

# Helping projects become more “programmatic”

Jim Rugh, June 15, 2007

*The higher we soar, the smaller we appear to those who cannot fly.  
(quote attributed to Nietzsche 1844-1900)*

The ideal written about in much of the grey literature by CARE thinkers in the past few years has directly or indirectly advocated for programs rather than projects, policy advocacy rather than direct service, addressing rights rather than human conditions, action-learning rather than pre-planning, process rather than results or outcomes, and accountability to beneficiaries rather than donors. As laudable as these ideals are, there is a danger that the language and style in which they are being written about could leave our colleagues in the field confused. Or at least asking how they can really be expected to apply them in practice.

It would be helpful if we could find ways to help Project Managers move from where they are to at least relatively higher levels of program quality. In terms that fit the realities they face in designing projects, submitting proposals to donors, securing funding, doing all the administrative tasks needed to initiate and implement projects, monitor processes, and conduct evaluations that provide accountability to donors and community participants, as well as contribute to on-going learning.

I remember seeing a poster in the Principal's office when I was in high school. It said "It's fine to have your head in the clouds, as long as you keep your feet on the ground." What I am advocating for in this treatise is that those of us with HQ-level advisory roles continue to help our colleagues in the CARE world to aim at a broader, more holistic, more enlightened 'programmatic' perspective, while recognizing the real-world realities they face.

The approach for which I am advocating reminds me of something else I remember from school, this example being one of the main lessons I learned from my graduate work in adult education: begin where people are, then help facilitate an environment where they can be encouraged to take the next steps towards learning new things and applying them in their lives.

I would like to believe that what I am proposing resonates well with what Barbara Durr had in mind when she included in her notes of the December 14, 2006, ET meeting on strategic planning: **"Aim for project excellence with short-term measures, but take a long-term program approach."**

Before getting into further details let me propose a generic definition of 'project': It involves a plan to address one or more fairly specific problems for a defined community of intended beneficiaries (which can be quite large), requiring funding for a limited amount of time, with proposed results for which it is willing to be held accountable. The quality of a project can be greatly enhanced if it is guided by the CARE International Program Principles and Project Standards. These include having a broader programmatic perspective, contributing (along with other initiatives by CARE and

partners) to higher-level, sustainable impact; to significant participation by the intended beneficiaries in the planning for, implementation and evaluation of the project interventions; accountability to such beneficiaries for the results of our initiatives, etc.

Whether they're called 'projects' or 'programs' or other forms of interventions by CARE and partner staff, it would, of course, the should, of course, directly or indirectly address human rights and underlying causes of poverty. But more than 'address' them (in the narrow sense), our interventions should be ready to demonstrate that they *actually make a difference*. Even though it is hard for a particular intervention to be held directly accountable for achieving high-level impact, it *does* need to be held accountable for the quality of the process and evidence of outputs (services provided), even intermediate outcomes (changes in behaviors by individuals or institutions), and the plausible contributions these make (along with others') to impacts (improving the quality of life of real people). Yes, this includes strengthening the 'enabling environment' and 'social positions', which are part of CARE's global logic model or theory of change; but ultimately the impact needs to be realized by our intended beneficiaries in terms of improved 'human conditions'. Forms of evidence of such impact can be found in the HLS framework and the set of indicators that are part of the MDGs.

Rather than promoting theories that disdain projects or results or planning or accountability, let's see if we can recognize good examples (as the IPFT's recent RBA mapping report does) and help our colleagues in the field move their projects further along the continuum towards better program quality and effectiveness. The Project Managers Skills Initiative being led by Noha Hussein on behalf of Michael Rewald, including a manual (collection of relevant guidelines), is a good example of the recognition of the need for practical guidance to Project Managers, who are referred to as being on the cutting edge of CARE's programming.

I'm not exactly sure I fully understand what some in CARE now refer to as "the New Basics of DME", but might these thoughts be related?

I will try to further articulate these thoughts in the format of the following table:

<b><u>Perceived shortcoming</u></b>	<b><u>Proposed improvement</u></b>
CARE staff providing on-going direct services	Strengthening the capacity of other organizations (NGOs, government) to provide needed services
Addressing symptoms	Doing participatory diagnosis of causes of identified problems; identifying ways to actually contribute to sustainable impact on those causes ( <i>See Caldwell's Design Manual</i> )
Isolated interventions	Do holistic (HLS) diagnosis; determine what inter-related interventions are needed to have greater impact ( <i>see DME Standard #4</i> )
Cookie-cutter (even if 'best practice') interventions; often imposed by donor via RFP or RFA	Customized project design informed by contextual, holistic diagnostic assessment, whether by donor, CARE or others

Isolated projects	Situate project within broader programmatic framework and longer-range strategic plan ( <i>see DME Standard #2</i> )
Blueprint, inflexible logframes that meet donor requirements but have no meaning for project staff or participants	Flexible, learning-as-you go, evolving plans – yet plans (developed in a participatory fashion) that <i>do</i> state goals and objectives ( <i>see DME Standard #5</i> )
Focus on monitoring indicators related to activities and tangible (quantitatively measurable) outputs	Greater emphasis on gathering evidence (whether quantitative or qualitative) of progress (or lack thereof) towards important, lasting change, and using that evidence to learn how to make interventions even more effective ( <i>see DME Standard #11</i> )
Focus on meeting targets ('imposed' by donors)	Once plans and objectives are agreed to (with participants, not just donors), there <i>do</i> need to be agreed milestones of progress towards such objectives. But targets should be based on a coherent and relevant theory of change – that achievement of certain outputs will lead to desired outcomes and impact. It's the achievement of the latter that really counts. ( <i>See DME Standard #9</i> )
Evaluations only done minimally to meet compliance and accountability requirements of donors	Periodic evaluations should be seen as part of 'reflective practice', collecting 'deeper' information than that routinely collected through monitoring, and conducting 'deeper' analysis that answers <i>why</i> and <i>how</i> , not just <i>what</i> or <i>how much</i> questions. ( <i>See CI Evaluation Policy, and DME Standard #12</i> )
Policy advocacy not directly related to issues and underlying causes identified and faced by community partners	Closer tie between national and international-level advocacy and problems and causes addressed by projects and their participants (target beneficiaries)
CARE staff directly addressing power structures	Collaboration with partner institutions, especially those that empower the poor to have their own voice ( <i>See Sofia Sprechmann's Advocacy manual</i> )
CARE being perceived by others as arrogant, huge agency with lots of money doing its own thing	True, humble partnership with others (including other INGOs, national NGOs, other civil society actors) ( <i>See Partnership materials produced by Joe Stuckey and Barbara Durr</i> )
As an over reaction against <i>doing</i> instead of <i>learning, sharing knowledge</i> , we become academics	Though there is a role for special research (internal and external to CARE), knowledge acquisition, sharing and learning need to be based on and relevant to programming, including project M&E information. ( <i>See DME Standard #13</i> )
Being satisfied with the writing of 'think pieces', whether published or not	Being <i>accountable</i> for actually making tangible contributions, not only at the community level, but to organized movements (as appreciated by them), enabling them to be more effective in <i>actually</i> bringing about real (desirable) change.
Talking about 'downward and	While recognizing the need for improving 'reflective

lateral' accountability without being willing to actually be held accountable for our own outputs and outcomes, the results of our efforts	practice' we still need systems for soliciting feedback from intended beneficiaries, and evidence that our efforts are actually appreciated and making a difference ( <i>See CI Principle #3</i> )
Pointing finger at others as 'duty bearers'	Recognize that in many cases CARE <i>is</i> one of the duty bearers
Vague concept of 'marginalized' groups	Clear identification of <i>who</i> the people and communities are with whom we should work (directly or indirectly) and who's quality of life we intend to help improve / who's poverty we help to reduce ( <i>See DME Standard #3</i> )
Wishful thinking: that we'd have unlimited unrestricted funds so we could 'do our own thing'	Recognize that projects (with defined purpose, timeframe, budget and accountability) are the reality we have to deal with; that if we have a better 'programmatic' approach (e.g. to addressing RBA and UCP) then we ought to be able to convince donors to fund such programs!
We talk about impact but don't like to talk about evaluation (the new CI Strategic Plan mentions <i>impact</i> 32 times, but <i>evaluation</i> only once – within Principle #1)	We actually find and read the CI Evaluation Policy and apply it as M&E systems for programs and projects are designed and as they are evaluated.

For the DME Basics I invite CARE staff to take the time to re-read the CI Programming Framework, including the Programming Principles and the DME Standards (including the Project Standards Measurement Instrument), and to appreciate the value they still have in helping project and program staff (indeed, all of us who have any related responsibilities) to see how they can guide us to more effective programming. Beyond that, I invite CARE staff to peruse, either as reminders or for the first time, the excellent collection of policies, guidelines and cutting edge ideas contained in the Program Quality Digital Library (<http://pqdl.care.org/>).

Hopefully at least some of those documents and ideas are understandable by our field colleagues and relevant to their work. If not, perhaps it is up to us to be more practical in the advice we offer others – to be aware that by soaring too high we become irrelevant to those on the ground, the front lines of CARE's work.