



Helping children since 1937

## Capacity Statement

### **Child Health and Nutrition Programs for Under-Five Children<sup>1</sup>**

#### **Global Overview and Plan's Reach**

Globally, the mortality rate for under-five children has declined steadily from 93 deaths per 1,000 live births in 1990 to 67 in 2007, where 9.2 million children born alive died before their fifth birthday.<sup>2</sup> Most of these children lived in developing countries concentrated in sub-Saharan Africa and Southern Asia, and died from a disease or combination of diseases that could have easily been prevented or treated. The five major causes of child mortality are due to diarrhea, pneumonia, malaria, measles and malnutrition. Malnutrition contributes to a third of these deaths; pneumonia kills more children than any other disease, accounting for nearly one in five child deaths globally; and diarrheal diseases make up 18% of deaths among under-five children.<sup>3</sup> Malaria kills 1-3 million people every year, of which 2/3 are under-five children. Immunization has saved over 20 million lives in the last two decades, as coverage for the six major vaccine-preventable diseases -pertussis, childhood tuberculosis, tetanus, polio, measles and diphtheria- has risen from less than 5% to 79% of children since the Expanded Program on Immunization (EPI) began in 1974.<sup>4</sup>

The Integrated Management of Childhood Illness (IMCI) strategy was developed by the World Health Organization (WHO) and UNICEF in 1992 to address these five major causes of child mortality using a holistic approach to manage child illnesses. The IMCI strategy includes three components: (1) improving case management skills and protocols of healthcare staff; (2) strengthening primary health care systems; and (3) improving family and community health practices.<sup>5</sup> In 2001, the CORE Group, WHO and UNICEF took this framework one step further and developed the Community Integrated Management of Childhood Illness (C-IMCI), recognizing the importance of community-based activities and approaches for successful child health programming.

Building on a multi-sectoral platform to support sustainable child health and nutrition, the three elements of the C-IMCI framework are: (1) improving partnerships between health facilities and the communities they serve; (2) increasing appropriate and accessible health care and information from community-based providers; (3) integrating promotion of key family practices critical for child

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<sup>1</sup> Prepared by Sabrina Kwauk, Ryan Lander, Laban Tsuma and Luis Tam in August 2009 based on Plan-related documentation.

<sup>2</sup> United Nations 2009. The Millennium Development Goals Report.

<sup>3</sup> Childinfo, UNICEF. Available at <http://www.childinfo.org/index.html>.

<sup>4</sup> Childinfo, UNICEF. Available at <http://www.childinfo.org/index.html>.

<sup>5</sup> WHO Integrated Management of Childhood Illnesses, available at [http://www.who.int/child\\_adolescent\\_health/topics/prevention\\_care/child/imci/en/index.html](http://www.who.int/child_adolescent_health/topics/prevention_care/child/imci/en/index.html).

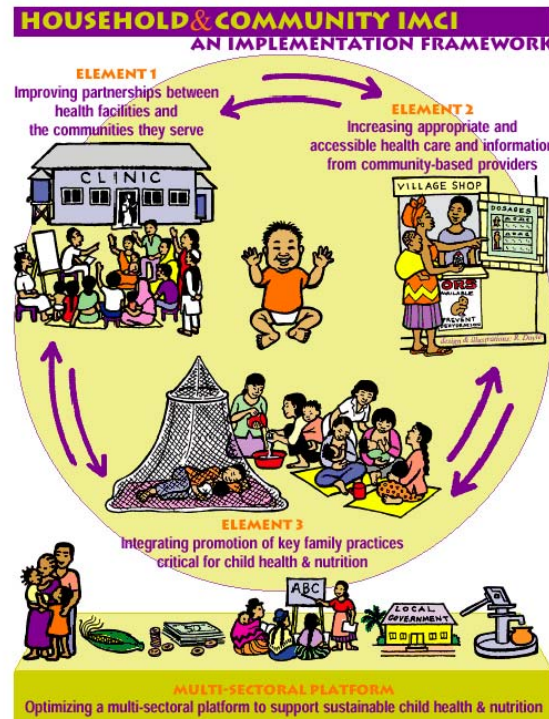
health and nutrition (please see Figure 1. C-IMCI Framework below).<sup>6</sup> The framework includes a multi-sectoral platform to support sustainable child health and nutrition. Please find below a pictorial representation of the C-IMCI approach.

Plan has invested heavily in implementing the C-IMCI approach as part of its Community Health Program, which received approximately \$80 million in fiscal year (FY) 2008. Building capacity in the more than 10,745 communities it serves Plan provided technical training to 83,580 community and 13,458 professional health workers and rehabilitated/built 240 health facilities. Within its community health programming, Plan expended approximately \$13 million on under-five child health and nutrition activities in the following areas: behavior change interventions, training for health and community workers, immunization (all age groups), supplementary feeding, and micronutrients.

Recognizing the importance of child health and nutrition programs within its development agenda, Plan commissioned the external evaluation of this global program in 2007. While the evaluators praised the comprehensiveness of Plan’s programs, its technical expertise combined with local knowledge and Plan’s deep engagement with communities and local governments were praised, they also suggested enhancements in Plan’s methods and approaches to achieve sustainability and to monitor and evaluate the results of its programs. Annex 1 summarizes the procedures and results of this external evaluation.

An important catalyst to improve the coverage and quality of Plan’s child health and nutrition programs has been the 23 Child Survival projects awarded by USAID since 1985 in Bolivia, Burkina Faso, Cameroon, Dominican Republic, Ecuador, Ghana, Guatemala, Haiti, India, Kenya, Mali, Nepal and Senegal. With a total investment of \$29 M (\$20M provided by USAID matched by \$9M from Plan), these projects have directly benefited more than 1.37 million under-five children and 2 million women of reproductive age.

Consistent with its child-centered, community-based development strategy, Plan is applying the C-IMCI approach in 90% of the countries where it operates. Its results have been very successful. For example, a 5-year Child Survival project (2001-2006) in the Kita rural district of Mali (total population 350,000), achieved significant coverage in terms of malaria prevention and control, treatment of pneumonia, promotion of exclusive breast-feeding and vitamin A supplementation. Based on these results, USAID estimated that the project prevented 2,879 child deaths and reduced under-five mortality by 20%.



**Figure 1. C-IMCI Framework.**  
**Source: CORE 2001**

<sup>6</sup> CORE Group, Plan and USAID. January 2009. "Community Approaches to Child Health in Cameroon: Applying the Community-based Integrated Management of Childhood Illness Framework."

## Plan's Experience in Applying the Four Elements of the Community IMCI Approach

***C-IMCI Element 1: Improving partnerships between health facilities and the communities they serve.*** As part of its community-based approach, Plan works from within the communities and leverages long-developed relationships, existing MOH policies, and established community structures to strengthen partnerships between the communities and the health facilities. Improving partnerships means building the capacity of health facility workers and capitalizing on pre-existing community groups within the community to support the coordination mechanisms and community activities. For example, as part of the child survival program in Cameroon (2000-2004), Plan staff built the capacity of health area management committee members by training them on the development of a clear organizational vision, planning and management. This effort has led to a substantial increase in the organization's outreach activities and impact. Women-led community-based organizations were used to help mobilize community members during outreach activities, and collect and consolidate community information. Plan also trained facility-based staff in IMCI, which resulted in the creation of outcome objectives aimed at improving the health situation of under-five children, pregnant women and the population as a whole. In another example, Plan is working on improving *accountability* in communities across Pakistan by establishing health committees at multiple administrative levels – village, sub-district and district levels - tasked with overseeing and strengthening mother and child health care facilities in their areas.

### **Case study - Children's Participation in the Successful Reconstruction of the Community-Based Primary Health Network in Aceh, Indonesia (2006-2009)**

Indonesia was the hardest hit by the tsunami in December 2004, especially in the districts of Aceh Besar and Aceh Jaya, where health infrastructure collapsed. In the immediate aftermath of the tsunami, it was estimated that one-third of health centers were destroyed and another one-third required renovation. Children suffered enormously, both due to physical suffering (e.g. trauma, disease) and psychological stress.

**Method** - Plan Indonesia received a 3-year grant from the American Red Cross to re-build the primary health services in both districts. Participatory methods were applied in the design of the project activities and included children, families, community leaders and government officials. Village mapping and open discussions were applied. In these discussions, children voiced their needs for psychological support from health providers, and for recreational and social areas and activities. Based on these contributions, major project components included: (a) rebuilding and re-equipping of 39 Posyandus (village health post) and 24 Polindes (village birth delivery post staffed with a trained midwife) with child friendly spaces for early childhood development programming; (b) training for 40 midwives and 139 community health volunteers on psychological counseling and support in addition to disease prevention and control; (c) development of a service network with District Health Office managing both disease and emotional distress; and (d) community mobilization and education activities using radio, and group/individual education.

**Results** - Outputs- 39 Posyandu and 24 Polindes were rebuilt in 56 villages (7 sub-districts) of Aceh Besar; 504 Posyandu cadres and 50 village midwives were trained; and 20 managers from Aceh Besar district's health office were trained. In addition, moderate child malnutrition decreased from 15% to 3%; anemia during pregnancy decreased from 42% to 39%; and child immunization coverage has sustained levels in the 70%. Most importantly, the emotional and social standing of these children have improved by both taking into account their needs and also making them participants of the project.

Plan has also been active in helping local and central governments partner more effectively with communities on child health and nutrition. In Nepal, Plan is supporting the ongoing decentralization of the national health system by building the capacity of local health groups, with a particular focus on women and children's health issues. As a result of the success of the effort, the model is being broadly scaled up – the Government of Nepal has expanded the Community IMCI program to 65 districts of the country. In Peru, Plan's four training manuals for community volunteers and

government health providers on C-IMCI have been adopted by the MOH (with the endorsement of WHO) to be used nationwide.

***C-IMCI Element 2: Increasing appropriate and accessible healthcare and information from community-based providers.*** Plan-implemented programs support governments in educating communities on promotion of good health practices, identification of disease symptoms, and referral to health facilities. In Ghana, these activities increased the access to child welfare clinics and basic health care, including growth monitoring, nutrition education and immunization services, from 14% to 50% for under-five children and women of reproductive age in communities in the Upper West Region.

**Case Study- Empowering Communities and Local Health Services to Enhance Infant and Child Health in Philippines (2005-2008)**

Philippines' central provinces of Occidental Mindoro (pop 380,000) and Masbate (pop 600,000) endure high infant and child mortality. A 2005 population survey showed that 35% of deaths among under-five children were due to infectious diseases that if attended and treated without delay could have been prevented.

**Method -** In the Philippines, Plan, the local government and community partners implemented a project to improve the home diagnosis and management of illnesses, including the proper identification of danger signs and timely health-seeking practice to government health service providers. Project strategies included: (a) the design of the family-managed health resource and monitoring tool; (b) training of adult-child family health volunteers; (c) certification of local government health facilities under the government's Quality Improvement Program; and (d) participatory project design and evaluation.

**Results -** (a) the proportion of cases administering appropriate home management increased from 36% to 62%; (b) cases brought to a health service provider within one day of onset increased from 8% to 36%. Moreover, (1) family health volunteers reported that the family health resource and monitoring tool enabled them to easily access information on appropriate first aid, proper care of the sick, preventive health measures and timely seeking of medical attention; (2) community leaders and local officials noted that families became more responsible in taking care of their health; and (3) health service providers noted that the incidence of severe cases brought to the health facility was reduced due to enhanced home management. Given the success of this experience, Plan Philippines, the government and community partners are planning to scale up these methods and tools to the 9 provinces where it works.

***C-IMCI Element 3: Integrating promotion of key family practices critical for child health and nutrition.*** Plan implements health promotion and monitoring using group gatherings, behavior mapping and a community-based health information system (C-HIS) that gathers health-related data and encourages behavior change. In Cameroon (2000-2004), Plan introduced community-level data collection that linked to the existing MOH system. Currently, the system tracks data on child deaths, use of insecticide-treated nets (by pregnant women and children), children who are underweight, and children who are behind on their immunization schedule. The registry could be checked against clinic records to determine whether community members followed through with recommended care-seeking, and follow-up data helped inform the clinic of outcomes once a patient left the clinic. Additionally, the C-HIS is used as a means to record numbers of pregnant women, under-five children, and births. C-HIS allows health facilities have access to more precise data rather than simply using projections based on outdated Demographic and Health Surveys or other general demographic information.

***C-IMCI Multi-sectoral Platform: Optimizing a multi-sectoral platform to support sustainable child health and nutrition.*** Plan uses three approaches based on the CORE Group's *Reaching Communities for Child Health: Advancing Health Outcomes through Multi-Sectoral Approaches*, to optimize the multi-sectoral platform: (a) leverage use of non-health community-based organizations; (b) promote joint multi-sectoral programming; and (c) promote health area and district capacity building. In Cameroon (2000-2004), women's groups associated with micro-enterprise or other

activities were used to introduce and manage health programs at the community level. As part of Plan's child sponsorship program, Plan conducted activities in water and sanitation, education, livelihood and habitat to promote joint multi-sectoral programming. In addition, Plan has worked within the health system to build management capacity of provincial, district and health area personnel.

#### **Case Study on C-IMCI Element 3 - Closing the Loop: Pregnant Women's Groups [Nepal]**

Plan International implemented a five-year Child Survival project funded by USAID in partnership with the Ministry of Health and local agencies in the Bara District of Nepal from 2001-2006. The project's goal was to assist the Ministry of Health in improving the health status of under-five children and women of reproductive age. Project interventions included control of diarrhea, pneumonia case management, maternal and newborn care, and child spacing.

**Method -** The project noticed that pregnant women and mothers of under-five children weren't participating as expected and key project messages weren't being delivered. The team came up with a strategy to rejuvenate the MoH's standard Mother's Groups with the creation of Pregnant Women's Groups (PWGs) to capture this population. Each PWG was comprised of 7-15 pregnant women living in the same village who meet once a month to discuss issues related to mother and child health. Postnatal mothers, mothers of under-five children, and mother in laws were also encouraged to participate. The Female Community Health Volunteers, who are part of the MoH public health system of every village in Nepal, facilitated these meetings. Outreach workers from the local health facility were encouraged to participate and support the sessions technically and managerially. Meetings took the form of a social mapping session: pregnant women drew a community map and identified major landmarks, such as their homes, the health clinics, etc. The women then tracked their ANC activities in each meeting with a mark on the map. This self-monitoring and peer review/pressure of ANC behaviors proved extremely successful in getting women to adhere to important pre and post-natal care practices, such as getting check-ups and taking their iron pills. The female health volunteers use these meetings to distribute iron tablets, vitamin A capsules to postnatal women, and family planning commodities, and delivered an educational talk at the end of the session.

**Results -** 450 groups have been formed in the Terai Region of Nepal alone. Health facility staff report increased uptake of services such as antenatal check-ups, postnatal vitamin A supplementation and immunization among children aged 12-23 months. In some areas, uptake is reported to have increased from <5% to 70%. The MoH has adopted the PWG as a standard component of Safe Motherhood programs in every District, and this intervention is being disseminated globally to share these results with any agency that works with mothers in resource-poor settings. By targeting pregnant women and engaging them in self-monitoring, this population has dramatically increased healthy behaviors and decreased maternal and infant mortality in one of the most high-risk areas of the world.

#### **Case Study on C-IMCI Multi-Sectoral Platform - Successful Multi-Sectoral Approach to Improve Child and Women Nutrition in Bangladesh (2004-2007)**

In Bangladesh, Plan implemented an Integrated Nutrition Program among 500,000 poor rural and urban inhabitants of the country to demonstrate the effectiveness and feasibility of a participatory, multi-sector approach to improve the nutritional status of under-five children and of pregnant/lactating mothers.

**Method -** (1) Extensive consultation on the causes of and solutions to malnutrition among community members led to a program design involving the health, sanitation, agriculture, and livelihood sectors. (2) Trained community nutrition workers supported household nutrition education while village nutrition committees linked these efforts to the local government agencies. (3) At sub-district, district and national levels, multi-sector coordination committees of the ministries of health, livestock, education and water collaborated on the program implementation. (4) The program's findings were shared with government and community actors.

**Results -** Comparison of two population surveys at the baseline study (early 2005) and midterm review (late 2006) showed significant improvements in (a) the early use of colostrums and exclusive breastfeeding; (b) the use of skilled antenatal and birth delivery care; (c) the use of appropriate complementary feeding; (d) the practice of livestock and poultry vaccination, and home gardening; (e) household intake of iodized salt; and (f) household access to and use of sanitation facilities. It is also important to note that (1) government and communities contributed the majority of the program's resources; and (2) the results and methods of the program were discussed as part of the design of a National Nutrition Policy. This Integrated Nutrition Program has had successful results largely due to community ownership and multi-sector collaboration between government departments. Plan Bangladesh will extend the project to other districts for an additional 5 years.

## Plan's Experience in Implementing Effective IMCI Technical Interventions

***Malaria Prevention and Control:*** Plan's efforts have gone into strengthening and supporting partners on the control of malaria among under-five children and pregnant women. One key strategy is to support the MOH in acquiring long lasting insecticide treated nets and distribute them to dispensary health committees to be sold to pregnant women and under-five children years at a subsidized rate. In Kenya, Plan has supported the MOH in combating malaria through distribution of free insecticide treated nets to target populations; administration of intermittent preventive treatment to expectant mothers; and assuring regular supply of Coartem tablets (current anti-malarial drug) to all health facilities. Health workers are trained in dispersing Coartem tablets, which is the first line of treatment for malaria.

In Tanzania, Plan supported a child voucher program for long lasting insecticide treated bednets. Over 90% voucher redemption was achieved, with household net ownership increasing from 71% at baseline to 78% at completion. Net ownership among families with under-five children was much higher (44%) than in others groups compared (28%). The program was responsible for 58% of nets used by all under-five children; the remaining being distributed through government health facilities and local stores.

### Case Study- A Successful Community-based Strategy for Malaria Control in Senegal (2006- 2009)

In Senegal, malaria constitutes the primary reason for consultation in health facilities and represents the largest cause of morbidity (32.5%) among under-five children years and pregnant women.

**Method** - Plan, as part of a consortium of international NGOs funded by USAID, has managed a community health project. It includes two parts: an integrated package of community-based maternal, neonatal, child health and family planning interventions and a community-level component of the Presidential Malaria Initiative (PMI). Thus, the fight against malaria, implemented in the 11 regions of Senegal and 59 health districts with a population coverage estimated at 4,014,829 inhabitants including 778,877 under-five children, aims at reducing malaria-related morbidity and mortality by 50%. The community actors underwent a standardized training. The fight against malaria relies on seven principle strategies: early diagnosis and treatment of cases, protection of pregnant women, mobilization of community members for the fight against malaria, testing and early referral of cases, utilization of insecticide-treated bed nets, hygiene and sanitation, and household spraying.

**Results** - During the April-June 2008 quarter, 98% of malaria cases were treated according to the norms; and close to 20,000 individuals were reached by an activity and/or by malaria prevention. In June 2008, the coverage of free distribution of long-lasting, insecticide-treated bed nets was 98%. During the second round of household spraying in this test district, the rate of buildings treated in the concessions was 95%.

The Government of Senegal, in agreement with its development partners, is in the process of studying the possibility of extending this community-based and integrated strategy to all the districts of the country.

***Child Nutrition:*** Plan programs support child feeding centers for mothers of malnourished children, facilitate community and home gardens, and assist government health services in the distribution of vitamin A and zinc supplements. Training is provided to communities on the importance of exclusive breastfeeding for six months; how to use locally available foods to prepare various weaning and complementary foods for children; and the micronutrients necessary to meet children's nutritional needs. Plan's country programs also conduct activities for educating fathers on the nutritional needs of children. This is imperative as most of Plan's programs are in traditional societies where male support for utilization of funds, traveling to seek services and changing household practices is critical to sustained improvement in child survival.

In Niger, Plan supported seven villages in the construction of community gardens. These are intended for women to grow vegetables and other crops to provide nutritious meals for under-five children. Participants are provided with simple tools and seeds, and have been trained on gardening techniques, healthy eating and cooking practices. As a result of this initiative, under-five children have benefited from improved diets. In Senegal, about 87,000 children aged 0-23 months and their mothers were enlisted for nutritional education, growth monitoring and promotion. As a result, 63% of children enrolled were regularly weighed; 78% of them gained adequate weight; and 2,000 strengthened food pouches were distributed in the extremely poor zones of poverty of Dakar.

**Case Study -A Successful Community-based Strategy to Improve Child Nutrition in Senegal (2004-2011)**

In 2003, 24% of under-five children in the rural district of Tivaouane in Senegal were under-weight; well above the national average of 19%.

**Method –** In Senegal, Plan partnered with the Cellule de Lutte contre la Malnutrition, the government and the Municipality of Tivaouane to implement the Nutrition Reinforcement Program with World Bank funding in Tivaouane and 12 other districts in Senegal. This program currently covers more than 95% of the under-five children in this 10,000-inhabitant district. This project relied on 13 community-based organizations to bring together several community leaders for joint action planning in the delivery of the project's information and services; and a Communal Coordination Committee was formed to lead these efforts. Behavior change communication activities were carried out by trained community health workers and included- taking a census of the target population; monthly weighing of children to detect inadequate growth; cooking demonstrations and nutritional education; distribution of vitamin A supplements; deworming; promoting the use of insecticide-treated bed nets; promoting iodized salt consumption; and educating pregnant women on the use of prenatal consultation and iron supplements.

**Results -** As of June 2008, (a) coverage of children receiving vitamin A supplements rose from 30% to 91%; (b) coverage of de-wormed children increased from 23% to 100%; (c) household utilization of insecticide-treated bed nets improved from 55% to 87%; (d) children sleeping under mosquito nets increased from 45% in 2005 to 56% in December 2007; (e) percentage of households consuming iodized salt rose from 59% to 78%; and (f) the rate of malnutrition (under-weight) among under-five children decreased from 24% to 5%. Plan Senegal is expanding its child nutrition program to other communes, currently covering a total of 100,000 people.

**Diarrhea Case Management:** Plan programs address diarrhea case management through oral rehydration therapy, provision of zinc supplements, and improved sanitation investments. Plan directly educates community members, especially health workers, mothers and care-givers on diarrhea prevention and management techniques for under-five children. In Nepal, Plan-supported community health workers provide zinc and oral rehydration salts for children with diarrhea.

**Case Study- Preventing diarrhea through improved water and sanitation services in the Kilifi Development Area, Kenya (2004-2009)**

This project was carried out in 357 villages in the Kilifi district, Kenya, with a total population of 257,522 including 46,354 children.

**Method -** Plan Kenya's partnership with Population Services International was instrumental in creating awareness, demand and distribution of water treatment kits. Plan Kenya also partnered with the MOH in the provision of chlorine in clay pots to treat water pans in the community. The government adopted zinc as part of the management of diarrhea and consequently, the project supported 14 MOH health facilities with zinc and oral rehydration solution (ORS) for the management of children with diarrhea. In May 2008, Plan adopted the Community Led Total Sanitation (CLTS) methodology and supported the training of 45 MOH staff in CLTS. This was followed by the mentoring of community owned resource persons and triggering of community action on sanitation.

**Results -** Currently, there are 33 villages where over 75% of the households own and use pit latrines. The communities have also increasingly adopted good hand-washing practices. As a result, monitoring indicators for diarrhea prevention and management have improved and exceeded the monitoring target coverage. The percentage of mothers with children aged 0-23 months who wash their hands before feeding their children increased from 4% at baseline to 38.3%; the percentage of children with diarrhea who received increased fluids rose from 48% to 76.8%; the percentage of children with diarrhea who received ORS increased from 31% baseline to 44.6%; and the percentage of mothers who prepare ORS correctly increased from 32% to 72.3%.

***Pneumonia Case Management:*** Plan's interventions in pneumonia case management are designed to enhance the recognition of danger signs by children's caretakers and the prompt referral of suspected cases to a qualified provider. As part of the child survival program in Kenya (2004-2009), Plan Kenya assists health facilities in acquiring drugs and buffer stocks for the treatment of pneumonia. Community members were trained in identifying the danger signs of pneumonia, improving care and treatment for pneumonia. As a result, the percentage of children aged 0-23 months with coughs or difficulty breathing who received care from a health facility increased from 87% at baseline to 97% in 2008. Additionally, mothers who were aware of the danger signs of pneumonia increased from 38% baseline to 61.2%.

***Child Immunizations:*** Plan works with local health facilities and community organizations to conduct immunization outreach campaigns. In Kenya, community volunteers intensified community mobilization of mothers and caregivers to seek immunizations for their children, and the opening of three health dispensary facilities increased access to immunization services. These efforts have contributed to improvements in the full immunization and measles coverage for children aged 12-23 months. In addition, Plan aided dispensary health committees and community health workers to conduct training for health workers on the Kenya government's immunization program, which includes cold chain maintenance, how to identify missed opportunities, how to reduce in vaccine wastage, how to conduct disease surveillance and to trace the children not completing their immunization schedules. Furthermore, two National Immunization Days were held in November 2007 and May 2008 following intensive mobilization that resulted in the immunization of many pregnant women and children aged 0-23 months.

## **Annex 1 – Plan’s Global Commitment to Better Programs for the Health and Nutrition of Children: The 2007 Global Thematic Evaluation on Child Survival and Health Programs**

As part of our commitment to quality programming, Plan hired the US-based consulting firm “Social Sector Development Strategies” in 2007 to conduct a Thematic Evaluation of its global programs on child health and nutrition. The 6-month, \$200,000 evaluation included desk reviews, analysis to responses from questionnaires prepared by the evaluators and field visits to 8 Plan country programs. Below are some of the highlights of the evaluation, and steps for moving forward.

**Wide-ranging child survival programs** - Plan country offices implement a range of interventions to address child survival, including nutrition, potable water, maternal health, access to health facilities, and training of health staff. Innovative approaches, such as child-to-child programs, have great potential for bringing about long-term improvements in child survival. In Malawi, community-based child-care centers supplement health center activities with integrated child health, food security, water and sanitation, and early childhood education activities. Specific activities such as immunizations, communal gardens, and nutrition education work together in a holistic manner to address the multitude of factors impacting child survival.

**Technical expertise combined with local knowledge** - The evaluation highlighted the high level of technical expertise and on-the-ground experience of Plan staff — both in country offices and among advisors from the U.S. and international offices. Such expertise helps augment Plan’s influence in national-level advocacy for health policy changes as well as helps garner respect at the community level.

**Community engagement**- One of Plan’s great strengths is its ability to engage local communities and organizations in partnerships and collaboration at the grassroots level and at the national level (Plan has a strong record of collaboration with government ministries of health). With culturally-sensitive programming respectful of and responsive to local communities, Plan has earned a strong organizational image in the communities where it works. In Bolivia, the Monitoring Mothers program is used to improve nutrition surveillance and health education. With a focus on empowering women, the program has given women greater leadership capacity in their male-dominated communities while still recognizing the importance of involving men in child survival activities.

While Plan has an excellent record of working with communities, a renewed focus on local capacity building and planning for eventual withdrawal at the beginning of all partnerships needs to occur in order to maximize and sustain the positive impact of Plan’s work.

**Monitoring and evaluation** - In the monitoring and evaluation of Plan’s programming, some countries have taken a clear lead. Plan Nepal has established methods of systematic data collection and evaluation, and Plan El Salvador has conducted well-evaluated pilot programs that have stimulated scaling up by the Ministry of Health, with support from the World Bank. However, globally, this area was identified as one of the biggest challenges facing Plan. The commissioning of this Thematic Evaluation was a strong indication of upper-level recognition of this, as well as support for improvement in this area.

**Moving forward** - Looking ahead, under-nutrition, major childhood infectious diseases, and birth spacing are three critical areas of child survival that need to be addressed. All three areas exemplify the need for a greater focus on preventative, rather than curative, interventions. Integrated planning will be essential, and approaches such as social marketing and community involvement will be at the forefront of these activities. In this era of increasing need for accountability, producing objective measures of program effectiveness is essential. Two guiding standards – the UN’s Millennium Development Goals and the Convention on the Rights of the Child – already closely reflect Plan’s activities. As we look to align our own goals more directly with these standards, our role as a major player in the achievement of these comprehensive targets will become even clearer to our donors and partners.

Finally, a renewed focus on increasing the sustainability of our programs will be essential. New approaches, such as working to integrate economic development and child survival, and more directly engaging the local private sector in our activities, will guide us forward in our efforts to facilitate lasting improvements in child survival around the world.