Nepal and Zambia. The three CFAs formulated the following criteria for the selection of the case study countries:

- Substantial financial CFA contribution to health-related programmes
- Considerable number of partner organisations active in the health (related) sector
- Existence of a network, support organisation or other formal or informal structure in the health system in which the partner organisations participate in order to undertake lobbying, advocacy or other activities or receive support from it
- Evenly spread over the continents
- Have had no recent evaluations

3.2 Research teams

In line with the philosophy and practice of the CFAs, the evaluation study in each country was undertaken by national teams, with oversight provided by two international consultants. The teams were recruited through the HLSP Institute's existing networks, with care taken to ensure that members of each team had no conflict of interest and could therefore provide an objective overview, e.g. none had worked for any of the programmes selected for evaluation.

3.3 Definition of terms

A number of terms were used in the evaluation questions and in the variables considered during the evaluation. The research teams understood these terms as follows:

'Health related': Activities that lead to direct health improvement, including health promotion, disease prevention (e.g. water and sanitation), clinical treatment and care; as well as activities whose main purpose is to improve health, e.g. health advocacy and health systems support.

'Partnership':	The primary partnerships evaluated were the formal partnerships and networks receiving support from the CFAs. The other level of partnership examined was between the CFAs and the organisations they fund and support in the three countries.
'Impact/Effectiveness':	Achievement or likely achievement of objectives Improvement in programme health indicators Improvement in organisational development indicators Improvement in advocacy indicators
'Quality':	Technical quality of the design of programmes Quality of personnel – qualifications and professional development Quality of services – adequate and consistent supplies of drugs and equipment User views on quality of services (acceptability and satisfaction)
'Coherence'	With national health policies and standards With CFA health policies With Dutch government policies in the three countries Potential for innovations to influence the development of improved policies and strategies of both national governments and of CFAs
'Participation'	Full involvement of beneficiaries and/or partner organisations in planning, managing and monitoring Full and equal involvement of normally disadvantaged groups (women, youth and ethnic minorities/low caste) in planning, managing and monitoring programme activities
'Sustainability'	Financial, institutional and human capacity to continue beyond programme support Of expected outputs and outcomes of programme interventions Of partner organisations themselves
'Added value'	The benefit of receiving CFA support beyond funding • To individual organisations and partnership/networks • Complementarity of the relationship • The benefit to individual organisations of membership in a network or partnership

3.4 Sampling strategies

Sampling of partners in countries
Selection of the specific partners to be involved in the study was based on the following criteria:

- Aims and objectives of the partner organisation and/or the health interventions
- Level of activity of the partner in the health field
- Balancing rural and urban interventions

- Mixture of different types of organisations and interventions (direct service delivery, advocacy, community health promotion and empowerment etc.)

Gender is a cross-cutting theme of all the CFAs and featured within the analysis of individual partner programmes.

In order to reflect the change from a needs-based approach to a rights-based approach, whereby the poor are empowered to claim their rights, other organisations beyond the health sector were included. In this respect the teams looked at the country level at links with networks with strong judicial aspects, civil society networks advocating for and monitoring health within PRSPs, women's networks that promote health improvements and, in the case of Congo, also networks that address violence issues.

In order to make the most objective selection of partners possible, each CFA was asked to fill in a partner information sheet for any partner that was being funded to implement a health-related component within their organisation (see Appendix 5). One of the international evaluators also interviewed the relevant programme officers in each organisation to gain a better insight into both the overall programme strategy for the country as well as the individual partners and programmes. Once the teams began working within the countries adjustments had to be made to which partners were selected based on security concerns (especially in Nepal and DRC) and logistical concerns (e.g. physical and financial access for visits). For this reason DvDW in Nepal had to be dropped from the initial list as the team could not reach their area of work.

Using the criteria outlined above a selection of partners was made in each country, as set out in Table 1.

Table 1 – Partners selected to participate in evaluation

DRC	Nepal	Zambia
Cordaid Bureau Diocesan d'Oeuvre Medicale (BDOM) Kinshasa, Kananga and Bukavu Ecole de Sante Publique (ESP) Comite National Feme et Development (CONAFED) SPS (Cordaid assistance discontinued) Centre Olame	*ICCO* United Ministries of Nepal (UMN) - Yala Urban Health Project (YUPH) - Centre for Community Development (CCDN) – Makwanpur - Sakriya Sewa Samaj (SSS) British Nepal Medical Trust (BNMT) CVICT WOREC Community Based Rehabilitation Services (CBRS)	*Cordaid* Catholic Centre for Justice, Development and Peace Christian Health Association of Zambia Civil Society for Poverty Reduction Diocese of Ndola Diocese of Mpika Diocese of Mansa
DRC	**Nepal**	**Zambia**
ICCO Bureau Oecumenique d'Appui au Developpement (BOAD) Centre Medicale Ecumenique (CME) Beni ELIMU Institut Panafricain de Sante Communitaire (IPASC)	*Plan* Evaluated projects in - Makwanpur - Kathmandu	*Plan* Evaluated projects in - Mazubika - Chibombo

(Partner details are provided under individual country sections of this report. See separate country reports).

Sampling of health data
Partners were asked to provide baseline and monitoring data that they collect for assessing progress within their projects. The teams also tried to collect national and local area health data with which to compare project data.

Sampling of key stakeholders
Interviews were held with government staff from relevant departments (national and local), service provider staff and beneficiaries. At the inception workshops partners were asked to provide a list of whom they thought were the key people to be interviewed about their projects (e.g. their contact persons in Ministries of Health.) Beneficiaries to be interviewed were selected through purposeful sampling in order to ensure representation of views of women, men and youth. Organisations being evaluated provided initial introductions into communities, which the teams then followed up with invitations to be part of a focus group discussion.

3.5 Data collection methods

International level
The international consultants reviewed policy and programme documents of the three organisations in order to understand better the policy context within which they were funding partners and programmes in the three case study countries. Particular emphasis was given to health policy documentation, and to any documents referring to country-specific policies and strategies. These were then summarised to inform both the country-specific evaluations as well as the overall findings for this report.

Country level
Standardisation of data collection across countries was assured through development of interview guides and focus group protocols (see Appendix 7), though teams were advised to adapt these to local circumstances. Organisational and partnership assessments were carried out using a validated self-assessment form, either filled in individually or as a group. Research team members then discussed why individuals and groups had rated their organisations the way they did (see Appendix 8 for tool used).

Each research team was tasked with carrying out the following evaluation activities:

- Inception workshop – Research teams were asked to invite partners to an inception workshop so that the evaluation process could be explained, their questions could be answered and they could have input into the process more generally by suggesting any key issues they wished to see covered.
- Health data collection – In order to evaluate the possible impact of projects and programmes, research teams collected project health data (service statistics and disease data) and compared these with local area and national statistics.
- Organisational assessments – An organisational assessment tool was also provided to assist with evaluating organisation-related variables (see Appendix 8). The organisational assessment tool was piloted during two inception workshops (in Zambia and Nepal), both to assess the acceptability of using the tool during the evaluation, as well as to test its applicability. In both cases participants found the tool to be a useful addition and agreed to its use in their organisations.
- Organisation/project staff interviews – Partner organisation and project staff were asked to provide their perspectives on how well their health-related work was

progressing towards achieving their objectives as well as to give views on the added value of the partnership with the CFAs.
- Key stakeholder interviews – Stakeholders in each country who were not directly involved in partner programme implementation were asked for their views on the Dutch CFA health programmes. These stakeholders included staff in national ministries and the relevant staff in Dutch embassies (where appropriate) amongst others.
- Beneficiary interviews – focus group discussions and individual interviews were carried out with beneficiaries to explore how health-related activities funded by the CFAs may have improved their access to, use of and control over health-related services.
- Feedback workshops – Once data collection had been completed and an initial analysis developed, partners participating in the evaluation were invited to attend a feedback workshop so that they could hear the results from the research team, fill in any further gaps in information and correct any misconceptions that arose from the evaluation.
- Interviews and correspondence with key CFA staff.

3.6 Limitations and constraints

Data limitations: Most of the organisations covered in this evaluation, including ICCO and Cordaid and their partners in-country, have not developed measurable indicators against which to monitor progress towards achieving objectives, rendering attempts to measure impact difficult. Efforts were made to compare outputs with local area and national health indicators, but this also proved methodologically difficult, due to problems with identifying the denominator and the generally poor levels of data available.

Methodological constraints: In order to ensure reliability and validity within the evaluation process, the same methods were used across all three countries. While this worked to some extent, the rigidity imposed by such standardisation led to problems particularly in the DRC component of the evaluation. Other methodological constraints related to this evaluation being asked to measure health impact, which requires far more in-depth evaluation resources than the time and finances allocated.

Generalisation concerns: Case study methodology is limited in its ability to generalise findings to the whole of any organisation's programme. The findings presented in this report relate to the situation in the countries covered by the evaluation. However, the analysis examines these findings in the light of CFA policies and general trends in development aid. To generalise these findings it may be necessary to test the analysis with partners in other, non-case study, countries.

Logistic concerns: Problems impeded certain aspects of the evaluation process. As participating partners were not chosen until after the tendering process and budget had been completed the time and distance to be covered to reach certain partners imposed considerable constraints on the research teams. The planned inception workshop could not be held with Eastern-based partners in the DRC due to communication and logistical problems. However, feedback workshops did occur in all three countries and were very helpful to the research teams. On reflection, the tender documents could have provided more detail about the numbers and location of potential partners to be evaluated, as

well as a proposed number of organisations to be included from each country. This would have helped ensure better tailored budgeting and planning.

Security issues were another concern the teams had to cope with. The security situation in DRC and Nepal also limited the ability of research teams to either reach certain project areas or to interview beneficiary groups. As a result, certain partners were dropped from the original list chosen or were asked to meet with the research team in a location that the team could access more easily.

Time constraints: Related to the above, all the research teams felt seriously hampered by time constraints. On reflection, the scope and scale of the work required and expected by the CFAs was greater than the time and funding permitted. As a result, some aspects of the programmes evaluated could only be looked at superficially, especially with regards to getting a broad spectrum of beneficiary views.

4 Findings from CFA Document Review

4.1 Overview

A number of policy documents were reviewed for this evaluation, both for the overall Co-Financing Programme and from the individual organisations themselves (see Appendix 6 for a complete list). From the overall CFP (or '*MFP-breed*') documents it is clear that the policy framework of the Netherlands CFP aims at promoting structural poverty reduction in the South and in the poorest countries of Central and Eastern Europe, while also working to achieve universal human rights. All of the Co-Financing Agencies (CFAs) must align their own programmes to this overarching policy framework. The six CFAs are allocated core funding from the Netherlands government on the basis of their business plans, with total co-funding equalling approximately 11% of total Dutch ODA.

The Co-Financing Programme defines structural poverty reduction as improving living conditions and building social structures, thus empowering the poor and future generations to adopt a sustainable and humane lifestyle. Intervention strategies outlined in the policy include:

- Direct poverty reduction
- Civil society development
- Lobbying and advocacy

Structural poverty reduction thus includes direct support to services with sustainable improvement of social relations and aims at fair distribution, economic growth, democratisation and ecological sustainability. Civil society should provide the framework for citizens to claim their rights and to demand democracy.

The Co-Financing Programme Advisory Committee also underlined in 2003 the importance of the role CFAs play in developing civil society capacity and supporting structural poverty reduction. As such it has recommended that criteria should focus more on the quality of the management of civil society organisations rather than on the character of the organisations themselves, as well as that CFAs be less restrictive in terms of what they fund and where their programmes are.

4.2 Overview of Cordaid, ICCO and Plan general and health-related policies and strategies, partner policies and gender policies

Table 2 provides an overview of the general and health-specific policies, strategies and activities of Cordaid, ICCO and Plan. As can be seen in this table, each organisation has adopted a slightly different approach to aligning their own policies to those of the CFP.

Partner policies
Cordaid has shifted from project funding to strengthening social organisations (Partner Focus Policy). These are intermediary or service organisations, network or umbrella

organisations working for the poorest sections in society and national capacity-building organisations. Cordaid's policy towards technical assistance is changing from providing long-term external assistance to building local capacity and human resources. Cordaid's code of conduct increases accountability towards partners.

ICCO's partner relations can be based on funding programmatic issues, or strengthening institutional and strategic capacity. As a result of the changing focus from a needs-based to a rights-based approach, ICCO's partners are increasingly being selected from an empowerment perspective, whereby short-term service activities are linked with more structural approaches (with a mix of different partners).

Plan's partnerships are currently being discussed with a view to more effectively pooling knowledge and strengthening lobbying and advocacy. Capacity building focuses on organisational aspects, networking and building leadership in CBOs and the country offices.

Gender
Gender is a clear criterion in Cordaid programmes, and Cordaid recognises that in certain countries, like in DRC, there is a need to strengthen the capacity of its partner organisations in this respect, especially where it concerns reproductive health and HIV/AIDS programmes. Cordaid has a tool to help with improving the gender orientation of its programmes, but recognises that it is not working very well.

Gender is represented in each of ICCO's policy themes, with a focus on women's rights, access of girls and women to basic services and women's access to trade and markets. Counterpart programmes must include a policy on gender. ICCO has an instrument to assess gender issues when analysing applications from organisations. However, there is no tool for supporting partners to improve their own gender-sensitive strategies in line with ICCO's policies.

Plan's strategic priorities for gender are gender mainstreaming, personal safety and security (child abuse, prostitution, trafficking, HIV/AIDS) through developing capacity in Plan to address and institutionalise gender aspects, and to increase the participation of girls and women in community development.

Youth
The only CFA out of the three that focuses on children and youth is Plan. Plan's policy documents have the theme of a child-centred approach interwoven with all its policy themes and strategies.

Health
The three CFAs have broadly similar health objectives, and employ similar strategies, as outlined within their organisation's health policies.

Cordaid's health policy aims to improve the health of poor and vulnerable people through a combination of organisations (primarily Catholic dioceses) that are involved in direct health service provision, community-based programmes (whose focus is more on health promotion) and care for the chronically ill, especially people living with AIDS. ICCO does not have a written health policy *per se*. The focus of its health-related work is to improve access to health services and health-related services in the countries where it supports such programmes. Its strategies include supporting direct service provision through faith-based organisations, as well as support to national NGOs working on

community health-related activities. ICCO also supports advocacy organisations and networks, whose work has an effect on health improvement initiatives.

The focus of Plan's health-related programmes is on improving the health of children and their families, especially mothers. Plan provides direct health service delivery, through running its clinics or giving support to public facilities. Plan has also incorporated community-based health work in its Early Childhood Care and Development centres and funds other public health-related activities, such as improved water and sanitation, as well as improved nutrition programmes.

4.3 Similarities and differences in health programme support

All three CFAs are learning organisations and assume an active role in working in international alliances and in building stronger relations between civil, bi-lateral and multi-lateral stakeholders. Although the individual CFAs in certain circumstances collaborate with each other at regional and country level (emergency aid in Eastern Congo for example) and in several working groups as 'Evaluation and Policy' and 'Gender' they mainly attune to their own international networks and have their specific constituencies and partner organisations.

The three CFAs evaluated recognise that direct poverty reduction, civil society building and advocacy should reinforce each other, thereby changing their paradigm from a needs-based to a rights-based approach. In ICCO's policy theme 'access to basic services' this shift implies matching programmes that serve to fulfil the immediate needs of people with a more long-term process aimed at strengthening their capacity in claiming rights. Plan is changing its emphasis from a child-focused approach towards a child-centred approach, with child rights as a central theme in setting priorities for programmes and policies, and putting emphasis on active involvement of children and youth in decision-making processes. Cordaid sees improvement in health not only as increasing access to health services, but also as strengthening participation of the target population in the management of and control over health care resources and programmes

Cordaid, ICCO and Plan, each in their own way, encourage innovation in products, strategies and operations. Improving knowledge management is a new and indispensable challenge for Plan-N. Plan-Int and Plan-N are systematically improving analysis and follow up of evaluations and other internal studies, with linking and learning as the prime objective. Plan-N will in certain areas where it has a comparative advantage build specific knowledge centres. Cordaid will develop further to become a leading organisation in the field of private development cooperation and envisages responding in an alert way to current developments and new insights. An example of innovation is the performance-oriented contractual approach that Cordaid's partners use to monitor performance of clinics. For ICCO the changing focus on rights-based processes involves training and strategy building sessions at regional or national level, follow-up sessions, drawing up civil society reports to be submitted to regional or UN Human Rights committees, working with UN special reporters, preparing toolkits or training materials, and promoting regional networks, and training and resource centres for economic, social and cultural (ESC) rights.

Table 2: Summary of the CFA's general and health-related policies, strategies and themes

	Cordaid	ICCO	Plan-Netherlands
Vision/Policy Aim	Poor people achieve self-reliance in development through: • Poverty reduction • Civil society building • Advocacy work, which are interrelated	Contribute to the elimination of poverty and injustice through: • Structural poverty reduction • Promotion of fairer systems, structures and processes worldwide	Contribute to enhancing Southern society's structural capacity to: • Reduce poverty • Protect, promote and enforce children's rights
Strategies	Focuses primarily on the non-state sector, providing: • Financial support • Institutional support and development • Learning and innovation • Technical assistance	Focuses on different actors who employ rights-based and empowerment approaches: • Financial support • Institutional strengthening • Promotion of national and regional networks working on rights and advisory services	Direct service delivery through programmes defined at country level providing: • Basic services • Community strengthening and empowerment • Institutional strengthening of CSOs, LNGOs and local government
Themes/Activities	Themes are aligned with the MDGs: • Quality of urban life • Access to markets • Health and care • Peace and conflict • HIV/AIDS	Themes aligned with MDGs: • Access to basic services (health care, HIV/AIDS, education, drinking water and food production) • Fair economic development • Democratisation and peace building	Themes aligned with MDGs: • Early childhood care and development, focusing on: - Education - Nutrition - Health promotion - Water and sanitation • Gender mainstreaming
Health Policy	Improve the health of the poor and vulnerable through: • Community-based health care • Basic health services • Reproductive and sexual health • Care for vulnerable groups	Increase access to basic health-related services focusing on quality, not quantity. No specific health policy as it is incorporated into ICCOs 'access to basic services' policy	Directly or indirectly contribute to the elaboration and implementation of pro-poor health policies and strategies

Table 3 summarises financial flows from the three CFA organisations, both in terms of total expenditures for 2002-2004 as well as percentages related to funding from the CFP and specifically to the three countries studied in this evaluation. Cordaid spends a higher amount on health overall, as well as a higher percentage of its total budget on health-related programmes. Plan is the next highest spender on health with ICCO putting the least percentage of its total funding towards health-related activities globally.

ICCO's and Cordaid's policies recognise that co-operation on an equal basis with partner agencies in the South is imperative in effectively reducing poverty. Partners are increasingly claiming their autonomous role in society and in so doing influencing the agenda. Therefore for both organisations the relationship with partners has been reviewed, with an increasing tendency to provide organisational and institutional support with a focus on improving efficiency and quality. Both organisations have laid down their own role and responsibilities in a code of conduct. Dialogue is being enhanced with partner organisations about their vision, mission, how to evolve towards strategic planning and how to improve managerial and financial capacity. In this respect, the two organisations use both the instruments of financial support and technical assistance and advisory services.

In view of its position in the international setting of Plan, Plan-N funds projects, which are proposed by the Plan Country Offices rather than organisations (in contrast to the operation of the other two CFAs included in this evaluation). These projects are mainly implemented by Plan staff, CBOs and local NGOs, whereas ICCO's and Cordaid's partners are mainly intermediary or service delivery organisations and network or umbrella organisations. Cordaid's main service delivery partner is the Catholic Church in the countries where it works, while ICCO works with both Protestant missions and local NGOs. For Plan local governments are also considered as partners, which is not the case for ICCO and Cordaid, though some of ICCO and Cordaid's partners are themselves key partners for national and local governments in the three countries. Plan's programmes have a stronger emphasis on capacity building of local government staff, while ICCO and Cordaid focus on capacity building of their partner organisations.

With regards to cohesiveness of policy and programme, Plan's policies and programmes are the most directly linked to each other. This is not surprising as Plan is an operational organisation with connections from international level through to community level staff. Cordaid has maintained cohesiveness as it has defined country level policies and through working with one primary partner in developing countries, the Catholic Church. ICCO has perhaps the weakest cohesiveness, with country policies remaining vague, with no clear objectives or indicators laying out what ICCO hopes to achieve through its programme.

Priorities of the three CFAs are closely linked to the MDGs: alleviation of poverty and hunger; global partnership for development; equality of women and men; improving basic health care with special attention to reducing child mortality, improving maternal health, increasing access to affordable medicines and combating HIV/AIDS; sustainable management of natural resources, particularly by cultural minorities; and improving the circumstances of young people.

For all three CFAs gender is a cross-cutting issue, although capacity to mainstream and monitor gender activities needs strengthening. Plan-N also emphasises children's rights and advocates greater involvement of children and youth in their programmes.

Table 3 – Volume of financial flows for health overall and to three case study countries

	Cordaid			ICCO			Plan		
	total	of which CFP funds	%	total	of which CFP fund	%	total	of which CFP funds	%
Total CFA expenditure									
2002	€ 137,830,000	€ 84,844,000	62%	€ 112,000,000	€ 87,000,000	78%	€ 79,984,766	€ 22,591,986	28%
2003	€ 130,795,779	€ 85,893,312	66%	€ 123,000,000	€ 100,000,000	81%	€ 68,680,162.	€ 25,871,392	38%
2004	€ 150,785,786	€ 99,033,317	66%	€ 125,000,000	€ 106,000,000	85%	n/a	€ 30,020,889	
Total CFA expenditure for three years	**€ 419,411,565**	**€ 269,770,629**	**64%**	**€ 360,000,000**	**€ 293,000,000**	**81%**			
Expenditure for health									
2002	€ 32,652,000	n/a		€ 13,455,559	€ 10,452,086	78%	€ 15,510,870	€ 5,912,698	38%
2003	€ 39,378,960	€ 14,742,103	37%	€ 16,843,307	€ 13,693,74	81%	€ 14,762,314	€ 5,833,893	40%
2004	€ 35,562,532	€ 17,833,250	50%	€ 16,468,705	€ 13,965,462	85%	n/a	€ 4,951,426	
Total CFA expenditure for health	**€ 107,593,492**	**€ 32,575,353**		**€ 46,767,571**	**€ 38,111,294**	**81%**		**€ 16,698,017**	
Expenditure for health as % of total CFA expenditure									
2002	24%			12%	12%		19%	26%	
2003	30%	17%		14%	14%		21%	23%	
2004	24%	18%		13%	13%		n/a	16%	
Average % expenditure on health	**26%**	**12%**		**13%**	**13%**				
Expenditure for health in three case study countries as % of total health expenditure									
2002	8%			7%	9%		2%	6%	
2003	3%	8%		6%	5%		4%	10%	
2004	6%	7%		4%	5%		n/a	11%	
Expenditure on health as % of total expenditure in the selected countries									
2002	38%			73%			20%		
2003	27%			37%			28%		
2004	30%			23%			25%		

5 Findings: Democratic Republic of Congo

5.1 Country context

The Democratic Republic of Congo (DRC) has one of the most challenging profiles, socially, politically and economically, in sub-Saharan Africa. Having endured over three decades of 'kleptocracy' under Mobutu Sese Seko's presidency, the country has been in the throes of civil war since 1996. It is estimated that almost 4 million people have died in the DRC as a result of the conflict there. Despite this, both the conflict and the suffering it has caused have gone relatively unnoticed by the international community. The worst-affected provinces in the country have been the eastern provinces, especially North and South Kivu.

Table 4 – Key health data for DRC

Infant Mortality Rate	177/1000
Under Five Child Mortality Rate	205/1000
Maternal Mortality Rate	990/100,000
Life expectancy	41.4 years
Total Fertility Rate	6.7
HIV/AIDS prevalence	5%
Moderate malnutrition 1 to 4	13.2%
Severe malnutrition 1 to 4	10.7%
<5 fully immunised against TB	55%
<5 fully immunised against measles	45%

* from UNDP (2004) Human Development Report 2004

Even though health statistics in the DRC are of questionable validity, due to problems with data collection, Table 4 shows that the infant and maternal mortality rates in DRC are very high. It is likely that these rates are even worse than current health statistics are showing, as various humanitarian organisation reports for highly vulnerable groups have calculated estimated mortality rates at over 200/1000.

In the 1970s donors and NGOs worked with the then Zaire Government to set up what was one of the first decentralised health systems in the world. '*Zones de sante*' were created for the entire country and then essentially divided up between donors and health service provision organisations. Central government support was non-existent and external funding for health services was augmented by user fees and payment for drugs.

Today, health services continue to be highly dependent on external funding and on non-state provision, including the churches. The government has, with support primarily from the European Commission, begun to assume a stronger coordination role, accepting that it will be a long time before it will be able to provide adequate services through a government system. (See DRC country report, section 1 for more detail on the national context).

5.2 CFA country policies and partners

Table 5 – Cordaid and ICCO health policy and programmes in DRC

	Cordaid	ICCO
Policies/Objectives	1 Community-based health care and basic health service provision a Ensuring package of essential curative and preventive quality care b Strengthening organisational capacity of health services c Increasing participation of target groups in management of health care 2 Improving reproductive health care a. Increasing awareness about sexual and reproductive health b Increasing participation in managing reproductive health c Participation in lobbying and advocacy for reproductive rights 3 HIV/AIDS a Prevention, treatment and care b Mainstreaming	There is no country strategic framework for ICCO's programme in DRC. Basic services constitute the largest sector, of which approximately 50% is health, including water and sanitation in North and South Kivu. Mainly due to limited impact on poverty reduction, over the past 10 years focus of collaboration is shifting from church-based to secular organisations, with a more geographical concentration. In the course of 1994, partners in the eastern part of the country became a priority, which resulted in a downward trend in overall expenditure for the country. The war brought expenditure further down to 50%. Starting in 2000 remarkable recovery occurred, leading to cash flow problems; funds for Burundi were reallocated to close funding gaps in Eastern Congo.
DRC government policy and strategy	Organisations supported by Cordaid work within strategy of DRC *zone de sante* and are actively advocating for poverty reduction and gender equality.	Health integrated into access to basic services. There is a potential role in improving quality of services through IPASC and CME.
Fit with Dutch – DRC government policy and strategy	The evaluation team was not able to meet with Dutch Embassy officials	
Partners included in this evaluation	BDOMs: Medical arm of the Catholic Church in the DRC, providing health services, community-based health promotion and in some cases managing '*zones de sante*'. BDOM Kinshasa BDOM Kananga BDOM Bukavu CONAFED: Works at a national level to promote gender equality. Has branches at provincial level, runs awareness-raising and training modules with its members, and promotes the leadership role of women in organisations. ESP: Works within the Ministry of Education and is part of the University of Kinshasa, training public health professionals. Centre Olame: Provides psychological and social support to traumatised women and in particular those who have suffered from sexual violence. A specific arm of the BDOM in Bukavu. Total 2004 health-related funding = € 1,703,061, € 949,952 from CFP. 27 partners total	IPASC: Primary health care training institution located in the far north-eastern corner of DRC. Provides training and support for auxiliary nurse level staff and registered nurses, runs community-based health programmes and carries out research activities. CME: Supports 7 evangelical organisations working in and around Beni, to run hospital services, ensure constant drug supplies, runs training programmes and operates community-based health programmes. ELIMU: Works in Uvira and Fizi supporting the set up and development of community-based women's organisations. Runs literacy training and training in income-generating activities. BOAD: Supports 9 organisations in and around Goma, which assist 180 CSOs in providing material assistance and training to communities affected by conflict. Total 2004 health-related funding = € 327.505, with € 327,505 from CFP. 4 partners 3 strictly health

Table 6 – DRC: Partners, strategies, finances and outputs/outcomes

Organisation	Strategies	Target groups	Coverage	Financial support	Programme Targets	Effectiveness/ Output – 2003 data
Service delivery						
BDOM Kinshasa Cordaid partner for 15 years	1 Providing health services for the poor 2 Supply of drugs, equipment to PHC facilities 3 Renovating/maintaining health infrastructure	General population in Kinshasa	20-25% PHC needs of population of over 1 million in town of Kinshasa	Cordaid has been supporting BDOM for 15 years; over the last 3 years € 525,000+ HIV/AIDS € 93,461 Other key donors: MISEREOR, Christoffer Blinden Mission, CARITAS	To Improve the state of health of Kinshasa's population by rendering the town's health services operational	• Pre-natal consultation 24% • Average Hospital occupancy rate:74% • Vaccination rate: 75% • Frequency of curative health care: 54%
BDOM Kananga Cordaid partner for 5 years	1 Providing primary health care services 2 Strengthening contact with organisation benefiting the health sector 3 Mobilising the community so it takes care of itself 4 Insuring the continuous training or retraining of staff	General population in Kananga	20-25% PHC needs of population of over 1.5 million in the Province of Occidental Kasaï	Cordaid € 150,000 over the last 3 years Other organisations = EU € 740.000 + € 450,000 Pharmaciens sans frontiers	To contribute to the improvement of the state of health of the population in its sphere of activity	• Pre-natal consultation 60.5% • Hospital occupancy rate:21.3% • Frequency of curative health care: 31%
BDOM Bukavu Cordaid partner for 24 years	1 Implementing health services accessible to the majority of the population 2 Supply of medication equipment and other medical materials to health facilities 3 Renovating/maintaining health infrastructure 4 Psychosocial and spiritual support of patients	General population in South Kivu	24 % PHC needs of population of over 1.1 million in the South-Kivu	Cordaid € 91,896 + HIV/AIDS programme € 138,774+ TB programme € 180,000 over the last 3 years Other key donors: EU MISEREOR Louvain-Development Caritas- Spain Secours Catholique	To improve the state of health of the population of South-Kivu by rendering the province's health services operational	• Pre-natal consultation 75% • Average Hospital occupancy rate: 56% • Vaccination rate: 78%

CME Nyankunde ICCO partner for 12 years	1 Organizing health activities in hospital environment 2 Producing and providing medication and medical equipment to heath centre facilities 3 Training and retraining medical and paramedical staff 4 Implementing community development projects	General population in Ituri and Beni area	30% PHC needs of population of over 300,000 in town of Beni area	ICCO € 223,298 in 2002 – 2004 health-related activities Other key donors: Samaritan's Purse SEL-France DIFAEM Germany MEDAIR- Switzerland		• Average number of monthly pre-natal consultations : 780 • Average number of daily consultations: 80% • Average number of monthly assisted births: 90
Centre Olame Cordaid partner for over 2 years	1 Supporting women who have experienced rape and sexual violence 2 Literacy and learning of income-generating trades 3 Promoting local produce to contributing to the improvement of food 4 Raising awareness on the rights of women, gender and the values of peace and democracy. 5 raining women in development and culture of peace	Victims of rape and sexual violence and South Kivu	20-25% of raped and sexually violated women of the province	Cordaid € 71,262in 2002-2003 Secours Catholique: € 20,573 (2001-2003) plus others MISEREOR Caritas France Belgian Cooperation	To train women in order to make them capable of defending their rights and increasing family income	• Average number of women raped seen in 2004: 1,795 • Women under 21 years raped and seen: 19.5%-32.4% • Number of cases seen longer term and socially reintegrated: 80 • Number of sexual assault cases with gynaecological trauma: 40 • Number of HIV positive cases registered: 27 • Number of women referred to hospital for specialised care: 74
Service delivery and networking						
BOAD ICCO partner for 7 years	1 Making partner organisations more professional 2 Support peace initiatives through bringing together agricultural/small holding workers and local population 3 Support new gender approaches and development of actions to be carried out. 4 Strengthening team management abilities	Population in the 3 sub-regions of North-Kivu	Less tan 5% of population of over 2 million in North-Kivu	ICCO 150,694 euros in 2002-2004 health-related activities Other key donors: Primarily the ACT Network (aims to provide US$ 375,000 per year) Dutch Inter-Church Aid	To strengthen the organisational abilities of grass-roots populations for united action on durable development	75-90% of envisaged activities accomplished in 2004 • Number of households helped : 100 • Number of beneficiary committees organised : 34 • Number of mutual benefit associations for solidarity set up: 25 • Number of partners trained in participation and taking responsibility: 64 • Number of people receiving agricultural training: 1,624 • Number of households able to do year-long market gardening: 525 • Number of health centres renovated: 8

ELIMU ICCO partner for 12 years	1 Support activities reflective on local population living conditions 2 Support of community groups' socio-economic activities 3 Training of facilitators and educators for women and youth, and the production of teaching materials 4 Forming network of activities to drive an education movement in communities	Population in the territories of Uvira and Fizi in the South-Kivu	Less than 5% of population territories of about 1 million in the South-Kivu	ICCO € 35,880 from 2002-2004 (health-related activities) Other key donors: EPR Switzerland Institute for the Development of Adult Education World Food Programme Bureau for Studies and Expertise in Development	To strengthen the abilities of populations (men and women) through the consolidation of durable and indigenous development process	• Number of students: 1,031 • Women learning: 87%, • Number of centres: 25, • Number of educators trained/ retrained: 69 • Teaching material produced: 2500-5000 copies.
Health training						**Outputs since inception**
IPASC ICCO partner for over 10 years	1 Training and development of research programmes 2 Consultation for training and health programmes 3 Implementation of specific projects linked to the priority health problems of the targeted populations	Population of Eastern DRC		ICCO € 500,000 from 2002-2005 Other key donors: Bread for the World Tear Fund ECC Switzerland DIFAM Friends of IPASC Trust	Training health professionals by integrating the community aspect into their health care provision services	• Number of technicians put into the field: 169 • Number of community health graduates since 1992: 120
Ecole de Santé Publique	1 Training for public health specialists 2 Training in the economics of health 3 Short-term training for health personal 4 Research and scientific activities	National and Regional	–	Cordaid € 205.535 in 2004 Other key donors: USAID, DU, UNFPA and WHO	To furnish the DRC with personnel capable of competently managing the Ministry of Health Zones, services, and programmes	• Number of sessions in 18 years : 16 • Number of specialists trained: 91% of candidates • Number of short-term training sessions organised: 6, 30 people in each training session. • Number of research projects carried out: 17

Networking						
SPS Ceased being funded by Cordaid in 2004	1 Providing health services for the poor 2 Supply of drugs equipment to PHC facilities 3 Renovating/maintaining health infrastructure	General population in Kinshasa	20-25% PHC needs of population of over 1 million in town of Kinshasa	Cordaid € 175.000 in 2003	To improve the state of health of the population, and more particularly the poor populations through BDOMS	
CONAFED Cordaid partner for over 5 years	1 Training trainers to strengthen provincial networks by training professional trainers 2 Integrating gender approach into actions to be carried out 3 Cooperation-exchange and collaboration between actors 4 Inter-training and communication between provincial networks	General population in DRC		Cordaid € 171.893 (89% of total funds in 2003) Other key donors: UNIFEM, 11.11.11. and Winrock Foundation	To train women in order to make them capable of defending their rights and increasing family income	• Number of member organisations: 365 • Number of members: 10,950 • Number of people reached through advocacy: 2,215 • Number of people trained: 110

5.3 Results

5.3.1 Impact/effectiveness

Table 6 shows that service delivery organisations in DRC are seeing substantial numbers of patients. While the figures provided are for 2003, these should be taken as averages of the level of service provision activity as there is little variation between these and the previous two years (2001, 2002). It must be stressed, though, that the faith-based service providers in DRC are the only health care providers in their area. The DRC has long had a policy of contracting out health services and health management to non-state providers. The faith-based organisations supported by the CFAs are amongst the most important non-state providers in the country, without whom the health system would collapse. Therefore one measure of their effectiveness would be to consider what health care would be available if the CFA partners stopped providing services. The answer is that there would be no health care within entire regions of DRC.

This being said, quantitative data for DRC, at national and local level, as well as from project partners is extremely difficult to obtain for a variety of reasons. These include unreliable national data due to data collection problems, lack of standardisation of data collected by different service providers, as well as no baseline data (or lost data due to the conflict) within the projects or organisations. There is also almost no data on the situation of the general public in the areas where the CFA partners intervene. As Tables 5 and 6 indicate, there is no true picture of what the population base is for providing service use rates, with percentages rising well above 100%. This has made quantifying and comparing the impact of ICCO and Cordaid's partners very difficult.

Neither Cordaid nor ICCO have quantitative health-related indicators that allow measurement of progress against health-related objectives in the DRC. While Cordaid has a country programme plan, ICCO has no strategic framework for DRC. Therefore, both quantitative, and to some extent qualitative measures of impact are reliant on the partners' own strategies and targets. Key indicators for impact are the immunisation rates obtained by Cordaid service provider partners, which are substantially higher than national rates. These are presented in Table 7.

Table 7 – Comparison of national and project level data-immunisation

	BDOM Kinshasa	BDOM Kananga	BDOM Bukavu	National
BCG	112%	68% (BCG4)	97%	55%
Polio	98%	57%	75%	41%
DPT3	91%	59%	93%	39%
Measles	76%	51%	77%	45%

There are also no clear indications that CFA inputs into individual organisations, as opposed to those of other funding partners of those organisations, have led to any greater or lesser impact on improving access to, use or control over health services. As can be seen in Table 5, most organisations are recipients of funds from multiple donors, all of whom have some influence over partner organisation policies and programmes. While the CFA funds are seen as more flexible than those of other donors it does make it even more difficult to ascertain how important the financial (and even non-financial) contributions are to the overall strengths or weaknesses of partner organisations.
It is also hard to analyse the impact of the length of partnership between the CFAs

and individual organisations, as most of the longer-term relationships are with well established mission organisations with multiple partner relationships.

On a more positive note, it cannot be overemphasised how critical the service providers and training institutes are for maintaining and improving the health of the populations they serve. In the DRC context, these non-state organisations are not only providing essential services but also helping to maintain a sense of normalcy in very challenging settings. The contributions made by the CFAs, while perhaps not making a large impact on their own, are part of supporting these vital services. The findings are provided below and in sections 3.2.1, 3.2.2 and 3.2.3 of DRC country report.

Organisations that provide services: It was clear from interviews that those organisations that are involved in direct service provision are improving access to and use of health services in their areas of operation according to those providing and using them. The Diocesan Medical Offices (BDOMs) play a very important role in the DRC in health service provision, including managing certain health zones, running clinics and hospitals and providing community-based health services, as does the CME in Beni. The poor state of government health services in many of the zones where the various church services operate means that public medical care is not a viable option for health service users.

BDOM Bukavu's system of flat rate user fees (where all consultations and treatments are provided for the same fee, with no regard for how complex the health problem is) and support for health '*mutuelles*'[3] have had a particularly positive impact on increasing the poor's access to church-based health services. BDOM Kananga and Kinshasa have reduced the cost of services for some specific interventions (malaria and caesarean section were mentioned specifically). However, beneficiaries across all three BDOMs indicated that user fees represent an obstacle to accessing certain services, especially hospital services.

The BDOMs and CME Beni also assure a regular supply of medicines and other health-related material, to enable service users to receive appropriate treatment. These institutions have also, with their donors' support, supported the construction and rehabilitation of health units. Concerns were raised in Kananga, though, as it would appear that some of the construction projects are left unfinished because the donor's project period runs out before completion of the building. Government officials in Kananga were keen to see more commitment by Cordaid and other donors to seeing projects through to their logical conclusion.

The Centre Olame in Bukavu has had a significant impact on the women helped through the centre's counselling programme, as can seen from one woman's comments 'Olame's activities for women who have been raped or sexually assaulted have helped to prevent deaths. Those who thought they could only find relief through suicide are little by little finding the will to live'. The Centre Olame's impact is limited by its small resource base, with demand for services far exceeding what staff can provide.

[3] Mutuelles are local area, member-based insurance schemes where all members contribute an agreed amount of money on a regular basis and the mutuelle then pays the member's user fees as and when required.

The other service provider evaluated in DRC was the Goma-based Ecumenical Development Office (BOAD). Rather than providing health services, BOAD works through community-based organisations to provide emergency assistance to families affected by conflict. BOAD is changing from an emergency organisation to a development agency. Their interventions have been highly effective in supporting families in desperate need. Improvements on control by users over health services have been highly dependent on the management of the various health units and of the BDOM. While national policy is to have community health committees for every health unit, the degree to which these committees have been involved in planning and monitoring services varies. This is covered in more detail under 'participation' below. The impact of greater user involvement in managing health services is very positive where it has been supported. BDOM Bukavu and Kinshasa support to local health committees has helped to ensure not only active involvement of those committees in supervising health services but also has helped to ensure a greater participation of women in having a say over various community-based health activities, though women still remain under-represented on the committees themselves.

The faith-based organisations covered in this evaluation tackled the serious issues of reproductive health and HIV/AIDS in highly variable ways. This ranged from an active HIV/AIDS prevention programme in Bukavu and Kinshasa to the non-existence of a similar programme in Kananga.

Impact and effectiveness could be improved in a number of ways:

- Adopting more consistent pro-poor policies to ensure greater access to services by the poor. The various faith-based organisations are in a strong position to influence government policy on charges for services, to support other activities that would help to pay for the cost of care (e.g. local 'mutuelles' or insurance schemes), as well as to linkincome-generating activities to paying for care.
- Establishing stronger links with government policies and priorities, such as priority national disease control programmes, e.g. the National AIDS Control programme and the National Malaria Control Programme.
- Reinforcing the use of the National Health Management Information System to ensure a more standardised set of data is collected and can be compared within provinces and nationally.

Organisations that operate as training institutions: Both health training institutions covered in this evaluation (IPASC and ESP) provide an invaluable contribution to health services in the DRC. Training is geared to the specific conditions of providing services in the DRC and African context, ensuring that graduates have appropriate skills for working within the DRC system. The ESP is the only institution in the country that trains public health professionals, and it was reported that these trainees are then employed in health zones and the Ministry of Health, in roles where their skills are most relevant. IPASC concentrates on training nursing and auxiliary health staff with public health understanding and skills in community-based health care.

Organisations that advocate rights as well as provide services: These included CONAFED and ELIMU. The impact of these organisations would appear to be fairly localised, especially in the case of ELIMU. CONAFED has had some success at the national level: incease in number of women parliamentarians, inclusion of gender in the Family code, political negotiation meetings, getting gender more firmly on the agenda of

networking members, etc. While the activities they support have been very important for the communities they serve, their area of work has been limited by levels of staffing, resources and the conflict.

The evaluation team found that the management structures of these organisations needed more institutional development support to be more effective. Strategic planning skills of staff are weak. More inclusive planning processes, whereby ELIMU in particular works with community constituents to develop its mission and strategies, would both improve communications with communities and strengthen the organisations themselves.

5.3.2 Quality of services

A number of indicators were used to consider the quality of services being provided. These included the amount of continuing professional development provided to professional staff, stock and drug supplies in clinics and validation of courses where training is concerned. Staff and service user opinions were also solicited.

Organisations that provide health services: The evaluation found that the quality of services provided was generally good, despite the extremely challenging circumstances many of the services operated under. All service provider organisations have ongoing continuing professional development, through training and supervision, as part of their quality assurance system. Service quality is hampered by an overall lack of staff, limitations in infrastructure (especially in conflict-affected areas, e.g. CME clinics were looted and destroyed two years ago and current services are operating out of buildings not suited for the purpose.) BDOM Bukavu has introduced performance-related contracts and staff evaluations, which has had a positive impact on staff performance. Beneficiaries of BDOM services in Bukavu claimed that these were the highest-quality services available in South Kivu, due to the attitudes and professional quality of staff and the quality of the medicines prescribed.

BOAD Goma has a monitoring and supervision system in place to ensure its partners' activities are being carried out to agreed levels, though evaluators found that a more detailed strategic plan needed to be developed to help with measuring programme progress over time. Community facilitators within partner organisations are also trained by BOAD, helping to increase levels of participation from communities in supervising activities as well.

Centre Olame's quality was measured on the basis of the number of trained staff available to carry out the highly sensitive and specialist work of counselling traumatised women. Staff were found to be well qualified for their work, however evaluators felt that greater role differentiation between the different staff members could cut down on duplication of services and free up time to see a greater numbers of clients. Quality was also measured based on beneficiary perceptions of the services provided, which were very positive.

Organisations that provide training: The training institutions evaluated adhere to national curriculum and international standards where they exist. Staff are provided with professional development. High standards have been assured to date at ESP due to rigorous entry requirements for students.

Organisations that advocate rights as well as provide services: Training modules run by CONAFED and ELIMU were developed based on the expressed needs of community groups and have been well evaluated in other assessments of the organisation's work.

5.3.3 Coherence

Organisations that provide health services: All the service provider organisations evaluated work within the DRC health policy framework. The BDOMs manage a number of health zones in their provinces as well as run clinics. In the past the government had a *laissez-faire* approach to its partners and how they worked within individual health zones. The new government, under encouragement from the EC, is taking a more active interest in coordinating the activities of its partners, working through provincial health inspectors.

There would appear to be some tensions between the state and faith-based organisations running health zones, due primarily to lack of clarity of roles and responsibilities, especially in relation to staff. For example, in Kananga, staff are unclear as to who is ultimately responsible for their contract (the state or BDOM), which is creating some problems. BDOM Kananga has also not implemented national priority programmes, such as the national HIV/AIDS strategy, though a programme is being put in place now for reproductive health.

In general there is poor coherence across BDOM areas, as successful innovations developed by certain BDOMs are not being picked up by others. The Health Promotion Service of the Catholic Church would normally be the best body to help spread learning and innovation, but due to funding cuts[4] it has not provided the coordination service it was set up to provide.

The BDOMs and CME Beni clearly link with Dutch CFA policies and priorities in making health services more accessible to communities that would otherwise not have services provided to them. Their community-based health programmes in particular improve access to primary care in its broadest sense, focusing as many do on water and sanitation as well as health promotion activities. Most of the work continues to be needs based, though rarely elaborated on the basis of systematic needs assessments within communities. Moves towards greater gender equity and gender programming in general are highly variable between the BDOM, demonstrating some lack of consistency with CFA gender policies. Interest in gender issues remains very dependent on those running the dioceses and has not been institutionalised across the BDOM in any consistent way.

BOAD Goma conforms well with the DRC's need for humanitarian assistance to those affected by conflict. They have become a key government and external donor partner in Goma for working to reduce the vulnerability of war-affected communities.

In terms of coherence with CFA policies, there has been little development of rights-based approaches amongst these partner organisations. The evaluation team reflected that RBA may be difficult in the DRC context, especially in conflict-affected provinces, where the focus remains on basic survival for the majority of people. Even so, the BDOMs, CME and BOAD could work more through their own community-based

[4] Due to a difference in strategic view between the Health Promotion Service, which wished to move towards implementing projects and Cordaid, which felt it needed to develop its role as an umbrella organisation.

networks to support education programmes that support claiming rights, calling for more democratic structures and promoting peace, as well as supporting more demand-side initiatives that put communities more in control of their own health care (e.g. voucher schemes).

The DRC government has no specific policy that targets the protection of women from violence and there are few programmes that support women who have been victims of violence. In this sense, the Centre Olame provides an example of important innovation that could and should be translated into a model for other programmes to follow. At present the Centre's experience and learning remains highly localised, with staff under enormous pressure to respond to the day-to-day needs of their clients. Cordaid could help to support the sharing of Olame's experiences to other like-minded groups in the DRC, and find ways to advocate for national level policy debates and strategies to protect and support women who are victims of violence.

Organisations that provide training: As mentioned previously, both ESP and IPASC conform to national curriculum and standards. Their curriculum is highly appropriate to supporting the delivery of health care and public health in the DRC. Graduates are considered to be well prepared to work within the varied structures of the DRC health system. IPASC also operates a system of concessional rates for women who wish to study at IPASC, in order to redress gender imbalances in the health care workforce.

Organisations that advocate rights and provide training: The absence of any national policy on the rights of women limits how coherent CONAFED and ELIMU's advocacy work can be. As with the Centre Olame, these organisations are on the cutting edge of their fields. However, their ability to influence the development of policies and strategies remains limited, ELIMU because of its relatively small size and isolated position, and CONAFED because its secretariat is fairly small and it hasn't yet identified strategies and specific targets for its work. The evaluators felt CONAFED in particular could put more effort into lobbying the NGO/CSO coordination body to promote a more coherent gender policy across civil society.

5.3.4 Participation

Organisations that provide services: BDOM, CME and BOAD are all active participants in government coordination meetings for the sectors that they are engaged in. Beneficiary involvement in the management of BDOM and CME services is much more variable. There is a national policy promoting the setting up of community health committees to support the management of health centres and hospitals, but the degree to which they are functional, and who is represented on these committees, is highly variable.

BDOM Kinshasa has set up community health promotion groups, known as Mama and Papa Bongisa, made up of volunteers who define and promote health activities in their neighbourhoods. BDOM Bukavu actively supports community health committees to carry out planning and monitoring activities in their health centres, while also supporting the development of health *mutuelles* that help local communities raise the necessary funds to pay for health services. The role of BDOM Kananga in local health committees is unclear.

CME Beni involves communities by working with local development committees, which provide health education and support user fees. However, there is poor participation of community members in managing CME-managed health centres, partly due to the

unstable situation in north-eastern DRC. Women's participation in health committees and in the management structures of BDOM and CME remain deplorably low.

BOAD's approach is highly participatory, with local partners using participatory assessments to identify local needs. Local solidarity groups have been developed that have helped to create a greater sense of ownership of activities and of self-help within communities. The evaluators reflected that there is a real tension between delivering much-needed humanitarian assistance and increasing self-help initiatives within the communities where BOAD's partners function. BOAD staff are keenly aware of this tension, but have little influence over international humanitarian assistance during crisis periods when aid pours into the region. BOAD plays an important role in the provincial mechanism coordinating humanitarian aid and has as such an import advocacy function for its partners.

Centre Olame supports awareness-raising activities in communities through facilitators for community-level peace committees, though the evaluators found it difficult to assess how this relationship works in practice as there are no protocols for partnership or collaboration. Olame staff are themselves engaged in partnerships with other networks, such as regional Coalition Against Rape and Violence Against Women and the Human Rights Action Network.

Organisations that provide training: ESP Kinshasa has a strong collaborative relationship with the government and sections of the University of Kinshasa. Former students work with ESP as resource persons to facilitate community level work for current students. At IPASC, students enrolling at the beginning of the year are asked to give input into the validation of the training programme as a way to encourage greater participation. IPASC has strong collaborative relations with other organisations in their area working on health and environmental issues.

Organisations advocating rights and providing training: Members of the CONAFED network are involved in both planning and then implementing the network's activities. More could be done to support these members to participate more actively and generally in civil society, as well as to advocate more strongly for women's rights in government policy making. ELIMU, by the nature of its work, must work hand in hand with other organisations in its locality. Community groups that have received training from ELIMU have begun organising themselves into local committees that are founded on more democratic and egalitarian principles.

5.3.5 Sustainability

For the foreseeable future, long-term financial sustainability of all partner activities in the DRC will remain dependent on external resources. User fees can only provide a small percentage of the operating costs of health services, and of training institutions, and in themselves are a substantial barrier to the poor. However, other aspects of partner activities have led to sustainable improvements in the communities where they work, leading to greater sustainability of programme outcomes, institutional mechanisms and human capacity.

Organisations that provide services: Where partners such as the BDOMs give substantial support to local health promotion groups and health management committees there is clearly greater community ownership of certain health activities. In Bukavu, BDOM's strong connections at community level have helped to ensure the sustainability of

services despite frequent disruptions and looting due to the conflict. Another apparent feature of sustainability is seen in those organisations with strong governance structures, such as CME Beni. The board of governors is strongly involved in deciding what new areas of action the CME should move into, basing part of its decision on the management and financial burdens these new areas impose.

BDOM Bukavu has moved towards greater financial sustainability by manufacturing essential drugs and packaging, though there are concerns that the health service provision part of the BDOM's 'business' could represent too much of a financial burden on the manufacturing side of the business.

At present the Centre Olame's future sustainability is questionable. It is not only heavily dependent on external funding (which is appropriate given its clientele), but it has also failed so far to establish linkages into local communities and with local government. Given the invaluable service provided by the staff at the Centre its donors should be working with centre staff to develop long-term plans, in association with local stakeholders, that will help the Centre's work brave any possible future disruptions to funding and secure longer-term support.

Organisations that provide training: Both ESP and IPASC will remain financially dependent on external funding for some time to come. Their strengths lie in the fact that, due to the quality of the training and other services they provide, they are able to acquire reasonable amounts of funding. The substantial involvement of former students in the community training programmes of ESP allows further opportunities for sustainability, as this has created a community of public health trainers that can be drawn upon.

Organisations that advocate for human rights: Both CONAFED and ELIMU support groups and activities that work towards sustainable improvement in women's status overall. While their area of activity is admittedly limited, the individuals who have benefited from literacy training, income-generating activities and involvement in community structures have developed lasting skills. Both organisations need further support to scale up the work they do to reach larger numbers of people and achieve greater impact.

5.3.6 Added value

Organisations that provide services: The added value of the relationship with the CFAs for BDOM and CME is not only the flexible funding made available to them by Cordaid and ICCO. These partners also felt that CFA funding had helped them to leverage other external funding, and, particularly in the eastern provinces, has allowed these institutions to respond to health-related problems arising from the conflict in ways that they otherwise couldn't have managed. In the case of CME and BOAD, both partners felt that ICCO's support had helped them to develop much greater organisational capacity to respond to the humanitarian crises generated by the conflict in their areas. Another observed significant added value of ICCO's support is that it enabled partners to adopt and maintain a more holistic approach to health, which doesn't address health in isolation but as an integral aspect of development.

Centre Olame has benefited from being linked to wider networks that are dealing with similar women's rights issues to those addressed by the Centre's work as a direct result of its partnership with Cordaid.

Cordaid and ICCO risk having a fragmented programme in the DRC, which reduces the potential added value they can provide. While Cordaid has a strong 'common thread' running through the support it gives to the BDOMs, this isn't as effective as it could be without there being an organisation providing the umbrella functions formerly carried out by the SPS. It could be said that Cordaid is providing some of the umbrella institution functions, at least for Catholic health services, that are being provided by national Church Health Associations in other countries. However, Cordaid cannot and should not fully play this role. Its other partners have little connection with each other, except through meetings facilitated by Cordaid, and the evaluation team observed that innovative practice and lesson learning isn't being emphasised enough to influence changes in more recalcitrant partners (e.g. transferring experience gained from BDOM Bukavu to BDOM Kananga).

ICCO's programme is determined primarily by the strategies and activities of its partners with no clear connection or learning between them. While this provides maximum flexibility to partners it does lessen the impact that ICCO's support can have on its priority policy concerns. The lack of a country strategic framework also means that ICCO programme officers have little guidance to go by when assessing whether to fund new organisations or new activities, and there is no coherent way to link the achievements of partners in the DRC to ICCO's global basic services strategy.

Neither CFA uses its influence to develop a more gendered approach to the work of their partners. This is particularly apparent in Cordaid's relationships with the BDOMs, which, as can be seen above, have highly varied responses to both gender concerns and sexual and reproductive health. Given the conservative and patriarchal tendencies of many of the Catholic and Protestant churches and missions, both ICCO and Cordaid need to decide whether continued support to organisations that will not heed calls for greater participation of women in decision making, both at community and organisational levels, constitutes colluding with this more conservative agenda. The evaluation findings indicate that traditional approaches are not being challenged sufficiently and that Cordaid in particular needs to exert more progressive influence over its Catholic partners.

6 Findings: Nepal

6.1 Country context

Nepal has been in the throes of violent conflict in parts of the country for the last eight years, with more than 10,000 civilian lives lost so far. This insurgency has made the running of development activities very difficult in the remote and rural parts of the country, which are also the most deprived and needy areas. Development infrastructure has been badly damaged, while security forces and the insurgents have committed human rights violations with apparent impunity. Many NGOs and other development agencies are facing threats and pressures from both sides in the conflict, and some have been forced to stop their activities altogether in Maoist-controlled areas by the Maoists themselves.

Nepal, like many countries, has been undergoing political and structural reform, following a policy of decentralisation from national to local government. Services such as primary health care, education, postal services and agricultural extension work now report to local authorities, though the political disturbances have badly affected the effective running of these authorities.

Health services are multi-tiered and very clinic-focused in Nepal. While the government continues to provide the majority of health services for the Nepalese population, private service providers and NGOs are also major players in the health system. The government also promotes Ayurvedic medicine as an important alternative to western-style medicine. Donor coordination in most sectors has been poor, though there have been recent moves towards greater donor harmonisation. Special development interventions for health, education, and local government are to be launched for neglected areas of the country. The new Ministry of Health and Donor Health Forum will tackle health sector development and public sector reform. The health sector does not currently have a meaningful decentralisation strategy and practical devolution is a critical reform issue. Also there is a plan to explore more formal contractual arrangements between the government and non-state providers of services. More on the Nepal context can be found in Nepal country report, section 2.

Table 8 provides some key health indicators for Nepal.

Table 8 – Key health data for Nepal*

Infant Mortality Rate	66/1000
Under Five Child Mortality Rate	91/1000
Maternal Mortality Rate	740/100,000
Life expectancy	59.9 years
Total Fertility Rate	4.3
HIV/AIDS prevalence	0.3%
<5 underweight for age	31%
<5 fully immunised against TB	85%
<5 fully immunised against measles	71%

* from UNDP (2004) Human Development Report 2004

6.2 CFA policies and programmes in Nepal

Table 9 – Country-specific health policies

	ICCO	Plan Nepal
Policies/Objectives	No specific country health policy ICCO does have a Nepal country strategy.	Improved health and nutritional status of children and families (working primarily through Early Childhood Care and Development Centres, ECCDs).
Fit with Nepal government policy and strategy	Conflict situation has led to the suspension of most local government service delivery. ICCO partners work closely with communities, are not being targeted by either government or insurgents, so policy of demand-driven development appears appropriate in the Nepal context.	ECCDs have been written into the Nepal Poverty Reduction Strategy, with government hoping to set up and maintain 74,000 ECCDs nationwide by 2015. • Fears that minimum standards for ECCD have not been adequately considered – nutrition component is missing from government plans.
Fit with Dutch – Nepal government policy and strategy	The Dutch Government no longer has a bilateral programme with the Government of Nepal, though a few projects are being supported to their conclusion. Therefore Dutch aid for Nepal is put through NGOs such as ICCO, Plan and SNV.	
Partners and health-related funding	UMN-YUHP: Provides basic health care services to carpet industrial workers living in poor neighbourhoods of Kathmandu. CCDN: Newly created NGO (from a UMN project) providing services to ethnic minority communities in Makwanpur District. CBRS: Supports physically disabled people and their families in Pokhara District, through community-based activities and home visits. SSS: Kathmandu-based organisation supporting HIV and AIDS activities, primarily in Information, Education and Communication. BNMT: International NGO providing direct health services in Nepal in a number of districts. CVICT: Provides support to victims of torture and training for NGO workers in counseling. WOREC: Community-based, women focused organisation supporting reproductive health and income-generating activities, as well as campaigning on trafficking of women. Total health-related expenditure = € 338,954 in 2004 Total expenditure in Nepal was € 1,333,563	Plan Nepal focuses on improving the health and nutritional status of children and families working primarily through Early Childhood Care and Development Centres (ECCD). Main health-related activities include immunisation, diarrhoeal disease control, acute respiratory disease control, nutrition, reproductive health, water and sanitation, as well as rehabilitation of physical infrastructure. Plan Netherlands support to Nepal 2004 € 1,486,647, of which € 139,151 for health

Table 10 – Nepal: Partners, Strategies, Finances and Outputs/Outcomes

Agency	Strategies	Target Groups	Coverage	Financial support	Programme Targets	Outcomes/Outputs
ICCO						2004 outputs, unless otherwise stated
All service delivery in the health sector						
UMN/YUHP ICCO partner for 6 years	A project of UMN Nepal (INGO), managed by a team of project staff. Set up to develop urban-based health services for migrants and poor people in one area of Kathmandu.	200,000 people of Lalitpur	Lalitpur municipality	2002 – 2004 ICCO funding is 100% of budget 2002 – 2006 ICCO health-related funding = € 593,452	No quantitative indicators against which to measure progress towards achieving objectives.	• Number of beneficiaries using clinical services: 36,822 (75% women) - MCH/FP: 26,987 - TB: 238 - General 302 - Health camps 9,295 • Number of people reached through school outreach services: 2290 • Number of people trained in capacity building: 14 (100% women) • Number of people provided with health education: 498 (94% women)
BNMT ICCO partner for >30 years	An international trust working in the eastern part of Nepal for more than 35 years providing clinical services and public health programmes. The programmes are managed by a team of professional national staff.	Women, children, marginalised groups, TB patients	16 districts in the eastern part of Nepal	2001 – 2004 ICCO contribution approx. 10% of total budget 2004 ICCO funding = € 278,212 Other key donors: USAID DFID ADRA SIMAVI	No quantitative indicators against which to measure progress towards achieving objectives available at the time of the evaluation.	These results are from the overall BNMT programme and cannot be directly related to ICCO funding. • Number of beneficiaries using clinical services: 1,183,551 (48% women) • Number of patients treated by project supported services: 942,223 (49% women) • Number of people trained through capacity building: 4,960 (21% women) • Number of people trained through health education: 61,771 (52% women)
CCDN Makwanpur ICCO partner for < 1 year	Local NGO emerged out of UMN CHDP, managed by ex-staff of UMN CHDP. Majority of the members are also staff members of the organisation. Provides health services to marginalised communities.	Marginalised and disadvantaged group-women and child focused	5 VDCs east Makwanpur, West 2 VDC, 1 Municipality	2004 – 2007 ICCO funds more than 80% of budget ICCO funding 2004 = € 60,000	No quantitative indicators against which to measure progress towards achieving objectives.	• Number of beneficiaries using clinical services: 12,700 • Number of patients treated by project supported services: - BCG- 1792 - DPT3 – 1327 - Measles – 1374 - ANC visit – 1948 - TB patients – 44 • Number of people trained through capacity building: 52 (92% women and 52% government staff) • Number of people trained through health education: 240 (64% women)

SSS ICCO partner for 2 years	UMN Sakriya Unit (support unit for HIV/ AIDS issue) has been turned into an NGO. Managed by ex-staff of UMN Sakriya Unit. Provides HIV prevention education and materials.	PLWHA, Families, youth, women	National	2003 – 2007 € 118,784.00 2002 – 2004 ICCO health-related funding = € 63,784	360 trained counsellors 90 trainers 135 Home-based care providers supported 150 HIV+ people will be identified from selected communities and among them 100 HIV+ people will be accepted by their families and communities by 2007 Two self-help groups among PLWHA (in Kathmandu 1 and I group in Lumbini Zone level) and affected people will be formed and involved in prevention, care and support services by 2007. 75,000 people aged 13 to 60 will be given HIV prevention and transmission facts and among them 70% will have practised safer behaviour in selected communities by 2007.	• Number of people trained in capacity building: 14 • Number of people trained on AIDS education: 301 • Number of people reached through AIDS outreach services: 122 • Estimated numbers reached through campaigns: 21,000

CBRS **Pokhara** ICCO partner for 4 years	A local NGO managed by a good governance structure with no overlap between the staff positions and leadership positions. Gives social and health support to physically disabled and differently abled individuals living in and around Pokhara.	Targeting disabled (differently abled physically)	29 VDC and 2 municipalities in Kaski District 24 VDCs and 2 municipalities in Shyangja DistrictPhysical	2000-2004 ICCO funding: 70% of total CBRS budget 2002-2004 ICCO health-related funding = € 174,379	At least 90% of disabled people in project area assisted by CBRS (but there is no baseline data to indicate what is the total population of disabled people)	• Number of patients treated by project supported services: 625 (38% women) • Number of people reached through outreach services: 6418 (75% women)
WOREC ICCO partner for 5 years	A national NGO working mainly in the area of women's rights, women empowerment, and reproductive issues.	Targeting women, children, marginalised communities > 500 women's groups, youth, child groups	Morang 29 VDCs Sunsari 14 VDCs, Siraha 3 VDCs, Udaypur 14 VDCs, Dhanush 15 VDCs, Rupandehi 5 VDCs, Mustang 3 VDCs	2002-2004 ICCO: 30% of total funding 2004 ICCO health-related funding = € 67,382 Other key donors: Ford Foundation WPF Holland AEI Luxembourg MISEREOR UNDP TAF Nepal	No quantitative indicators against which to measure progress towards achieving objectives.	These are overall results and do not relate specifically to ICCO's contribution to WOREC • Number of people using clinical services: 3896 (65% women) • Number of people treated by project supported services: 1938 (71%) • Number of member organisations: 1317 • Total number of members: 19236 (75% women) • Number of people trained in capacity building: 285 (57% women) • Number of people trained through health education: 6689 (80% women)
CVICT ICCO partner for 1 year	A National NGO managed by professional people with some overlap between leadership and implementation. Specialises in serving the torture victims through medical and social care.	Targeting torture victims, children	National focus with one centre.	2002-2004 ICCO health-related funding = € 100,089 Other key donors: only a few short term funders	No quantitative indicators against which to measure progress towards achieving objectives.	• Number of people using clinical services – 317 (17% women) • Number of people reached through outreach (AIDS work, counselling): 454 (37% women) • Number of member organisations – 91 • Total membership – 5139 • Number of people trained – 48
PLAN NEPAL						
Supported by Plan Netherlands for 6 years	Country office of PLAN international, implements child-focused activities in different parts of the country.	Children and mothers	Working with 124 VDCs in Morang, Sunsari, Makwanpur, Bara, Rautahat, Banke Districts	2002 – 2005 US$ 3,480,025 ECCD programme 100% funded from Plan Netherlands	2003 planned results 290 ECCD centres to be constructed 16,050 children receiving supplementary feeding 35% of children below 6 years attend ECCD in Plan communities	2003 results • Number of ECCD centres set up: 333 • Number receiving supplementary feeding: 18,461 • Number of children attending ECCDs: 17,636 (52% girls) – no information provided on % of total child population.

6.3 Results

All organisations included in the Nepal evaluation were found to be service providers as far as their health-related activities are concerned, except for SSS, which to date has provided information, education and communication support on HIV and AIDS to the Nepal AIDS Programme, along with some outreach to people with HIV/AIDS. Some of the organisations function as umbrella organisations operating through community organisations (e.g. WOREC), while United Missions of Nepal (UMN), which founded some of the organisations covered, still links the organisations they have spawned. WOREC and CVICT also have strong human rights advocacy elements to their programmes. As all the organisations involved in this evaluation were primarily service delivery organisations, or the components of the evaluation were service delivery focused, there is no differentiation in the reporting of findings between service delivery and network organisations in this chapter. More detailed information on findings can be found in separate country report, section 4.

6.3.1 Impact/effectiveness

CFA partners themselves have few, if any, strategic objectives and SMART indicators against which quantitative impact or effectiveness could be measured. However, due to the conflict in Nepal, as with DRC, many of the CFA partners are the only health care providers for whole sub-districts or even regions (in the case of BNMT). Their withdrawal from these areas would mean no health services would be available for the communities currently being served. The figures given aboveconsisting of 2003 or 2004 data provide a view of the average annual health activity level of the organisations evaluated, as these are very similar to service use levels from previous years. Due to the conflict situation in Nepal government health services barely function at all, making non-state health services that much more critical to communities.

ICCO's lack of a country strategy framework makes it impossible to measure progress towards either country or global policy objectives. Furthermore, lack of baseline data for most of the health indicators amongst Nepalese partners made it very difficult to make a comparative analysis of quantitative results of the work of partners. As with the DRC programmes, there is no discernable association between length of partnership or commitment of resources to the partners by ICCO, as most of the longer-term partners are recipients of multiple sources of funds. Plan, on the other hand, is able to provide concrete evidence of progress against programme objectives by having measurable indicators and regular progress reports that monitor progress against these indicators.

The evaluation team did try to compare HIV/AIDS awareness and DOTS (Directly Observed Treatment of TB) using data of some partners and national data, notably for BNMT and Plan, but found that the poor quality of the national data rendered the comparison meaningless.

The data below compares the proportion of women giving birth at home[5] in the working area of BNMT, Plan and YUHP with the national figure. Deliveries at home are less than the national average in the programmes of all three partners. However, in YUHP area and in much of the operating area of BNMT women do have access to hospitals and

[5] Safe Motherhood initiatives emphasise the importance of having skilled birth assistance and ready access to emergency obstetric care during labour and birth to avert maternal illness and death. Home births tend to be attended by unskilled family members.

health centres providing delivery services, so the figures for home delivery could be considered as very high. Whereas use of the safe delivery kits[6] during delivery is very low at national level as well as in BNMT area, their use in the Plan area is very high. No data on the use of safe delivery kits for deliveries at home were found in YUHP area.

Deliveries at home	%	Use of Safe Delivery Kits	%
National	89	National	9.4
BNMT	80	BNMT	30
PLAN	77	PLAN	77
YUHP	70		

As set out in Table 10, most of the other partners have specific targets set out in their project proposals and the trend for achieving the target is on the positive side. The main issue here is that most of the partners do not have any baseline data related to their interventions. Most of the available data are input/output data only, which demonstrates the effective delivery of the project and its target achievement but makes it difficult to attribute overall impact. For example, CVICT's targets largely depend upon the needs of the torture victims it caters for, and are based on the reported cases only. CBRS has a target of serving 825 physically disabled persons during the current project period, which it is likely to achieve. But it has no baseline data of how many physically disabled people there are within their operating districts or Village Development Committees (VDCs)

Qualitative information on impact is generally very positive. National government views on impact (see Nepal Country Report, section 4.2.) were confined to those projects that Ministry of Health staff were aware of, which were the BNMT and Plan programmes. MOH officials expressed high appreciation for the contribution made by BNMT to the DOTS programme in Nepal's eastern region. The view is that BNMT's efforts have meant that the poor in this region have benefited in particular, as they are also the most affected population.

Plan is recognised by the national and local government as a major contributor to health- and education-related programmes in the areas where they work. Plan Nepal is considered as a long-term supporter, pioneer and champion of running the Early Childhood Care and Development Centres (ECCD). The impact of Plan's programmes is considered to be mainly in strengthening the delivery capacity of government health workers and volunteers, improving service quality and improving accessibility to basic health and nutrition services of mothers and children. Plan's ECCD programme and advocacy work have led to the inclusion of ECCDs in the Nepalese Government's PRSP, which has set a target of putting 74,000 ECCDs in place by 2015, though Plan could do more to ensure that the government strategy adheres to a higher standard programme. Currently, for example, the government is proposing to not provide any food for children in government-run ECCDs, even though this is a core element of the Plan ECCD programme, and it is vital to improving the poor nutritional levels of Nepali children.

Kathmandu municipal authorities are very appreciative of YUHP's work in improving health service accessibility and availability to the urban poor and migrant population living in one marginalised area of Kathmandu.

[6] The percentage of births using safe delivery kits gives a good proxy for whether women have been assisted by someone with some formal training.

6.3.2 Quality

Beneficiaries interviewed by the research team were generally satisfied with the quality of services being provided. The government line agency staff also expressed their satisfaction with the quality of the services of the NGOs. Skilled and qualified personnel (with required technical competencies) are engaged in the delivery of the programmes by all partners, and this is viewed as an indicator of service quality by those interviewed. Regular access to drugs and supplies were another indicator of quality for health service provision.

6.3.3 Coherence

Partner programmes are both coherent with government and CFA policies, where they exist, and, in some cases, are at the cutting edge of policy, helping to influence the creation of new pro-poor policy. The key areas of convergence include:

- In line with 'Health For All' and 'Long Term Health Plan' of the government (but not strategically planned by small NGOs)
- In line with the government's priority for primary health services
- Promote 'Right-Based Approach' for health and nutrition (in the PRSP) in service delivery but not in advocacy strategies
- Indirect contribution to the livelihood of the beneficiaries (e.g. through ECCD's development activities, DOTS TB control and RH/MCH)
- Pro-poor focus and involvement of community and local agencies are pursued by the programmes
- Many programmes support strategies for assuring gender equity and women's empowerment (ECCD, CVICT, SSS).

However, poor-quality baseline and quantitative data create difficulties in attribution of the target achievement in macro-level indicators. In other words, it is difficult to measure the degree to which the partners' programmes are contributing to overall Nepal MDG and PRSP targets.

YUHP has worked on filling a policy gap through its innovative work with the urban poor. Nepal has no urban health policy and the health system has not yet created structures to cater for urban populations. YUHP's approach of involving the municipal authorities from the beginning of the project has led to the municipality first increasing the levels of staffing and funding for a municipal health office, and now being in a position to have YUHP clinics handed over to municipal control. This project should serve as a model for other urban health service provision.

It is unclear the degree to which United Missions Nepal has worked with the government on incorporating some of the key systems concepts introduced by this project, which represents a missed opportunity for influencing government policy in this area.

Plan's projects emphasise capacity building not only of local community organisations but also of local government staff. Their capacity-building work is very well regarded by local and national government, and has probably played a useful role in ensuring that Plan's approach to early childhood care has become institutionalised within the government's medium- and long-term plans.

In some cases local authorities reflected that they would wish to have closer contact with some of the organisations, and a better understanding of their activities. However,

the evaluation team also found that these same local government staff realised that the current conflict probably necessitates organisations keeping a certain distance from government structures. This understanding reflects both the balancing act performed by organisations working in Nepal today (especially in rural areas) and the maturity of local government officials.

CVICT works with an extremely vulnerable population, and somewhat outside government policy frameworks. CVICT's work is primarily supply led at present, providing individual counseling and support to people who have been tortured.

Given the scale of the problem in Nepal (it is estimated that 200,000 women and children are 'missing' from their homes due to trafficking) CVICT and WOREC could do more in advocacy to encourage government decision makers to respect and promote legislation on protecting and promoting the rights of women and children and to enforce existing legislation on trafficking.

6.3.4 Participation

All service provider projects adhere to principles of community participation and management of health services to a great extent. Community management committees, women's groups and community-based organisations are being promoted by service provider partners, where communities are encouraged to play a role in managing health programme activities. This includes planning of field activities with community groups and providing training to community-based organisations. The social structure of Nepal (caste system and low status of women) has also meant that most programmes place an emphasis on ensuring the inclusion of marginalised groups, including those of a low caste, women and, in the case of Plan, children.

BNMT, the various UMN associated programmes and Plan put a great deal of emphasis on promoting community participation and ownership of their activities. One key indicator of the success of the participatory approach of all these organisations is that the Maoist insurgents, having assessed how the projects operate, have decided that they meet community priority needs and the insurgents thus largely leave the staff alone to get on with their work. CCDN was highlighted by the evaluation team as managing to work in especially difficult circumstances by maintaining a good relationship with line agencies in local government while also being seen to be addressing the key needs of the poor and vulnerable in their project area.

Plan's work at community level includes employing community facilitators, who in turn work closely with community volunteers who contribute enormous amounts of time to project activities. Women volunteers in the ECCDs take turns to look after children and provide food for the one meal served to children at the centres. The evaluation team found that more support needs to be provided to some Plan staff to help them overcome some of the prevailing social attitudes. For example, in one area visited, staff were asked how the rotation system for food preparation at ECCDs worked in practice where members of the rotation included Dalit women. The staff replied that, in this case, other non-Dalit women in the rotation list prepared the food rather than allowing the Dalit mothers to do so. While acknowledging that changing social sensibilities is very difficult, the team felt that because Plan has built up such good relationships with its programme communities its programmes could be doing more to challenge those attitudes and beliefs that continue to exclude Dalit women from many activities.

However, community-based staff will need training and support in order to facilitate this.

With regards to the participation of young people in Plan's programmes, as the programmes assessed for this evaluation considered only the early years' centres that cater to children under 5 and their mothers, the research team focused on the mothers' participation and control over health-related activities.

6.3.5 Sustainability

As with the programmes in the DRC, the financial sustainability of development organisations in Nepal is weak. Most programmes will remain dependent on external funding for the foreseeable future, as even if the conflict should be resolved, it will take a long period of reconstruction and economic growth to assure that both the state and non-state service providers have some ability to be financially viable.

The sustainability of the organisations themselves and of the changes they have promoted in the communities they work in is more variable. CBRS was highlighted by the evaluation team as having a particularly strong governance structure, where board members were both independent of implementing staff and also important individuals with high local profile who are committed to assuring the ongoing work of CBRS. This type of governance structure lays the foundation for supporting the maintenance and expansion of CBRS's work in future, though there are other constrains on sustainability (see below). In contrast, CCDN's governance structure is staff driven, so that the organisation could find itself in the somewhat compromised position of having its accountant also being the treasurer (there are no organisational rules that would prevent this at present).

The strong emphasis on community management and ownership of programme activities in all organisations, except CBRS and CVICT, also bodes well for the future sustainability of programme activities. The evaluation team felt, for example, that Plan-supported community structures had very high levels of voluntary participation and engagement, which could mean that basic aspects of programme activities could be sustained even without ongoing Plan funding. CBRS and CVICT, despite their very special service area and very effective service delivery, have perhaps the weakest sustainability situation. The phase in and phase out strategy, service content and spectrum and community-based approach are the areas where these organisations need to put more effort to ensure sustainability of their services after CVICT and CBRS phase-out their support.

The sustainability of SSS was raised as a concern by the evaluation team, as it appears to have not found a particular niche for continuing its HIV and AIDS work, nor does it have a particular constituency that owns and supports its work. This is especially true now that more actors have become involved in supporting HIV and AIDS work in Nepal, so that competition for funding in this area is growing stronger.

BNMT's work is highly integrated into government systems, and in fact works as a substitute for government structures in the Eastern Region. While the level of integration should be an indicator of longer-term sustainability of programme activities, there are concerns that, should BNMT support withdraw from the region, the government would not have the resources to continue the work. The evaluation team strongly felt that BNMT needs to put more emphasis on the longer term, by identifying

handover arrangements with government authorities. In contrast to this, YUHP provides a model of programme sustainability, where programme managers built sustainability into their programme from the outset. This was done through active engagement with the municipal authorities and devising a plan to handover project activities to the municipality after a certain period of UMN support.

6.3.6 Value added

The partners in Nepal were universal in their acknowledgement of the many positive aspects of working with ICCO and Plan Netherlands. These aspects included:

- The CFAs provide stable resource support that allows the Nepal partners to make longer-term plans.
- The flexibility in budgeting and use of funds enables the partners in Nepal to respond to the needs of the community in an ongoing manner.
- The CFAs are responsive to the needs of their partners in Nepal, and do not interfere much with implementation. In essence, they are left to get on with their work.
- In the case of SSS, their relationship with ICCO has allowed them to be involved in regional and international HIV and AIDS networks, which staff have found highly beneficial. (Although it is unclear how this has translated into taking a more strategic approach to their work).

However, ICCO's country strategy for Nepal is less defined than for the DRC, and there is no apparent cohesiveness in terms of who is supported, other than the fact that each partner does share similar values to ICCO, and their activities fit within ICCO's priority policy areas. This does limit the added value that ICCO can bring to its Nepalese partners.

Also, limited direct monitoring and changes in Netherlands-based staff (in particular ICCO) creates confusion sometimes, with partners unclear about how shifts in policy direction have come about and how they should respond. There appears to be little support provided by the CFAs for the organisational development of their Nepal partners. Partners indicated that staff turnover at ICCO inhibited developing a longer-term working relationship with the organisation. Also, each ICCO programme officer covers a number of organisations and projects. This means that they have very little time to work in depth with any individual project and cannot, therefore, provide institutional development support. Partner representatives also commented that the workshops run by this evaluation were the first occasion ever where they had met as CFA partners and that they would welcome more opportunities to do so.

In terms of partnerships, the organisations interviewed felt that their key partnership was both with the communities that they worked with and with government. They emphasised the linkages and coordination with the Nepal Government's line agencies in the areas they worked in. However, the vision and commitment of some of the partners, and in particular field-based staff, to institutionalising their work along the lines of government policies in the longer term was very limited.

7 Findings: Zambia

7.1 Country context

Zambia is a landlocked Southern African country with a population of approximately 10 million people. It is considered to have one of the most urbanised populations in Africa, a feature that is due primarily to Zambia's mineral extraction industry, which has led to the creation of various urban centres. Since independence in the 1960s Zambia has unfortunately experienced a large decline in social and economic indicators, caused primarily by a dramatic fall in the world market for copper, one of Zambia's primary industries. It is now one of the world's least developed countries though, unlike DRC and Nepal, benefits from the fact that it has a stable and increasingly democratic government, and no internal conflict to contend with.

The Zambian health system has undergone public sector reform, including a robust decentralisation process. Health services are managed by District Health Management Teams now, rather than through the national Ministry of Health. The donor community in Zambia has begun to coordinate its assistance more in order to provide better support to the government's poverty reduction strategy. In the health sector, a number of donors, including the Dutch government, now pool their assistance in a basket fund for use by the Ministry of Health. Negotiations are underway to move towards a Sector Wide Approach (SWAp) in health in the near future. Zambian health infrastructure is poor and levels of staffing are very low compared to what they should be in both government and non-government health services. The situation has become more acute as the most qualified staff seek employment outside Zambia, either in the region or in northern countries, in an effort to improve their families' economic position. Another part of the health sector reform process was the introduction of user fees for services across the country.

About 40% of health care in Zambia is provided through the non-state sector, with faith-based organisations making up the largest proportion of non-state provision. The government has increased its share of funding to its non-state partners from 25% to 75% of church facility running costs to cover loss of other income for especially mission hospitals.

A recent Ministry of Health report (2004), which reviews the progress of the health sector reform, has found that in general districts have taken on planning activities, though district teams need to do more to prioritise what they will do. It was also noted that the current district planning format gives no space to explore cross-cutting issues such as mainstreaming of gender or poverty issues or ways to improve equity. The MOH review also notes that the impact of user fees has been fairly negative, as the revenue generated is tiny compared to what is needed, and that fees have had a deterrent effect on service use by poor people.

The Zambian population, as with all of Southern Africa, has been heavily hit by the HIV and AIDS pandemic. This has led to severe social and economic problems, as well as the individual health problems for those diagnosed as HIV positive. One of the most striking

impacts of the level of HIV infection in the country is the fall in life expectancy to only 32.7 years. HIV and AIDS have also had a severely detrimental impact on key public services such as health, as many workers have become ill and died from AIDS. Key health indicators for Zambia are in Table 11. Further information on the Zambia context is available in Zambia country report, section 1.

Table 11 – Key health data for Zambia*

Infant Mortality Rate	108/1000
Under Five Child Mortality Rate	192/1000
Maternal Mortality Rate	750/100,000
Life expectancy	32.7 years
Total Fertility Rate	5.6
HIV/AIDS prevalence (%15-49)	16.5%
<5 underweight for age	28%
<5 fully immunised against TB	92%
<5 fully immunised against measles	85%

* from UNDP (2004) Human Development Report 2004

The Dutch government provides significant support to the health sector in Zambia. It is embarking on a pilot programme with the government that aims to motivate more qualified staff to move to and stay in health centres and hospitals in more remote areas of the country. The programme is introducing a package of incentives to health staff, which includes subsidised salary payments, improvements in living accommodation and working environment, as well as school fees for school-aged children.

7.2 CFA policies and programmes

Table 12 – Country-specific health policies and programmes

	Cordaid	Plan
Policies/ Objectives	Contribute to improving the quality of and access to health services (preventive and curative) for the poor and vulnerable. Specific objectives of CORDAID's health programme are: • Human resource development • Capacity building of organisational and institutional development • HIV/AIDS • Basic health services and community-based care	Improve the quality of health among children and mothers in Plan communities: • Increased access to basic primary health care that provides integrated health services based on cost sharing • Reduced disease levels by increasing awareness of PHC, watsan and nutrition • Greater emphasis on HIV/AIDS interventions • Increased access to potable water • Community management to maximise cost/ benefits and utilisation of volunteers linked to continued capacity building
Fit with Zambia government policy and strategy	Strong decentralisation and integrated service funding and delivery programme. CORDAID partners are mostly church-based service delivery organisations, are also key partners in the government's overall service delivery strategy. Funding to support partners working in advocacy for human rights, monitoring PRSP.	Plan works closely with the Zambian government in building infrastructure and training district health staff.
Fit with Zambia – Dutch government policy	Dutch government health programmes in Zambia are focused on human resource development, in particular training and retention of health staff. 10 year commitment to providing increased incentives to staff to work in more remote areas and to remain within government service.	
Partners and health-related funding	**CSPR:** A national network organisation supporting provincial and district poverty monitoring groups who monitor government progress on the National Poverty Reduction Strategy **CCJDP:** Supports parish-based organisations with training and mobilisation activities in the areas of poverty reduction, social action, HIV and AIDS and gender equity. **CHAZ:** Faith-based community's umbrella organisation made up of 90 faith-based institutions. Liaises with the Zambian Ministry of Health on behalf of its members **Dioceses:** Run hospitals and health clinics throughout Zambia, as well as community-based health programmes. Ndola Diocese manages an integrated AIDS programme Total Cordaid budget 2004: € 2,328,829 Total committed to health 2004: € 498,825	Plan Zambia: Main areas of action in Zambia include the provision of integrated basic primary health care services, water and sanitation activities, health and nutrition promotion, HIV and AIDS prevention activities and community capacity building through community facilitators. Programmes funded at 100% but exact figures were not provided. Health activities in the 3 regional programme units in Zambia, operating in Mazabuka, Chadiza and Chibombo districts of Southern, Eastern and Central Provinces Total Plan Netherlands Zambia budget: € 657,356 Overall health budget 2004 – € 400,116

Table 13 – Zambia: Partners, Strategies, Finances and Outputs/Outcomes

Agency	Strategy	Target Groups	Coverage	Financial Support	Programme Targets	Outcomes/Outputs
12.2.0.0.0.1 Cordaid						
Diocese of Mansa Cordaid partner for 32 years	Catholic diocese: Health programme aims to provide leadership and guidance to health institutions and community-based health programmes. Runs two hospitals in Mansa District, coordinates health institutions and programmes and provides home-based care.	Directly supports 52,000 people in three districts, and indirectly 220,000 people	Mansa, Samfya and Nchelenge Districts	2004 Support to two hospitals: US$ 12,000 9.7% overall funding	No strategic plan or indicators available	Hospitals under diocese (3) Totals for 2001: OPD attendance: 18,267 In-patients: 12,447 No. of assisted deliveries: 283 Fully immunised: 1,303 (not including St. Paul's, as immunisation carried out by district health team instead)
Diocese of Mpika Cordaid partner for 27 years	Catholic diocese: Runs Our Lady's Hospital in Chilonga, which aims to deliver qualitatively good and affordable health care services	Covers the population of Mpika District, approximately 150,000 people	Mpika District	2004 Support to one hospital: US$ 54,759 40% overall funding	No strategic plan or indicators available	Hospital under diocese (1) Totals for 2003: Curative contacts: 14,217 (2000 less than in 2002, possibly due to the introduction of a 'by-pass fee' for people using maternal health services) Antenatal visits: 5097
Diocese of Ndola Cordaid partner for 11 years	Catholic diocese: Aims to promote integral and integrated development of all human beings and encourages maximum participation of people as subjects of their own progress. Programme supports holistic care for people with symptomatic HIV infection and their families, including home-based care, orphan care, living positively with AIDS and respect for rights of PLWA.	Covers 27 shanty compounds in five main towns of the Copperbelt in Zambia – up to 400,000 people living in this area	Copperbelt	2004 General: US$ 267,275 14% overall funding	No strategic plan or indicators available	Hospital (1) and Health Centre (4) under diocese 2001/2 – total increase in use attributed to church medical institutions Children < 5: 560 Women: 294 Men: 293 Maternity services: 383

CHAZ – Church Health Association of Zambia Cordaid partner for 12 years.	Network organisation representing and providing assistance to church health institutions and programmes to improve health in Zambia. CHAZ serves as an advocacy body representing faith-based interests to government offices, and provides technical support to its members.	Represents 90 health institutions in the country	National	2004 General: not available		
CPRS – Civil Society for Poverty Reduction Cordaid partner for 1 year	Civil society network organisation, promoting the effective participation of civil society in poverty eradication. Strategies include poverty monitoring to ensure poverty strategies are being implemented, as well as information dissemination and civil society capacity building. Health-related work is through PRSP monitoring and capacity building.	Works nationally with a wide range of civil society organisations.	National	2004 US$ 56,063 14.2% overall funding	No quantifiable objectives related to this work. Has focused mainly on ensuring CSO participation in production of the PRSP, and now its monitoring.	
CCJDP – Catholic Centre for Justice Development and Peace Cordaid partner for 6 years	Catholic centre promoting integral human development, economic and social justice, and empowerment, using awareness building, advocacy, research and training and institutional strengthening. Health-related work includes improving access to medicines and HIV/AIDS work.	Works with Catholic parishes throughout Zambia	National	2004 US$ 187,506 14% overall funding	No quantifiable objectives related to this work available.	

Plan Zambia	Plan is an operational development organisation implementing its own projects at community level. Its focus in Zambia is on improving the quality of health among mothers and children; improving household food security; improving the participation of children, families and communities in the development process and improving the quality of education. Health activities include water and sanitation improvements and support to district health services Supported by Plan Netherlands for 4 years	General populations of Mazabuka and Chibombo Districts	Mazabuka, Chibombo and Chidaza	2004 General: US$ 16 million over 5 years 53.75% ($8.6 million) goes to health programme	1 To contribute to reducing the National Maternal Mortality rate by 22.9% from 649 per 100,000 to 500 per 100,000 by the FY 2005 (June). 2 To reduce the percentage of children under 3 years in Plan communities who have a weight for age score –2 standard deviations from the median weight for age of the international norm from 17.36% to 15% by FY 2005. 3 To increase the percentage of households in Plan communities with access to potable water all year round from 41.10% to 70% by FY 2005. 4 To increase the percentage of households in Plan communities using basic, safe sanitary facilities from 46.65% to 55% and adopt good hygienic practices by the FY 2005. 5 To increase access to information among women and adolescents and increase percentage of those taking correct measures in Plan communities from 14% to 50% in order to reduce the spread of HIV/AIDS and STIs by FY 2005.	**Outputs in 2003** All Plan supported clinics provide skilled birth assistance 41% of women are using modern contraceptives 60 TBAs trained 129 MT of nutritional supplement distributed in 2003 52 new boreholes provided 13 IEC sessions on basic hygiene and sanitation carried out HIV and AIDS awareness campaigns held in 13 communities

7.3 Results

The above tables indicate that there is a considerable amount of health-related activity supported by CFA partners in Zambia. Many of the programmes have received CFA support for several years, with the CFA providing a variable percentage of the overall funding their partner organisations require. As with the DRC, the Cordaid partners do not have health-related indicators related to their work. On the other hand Plan does have very specific health-related impact indicators and detailed mapping of outputs against indicators provided in their annual reporting system.

As with the other countries, the faith-based network supported by Cordaid and the operational programme of Plan are making an important contribution to health service provision in Zambia, as reported both by community members interviewed and government counterpart organisations. More detailed results are provided below.

7.3.1 Impact/effectiveness

Organisations that provide services: The majority of organisations included in this evaluation have significant elements of health-related service provision in their programmes. These include the Dioceses of Ndola, Mpika and Mansa supported through Cordaid and Plan Zambia's programmes.

7.3.2 Quantitative

As with the DRC Cordaid partners it is difficult to measure quantitative results of the dioceses and advocacy programmes supported by Cordaid. The evaluation found that health indicators for CFA-supported units show little difference to rates found in the national or district health information system (see Zambia country report, section 3.2 for detailed health information). As the programmes themselves do not have baseline data it is impossible to build a 'before and after' picture of the quantitative impact of health services in any particular communities. In some cases the length of operations of the diocesan health services would make baseline data meaningless, so that the only comparison is with comparable districts and national level statistics. However, the indicators used within the health system and within specific institutions have changed over time, also making it difficult to do any trend analysis.

With the above caveats in mind, it is again useful to consider what the health situation would be if Cordaid's partners were not providing or reducing the provision of health services. As faith-based organisations make up almost 40% of Zambia's health care system, they play a critical role. Cordaid's partners also go beyond providing just curative health services, by supporting an extensive range of community-based health care. In particular, Ndola Diocese's AIDS outreach programme is highly celebrated and seen as a model to be replicated in other countries.

Plan is making steady progress against this current period's indicators, with annual targets more or less being met. Respondents in Plan project areas also reported that there had been a noticeable decline in water-borne infections, especially diarrhoea, as a result of Plan's water and sanitation programmes.

7.3.3 Qualitative

Government stakeholders that were interviewed felt that the health projects supported by Cordaid and Plan partners were making a meaningful impact on their respective catchment areas. In terms of health service delivery, access to services is assured at both

institutional level (health centres and hospitals) and within communities. In Nchelenge and Mpika, the two Cordaid-supported hospitals of St. Paul's and Chilonga Mission also serve as first-level referral hospitals, so they serve a larger population area than just their districts. In districts where the government also runs a district hospital, the Cordaid-funded hospitals tend to have more qualified staff.

Plan was also commended by government stakeholders for supporting the building of seven health centres in Mazabuka (out of a total of 42 in the district). This was seen as an important support to the government's infrastructure as the DHMT couldn't afford to build new centres from their own funds.

District teams also appreciated the community level work offered by the different CFA partners. Besides the support to infrastructure it was felt that the importance given to community capacity building was very valuable. Plan was singled out for its work in community mobilisation, whereby user groups are set up and trained by Plan community development facilitators. As this work is undertaken in collaboration with local government staff, district staff felt there was a high degree of synergy between Plan's operations and their own programmes.

Organisational staff also felt that programme impact could be measured through support to health service infrastructure and clinical activities, as well as through support given to community-based activities. As a result of working at both levels (health structures and community) access to and use of services had improved greatly. However, staff also felt that user fees were a significant deterrent to poor people's access to services, and in Mpika District, declines in service use were directly attributed to the introduction of a by-pass fee. At Our Lady's Mission hospital, for example, the poor financial position of the hospital and high running costs (partly resulting from inadequate and erratic funding from government) meant that the beds in the hospital were almost all empty as the hospital's management was very strict in requiring that individuals pay their user fees before using services. Even though the government has put in place a user fee exemption policy, this is generally too difficult to implement and most poor people do not attempt to use health services for fear of being charged anyway.

In all programmes visited, it emerged from staff interviews that there was a strong presence of, and support for, community-based health and health-related services. These are felt to be making a profound impact on the quality of community well being. For example, home-based care programmes and training of home-based care providers for HIV and AIDS are taking place in all sites visited by the evaluators. It was felt that the effects of the home-based care programmes included:

- An increased number of women delivering babies under the supervision of a trained attendant
- Better access to treatment by community health workers
- Better nutrition levels and availability of growth-monitoring services for under 5's
- Greater HIV and AIDS awareness in the community on prevention, support and mitigation measures
- More care for those with HIV and AIDS and their families

Staff further felt that the community-based programmes meant there were less pressures on clinic-based services, as individuals would first seek out (free) community health worker assistance before going to the health centre.

Staff perceptions were mirrored by community members who participated in the focus group discussions run by the research team. Key features highlighted by community members also included better access to curative services and the positive contribution that community-based services were making in people's lives. Community members also confirmed that user fees were a major deterrent to accessing services for some individuals who could not afford them. Community members also found that the hostile attitude of many Classified Daily Employees (CDEs) in health centres was a significant deterrent to using clinic-based services. CDEs are semi-skilled staff who are often the first person that health clinic users encounter. At present there do not appear to be any programmes in place to train and support CDE level staff.

Community level control over health services is dependent on how motivated individual health units are in organising community health management committees. While government policy states that all centres should have management committees, adherence to this policy is limited.

Organisations that work as partnerships/support advocacy: The three partner organisations that work primarily as networks and advocacy groups reported that they had achieved positive results in the areas that they work in. The Church Health Association of Zambia (CHAZ) has been very successful in lobbying the government on behalf of faith-based organisations in order to increase the proportion of government health funds going through mission health services.

The Catholic Committee for Justice, Development and Peace (CCJDP) reported that its work has had a 'profound' impact on beneficiaries through its community sensitisation and mobilisation work. Through working with community groups CCJDP has helped them to be actively involved in advocacy and lobbying activities. As a result, communities have demanded justice on issues that affect them. CCJDP training at diocese level has also improved diocesan staff capacity to discern issues, generate and engage in debate without necessarily involving the central level.
Overall, it was observed that there has been an increase in levels of economic literacy and that people are able to see how economic and other policies affect their day-to-day lives. Despite the positive impacts on beneficiaries registered, it was revealed in one interview that within the church issues of gender equity have yet to be looked at; the church itself is not very gender aware, while staff face a great number of stereotypes with regard to culture and gender relations. Often women are not in the forefront of activities, and their participation is hampered by social norms where target project communities are ordinary members of society.
In the case of CSPR, it was reported that the organisation responds to this at two different levels. Issues of gender and HIV and AIDS have recently been mainstreamed in their Poverty Monitoring Tool. The different impact of government policies and programmes on the sexes as it relates to poverty is one of the organisation's core issues in monitoring PRSP implementation.

7.3.4 Quality

Organisations that provide services: It was generally felt by all interviewed that CFA-supported health services were of a higher quality than government services. The reasons for this include the fact that the diocese and Plan services tended to have more qualified staff working for them than did the government-supported services and tended to have a more ready supply of drugs available for treatment. Better quality was also attributed to the fact that CFA partners tended to emphasise continuing professional

development and community capacity building. For example, Plan trains health centre staff in a number of subjects, including integrated management of child illness. This was reported to have resulted in improved diagnosis, classification, treatment and more appropriate referrals to higher-level facilities.

Health centre and hospital staff felt that while providers strive to provide affordable and appropriate quality health care, these efforts are compromised by a shortage of drugs and by poor staffing levels. Staffing problems are especially acute in rural hospitals, where it is difficult to retain medical doctors. As a result, the few that remain in active service are overwhelmed by the workload.

Organisations that work as partnerships/support advocacy: The quality of the work of the various partnerships/networking agencies can be demonstrated through the effectiveness of their advocacy and training activities. As seen above, these do appear to be having an impact at both local and national levels. However, whilst acknowledging that much work is being done, respondents from these organisations also indicated that they needed more support to build capacity in technical analysis in order to sharpen skills in dealing with their programmes, as this was said to be lacking in some instances. Furthermore, it was observed that the rate at, and extent to, which social issues arise that require their involvement, coupled with limited capacity in terms of staff, often overwhelmed them. This indicates more effort is needed for continuing professional development, for setting priorities and ideally for recruiting and retaining more staff both within the partnerships and within their member organisations.

7.3.5 Coherence

Organisations that provide services: Diocesan and Plan health-related services are well integrated into Zambian government systems. The Church Health Association of Zambia (CHAZ) receives government funding to support faith-based health centres and hospitals, and national health planning includes the contribution made by faith-based organisations. Plan's support to district health services and early childhood development also conforms well with the government's decentralisation strategy, where the emphasis is on district-level planning and service provision. Therefore, at a macro level, there is strong coherence between the Plan's operations, churches and government.

In districts where Plan operates, there is a good collaborative relationship between the Plan programme and district authorities. In Mazabuka, for example, it was pointed out that whereas Plan has the capacity and resources to build health centres, the district health office had to be consulted. The DHMT ensures a fair geographical distribution of health centres and is also responsible for providing staff, drugs, technical and supervisory support to the health centres once they are built.

District-level government staff felt that relations were not strong with the diocesan services reviewed by this evaluation. Dioceses are invited, along with other key stakeholders, to participate in annual planning cycles at district level, as well as to take part in reviews of district health action plans. In turn, DHMTs are invited by the dioceses to take part in their own planning and review activities. However, DHMTs felt that they were often not informed about all of the health-related funding of the dioceses and that there were still problems with coordination. DHMTs stated that the District Health Office only knew the amounts that faith-based facilities receive as government grants and often did not know the overall financial position of these partners. As a result it is difficult for district offices to clearly know what these partners are and are

not able to do, especially in terms of targeting, monitoring and evaluating their services. Furthermore, district staff criticised diocesan health services for not doing more to support family planning services, which are explicitly requested by community members in their catchment areas. As a result, district health officers have to make up for this despite their own weak logistic and resource capacities.

Diocesan health managers admitted to the research team that they are not always open and transparent about their activities with their respective DHMTs as district staff already perceive church health services to be more wealthy than government services, and if the scale of funding for diocesan programmes were revealed this would only reinforce the perception and lead to a reduction in government support for their services. There was also a feeling that relationships with the district are highly dependent on the quality of individuals within the DHMTs, and the willingness of DHMTs to interpret government policy in a more flexible manner. For example, some of the diocesan health services had managed to secure housing allowances for their staff from DHMTs, as these particular DHMTs were willing to take a broader interpretation of housing allowance policy.

The above discussion needs further reflection on how faith-based organisations and other non-state providers interact more fully with decentralised authorities in countries that have gone down this route. Longer-term sustainability and scaling up of services are highly dependent on how well faith-based programmes can cooperate and integrate with government services.

Coherence with CFA policy is also somewhat mixed. Where gender is concerned, some of those interviewed in the Cordaid-supported projects admitted that the Catholic Church has not taken proactive measures to address gender inequity and that the issue did not even arise in planning discussions. As one of the staff said “As a diocese I do not remember us saying let’s look at gender inequality or programmes that will address this”. The research team did find that there were some efforts made to ensure that women were included in community structures, but not within diocesan management structures.

As far as services adopting a stronger ‘rights-based approach’ is concerned, there is little evidence that this approach has been fully integrated into the thinking and processes of partner programmes. In the Zambian context, ‘demand-led’ services would probably make services free at the point of delivery, with much higher community involvement in health service management than is currently the case. Neither of these are being actively promoted by CFA partners. On the other hand, community-based services would appear to be very much community owned and receive a great deal of support through community volunteer activity. Even in these cases, though, it is unclear the degree to which community members are actively involved in claiming their rights to such services, nor the degree to which CFA partners encourage them to do so.

Organisations that work as partnerships/support advocacy: CHAZ’s work is fully coherent with both government and CFA policies, though implementation through its members is more variable (as seen in the discussion above). CCJDP and CPRS are working more at the cutting edge of government policy, helping to influence policies that promote greater equity and social justice. It was also pointed out that because of the organisation’s voice for the poor, the government was challenged to meet its responsibility to the poor. Partly as a result of CCJDP’s advocacy, the government

started being more vocal about the poor and improved resource allocation for poverty-reduction activities.
CSPR has made an impact in its work through generation and dissemination of information aimed at poverty reduction. It was reported that CSPR is often consulted in the development of various international agencies' Country Assistance Strategies, despite the difficulties in accessing information from various government stakeholders. Other constraints include the lack of a concrete framework within which civil society can operate easily with government, since the government was not obliged to involve civil society organisations in decision making. In other cases, it was reported that organisations' advocacy was perceived as a threat to the government, raising anxieties for certain civil society organisations that do not wish to engage in an open conflict with government institutions.

7.3.6 Participation

Organisations that provide services: Beneficiary involvement in health services planning and management was reported to be more pronounced at health centre level than hospital level, with most participation occurring at planning and implementation stages. It was observed by government staff that popular structures such as the Neighbourhood Health Committees (NHCs) and Health Centre Committees (HCCs) consult ordinary community members on community health concerns and priorities through community level meetings. However, the extent to which committees are active varies from place to place and depends on the calibre of staff in the health facilities themselves. In some places it was reported that the level of community participation is reduced to only providing labour or raw materials when building or rehabilitating the health infrastructure. Wider community representation on hospital boards is absent and was attributed to the referral role that hospitals serve.

Programme level staff reported that while attempts were made to involve communities in planning and managing services, there was often a subtle reluctance on the part of community members to become actively engaged in such activities; they say that if they are happy with what the programmes are doing, why should they be involved. Despite this, some examples of good practice are worth highlighting. In Ndola Diocese, staff, doctors and community members and representatives drawn from Hospital Health Boards and NHCs meet annually to share experiences and discuss developments. This is in addition to progress reviews that are held four times a year by the Diocesan Board.

In Plan areas, community-based agents working under the supervision of Neighbourhood Health Committees are active in community mobilisation. In Mazabuka, community members are involved in problem identification, decision making at different levels, including involvement in health centre related structures and in developing community development plans. Community members in Plan programme areas also reported that, as a result of health interventions in their communities, community members have felt more empowered to deal with issues that concern them through being linked to MOH structures. Plan staff provide capacity building for community members so that they can engage more effectively in community level committees and this would appear to have had a significant impact on community member confidence.

Focus group interviews with young people found that Zambian youth are generally excluded from involvement in community management activities. Younger people have been barred from joining committees by their elders, who tell them that as they are not yet married they have nothing to contribute. This is a great source of frustration

for young people in the programme areas, though organisation staff admit that this problem is a general one across the country, where all types of community activities are dominated by elders. Even in Plan Zambia programme areas, where there is much more active engagement with youth to encourage their involvement in managing project activities, young people still have no representation on Neighbourhood Health Committees or Community Development Committees.

Organisations that work as partnerships/support advocacy: Participation of members in the various network organisations is high. As far as the church-based organisations are concerned, the various dioceses and missions are actively involved with CHAZ in supporting lobbying activities, while the diocesan community-based activities have provided an ideal vehicle for CCJDP's training programmes. CCJDP works primarily through parish committees at community level, providing training the trainer activities in subjects such as Justice and Development or Mobilisation for Social Action.

CSPR involves beneficiaries through Provincial Civil Society Groups, which represent community organisations. By working with members who have contacts at local level, CSPR has helped increase community ability to ask or raise questions. This has a deterrent effect on misuse or misdirection of resources by leaders or indeed any service providers. For example, pressure on Members of Parliament (MPs) to have more interaction with the electorate resulted in opening of constituency offices in a number of constituencies.

7.3.7 Sustainability

Organisations that provide services: Concerns about financial sustainability raised in both the DRC and Nepal evaluations hold true for the Zambia partners as well. In some ways financial sustainability of church-based services are better assured now that they receive some proportion of government health funding, though this is still far too low to cover the actual costs of running the health services. Efforts by health services to raise more income through user fee charges have proven to be not very effective. Moreover, where user charges are strictly administered, they are proving to be a barrier to health service access for the poor.

Other aspects of sustainability are more positive. Government stakeholders felt that the substantial capacity-building activities undertaken by CFA partners helped to increase service quality and assure sustained improvements in service delivery. The only negative side to the capacity building and training work cited is the fact that many of the staff who benefit from more comprehensive training programmes often use this to then seek better paid jobs elsewhere, especially outside Zambia.

Plan's programme of training community volunteers has also contributed to programme sustainability as these volunteers then report to and are supervised by NHCs, HCCs and health centres. Community mobilisation activities are complemented by training community groups in community partnerships and project sustainability. In Mazabuka, for example, community management committees have taken over the management and maintenance of the water and sanitation infrastructure put in place by the Plan project.

Organisations that work as partnerships/support advocacy: Sustainability of the various network organisations is found more in the reach of their activities and the degree to which their training and advocacy work is leading to changes within their member organisations. The evaluators found that CHAZ, CCJDP and CSPR had all contributed

to lasting changes within their member organisations. Sustainability could be further enhanced through more efforts at capacity building of member organisations, especially those that feel overwhelmed by the social change agenda they are confronted with.

7.3.8 Added value

In Zambia, the contributions of Cordaid and Plan Netherlands to their partner organisations have had a significant impact on programme performance. Financial and other forms of support extended to these organisations make it possible for planned activities to be implemented in a timely and appropriate manner. For example, Cordaid support to different health programmes helps to complement funding from elsewhere, ensuring that much-needed resources are available for a wider range of services. On top of this, Cordaid supports training of personnel and retention schemes for medical doctors, which are much-needed incentives to maintain staffing levels.

It is also evident from the findings that where there is little expertise, building of technical capacity amongst staff is required for effective planning and implementation of programme activities. Plan Netherlands' support to Plan Zambia in this area over the years has resulted in the scaling up of activities in programme areas.

There are also many challenges to the partnership between the CFAs and their Zambian counterparts. Organisations receiving Cordaid funding are very appreciative of the long-standing relationship they have enjoyed with Cordaid and its predecessors. They are also aware of the pressures Cordaid staff in the Netherlands are under to respond to government demands for results. However, Cordaid's partners noted that the transformation undertaken by Cordaid felt somewhat rushed from their perspective, with a resulting loss of sight of how things are actually working on the ground in Zambia. There is a sense that Cordaid staff are not aware of the capabilities and constraints under which their partners operate, and that they make unrealistic demands for results in too short a time frame.

One particular area of concern highlighted by partners was the fairly bumpy communications between Cordaid in the Netherlands and their Zambian partners. High staff turnover at Cordaid was identified as having contributed to a loss of understanding of partner perspective, while also forcing partners to resubmit information that they had already sent to a previous post holder in the Netherlands.

Service delivery partners were also critical of the short rotation of Cordaid interns working with Zambian partners. Having interns coming for just a few months does not create continuity, as individuals are being replaced just at the time when they are beginning to get used to the system. Interns also arrive with very weak knowledge of the partner organisation they have come to work with and have unrealistic expectations of how much can be accomplished.

For networking partners, according to the findings, Cordaid's support to CHAZ, CCDJP and CSPR has been more in terms of financial support. This has contributed to scaling up of activities to sub-national levels. More intervention from Cordaid especially in supporting skills development in these organisations is essential for improving the technical capacities in these organisations.

Finally the restrictive funding process imposed by Cordaid was raised as a pressing concern for partners. The partners noted that they feel they are better able to judge

which programme areas are more urgent than others and therefore need more attention. As such, it would be better if Cordaid could just send a lump sum of funds without restricting how much should go to which area. When partners do use funds to cover urgent needs but outside the stipulations of Cordaid they are met with punitive actions. In response to this, Cordaid staff insist that their contracts are highly flexible. In this case, there is an apparent communication problem that needs resolving so that Cordaid and its partners are more in accordance about their contractual relationship.

8 Analysis and Discussion

In this section, the report responds to the evaluation questions developed by the CFAs, based on the results presented in Sections 4 through 7. The three countries evaluated all had very different contexts, from Zambia's very stable political context to DRC's highly unstable and conflict-torn situation. In Nepal, conflict is also affecting parts of the country. All three countries have poor socio-economic indicators and health systems that struggle to provide adequate services for their populations. As such, the role of non-state providers in all three situations is of vital importance to the health of communities. In countries in conflict, such as DRC and Nepal, non-state providers such as those supported by the CFAs lend a sense of normalcy to very abnormal lives, by bringing communities together to work for their own improvement, while also providing much-needed services.

All three organisations covered in this evaluation put much emphasis on ensuring community participation, either by facilitating community management of project activities (e.g. ECCDs for Plan) or through engaging community members in various actions (e.g. health promotion work by community groups in DRC or Zambia). The partners supported through the CFA's work are also important parts of the development processes in their respective countries as they are made up primarily of highly motivated national staff. The evaluation found many positive elements to the health-related work being done by partners, as well as several challenges. Both successes and challenges are highlighted below.

8.1 Which visions, strategies and activities do partner organisations have to improve access to, use of and control over basic health (related) services by potential users?

All organisations evaluated in all three countries have clear mission statements and objectives relating to improving the lives of poor people, either directly through health service delivery, or through health promotion and networking activities. While it was impossible to measure the quantitative impact of the various partners' work, it was clear through interviews with various stakeholders, staff and community members that the various partners were improving services, and as such, achieving their organisational objectives. This was true for both service delivery and partnership/networking organisations.

Few of the service delivery organisations have explicit objectives to improve or monitor beneficiary access to or control over basic health-related services; they see this as being mediated more through existing national policies that promote some form of community health management committees. Furthermore, there is currently no means of monitoring the involvement of poorer sections of the community. Anecdotal evidence indicates that it is the better off in most communities who participate in community committees.

One area of concern raised in the evaluations in DRC and Zambia was the lack of vision or objectives for assuring gender equity or increasing the role of women in Catholic

diocesan programmes. Whilst recognising that there is a prevailing male-dominated culture within the Catholic Church, diocesan funders such as Cordaid could and should do more to challenge norms that disadvantage women. Only Plan projects have specific objectives for improving children and young people's say over services targeting them, though cultural and social norms in Plan communities again limit the degree to which they are involved in community decision-making processes.

It is unclear how much beneficiaries are included in the strategic planning activities of partner organisations, except through their local government or parish representatives for most of the service delivery partners. In general Cordaid and ICCO partners interviewed did not see the relevance of community participation in management of health services, especially above primary care level. Beneficiary participation was seen as more of a conduit for improving user fee collection or extending health promotion activities. The exception to this is Plan in both Nepal and Zambia, which actively engages community members in developing local community development plans, which Plan then helps them to implement, and which feed into Plan's country strategy cycle.

Questions were raised by a number of beneficiaries interviewed as to who participates in the various committees and meetings, with concerns raised about poor levels of participation of both women and youth. As all the CFAs are increasingly advocating for a shift to a rights-based approach in the work they fund, the question of how beneficiaries can influence even the partner organisations themselves needs to be addressed more explicitly, while also addressing the problems of engaging more socially marginalised groups within communities.

Community participation in partner organisation activities is reasonably strong, though this evaluation found much could be improved. There is a large difference, for example, in how the different BDOMs supported by Cordaid in DRC approach communities and support community mobilisation activities (e.g. BDOM Bukavu versus BDOM Kananga), which in turn affects the degree to which community members engage in health management committees and other actions for improving their health and health services. In Nepal, active community engagement was found to be an important element in keeping programmes running, as the insurgents in particular will not bother organisations that they see as responding to the expressed needs of communities. In Zambia, as with DRC, community involvement in health management committees was highly variable between the dioceses. However, there is high community engagement in community-based health activities, such as home-based care and Plan's ECCDs. The research teams in both Nepal and Zambia were impressed with Plan's community mobilisation efforts, which are assisted by Plan community development facilitators. The degree of volunteerism in those communities is markedly high, and community members who were interviewed expressed great enthusiasm for the work they were doing.

Networking/partnership organisations are member driven, and therefore have high levels of engagement of members in their strategic planning processes. The degree to which beneficiaries feed into this process is highly dependent on the members of the partnerships. Some of those working in the secretariats of partnership organisations cited numerous challenges to maintaining high levels of participation and engagement from members, as each member organisation brings to the table its own set of visions, objectives and ways of working. This can create problems for implementing strategies in support of improving health-related services. In some cases CFA partners who have been

labelled as a partnership or networking organisation are in fact rather large local NGOs that implement their programmes through community organisations (e.g. WOREC).

The visions, strategies and activities of all partner organisations evaluated either represented an excellent fit with current government health policy (e.g. many of the partner organisations help to implement government health policy in close collaboration with Ministry and district level officials) or were on the cutting edge of policy making, so that their own activities were helping to break new ground in government policy (e.g. the work of Centre Olame in DRC, YUHP and Plan in Nepal and Ndola Dioceses' HIV/AIDS work in Zambia). All organisations subscribe to features of community participation, which have also been mainstreamed in national Poverty Reduction Strategies in all three countries.

The diocesan programmes in both DRC and Zambia work within the decentralised health system of both countries, and in the case of DRC, even oversee the management of certain decentralised areas. Similarly, BNMT in Nepal is providing health services, often on behalf of the government, in the eastern region of the country, while smaller groups such as CCBN make smaller-scale contributions. All stakeholders saw the faith-based organisations as vital parts of the national health system. The training programmes supported through organisations such as ESP and IPASC in DRC, and through the dioceses in Zambia, were also seen to fit well with national priorities and programmes.

While in general the CFA service delivery partners are working in line with government policies on basic health care provision, one area of concern raised was the Catholic Church's stance on family planning and HIV prevention. In communities that are 100% reliant on Catholic diocese facilities access to family planning and condoms is extremely limited.

The level of coherence between the partner organisations' vision, strategies and activities and the policies of CFA is more variable. The weakness of efforts to assure gender equity in a number of the Catholic dioceses in both DRC and Zambia was flagged by both research teams. Understanding and ownership of rights-based approaches amongst service delivery partners is also weak, except in Plan programme management. Numerous partners asked the evaluators for clarification about what is meant by a 'rights-based approach' and how they were supposed to change their work to shift in this direction. Understanding of RBA remains poor even among Plan's field-based staff. It is evident that, while partner organisations have received the message from CFAs that CFA policies and strategies are changing, they haven't been adequately supported to understand how they can respond to this shift, even when elements of their programmes already conform to new CFA strategies. The following quote from Zambia illustrates the frustration partners feel in meeting what are perceived to be unrealistic demands from their CFA partner:

We are involved in so many activities. We are not where they think we are in terms of capacity and technical know-how. They might talk about a strategic plan. First of all, we do not know it. Before we start sharing ideas, they ask us how far we have gone with the process.

The research teams in Nepal and the DRC also reflected that the whole subject of 'claiming rights' in the current context of conflict presented understandable challenges to partners. In both countries government bodies are barely in a position to respond to

the needs of communities, and in Nepal local government staff have to be careful in how much they interact with community-based organisations so as not to compromise their activities. It is important that the CFAs give more considered thought to how to apply RBA in conflict and post-conflict situations.

For the partnership organisations evaluated, their vision, strategies and activities are much more related to advocating for pro-poor changes to government policies and therefore have a stronger fit with CFA concepts of rights-based approaches. Many are dedicated to helping their members, and the communities their members represent, to claim their rights.

Those partners whose vision, strategies and activities feature a strong element of community ownership and engagement are likely to find they have the most sustainable impact on their beneficiaries. Where the emphasis is on capacity building (through literacy, empowerment to lobby or self-help to respond to crises) partner organisations' activities are having a lasting effect that should survive even if the organisations themselves cannot. Other organisations, such as UMN's YUHP programme in Nepal, have built in the handover of activities to local government from the beginning of the project, ensuring that health services will continue to be delivered beyond the life of the project itself.

Within the CFAs themselves, programme coherence varies tremendously . Plan programmes have the clearest connections between international organisational policy and its implementation on the ground. This is expected as it is an operational organisation, with staff down to field level working on common aims and strategies. Cordaid's programmes also show reasonable coherence between international policy and implementation, due primarily to the fact that it works mostly through Catholic structures within countries, and supports umbrella organisations, such as CHAZ, which serve to link partners' work together and advocate on their behalf.

ICCO has the least demonstrable programme coherence, as its approach has been to select partners that fit with ICCO policy priorities but that may have little connection to each other. As such, the synergistic impact ICCO has through its partners remains weak and fragmented, even though the work of individual partners is laudable. All three approaches are valid, as it can be argued that ICCO's approach gives maximum ownership of development processes to its partners. The critical question therefore is what level of health impact does each CFA wish to achieve, and does its current approach allow it to achieve this?

8.2 What are the qualitative and quantitative results of these programmes and for whom do they improve sustainable access to, use of and control over basic health (related) services?

In all three countries CFA partners were on track with meeting annual activity targets, where they existed. In most cases, though, it was virtually impossible to quantify the impact of the various programmes, due to a lack of indicators and data within organisations and programmes. Partner organisations either expressed the need themselves to be supported in developing objectives and indicators, or the evaluation team members indicated that this support is much needed.

The service delivery organisations that took part in the evaluations are clearly providing much-needed health and health-related services that increase access to and use of these services. Many of these services, such as those delivered by the dioceses or Protestant missions are provided in areas where government services are weak or non-existent. When pressed for indicators and targets the general response from these organisations is that they exist to respond to the health care needs of their communities and therefore did not need impact indicators to measure their effectiveness.

Plan's Early Childhood Care and Development Centres are often the only community-based health support available to women and young children in those areas. Partner organisations such as BOAD, CME, the Centre Olame in DRC, CVICT in Nepal, the YUHP programme in Kathmandu and the HIV and AIDS home-based care programmes in Zambia are providing essential services to very vulnerable people that no one else is providing at present. These have a significant impact on vulnerable people's well-being in the programme areas.

At present it is impossible to know to what degree most of the CFA partners are in fact reaching the poorest and most vulnerable in the communities where they intervene, as there are no monitoring systems in place that specifically examine this.

There is no apparent link between how long organisations have been supported by the CFAs, the amount of resources committed by the CFAs and the overall effectiveness or impact they are having. There are a number of factors that make such an analysis highly suspect, including the fact that most of the longest running partnerships for ICCO and Cordaid are well established institutions in their countries (e.g. mission hospitals and international NGOs), with numerous sources of funding other than the CFA. Institutional capacity has existed in these organisations for a long time, and is likely to have been the main determinant in their becoming a CFA partner in the first place. Given how long some of these relationships have existed (20 years or more), it seems that ICCO and Cordaid have not been sufficiently challenging or critical of their partners, especially as the CFA's own policies have evolved. This is especially true with respect to the Catholic Church's attitudes and practice related to gender, sexual and reproductive health-related issues.

This evaluation has found that there are a number of deterrents to poor people's access to and use of services provided by partner organisations. The key ones cited by beneficiaries were user fees, poor levels of staffing in health units and the hostile attitudes of some health care staff. Research into health service access in developing countries concurs that user fees and poor service quality are major obstacles to poor people's access to services[7]. Research has also shown that developing and transitional economy countries that do not charge user fees have substantially more equitable health systems, and have created a far greater sense of social responsibility.[8] Pressure from citizen's groups and donors has led to the abolition of user fees for health care in various countries.

[7] Coalition for Health and Education Rights (2002) User fees: the right to education and health denied. London: CHER

[8] Rannan-Eliya R and Somanathan A (2005) Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap. London: DFID Health Systems Resource Centre

If CFAs are genuinely concerned about improving access to and use of health services for poor and vulnerable people, they need to explore with partners and their government stakeholders how they can improve access for the poor and the very poorest. There are a number of strategies available for doing this, including:

- Health equity funds: Facility-based funds, managed by an organisation independent of the facility, that provide financial support to cover user fees, transportation costs, food and basic items while undergoing treatment and social care costs[9]
- Means-tested waivers: Families identified as living below the national poverty line are provided with health cards that entitle them to free care[10]
- Cash transfers: social assistance schemes where funds are paid to poorest families tied to certain conditions, including children's attendance at school, women's attending antenatal consultations, etc.[11]

The CFAs need to also examine the strengths and weaknesses of current efforts to make services more accessible to the poor, such as government-run social insurance schemes, facility-based *mutuelles* and cross-subsidising from other programmes, as is done by BDOM Bukavu with its generic drug production.

As far as control over health-related services is concerned, the greatest community engagement was found in diocesan programmes of home-based care and in Plan's ECCD programmes, where there is heavy reliance on volunteer support and community committees. In both cases, community members are provided with training and support from programme staff to help them have the confidence to engage more fully. Community health management committees and other community-based structures that have been set up to help with managing health units are extremely variable in their effectiveness, and even in their existence. Whether these have been set up and the degree to which they are effective is very dependent on the staff of the health units the committees are supposed to manage. This mirrors experience with community involvement in health management committees in other countries.

What is less clear is the degree to which partnerships are encouraging the scaling up of successful activities of their members, or are acting as vehicles for the spread of innovative practices. In the DRC, different BDOMs appear to have highly divergent strategies for addressing similar problems and are not learning from each other. It is also unclear how well CONAFED is linking the activities of its various members, or is using the potential strength of its partnership to advocate more strongly for women's rights.

In general the quality of care provided by different partners can be considered to be technically good or very good. Quality is determined by factors such as the quality (and presence) of qualified staff, staff attitudes to patients, and levels of material, drugs and equipment available to diagnose and treat patients appropriately. All services evaluated rated well in terms of material, drugs and equipment in health units. Partner

[9] Hardeman W, Van Damme W, Van Pelt M, Por I, Kimvan H and Meessen B (2004) Access to health care for all? User fees plus a Health Equity Fund in Sotnikum Cambodia. *Health Policy and Planning* 19: 22-32
[10] Bitran and Giedion (2003) Waivers and Exemptions for Health Services in Developing Countries. Social Protection Discussion Paper Series No. 0308. Washington DC: World Bank
[11] Nigenda G. and Gonzalez-Robledo L (2005) Lessons offered by Latin American cash transfer programmes: Mexico's Oportunidades and Nicaragua's SPN. Implications for African countries. London: DFID Health Systems Resource Centre

organisations also indicated their appreciation for support to their ongoing professional development activities for clinical staff (as assisted by Cordaid in the dioceses, and through national training programmes such as ESP, as well as ICCO's support to CME and IPASC), while local government agencies expressed deep appreciation to Plan for the training Plan provides to government staff, allowing them to improve how they serve their communities. All training programmes were positively evaluated, either based on how well they conformed to national curriculum standards or based on previous evaluations of the effectiveness of the training.

There remain, however, serious challenges to service quality in all three countries. The conflict and weak state structures in DRC and Nepal mean there are severe problems with recruiting and retaining qualified staff in partner health units. Zambia also faces serious problems with retaining staff in remote health units, whether in the state or non-state sector, and these problems are further compounded by the loss of many trained staff to AIDS. Front-line, semi-skilled staff in health units, who are often the first person encountered by patients, are not benefiting from appropriate training and development opportunities, and yet can determine whether a patient continues to use that service or not.

In terms of impact on country policy and practice, Plan's ECCD programmes in both Nepal and Zambia, and its health programme in Zambia, have been influential with government policy on child health and early years development. In both countries, national and local government staff expressed high appreciation for Plan's efforts to work with, support and train government staff alongside Plan's own programme staff.

Many of the organisations evaluated are also working on the margins of existing policy, and could therefore provide models for how similar work could be approached in future. Key examples of this included Centre Olame, BOAD and ELIMU in DRC; CVICT, CBRS and YUHP in Nepal; and Diocese of Ndola's HIV and AIDS programme and CPRS's support to civil society structures in Zambia. In some cases, these organisations are already well networked and are influencing the development of national policies. In other cases, such as CBRS or Centre Olame, the activities remain at a very local scale with little prospect for their model being adopted elsewhere, as much as the services they provide are needed.

The evaluation also found some important areas for improving the links between partner organisations and local/national government structures. In Zambia, with all government health budgets targeting the faith-based health services passing through CHAZ at national level, there is little incentive for dioceses and missions to interact with district health teams. In fact, diocesan staff cited a number of disincentives for working in a transparent manner with their district counterparts. While acknowledging the very real challenges facing districts and dioceses, the long-term sustainability of health services from both levels is dependent on their working closer together. Some tensions were also found between BDOMs (particularly Kananga) and provincial health inspectorates in DRC.

While these tensions exist, the models for state/non-state cooperation in the health sector offered by both Zambia and the DRC provide the best possibility for longer-term sustainability and coherence within the health sector. In both countries the national programme contracts the larger non-state providers to provide services, and in the case of the DRC, manage health services in a geographical zone, with the government (or

its donors) contributing to the non-state provider budget. These sorts of arrangements are developing in several countries now as more attention is given to rationalising the contributions of all providers to the health sector. Cordaid and ICCO need to discuss with their providers how they can work most effectively with these contractual arrangements.

For network and partnership organisations, CPRS provides an interesting example of being coherent with national poverty reduction policy, while also being at the cutting edge of ensuring that this policy is well implemented throughout Zambia. CONAFED in DRC works at the margins of national policy, as the DRC does not have policies in place that protect and promote women's rights. The DRC research team felt strongly that CONAFED could be doing more to advocate for women's rights with government and especially within the larger civil society network.

A major area of concern mentioned in both the DRC and Zambia studies was the need to increase the involvement of women in planning, implementation and management of health-related activities run by faith-based organisations. Attempts are made to involve women in health promotion and caregiver-support activities, and some health committees have reasonably equal representation of men and women. However, women remain excluded from the management structures of many of the diocesan and mission structures. A similar picture emerges for involvement of young people. In Zambia, young people are engaged in various project activities by Plan but youth groups also expressed frustration at not being given more of a role in various community committees in their areas. It would appear that a 'glass ceiling' exists that prevents women and youth from participating beyond certain levels of organisational and community structures.

Some of the more innovative programmes have yet to develop a real community-based constituency. These include the Centre Olame in DRC as well as CVICT and CBRS in Nepal. Many of these initiatives are still fairly young, and staff are overwhelmed with demands for their services. As such, the organisations would benefit from greater support from their CFA partners in developing strategies for greater community involvement and ownership.

Network and partnership organisations by their nature are participatory and highly dependent on their members for being able to implement activities. As shown above, CCJDP and CSPR in Zambia have been able to be effective through working with community-based organisations that form parts of their network, while also providing much-needed capacity building of community groups.

Across all countries, financial sustainability of partner activities is extremely weak, and will continue to be so for the foreseeable future. This is not surprising in such aid-dependent countries, nor in countries such as DRC and Nepal, which have to contend with conflict and the threat of conflict. As seen in the discussion above, some efforts have been made to ensure better financial sustainability through employing user charges, but the disadvantages of user fees far outweigh the advantages they bring.

Sustainability of programme activities, especially those that are community based, appear to be more certain in those programmes that actively engage community members, that encourage self-help initiatives and that build community capacity to carry on beyond the life of the project. Examples of programmes that have high prospects for longer-term sustainability through community mobilisation include

BOAD's work, ELIMU's literacy programme and the various home-based/community-based care initiatives supported by CFAs. Strong governance arrangements could also improve chances for sustainability, as shown by CBRS in Nepal.

Sustainability can also be better assured by integrating programme activities into government systems, as is being done with Plan's programmes and YUHP in Kathmandu. However, as can be seen with government plans to expand the ECCD programme in Nepal, public resource constraints may limit the government's capacity to implement programmes to the standard set by non-state providers.

The sustainability of the network and partnership activities seems more assured than some of the service delivery programmes, due primarily to the reach of these networks and the capacity-building work that is being undertaken to support network and partnership members. While membership subscriptions can help to provide a certain degree of sustainability, these partnerships and networks need to also ensure they have a diverse funding base to continue their work.

8.3 To which extent do complementary partnerships, participation in networks and/or alliances contribute to better performance of partners?

Many of the networks and partnerships evaluated have strong elements of capacity building of members and community organisations as key strategies for enhancing the work of their networks. The following examples illustrate the importance of capacity building for improving the performance of partners:

- CONAFED has developed and runs training modules for members in raising awareness of gender issues and supporting the mobilisation of women.
- ELIMU has developed literacy training modules and management training programmes for community-based women's groups, which directly benefits the performance of these groups when applied to their income-generating activities and other areas of work.
- Plan's programmes in both Nepal and Zambia have worked closely with and supported the training of local government counterparts, leading to improved performance in such areas as Integrated Management of Child Infections.
- BNMT's collaborative work with government staff has built government capacity to plan and manage TB programmes.
- CCJDP and CSPR, through training programmes aimed at members of their own networks, have built the capacity and confidence of community-based organisations to monitor and hold to account government officials.

Where partnerships and networks are working well, as in the cases cited above, there is a good chance for sustainability and high level of added value. The research teams also noticed many areas in which partnerships and networks should be working closely together, but are not. For example, the dioceses in both Zambia and DRC operate similar structures and within similar systems. However some have been more innovative and responsive to community need than others, and yet there seems to be little sharing or spread of good, innovative practice. Another example was found with the organisations that had branched off from UMN projects in Nepal, where again, there appeared to be little sharing of good practice (e.g. in terms of governance), which could help organisations to improve their performance.

The effectiveness of the partnerships is highly dependent on a variety of other factors. In Zambia, CHAZ has been highly effective in lobbying for more government resources to be channelled through CHAZ members for health service delivery, but does not see a role for itself in mediating between dioceses and their district counterparts. CCJDP makes very effective use of the parish networks of the Catholic Church to promulgate its programme of social action and justice. In Nepal, UMN has successfully spawned a number of small local organisations that provide community-level health services. Partnerships that function more as umbrella NGOs (WOREC, BOAD and ELIMU) are effective in transferring funds and providing training for local community organisations that they support. However, these do not operate as real partnerships or networks where community organisations have an equal say in partnership management or strategy.

8.4 With what results do (complementary) partnerships, participation in networks and/or alliances contribute to a better performance of the partner organisations and the health system in general?

All organisations assessed in this evaluation are part of some type of partnership or network, whether formally or informally. The results that can be attributed to working through partnerships, be it with government partners or within a network, are as follows:

- Avoiding duplication of services and effort: Good coordination between faith-based organisations, Plan programmes and the government has helped to decrease redundancy in service delivery and improve efficiency. This has allowed different parties to these partnerships to share resources more effectively.
- Increased profile and awareness of issues of interest to the partnership: CONAFED's work on gender equity has helped raise the profile of women's rights in DRC, even though there is still some way to go. Their work has also raised awareness of HIV and AIDS within their membership. CHAZ has become a powerful voice in discussions on Zambian health policy as it represents a group of organisations that together make up over one-third of Zambia's health care delivery system. CPRS's network has increased awareness amongst its members of government poverty reduction policies and has set in place the means of monitoring how well government is doing as a result of its activities.
- Increasing the potential sustainability of programme activities: some of the programmes evaluated are implemented through partnerships in order to ensure smooth handover and community ownership. For example, the YUHP programme in Nepal was set up to work closely with the municipality of Kathmandu as part of its handover strategy. BOAD Goma works through its CBO partners to encourage greater community capacity and resilience in the face of a humanitarian crisis. Plan works closely with local government to ensure that its health-related projects are integrated into local government services once the project is finished.

While partnerships and networks can achieve powerful results, they do come at a cost. A number of respondents indicated that meetings and working out relationships were time consuming and fraught with tension. However, as seen in Section 6.3., programmes working in isolation of potential partners fail to spread innovative practice and constrain opportunities for scaling up their activities.

Also, there is little attempt made by CFAs to connect up the work of different partnerships and partners in countries, even where creating these links could be valuable to partners. Working within partnerships and networks should be an effective way of scaling up small-scale interventions. The evaluation found that service provider organisations are not as well networked as they could or should be for scaling up innovative activities. The evaluation team found the following examples, among others, of where connections could be made: Centre Olame appears to have no link into CONAFED in the DRC, despite both being Cordaid partners. In Nepal, local NGOs supported by ICCO rarely if ever have contact with each other, even though they each have technical and organisational experiences that others would value. The CFAs state that they do not wish to impose new networks on their partners. On the other hand, if the organisations are not broughttogether they are not given the opportunity to consider whether they wish to carry on meeting with and learning from other CFA partners.

There is a particularly serious gap in partnership development amongst DRC faith-based organisations that needs concerted effort to fill. At present there is no organisation that serves the same function as the Church Health Associations in other countries, which help to mediate between the state and faith-based organisations, and serve as a quality assurance body and conduit for funding to members. In the longer term, such an organisation must be established, either by revitalising the SPS or through the creation of a new body, to ensure the spread of good practice and to advocate on behalf of faith-based health services across the country.

8.5 What is the added value, in terms of the results and partnership aspects, of the CFAs' support for the partner organisations and their programmes?

The first obvious answer to this question is the financial gain that the relationship with the CFAs brings to their partners. All partners were appreciative of the commitments made by their CFA donors, many of which are long term. ICCO is seen as being especially flexible in how it disburses it funds, allowing maximum flexibility to partners, within certain boundaries of the agreed programme. An observed, a significant added value of ICCO's flexible, untied support is that it enabled partners to adopt and maintain a more holistic approach, which doesn't address health in isolation but as an integral aspect of development. Cordaid and Plan are somewhat more rigid in how they disburse funds, sometimes setting budget lines that do not allow much flexibility, but which are still valuable contributions to the organisations they support.

Partnership with the CFAs has also provided opportunities for some organisations to make contact with regional and international organisations that are like-minded, helping to stimulate ideas for work within their own programmes. For example, SSS in Nepal expressed high appreciation for the opportunity to attend the last AIDS conference in Bangkok, and the chance to network with other AIDS IEC organisations.

The evaluation found many examples of innovative work of CFA partners, supported by the CFAs and other donors. Some of the more innovative work that is being scaled up, or has the potential for scaling up, includes Plan's ECCD work in Nepal, the AIDS outreach programme in Ndola Zambia, the performance-based operations of BDOM Bukavu and the municipal health programme in Patan, Nepal. The added value the CFAs bring to these programmes is primarily the stability of their support and their willingness to take on programmes that, at least at their outset, seem unconventional.

Many partner organisations were highly appreciative of the CFAs' support for training of staff and their funding of various staff development activities. The support to diocesan technical training in Zambia was particularly appreciated by those interviewed. Cordaid has also brought DRC and Zambia partners together on occasion to explain changes to Cordaid policy and to share experiences. However, most of those interviewed felt that they had received little or no organisational development support, so that they were not able to undertake the strategic planning and management activities that they seemed to be expected to do. In this case, there is some disconnection between CFA policy documents, where emphasis is given to the shift towards working with organisations and organisational development rather than with projects, and what is actually happening in the relationship between CFAs and their partners.

Many partners reflected on the fact that, at least as far as Cordaid and ICCO are concerned, they were aware that Netherlands-based programme officers were overstretched with the number of countries and organisations they cover. Also, frequent changes in staffing within these key link posts made communication very difficult, especially regarding any dialogue on organisational strategic changes. To many partners, the organisational changes in direction outlined in the various CFA policy documents were perceived as more of a 'whim' of individual programme officers, as policies seemed to have changed with the individuals contacting them. The CFAs acknowledge that staff turnover is a problem, but one they have little control over. The evaluation team noted that having a Cordaid office in the DRC did help with communications, which is important given the particularly difficult problems of working the DRC.

The results of the work of CFA partner organisations add value in a number of ways. Besides the obvious importance of the services provided by most of the organisations evaluated, some of the partners have also developed models at a small scale that have either been, or have the potential to be, adopted more widely. Examples can be seen in the work by Centre Olame, ELIMU, IPASC and BOAD, as well as BDOM Bukavu in DRC; by Plan's ECCD programme and the YUHP programme in Nepal; and by the home-based care work of the dioceses in Zambia.

Furthermore ICCO, and to some extent Cordaid, are missing opportunities for bringing real added value to their country programmes by having weak country strategies (ICCO) or by funding partners that have little connection with each other. This needs to be addressed within each organisation and with partners.

9 Conclusions and Recommendations

9.1 Vision, strategies and activities of CFA partners

The visions, strategies and activities of all CFA partners evaluated favour access to, use of and control over health services by the poor. Partner staff have a strong commitment to the work they are doing for the communities they serve. However, many of the organisations evaluated, especially Cordaid, ICCO and their partners, rarely have indicators designed to help them monitor whether their visions, strategies and activities are in fact achieving their purpose. So, while in general organisations are achieving their targets (where these are specified), it is difficult to link up organisational vision with outputs, outcome and impact.

Furthermore, the CFA policies for gender and rights-based approaches are not being translated into effective implementation strategies in any consistent fashion with CFA partners. Plan is the most effective at bridging this policy-implementation gap, not surprisingly, as it can facilitate greater understanding through its staff structure down to community level. Plan could do more to strengthen staff capacity to challenge societal norms where those norms lead to the continued marginalisation of certain groups (e.g. Dalit in Nepal and youth in Zambia). Cordaid and ICCO's ways of working, while giving greater ownership to local/national organisations, also necessitate programme officers putting greater energy into communicating with partners.

However, more thought also needs to be given to how best to encourage 'rights-based approaches' in conflict/post-conflict situations. This evaluation found that in the highly sensitised atmospheres of Nepal and Eastern DRC, more nuanced approaches are required. The DRC and Nepal governments are not able to fulfil their obligations to citizens claiming their 'right to health'. In the case of Nepal local government staff themselves feel that their involvement in service delivery could compromise effective provision of much-needed health services. Rather than approaching rights-based approaches from a 'duty versus claim' dichotomy, partner organisations could be looking at other demand-side approaches that help build community confidence to claim their right to health from a wide variety of duty holders.

Recommendations for improving health-related visions, strategies and activities

All CFAs

- More concerted support needs to be given to partners (government and non-governmental) in organisational development capacities such as strategic planning to help them operationalise their goals, and assess their achievements. Expertise for doing this exists in all three countries studied in this evaluation, and specific funding should be given by CFAs to buy in this support.
- In-country workshops should be held to work with partners (ICCO and Cordaid) and staff (Plan) on how to understand and adapt CFA core policies on gender and rights-based approaches (RBA). RBA in particular needs specific attention in Nepal and DRC, and the CFAs should look at how to improve demand-side approaches with their

partners, including strengthening community management of partner health facilities and voucher-for-service schemes that target poor and marginalised groups.

Cordaid and ICCO

- National frameworks should set out the CFA's priorities and strategic directions in terms of pro-poor development and target groups, and draw out coherent links between its policy and the expected results of its support to existing partners, as negotiated with them. This latter point, of defining the CFA's niche with the partners is particularly important, given that the CFA is only one among several donors for some partners. It would also indicate the kinds of inputs (financial, capacity building, support to advocacy, etc.) that partners could expect from CFAs. Such a framework would create a 'common thread' that draws an explicit line from global policies and strategies to implementation of those policies as agreed with partners.
- As part of their organisational development programme, ICCO and Cordaid should continue to support internal organisational and partnership assessment exercises such as the one employed during this evaluation, to help their partners evaluate their own development needs.

Cordaid

- Given the importance of Cordaid's global gender policy, the CFA needs to negotiate more robustly with its Catholic partners to ensure a much more meaningful involvement of women within diocesan structures. It should build on models of strong female leadership in the Catholic Church in other countries and explore how these can be adapted with its partners who work with more male-dominated models. As mentioned above there are examples of good practice in the case study countries to draw upon. However, the evaluation also found that Cordaid in particular needs to consider its collaboration with Catholic-run health services that are not open to focusing on women's participation in decision making and that will not engage in effective delivery of sexual and reproductive health services in countries with high maternal mortality and sexually transmitted infection/HIV rates. Where church partners prove particularly resistant over time, Cordaid should as a last resort consider reducing or withdrawing support altogether.

Plan

- As part of developing rights-based approaches, Plan should develop a programme of support to its own staff, many of whom come from their programme communities, to build understanding of the dynamics of social exclusion and ways in which to challenge social norms.

9.2 Summary of qualitative and quantitative results

Overall, the findings of this evaluation indicate that the CFA partners assessed are making an important contribution to health-related services in the three countries studied. Whether working through partners (Cordaid and ICCO) or through direct project implementation (Plan), the programmes supported by the CFAs are critical components of the health systems within which they operate. The absence of CFA partners would leave a gaping hole in health-related services, especially where partner organisations work in remote areas of the country. Both government and beneficiary stakeholders repeatedly expressed their deep appreciation for the ongoing support to the health-related services provided by the CFAs.

Quantitative impact of the CFA contribution is particularly difficult to assess as neither Cordaid nor ICCO have measurable indicators related to their country programmes, and in the case of ICCO, there are no country-specific strategic frameworks for health or other interventions. Only Plan's programmes are mapped out against a set of objectives and indicators, supported by a robust monitoring system and annual reporting against expected results.

Quantitative health impact is also difficult to assess amongst CFA partners, due to poor baseline and monitoring data. New systems do not need to be created to address this, as national systems already exist. As the main barrier to the widespread use of HMIS is logistical, the partners need more support to use existing national systems while also considering what other data they need to collect on a routine basis in order to measure achievement of organisational and programmatic objectives.

From a qualitative perspective, health services provided by CFA partners are widely appreciated by government stakeholders and beneficiaries. These services are considered to be of higher quality than alternative (public) services. Community-based activities are filling a real public health need and benefit poor and non-poor alike. For many beneficiaries, though, user fee charges continue to be a significant barrier to their ability to use health services, even where costs have been reduced. Other quality issues related to staff retention and attitudes also represent obstacles to equitable access to services for poor and marginalised people. While the CFAs are helping to improve the situation with regards to staff retention, they are not, at present, working with partners on reducing the damaging effects of user fees. Those organisations that are working on more specialised issues, such as gender-based violence, are creating models for how services for vulnerable women could be developed in future at a much larger scale.

New trends in contracting health services between the state and non-state sectors provide opportunities for Cordaid and ICCO's partners to review their relationship with the state sector and will require shifting towards more conformity with nationally agreed quality assurance standards and health monitoring systems. Similar issues arise where Plan runs health clinics or schools on behalf of the government.

The evaluation also found that Cordaid in particular needs to rethink its funding of Catholic-run health services that are not open to focusing on women's participation in decision making and that will not engage in effective delivery of sexual and reproductive health services in countries with high maternal mortality and sexually transmitted infection/HIV rates.

Recommendations on improving the quantitative and qualitative impact of health-related services

All CFAs

- All CFAs should continue to work with and strengthen their community-based programmes, as these are having the greatest effect on the health of poor people, and have greatest sustainability (e.g. Mama and Papa Bongisa, Kinshasa Diocese; Ndola Diocese's AIDS home-based care; Plan's ECCD outreach work in Zambia and Nepal).
- All the CFAs need to reconsider their own and their partners' strategies that depend on user charges for services they support. User fees are a deterrent to the use of services by poor people and appear to contradict the CFAs' own pro-poor policies; yet they also provide much-needed resources to maintain services at local level. A first

step should be to hold a policy forum that includes staff of the CFAs, representatives of their partners/field staff and leading researchers to help frame how the CFAs can respond to this and how they can support or influence national policy development in either eliminating user fees or creating social safety nets for those who cannot afford them.
- Training should be provided to CFA partners (governmental and non-governmental) in the collection and use of routine health data to help develop an evidence base with regards to health outcomes and ensure it is well linked to the national health management information system.

Cordaid and ICCO
- In order to measure the health impact of CFA support, national strategic frameworks should include objectives with measurable indicators that reflect the aggregate results of their partners' own strategic plans and targets. CFA partners also need help in developing capacity in this area. This will greatly support partner M&E activities, and facilitate future evaluations of health-related programmes.
- Sustainability of health-related services remains a key concern for ICCO and Cordaid partners. ICCO and Cordaid should work with their service delivery partners on improving the prospects of longer-term sustainability of their activities, through designing handover strategies, creating more transparent links with government services by making better use of contracting arrangements and building on models of good practice for community involvement identified in this, and other, evaluations. ICCO and Cordaid should also continue to encourage their partners to seek ways of diversifying their funding base.
- ICCO and Cordaid should examine the model of community capacity building employed by Plan and discuss with partners if and how this model could be adapted into their community-based work.

Cordaid
- Cordaid needs to give serious consideration to how it can support filling the gap left by its partners in family planning and other reproductive health services. One suggestion is that where the Cordaid (Catholic) partner is the sole service provider, Cordaid could also fund an alternative non-Catholic partner to ensure that these services are accessible, or that it use its influence to persuade another donor to provide support in this area. At the same time Cordaid should embark on a programme to facilitate greater cross-learning between the Catholic organisations it supports and negotiate more emphatically for attention to be given to sexual and reproductive health.
- Health reforms leading to decentralisation have created a new set of dynamics that Cordaid's partners in Zambia have not fully incorporated into their own thinking. Cordaid and its partners also need to reflect on how to build a more transparent and trusting relationship with government line agencies in Zambia, including being more open about financial flows.

Plan
- Plan programmes should consider exploring the UMN experience in Nepal to see whether an approach to the institutionalisation of their programmes could be to set up and support a local NGO, which would then carry on the main areas of Plan's activities.

9.3 Summary of extent of, and results of, partnership impact on health-related services and health systems

The partnerships supported through CFA funding are making a meaningful contribution to local and national policies on health for poor people. However, networking and advocacy organisations also need much more targeted support to develop objectives and indicators that will help them monitor their progress in achieving the purpose of their partnerships or advocacy campaigns. Much of the impact reported in this evaluation is anecdotal; better data is needed to back up the stories of improvements provided to the research teams.

The CFAs also need to create a clearer definition of what they mean by a partnership or network organisation, as in some cases organisations evaluated under this category were not in fact partnerships or network, but rather fairly classic operational NGOs. These provide an efficient conduit of CFA funding to community level and are therefore important in their own right, but there needs to be greater clarity on the mandates and functions of these organisations, and levels of representation and participation within them, in terms of beneficiaries and stakeholders.

Cordaid and ICCO are also not yet creating effective links between their partners and relevant networks in the countries they work in, nor are they playing a role in bringing together like-minded organisations within countries, which has the potential for creating greater synergies. Plan is also not creating sufficient links between its various project teams, nor between these teams and local/national networks that could allow them to scale up innovative practice beyond the scope of their projects. This has resulted in some 'atomisation' of programmes within countries, with little sense of an overall, coherent health strategy that works towards improved population health.

Recommendations for improving partnerships/networks

Cordaid and ICCO

- Networking and advocacy partners need particular support in developing ways of measuring the outcomes of their less tangible activities. The strength and results of partnerships can be assessed within the partnerships themselves, using validated tools, one of which was introduced in this evaluation. Cordaid and ICCO should also support advocacy partners to develop key indicators that will help them to benchmark progress towards reaching their advocacy objectives.
- Once partnerships and networks have undertaken a more robust assessment of their partnerships, Cordaid and ICCO should support these organisations to build on their members' strengths so that they become more influential. At present, many of the partnerships and networks supported are not creating the synergistic effect expected from organisations working together.
- Cordaid and ICCO already provide some South-South networking opportunities for partners and these should be continued and expanded to include a cross section of both organisations' partners where appropriate. Innovative work done by partners on gender-based violence should be a key area of expansion as some of the organisations working in this area remain small and isolated.
- In the DRC, Cordaid and ICCO should work together with their faith-based partners and other donors to develop a national faith-based health association that can advocate on behalf of faith-based health service providers as well as provide a

framework for quality assurance of health services. It may be helpful to involve CHAZ, to draw on its experience as an effective umbrella organisation in Zambia.

9.4 Summary of value added by CFAs to partner programmes

The CFAs are bringing added value to the work of their partners, primarily through flexible and consistent funding and support for capacity building. While there is much overlap between the policies of the CFAs, each also has unique elements to its approach. Assessment is limited by the lack of identified added value in CFA strategy, in terms of, for example capacity building and human resource development, global North-South advocacy, promoting innovation and facilitating linkages and information exchange.

Examples of added value include Cordaid's support to strengthening BDOMs and provider partners in Zambia in building up their managerial competencies, which is contributing to making the organisations more efficient and effective, and broadening their funding base. Respondents in DRC felt that the presence of a local office for Cordaid facilitates interaction between Cordaid and its partners, enhances their participation in donor coordination, and facilitates advocacy for improved legislation and policy making at the national level. Cordaid's technical assistants are also filling in human resource gaps in hospitals and clinics where it is very difficult to recruit and retain staff, while Cordaid is also providing packages of training and incentives to national staff.

ICCO has a very flexible approach to its funding, allowing it to build partnerships with civil society institutions, while also maintaining links into faith-based organisations, which are critical health service providers in many countries. ICCO's approach opens opportunities to small organisations that are usually below the international development radar. An observed significant added value of ICCO's support is that it enabled partners to adopt and maintain a more holistic approach, which does not address health in isolation but as an integral aspect of development. It was felt that the importance given to community capacity building was very valuable though extremely challenging in war-stricken areas. Support rendered by ICCO is strengthening civil society in Eastern Congo in terms of providing specialised services as with CME, increasing training capacity for community health and creating enabling environments (IPASC), and networking with grassroots organisations (BOAD and ELIMU).

Plan's field work in each country brings a more 'hands on' approach to community (and civil society) capacity building through its community facilitators and through facilitating training for health facility staff. Plan Netherland's contribution is to provide active support for this work, and to promote the child-centred approach.

Numerous areas of effective innovation were also identified by this evaluation, for example, in Plan's programmes for early childhood care, in the organisations supporting women who experienced sexual violence (Cordaid-DRC and ICCO-Nepal), in institutionalising new approaches with government and influencing policies on urban primary health care (ICCO-Nepal), AIDS outreach and care in Zambia (Cordaid) and performance-based contracting in the DRC (Cordaid).

Some of the partner organisations visited have been involved in a number of capacity building workshops in Zambia and DRC. ICCO has also organised regional-level sharing

meetings for some of its partners, and partners have been enabled to attend regional conferences. Some North-South networking is taking place at the global level. However, no formal or informal networking and coordination among CFA (mainly ICCO) service delivery partners had taken place in Nepal. Networking activities in general are weak among all NGOs. While the conflict situation may explain some of this, the fact that this evaluation was able to conduct two workshops with health-related partners during particularly tense periods shows that it is possible to facilitate greater networking.

While many positive results of the CFA – southern organisation partnership were cited, those partners that took part in the evaluation also identified many areas where this relationship could be improved. These included:

- High turnover of CFA programme officers has disrupted communications and complicated relationships with partner organisations.
- Rapid changes in policy direction, with little consultation and explanation has led to a great deal of confusion amongst partners.
- Little support to organisational development activities has made it hard for partners to respond to requests for strategic plans and other CFA demands.
- Weak engagement in the advocacy work of southern organisations wastes an opportunity for linking southern and northern advocacy networks.

This evaluation has found that added value could be strengthened. The CFA organisations have undergone a period of change in the last few years, which has also brought with it some significant changes in policy and strategy. All CFAs are struggling to some extent to see these changes implemented in concrete programme terms. Where partners are already well funded by other donors (e.g. the majority of service provider organisations evaluated) Cordaid and ICCO in particular should reconsider how their funding can best be used to ensure that their more progressive policies in gender and rights-based approaches can be implemented through partners.

Recommendations for increasing added value of CFAs

All CFAs

- As an initial step CFAs should support cross-learning opportunities that bring together partners in single countries or regionally to share experiences and discuss good practice. These could be done at a sectoral level, though much of the good practice observed during the evaluation has cross-sectoral application. This should include making more deliberate efforts to link partners involved in running networks for advocacy-related work and service delivery partners.
- CFAs should also develop strategies to strengthen the northern voice of their southern partners, working with partners to agree on priority issues for advocacy strategies developed by CFA policy units.

Cordaid and ICCO

- Both Cordaid and ICCO need to elaborate more explicit links, through strategic planning processes, between their global policies related to access to health and basic services and the programmes they support in countries. These links should delineate how the CFAs are adding value to partners programmes, including:
  - Challenging prevailing social and organisational norms relating to gender, as well as paternalistic attitudes of some partners towards communities they work with

  - Developing mechanisms for cross-learning between partner organisations to ensure the spread of good innovation and to promote stronger coherence. This is particularly important in DRC and Nepal where normal coordination mechanisms are weak or non-existent and need developing. This could start with an exploration with partners as to what coordination mechanism would best suit their needs and could extend to non-CFA partners in time.
- CFAs should strive for greater stability of programme officers to allow for more consistent and longer-term contacts between partner organisations and the relevant CFA. Where this is unlikely, or hard to influence, the CFAs need to develop a more consistent communication strategy with partners, which allows them to engage more in dialogue with the CFA organisation concerned.

Plan

- Plan should encourage greater cross-learning between staff working on different projects, as innovations are not being spread effectively across each country's programme.
- Plan staff should be provided with further training and support to challenge social norms within the CSOs they work with that exclude particular groups, and to use their prominent role in the communities they work in to advocate more directly for the rights and needs of the most vulnerable.