Evaluation Capacity Building and Humanitarian Organization

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Abstract

This paper documents a process of evaluation capacity building in a humanitarian organization in Afghanistan between 2001 and 2003. The authors carried out an annual evaluation and they undertook evaluation capacity building activities. The analysis of the empirical data shows that in the context of humanitarian organizations, the capacity building process would be improved if it would i) employ a mix of participative and utilization-focused approach, ii) organize participative workshops and on-the-job training, with the continuity of collaborators ensured, iii) use a myriad of dissemination/advocacy activities for a varied public.

Résumé

Cet article vise à expliciter un processus de renforcement des capacités en évaluation de programme d'une organisation humanitaire en Afghanistan entre 2001 et 2003. Nous avons effectué une évaluation chaque année et certaines activités visaient le renforcement des capacités. L'analyse des données empiriques montre que dans le contexte des organisations humanitaires, le renforcement des capacités gagnerait à i) employer une approche participative et centrée sur

l'utilisation des résultats, ii) organiser des ateliers de formation participatifs, former les acteurs sur le terrain et s'appuyer sur des collaborateurs récurrents, iii) user d'une myriade de formes de valorisation des résultats et de plaidoyer en faveur de l'évaluation pour un public varié.

Introduction

The capacity building of humanitarian organizations relates to the multiple functions and activities carried out by these organizations. Literature is rich with articles and chapters depicting poor capacity building practices in these types of organizations, "capacity development has been largely unsuccessful" said ALNAP in the 2003 review of humanitarian action[1]. These are often written in a very negative way. In this paper we wish, to provide a more constructive perspective, as Morgan et al.[2] have done regarding training and education, on the way in which capacity building activities of humanitarian organizations is carried out, while remaining critical and rigorous at the same time. For this purpose, we will present the case of a Non Governmental Organization (NGO) implementing community health programs in Afghanistan. Milstein et al[3] said that "an important distinction might have to be made between the conditions that confer evaluation capacity building to an organization and the strategies used to bring about those conditions and sustain them over time. The former is a theoretical question, the latter an empirical and practical one". This paper deals with the latter case, it does not pretend to provide a theoretical basis, but it exclusively aims to present empirical data concerning the process of capacity building in a particular double context: a country in a transition and a humanitarian NGO. It has been particularly interesting to study a case in this country, as for the past three years, this part of the world has lived upheaval, passing from a situation of war to a situation where democratic elections were organized in a post-conflict country. That being said, we cannot in

these few pages review all the capacity building activities of this NGO, particularly those for medical or administrative activities.

This is why this paper will only focus on the evaluation capacity building (ECB) activities of this organization in Afghanistan. ECB is the intentional work to continuously create and sustain overall organizational processes that lead to quality evaluation and its routine use[4]. In this paper we will handle this topic for three essential reasons. First, experts in this field are asking for more empirical case studies to document the range of practices in order to improve their knowledge[3-6], as ECB is "an emergent field of practice"[7]. For example, the topic of ECB was only brought up in the agenda of the Annual American Evaluation Association National Conference in 2000[8]. Second, it should well be recognized that papers on this subject in a context of humanitarian aid are relatively rare. Donors and NGOs are supporting ECB activities for at least three decades[9]. But most of these activities occur in developing countries and not in conflict or post-conflict settings. Third, we believe that what makes this of particular importance is that the evaluator, the author of this paper[1], has carried out three evaluations in continuation in the same country for the same NGO during three years in 2001, 2002 and 2003. This is a rare situation, and we believe contributes to the abundance of knowledge. We thus consider it is important to share this experience,

[1] The first author knows this NGO well since 1996. He has served as its Head of Mission in Afghanistan from 1996 to 1998, then in Mali and Niger in 1999. He has also conducted evaluation work for this NGO in other countries, like Niger (98), East-Timor (99) and Iraq (2003). But we will focus the case study on Afghanistan. In other words, the CBE activities were not only implemented in Afghanistan. In addition it is thought that other evaluation practices undertaken by this consultant and others contributed to the building of the evaluation capacity of this NGO. These endeavours are clearly beyond the scope of this paper.

and our reflections, with the humanitarian community. One of the limitations of this paper is that it focuses more on process than outcome of ECB, even if some indicators of changes that occurred as a result of those activities will be shared. It seems to be the case most of the time in this kind of papers[10]. As this Afghan process is new and recent, outcome based evidence is scarce and its description is considered to be the first stage to climb the evidence-based iceberg.

Context

A thorough description of the context is important as ECB practices are highly "context-dependent"[7] according to the most cited definition. After more than 20 years of conflict and important economic decline[11], chances for development in Afghanistan are impaired by the worsening health condition of the population. Indeed, health indicators, especially maternal and infant mortality rates, are among the worst in the world and some of them are increasing: UNICEF shows a rise from 600 maternal deaths in 1981 to 1,700 deaths in mid-1990. A recent women's mortality survey, conducted in four provinces of Afghanistan, confirms this scenario: the maternal mortality ratio is 1,600 per 100,000 live births. Even more, the maternal mortality rate reported in Badakhshan province is the highest ever reported globally in the world with 6,500 per 100,000 live births[12]. The infant mortality rate is thought to be 165 per 1,000 successful births and the under five mortality rate about 257 per 1,000 live births. The low socio-economic status of women renders them and their children particularly vulnerable[13]. Most of the burden of illnesses stems from infectious diseases, particularly among children, where diarrhea, acute respiratory infections and vaccine-preventable diseases are likely to account for 60% of the children's deaths[14].

According to a recent report done for the Afghanistan Research and Evaluation Unit (AREU)[15], the health system is adversely affected by major problems: a grossly deficient, and even absent, infrastructure; a top-heavy health system; poorly distributed resources; health care delivered on a 'project' basis by many distinct, relatively uncoordinated service providers; absence of a practical, useful, coordinated information system for management decision-making. In addition, the pre-war in human resource capacity has been eroded and there is scarcity of personnel with managerial and technical skills throughout the country. There is also a lack of training and a lack of public health expertise, for all health staff and doctors are generally not able to deal with the most urgent problems at a community level. Indeed, medical facilities and personnel are very few in number and are primarily found in Kabul; approximately 90% of all trained physicians practice in urban centers, with almost 80% in Kabul itself. In rural areas, NGOs are in charge of the large majority of the health facilities. They have to implement, mostly through a contractual approach[16], the new Basic Package of Health Service defined by the Afghan Government in its new National Health Policy[17]. However, access to health services remains appalling for rural populations because of limited public transport, cultural constraints that limit the access to health care for women, high illiteracy levels with lack of knowledge about health care, few hardtop and rural roads and the absence of telecommunications. Moreover, twenty-three years of war and recent droughts have eroded household assets and many families live in abject poverty[18].

In 2004, Afghanistan is not yet safe and secure; tensions still run high in most parts of the country. Moreover, there are signs of nascent problems, notably harassment of the International Community by Government authorities and the potential return to violence in some areas. Current insecurity and political instability will obviously

constrain the pace and geographic scope for extending health services. Intense ethnic rivalries and local conflicts have undermined trust in public and government institutions and will remain a challenge in the years to come.

A French medical NGO founded in 1979, Aide Médicale Internationale (AMI), is acting and working in Afghanistan since the early eighties, undertaking different kinds of activities that focus on the rehabilitation of health care structures and on medical training for health care workers. Initially, all missions were secret ones taking place during the Soviet occupation of the Afghan territory. From 1985 to 1993 AMI ran a training program (Medical Training for Afghans) in Peshawar (Pakistan), and provided the 115 graduated students with medical kits to start their activities inside Afghanistan[19]. This was a huge project in term of medical capacity building for Afghanistan. Unfortunately, AMI do not have much information regarding the current position and profession of those hundred medical trainees. In 1993 AMI started two dispensaries in Kunar Province, and a reference Hospital in Logar Province that was linked to a training centre. In 1995 the NGO started two dispensaries in Laghman Province and took over the provincial hospital of Laghman. From 1995 to 1998, AMI ran ten Mother and Child Health (MCH) clinics in Kabul. Then, in 1997 AMI rehabilitated the Central Reference Laboratory in Kabul and still supports it through supply, training and supervision activities. In April 1998 a medical team went to the Upper Panjshir Valley and opened three Dispensaries.

Since 1996, AMI run a multi-disciplinary health program funded by the European Union and implemented in partnership with the British NGO “Sandy Gall Appeal for Afghanistan”, with AMI acting as a primary agency in the partnership. AMI supported different health facilities in three provinces (Kunar, Logar, and Laghman) in the Eastern Region of Afghanistan. From 2001 to 2003, the name of

the program was: “Support to the Health Care system in three provinces, Salamati, a distance-learning magazine for Afghan health workers and The Rehabilitation and Prevention Program for Disabled Afghans in the Eastern Region of Afghanistan”. The general objectives of that program were to improve the quality of services and to improve access to health care for the most vulnerable groups in the target areas of the project, especially women. To reach these objectives, AMI was providing financial, technical and logistical support to implement the following activities in three provincial hospitals and six clinics as well as in the surrounding communities: i) to train the medical and administrative staff; ii) to supply the facilities with necessary medication and equipment to treat the patients; iii) to maintain the buildings in proper conditions and add new constructions where necessary; iv) to train community health workers and organize information meetings in the communities; v) to edit, publish and distribute a quarterly distance-learning magazine.

Evaluation Capacity Building Framework and Practices

Medical and Administrative Capacity Building Activities

As we can see, most of the past and current programs run and supported by AMI have a capacity building component, mostly on the medical and administrative side, like many other organisations in international health development[2]. The training of 115 graduate students during the Mujjahidine times is an earlier one, but in the past years some Afghan employees had the opportunity to reinforce their capacities thanks to three strategies: on-the-job training, formal workshops and courses at the headquarters and formal training abroad. The Afghan responsible for the biology programme spent two months in different hospitals in France in 2000 and he started in the end of 2004 a six-month training program at a French

university. The Afghan financial director worked in dyad during three years with some expatriates and followed distance courses in accounting and finances. He was in Paris for a few weeks in 2004 to pass the national (French) accounting exam. The «Salamati» magazine in one of the famous medical capacity building activities done by AMI in Afghanistan. “Salamati” means «health» in Persian. This journal was created in 1994 as a medium to foster continuous education amongst midlevel Health Care Workers in Afghanistan. The Journal is published quarterly with 6,000 copies. It is distributed all over the country, through the outlets of different medical NGO’s and United Nations agencies.

ECB Framework

During the last three years AMI commissioned one program evaluation a year in Afghanistan and, even if it was not explicitly stated, there were important ECB components established in this exercise. This is what we are going to describe in the following pages. We wish to demonstrate that ECB practices and evaluation practices are two faces of the same coin.

In one of the most recent publications on ECB, experts from the Center for Disease Control (CDC) said “One problem is that the evaluation profession as a whole still lacks a well-developed theory and associated indicators for understanding evaluation capacity at an organizational level, particularly its inherent change over time and “ongoingness.”. This is why, first, this paper does not pretend to provide extensive data on ECB outcomes, and second, we will use a broad framework to make the way in which the ECB activities were held in Afghanistan understandable. Using an adaptation of mainstreaming evaluation and key elements of building evaluation capacity according to Duignan[20], we will present in this paper some activities that we implemented during the past three years, in term

of i) evaluation model, ii) evaluation skills, and iii) advocacy/dissemination. Even if for some authors[2] mainstreaming and ECB are different[7], the divergence between these two evaluation streams does not appear so big in term of their main components. Although ECB literature is limited[7], these three elements which were chosen from a mainstreaming author to depict the Afghanistan process are usually described as part of the ECB practice. According to Bozzo[21], two of the challenges for ECB in the voluntary/nonprofit sector are evaluation skills and finding the appropriate approaches. The recent conceptual framework and the accompanied extensive review proposed by Cousins et al.[10] regarding the integration of evaluative inquiry into the organizational culture present three key variables of interest in the evaluation dimension: evaluative inquiry, evaluation capacity and evaluation consequences. The first variable corresponds to our evaluation model and approach element, the second to the skills component and the third to the advocacy/dissemination activities. In this paper, the spirit of the use of this last component, according the ECB definition retained[4,7], is that we believe that the aim of ECB practices is not only directed to "the ability to conduct an effective evaluation", as Milstein and Cotton[8] or Bozzo[21] said, but also in order to increase the utilization of quality evaluation results by NGOs. This is why we consider that advocacy and dissemination activities could contribute, as a component of ECB, to the utilization of conclusions, lessons learned and recommendations of evaluation.

Appropriate Evaluation Model

Between 2001 and 2003, three evaluations in Afghanistan were conducted by the first author of this paper. The second author is responsible for the programme at

[2] Note that if the 2000 Annual American Evaluation Association National Conference was on "Capacity Building", the 2001 topic was "mainstreaming evaluation".

the NGO headquarters and he supervises, at distance and a few times per year in the field, the programme in Afghanistan.

We have argued elsewhere[22] that in an international situation of humanitarian aid where the context of the evaluation is an essential element, but impossible to manage, it is best to use a participative approach and to minimize the distance between the evaluator and the participants. This evaluation model could significantly increase the probability of appropriation of the evaluation results and the application/adaptation of the recommendations. Thus, NGOs wishing to organize an evaluation in such a context may find it very useful to collaborate with expert-facilitators (as evaluators) who use the participative approach, and who at the time same know well the specific situation and the organization that implements the program. The expertise in evaluation is not its own self sufficient. For all these reasons, we believe that this specific approach is, in this particular context, one of the most appropriate evaluation models to improve and build the evaluation capacity of NGOs. We also argue that this does not only hold true for development projects, as we have known for a long time[23], but also, as is the case in this paper, it holds true for humanitarian projects run by NGOs in complex settings.

Having said this, we must add that the extent of participation was not the same during the three above mentioned evaluations. Implicitly, we decided to use an evaluation model which employed approaches more and more near the ideal-type of the participative model (practical type and not empowerment type[24]). The goal was to gradually reinforce competences and knowledge of the NGO stakeholders in terms of evaluation and institutionalization of those activities. Although in the context of international development NGOs have been first to mainly apply this type of pluralist approach[22,23], AMI was not truly accustomed to such a process in

Afghanistan. The context of permanent war during more than 20 years, obliged the NGO to work in substitution of the State and without much of participation of the communities in decision making, is one of the explanations to the lack of use of such an approach. It should be noted that the implementation of the participative approach for the first time in 2001 during the first evaluation proceeded in parallel with the will of the NGO to give a wider role to the local populations in the management of health centres. It is as of this time that the first attempts to establish Health Management Communities were tried. Also, the gradual approach with regards to participation is justified by the gradual evolution of the context passing from a situation of war with the presence of Tabebans (2001) to a situation of post-conflict and rebuilding of the State (2003).

Before we show and analyse the depth of the participation, let us summarise in few words the purposes of those three evaluations (see Table 1).

Table 1. ***The Three Evaluations from 2001 to 2003***

Evaluation Component	2001	2002	2003
Context	War, American Invasion	Sporadic conflict, interim government, donors come-back	National health policy, performance-based contract approaches
Evaluation Team	One External Evaluator, two internal data collection supervisor, four internal data collectors	One external evaluator, two internal workshop facilitators, three internal indicators team members	One external evaluator and a team of six internal evaluators
Type	Effectiveness and efficiency	Criterion-focused	Process evaluation
Objectives	Assessment of health care financing mechanisms	Determination of performance indicators for the programs	Analysis of program activities and strategies implemented and development of "lessons learned"
Tools	Household survey, bed census, interviews	Three Regional Workshops with stakeholders, NGO Health Information System, WHO indicators	Evaluation workshop, questionnaires, focus group, interview, documentation, action plan workshop
Data	Mostly quantitative	Mostly qualitative	Mostly qualitative
Duration in the field	One month	Three weeks	Three weeks
Potential Utilization	Change in the user fees schemes	Implementation of a monitoring and evaluation system	Improvement in future programs

In another article where we analyze in depth the 2001 evaluation participative process[22] we proposed, following and adapting Patton[25], to define participative evaluation according to nine criteria gathered in three categories. We will distinguish three categories of participants whose hierarchy is instituted according to their capacity to intervene in the use of the evaluation results since we are using

an utilization-focused evaluation approache[25]. Table 2 illustrates the depth of the participation in the three processes and how, gradually, we use the appropriate evaluation model according to the context and the NGO wishes. We will, in the next section, explain in more detail how this progressive practice allowed us to build the evaluation skills of the local staff in order to improve their participation in the process.

The detailed analysis of the elements in Table 2 is beyond the scope of this paper. However, we think that it is useful to give some empirical elements. For that purpose, we are using this table to show how much the degree participation was gradual important from 2001 to 2003. The top of the use of this approach was the evaluation of 2003 which, adapting a method proposed by Aubel[26], allowed the utilization of a model close to the ideal-type of the practical participative evaluation model. The details of this last evaluation are presented elsewhere[27]. We just want to add that to overcome the problem of integration of lessons learned into the program and appropriation of recommendations, it was proposed that the evaluation exercise include a final one-day workshop in which a draft action plan regarding the implementation of recommendations was developed based on the evaluation findings and lessons learned. Then, it was decided to establish an evaluation steering committee in order to organize a participative process to finalize the document of action plan by topic and implement it.

One of the arguments in favour of the utilization of the appropriate evaluation model in order to improve the capacity building activities is that a wrong model will, not only be unable to answer the evaluation question asked by the NGO, but also it would decrease the understanding and the trust of stakeholders regarding the evaluation practice. In others words, as said Bozzo[21], “the efforts undertaken will be sustainable over the long term”. Table 2 is of special interest with regard to this

point and it demonstrates that the participative approach, in its ideal-type sense, is maybe not the most appropriate model for an effective evaluation. In fact, if the depth in participation gradually increased it was also due to a pragmatic objective: to increase the appropriation of the evaluation model. In other words we can say that if in 2003 AMI wanted an efficiency evaluation, it could be sure that the depth of participation was not as it was for the process evaluation. This observation is not new for evaluation theorists but with this empirical data we confirm it and show that this was certainly one of the elements of the capacity building process.

Table 2. ***Degree of Participation of Three Categories of Participants According to the Nine Minimal Criteria of a Participative Evaluation***

	On the field: head of mission and medical coordinator **In the headquarters: persons in charge for program and medical**	**Local department responsible, expatriates in the field and directors and staff of clinics/hospitals**	**Population and patients**
Content			
The evaluation process involves participants in learning evaluation logic and skills	+/-	+	-
	+	++	+/-
	+	++	-
Participants focus the evaluation process and outcomes they consider important and to which they are committed	++	+/-	+/-
	++	+/-	+/-
	++	++	++
All aspects of the evaluation, including data, are understandable and meaningful to participants	++	+	-
	++	++	+
	++	++	+
Process			
Participants in the process own the evaluation. They make the major focus and design decisions, they draw and apply conclusion	+	++	+/-
	+	+/-	+/-
	++	++	+/-
Participants work together as a group and the evaluation facilitator supports group cohesion and collective inquiry	-	+/-	-
	++	++	+
	-	++	+/-
The evaluator is a facilitator, collaborator, and learning resource; participants are decision makers and evaluators	+	++	+/-
	++	++	+/-
	+	++	+/-
Status differences between the evaluation facilitator and participants are minimized	++	++	-
	++	++	+/-
	++	++	+/-
Finalities			
Internal, self-accountability is highly valued	++	+	-
	+	+	+/-
	+	++	-
The evaluator facilitator recognizes and values participants' perspectives and expertise	++	+/-	+
	++	++	+
	+	++	++

Note. Degree of participation from 2001 (first line) to 2003 (third line) + + = > very intense, + = > intense, +/- = > average; - = > absent.

Developing Evaluation Skills

Since 2001 and throughout the three evaluations, we used every favourable moment to the develop program evaluation skills of the stakeholders engaged in the evaluated projects. Two particular strategies were retained: on-the-job training and workshop training.

On-the-Job Training During the Evaluation Process

Thanks to the fact that the Afghan medical coordinator of the NGO remained in his position during the three years, his presence contributed largely to the NGO capacity building in evaluation. Admittedly, these evaluation exercises were not the only capacity building opportunities, and his work throughout the year with expatriates was as much of an occasion to improve his general knowledge and skills in public health and project management. In the same vein, the three evaluations were particular opportunities for him to learn and use concepts in program evaluation. We use the recommended strategy for adult learners: "learning by doing"[2]. The first evaluation was less participative than the others and more technical, it was also more research oriented. This enabled us to evoke subjects such as the construction of a questionnaire, the constitution of a sample, statistical tests, and concepts like ethics or external validity. This person had also the responsibility for the administration of the questionnaires in villages aided by a team of investigators. This enabled him to become aware of the difficulties on the ground and to assume responsibilities and decisions which could impact on the validity of the evaluation. Since all investigators did not speak English (and we know that ECB is language-dependent[28]), he had to transmit a certain amount of

knowledge to his colleagues, which certainly contributed to reinforcing it. As an outcome of the ECB process, the medical coordinator was able at the end of 2001 to design and administer a quick survey when a huge number of displaced people reached the Laghman Province during the Taleban departure after the US-Troops attack. He could also contribute largely in the design and the implementation of a drug use survey in 2003 based on the WHO guidelines.

This being said, we should mention that the most significant moment in term of capacity building for him and one other colleague who is no longer with the NGO, was the second evaluation in 2002. The method employed for this evaluation consisted of drawing up a list of indicators through the carrying out of three regional workshops with all project stakeholders. The medical coordinator acted as a translator for the foreign consultant, but the translation of certain concepts required a real understanding of the training contents. How to explain, for example, the difference between output and outcome, or between objectivity and subjectivity. We thus worked together to find useful examples. It was necessary to adapt examples and exercises to the Afghan public, all the more so since the group members had very diverse backgrounds (which we take pride in), with some illiterate members. Having doctors and farmers (or teacher, community health workers) work on the same project is not customary, in Afghanistan or anywhere else! It was therefore necessary to adapt training tools both before and during the workshops in order to take into account the various reactions of the participants to the examples. For instance, it was very useful to illustrate the concepts of the logical model through concrete examples inspired by everyday life, such as the example of seeds (inputs) to obtain apple trees (outputs) then apples (outcomes) used to feed children and reduce malnutrition (impact). To illustrate the concepts of objectivity and subjectivity, we used the example of a judge who had to hear a

case of excessive use of a field by a neighbour who happened to be his brother. Additionally, numerous role-playing sessions, simulation games and practical exercises[29] were used to alternate with useful but austere theoretical and conceptual sessions.

This medical coordinator was also part of the third evaluation (2003), but most of his evaluation (and facilitation) skills were developed through collective action, as well as for a large part of, the second evaluation (2002).

Workshops Training During the Evaluation Process

In 2002, three training/action workshops were carried out over three days in Mazar-e-sharif, Gulbahar and Kabul (three regions where AMI is involved) in the presence of 77 people from local communities, the Ministry of Health and AMI (medical and non-medical staff). The aim of those workshops was to make participants aware of the basic concepts of program evaluation and to teach them a logical model to determine what to expect from projects in their local context[30]. The AMI logical performance model served as a tool for sharing a common vision of projects by identifying the chain of results from input to impact. This method, which aims to create useful and usable indicators of performance through training sessions, appeared somewhat laborious at the time. However, it emphasized the importance of using a participative method. It would have been easier and faster to implement WHO indicators for AMI programs in Afghanistan, but it would have been unnatural and nobody would have actually used this method of performance evaluation. These workshops led to the creation of a list of indicators related to the concerns of local actors. To that list, we added generic indicators usually used on this type of programs and indicators used by AMI. Through the two AMI local experts, a first selection of significant and useful indicators was carried out using

criteria of quality and relevance. This work constitutes an answer to the need of tools to facilitate continuous feedback and periodic production of reporting results.

In terms of the outcome of the ECB process and according to the shortened cascade approach in training[2], the medical coordinator was able, a few weeks after those three workshops to organize, on his own, the same workshop in another province (Laghman) with 24 participants. He was also in a better position, knowing the logic model approach, to interact with expatriates and contribute to the formulation of new AMI projects and proposals sent to donors. The annual obligatory presentation of NGO program results in the Ministry of Public Health (MoPH) during the National Technical Coordination Committee in front of many stakeholders it was easier to explain the logic of the programmes, performance indicators and the result-based management activities. There were also outcomes for provincial MoPH staff, notably regarding their skills in writing proposals and program planning according to the new health policy (Basic Package of Health Services).

In 2003, the participatory evaluation process started with an evaluation planning workshop held in Kabul. We established an evaluation team composed of six people which was balanced in terms of gender, location and professional status. The purpose of the first workshop was to build consensus around the aim of the evaluation; to refine the scope of work and clarify roles and responsibilities of the evaluation team and facilitator; to review the schedule, logistical arrangements, and agenda; and to train participants in basic data collection and analysis. Assisted by the facilitator, participants identified the evaluation questions they wanted answered. Participants then selected appropriate methods and developed data-gathering instruments and analysis plans needed to answer the questions. Some of the participants already had some knowledge of evaluation and for them this

workshop represented a form of revision. In fact four of them and the medical coordinator were participants in the 2002 workshop in one of the three regions where AMI is involved. During this workshop we assessed whether or not the AMI program was ready for evaluation (evaluability assessment[31]). During the assessment, calls for early evaluation were made, in collaboration with people working on the programs, in order to ascertain whether their objectives are adequately defined and their results verifiable. To do this assessment evaluators used the Logical Framework (LF) Approach[32]. The evaluation team first reviewed the current LF of the AMI program. For most of the team, it was the first time that they saw the LF with its activities and objectives. After this, it was necessary for the evaluation team to study the LF of the next program financed by the European Union. Indeed, since we had decided to carry out an evaluation of the implementation process of the program, it was necessary to select the relevant fields of activity to be evaluated. In order to use the lessons learnt to improve the program developed in the following months, it was necessary to choose some common activities. Each evaluation group developed a number of evaluation questions for each topic. A maximum of three questions could be answered during the evaluation but each team could start by choosing more than three. Then, the consultant selected the three most important (or feasible) questions and the evaluation team agreed on the choice. Here the role of the consultant, as in other phases of the evaluation process, was both to structure the task for the group and to actively contribute to the development of evaluation questions based on insights from the fieldwork and on their own experience with other programs.

We used different sources of data collected through quantitative as well as qualitative methods. The following methods were used: interview (22), focus group (16), observation (6), document analysis (2), and questionnaire (3). In

addition to the people observed, 205 people (51% of women) had the opportunity to express their views on the implementation of the AMI program in Afghanistan. Once the data was gathered, a participatory approach to analyse and interpret it helped participants to build a common body of knowledge. The consultant allowed the evaluation group to carry out their own analysis but was always present to ensure that the quality of the analysis was of an adequate level. The daily qualitative data analysis process was structured around the interview questions asked of each category of interviewees. A simplified approach to content analysis[26] was used by each group.

So, we can say that this whole evaluation process done by an evaluation team from the organization was a perfect approach to develop their evaluation skills in all the evaluation areas, from the evaluability assessment to the data analysis and action plan formulation phase. It is also clear that skills to participate in the whole process were increased, for some, partly due to the capacity building process done over the past two years. Some of them were able in 2004 to use some evaluation techniques (focus group and bed census) during an assessment of the NGO cost-recovery schemes.

Follow-Up of the Baseline Survey in 2004

In addition to those individual and collective training sessions during the last three evaluations, we had another opportunity to develop the evaluation skills of the NGO staff in 2004. During this year, the European Union grant given to AMI covered four clusters of districts spread out among three provinces of Afghanistan. In accordance with the donor, the realization of a baseline survey on the health status of the population in the targeted clusters need to be done at the beginning and at the end of the project by the cluster supervision teams. AMI recruited an

expatriate specifically for this task. She was, not surprisingly, one of the six members of the 2003 participatory evaluation team. This was a good opportunity for her to use some of the knowledge that she had acquired during the previous year. In addition even though she was not part of the 2001 survey using household questionnaires, she was in the hospital, as a physician and not as an evaluator, who serve as an office during the evaluation. For this 2004 baseline survey, a questionnaire was designed and conducted in at least 6 randomly selected villages in each of the districts of the targeted cluster. At the beginning of the project the results of the baseline survey on the health status of the population in the targeted clusters were to be published. These survey results and overall approach need to be readily used to measure the progress at the end of the project, compare the performance of supervisory areas, identify good performers and weak performers and target their resources more effectively.

The expatriate in charge of the survey, asked us to follow the whole process, from a distance in a voluntary and informal capacity. She also solicited our advice and guidance during the evaluation process. As a result many methodological discussions were carried out through e-mail and phone. She decided to adapt the questionnaire that we used in the 2001 evaluation. For some part of the baseline survey, she asked us for some scientific literature (e.g. how to evaluate the quality of health care services) or statistical advice. We also reviewed part of the final report. This 2004 windows was not only an opportunity to develop the staff skills in program evaluation but also to start the building of an infrastructure for data collection, analysis, and presentation that would support program evaluation, in addition to the routine health information system (HIS) which focuses more on input and output than outcome indicators. This infrastructure is now in place and the Afghan collaborators are still in the NGO after the expatriate left. It should be

noted that, even though, the expatriate was involved in the design, coordination and analysis of the survey, she was in the field only in one of the four provinces. Therefore in this three other settings, the process was in the hand of the local staff. The medical coordinator delivered 80% of the training for the surveyors in three provinces and 100% in the other. The ECB of the last three years was surely responsible for this outcome.

Advocacy and Dissemination

The third element which helps us to meet the ECB objective for this NGO consists of myriad activities of advocacy in favour of the program evaluation practice and dissemination of results of various evaluations. As we said earlier, the final aim of those advocacy/dissemination activities are to increase the probability of results utilization per se, following the Patton[25] approach.

In terms of advocacy, and in addition to our continual personal interaction in favour of evaluation culture, we produced different papers in order to increase the awareness of the NGO staff regarding different topics in relation to evaluation. These papers, in addition of the evaluation reports, targeted NGO staff directly and more generally the humanitarian community. All these papers carry out a discussion on evaluation in a language that is understood. Some of these papers were published in peer reviewed journals and others in professional reviews or books. The following topics were discussed:

Table 3. ***Publications in French (F) and English (E) Following the Three Evaluation***

Evaluation in	2001	2002	2003
Publication on the results	• Book chapter on Canadian humanitarian aid (F) • Poster and proceeding of an international health care financing conference in France (F)		
Publication on the process or on the general topic	• Article in *Humanitarian Affairs Review* on health financing in a complex emergency context (F, E) • Article in the *Canadian Journal of Program Evaluation* on usefulness of a participatory evaluation model in an emergency context (F) • Article in *The Journal of Afghanistan Studies* on the results and on the usefulness of a participatory process to explain changes implemented ,results show 2 years after the evaluation (E)	• Book chapter in the *Encyclopedia of Evaluation* on participatory determination of performance indicators and utilization-focused evaluation model (E) • Article in the internal newsletter (*Tam-Tami*) for AMI staff on ethics (F)	• Article in *Développement et Santé*, on basic concepts in evaluation and the usefulness of a participatory evaluation model (F) • Article in *Revue Humanitaire* on usefulness of a participatory evaluation model and lesson learned workshop (F) • Article in the AMI newsletter (*La Chronique*) for donors : advocacy for humanitarian program evaluation (F) • Book chapter in the 25th anniversary book on AMI on the basic concepts in evaluation and the usefulness of a participatory evaluation model (F)

We clearly know that following the different stages of knowledge utilization (from transmission to application), dissemination of results does not mean their

utilization. But, we can also say that these dissemination activities through all these papers published for various members of the public and in different forms could contribute to the installation of an evaluation culture in the organization. Moreover, some articles were specifically written, in their languages, to train the readers and explain to them the logic of evaluation and the importance of practicing it (e.g., [33]). We tried to translate one of these articles in the local language and publish it in the Salamati magazine published by this NGO. But unfortunately, the expatriate in charge on this publication in Afghanistan stated that health workers (the readership) are not prepared to read this kind of material. We are not sure this holds to be true and this story illustrates that ECB "is not "power neutral""[6] and how an explicit capacity building policy needs to be established in the organization in order to avoid this kind of personal decision which could counter a whole (implicit) process. Fortunately, it seems that the same publication project for medical staff in East-Asia (Saytaman) will translate and use this introductory paper on programme evaluation.

In addition to these publications, during the past four years we conducted various oral presentations to present some evaluation results and to raise the awareness of the NGO staff on the evaluation practice. In Afghanistan, for example, we presented the 2001 evaluation results on health financing for the whole NGO community in Kabul. The presentation was organized in the NGO coordination body office (ACBAR) and around 30 persons represented various NGOs and the Ministry of Public Health. The Afghan medical coordinator took part in it and contributed to the discussions with the participants. Part of the results were used in some preliminary meeting for the development of the National Health Policy, as this was the first survey done regarding this topic in 10 years in Afghanistan. During the same year, the headquarters asked us to train, during one day, all

country projects Head of Mission, about the topic on health care financing. This day was organized in June 2001 in Paris with around 25 people from the field and from the headquarters. In 2002, before starting the criterion-focused evaluation, we spent one day at the NGO headquarters in Paris and organized an oral presentation of the proposal process. This was a window of opportunity to receive feedback and critiques on the proposal and a perfect moment to do some advocacy on evaluation among the staff. In 2003, when the evaluation team presented the results and the recommendations, we started the workshop with a presentation of basic concepts and practices of program evaluation to ensure that the participants had basic notions of evaluation. The same presentation was done in Paris during the monthly board meeting of the NGO where headquarters staff were also present. Most of the people were impressed by the usefulness of the evaluation participatory process and some of them learned some concepts of evaluation.

Last but not least, we took the opportunity of a Canadian bursary program to invite the Afghan medical coordinator, who was present in all evaluations since 2001, to the 2nd International Conference on Local and Regional Health Programmes held in Quebec (Canada) in October 2004. He presented a paper that we co-authored. The topic of this article, then published in the Journal of Afghanistan Studies[34], was health financing and participatory evaluation. In the paper we tried to demonstrate the relevance of a participative approach in program evaluation and the importance of contextual (local) evidence to make program staff aware of user fees schemes in a complex setting. This conference was an opportunity to share our collaborative experiences on health financing evaluation with colleagues from other countries. In addition, it was an important occasion, even if aid donors are still skinflint, to show that Afghanistan is back in the international public health scientific community, as more than forty countries were present in this conference.

The *Journal of Epidemiology and Community Health* presented this story in its Gallery section in May 2005 (vol. 59). During this meeting, the medical coordinator improved his skills in term of evaluation results dissemination. The presence of this medical doctor in Canada, the first time for him in the "developed" world, was also an empowerment activity and a kind of acknowledgment of his involvement with the NGO for many years, taking into account the turnover problem that NGOs face in the post-conflict settings.

Conclusion

The descriptive elements presented previously clearly show that the implicit step of capacity building was gradual and effective as demonstrated by some of the partial outcomes. Contrary to our definition of ECB which claims that the process need to be intentional, the case shows that a non-intentional process (from the organization point of view) could also have some impact in term of capacity building. The "evaluation capacity building practitioner considers how each study is connected to the development of the organization and to meeting the organization's goals and mission"4. For this reason and to counter the non-intentional process, we (as individual and not as an organization) decided to use all windows of opportunity, or "teachable moments"[3], to act in favour of the ECB for the NGO and its staff. One of the recommendations by Gibbs et al[35] after their study on 61 NGOs in the USA in terms of ECB was to "take advantage of every available opportunity to use existing evaluation data as a resource for program improvement". We have tried to implement this recommendation, and more. This strategy was based on three particular components which, in a concomitant way, allowed us to reach this goal, as shown in Figure 1.

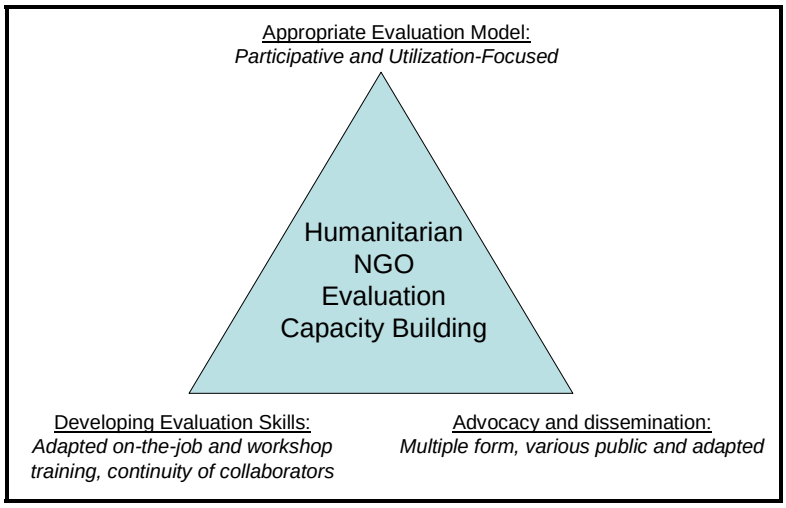

Figure 1. ***Evaluation Capacity Building Components***

The implementation and the quality of the baseline survey planned in 2006 will be a good test for these capacity building activities. For the moment, this paper has highlighted some the ECB outcomes, mostly at the individual level for the Afghanistan staff that we previously mentioned: understanding of evaluation concepts and practices, use of evaluation techniques (logic model, data collection and analysis), ability to facilitate training and disseminate results, etc. But at the organization level, two learning organisation indicators lead us to believe that our approach caused that the actors of this NGO to become more attentive to the importance and the necessity of quality program evaluation. First was a request by the president of the AMI board to produce a chapter devoted to the topic of program evaluation in a book to celebrate its 25 year anniversary intended for general public[19]. This testifies the degree of importance granted today to this practice. The second indicator relates to the realization of an evaluation in Thailand another country where this NGO intervenes. The NGO granted a significant amount of money for this evaluation. Then, contrary to the past practice, detailed care was given to the selection procedure of consultants. A detailed term of reference was written and one of the persons in charge (who is based in France but

was, by chance, in Afghanistan during the evaluation lesson-learnt workshop in 2003) asked us for some advice on this matter. Moreover, whereas usually one is satisfied with only the resume of the consultant, it was required that the consultant send some pages of an evaluation plan. Also, the practice that we implicitly employed was intentionally institutionalized, which is a good indicator for continuation and organization learning.

Now, it remains for the NGO to pass from a process of non-intentional ECB program level (Afghanistan) to a process at agency level as a whole. This does not mean that there nothing left to be done at the program level in Afghanistan to improve the current evaluation capacity ("building capacity for evaluation never ends", Milstein et al[3]), as there is much that needs to be implemented at the organization level. This Afghanistan case study allows us to draw some lessons in terms of the three ECB components processes. The most significant and useful processes for this purpose can be adapting from some recommendations from the literature[4,21,35,36]. AMI and other NGOs need to consider:

- Designating organizational (independent) evaluation leader at the headquarters and in the field
- Locating those leaders in the organization hierarchy
- Formulating and adopting an evaluation policy (stated for example the preferred evaluation model, the choice for internal or external evaluation, the way for results dissemination and capacity building, etc)
- Producing internal material
- Developing an evaluation consultants network
- Coordinating evaluation activities around projects countries

- Training expatriate and national staff
- Sustaining leadership

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