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CARE

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Acronyms

ACD	Assistant Country Director
API	Assessment of Program Impact
ASACO	Association de Sante Communautaire
BHR/ PVC	Bureau for Humanitarian Response/ Private and Voluntary Cooperation
CBO	Community-based organization
DAD	Developpement Agricole du Delta
DAP	Detailed Activity Proposal
DAZA	Developpement Agricole des Zones Arides
DFID	Department for International Development
DIP	Detailed Implementation Plan
DM&E	Design, Monitoring, and Evaluation
GIS	Geographic Information System
HLS	Household Livelihood Security
LRSP	Long Range Strategic Plan
M&E	Monitoring and evaluation
MER	Monitoring, Evaluation, and Reporting
NGO	Non-governmental organization
OPP	Organisation de Propriete des Partenaires
PAD	Program Analysis and Development
PHLS	Partnership and Household Livelihood Security
P/ID	Partnership and institutional development
PL-480	Public Law 480
RECOL	Renforcement de la Capacite des Organisations Locales
SCVM	Securite des Conditions de Vie des Menages
SIME	Sistema para Monitoreo y Evaluacion
SMVH	Seguridad de los Medios de Vida del Hogar
SVP	Senior Vice President
USAID	United States Agency for International Development

Executive Summary

The Partnership and Household Livelihood Security (PHLS) Matching Grant was awarded to CARE/USA for the three-year period from October 1, 1996 to September 30, 1999. The Matching Grant funds a cooperative agreement between CARE and the Office of Private and Voluntary Cooperation of USAID/Washington. The agreement broadly defined seeks to institutionalize within CARE country programming the concepts and methodologies of Partnership and Household Livelihood Security. Several key positions in CARE Headquarters/Atlanta and in each of the four pilot countries are funded wholly or partially through these matching funds. The pilot countries are Bolivia, Mali, Peru, and Tanzania.

CARE proposed to use four different approaches in its pilot countries—Bolivia, Peru, Mali, and Tanzania. Bolivia was to work with “established, formal non-governmental organizations”, Peru with sector-based partnerships, Mali with formal, *beneficiary-owned* organizations, and Tanzania with local organizations and indirect service delivery. The PHLS cooperative agreement was structured to be a *capacity building project* (a primary focus of the PVC Matching Grant Program), rather than a direct *impact* project.

The Partnership and Household Livelihood Security (PHLS) Unit in headquarters and its coordinators in each of the pilot country offices were expected to assist the process of institutionalizing both Partnership and Household Livelihood Security throughout country programming, with lessons learned in the pilots forming a body of experience to inform and promote worldwide extension of this strategic framework. PHLS, in fact, contains three components: Household Livelihood Security, Partnership, Design, Monitoring, and Evaluation.

Through the institutionalization of PHLS, CARE/USA sought to shift from a purely sectoral orientation in development work to a holistic focus on the complete set of household subsistence needs (insecurities). While these include many basic needs as traditionally defined, they also include higher-order needs, such as environmental protection and building social capital and participation in civil society. Partnership provided not only a means to implement activities addressing more than one of these needs simultaneously, but also promoted the sustainability of these interventions.

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

Evaluation methodology has combined document review and visits to three of the four pilot countries under the PHLS grant. In view of the large number of documents generated by the PHLS Unit in Atlanta and by PHLS program managers in pilot countries, only key documents were selected for review. This is particularly true for CARE/Atlanta.

The evaluation report has not attempted to summarize every project or country program in detail, but rather has focused generally on the implementation and institutionalization of PHLS in the pilot countries and in CARE/Atlanta. The overall logic, sophistication, consistency, and application of the PHLS model has been evaluated both intellectually and in its practical application to real world sites.

Two team members participated in this evaluation of progress to date: Martin Hewitt, USAID/BHR/PVC Project Officer for the PHLS Program and Philip Boyle, team leader and independent consultant. Mr. Hewitt visited CARE Headquarters/Atlanta and CARE/Bolivia, while Dr. Boyle carried out visits to all sites. The field evaluation was carried out between September 27 and November 2, 1998. Only the pilot country program of CARE/Tanzania was not visited.

Overall Conclusions

- 1 The Partnership and Household Livelihood Security (PHLS) cooperative agreement has been implemented satisfactorily by CARE/USA over the first two years of its three-year first phase. Progress toward grant objectives has been essentially as planned, and it is expected that all objectives will be met by the end of Phase I (September 1999). A two-year, final phase envisaged in the grant agreement is recommended, in order to strengthen monitoring and evaluation, new program design, and partnership activities.
- 2 CARE pilot countries have been most successful in establishing viable partnerships of various kinds, while much slower progress has been made in applying the HLS conceptual framework to existing and future development interventions.
- 3 While overall program progress has been satisfactory, some weaknesses remain. Monitoring and evaluation of PHLS activities have lagged well behind other accomplishments in three of the four pilot countries. Only in Mali has significant progress been made in establishing an impact measurement system, although this remains largely project-specific, rather than multi-sectoral, cross-cutting, and comprehensive, as envisaged in the cooperative agreement.
- 4 Implementation of the PHLS agreement in pilot countries has been hampered by donor focus on sector-specific project implementation, the inability to redesign existing projects to conform to the multi-dimensional paradigm of PHLS, the scarcity of new project design opportunities, the need to strengthen partners institutionally, and the difficulty of defining an appropriate mix of development impact indicators in addition to those required by donor agencies. Nevertheless, CARE pilot countries have all made progress in these areas.
- 5 Of the four pilot countries of Bolivia, Peru, Mali, and Tanzania, most impressive progress in applying the HLS concept has been made in Peru, while partnership with other implementing organizations has been the focus of the Bolivia country program. CARE/Mali has made considerable progress in establishing monitoring and evaluation baselines and partnerships with beneficiary organizations, and Tanzania appears to have excelled in both local-level partnership

and HLS assessment, although it has been unencumbered by previous CARE projects and donor relationships in its area of PHLS focus

6 The PHLS Unit in CARE Headquarters/Atlanta is operating effectively, although seemingly stretched to its limits. Moreover, it is currently functioning without a partnership coordinator, although this is in part mitigated by the significant progress being made in this domain by the pilot countries

7 The Monitoring, Evaluating, and Reporting (MER) system has been developed in both a long and abbreviated (*light*) version, neither of which is yet free from software defects. Consequently, it has not yet been installed in any of the pilot countries, although this may occur in Mali within the next few months. It is expected, but not assured, that MER will be functional in all pilot countries by the end of Phase I (September 1999)

8 Partnership as theory and practice has been interpreted differently in pilot countries. In Bolivia and Peru it is applied to relationships with other implementing organizations, whether governmental or non-governmental, and tends not to include beneficiary organizations, although this is far more true of Bolivia than Peru. CARE/Mali, on the other hand, has taken great care to partner with beneficiary-owned organizations, neglecting partnerships with local or international NGOs. CARE/Tanzania appears to have involved both types of partner organizations in its urban assessment process in Dar Es Salaam

9 Defining, operationalizing, and particularly measuring the concept of Household Livelihood Security has not been easy for CARE country management and staff, although no one denies its essential appeal. Country sector and project personnel in Bolivia and Peru extolled the virtues of both Partnership and HLS, finding considerable value in joining forces with like-minded organizations to address multi-sectoral and geographically-focused poverty issues. In Bolivia and Peru personnel at all levels were familiar with the basic concepts of Partnership and HLS, although in Mali this was true only of Partnership at the field office level. The Tanzania country office was not visited

10 The elements of PHLS are not new, although they may be new to CARE. Partnership has become a common strategy for international NGOs since the end of the 1980s. Most of these organizations have moved to an intermediary position between local NGOs and international donors. With the advent of attention to democracy and good governance, many donor organizations support NGOs in local organizational capacity building. Clustering of projects in the same geographic area or the implementation of integrated rural development projects have been tried since the 1970s, although the latter fell seriously out of favor during the last decade. The definition and monitoring of *impact* has been a preoccupation for many donor agencies for at least two decades, although little success has been achieved. The conduct of multi-sectoral baseline surveys and qualitative rapid rural appraisals have been carried out since the 1970s. Finally, projects embracing the concept of basic human needs have been in existence since the early 1980s

11 What is new in PHLS is the packaging of all these elements in a well articulated and internally consistent theoretical framework that remains solidly empirically based. Country office sector and project managers generally relate well to this theoretical framework because it promises concentration of resources, coordination of efforts, and a concerted attack on the many dimensions of rural (or urban) poverty. Anyone with field experience knows the general futility of attacking one problem in isolation of the many others facing poor populations. Some other advantages of this approach in CARE's opinion are development of a CARE programmatic personality, replacing the previous eclecticism, shortening the time lag between project design and implementation, and, elaboration of a model of development learning that can be shared with other implementing organizations.

12 The very intuitive appeal and simplicity of PHLS has resulted in easy adoption by CARE pilot countries, although this process has not progressed as far in Mali, where field staff and major donor organizations do not realize that Household Livelihood Security is an overarching concept, not just the name given to a recent project. Nevertheless, conversations with sector and project managers in both Peru and Bolivia reveal the following three things: 1) that interventions are still essentially sectoral, 2) that communities tend to be the target rather than households, and, 3) that serious diagnostic assessments are seen as an expensive and risky luxury. That costs of diagnoses can be reduced over time, however, is apparent from Peru, where the first assessment cost was \$32,000, the second \$26,000, and the third only \$15,000. Added to this is the tendency of donor organizations to fund precise sectoral interventions, replete with numerous sector-specific impact indicators. There have been occasions in both Bolivia and Peru where donor organizations felt their resources were being deviated by CARE for other development purposes in project areas. CARE, on the other hand, contends that they were simply trying to conduct wider assessments or eliminate overlap in various interventions by different donors in the same geographic area.

13 If household livelihood security is to have more meaning, there should be greater understanding of the intra-household dynamics of the population of a given area. In documents devoted to HLS, there is significant lack of attention to gender relations, local social values, and other aspects of household welfare strategies, although some of the broader economic and political constraints are becoming clearer as CARE works with community-based organizations.

14 The principal contradiction in the conceptual framework of HLS is that most interventions remain sectorally focused and community oriented, and multi-sectoral household focus only becomes a reality in impact measurement. Clustering of projects in the same geographic area is not the same as focusing these projects on the same households. Although the difference may appear trivial, it does have importance for the meaning of HLS as development methodology.

15 The inclusion of community participation and social capital formation as one of the household's basic securities, while not on the same level as food, water, and shelter, opens up development interventions focused on the wider set of relations affecting household poverty and offers a new dimension to the usual mix of basic needs. The work being conducted in Mali on the strengthening of "beneficiary-owned" local organizations shows the importance of building community organization for sustaining individual household livelihood.

Recommendations

1 Continue Funding for Two More Years One of the key evaluation questions was to determine whether PVC should continue to fund this cooperative agreement for two years beyond the basic three-year cooperative agreement with CARE. Although the major targets for the initial grant appear on track, with the exception of monitoring and evaluation of impact in Peru and Bolivia and partnership with local NGOs in Mali, it is likely that these components will have achieved satisfactory levels by the end of the agreement period (September 1999). It is recommended that funding from USAID/PVC be continued for the final two-year period at or near the same level as the first three years. The purpose of the grant extension will be to consolidate gains made, establish lessons learned for dissemination to other country offices, and correct weaknesses in some pilot country components.

2 Reinforce Technical Service Support The PHLS Unit in Atlanta should reinforce technical service support to the pilot countries, particularly in Mali, where the conceptual framework for HLS and Partnership seems weakly developed. On the other hand, Design, Monitoring, and Evaluation (DM&E) has lagged in the Latin American pilots in spite of the development of a set of 26 indicators by the Regional Technical Committee. With the recent departure of the DM&E expert in Mali, all three country offices will need to hire or train specialists in monitoring and evaluation of multi-sectoral impacts. Perhaps this can accompany the delivery of a fully functional Monitoring and Evaluation Reporting (MER) system, currently in the final stage of development in Atlanta.

3 Exchange Lessons Learned While it is not recommended that resources be diverted from the pilot countries during the final two-year grant period, more headquarters time should be spent in exchanging lessons learned between pilot countries and between these pilots and other CARE countries attempting to restructure their programs around PHLS concepts (such as Guatemala and El Salvador). Each of the pilots has particular strengths, such as DM&E in Mali, partnership in Bolivia, HLS concepts in Peru, and urban diagnostic assessments in Tanzania. More spread of these achievements is required, followed by systematic "echo" training down to the field agent level. All examples of successful coordination between CARE projects or between CARE and other donor projects need to be documented and studied. It is the role of the Atlanta PHLS Unit to galvanize and inform this process.

4 Staff Positions At the end of the full five-year Matching Grant period the PHLS specialist in the four pilot countries can be converted into or combined with training or institution strengthening positions, already the case in Peru and Mali. The position of PHLS coordinator in Bolivia, recently vacated, should be filled as soon as possible, preferably with someone well versed in impact monitoring systems. At the end of five years this person would occupy herself full-time with DM&E. At the same time overall PHLS programmatic supervision in each of the pilot countries can be assumed by the Deputy Director for Programs.

5 Institutionalize PHLS At the end of five years the PHLS Unit in CARE/Atlanta should devote itself fully to institutionalizing PHLS into all other CARE country offices. This may require as much as five more years, but it is likely the concepts and practices of PHLS will catch on among donors as the advantages of this approach are demonstrated. The director of Program Analysis and Development (PAD) in CARE/Atlanta should be charged with supervising PHLS integration into CARE country programming. The PHLS Unit should be a direct resource to this person, as well as to the other sectoral and regional divisions in headquarters. There is no reason to elevate the unit above the other major divisions, but it will have a direct link to the PAD director. This position, currently vacant, should be filled by someone capable of promoting PHLS strongly throughout CARE/USA's country offices. This should be an important aspect of this manager's functions, just as country office deputy directors for program should be those responsible for ensuring PHLS integration in their country strategies. These actions should be taken at the end of the two-year extension of the Matching Grant.

Partnership and Household Livelihood Security

Introduction

I PROGRAM IDENTIFICATION

The Partnership and Household Livelihood Security (PHLS) Matching Grant was awarded to CARE/USA for the three-year period from October 1, 1996 to September 30, 1999. The Matching Grant funds a cooperative agreement between CARE and the Bureau for Humanitarian Response's Office of Private and Voluntary Cooperation of USAID in Washington, DC. The agreement, broadly defined, seeks to institutionalize within CARE country programming the concepts and methodologies of Partnership and Household Livelihood Security. Several key positions in CARE Headquarters/Atlanta and in each of the four pilot countries are funded wholly or partially through these matching funds. The pilot countries are Bolivia, Mali, Peru, and Tanzania.

II PROGRAM BACKGROUND

As required under the Matching Grant Program, CARE was given six months to submit a Detailed Implementation Plan on what it expected to accomplish over the three years of the agreement. The possibility of a two-year extension was made contingent on satisfactory attainment of project objectives over the first three-year period.

CARE proposed to use four different approaches in its pilot countries—Bolivia, Peru, Mali, and Tanzania. Bolivia was to work with “established, formal non-governmental organizations”, Peru with sector-based partnerships, Mali with formal, *beneficiary-owned* organizations, and Tanzania with local organizations and indirect service delivery. The PHLS cooperative agreement was structured to be a *capacity building project* (a primary focus of the PVC Matching Grant Program), rather than a direct *impact* project.

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Through the institutionalization of PHLS, CARE/USA sought to shift from a purely sectoral orientation in development work to a holistic focus on the complete set of household subsistence needs (insecurities). While these include many basic needs as traditionally defined, they also include higher-order needs, such as environmental protection and building social capital and participation in civil society. Partnership provided not only a means to implement activities addressing more than one of these needs simultaneously, but also promoted the sustainability of these interventions.

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

Household Livelihood Security evolved conceptually from the concept of food security contained in USAID food aid programs (PL-480 Title II). Food security was broadened to encompass all basic household securities. These are to be assessed through rapid, participatory assessments conducted in areas selected on the basis of preexisting needs. Once the exact nature and frequency of these household insecurities are known, key, leverage-point, interventions can be designed by CARE and funding sought from one or a number of donors. Baseline studies and effective monitoring and evaluation systems are to be incorporated in these poverty-reduction efforts from the design stage. Design, Monitoring, and Evaluation are collectively referred to as DM&E under this approach.

III PURPOSE OF THE EVALUATION

This final evaluation is required under the conditions of the Matching Grant between USAID/BHR/PVC and CARE/USA. The PVC Office will use this evaluation to determine whether a final, two-year phase under this cooperative agreement is warranted. It will also extract institution-building accomplishments for inclusion in its annual Results Report to USAID. Further grant proposals from CARE will need to be compared to the achievements and shortcomings indicated here.

IV PROGRAM IMPLEMENTATION

This evaluation examines program progress in CARE Headquarters/Atlanta and in three of the four pilot countries. Should it be deemed feasible in the future, an examination of the fourth pilot country program in Tanzania can be undertaken. This section of the evaluation examines the stated objectives of headquarters and the pilot countries as indicated in the Detailed Implementation Plan (DIP) and compare them to the progress made over the last two years since grant initiation. Both field observation and document review have contributed to the findings, conclusions, and recommendations indicated here. Since each country program has adopted its unique approach to Partnership and Household Livelihood Security, these particularities will be presented in the appropriate sections. The expectations, practicality, sustainability, and effectiveness of HLS and Partnership methodologies are examined closely. Recommendations for improvement in implementation are made for the final year of this cooperative agreement, as well as for any extension phase.

A Detailed Implementation Plan

Six months into a Matching Grant, it is customary for the grantee to submit its Detailed Implementation Plan to USAID/PVC. In March 1997, CARE/Atlanta submitted a comprehensive document, replete with substantial DIPs from the four pilot countries. Since the DIP is the final statement of what the grantee intends to undertake and accomplish over the length of grant, it is worthwhile reviewing the major intentions here.

CARE/Atlanta

The DIP indicates that the PHLS Unit in headquarters was created from the Food Unit in 1996 as part of the overall CARE restructuring process. The PHLS Unit continues to monitor and support the all Title II programs in the field. The unit is thus characterized by the integration of programming resources (Title II food aid) and the cross-sectoral framework of HLS, Partnership, and DM&E.

The PHLS Unit serves to spearhead the implementation of the PHLS program purpose, whose major points are operationalizing the concept of HLS throughout CARE country programs, assisting the four pilot countries in their targeting of beneficiaries, choice of sectoral interventions, design and redesign of projects, and monitoring and evaluation of impact, and building CARE country office ability to partner with local organizations and strengthen their capacity to improve service delivery. Fundamentally, the HLS concept is seen as the essential framework for the formation of partnerships and the establishment of more effective design, monitoring, and evaluation systems. The core interest in improved DM&E is sustainable impact.

By the end of the initial three-year agreement, the DIP states that the PHLS Unit will have

- 1) "Defined clear strategies, tools and methods for the design and implementation of well-targeted, cross-sectoral projects"
- 2) "Focused on developing an integrative framework for CARE programs by working with the four pilot countries to define integrated strategies, institutionalize the partnership initiative, and assess and strengthen the design, monitoring, and evaluation systems"

The section of the overall DIP relating to the PHLS Unit in Atlanta (Annex E) follows the same format as that for each pilot country. Section C (Project Design) sets out the steps below that the unit will follow during the grant period. However, beyond outlining the basic steps in implementing HLS programs, the DIP does not specify precise actions and activities to be followed by the PHLS Unit.

- 1) "**Develop regional strategies** to identify the key livelihood security issues found in the region and the cross-cutting themes that will facilitate decisions regarding the allocation of resources and technical assistance" These will be developed in "all regions where CARE works"

- 2) “**Identify potential sub-regions** within countries for program targeting by utilizing existing secondary data to identify where absolute poverty is concentrated ” These geographic profiles will permit strategic targeting of interventions and assist collaboration with partner organizations
- 3) “**Identification of various vulnerable groups** in the area as well as the major constraints they face ” These groups will be identified through rapid livelihood security assessments Decisions will be made concerning the groups and livelihood needs to be targeted, interventions to be selected, and the minimal data set to be tracked in measuring impact
- 4) “**Conduct a baseline** to collect information on a set of indicators that will be monitored and evaluated for measuring impact ”
- 5) “**Select a set of communities** for program interventions chosen in such a way that they have similar characteristics to a larger group of communities in order to maximize the multiplier effect of successful interventions ”
- 6) “**Secure resources** to carry out program activities to implement household livelihood security strategies ”

CARE/Bolivia

CARE/Bolivia puts a great deal of detail into its response to Section C 3 Project Design of the DIP It states up front that HLS and Partnership/Institutional Development will be developed and implemented in “two parallel efforts ” The country office had already hired a PHLS manager with full responsibility to implement the activities described in the DIP

(1) CARE/Bolivia was to begin the grant period by developing an HLS strategy to establish basic guidelines for activities Geographic areas would then be selected for HLS activities with priority given to areas with existing projects, “in order to build around these, benefit from scale economies, and utilize its baseline and other relevant information ” HLS, nevertheless, would be implemented in new, as well as existing project areas

In areas with existing projects, CARE would attempt to introduce complementary projects, or would expand or modify the existing project component mix to fit into the HLS framework In the design of HLS programs partnering would be considered to improve the approach Project profiles would be prepared and presented to potential donors prior to proceeding to “elaborate full-blown project designs ” Training in HLS was to be provided to all sector and project managers, as well as all staff of projects with an HLS focus

(2) Beginning in late 1996, CARE/Bolivia had already conducted a workshop to clarify, define, and operationalize the concept of partnership and institutional development (P/ID) A partnership strategy was to be developed later in the grant period

Following the guidelines of this new partnership strategy, CARE/Bolivia intended to develop partnerships within existing projects, if this could lead to an enhancement of HLS activities. P/ID was also to be examined in relation to all new projects, but would be determined on a case by case basis. A third means by which CARE expected to develop P/ID in future was by linking with institutions implementing their own activities in a given area. Finally, the DIP foresaw the possibility of partnering with institutions that would enhance CARE's ability to work in partnership with other institutions.

The DIP also foresaw the need for CARE to provide its partners with "technical assistance, hands-on training, and institutional development." Within CARE training in P/ID would be provided to sector and project managers, as well as to the staff of all projects involved in partnerships.

Partnerships with municipal governments were identified in the DIP as a specific type of partnership targeting full and effective implementation of the decentralization and popular participation laws recently enacted by the Bolivian government. While this would appear to be a unique form of partnership, it has actually become a familiar piece of the development picture in Bolivia.

The need to modify its internal structure in order for CARE/Bolivia to engage in effective partnerships was recognized by the DIP. The process of internal institutional change had already begun in the 1996 Partnership and Institutional Development (P/ID) Workshop, well ahead of efforts to define and operationalize HLS.

CARE/Mali

Section C 3 of the DIP on Project Design divides its intended activities into monitoring and evaluation and institutional reinforcement (*strengthening*).

(1) In the domain of monitoring and evaluation CARE/Mali admitted it "does not yet have a true quantified picture of the impact its projects are having at the household level." The P/ID grant would thus be used in part "to increase CARE Mali's capacity to identify and evaluate effective program interventions." These improved interventions, besides improved program impact on households, "will be a significantly improved project design and M&E capacity within CARE Mali."

The primary input in pursuit of these objectives was to be the services of an "expatriate Monitoring and Evaluation Coordinator" charged with institutionalizing a sustainable M&E system in country operations. The new M&E system would be project-based to provide "structured on-the-job training opportunities" for local staff.

Two projects would be selected for intensive M&E assistance each year of the three-year grant. Following an evaluation of each project's M&E system, improvement plans would be designed and implemented over a 10-month period. The core intention was to shift staff from output-

oriented thinking, or thinking operationally, to thinking evaluatively and strategically in terms of program impact and sustainability

CARE Mali program design skills would be improved through the use or adaptation of HLS assessment techniques. These HLS assessments were to be carried out in at least three zones during the course of the grant. Each of these was to be followed by a comprehensive program design effort in the zone.

(2) The institutional reinforcement component of the grant aimed to “provide institutional support to four local associations and four local NGOs.” The weaknesses this component sought to remove were poor governance, poor fund-raising capacity, weak and non-transparent systems, and lack of strategic planning.

Once again the primary input in pursuit of institutional strengthening was to be the services of a Malian Institutional Reinforcement Coordinator. This person would not only directly supervise institutional reinforcement projects, but also provide technical assistance to other projects.

Four local partners had already been chosen and were named in the DIP: Djennery Community Health Association, Sofara Livestock Owners Association, Djenne District School Parents Association, and Syn Rice Growers Association. Based on institutional diagnoses organizational strengthening plans were to be developed with each association, implemented on a pilot basis for two years, then expanded in the third year of the grant. Support to local associations was also to include modest funds to launch small projects.

Four Malian NGOs were also to be identified, “based on their potential to replace international NGOs.” Following diagnostic exercises, institutional development plans were to be adopted for all four, and additional funding sought for five-year partnership activities with CARE/Mali.

CARE/Peru

In Sections C 2 and 3 (Goals and Objectives and Project Design), the CARE/Peru DIP declared its intentions somewhat broadly and without great detail. The twin objectives of the grant were “to ensure a cross-sectoral approach in project implementation” and to develop CARE/Peru’s ability to work in partnership with other organizations.” A cross-sectoral approach is defined as “different project interventions of different CARE/Peru sectors, such as health, agriculture, etc., operating together in the same geographic location with the same populations.”

PHLS Matching Grant funds were to be used to “develop and validate effective experiences and methodologies” in pursuit of cross-sectoral activities and partnership. Major planned activities under this grant included

- Training of staff in methodologies for working in partnership, baseline studies, and HLS assessments,

- Expanding project activities to the poorest areas of two pilot PHLS provinces (Azangaro and Celendin),
- Developing and refining partnership strategies and knowledge,
- Analysis of project replicability, and
- Developing and implementing cross-sectoral design, monitoring, and evaluation systems with emphasis on the capacity to measure impact and provide replicable models

A series of major workshops were planned under the three-year grant, including HLS and baseline study workshops in both pilot regions in late 1997 and early 1998 and a series of M&E workshops in the last quarter of 1998. Finally, in March 1999 a project design workshop was to be held to integrate the planning, partnership, implementation, monitoring, and evaluation lessons learned and skills acquired during the first two years of the grant.

There is explicit mention of regional training to promote information exchange and mutual institutional strengthening between the CARE/Latin American offices. Beginning in early 1997, a regional workshop would be held in Honduras to coordinate PHLS operating plans and share guidelines, instruments, and methodologies.

As in the other pilot countries, a major part of grant funding supports specific positions. 30% of the salaries of the National Training Coordinator, Assistant Training Coordinator, and Documentation Coordinator, and regional directors in Puno and Cajamarca, plus 20% of the salary of the Assistant Country Director for Program, an international position.

B Evaluation Findings

CARE/Atlanta

1 The Partnership and Household Livelihood Unit in CARE/Atlanta consists of seven people and is responsible for coordinating food aid, as well institutionalizing partnership, M&E, and the HLS model throughout CARE country programs. Both the HLS coordinator and food resource coordinator are assisted by deputies.

2 The PHLS Unit is organizationally on the same level as the other sectoral units of the Program Analysis and Development (PAD) division. Other technical units are Economic Development, including agriculture, natural resources and credit, Health and Population, with health, reproductive health, children's health, and water and sanitation, and, Girls Education. PHLS/Food with seven positions is second only to health and population with thirteen. The other two sectoral units have only three to four people each. This sectoral backup appears extremely lean and attests to the significant devolution of programmatic and technical responsibilities to the country offices.

3 Because of its position on the same level with other sectoral units and because the PAD itself is on the same hierarchical level as the four Regional Management Offices and the Emergency Group, the PHLS Unit does not have a superior position in the organization from which it can

oversee headquarters internalization of PHLS concepts and models. This authority is even more tenuous with regard to the largely autonomous country offices. Nevertheless, by virtue of the position taken by CARE senior management, senior vice president for programs, chief of staff, and CARE president—the PHLS Unit is clearly mandated to develop and support full institutionalization of PHLS throughout the many country programs.

4 CARE senior management are currently considering the possibility of mandating the program analysis and development director (vacant at the time of this evaluation) with responsibility for PHLS programmatic and conceptual oversight, which would considerably empower the existing unit. The unit would remain, however, at the same hierarchical level. CARE/Atlanta is not only lean, it is also a relatively flat organization. The same flatness characterizes country offices.

5 The PHLS Unit is technically and conceptually well qualified to support the PHLS activities of 36 country offices, although it is obviously limited in the degree to which it can follow activities on the ground. Even maintaining a close eye on the details of the four pilot countries is beyond the unit's capacity, and it is said there are a number of other CARE countries that are attempting to integrate the PHLS model.

6 The conceptual and technical clarity of the PHLS model in Atlanta sometimes loses its focus when applied on the ground in country programs. This is to be expected, and it is the principal reason for having pilot countries in different developmental and cultural contexts. It is of interest to note some of these twists and discrepancies in this evaluation.

7 Perhaps one of the most interesting surprises is the way in which *partnership* has become detached from HLS in Bolivia, Mali, and probably Tanzania, while HLS continues to subsume the partnership concept in Peru and CARE/Atlanta. In CARE/Bolivia, programming Partnership and HLS are on distinct, parallel, but certainly related tracks. Most success there has been in discovering and implementing new partnerships. This is not to say that CARE/Bolivia has abandoned HLS, rather that they have found it much easier conceptually and practically to explore partnerships than to grapple with the slippery nature of designing, monitoring, and evaluating HLS. The evaluator is confident this will come with time.

8 Another interesting conceptual gap lies within that household security defined as the “opportunity for community participation”, or what may be called “household social capital formation.” This is clearly not at the same level as the basic household needs of food, water and sanitation, housing, income, health, and basic education. Nevertheless, it is arguably indispensable along with environmental protection in assuring a decent and sustainable standard of living over the long term. It is, furthermore, the centerpiece of many USAID Mission democracy and governance programs.

9 The definition of a household's basic subsistence needs in the PHLS model is overwhelmingly in terms of lack of material satisfaction. It is focused on resolving basic, even absolute, poverty issues. The implication is that eliminating such insecurities as lack of education and community participation serve primarily to increase a household's ability to solve its basic material needs. There are, however, some development workers that see education,

democracy, even environmental objectives, as having value beyond their use as means to material ends. There are thus at least two levels of basic need being addressed currently by the PHLS concept. One is that addressing material poverty—lack of water, food, sanitation, shelter, and income generation. Another addresses higher-needs related to education and social capital formation. These relate less to material security than to human well-being. They are generally seen as “basic needs”, if not always as part of livelihood.

10 Partnership is probably the best example of a concept currently treated by CARE field staff as either a tool to attain fundamental HLS objectives or as a means to build local self-reliance and voice in decision making, with long-term implications for household and community development.

11 Another of the tenets of PHLS is that CARE’s approach will not be implemented by generalists but by sector specialists. This is said to be a major way in which HLS differs from the integrated rural development projects of the 1970s and early 1980s. CARE will focus sector specialists on a set of problems based on a holistic appraisal of household needs in a particular place. Since the set of sectoral solutions all focus on the same group of households, the relationships between household insecurities can be appreciated, addressed in appropriate order, measured within the households, and synergistic solutions can be discovered for replication to new areas.

12 In practice, however, the PHLS methodology is too influenced by donor sectoral interests and by issues of cost efficiency and the need for scale to function as theoretically stated. This does not invalidate the model, rather it means that the differences between its practical application and previous clustering or integrated models are more academic than real.

13 Perhaps one of the most difficult parts of the model is keeping the focus truly on households. An HLS assessment, normally a relatively rapid exercise for reasons of cost and time, identifies fundamental livelihood problems in a specific area. Naturally, not all or even a large proportion of households are surveyed for their needs. The fundamental types of problems families have in ensuring their livelihood are identified and the approximate degree of each is estimated for the area. Projects that address these issues are designed by CARE and funded by donors, and under the HLS model they should be implemented in a tightly coordinated and sequenced manner.

14 Ideally, however, each project should work with just those households requiring its assistance, but in practice projects cannot be so selective. Logically, field agents should be tracking the resolution of subsistence insecurities within a precise set of households, channeling appropriate inputs to these families, and measuring the synergistic results periodically. Unfortunately, such an approach would be highly labor intensive, expensive, and would not appeal to funding agencies. In reality, donors continue to fund projects oriented toward sectoral objectives, while CARE attempts now to cluster them in the same geographic area. But is this truly a household approach?

15 The development of area entry and exit strategies within CARE seems to have lagged behind other products. In the field, entry and exit in a given area still depends largely on donor funding.

opportunities, although these could be influenced by careful diagnostic analysis, objective setting, indicator selection, and monitoring activities. One of the stated problems with the assessment process is that it is too expensive, unless there is a fair chance that one or more donors is interested in a specific geographic area or set of subsistence problems. Ideally entry and exit strategies, intervention time frames, and phase-over plans should accompany PHLS activities. In practice they remain hard to realize. Nevertheless, discussion of these issues continues within CARE PHLS countries in the context of Long Range Strategic Plan development and this, in itself, represents a serious step forward.

16 Another of the tenets of PHLS is that it must not only be multi-sectoral, but should also be able to address the continuum running from relief to rehabilitation to sustainable development. Sometimes these stages are referred to as livelihood provision, protection, and promotion. Ideally, household problems should drive the analysis of which interventions at which levels to deliver to a particular geographic area. In practice, one wonders just how far one can go in developing such a strategy. Clearly, most emergencies cannot be predicted and donor longer-term interests following an emergency are largely unpredictable. Nevertheless, that such a proactive, multi-stage approach is possible is demonstrated by CARE and several partner organizations in Peru under the El Niño Phenomenon project. Following the 6-month relief project in early 1998, CARE and its partners have outlined a further two-stage effort to address first rehabilitation (2 years) then long-term development (3-5 years) interventions. Donor funding for these two stages will need to be identified.

17 CARE/Atlanta is careful to stress that the HLS framework requires much more than area livelihood assessment and clustering of sectoral projects. PHLS should show up first in the Long Range Strategic Plan of a country office, followed by selection of potential geographic areas based on secondary data. HLS diagnostic assessments should be carried out in these zones, followed by problem and decision tree analysis. New projects should be designed based on a prioritization of problems found by the area assessments, and once funded baseline studies should be carried out. The monitoring and evaluation of a set of indicators designed to address household insecurities should occur regularly during the period of work in the geographic area, followed by evaluation and the decision to phase out activities in favor of a new zone. Lessons learned in this area should be incorporated into the next strategic plan.

18 The whole process outlined above is clearly an idealized process. There are many problems in its application in the real world, as exemplified by much of the experience of the pilot countries. This does not mean that a PHLS idealized model is not required, only that CARE (and CARE's donors, such as USAID) should not lose sight of the real hindrances to its application. It is difficult for CARE, given its reliance on a variety of bilateral donors for its funding, to depart too far from responding opportunistically to donor requests for assistance. This means that too much time spent in site selection, area assessment, problem analysis, and project design may entail serious costs and lost time without compensating opportunities for action. As yet none of the pilot countries has followed the ideal sequence of activities as defined by CARE headquarters. CARE/Atlanta will need to establish clearer entry and exit criteria for different types of PHLS programs for its country pilots.

19 CARE/Atlanta is developing its conceptual understanding of social capital formation because it believes it has a comparative advantage in this domain compared to many implementing organizations. The PHLS Unit defines social capital to include social safety nets, civil society, social networks, and all aspects of community organization and participation that enable households to improve the viability and sustainability of their livelihood in a given physical and political environment.

20 An issue that was raised by the PHLS Unit in Atlanta and generally borne out by experience in the pilot countries is that higher-level understanding of PHLS concepts and associated training has not always translated into lower-level understanding. CARE/Atlanta called this a lack of *echo* training. Except in the case of Peru, where field agents did appear to have a fairly strong grasp of HLS and *Partnership* concepts, at least in the pilot areas, the lack of lower-level exposure was generally evident. The same is true for the M&E indicators adopted recently by the Latin America Regional Technical Committee. In Mali, the field project managers and agents had virtually no exposure, even to the terminology, except in regard to partnership with community-based organizations. In Peru, according to some accounts, the concepts were rushed so quickly to the pilot zones that many sector and project managers in headquarters were left wondering what the new HLS concept was all about. This problem in Peru has largely been resolved as of this writing.

21 Impact measurement can probably be considered the core of the PHLS framework, since it maintains focus on household progress toward the achievement of certain end conditions. These outcomes are measured by indicators selected to represent increases in household well-being. Cluster programming or integrated projects have all been tried before, and partnership is common practice within the NGO community today. Real impact measurement, although not a new concept, has been notoriously absent in development practice, particularly that pursued by NGOs. Given the fact that PHLS practice still views the world in sectoral segments and that donor projects will continue to focus on geographic or community-level scale, impact measurement through household surveys will remain the acid test of whether a combination of various interventions is actually changing household welfare.

22 Thinking in sectoral perspective is still very much a part of donor and NGO practice, particularly in the PHLS pilot countries. Focusing on the household as nexus of these interventions and on household well-being as a composite of the results of these interventions is an appealing concept to many, but runs in the face of everyone's experience. This is all the more true in the current environment of results-oriented planning. The pressure to achieve sectoral results risks creating opposition to experimentation with various innovative combinations of sectoral activities, although these are implied by the HLS model.

23 For some time to come in most CARE country operations, HLS indicators will need to be retrofitted to existing sectoral projects. Where the possibility exists of designing a multi-component project, such as in upcoming Title II activities in Peru and Bolivia, indicators serving several interrelated outcomes, such as agricultural production and nutrition, water/sanitation and health, income generation and nutrition/health, and community participation and agriculture/income, should be included to test synergies. If data collection is quantitative and

carefully collected on interrelated variables, correlations and causal relationships between these factors can be explored through regression analysis

24 There is continued debate within CARE over the evolving concept of *partnership*. Originally seen as a way to expand the impact of CARE's programs without further increase in organizational size and expense, partnership implications seem more problematic. Employing partners to implement programs implies a downsizing of CARE at some point. On the other hand, building partner capacity is proving necessary even with well established national-level NGOs. In some cases, such as Mali, local NGOs are so weak that CARE is reluctant to pursue their institutional strengthening, but would rather pass this training on directly to community-based organizations. Sustainability probably implies working with both levels, however. Explicit partnership outcomes should be part of any exit strategy. At present, it seems clear that no consensus yet exists within CARE on the definition of *partnership*. At times, *partnership* is seen as a means to reach significant scale, improve the quality of development work, broaden the number of implementing organizations, or as simply means to the end of achieving CARE's development objectives. This is related to the discussion over whether CARE should include community participation, democratization, and civil society as basic household security areas and has implications for programming.

25 Sequencing or phasing of interventions in a given impact area is often referred to in the context of PHLS activities. This implies that not every key intervention has to begin at the same time, rather a set of interventions should have a logical order and that the order should be carefully considered in program design. This is an important concept in PHLS, as important as problem as assessment and impact measurement. It goes right to the difficulty of having control over the mix of interventions, many of which depend on donor perspectives and interests. What is important to present to donors is that CARE has assessed a situation, selected a timeline of various needed interventions, and will come as close to an ideal plan as possible. Over time donors may come to buy in to area plans such as these.

26 Analogous to the sequencing of various sectoral interventions is the need to define types of partnerships required at various times in project implementation, as well as the sequencing of institution building within various types of partners at various times. It is obvious that some of the first needs of implementation partners are financial and administrative systems, while community-based organizations require exposure to planning and project design, even before they can address issues of accountability.

27 Some in CARE/Atlanta feel that PHLS has been most intuitively obvious to field agents and to local NGOs on the one hand, and on the other to senior-level staff, such as country directors and program officers. Middle-level sectoral and project managers have tended to resist the PHLS model. While the evaluation team found little overt criticism of the model, it was obvious that some project managers had trouble defining the ways in which their projects were directly operationalizing PHLS concepts. This was particularly true of Mali, where field managers saw PHLS only in terms of monitoring/evaluation and local organizational strengthening.

28 The whole discussion of synergies is likely to remain highly academic for many project managers for some time to come. Some managers even raised the issue of how CARE knows that such synergies even exist? Probably the only way to explore these questions is to design interventions where linkages are obvious and then try to measure the correlation between outcomes. Some of these relationships may only become obvious over long time periods, such as that between girls education on the one hand, and fertility, child survival, and long-run household income generation, on the other.

29 During the first year of Matching Grant implementation, CARE/Atlanta outspent the USAID contribution by a ratio of 1.8 to 1 (\$1,124,400 to \$624,443), although this pattern was reversed in Year 2. In the second year CARE spent \$417,978 to \$641,562, a ratio of 0.65 to 1. As CARE points out, by the end of the first two years of grant implementation, the CARE match exceeded requirements by \$342,000. In terms of actual expenditures made during these two years, the CARE match is \$276,373 above the USAID contribution, or about 22% more. Strictly speaking, CARE is obligated to spend some \$857,622 during the final year of the grant.

30 After two years of grant implementation, overall grant spending is approximately \$334,000, or 14% behind projected expenditures. According to CARE, this has resulted from the longer than expected delay in recruiting qualified personnel for the Mali and Tanzania programs, as well as to the departure of the CARE/Atlanta Partnership Coordinator in May 1998. The partnership position still was not filled by January 1999. Moreover, the departure of the PHLs coordinator in Bolivia in October 1998 and the DM&E Coordinator in Mali in December 1998 should further restrain spending in the final year. If the grant is given a two-year second phase, any shortfall in spending by the end of Year 3 could be moved into the final two-year period.

CARE/Bolivia

1 CARE/Bolivia has certainly taken serious steps to implement PHLs concepts and methodology, although it has concentrated on Partnership. While each of the four pilot country programs is distinct, Bolivia is a case where Partnership and HLS are seen as parallel tracks. In Peru, *partnership* is very much seen as a means by which HLS can be implemented. Yet in Bolivia most emphasis during the first two years of the Matching Grant has been placed on the mechanics and mechanisms of partnership.

2 Partnership is seen in Bolivia as a means to expand CARE's programs, to extend into new areas, such as micro-credit, or to add a particular skill to another NGO's comparative advantage. The example of CARE's partnership with CIES in El Alto and with ANED on Lake Titicaca are examples examined by the evaluation team.

3 The Amboro project in eastern Bolivia is another good example where partnership has been far more successful than HLS programming. The distinction is not trivial. CARE/Bolivia has been quite successful in launching partnerships over the last three years, yet it has not been able to implement HLS in pilot areas. Attempts to diversify interventions in Bolivia have moved slowly and have encountered donor resistance. USAID is not favorable to mixing new interventions with projects it funds, such as reproductive health. The USAID attitude in Bolivia

and Peru is extremely sector-specific, except in the domain of food aid—Title II. In Bolivia, CARE is now moving into the final stage of its proposal to implement a Title II food security program. It has seized upon this opportunity to introduce an appropriate multi-sectoral mix of interventions to address extreme poverty in the Bolivian context. Its concept paper fully integrates HLS concepts.

4. As in Mali, movement toward HLS programming in Bolivia has not been rapid. In June 1997, top staff in CARE/Bolivia met to discuss the meaning of PHLs concepts and how to institutionalize them into CARE programs. The PHLs coordinator developed coherent strategies in both Partnership and HLS over the next few months. In early 1998, training of middle and lower-level staff was carried out in CARE field office headquarters in La Paz. Since this time various attempts by sectoral project designers to build in attention to HLS concepts have largely failed to interest donors. Yet CARE/Bolivia is clearly committed to this approach and continues to attempt to integrate it wherever it seems likely to succeed.

5. There are several projects which should eventually diversify their components to allow a multi-sectoral approach. It will almost certainly be the new Title II project with USAID that will serve as a serious testing ground for the HLS methodology and concept. In other projects one will be hard pressed to see how household livelihood needs are being addressed in a comprehensive manner.

6. The strategic planning workshops for senior staff to discuss PHLs, held in June 1997, resulted in two distinct tracks: Partnership and Household Livelihood Security. However, this bifurcation was foreshadowed in the Bolivia DIP. The PHLs coordinator proceeded to develop a written strategy for both Partnership (August 1997) and HLS (February 1998). Training workshops for 160 of 200 CARE/Bolivia staff were then held (January-March 1998) in both concepts. In the PHLs coordinator's view partnership, easier to grasp and more likely to take off in the short term, would provide an entry point for the pursuit of HLS. To date most CARE/Bolivia accomplishments have been in the area of partnership definition and formation.

7. Partnership was a formal component of 6 of 13 CARE projects in June 1998—although one of these (CREA) ended shortly thereafter. With projects under design and likely to be funded, CARE/Bolivia indicates that it has reached a level of 66% of projects involving partnerships. This figure is up from about 20% at the beginning of the PHLs grant (October 1996). Most of these partnerships are considered *strategic alliances* with Bolivian NGOs, in which CARE finds an implementing partner with expertise in a particular element of the project, rather than attempting to develop this capacity itself. In the CREA project, CARE introduced micro-credit activities to an area through ANED. In the health sector CARE has partnered with another Bolivian NGO (CIES), introducing health education outreach to CIES's clinic-based work. The Girls Education project sees CARE partnered with CISTAC. The Amboro Project finds CARE linked into strategic alliances involving international NGOs, local NGOs, and local municipalities in the implementation of a national park protection effort.

8. As CARE entered into partnership with these and other organizations, it found weaknesses in the accounting and administrative systems of even technically very sound organizations. There

is no doubt that CARE, by virtue of its donors and its own organizational sophistication, has high standards that may have surprised its partners. Although there were some initial frictions in working out acceptable administrative and financial systems, these seem to have been surmounted. At present, CARE's partnerships appear highly valued by all parties.

9 CARE/Bolivia has identified two institutional strengthening modes in its partnership work: short-term institutional development to enable partners to carry out joint projects with CARE, and long-term capacity building to ensure partner and/or project sustainability. Institutional development for CARE in Bolivia does not yet significantly involve community-based organizations, the major focus in Mali and Tanzania. Rather, institution building in Bolivia involves local governmental bodies (municipalities), a situation entirely absent in Mali. Tanzania and Peru appear to be in the middle range, engaging in some regional and municipal government capacity building.

10 Attempts to design new HLS programs or retrofit existing projects with HLS concepts have met with generally poor results in Bolivia. Three HLS-designed projects have been turned down altogether by donors: an agriculture and health project submitted to PROCOSI (health umbrella NGO), a water, health, and women's micro-credit project submitted to Dutch cooperation in Potosi department, and a multi-sectoral HLS program building on previous experience in municipal government strengthening in O'Connor district of Tarija department. The latter proposal is built on a diagnostic assessment, problem tree analysis, partnership analysis, and donor analysis, resulting in the selection of six key interventions. None of these has been picked up yet by donor organizations.

11 The lack of success in attracting donors to HLS-generated project activities underscores the difficulty for most CARE country programs to engage in assessments (even rapid livelihood assessments), problem analysis, and design of key interventions. This remains a great luxury for most CARE countries and was most visible in Mali. On the other hand, CARE/Peru regional offices outside of pilot areas have begun their own assessments, even in areas where Title II funding does not exist.

12 CARE/Bolivia has also attempted to add new components to existing projects or to group projects in the same place. Examples of the first are the Madidi, Mirna, Chuquisaca Central, and Amboro projects. It should be noted that agricultural or water supply resource projects seem easier to expand to new activities than is the case for other sectors.

13 In the Madidi project, potable water supply was seen as the key entry point to reach other household insecurities and natural resource protection. A baseline assessment has been planned for Madidi, but some future activities have already been designed based on the pilot:

- watershed management,
- income generation and natural resource management, and
- national park management.

The various sub-projects are being submitted to a variety of donors and phasing of project interventions is being taken into account.

14 Interestingly, CARE/Bolivia is not marketing Phase II of the Madidi project to potential donors as a PHLS program. Why this should be is not clear, although it is analogous to the situation in northern Peru, where HLS is being packaged for donors as *secure communities*. This underscores the need for more donor familiarity with the HLS concept and terminology. It is unfortunate not to be able to market these concepts more strongly, but their time will surely come.

15 In the case of the Mirna project, CARE is attempting to build in a health component in Phase II alongside the new potable and irrigation water component. There is thus an expansion from agricultural techniques and natural resource management to water supply and to primary health and nutrition. While the new Mirna project demonstrates multi-sectoral complementarity, it is not being presented to donors in holistic form. The project did benefit, however, from a wide-ranging baseline assessment in Fall 1996, including examination of health and housing needs of the target population (migratory coffee producers).

16 In the Chuquisaca Central project a reproductive health, primary health, and nutrition component was added to a soil conservation and agricultural productivity project focused on women. On the other hand, British cooperation (DFID) turned down a CARE proposal to add a potable water component to the Amboro project, although it moved a reproductive health project into the zone based on socio-economic and gender studies carried out by CARE.

17 Amboro remains, in fact, a far better example to date of partnership accomplishments than of HLS breakthroughs. Amboro boasts at least five types, or levels, of partners: community (base) organizations, service-providing organizations, private sector organizations, local governments (municipalities), and four local NGOs. Implementation is occurring with CARE as umbrella organization.

18 With regard to HLS, three ways CARE/Bolivia may proceed, according to local staff, are through

- complementary CARE projects in the same zone,
- complementary projects implemented by different organizations in partnership with CARE, or
- a project implemented by CARE in a specific zone containing integrated and complementary components and which may or may not rely on local NGOs for component implementation.

The idea of linking several complementary projects in one area in some of which CARE is not involved directly or in partnership does not yet seem to be taken seriously.

19 The primary means by which CARE/Bolivia has sought to increase its PHLS programming is by locating several projects in the same area, for example, the city of El Alto. In El Alto, CARE has focused three sectoral projects on the same urban area: water/sanitation, girls education, and health education. In the case of girls education and health education, CARE has teamed with partner organizations. While all three projects are focused in the same urban communities, there appears to be no further linkage between these development efforts. There is

no unified baseline study, set of multi-sectoral HLS indicators, or cross-cutting M&E system for impact. The projects may be in the same area, but this does not mean that they have been designed to complement each other in pursuit of a holistic strategy.

20 The clustering of several projects in one area as in El Alto, or the addition of complementary interventions to existing efforts as in Madidi, Mirna, or Amboro, reflect attempts to inculcate PHLS principles into programming. Nevertheless, each project continues to have its own M&E reporting system. With the beginning of the PHLS cooperative agreement, the new Information Systems Coordinator began to tackle the problem of how to collect information across projects. This effort has been influenced by PHLS needs, and there has been contact with CARE/Atlanta in this regard. Nevertheless, efforts to develop this PHLS framework have remained embryonic.

21 Two of the problems that hinder the development of the new M&E system are confusion over whether the Regional Technical Committee indicators constitute a menu of choices or are binding and constitute the final form of tracking measures to be incorporated into the MER (Monitoring and Evaluation Reporting) system. This begs the question if these indicators are still being refined by the committee, and is there the possibility to adapt them selectively to each country and geographic region? The answer to these questions would appear to be yes on both counts, but this is unclear to the CARE/Bolivia information systems expert, who has gone on to develop his own system called SIME (*Sistema de Informacion para Monitoreo y Evaluacion*).

22 The SIME will be based on sector indicators provided by each sector coordinator to which the HLS indicators will be added. The idea is that each year sector indicators will be aggregated and reported.

23 The MER system, based on Foxpro, is not yet reliable and tends to breakdown. In the absence of local experts trained in this system, it is not useful to attempt to use the MER. And as of this writing, a *lighter* form is being developed. It is expected that the new Title II project will establish a true HLS baseline and employ MER as the tracking tool. It is also expected that an HLS assessment will be carried out in the Madidi project area. If the donor organization acquiesces, another baseline assessment will be undertaken under the Mirna project. Both of these projects are well under way, however, but the data can track future progress using the HLS indicators.

24 The HLS assessment carried out in Tarija Department, which resulted in at least 6 project concept papers, has not yet been computerized. This may not yet be a priority, since none of the proposed interventions has yet been funded.

25 Among the variety of socio-economic studies carried out in the Amboro project (poverty, gender, stakeholders), the 1996 stakeholder analysis has been offered as most similar to an area assessment, although admittedly not a formal HLS diagnostic study. Unfortunately, in the analysis no attention is paid to the HLS concept.

26 In sum, the problems plaguing the progress of the monitoring and evaluation component in Bolivia are

- 1) slow progress of the MER software,
- 2) uncertainty surrounding the 26 HLS indicators,
- 3) unclear relationship between the collection of API and HLS data,
- 4) nature of the future relationship between GIS and HLS reporting, and
- 5) lack of awareness by the information systems expert of the M&E experience in other pilot countries outside of Latin America (especially Mali)

CARE/Mali

1 CARE/Mali programs present a somewhat different application of PHLS than do the two Latin American pilots. Part of this difference is due to the developmental context, including USAID and other donor agency interests. USAID/Mali, a powerful contributor to the CARE country program, is very much interested in the integration of sectoral interventions, particularly in the synergies that may result. There is explicit encouragement of the concept of HLS, although key USAID personnel were not aware that Household Livelihood Security was a CARE-wide programmatic approach that should cross-cut all projects. Rather they identified it with a specific USAID-funded block grant which contained HLS as part of the title. The block grant is multi-sectoral, with each of its three sectoral thrusts responding to a distinct USAID strategic objective.

2 By packaging its grants in multi-sectoral, or block form, USAID overtly encourages an integrated approach, but this goes well beyond administrative convenience. At the time of the evaluation, a USAID/Washington team was examining USAID/Mali programs for the degree to which they were integrated and generating measurable synergies. This interest in multi-sectoral programming did not seem to exist in USAID/Bolivia or USAID/Peru. Rather, the view expressed there underscored the implacable nature of Washington's proclivity to sector-specific results. An example of this are the 54 reproductive health indicators required of CARE by USAID/Bolivia.

3 Perhaps because of CARE/Mali's developmental context, CARE programs in that country are much less overtly suffused with formal references to PHLS than is the case in Bolivia and Peru. Since integrated activities are encouraged in Mali to an extent not true in Latin American pilots, there is less need to proclaim the concept and methodology of PHLS. While in Peru and Bolivia CARE personnel often spoke of the need to "educate" donor organizations in the new approach, this was neither true nor necessary in the Malian context. On the other hand, CARE/Mali may be missing an opportunity to experiment further and faster in Partnership and HLS. It is, after all, a pilot country under the PVC Matching Grant.

4 PHLS in Mali is perceived by middle and upper-level managers as focused on monitoring and evaluation and institution-building issues. Field agents do not appear to be familiar with the concept at all, in contradistinction to the situation in Bolivia and Peru. Multi-sectoral interventions focused on the resolution of several household livelihood needs are not perceived as strikingly innovative by field personnel, in distinct contrast to the situation in Peru and Bolivia. Nevertheless, there has been a growing tendency within CARE/Mali programming to

cluster them in the same areas. A new project designed for the area of Macina contains all major sectoral interventions, including a pilot activity in girls' education.

5 While clustering of several sectoral projects is perceived by Malian field and managerial staff as a natural way to proceed given the enormous needs throughout rural Mali, the measurement and tracking of development impacts is to them rather novel. Mastering the meaning of development impact, as distinct from monitoring process and activity outputs, has required training and demonstration. CARE/Mali has been extremely innovative in the establishment of baselines from which future impact may be tracked. This has been made possible through the PHLS cooperative agreement which funds the position of M&E specialist.

6 Although these baseline surveys have been conducted in areas where one or more projects already exist, sometimes at the behest of USAID for its own reporting needs (R4 process), they represent a great advance over previous development practice, which relied on process indicators or rough estimates of population served. Monitoring and evaluation of household-level impacts is seen by CARE/Mali as an important means by which Household Livelihood Security can be defined operationally by field agents and managers, how development interventions can be connected logically to measurable changes in human conditions. This is why most field personnel tend to identify the concept of HLS—known as *Securite des Conditions de Vie des Menages* (SCVM)—with monitoring and evaluation of project impact. The M&E specialist feels this is exactly how she is making the concept real for Malian field personnel.

7 The establishment of baselines in existing project areas is not the same as conducting Household Livelihood Security assessments leading to the design of new projects. This has been attempted only once by CARE/Mali (1996) with dubious results, in spite of the design of two recent projects which clearly emphasize an integrated approach to resolving important population needs. The cost of such assessments and the need to respond fairly rapidly to donor initiatives is offered by way of explanation. This was also the case in Bolivia, but in Peru rapid diagnostic assessments were becoming popular in regional offices, including some not in PHLS pilot areas.

8 The other means by which PHLS is being institutionalized in CARE/Mali programming is through the strengthening of community-based organizations, termed *beneficiary-owned organizations*. The Coordinator for Institutional Strengthening, the second and more central of the two PHLS-funded positions, focuses primarily on partnership building and strengthening with CBOs. These are CARE's primary partners in Mali, with few if any linkages being forged at present with international or local NGOs. The PHLS coordinator's title thus stresses his focus on local-level partnership strengthening, rather than the institutional strengthening of CARE/Mali, as is the case in the much larger CARE/Peru. In Peru the PHLS coordinator has been named coordinator for regional strengthening, underscoring the continuing process of regional decentralization and PHLS programmatic internalization.

9 There are two reasons for partnership emphasis on strengthening community-based organizations: donor emphasis in Mali, particularly USAID, on issues of democratic governance and self-reliance of local populations, and the extreme institutional weakness of most Malian NGOs. This weakness is considerably greater than in Peru and even Bolivia, where CARE's

partnership efforts have focused on implementation partners rather than on beneficiary organizations. While CARE in Peru and Bolivia has taken significant steps in the last two to three years to partner with international and local NGOs, CARE/Mali has been reluctant to do so. Given the fact that Mali is a pilot country, initiatives in partnering with other implementing organizations would seem warranted.

10 As in the other pilot countries, the degree to which households were the focus of development efforts was not clear in Mali. Sectoral projects were being concentrated in one or a few geographic areas, although this did not mean that all households participated in the same projects. Clearly some households do participate in more than one project, but attempts to measure synergy between project impacts within households in Mali have been unsuccessful. This may have much to do with the bluntness of the measuring instrument, which cannot be too refined for reasons of cost and time. Neither Peru nor Bolivia has proceeded much beyond rapid assessments, although 26 PHLS indicators have been developed recently by the Regional Technical Committee for Latin America. And about 24 of these are reflected in the Mali baseline surveys.

11 The core area for PHLS-oriented activity in Mali is in the region around Djenne, south of Mopti. It is here that the RECOL project (Strengthening Local Organizational Capacity) is centered, based on a pilot activity in 1996-1998. Under the current block grant from USAID (1997-2002), RECOL has been extended to two new areas of USAID support—Koro and Macina. RECOL is now working to build the organizational capacity of rice farmer, community health, and parent-teacher associations in the area around Djenne. In Koro and Macina, RECOL is working only with community health associations (ASACOs in French).

12 The USAID block grant presently groups the RECOL project with three others: Delta Agricultural Development (DAD), Koro Health Project, and Macina Health Project. While RECOL cross-cuts all of these projects, the other two sectoral efforts (agriculture and health) are in separate geographic areas. Koro is well to the east of Djenne and Macina to the west.

13 The block grant with its four sub-projects carries the title of USAID/Mali's strategic objective: "Household Livelihood Security and Institutional Capacity Strengthening in the Mopti Region and in Macina and Koro Districts." The four components target all three Intermediate Result teams: Sustainable Economic Growth, Democratic Governance, and Youth, Health, Education. Key sectoral personnel in USAID were all familiar with the terminology *household livelihood security*, but they assumed it was only the title of the block grant. They did not know this was a central, programmatic concept within CARE/Mali or CARE/USA worldwide.

14 Block grant cooperative agreements were also made by USAID/Mali to World Education, CLUSA, and Save the Children, but no attempt was made to have them combine efforts in the same geographic area. The country is vast and its needs so great, that to concentrate efforts in one or a few areas would be considered unfortunate for those populations left with nothing.

15 The same sentiment was echoed by CARE staff from Macina, when it was pointed out that the Macina Health project was geographically separate from agricultural production projects in the same or neighboring zones. The felt need to spread projects to reach a maximal number of needy people runs somewhat counter to the concept of geographic focusing. A new project in the Macina area (ROCAM) will, however, place both agriculture and health components in the same places. This illustrates the influence of the HLS concept.

16 On the other hand, the health and agriculture projects in the area of Macina and Djenne, do not work directly with households, but rather with associations of agriculturalists, herders, and health and school users. The new ROCAM project (Strengthening of Organizational Capacity and Land Use in Macina) will be placed in the same area as the Macina Health Project in order to measure impact on the same set of households. Impact indicators will include those required by USAID in its results reporting and others developed by the CARE/Mali monitoring and evaluation coordinator. ROCAM will combine many of the successful elements of the soon-to-end Dry Zones Agricultural Development Project (DAZA), but this time the project will be placed in the area of the Macina Health Project.

17 CARE/Mali also has a major project in the area around Timbuktu, known as the Timbuktu Rural Development Project. This project, begun about 1985, has recently been re-oriented and a baseline survey conducted (1998) to permit impact measurement in the future.

18 CARE is working to build the long-term viability of local associations of rice farmers, users of community health centers, and users of community schools in its projects south of Mopti. This is the essence of partnership and institution strengthening for this pilot country. The Coordinator for Institutional Strengthening, also the PHLS coordinator, manages the two projects centered in Djenne—DAD and RECOL.

19 RECOL consists of 3 components: organizational development, accounting and management, and literacy training. CARE takes pride in referring to its partners as *beneficiary-owned organizations* (or by the French acronym OPPs).

20 It is clear that CARE/Mali is reluctant to transfer development implementation functions to Malian NGOs, in view of their generally weak organizational capacity. Malian staff at all levels of CARE stated this view. Nevertheless, with the encouragement of USAID/Mali, CARE has selected two local NGOs for organizational strengthening beginning in 1999. Malian NGO capacity is much weaker than in the other PHLS countries, Bolivia and Peru, and time will be required to build viable organizations capable of becoming implementing partners. However, partnership with local organizations has always been the CARE/Mali objective and was so stated in the PHLS DIP.

21 Two CARE projects currently have a complete M&E system in place: the Macina Health Project (since June 1998) and the Timbuktu Rural Development Project (since September 1998). In both cases these M&E baseline surveys were carried out well after project start-up. Depending on project components, the M&E surveys measure agricultural production on improved lands, women's credit, potable water supply, and household health. The idea is to

measure real impact on people within households. As in the other pilot PHLS countries the MER software is not yet functional, but it is intended to be used first in the Koro Health Project.

22 Only one true pre-project assessment has been carried out by CARE/Mali. This was a Rapid HLS Assessment contracted to the University of Arizona and was carried out in the area of Koro in December 1996. The assessment was conducted over a period of approximately three weeks and involved about 120 households (10 households in each of 12 villages). The methodology followed a standard participatory rural appraisal (PRA) methodology, and the questions were both quantitative and qualitative. The design, monitoring, and evaluation coordinator took part in the exercise.

23 The results of this activity do not seem to have been as useful as hoped. The exercise appears to have been too rapid, and the mix of quantitative and qualitative results of dubious analytical value for the DM&E coordinator. Moreover, care must be taken to ensure that HLS assessments are cost effective. While it is not known what was the cost of the HLS assessment in Koro, a similar exercise by the same contractor in Niger in 1997, witnessed by the regional Food for Peace officer, is reputed to have cost \$100,000.

CARE/Peru

1 CARE/Peru has undeniably made the most comprehensive use of the PHLS cooperative agreement. This does not mean that recommendations for progress cannot be made, only that compared to the other pilot countries PHLS has permeated this country to an extent not yet attained in other pilots. This is due, in part, to the magnitude and sophistication of the Peru program compared to Bolivia, Mali, and Tanzania. The one area of weakness at this point appears to be monitoring and evaluation of HLS impacts. Other components seem to be progressing well, even gaining momentum as non-pilot regional offices have launched diagnostic assessments of their own. As in Bolivia and Mali, another problem in Peru is the limited opportunity to freely design new projects in areas of interest. In all pilot countries development projects remain donor-driven and, especially in Latin America at least, highly sectorally focused.

2 With the beginning of the PHLS Matching Grant in October 1996, CARE/Peru established two pilot PHLS areas, one in the north in Cajamarca department and one in Puno Department around Lake Titicaca. These areas already contained a number of national-level CARE projects, although until the advent of PHLS there were few, if any attempts, to coordinate them on the ground. One of the most important accomplishments in the pilot areas has been the conscious attempts by field agents and managers to avoid project overlap, to coordinate project activities, and to dialogue with communities in a more holistic manner than previously.

3 Accompanying the establishment of pilot PHLS areas in contrasting zones of Peru, has been the decentralization process involving strengthening the responsibilities of the seven regional offices. Prior to PHLS these offices undertook few programmatic initiatives, with regional directors acting essentially as local administrators. Recently, these directors have been given programmatic responsibility, particularly in regard to institutionalizing the concepts of Partnership and Household Livelihood Security. It is now claimed that 80% of their time is spent

in program planning and oversight, with administrator officers taking over the chores of everyday logistics and program support

4 The real decentralization of these regional offices is underscored by the extensive planning process leading to the establishment of their long-range strategic plans (LRSP). The establishment of these five-year plans may involve up to a week and tends to begin with an extensive consultative process with local NGOs, local governments, beneficiaries groups, and other civil society institutions

5 To the extent possible the PHLS pilot areas have attempted to initiate new development activities in their areas of focus—Celendin Province in Cajamarca and Azangaro Province in Puno. Such attempts have met with limited success, however. In Azangaro, existing projects received permission to concentrate in a new area, permitting some operationalization of the integrated nature of HLS. In general, progress in applying the PHLS framework has been limited to coordinating and improving the efforts of several existing CARE projects in pilot areas. Efforts to involve other donor projects to complement existing CARE activities are still embryonic. The design of new HLS projects in pristine areas has not yet occurred.

6 The PHLS coordinator has recently been named the coordinator for regional strengthening, underscoring the importance given to CARE to the decentralization of PHLS to the regional offices. Partnership, on the other hand, remains limited, even in the pilot areas, although recent progress has been made. The El Nino Phenomenon project involved CARE with several local NGO partners and a second, post-relief phase of activity has been designed. A third phase of sustained development activity is also foreseen, increasingly involving CARE regional offices with local NGOs and governmental structures in providing development services to poor populations. In this case, Partnership and partnering are more clearly grasped than is the application of HLS principles, thus CARE must be careful not to impose the HLS model on its partner organizations, some of which are very small NGOs.

7 CARE/Peru seems to have gotten off to a faster start in implementing PHLS concepts than has been the case in the other pilot countries visited during the evaluation. Whereas in Bolivia and Mali training of sector and project managers in PHLS only occurred in early 1998, in Peru the process seems to have begun in November 1996 and lasted until mid-1997. Yet even in Peru, PHLS seems only to have gotten really under way until the arrival of the new country director and his deputy for programs in June 1997. Until that point PHLS activities were considered as pilot activities.

8 In all three countries some senior staff felt at first that PHLS was yet another development trend dropped on them by headquarters in Atlanta, just as attention to gender had been in 1993-94. In Peru, for example, it was pointed out that after all the attention to gender in the early 1990s, not one gender-related activity was contained in the 1996 Long Range Strategic Plan. There persists a tendency in both Bolivia and Mali to refer to PHLS as a project, rather than as a programmatic thrust cross-cutting all other projects. This is particularly true for field agents and sub-office managers in Mali.

9 CARE/Peru has found that many other organizations share the philosophies and concepts contained in the PHLS approach to poverty reduction. Spanish terms for both Partnership (*asocio*) and Household Livelihood Security (*Seguridad de los Medios de Vida del Hogar* – or SMVH) have had to be coined, the second of which is certainly laborious to repeat even as initials. Consequently, there has been a tendency to find a more palatable equivalent for use with other organizations. In the case of Celendin, the concept has come to be termed *secure communities*. Fully secure, or *five star* communities have satisfied all 26 HLS indicators, while those satisfying 20 are considered *four star* communities. Those communities ensuring 13 indicators are given three stars. With the emphasis on households in the original concept, one wonders why the term is not *secure households* or *secure families*.

Review of Progress to Date in Peru

10 CARE/Peru recently completed a review of its PHLS experience over the first two years. This compilation of lessons learned provides a base for assessing how this country pilot has proceeded since the inception of the cooperative agreement. The Peruvian example is certainly the most advanced of the pilot countries, including Tanzania, where funding has not yet been secured for interventions identified in the urban assessment process.

11 When the PHLS Matching Grant began in October 1996, pilot programs were initiated in Celendin and Azangaro with a focus on nine areas of Household Livelihood Security:

- a Food security – sufficient and nutritious food
- b Housing security – adequate and safe shelter
- c Economic security – sufficient income and meaningful employment
- d Educational security – access to quality basic education
- e Water and Sanitation security – access to potable water and basic sanitation
- f Health security – access to quality health services
- g Environmental security – protection of the environment and natural resources
- h Participation security – opportunity to participate in civil society activities
- i Physical security – domestic and community safety

12 The institutionalization of PHLS concepts was directly linked to a process of reengineering within CARE/Peru, characterized by the need to reduce costs and to decentralize decision making to regional offices. The incorporation of PHLS into country programming received a strong boost through the reinstatement of the position of Assistant Country Director for Programs.

13 As in other pilot countries, the PHLS cooperative agreement enabled the creation and staffing of a design, monitoring and evaluation (DM&E) position and that of a PHLS training coordinator, later renamed the coordinator for regional strengthening emphasizing the need to supervise regional programming and practice. From a role based on educating and training project and sector managers in the new programmatic approach, the PHLS coordinator has now taken on program supervisory and coordination responsibilities for all of Peru. She works

closely with the country director and ACD for programs in ensuring program conformity with the principles and practices of PHLS

14 During the first year of the Matching Grant (October 1996 – September 1997) activities under PHLS were centered on dissemination of concepts, training, and execution of diagnostic assessments in the pilot areas of Celendin (June 1997) and Azangaro (September 1997) The position of DM&E Coordinator was filled early in the second year and first steps were taken to analyze and coordinate the monitoring and evaluation systems of the various projects of the pilot areas Through September 1998, however, DM&E work has seriously lagged other aspects of institutionalization of PHLS in CARE/Peru

15 In the pilot areas of Celendin and Azangaro agreements were reached between project managers and various donors for the phased implementation and coordination of five projects in Celendin (ninos, altura, women's credit, population, and water and sanitation) and six in Azangaro (the basic 5 plus the Waru-Waru project) Partnerships were pursued in each pilot area between CARE and local municipalities, NGOs, and government agencies

16 In order to improve programmatic oversight in the decentralized management system, regional director took on responsibility for strategic vision, planning, and supervision of regional project directors, with administrative officers assigned to assume a majority of the purely administrative functions It is said that these regional director now spend 80% of their time on programmatic issues, up from 20% previously In the pilot regions PHLS coordinators were selected from among project managers with experience in multi-sectoral activities under PL-480 Title II projects These coordinators are now being used to disseminate lessons learned in pilot areas to other regions These positions will eventually be converted to that of technical assistant to the regional director Regional teams in future will focus on proposal development, monitoring and evaluation, and regional dissemination of lessons learned, while responsibility for maintaining PHLS concepts and practices within projects will devolve on regional project managers This process has already begun

17 Donors have been approached by CARE with the aim to educate them in the concepts of PHLS In at least one instance, evaluators from another donor organization (DFID) failed to understand the purpose of the Azangaro assessment activity and thought their resources were being diverted to unknown uses The misunderstanding was cleared up, but it underscores the need for donor coordination, even where all projects are implemented by CARE

18 On the other hand, conversations with the administrator of USAID Title II programs indicate substantial interest in the concepts of PHLS, particularly the multi-sectoral approach to various household insecurities This fits very well with the broad approach taken under Title II to the definition of food security It is likely that CARE/Peru will find an excellent opportunity to implement a PHLS approach from scratch under the next Title II program (from 2000)

19 Engaging with partners has generated some debate within CARE/Peru and up to 26 different types of partnership have been developed It seems that a short list of these partnership types now focuses on six models that CARE/Peru has already engaged in

- a Subcontracting with and institutional strengthening of NGOs
- b Joint ventures with Peruvian governmental entities
- c Networking with national-level organizations
- d Partnering with community-based organizations
- e Concertation groups and inter-institutional working committees
- f Partnering with organizations for emergency response

Lessons Learned

20 CARE/Peru has established a number of accomplishments and lessons learned (conclusions) in its recent study on progress to date. Some of the more important of these are presented and discussed by the evaluator below.

HLS Vision

21 CARE/Peru feels it has been particularly successful in institutionalizing the concept of HLS (including partnership) because many within CARE and in other organizations already sought an approach addressing synergistic impact of several interventions on families. In addition, the concept was introduced gradually and in a very participatory manner, with considerable consultation of staff. In the early stages, however, it appears that at least some headquarters staff in Lima were left out of this process as the concept was operationalized in the two pilot areas. This early information gap seems now to have been filled.

22 CARE also feels that the institutional success of HLS is due to its close linkage with institutional strengthening and restructuring within CARE. The HLS concept is closely intertwined with long-range planning, partnering at various levels, and decentralization of decision making. On the other hand, the linkage with gender analysis, certainly an expectable part of Household Livelihood Security, seems tenuous. Little attention was paid to this topic in numerous conversations between the evaluator and key sectoral and project managers in Lima and in the Cajamarca regional office. Perhaps CARE/Peru assumes it has mastered this topic appropriately, but the close linkage between gender analysis and household analysis goes largely unaddressed. Nor do written materials seem to explore this important aspect of intra-household dynamics.

23 The need to substitute a more *user-friendly* term for HLS (SMVH in Spanish) in dialog with local governments, partners, and local community members has been appreciated by CARE/Peru. The use of the term *secure communities* (*comunidades seguras*) is puzzling because it fails to incorporate part of the central concept of HLS – the household. This contradiction is not common only to CARE/Peru, however, and constitutes one of the challenges for field programs in the future. To what extent are CARE projects, even clustered in one geographic area and addressing complementary needs, really centered on households rather than communities?

24 CARE/Peru has correctly identified the need to build the concepts of Partnership and HLS into new projects from the design stage. The degree to which this has been possible in Peru in

the last two years appears limited, however The new PL-480 Title II project (2000-2005) provides probably the best test of how to design a true PHLS program from the drawing board Pilot activities over the next two years will allow CARE to test new interventions for inclusion in the new HLS “package ”

Assessment Methods and Tools

25 CARE/Peru’s experience with assessments has yielded valuable experience in their eyes The problem of finding good quality secondary data is noted Another issue is reaching consensus with partners and other researchers on what constitutes valid secondary data

26 The importance of involving partner organizations in the assessment process was realized after the first assessment in Celendin In the next two assessments of Puno and Huaraz, CARE involved future collaborating organizations in conducting area assessments from the beginning The HLS approach can thus be understood and modified as necessary through consensus of all participants at the diagnostic stage Without this there would be considerable risk of disagreement on assessment validity and reliability Lacking agreement, the design of priority interventions by various partners would be compromised

27 CARE went beyond the use of a household survey and community focus group interviews and employed tools from rapid *participatory* assessment, such as the annual calendar of activities and community mapping The use of multi-sectoral teams of researchers, including some familiar with the local context, was found to be particularly useful in developing these diagnostic assessments of household needs

Implementation

28 CARE/Peru has realized that implementing several sectoral projects under the concept of Household Livelihood Security requires continuous consultation and information sharing between project implementers Progress has been made in coordinating existing projects in the pilot areas, but mechanisms that maintain open lines of communication within CARE and between CARE and its various partners in civil society are essential to the success of PHLS To assist in this process, CARE staff hold monthly working group meetings at all functional levels At the regional level project managers participate in local governmental coordination working groups

29 CARE has discovered that a project in a given area that has a longer implementation period can logically function as “umbrella” to more recent complementary interventions This has generally been the case with the agriculture/natural resource projects into which shorter projects, such as Water and Sanitation and Project Children (Ninos) have been inserted in some pilot districts Perhaps more important than the length of project is its scope and involvement with households In this case, a child survival project involving monitoring of individual households, although shorter, may serve as diagnosis point and launch vehicle for subsequent or longer-term interventions

30 CARE feels that different implementation models may be used for existing projects, since little can be done to modify them. The secret to success in true PHLS programming, however, consists of establishing a coordinated set of sectoral interventions from the design stage. Otherwise, CARE can only go so far in realizing cost and staff efficiencies in coordinating and targeting existing projects, as it has done in the HLS pilot areas. The true test for PHLS will come when CARE/Peru can design a new multi-sectoral model and implement it from the beginning. The first of these opportunities may lie in the upcoming Title II Detailed Activity Proposal (DAP) to be submitted to USAID in 1999.

Design, Monitoring and Evaluation – the use of indicators

31 DM&E involves the use of precise, measurable objectives and the use of a set of indicators to measure the various household insecurities to be targeted. Currently all projects have process and output indicators and donors require some level of evaluation of results. True impact evaluation, implied by the use of HLS as a methodology, has yet to be undertaken in Peru.

32 Monitoring and evaluation of PHLS will involve the indicators developed by the Latin America and Caribbean Regional Technical Committee in July 1998. These indicators will need to feed into new project design and should probably constitute a *menu* from which a few key indicators for each *household insecurity* can be chosen. Measurement will obviously have to occur at the household level, but there remains some disconnect between largely community implementation procedures and households as targets. The distinction is probably more academic than real, but HLS is an academic concept in many regards. It does not seem feasible, in any case, to constitute a program by working only with households that demonstrate certain types or sets of insecurities. This would defeat many aspects of partnership with local community and municipal governmental structures.

33 The pilot areas contain projects from all three of CARE/Peru's development sectors

- agriculture/natural resources,
- health and water, and
- small enterprise and micro-credit

In spite of much attention to HLS monitoring and evaluation, it does not appear that much progress has been made in applying a set of HLS indicators across these sectors in the pilot zones. With the arrival of the 26 indicators from the technical committee, this process can now be launched in earnest.

34 According to a small update on the CARE/Peru PHLS Monitoring and Evaluation component (October 1998), the next steps listed for DM&E in Year 3 (1998-99) of the cooperative agreement indicate that M&E plans for both the Azangaro and Celendin pilots will be completed, then implemented. Between Years 3 and 5 the system will be extended to 14 other priority areas. These M&E plans will contain indicators on all eight household insecurity areas (the 9th household insecurity, physical safety, has been dropped recently).

35 HLS baselines will be conducted in Azangaro and Celendin in Year 3 employing the new indicators developed by the Regional Technical Committee. In addition, DM&E concepts and tools will be communicated throughout CARE's regions by means of a newsletter and regional workshops.

Human Resources

36 CARE/Peru has made the institutionalization of PHLS in the pilot areas the responsibility of the regional director assisted by the regional HLS coordinator. This HLS position is to last for approximately one year, at which time it will be converted to general technical advisor. Whether it will contain the same incumbents remains to be seen. In any case, the technical advisors will function as part of a team in support of project managers, with particular attention to proposal development, long-term strategic planning, program management, and linkage between project evaluation and new project design.

37 In creating the position of Regional HLS coordinator (pilot areas only), CARE risked establishing yet another *project* within the set of projects the pilot areas are implementing. However, this does not seem to be the case, and the short-term nature of the position should ensure that the regional director and project managers can carry out future PHLS activities without assistance. Proof of this will come in new project design and the future use of HLS monitoring and evaluation indicators and methods.

Partnering

38 CARE has learned a good deal about the challenges of partnering. First of these is to define who should be or should not be considered a partner. A number of types have been established and at least six types of partnership are already in use somewhere in Peru. Partnership in the pilot areas has begun slowly, but it appears to be bearing fruit. According to some partners, CARE still has some difficulty sharing resources in its pilot areas, at least beyond CARE projects. Another problem is the imposition of the PHLS package of tools and concepts which may at times appear intimidating or inscrutable to small NGOs, local governments, and community-based organizations. Careful education of these partners will be necessary, if PHLS is to become more than a slogan.

39 Related to this problem is the general institutional weakness of many potential partners. This weakness is, of course, relative. CARE is a sophisticated organization and requires a high level of institutional development from its partners in order to carry out its tasks of project implementation in an accountable manner. It is not surprising, therefore, that partnering may become virtually synonymous with institution building, at least until which time the pool of partners has reached a level where they can ensure an acceptable level of financial and administrative accountability. This is certainly the experience of CARE/Bolivia. The weakness of existing partners in the two pilot areas has been noted by CARE in its lessons learned.

Donor Community

40 CARE/Peru has learned the lesson that donor organizations have not yet seen the value of multi-sectoral, programmatic approaches. There has been some difficulty, even in pilot areas, in communicating the HLS concept to various funders, at least one of which (DFID) felt its resources were being diverted for obscure uses. The conceptual appeal of HLS is hard to deny, but donor acceptance will require convincing evidence that a multi-sectoral, household approach is likely to improve results in all sectors, with synergies and cost efficiencies for good measure. Sectoral divisions of donor organizations naturally are primarily interested in achieving their own results through the funding of carefully targeted projects. The use of HLS monitoring and evaluation may begin to reveal the interrelationships between many of these interventions, providing evidence of synergies that benefit all interventions. However, this remains to be seen.

Lessons Learned / Recommendations

41 The CARE/Peru lessons learned paper also contains a set of recommendations and next steps. Most of these refer to DM&E, reflecting the greater need for progress in this component. Others concern the need for flexibility in PHLS methods to adapt it to often very different local contexts and the large amount of work remaining with partner and donor organizations in orienting them to the concepts and methods of PHLS. The sharing of M&E baseline and follow-up data with partners and donors is seen a means to promote this learning.

42 CARE/Peru feels a clear definition of exit criteria needs to be developed for staff implementing a PHLS approach. Clearly, this will depend on the accuracy with which problems have been identified during the assessment stage, objectives defined, and indicators selected to measure progress toward achievement of these objectives. There may be phasing of withdrawal from an area of intervention, just as phasing in or sequencing of activities characterize implementation of PHLS.

43 Other lessons learned are that the use of qualitative data in HLS assessments has sometimes been problematic and will require further refinement in order to avoid biasing results. Moreover, assessments should not begin with questions on household income.

44 CARE/Peru feels that the design of leverage points for intervention requires further pilot testing, refinement, and clearer guidelines. This is not surprising, however, since some amount of experimentation in sectoral combinations is at the heart of adapting PHLS to country programming. The young have been suggested as a leverage group for targeting activities, since many donor organizations now focus on this population. This group, however, spans a rather disparate set of people, from infants, through children, to early adolescents. The latter offer interesting potential in terms of influencing a variety of household welfare strategies.

C Evaluation Conclusions

1 The Partnership and Household Livelihood Security (PHLS) cooperative agreement has been implemented satisfactorily by CARE/USA over the first two years of its three-year first phase. Progress toward grant objectives has been essentially as planned, and it is expected that all objectives will be met by the end of Phase I (September 1999). A two-year, final phase envisaged in the grant agreement is recommended, in order to strengthen monitoring and evaluation, new program design, and partnership activities.

2 CARE pilot countries have been most successful in establishing viable partnerships of various kinds, while much slower progress has been made in applying the HLS conceptual framework to existing and future development interventions.

3 While overall program progress has been satisfactory, some weaknesses remain. Monitoring and evaluation of PHLS activities have lagged well behind other accomplishments in three of the four pilot countries. Only in Mali has significant progress been made in establishing an impact measurement system, although this remains largely project-specific, rather than multi-sectoral, cross-cutting, and comprehensive, as envisaged in the cooperative agreement.

4 Implementation of the PHLS agreement in pilot countries has been hampered by donor focus on sector-specific project implementation, the inability to redesign existing projects to conform to the multi-dimensional paradigm of PHLS, the scarcity of new project design opportunities, the need to strengthen partners institutionally, and the difficulty of defining an appropriate mix of development impact indicators in addition to those required by donor agencies. Nevertheless, CARE pilot countries have all made progress in these areas.

5 Of the four pilot countries of Bolivia, Peru, Mali, and Tanzania, most impressive progress in applying the HLS concept has been made in Peru, while partnership with other implementing organizations has been the focus of the Bolivia country program. CARE/Mali has made considerable progress in establishing monitoring and evaluation baselines and partnerships with beneficiary organizations, and Tanzania appears to have excelled in both local-level partnership and HLS assessment, although it has been unencumbered by previous CARE projects and donor relationships in its area of PHLS focus.

6 The PHLS Unit in CARE Headquarters/Atlanta is operating effectively, although seemingly stretched to its limits. Moreover, it is currently functioning without a partnership coordinator, although this is in part mitigated by the significant progress being made in this domain by the pilot countries.

7 The MER system has been developed in both a long and abbreviated (*light*) version, neither of which is yet free from software defects. Consequently, it has not yet been installed in any of the pilot countries, although this may occur in Mali within the next few months. It is expected, but not assured, that MER will be functional in all pilot countries by the end of Phase I (September 1999).

8 Partnership as theory and practice has been interpreted differently in pilot countries. In Bolivia and Peru it is applied to relationships with other implementing organizations, whether governmental or NGO, and tends not to include beneficiary organizations, although this is far more true of Bolivia than Peru. CARE/Mali, on the other hand, has taken great care to partner with beneficiary-owned organizations, neglecting partnerships with local or international NGOs. CARE/Tanzania appears to have involved both types of partner organizations in its urban assessment process in Dar Es Salaam.

9 Defining, operationalizing, and particularly measuring the concept of Household Livelihood Security has not been easy for CARE country management and staff, although no one denies its essential appeal. Country sector and project personnel in Bolivia and Peru extolled the virtues of both *partnership* and HLS, finding considerable value in joining forces with like-minded organizations to address multi-sectoral and geographically-focused poverty issues. In Bolivia and Peru, personnel at all levels were familiar with the basic concepts of Partnership and HLS, although in Mali this was true only of *partnership* at the field office level. The Tanzania country office was not visited.

10 The elements of PHLS are not new, although they may be new to CARE. Partnership has become a common strategy for international NGOs since the end of the 1980s. Most of these organizations have moved to an intermediary position between local NGOs and international donors. With the advent of attention to democracy and good governance, many donor organizations support NGOs in local organizational capacity building. Clustering of projects in the same geographic area or the implementation of integrated rural development projects have been tried since the 1970s, although the latter fell seriously out of favor during the last decade. The definition and monitoring of impact has been a preoccupation for many donor agencies for at least two decades, although little success has been achieved. The conduct of multi-sectoral baseline surveys and qualitative rapid rural appraisals have been carried out since the 1970s. Finally, projects embracing the concept of basic human needs have been in existence since the early 1980s.

11 What is new in PHLS is the packaging of all these elements in a well articulated and internally consistent theoretical framework that remains solidly empirically based. Country office sector and project managers generally relate well to this theoretical framework because it promises concentration of resources, coordination of efforts, and a concerted attack on the many dimensions of rural (or urban) poverty. Anyone with field experience knows the general futility of attacking one problem in isolation of the many others facing poor populations. Some other advantages of this approach in CARE's opinion are

- development of a CARE programmatic personality, replacing the previous eclecticism,
- shortening the time lag between project design and implementation, and
- elaboration of a model of development learning that can be shared with other implementing organizations

12 The very intuitive appeal and simplicity of PHLS has resulted in easy adoption by CARE pilot countries, although this process has not progressed as far in Mali, where field staff and

major donor organizations do not realize that Household Livelihood Security is an overarching concept, not just the name given to a recent project. Nevertheless, conversations with sector and project managers in both Peru and Bolivia reveal that interventions are still essentially sectoral, that communities tend to be the target rather than households, and that serious diagnostic assessments are seen as an expensive and risky luxury. That costs of diagnoses can be reduced over time, however, is apparent from Peru, where the first assessment cost \$32,000, the second \$26,000, and the third only \$15,000. Added to this is the tendency of donor organizations to fund precise sectoral interventions, replete with numerous sector-specific impact indicators. There have been occasions in both Bolivia and Peru where donor organizations felt their resources were being deviated by CARE for other development purposes in project areas. CARE, on the other hand, was simply trying to conduct wider assessments or eliminate overlap in various interventions by different donors in the same geographic area.

13 If household livelihood security is to have more meaning, there should be greater understanding of the intra-household dynamics of the population of a given area. In documents devoted to HLS, there is significant lack of attention to gender relations, local social values, and other aspects of household welfare strategies, although some of the broader economic and political constraints are becoming clearer as CARE works with community-based organizations.

14 The principal contradiction in the conceptual framework of HLS is that most interventions remain sectorally focused and community oriented, and multi-sectoral household focus only becomes a reality in impact measurement. Clustering of projects in the same geographic area is not the same as focusing these projects on the same households. Although the difference may appear trivial, it does have importance for the meaning of HLS as development methodology.

15 The inclusion of community participation and social capital formation as one of the household's basic securities, while not on the same level as food, water, and shelter, opens up development interventions focused on the wider set of relations affecting household poverty and offers a new dimension to the usual mix of basic needs. The work being conducted in Mali on the strengthening of *beneficiary-owned* local organizations shows the importance of building community organization for sustaining individual household livelihood.

D Recommendations

1 The fundamental issue is whether PVC should continue to fund this cooperative agreement for two years beyond the basic three-year grant. Although the major targets for the initial grant appear on track, with the exception of monitoring and evaluation of impact in Peru and Bolivia and partnership with local NGOs in Mali, it is likely that these components will have achieved satisfactory levels by the end of the grant period (September 1999). It is recommended that funding from USAID/PVC be continued for the final two-year period at or near the same level as the first three years. The purpose of the grant extension will be to consolidate gains made, establish lessons learned for dissemination to other country offices, and correct weaknesses in some pilot country components.

2 The PHLS Unit in Atlanta should reinforce technical service support to the pilot countries, particularly Mali, where the conceptual framework for HLS and *partnership* seems weakly developed. On the other hand, DM&E has lagged in the Latin American pilots in spite of the development of a set of 26 indicators by the Regional Technical Committee. With the recent departure of the DM&E expert in Mali, all three country offices will need to hire or train specialists in monitoring and evaluation of multi-sectoral impacts. Perhaps this can accompany the delivery of a fully-functional MER (monitoring and evaluation reporting) system, currently in the final stage of development in Atlanta.

3 While it is not recommended that resources be diverted from the pilot countries during the final two-year grant period, more headquarters time should be spent in exchanging lessons learned between pilot countries and between these pilots and other CARE countries attempting to restructure their programs around PHLS concepts (such as Guatemala and El Salvador). Each of the pilots has particular strengths, such as DM&E in Mali, partnership in Bolivia, HLS concepts in Peru, and urban diagnostic assessments in Tanzania. More spread of these achievements is required, followed by systematic "echo" training down to the field agent level. All examples of successful coordination between CARE projects or between CARE and other donor projects need to be documented and studied. It is the role of the Atlanta PHLS Unit to galvanize and inform this process.

4 At the end of the full five-year Matching Grant period the PHLS specialist in the four pilot countries can be converted into or combined with training or institution strengthening positions, already the case in Peru and Mali. The position of PHLS coordinator in Bolivia, recently vacated, should be filled as soon as possible, preferably with someone well versed in impact monitoring systems. At the end of five years this person would occupy him/herself full-time with DM&E. At the same time overall PHLS programmatic supervision in each of the pilot countries can be assumed by the deputy director for programs.

5 At the end of five years the PHLS Unit in CARE/Atlanta should devote itself fully to institutionalizing PHLS into all other CARE country offices. This may require as much as five more years, but it is likely the concepts and practices of PHLS will catch on among donors as the advantages of this approach are demonstrated. The director of program analysis and development (PAD) in CARE/Atlanta should be charged with supervising PHLS integration into

CARE country programming The PHLs Unit should be a direct resource to this person, as well as to the other sectoral and regional divisions in headquarters There is no reason to elevate the unit above the other major divisions, but it will have a direct link to the PAD director This position, currently vacant, should be filled by someone capable of promoting PHLs strongly throughout CARE/USA's country offices This should be an important aspect of this manager's functions, just as country office deputy directors for program should be those responsible for ensuring PHLs integration in their country strategies These actions should be taken at the end of the two-year extension of the Matching Grant

V EVALUATION METHODS

Evaluation methodology has combined document review and visits to three of the four pilot countries under the PHLS grant. In view of the large number of documents generated by the PHLS Unit in Atlanta and by PHLS program managers in pilot countries, only key documents were selected for review. This is particularly true for CARE/Atlanta.

The key conceptual areas under this grant are household livelihood security programming, partnering, and design, monitoring, and evaluation. Documents from each of these areas were reviewed for their technical content and consistency with program objectives. In country pilot programs, key documents were also reviewed for their content, but much emphasis was placed on interviews with sector and project managers to judge the degree of their commitment and involvement with PHLS as a cross-cutting set of guiding principles for local programming and project design and implementation.

In each of the pilot countries visited, a field trip was made to observe one or more project activities. In Bolivia this involved the CREA project (microcredit) on the Altiplano, the Market Networks for Community Health (health education) project in El Alto, and the Amboro project near Santa Cruz (environmental management). In Peru the field visit was made to Cajamarca in the north with a visit to the PROSAY (HLS pilot) project near the regional headquarters. In Mali a field visit was made to the area of Djenne to observe the DAD (agriculture) and RECOL (local institutions) projects there.

Numerous interviews were conducted with CARE staff, partners, and USAID missions. Most of those interviewed were CARE staff from various levels of the organization, both in CARE/Atlanta and in the country offices. A list of those interviewed is appended to the report.

The evaluation team met with full cooperation from CARE, both in Atlanta and in the pilot countries. Most key people were available for interview, although some were traveling. Generally speaking, the evaluation team was satisfied with the exposure it had to CARE's programs, although the sheer size of these country programs, the cross-cutting nature of PHLS, and the short time available in each location was at times somewhat daunting.

The evaluation report has not attempted to summarize every project or country program in detail, but rather has focused generally on the implementation and institutionalization of PHLS in the pilot countries and in CARE/Atlanta. The overall logic, sophistication, consistency, and application of the PHLS model has been evaluated both intellectually and in its practical application to real world sites. The question of whether grant implementation is on schedule and on track has specifically been addressed, as well as whether and to what extent the cooperative agreement should be extended for two years beyond its termination date in September 1999. The latter was proposed as an option in the original grant agreement.

This is technically a final evaluation of a three-year project, but it has been conducted one year early to permit extension of the cooperative agreement beyond the termination date next year. The decision to do so will need to be made in early 1999, when grant funding from USAID/PVC is allocated to eligible US PVOs.

VI TEAM COMPOSITION AND PARTICIPATION

Two team members participated in this evaluation of progress to date. Martin Hewitt, USAID/BHR/PVC Project Officer for the PHLS Program and Philip Boyle, team leader and independent consultant. Mr. Hewitt visited CARE Headquarters/Atlanta and CARE/Bolivia, while Dr. Boyle carried out visits to all sites. The report was written in November and December 1998. Close coordination with the PHLS Unit in Atlanta and pilot country coordinators in the field made it possible to assimilate a considerable amount of material in a relatively short period of time.

VII SCHEDULE

The field evaluation of the Partnership and Household Livelihood Security (PHLS) cooperative agreement between USAID/BHR/PVC and CARE/USA was carried out between September 27 and November 2, 1998. Field visits were made to CARE headquarters in Atlanta, CARE/Bolivia, CARE/Peru, and CARE/Mali. Only the pilot country program of CARE/Tanzania was not visited.

The draft report was submitted to USAID and CARE in mid-December 1998 and finalized in February 1999. CARE/USA's response to this evaluation is attached.

VIII REPORTING AND DISSEMINATION REQUIREMENTS

The process for distributing this report is as follows: USAID/BHR/PVC, AMaTECH (PVC's support and technical contractor), CARE/USA, and from there to all relevant parties. At a minimum, this should involve the various technical and regional divisions of CARE and the four PHLS pilot countries. It is advisable that other CARE country offices study the progress of the pilot countries as indicated here, in order to streamline their own adoption of PHLS principles and methodologies.

ANNEX 1• Persons Interviewed

CARE Headquarters/Atlanta

1	Pat Carey	Senior Vice President for Program, CARE/Atlanta
2	Ginny Ubik	Director, LARMU, CARE/Atlanta
3	Colin Beckwith	Deputy Director, LARMU, CARE/Atlanta
4	Isam Ghanim	Director, AERMU, CARE/Atlanta
5	Milo Stanojevich	Chief of Staff, CARE Atlanta
6	Jeanne Downen	Director, PHLS/Food Unit, CARE Atlanta
7	Tim Frankenberger	HHLS Officer, PHLS Unit, CARE/Atlanta
8	Peter Lochery	Senior Advisor for Water and Sanitation, CARE/Atlanta
9	Mario Lima	Management Development Officer, LARMU, CARE/Atlanta
10	Lora Wuennenberg	Deputy Director, SWARMU, CARE/Atlanta
11	Kathy McCaston	Deputy HHLS Officer, PHLS Unit, CARE/Atlanta
12	Marshall Burke	Former Partnership Officer, PHLS Unit, CARE/Atlanta
13	Jane Benbow	Director, Girls Education, CARE/Atlanta
14	Bob Bell	Food Resource Coordinator, PHLS Unit, CARE/Atlanta
15	Jim Rugh	DM&E Officer, PHLS Unit, CARE/Atlanta
16	Virginia Vaughn	Emergency Group, CARE/Atlanta

BOLIVIA

1	Maria Woolgar	PHLS Manager
2	Kirsten Johnson	Country Director
3	Jayne Lyons	Reproductive Health Sector Manager
4	Victor Rico	Manager CREA Project
5	Irma Carrazana	Manager, Community Health II Project
6	Geraldo Romero	Water/Sanitation Sector Manager and Administrative Director
7	Rodolfo Siles	Monitoring and Evaluation Manager
8	Alfredo Machacao	Clinic Director, CARE/CIES El Alto Project
9	Matilde Sanchez	Program Coordinator, CARE/CIES El Alto Project
10	Brigitte Herrera	Manager, Agriculture and Natural Resources Sector
11	Francesco Boeren	Deputy Country Director for Program
12	Cecilia Espinosa	La Paz Regional Administrative Chief
13	Manolo Diez Canseco	Manager, Amboro Project, Santa Cruz
14	Alfonso Martinez	Director, Caritas, Santa Cruz
15	Cesar Serrudo	Caritas, Coordinator with CARE for Amboro Project
16	Edwin Serrano	Agribusiness Advisor, Municipality of El Torno
17	Carla Villarroel	Sustainable Development Advisor, Municipality of El Torno

18	Lourdes Cespedes	Land Activities Coordinator, Amboro Project, Santa Cruz
19	Vladimir Forero	Technical Assistance Advisor, Amboro Project, Santa Cruz
20	George Taylor	Environmental Office Director, USAID/Bolivia
21	Ilana Vaca	NGO and PROCOSI Liaison, USAID/Bolivia
22	Paul Ehmer	Health Office Director, USAID/Bolivia
23	Frank Almaguer	Mission Director, USAID/Bolivia

PERU

1	Josefa Rojas	Coordinator for Regional Strengthening
2	Jim Becht	Deputy Country Director for Program
3	Jessica Chipoco	Materials Production Coordinator, Lima
4	Beat Rohr	Country Office Director, Lima
5	Violeta Vigo Vargas	Regional Director, Cajamarca and La Libertad Regions
6	Alicia Sanchez-Urrello	PHLS Coordinator, Cajamarca Region
7	Zoila Vigo Obando	Regional Manager, PMP Project, Cajamarca
8	Marlevy Cerna Cabana	Regional Manager SEDER Project, Cajamarca
9	Hector Cisneros	Manager, Agriculture/Natural Resources Sector, Lima
10	Zoila Cardenas Tirado	Regional Manager, NINOS Project, Cajamarca
11	Carlos Cerna Yrigoin	Supervisor, PROSAY Project, Cajamarca
12	Roger Sanchez Lescano	Regional Manager, ALTURA Project, Cajamarca
13	Victor Leon Castillo	Regional Manager, ANDINO Project, Cajamarca
14	Alejandro Luna Victoria	Regional Administrator, Cajamara
15	Walter Chavez Briones	Regional Manager, Peru Project, Cajamarca
16	Walter Campos	Director, CEDEPAS, Cajamarca
17	Alfonso Guerrero	Director, APRISABAC, Cajamarca
18	Raul Pasco	Coordinator, ALTURA Project, Lima
19	Stan Stella	Food Aid Officer, USAID/Peru
20	Miriam Choy	WID and Evaluation Officer, USAID/Peru
21	Guillermo Fajardo	Coordinator, Small Enterprise Activity Development, Lima
22	Ines Gonzales	Coordinator, SEDER Project, Lima
23	Eva Guerrero	Coordinator, USAID Title II Food Aid, Lima
24	Raul Ho	Coordinator, ARN Projects, Lima
25	Norma Puican	Coordinator ARN Projects, Lima
26	Jose Aquino	Administrative and Financial Manager, Lima
27	Gladys Soto	Administrative and Financial Manager, Lima
28	Wilfredo Gutierrez	Coordinator, NINOS Project, Lima
29	Gloria Espinosa	Deputy Coordinator, NINOS Project, Lima
30	Marco Campos	Coordinator, Potable Water & Community Health Project, Lima

Plus--- group interviews with 7 assistant project managers and 8 field agents in Cajamarca

MALI

1	Diawary Bouare	Coordinator for Institutional Strengthening, Bamako
2	Linde Rachel	Coordinator for Design, Monitoring, and Evaluation, Bamako
3	Sarah Kambou	Deputy Country Director for Program, Bamako
4	Anna Diallo	Democracy/Governance Deputy Team Leader, USAID/Mali
5	Erin Soto	Democracy/Governance Team Leader, USAID/Mali
6	Kadidia Dienta	Democracy/Governance Team, USAID/Mali
7	Mariko Salimata	Democracy/Governance Team, USAID/Mali
8	Nancy Estes	Regional Food for Peace Officer, USAID/Mali
9	Amadou Camara	Program Manager, Sustainable Economic Growth Team, USAID/Mali
10	Lawrence Paulson	Program Manager, Sustainable Economic Growth Team, USAID/Mali
11	Aly Djiga	Coordinator for Agriculture/Natural Resources, CARE/Bamako
12	Brehima Diop	Deputy Country Director for Program Support, CARE/Bamako
13	Elie Bankineza	Director, Macina Community Health Project, Macina
14	Salina Sanou	Head of Girls Education Initiative, CARE/Bamako
15	Sekou Oumar Coulibaly	Head of Organizational Development for RECOL Project, Djenne
16	Abdoulaye Maouloud	Administrator of the Djenne Sub-office, Djenne
17	Boubacar Coulibaly	Training Coordinator for the DAD Project, Djenne
18	Boubacar Sanogo	Director of the RECOL Project, Djenne
19	Diamilatou Singare	Head of Management/Accounting Component for RECOL, Djenne
20	Moussa Sangare	Director of DAD Project and Coordinator of Djenne Sub-office
21	Aminata Jicko	Head of Hydro-engineering for DAD Project, Djenne
22	Moumouni Soumono	Consultant (civil society), Bamako
23	Nicolas Sidibe	Consultant (civil society), Bamako
24	Zana Kond	Head of Literacy Component, RECOL Project, Djenne
25	Oumar Nientao	Financial Manager, Djenne Sub-office, Djenne

Plus---group interviews with 4 leaders of a rice growers association in Syn and 6 officials of parent-teacher and health associations in Djenne

ANNEX 2: Selected Bibliography

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Annex 3

Draft SOW for PHLS Mid-Term Evaluation

STATEMENT OF PURPOSE

The Partnership and Household Livelihood Security Project (PHLS) was established to

Operationalize the concepts of HLS CARE-wide and disseminate lessons learned to CARE country offices (CO) and colleagues (NGOs, PVOs, and USAID),

Assist 4 CARE COs to improve targeting of beneficiaries, choice of sectoral interventions, design/re-design of projects, and monitoring and evaluation of impact on households by increasing their capacity to analyze HLS and moving projects to best practices with special technical support, and

Build CARE CO ability to partner with local organizations and the capacity of partners to deliver relevant services efficiently, effectively, and sustainably

By the end of the initial 3-year period, the PHLS unit will have defined clear strategies, tools, and methods for the design and implementation of well-targeted, cross-sectoral projects

The project is nearing the end of its second year. It is now time to take stock of where the project has been to provide insights into where it should go. This review will determine whether the project should continue after the third year. In addition to reviewing the accomplishments against the objectives and activities proposed in the first two years of the grant, the evaluator should step back and determine what has been the overall impact of this project on CARE globally. This would include determining not only what instruments, tools, ideas, and materials were shared with other countries outside of the 4 PHLS pilots, but also the other COs that are trying to operationalize these concepts. The pilot countries should also be reviewed for their catalytic role in promoting global learning on PHLS approaches in their regions. For example, Bolivia and Peru have played an important role in sharing information through the Latin America Regional Technical Committee and provided models for other countries to follow. Finally, the evaluator should identify future opportunities to build on the successes of the last two years to increase CARE's ability to promote PHLS global learning.

OBJECTIVES

Determine how effective the PHLS grant has been in helping CARE operationalize the concepts of PHLS in
the 4 pilot countries
select Title II countries
globally

2 Determine how effective the PHLS grant has been in operationalizing and strengthening partnership development in
the 4 pilot countries
select Title II countries
globally

✓

- 3 Determine how effective the PHLS grant has been in operationalizing and strengthening design, monitoring, and evaluation capacity in
 - the 4 pilot countries
 - select Title II countries
 - globally
- 4 Determine what is the synergistic relationship between PHLS support provided through this grant and the Title II Institutional Strengthening Grant
- 5 Determine the major obstacles that have limited the adoption of Partnership, HLS and DM&E practices in COs
- 6 Determine what are the opportunities that could be pursued by CARE to overcome some of these obstacles and to enhance global learning on Partnership and HLS principles and practices

SPECIFIC ACTIVITIES

Review relevant documents (e g , FY97, 98, & 99 Annual Operating Plans for PHLS, PAD, & Program, annual reports, training materials, assessments, methods papers, regional reports, etc)

Conduct interviews with PHLS HQ staff, Regional Directors, and other technical support staff

Visit and interview CO staff in the 4 PHLS countries

Interview other key staff from selected Title II countries (Guatemala, Haiti, Honduras, Kenya, Bangladesh) via phone calls and/or visits

Interview partner organizations in the 4 pilot countries

SCHEDULE

The consultancy would be carried from mid-September through October. A draft report would be prepared and submitted to CARE and USAID by the end of November. Review comments will be incorporated into the final draft, which will be submitted by the end of December 1998.

**Annex 4
Evaluation Schedule**

September 21-22, 1998	Document Review
September 28-30, 1998	CARE/Atlanta Headquarters
October 1-7, 1998	CARE/Bolivia
October 8-13, 1998	CARE/Peru
October 27-31, 1998	CARE/Mali
November 1998	Draft Report
February 1999	Final Report

