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MANAGEMENT REVIEW  
for  
PROJECT CONCERN INTERNATIONAL

A Report Prepared by PRITECH Review Team:

C. STARK BIDDLE  
NICHOLAS DANFORTH  
RONALD O'CONNOR

Editorial Assistant:

LISA KRAMER

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# PCI MANAGEMENT REVIEW

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## PCI MANAGEMENT REVIEW

### I. EXECUTIVE SUMMARY

This report, by Management Sciences for Health/PRITECH, requested by AID's Bureau for Food for Peace and Voluntary Assistance, reviews the technical and managerial capabilities of Project Concern International, a PVO which has received grant support from the Bureau for its activities in primary health care (PHC) and child survival. PCI has requested AID to sharply increase its current funding level. Several new AID grants to PCI are being considered: a new Matching Grant (1986-89), a new Child Survival Grant (1986-89), and a large five year mission-funded grant in Somalia. PCI's income and program activity could more than double in the next five years. Most of this increase could occur this coming year.

The purpose of this review is to analyze and review the management and organizational structure of PCI headquarters to assess PCI's capacity to handle a rapidly expanding field program, with particular attention to be paid to the organization and management concepts and practices being used by PCI in managing its field projects. Our goals are to improve PCI's ability to respond to the needs of ongoing projects, to strengthen PCI management, and to provide a more sound basis for organizational growth.

Section II, INTRODUCTION, gives background on PCI and its support from AID, and describes organizational improvements that have occurred since 1983 under the new Executive Director. PCI now works in six developing countries (and the USA) with an average of about 20 paid employees, including one American Project Administrator, in each country overseas. All field programming is managed by two full time professionals, supplemented by part time staff. Only one full time staff member is a public health specialist.

Section III, analyzes PCI's APPROACH TO PRIMARY HEALTH CARE in unserved, impoverished areas. Wherever possible, PCI focuses on direct technical assistance to ministries of health in training PHC workers and developing PHC subsystems such as drug supply and community participation. Four independent evaluations by MSH of PCI projects in Bolivia, The Gambia, Belize, and Guatemala indicate that PCI's approach has generally been effective, fulfilling AID's strategy of building the capacity of governments to provide maternal and child health (MCH) services.

Section IV, FINANCIAL CONDITION, projects PCI's income and expenses through 1986. The proportion of support to PCI from AID is likely to increase sharply by 1987, as will some from the public. We believe that PCI will have little difficulty in matching AID funds, but PCI will need to discuss carefully the organization and management changes which these projections imply.

Section V describes the ORGANIZATION of PCI, including its Board of Directors, its membership, committees, procedures, and needs; headquarters staff organization and job descriptions; and, of particular interest in this review, headquarters support of programs overseas. We recommend decentralization of management at headquarters and improved technical support to overseas staff in specialized subsystems such as information systems to strengthen project monitoring and planning.

Section VI, MANAGEMENT SYSTEMS, considers the strengths and weaknesses of PCI's administrative procedures. We suggest ways that PCI, now under the pressures of rapid, complex organization change, can improve systems for long term institutional and policy planning, budgeting, program planning, project design, and field program staffing.

Section VII, CONCLUSIONS AND RECOMMENDATIONS TO PCI, summarizes both PCI's management strengths and the management constraints which, if not addressed, could limit PCI's effectiveness in the future. The major PCI management needs we address are for:

- decentralization and delegation, requiring increased decision-making and responsibility for mid-level managers and field project staff;
- increased primary health care (technical) expertise, through consultants or full time staff, and staff development;
- systematic long term institutional, policy, and budget planning;
- improved information systems to ensure that both health information and management information collected in field programs is useful to field staff in project planning, as well as to headquarters for public relations and fund raising;
- reorienting the focus of the Board more toward planning and fund raising, less toward operations.

Section VIII, RECOMMENDATIONS TO AID, supports PCI's request for a third Matching Grant, and suggests an increase in the size of the Grant contingent on PCI progress in implementing managerial and technical improvements.

## II. INTRODUCTION

### A. Purpose

Project Concern International Inc. (PCI) has requested a third Matching Grant and will request a second Child Survival Grant from FVA/PVC. The combination of these grants has put PCI at a substantially higher level of funding this year than in previous years. Furthermore, several recent field trips by AID staff and independent evaluators have raised questions about the technical and financial supervision and support provided to field projects by PCI headquarters. It was therefore decided that an independent study should be conducted to review and analyze the PCI headquarter's operation and its organizational and managerial capacity to handle an expanded program portfolio.

PCI is the sole PVO receiving Matching Grants from AID which concentrates exclusively on the development of primary health care services (PHC). As such PCI bears a special responsibility -- to demonstrate, document, and disseminate information about the effectiveness and impact of PHC in different countries. To fulfill that responsibility, PCI must stay on the "cutting edge" of PHC, sharing with the international health community the lessons it has learned from PHC innovation and experience.

Since 1979, AID has provided small but significant amounts of support to Project Concern through two Matching Grants. Although PCI's current Matching Grant is among the smallest (except one) of twelve PVO health sector grants, PCI's performance is of particular interest to AID because a) its health strategies in PHC are at the forefront of AID's own health sector strategies; b) PCI's funding base is small, so AID funding is critical for developing new programs and for strengthening existing ones; and c) PCI is now the most thoroughly evaluated health sector PVO with AID Matching and Child Survival Grants. (Other recent evaluations included Bolivia in 1984, Gambia in 1985, Belize and Guatemala in 1986, as well as two field assessments by a PVC staffer in Mexico in 1984, and Belize in 1985). Thus it offers important lessons about AID's PVO programs support in health and nutrition.

### B. Review Team

The management review team from Management Sciences for Health (MSH) included Ron O'Connor, MD, MPH, President of MSH; C. Stark Biddle, MBA, MSH Consultant in PVO Management and finance, and Nick Danforth, MIA, EdM, Manager of the MSH PVO Evaluation Project, who has led MSH evaluations of PCI projects in Belize, The Gambia, and Guatemala. (Their qualifications for this study are included in Appendix A.)

## C. Methodology

The review team worked at San Diego headquarters of PCI for ten days in January and February 1986, interviewing in private all senior executive staff and all HSD staff, reviewing PCI documents (see Bibliography, Appendix B) and visiting the PCI project in Tijuana, Mexico. Several current and former field project administrators were also contacted by the review team in conjunction with this study.

## D. Background

### 1. AID Support

To date, AID has provided PCI with \$2.2 million in two Matching Grants for the period 1979 to 1985 for programs in Mexico, Gambia, Guatemala, Bolivia and Belize. In addition, PCI recently received a three year \$1,025,000 Child Survival Grant. PCI also receives funds through USAID's country programs and anticipates the award of a substantial grant to implement a PHC training and development program in Somalia. PCI has now requested a third Matching Grant in order to continue activities in Bolivia, Guatemala, and Belize and start new programs in Papua New Guinea and the Solomon Islands. Excluding Somalia funding, the two centrally funded grants would increase the annual funding level substantially from \$425,000 in 1985 to over \$600,000 in 1986, and will increase even more with a second Child Survival Grant.

### 2. Profile of Operations

PCI currently operates in six developing countries and in three U.S. locations, managing a total of eight PHC projects. As of November 1985 field staff consisted of 135 persons with 17 stateside and 128 in the field. The San Diego headquarters consists of 35 persons organized in four basic divisions; Administration and Personnel; Finance; Resource Development and Public Information; and Health Services and Development (HSD). The latter is the programmatic center of PCI and handles program design, implementation, monitoring, and all aspects of field relations. Programmatic communication with field missions flow through the HSD unit which is composed of five professional (some part time) and three support staff. In addition to PHC training, PCI manages a placement service for volunteer medical practitioners interested in serving in underprivileged areas. In 1985, 180 volunteers were placed representing a total commitment period of 87 person years.

Appendix C provides a profile of PCI activities for 1985.

### 3. Recent Developments

To understand PCI's current organizational structure and management approach, it is important to appreciate the recent financial difficulties PCI has faced. By 1982, a serious financial crisis was evidenced by steady deterioration in the income derived from the Walks for Mankind, which had dropped from \$2.1 million in 1976 to \$1.1 million in 1982. At one point "Walks" constituted 70% of PCI's income; it is currently roughly 30%. A new Executive Director, Henry Sjaardema, was hired in 1982 with a mandate to restore financial health to the organization through stringent budget controls and identification of new sources of income. Expenditures regarded as discretionary, such as staff and Executive Director field travel, staff conferences and chapter development, were cut sharply in order to protect ongoing core programs. Staff salaries were frozen and some vacant positions were not refilled (Regional Directors were reduced in number from three to two). Although program levels rose 36% from 1981 to 1984, fund raising expenses dropped 26%. The cost of management remained unchanged, while dropping as a percent of total expenses.

In addition to cutting costs, the new Executive Director negotiated a second Matching Grant with AID and secured additional AID funding through country program budgets (e.g., Indonesia and Somalia). Other sources of private sector income (e.g., an IBM grant) were also increased and strengthened. PCI obtained a \$100,000 IBM grant, and of particular significance, another AID contract was obtained to conduct a feasibility study on the development of a PHC program in nomadic areas in Somalia. The study also focused on methods of integrating health and nutrition projects with productivity and income generating activities, and identified new ways of using Title II, which has led to the major project opportunity in Somalia. The Somalia contract's overhead payments will allow PCI to further strengthen its headquarters operations, and may be the harbinger of an altered PCI/AID relation if PCI decides to deliberately gear up to bid on AID contracts.

In addition to dealing with a serious financial crisis, the new Executive Director brought with him a significantly different style of management and a different set of management priorities, including:

- more discipline and control over program staff, particularly Regional Directors who had operated with minimal oversight and relative independence;
- tighter centralized control over budgetary matters;

- a preference for one-on-one communication and exchange rather than staff meetings, once called weekly by the Executive Director, which now appear to be infrequent and ad hoc;
- strong administrative systems designed to ensure effective control of operations;
- a more rigorous emphasis on work output and staff performance; and
- an increased emphasis on seasoned field professionals with general managerial and administrative skills in multi-sectoral development programs, many of them former staff members of CARE.

This altered approach has, quite understandably, created moderate tensions among the staff and may have occasioned the departures of some who were more comfortable with the previous system of management. In the review team's view, the particular management approach and style employed during the difficult period of the financial crisis was appropriate and successful, although they are not as appropriate now that the organization is larger and more complex. The challenge for PCI now is to decentralize, to delegate decision-making responsibilities to new staff and redefine the roles of existing staff.

### III. PCI'S APPROACH TO PRIMARY HEALTH CARE (PHC)

#### A. PCI Policy

PCI's policies, goals, and objectives in international health are the result of nearly 20 years experience in many countries. Initially concerned with improving hospital and clinic based systems, PCI soon saw the advantages of community-based primary care and the importance of strengthening the capacity of Third World governments to deliver primary care themselves, without continued dependence on bilateral or PVO assistance. The result in the last decade has been a series of pilot projects, in Latin America, Africa, and Asia in which PCI field staff work within the host country's ministry of health (MOH) to train counterparts in methods for creating, testing and replicating PHC. Unlike many foreign aid programs which claim to create self-reliance, PCI's programs come closer to leaving behind a PHC structure which can maintain itself financially (through government and community financing), administratively (with the supervision and support of trained staff), and technically (using appropriate, low cost, health interventions).

PCI's current policy pronouncements have increasingly stressed the importance of developing linkages with other sectors of development activity as proper and essential elements in PHC development. It is recognized that this involves a complex series of continuing tasks. It also involves not only traditional and modern health workers, community leaders, and government bureaucrats, but also credit unions, farmers, shopkeepers, school teachers, and potentially hundreds of other types of participants, all carefully coordinated, motivated, and funded. No one should expect a relatively small PVO with a limited funding base to be able to implement such complex, costly, multi-sectoral, long-term programs all at once. PCI does not attempt to build such complex programs overnight, but rather attempts to phase in appropriate interventions over time. This represents a realistic compromise between the ideal and the practicable, replicable, model appropriate for each local area. PCI is seeking that balance, and to date has done well given its obvious constraints.

#### B. PCI Compatibility with AID Health Strategies

PCI policies and programs to increase host country self-sufficiency in PHC, although they have evolved independently, closely match AID policies and strategies in the health sector. AID's primary goal is to "strengthen developing countries' capacity"; to improve health services by "collaboration with developing countries to improve primary health care programs"; and by strengthening the "human resources and institutional capability to plan, staff, and manage the delivery of at least the basic package of health services." (AID, Health Sector Strategy, Washington, D.C. 1983.)

#### C. PCI Program Results

Recent internal and external evaluations of PCI programs in widely different countries have generally revealed the quality of PCI's approach and the competence of its field staff. Independent evaluations in Bolivia (1984) and Gambia (1986) in particular have documented Project Concern's many strengths in designing, implementing and institutionalizing good PHC training programs, but also indicate areas where PCI management of field programs can be improved. The Bolivia and Gambia evaluations also indicate that sustained, long-term commitment is required from PCI and its donors to test and develop nationwide primary care systems. USAID missions as well as PVOs should be aware that one or two three-year Matching Grants will not be sufficient to fully establish the PHC systems and subsystems which are urgently needed throughout the Third World.

PCI's major contributions to the improvement of basic health services in underserved rural areas are evident:

- PCI's approach to developing a low cost, self-financing health care system for the national government to replicate in other unserved areas has proven to be a viable approach and would appear to be adaptable to other settings;
- PCI's primary focus on PHC training is sound, and the health workers trained in PCI-supported training programs are not only increasing the availability of health services in rural areas but are also likely to be effective in improving health standards (although we and PCI were not able to document the latter);
- PCI's direct involvement in the government bureaucracy, while it may delay some project achievements, maximizes the possibility that the systems established and the results achieved by those systems will be replicable and sustainable;
- Field staff members, when backed up by a well-organized administrative support system in San Diego, appear to have been competent and effective, and have trained host country counterparts who have now been able to take over administration of the project's training aspects;
- Unlike many other PVO projects in health and nutrition, PCI's strategy in PHC training and development was designed to build local control and responsibility, and not create dependence on foreign funds or technical assistance. When the AID Matching Grant ended in The Gambia, for example, PCI was able to close down its project completely, having achieved nearly all of its major training objectives, leaving behind an affordable system for PHC training which The Gambian government had not merely accepted, but thoroughly adopted as its own, and was committed to sustaining and strengthening.

#### D. Gambia and Bolivia Examples

Unfortunately PCI's Gambia project also demonstrates a common weakness often shared by other PVO primary care programs: PCI was not able to take the next steps which are clearly necessary to ensure (a) that PHC is more fully developed and sustainable, and (b) that its effectiveness and impact have been measured and documented. This lack of completion was as much the fault of AID as it was of PCI, and both can learn lessons from it.

Those next steps, most of them planned to occur between 1983 and 1986, involved such subsystems as strengthening the Community Health Nurse (CHN) supervision system; health management training; improving the health information and evaluation system; refining MCH activities such as targeted growth monitoring and followup of at-risk infants; integration of PHC with secondary care, MCH, nutrition, EPI, and other health and non-health programs; village financing; village health committee (VHC) enhancement; drug management; and more.

In The Gambia, PCI also lacked sufficient resources to complete its program as planned. For reasons largely unrelated to PCI's performance, the USAID Mission terminated the program prematurely; thus PCI was unable to complete the work which it had agreed to do in its original Matching Grant Agreement. Nevertheless, the MSH evaluation team believes that despite the constraints of time and funding imposed by USAID's early termination, PCI should have been able to make a better start than it did at developing new or strengthening existing PHC subsystems which are essential for long term sustainability.

For example, issues of drug use (appropriate packaging, dispersion of adequate quantities to treat the problem, labeling for informed patient consumption) as well as resupply and pricing for increased self-reliance do not seem to have been addressed by technical oversight. Unfortunately, no baseline or benchmark surveys to measure the effect or impact of training on MCH were ever completed. Improved systems for supervision of community health workers (CHWs) by CHNs, involving clearer job descriptions or simple checklists for inspection visits, might have been (and should still be) tested. New approaches to village health information systems to the enhancement of village development committees (VDCs), or to financing health activities through drug sales could have been tested on a limited scale. Small random samples of "sentinel" villages could have been used to test and/or measure any number of PHC subsystems innovations.

PCI's inability to complete such tasks seems to relate not only to severely limited funds, but to the limited professional/technical guidance from its headquarters in San Diego. There seems little doubt that given adequate financial and staff support by AID, PCI's program in The Gambia, already exceeding its initial PHC training objectives, would have moved even closer to creating and documenting the model nationwide PHC system which Gambia -- and much of Africa -- urgently needs. At the same time, lack of progress in some of these health subsystems stemmed from the slowness of the MOH in supporting PCI initiatives.

The Gambia evaluation found, in short, that PCI/Gambia is one of the better examples of PVO/host government collaboration in PHC that has been evaluated by MSH to date. But it also illustrates that a PVO program with 50% AID central funding can be subject to policy changes within an USAID mission. And it indicates that a PVO without a large funding base (such as that provided by a church or by child sponsorships) may have difficulty finding the money and the manpower to develop and monitor sophisticated PHC systems which can explore beyond standard, tested approaches.

In the case of PCI's Bolivia program, the independent evaluators considered it a success "due in large part to the technical and administrative capabilities of the PCI staff" in the field. However, the evaluators also found that "local capabilities could be strengthened through periodic technical assistance." In addition, field staff perceived communications with headquarters in San Diego to be inadequate. PCI has sought to correct such deficiencies, partly as a result of its responsiveness to the evaluation, but it still does not have sufficient resources to provide its Bolivia program with all the technical assistance it needs.

#### E. Training Effectiveness

Training is a major PCI focus; however, to our knowledge insufficient systematic attention has been paid to assessing training impact on the knowledge and practices of VHWs after training to determine whether information is absorbed and retained. In The Gambia, Bolivia, and Mexico, PCI reports that their curricula and training materials have been revised regularly, but, as in any rapidly expanding program, PCI finds it difficult to constantly upgrade training materials and techniques. The materials are quite exhaustive and it is highly likely that many unnecessary items are taught for actual VHW practice, and that important lessons are lost in the mass of information.

Methods for measuring competency-based performance are not used regularly by PCI in all field programs although they are now accepted as standard practice in most training programs. Such methods require carefully defined competencies for each task, minimum performance standards for each worker, and a monitoring system to follow the performance of groups of workers. Not all PCI field staff use such techniques. Currently there is no health training consultant assisting the PCI headquarters staff (although there was such a consultant before 1982), even though PCI's major focus is on effective PHC training.

PCI's basic interest in PHC systems, in other words, is very sound, but PCI will have to do more to develop the supporting subsystems which PHC increasingly required for sustained operation and impact.

#### IV. FINANCIAL CONDITION

##### A. Overview

This section provides an overview of PCI's income base and an assessment of PCI's capacity to sustain and/or increase income in future years. Appendices C and D provide income and expense data for PCI for the 1984 to 1986 budget period and is self-explanatory. Appendix E is a rough, five-year income projection based on data supplied by PCI and extrapolations by the review team. The data in this table are tentative and should be used cautiously.

With regard to the composition and level of current and future PCI income, the Walk for Mankind Program currently continues to provide the largest single source of cash income for PCI (31% or \$950,000 in 1984). However, the overall importance of this program has been dropping sharply over the years as other sources of income increase. Income from "Walks" has dropped in absolute terms from more than \$2 million in 1976 to its current level of \$925,000. Management of the Walk Program has recently been transferred to San Diego and PCI believes that income from this source can be gradually and modestly increased by opening new walk routes in new cities. However, in view of the increased popularity of this type of promotional device by other non-profits, it is unlikely that the Walk Program can regain the stature it once had. Although the program is expensive to administer (roughly 35% of incremental "Walk" income is expended in direct costs), it is a critical source of discretionary income cash and provides potential access to an audience who may contribute through direct mail appeals and through organizations who may adopt Project Concerns' programs.

Direct mail appeals provided 9% of cash income in 1984, or \$295,000. The success of direct mail campaigns relies heavily on the quality of the "house list" and its continual update. Although beyond the scope of this study, PCI's direct mail campaign (with heavy reliance on senior volunteers) appeared to be professionally and expertly managed. The Executive Director, in particular, is very knowledgeable in this area. Income from direct mail is projected to remain stable in relative terms during the next five years.

PCI has been more successful than many other PVOs in the use of television, and radio fund raising. Income from media promotion is projected to increase from 5% of public contributions in 1985 to 12% by 1990. PCI receives a relatively small share of cash income (6% in 1985) from private US foundations and US corporations (although in-kind contributions are more significant). PCI currently receives funds from an affiliate organization in

Canada and is considering establishing an office in Ottawa. Because of the generous matching policies of the provincial and federal Canadian governments, this may prove a lucrative source of future income.

The relative and absolute magnitude of income from AID appears likely to increase sharply in 1986, reflecting the cumulative effect of the very large Somalia project, possible continued funding from a third Matching Grant, and a request for funding from a second Child Survival Grant. As indicated in Appendix E the proportion of support from all AID sources will increase from 24% of total cash income in 1985 to a low of 37% or a high of 46% in 1986.

#### B. Comment

While the projections in Appendix E are based on a number of assumptions which may prove incorrect, they do suggest that PCI is about to experience a sharp increase in the size of its program and a change in the mix of income. Based on these figures, PCI's income and program will more than double in the next five years with most of the increase occurring in 1986. It appears that the growth will be fueled largely by increased AID support (66% of the total increase) and a modest increase in public contributions (24% of the total increase). In other words, if the new FY '86 Child Survival request and the Somalia grant came through, AID support will grow from 24% of PCI's cash income in 1985 to 47% in 1987, declining thereafter in these projections as public contributions gradually increase.

With the possible exception of higher levels of corporate and foundation funding and increased support from a Canadian subsidiary, the review team feels that the PCI private sector income projections are realistic and reasonable. This conclusion was also reached by a professional fund raising consultant recently hired by PCI to review long range income forecasts. His observations are germane:

" . . . it is clear that PCI's program philosophy and the rigor and skill with which that philosophy is implemented make it highly attractive to a vital but narrow public with experience and sophistication in Third World development problems, (including) officials with AID, potentially CIDA, the staffs and leadership of other overseas PVOs and the academic community concerned with such problems. . . . The very reasons which make PCI's program attractive to AID tend to put it at a disadvantage in competing with other agencies for support from the general public. Training public health workers and community leaders. . . lacks the concreteness of building a tractor or the drama of an earthquake or famine."

It is not clear whether the modest level of corporate and foundation support reflects inattention on PCI's part or simply a reflection of the former's interest in PCI programs. Because of limited opportunities to increase other forms of private sector funding, it will be important for PCI at least to fully test corporate and foundation responsiveness to the PCI appeal. In this regard, it may be necessary for the Executive Director to allocate an increasing share of his time in this endeavor. In addition, Section V suggests that the PCI board consider the addition of members with senior contacts in the corporate community. (A volunteer IBM executive will shortly be seconded to PCI to work on the strengthening of corporate relations.) While the opportunity to dramatically increase private sector support is limited, PCI should have no current or future difficulty in matching AID funds at any of the alternative levels currently under consideration.

The quite dramatic approaching increase in the size of the PCI program as well as the shift in the composition of support will place a premium on careful financial, program and work force planning. In this respect it is clear that PCI will need to fully and systematically think through the implications of these changes. (The long range projections in Appendix E were prepared by the review team, not by PCI staff). For example, the Somalia project, which involves essentially a contractual relationship and a new way of doing business for PCI, would, if it materializes, be larger than the rest of the current PCI portfolio with important staffing, organizational, operational and budgetary implications. With regard to the trade-offs involved in increased reliance on government funding, an issue often discussed by the PCI Boards, the review team holds no particular views but believes that the implications of this shift should continue to be fully debated.

## V. ORGANIZATION

### A. Board of Directors

Project Concern is governed by a board which currently consists of up to 30 members, including the Executive Director. The full board normally meets twice a year, with the annual meeting scheduled in November. In addition, the Executive Committee meets twice a year. The board has established four committees, as follows:

- Executive Committee;
- Operations Committee, with responsibility for program oversight and program planning;

- Resource Development Committee, with responsibility for fund raising and income planning; and
- Corporate Committee, with responsibility for finance and budget.

In addition, the by-laws of the corporation establish an Advisory Council composed of former board members and a Committee of International Honorary Trustees composed of leading figures in development and PHC. These groups do not meet and are not active in governing the organization.

The Chairman of the Board serves for two years. The position is traditionally assumed by the individual who served as Vice Chairman the previous year. PCI's current board is composed of individuals from a professional and geographic cross section of the country including General Business (26%); Medicine (16%); Media and Entertainment (10%); Law (10%); Students (6%); PVO Officials (6%); and Other (26%).

Better than a third of the current board of directors have become involved with PCI through the Walk Program and have participated in the management of this fund raising activity. Aside from their work with PCI, only two board members have worked in the field of public health; and only one (excluding the Executive Director) has had overseas development experience. Although the board is relatively business oriented, only one board member (the current Chairman) is employed by a major U.S. corporation.

Through its committee structure, the board appears to be actively involved in policy and operational oversight. For example, it recently initiated a long range planning effort that includes the identification of program objectives, preparation of five-year income projections, and the fashioning of a fund raising strategy. In this context, the board asked PCI staff at the annual November meeting to develop and consider the implications of expanded and significantly more ambitious income targets than had previously been proposed.

While a detailed and comprehensive analysis of board operations is beyond the scope of this study, on the basis of staff comments and brief discussions with roughly ten board members, by and large the board appears to be highly motivated and dedicated to the goals of the organization. Members appear to be well informed and they give generously of their time and expertise. As an example, the board has taken a clear position that PCI should expand rapidly and has asked the Executive Director to upwardly revise income projections they felt were too cautious. On the one hand this positive and ambitious approach is admirable and attractive. At the same time, however it will be important for

the board to be practical and realistic with regard to what is "do-able," and to be sensitive to the pressures that they are placing on the Executive Director and fund raising staff. One member accurately remarked that it was "a citizen's board" representing a talented and committed cross section of "middle America." At the same time there appears to be under-representation in three important areas:

- high level access to prospective corporate supporters, particularly large U.S. multinationals;
- representation of international public health professionals, particularly those with first hand experience in the theory and practice of PHC in developing countries; and
- representation of development professionals with first hand overseas experience.

The board committee structure appears to be well designed and functions effectively. Roles and responsibilities are clear and straightforward. The PCI Board appears to be more involved in what is traditionally understood to be "operations" and hands on oversight than is normally the case with most nonprofit organizations. To some degree, this may reflect the fact that in the past the organization experienced severe financial difficulties, the change in leadership four years ago, and the difficult budgetary belt tightening previously described. This may have drawn more focus into the details of financial oversight and executive direction than had previously been the case. In addition, the practice of encouraging long tenure on the board, and of frequently choosing members from citizens who have volunteered their time and organizing talent to manage the Walk Programs, appears to have encouraged a strong sense of "ownership" and involvement unique to PCI.

PCI also has an International Health Advisory Committee (IHAC) but it is not active as a committee (although one member, Dr. Al Neuman of UCLA, has evaluated four PCI programs and has represented PCI in program development). IHAC should be considered as a resource for Board membership.

Board relations with the current Executive Director appear to be open and direct. The Executive Director is skillful and professional in his interactions with the board and there is every indication that he has their confidence and broad support. However, because of a tradition of close operational oversight, coupled with a lingering sense of distrust associated with what appears to have been a difficult period in the early 80's and the previous Executive Director, the nature of board interaction appears to be modestly confrontational, sometimes accusatorial.

Considerable staff time is spent preparing detailed quarterly and annual reports for board meetings.

## B. Headquarters Organization

### 1. Description

Appendices F, G and H are organizational charts for PCI headquarters in San Diego. Appendix F shows the relationship between the Executive Director and senior staff office heads; Appendix G provides a more detailed picture of reporting relationships within and between the HSD units; and Appendix H defines PCI's management structure. By and large, these organizational charts appear to be reasonably accurate and self explanatory. The following comments relate to points of clarification or issues that arose in the course of this evaluation: (a) Senior staff report directly to the Executive Director who does not have a Deputy or special assistant. In practice, some of the functions performed by the Director of Program Planning and Evaluation and the Director of Operations are of broad institutional significance and appear analogous to responsibilities that might be housed in the Office of the Executive Director in a larger organization.

(b) The Health Services and Development Department (HSD) is the programmatic center of Project Concern and handles program design, implementation, monitoring, evaluation, budgeting, and all field contracts. This Division is comprised of two clusters and one individual. All three report independently to the Executive Director, although the Director of Operations will tend to take the lead on operational and administrative matters while the Director of Program Planning and Evaluation will take the lead on program planning and design issues.

(c) The Medical Services Director, has a background in public health and conducts a private medical practice in San Diego. He serves as a volunteer at PCI two days a week. According to him, the position primarily involves establishment of medical "credibility" and certification regarding the receipt and handling of pharmaceuticals. He has participated in some field program visits and evaluations to strengthen training and performance of CHWs and to improve institutionalization of PHC. It is not the current function of the Medical Services Director to provide substantive technical backstopping to field missions in the area of PHC methodology or delivery. In fact, neither the Medical Director nor other HSD staff has had long-term overseas experience in the area of PCI's major technical focus: training and managing CHWs.

The Executive Director, Director of Program Planning and Evaluation, and other PCI staff have had considerable overseas

experience in design and implementation of various community-based programs in health, nutrition, agriculture, and rural development. However, under the current PCI management approach, specialized public health planning experience is appropriate in the field, not at headquarters. (Before 1980, in contrast, PCI employed a health worker training specialist at headquarters to provide training support to field missions and to develop training materials.)

(d) The Director of Operations position was created in early 1984 with the objective of establishing and/or upgrading administrative systems and procedures within HSD in order to improve communications with the field and the quality of support to the field missions. In addition, the Director of Operations is responsible for the design and smooth functioning of the field budget system; and, for cash forecasting and orderly cash disbursements to field missions.

(e) The position of Program Planning and Evaluation includes program planning, evaluation, project design, proposal preparation (including the proposals to AID); and, certain aspects of institutional planning and supervision of currently two program directors. This position is currently filled on a half time basis.

(f) The Deputy Director of Program Planning serves as the Director in the absence of the latter. Under the current arrangement, the Deputy also acts as Regional Director for Latin America. (This position has been vacant as of February, 1986.)

(g) Regional Program Directors (normally two) provide the principal link between headquarters and the field and are responsible for monitoring, correspondence, technical guidance and backstopping, new program development, proposal writing, evaluation, field budget preparation and planning. Qualifications for these positions include an advanced degree in public health and experience in community health in developing nations. Currently there is one Regional Director for Latin America (Bolivia, Guatemala, Belize, Mexico); the other is in charge of all other projects in Africa, Asia, the Pacific, and the USA.

(h) The AMDOC/Option Program is separately administered by the Director of Administration with the help of a full time assistant; and has little relationship to HSD programs in PHC.

## 2. Comments and Impressions

The following comments derive largely from staff interviews and a review of internal PCI documents.

(a) PCI is a small organization and formal organization charts can create the misleading impression that reporting lines and functions are rigid and tightly drawn. As in any small non-profit, there is considerable interaction, job sharing and "pinch hitting." This is healthy and desirable and adds to the effectiveness of the organization. At the same time it makes it difficult to draw an accurate "map" of responsibilities and relationships.

(b) PCI's basic organizational structure in four departments (finance, administration, fund raising and programming) is simple and straightforward and appears to be organizationally sound. With minor exceptions noted below, there is generally a clear delineation of functions and reporting relationships between departments. Occasional confusion and lack of clarity appears to result more from management "style" than to imperfectly drawn organizational relationships.

(c) As is frequently true in a small but growing organization, the Executive Director is quite heavily involved in operations and in decision making at a fairly detailed level. However, excessive centralization can and has hurt staff morale and has led to a pervasive feeling that staff lack the authority to take initiative. In summary, while we conclude that the current extent of executive involvement in the domains of policy making and financial control is warranted in view of PCI's recent financial troubles, we do not believe that the Executive Director needs to remain deeply involved in other, more operational areas. For PCI to grow and mature, it is necessary to increasingly decentralize operational authority.

(d) At the same time, as PCI grows, there will be a significant expansion in the importance and complexity of "leadership" issues (policy setting, board relations, staffing strategy) and cross cutting institutional concerns (planning, fund raising) that confront the Executive Director. In particular, if private sector support is to remain even roughly in pace with the growth of public (AID) support, the Executive Director will have to allocate an increasing share of his time to fund raising. This not only reinforces the critical importance of real delegation of authority for internal operations, but suggests that PCI should consider the possibility of adding a Deputy Director or special assistant to shoulder some of the Executive Director's very substantial responsibilities.

(e) The current HSD organizational structure raises several questions, particularly in the context of the quite significant program growth projected for the next few years:

- As mentioned, while HSD staff individually report to the Director of Program Planning and Evaluation, in his absence they deal with the Executive Director who must distribute his time among three other senior staff members, rather than dealing through a full time department head who has sufficient time to devote to program substance and supervision. The current approach gives the Executive Director direct access to program and field problems and insures tight financial oversight and budgetary control. The price is high, however; some HSD staff feel frustrated when their arena for decision making is overshadowed, and some good staff have looked elsewhere for satisfying work. In addition, the various functions of HSD (e.g., technical, operations, planning, evaluation, field relations) are becoming increasingly complex, varied, specialized, and difficult for a small staff. HSD operations could be better coordinated and integrated if they were consolidated under a full time department head.
- As an illustration, the delineation of responsibilities between the Executive Director, the Director of Operations (a very able professional administrator), and the Regional Directors is not always particularly clear with respect to field communications and responsibility for budgetary oversight and control. At the current level of operations this is a relatively minor problem yet one that could become more acute with significant program expansion.
- Similarly, there may be critical programmatic benefits to tightening the integration of the functions performed by the Medical Services Director with other programmatic and field functions within HSD.
- Two key positions, the Director of Medical Services and the Director of Planning and Evaluation, are currently filled on a part time basis. With expansion in the size and complexity of the PCI program, the level of responsibility associated with these functions will increase and full time staffing may be necessary.

#### C. Overseas Program Support

Overseas PCI is currently operating Matching Grant programs in three developing countries (Belize, Guatemala, and Bolivia), and Child Survival grant programs in Bolivia and Indonesia. In addition, PCI oversees a program in Hong Kong which has become financially and administratively independent and requires minimum

attention. In total, PCI oversees 15 separate projects in eight countries and three in the USA.

Communications with the field occur through a variety of formal and informal channels including: personal correspondence and telexes; field visits; preparation of four routine monthly reports (statistical report of program information, status of program activities, financial report, and local input report); interaction during the budgetary process; preparation of routine administrative forms and authorizations (e.g. travel, purchase requisitions); and a periodic newsletter from headquarters. By and large, communications are coordinated through the Regional Directors, although the Director of Operations administers the budgetary system, establishes and monitors field headquarters administrative systems, oversees the distribution and followup of all field communications; and provides support on personnel, logistics, and procurement matters.

In 1985 PCI budgeted funds for an agency wide conference in San Diego that would have included the participation of all PCI field directors. However, due to budget constraints, the conference was cancelled and rescheduled for the fall of 1986. According to the Executive Director, future annual conferences are planned.

#### 1. Technical Support by Headquarters

Many PCI field staff, nearly all of whom are specialized to some degree in public health, have been appreciative of the skilled administrative support which they have increasingly received from San Diego. Field staff interviewed in person or by phone by members of the review team report prompt responses to their requests and have no complaints about headquarter's operational backstopping. They sense recent improvements in administrative communications.

A few field staff do complain, however, about what they perceive to be a lack of substantive technical skills and support at headquarters in public health planning, management, training and information systems. Members of the review team, based on conversations with PCI headquarters and field staff, on their own experiences in Tijuana and The Gambia, and on their reading of field program evaluations and headquarters files, generally agree that headquarters staff lack sufficient hands-on experience in actual management, monitoring, and evaluation of primary or community health programs as opposed to general community-level development expertise in which PCI has strong experience.

While some of the field staff's need for more public health expertise undoubtedly results from the inexperience of the field staff themselves, PCI's executive staff would like to have

additional resources to hire public health specialists in such fields as health information, PHC training, PHC financing, or drug management. Thus headquarters is not able to provide more than minimal support in such areas. Nor can PCI afford to hire specialist consultants to help strengthen its subsystems at its current resource levels.

The result is that when even the most experienced and specialized field staff members need technical assistance in a particular area, an inevitable occurrence in any multidisciplinary development effort like PHC, PCI usually will not or cannot provide it. It appears to the review team that PCI's PHC technical assistance limitations have resulted both from a lack of resources and the higher priority given to strengthening the management capabilities of staff. In PCI's view it was necessary to achieve progress in these management areas prior to specialization. However, this has resulted in a paucity of specialized PHC subsystems assistance to field programs which has affected field staff selection, attitudes, performances, and reports. For example:

- in the past PCI has had to hire relatively junior, near entry-level field program administrators partly because they were willing to work for low salaries and did not expect a long term commitment from PCI; although this has begun to change, with more experienced, more specialized, and better paid field staff being hired, PCI field programs have previously lacked specialized subsystems which might have been developed by more senior field staff;
- field staff job descriptions are lacking in details about the PHC planning, management, training, and evaluation tasks which should be performed in all programs;
- field staff are not given much if any technical briefing before or after going to the field; it is implied at headquarters that they should already know all they need to know to have been hired;
- little direct technical or PHC-oriented feedback is provided to the field from headquarters either in response to the monthly field reports or during field visits by headquarters staff;
- headquarters visits to the field are far less frequent, briefer, and less concerned with substantive technical matters than is normal among other PVOs and bilateral contractors (one exception is the former Latin American Regional Director who visited his four programs from two to four times annually for three years);

- since 1982, very few newsletters sharing PHC information, findings, and questions among field staff have been produced (from 1979-1980 they appeared several times a year); and
- poor documentation exists at headquarters regarding each field program's history, lessons learned, effectiveness, and impact, a fact which PCI staff have themselves pointed out as a deficiency.

## 2. Information Systems

PCI's deficiencies in technical matters are perhaps most evident in the headquarter's incomplete analysis, feedback, and use of both health information and management information from the field. Once again, this weakness is shared by other PVOs; but because PCI is the only PVO supported by AID which works exclusively in PHC, it bears a unique and visible responsibility for monitoring and quantifying the effectiveness of its field work. This special responsibility was fully appreciated by the Executive Director, who wrote, soon after he joined PCI in 1982, "We're going to be in the process of measuring the real results of our field programs. Our purpose is to permit PCI to realize its promise and potential as one of the most important organizations in the grass roots health field." He wanted field staff to "begin thinking of quantitative measurements of process outcomes to better evaluate accomplishments." (Field notes, 8/82.)

Despite careful monthly reporting of several indicators of activities and costs by every field program, analysis and feedback of those indicators to ensure that they are useful in programming is not occurring. For example, interesting data comparing training outputs and costs was tabulated in November, 1985, but is not yet utilized by headquarters or field staff in any practical way. The measurements and evaluations the new Executive Director sought in 1982 are still not effective tools in 1986.

## VI. MANAGEMENT SYSTEMS

### A. Institutional Planning

In May 1984, the Board of Directors asked PCI to initiate a two-part, long-term planning process involving the establishment of planning goals for program operations and the development of five-year income projections. Consolidation of these two components was to be the responsibility of the Board's Operations Committee.

In response, PCI staff identified six long range goals:

- (1) negotiating a Basic Agreement or Memoranda of Understanding with all host countries where PCI is operating;
- (2) increasing the flow of resources to PCI and diversifying relations with prospective funders, including AID, other PVOs, etc.;
- (3) adopting and fully implementing a multi-sectoral approach to PHC;
- (4) increasing administrative and management capability in field programs;
- (5) enhancing headquarters support systems; and
- (6) fully implementing the PCI monitoring and evaluation system.

In identifying these goals, PCI made clear to the board their conviction that this type of long range planning, ". . . where rigid goals and targets are set, should be avoided; for this sort of planning soon takes on the character of the plan being the thing rather than being a tool for implementation. . . . long range goals should set general directions . . . the plan is far less important than evaluation and monitoring."

In a recent study of the management problems facing PVOs, inattention to careful planning at the project, program and institution level was cited most frequently. In this context, PCI's approach and performance to date are better than most and the following critical observations should be viewed in that light. The current PCI plan appears to be a list of general and laudable goals, rather than a clear statement of the institution's direction in terms of size, program composition and program strategies.

PCI's understandable caution with regard to the establishment of "rigid goals" appears to have led to the extreme opposite of identifying intangible goals and policies.

It has not yet established a system or process that would focus the talents, energies and time of the senior staff and board on the strategic, institutional issues that will evolve as the organization matures. For example:

- the appropriate rate of program expansion given current staff constraints, i.e., the institutional capacity to absorb new programs;

- the implications of different degrees and types of dependence on federal financing;
- technical backstopping requirements at alternative program levels and mixes; and
- systematic identification of growth opportunities by country, region and type of service provided.

This is not to suggest that the PCI staff, Executive Director and board are unaware of these issues or that PCI's current program focus is at fault. However, as PCI grows and the program becomes more complex, it will be critically important for the organization to weigh the implications of alternative strategies. The board initiated and is heavily involved in the current long-range planning process. However, if long-range planning is to become an integral component of PCI operations, it will be important that it become an increasingly regular staff activity. The role of the board is clearly to review overall plans and policies, suggest alternatives and help identify priorities. The preparation of the plan itself should be left to the Executive Director and staff, with the Executive Director responsible for broad policies, leaving specific planning of regional and technical strategies, such as country-by-country implementation plans, to the regional, technical and field staffs.

Planning and budgeting should be tightly integrated. On the income side, PCI has prepared long range projections based on prior experience which appear sensible and achievable. Preliminary and very rough but achievable expenditure projections have been developed for some programs. These need to be built up from field estimates, and then refined, consolidated and reviewed in the context of feasible income estimates. It will be particularly important to examine the rate and composition of growth and the balance of managerial vs technical staff needs for the next three years in view of the very large potential increase in AID resources. There is little evidence that PCI has as yet attempted to systematically think through and develop work force projections based on the anticipated increase in program level.

## B. Budgeting

As noted in Section II.D., in 1982 PCI experienced severe financial pressures and was forced to cut back on all but the most essential activities. By necessity, budgetary decisions were centralized in headquarters. As a result, the Executive Director was understandably forced into the details of the allocation process to a greater extent than would have been the case with a financially healthy organization. There is indication

that PCI's ability to deal with this financial crisis is attributable to the adroitness and programming skill of the Executive Director.

To its credit, PCI plans future budget allocations on the basis of a cautious and conservative estimate of income. To accommodate a range of future income levels, budgets are prepared on the basis of "high" and "low" income estimates. However, the PCI budgetary process appears to be centralized and tightly controlled. Current and former staff of PCI repeatedly complain that they are privy to only partial information about the various components of the budget and about the premises underlying budget priorities and the allocation process. For example, Regional Directors and field staff have knowledge of and responsibility for only the direct costs of field programs. Overhead allocations and direct offshore program costs are handled separately. Because of this system field staff sometimes perceive budget decisions to be arbitrary and whimsical. Field staff need to be more aware of the total budget process.

PCI has had difficulty in structuring a clear, sequential budgetary cycle and schedule. As a result, budget decisions are made hurriedly with little opportunity for internal debate or budgetary reclaims from the field. (The staff conference planned for the fall of 1986 will provide an opportunity for face to face exchange on budget issues.) With one exception, PCI field budgets are constructed on the basis of accounting categories, rather than on the basis of program elements. This makes it difficult to weigh program priorities and to carry on a reasonable dialogue with respect to alternative budget strategies.

The budget function appears to be viewed primarily as a mechanism to provide financial oversight and control rather than as a technique for planning, establishing program priorities and communicating program objectives. Even after annual budgetary allocations are made, headquarters continues to impose tight control on individual spending decisions. (This practice is justified because of an uneven cash flow that imposes periodic spending constraints) and, in some cases, weaknesses in fiscal management in the field.

These deficiencies are likely to become more serious as the PCI program expands and as budgeting becomes more complex. In addition, continued centralization of decision making, and the perception that allocation decisions are arbitrary, is likely to aggravate relations between headquarters and the future, senior field managers. For these reasons, it will be important for PCI to design and install a decentralized program budgeting process that will give field staff in particular an opportunity for greater intervention in the process and increased subsequent budgetary autonomy.

### C. Program Planning and Project Design

Issues related to PCI's policies concerning health systems have been discussed (Section IV), but more specific questions about the quality of PCI program or project planning and design have also been raised by evaluators and PCI field staff. Often these questions actually reflect concern over policy: for example, is PCI both willing and able to expand its activities and risk widening the traditional scope of PCI operations, focused primarily on PHC training, in which PCI has proven skills, to include multisectoral development such as water supplies, agricultural extension, or small enterprise development? PCI as an organization has little or no specialized experience in those sectors, although individual members of the PCI staff have worked in many of them. Other questions relate to planning the implementation of programs once policy has been determined, such as which specific project activities should be developed, and in which areas.

PCI, like many PVOs, does not appear to have a formal, systematic method for developing and locating its overseas projects. PCI receives formal requests for assistance from governments, and responds based on such criteria as health needs and the host government's capacity and interest in working with PCI, and the availability of appropriate funding resources. However, PCI should do more to strengthen systematic, rational planning for new programs and identification of specific project opportunities by country, region and type of service provided.

Usually PCI's program designs have by intention been very general, containing broad objectives and major targets but few specifics concerning work schedules, intermediate indicators, benchmark data, cost projections, milestones, and the like. Plans are not always updated and modified on a systematic basis, with each month's or quarter's achievements compared to those planned. While field staff do not complain about the headquarter's administrative support related to procurements, budgets, and personnel matters, many do find a lack of feedback from San Diego about technical (PHC subsystems) matters. Given the small size and unspecialized focus of the HSD staff this deficiency is not surprising.

PCI field staff have commented that turnover with outgoing staff has been deficient in not providing adequate background information and data on the history and setting of each program. This has impact on their ability to plan new activities and implement ongoing programs. HSD has not provided the necessary guidance to meet such gaps.

#### D. General Administration

During the last two years, PCI has made a substantial effort to introduce and strengthen existing administrative procedures, particularly with respect to field operations and headquarters/field relations. The continued strengthening of these systems is a priority objective in the planning process, discussed above. Past and current efforts have included:

- a rational salary scale;
- establishment of personnel recruitment and orientation procedures;
- preparation of a Policies and Procedures Manual for staff on foreign assignment;
- filing, routing and communications procedures for HSD and field staff;
- revised and standardized procedures for field staff with respect to international air travel, shipment of household and personal effects, education allowance, salary advances, procurement of professional services, material and equipment requisition, purchasing, etc.;
- a cash forecasting system, designed to adjust disbursement rates with the uneven income flow resulting from the seasonal nature of the "Walk" program; and
- preparation of job descriptions for headquarters staff.

A detailed assessment of these new and revised administrative approaches is beyond the scope of this evaluation. In general, they appear to be well conceived and carefully designed and enhance PCI's capacity to manage its current portfolio of activities. (To a modest extent these procedures appear, in tone and structure, to be headquarters oriented. The review team expects that this centralization of control will have to be relaxed in the future as the PCI program grows and as PCI employs more senior field staff that can handle and will demand greater administrative autonomy.)

#### E. Staffing Field Programs

PCI has traditionally relied on younger, relatively junior, lower paid personnel to staff and administer their overseas programs. According to the Executive Director, while these individuals have possessed strong technical skills, they have lacked the management capacities and judgement increasingly

needed to handle the more complex programs that PCI is implementing. In addition, because the PCI salary structure was geared to junior professionals, it provided little incentive to stay with PCI beyond the initial tour of duty. As the Executive Director explained to the board in his annual report:

"What we learned was what many of us already knew and this is that your strongest program people are all too often your weakest administrators and find it impossible to meet the demands imposed by the complexities of large and diversified programs calling for broad management expertise. We need staff with solid personnel administration, good accounting and audit capabilities, negotiating skills at the highest level, as well as an ability to be persuasive within the community context, along with good programming skills."

Accordingly, PCI recently revised its hiring and staffing policy to emphasize the importance of management skills and experience. At the same time, PCI has reviewed and is in the process of upgrading its overall salary structure to become more competitive. In addition, in view of the reality that few if any candidates for PCI field positions are likely to combine all skills the Executive Director seeks in one person, it is becoming PCI policy to place increased emphasis on staff training and development, although to date specific initiatives have not been identified.

This shift in staffing and salary policy appear to be appropriate and overdue. As emphasized in other sections of this evaluation, it is important for PCI to upgrade and professionalize several aspects of its operation if it is to handle a significantly larger program, and remain on the "cutting edge" of PHC training. Enhanced technical capacity at the field level is a critically important element of this process.

## VII. CONCLUSIONS AND RECOMMENDATIONS TO PCI

### A. Management Strengths

PCI has demonstrated some very substantial institutional and programmatic strengths.

1. Unlike many PVOs, PCI has a clear and distinct identity and programmatic focus and, with minor exception, has to date demonstrated the self discipline to stick to programs and projects where it has an established comparative

advantage. In view of the financial pressures on most PVOs this demonstrated ability to "stick to the knitting" is impressive; particularly when other types of programs, which may be less cost effective in the field (e.g., emergency feeding or sponsorships of individual children), nonetheless prove to be more lucrative for fundraising in the USA.

2. The PCI approach is soundly conceived and based on a proven and effective PHC training model and approach. PHC has been established during the past decade -- thanks in part in some countries to the efforts of PCI -- as the most effective way to improve health, especially of children and mothers, in poor rural areas. The major obstacles to providing PHC include the effective training, supervision, and support of PHC workers; PCI focuses on designing, testing, and replicating these areas in countries which badly need them.
3. As indicated by internal and external field evaluations, PCI's field programs are usually well designed, well administered and generally effective, often exceeding their training objectives.
4. PCI is blessed with a loyal, energetic and committed Board of Directors with good regional and professional representation. Board procedures and structure appear to be appropriate and effective.
5. The Executive Director has been creative and adroit in guiding the organization through a difficult financial crisis and in developing alternative additional sources of income. He has the confidence of the board and respect of most of the staff.
6. PCI appears to be unusually responsive to constructive criticism. Repeatedly the review team found evidence that headquarters staff had taken evaluation recommendations and suggestions seriously and had often initiated corrective action where appropriate. This was particularly evident with respect to plans to strengthen headquarters operations and administrative systems.
7. PCI has made a major effort to design and implement improved administrative procedures which strengthen the organization's capacity to increase its portfolio.
8. PCI plans to improve the management of its field programs through a deliberate policy of upgrading the managerial capacity of senior overseas staff. Over time, this will

substantially strengthen the quality of the PCI program. Attention should be paid to establishing such conditions as professional satisfaction, which will hold current and/or attract new headquarter leadership for HSD.

9. PCI's fund raising efforts are effectively handled and professionally staffed. The narrow, technical nature of the PCI program places limits on the capacity of the organization to find and exploit new sources of private sector income. Given this constraint, in view of the intense competition for the philanthropic dollar, PCI appears to be doing quite well.
10. Through its planning process PCI has identified several important goals and areas for improvement. While the review team has some questions with regard to the process itself, the identified goals are important and worth pursuing.
11. PCI headquarters operations are reasonably well defined and organized, though the structure and organization of the HSD unit, the substantive core of PCI, is unclear and needs to be clarified and strengthened.
12. PCI's program planning and evaluation activities are advanced compared with similar PVOs. At the same time, more can be done to ensure that field programs are planned in more detail, that baseline and periodic surveys are designed to monitor program costs, effectiveness, and impact, and that headquarters staff are available to provide assistance whenever field staff need specialized technical help.

While the review team is strongly supportive of the PCI program and of recent efforts to improve headquarters operations and field relations, we believe there are important constraints facing PCI which must be addressed if the organization is to grow significantly and remain in the forefront of PHC training. Each problem discussed below is followed by recommendations to PCI for possible solutions.

## B. Management Constraints

### 1. Overcentralization

The current management style and system is too centralized and personalized for continued effective growth. If PCI is to grow appreciably and program quality is to be retained, it will be important to gradually decentralize operations and decision making throughout the organization, and to give mid-level managers increased authority. It is important for the Executive Director

to allocate more time to concentrate on institutional planning, the development of financial strategies, overall program design, public relations, fund raising, board relations, and external affairs.

Successful management and growth will depend on adaptive management plans, both internally and externally. Internally, PCI should select and support a front line, operating management team for its field programs. The Executive Director needs to delegate authority to strengthen technical support to parallel currently strong administrative support. Retention of staff will depend on both financial and personal recognition.

To strengthen PCI's institutional capacity in the areas of planning, program design, fund raising and board relations, and to encourage increased decentralization and delegation, PCI should consider adding either the position of Deputy Director or the position of Special Assistant to the Director.

In order to encourage decentralization and at the same time increase the integration of technical considerations, the functions and responsibilities that currently comprise the HSD division should be consolidated under the direction of a (full-time) division head who would report to the Executive Director. (Alternatively, the Deputy Director could be given operational responsibility for HSD).

Within HSD, the roles and responsibilities of the Director of Operations and the Regional Directors need to be rationalized and clarified. All matters (including budget preparation) related to field monitoring and oversight should be clearly centered in and channeled through the Regional Directors with Operations serving primarily as a support and/or cross cutting function.

In sum, we do not believe it will be possible for PCI to expand significantly and remain technically competitive if the Executive Director attempts both to exercise close operational oversight and to simultaneously perform critical leadership functions. At the same time, we are sensitive to the fact that decentralization and delegation cannot take place in a vacuum and that it will be essential to have a reliable system of accountability in place to allow for a smooth transition. In evaluating the pros and cons of different organizational structures and revised systems, it will be important to design them in a fashion that will encourage and facilitate the delegation process.

## 2. Inadequate Primary Health Care Expertise

PHC systems in many developing areas are no longer new nor simple; they increasingly demand specialized skills in such areas as

training, curriculum development, supervision, drug logistics, management and information systems. PCI cannot claim to be either more skilled or experienced than other PVOs if it continues to have few headquarters staff, consultants, advisors, and board members with direct, specialized experience in these activities. Full or part time, long or short term, more experts are needed today to strengthen PCI program activities in vital areas where PCI has a self-imposed responsibility to incorporate into its future programs, new PHC strategies from its own experience and that of other organizations. Without strengthening health staff expertise and involvement, PCI cannot maintain its position and respect, and is already in danger of maintaining programs which are no longer on that "cutting edge." PCI recognizes that need but insists that it will need more resources to afford such expertise.

### 3. Other Management Problems

#### a. Budgeting

PCI should devote considerable attention to redesigning the budgeting system and to establishing a related, long-range planning process designed to identify the critical implications of current decisions. A program budget system coupled with a planning process based on broad participation and information of PCI staff should help facilitate greater delegation.

This system should include the establishment of a predictable and orderly schedule, increased staff interaction, the use of program budgeting, and the adoption of work or program plans that are integrated with the budget. In general we believe that staff should be fully informed of the influential factors regarding budgetary decisions, and that they themselves should have an increased role in the decision-making process. Once core field budgets have been established, field directors should be given the widest possible latitude to operate within the budget limits.

The PCI staff appear to be aware of the deficiencies in the current system and have already taken some steps to correct it, including a plan to revise the scheduling of budget actions, and the use of a program budget in at least one instance. In addition, the proposed staff conference should provide an opportunity to interact with field staff on budget issues and decisions.

PCI should review its current Matching Grant application and other applications to AID (such as for child survival grants), to augment funding to cover a portion of the training, staffing and related changes discussed in this evaluation.

b. Institutional Planning

The growth and increasing complexity and sophistication of the PCI program underscores the importance of long range program and financial planning. The purpose of this planning process should not be primarily to set future goals or targets but rather to identify the future implications of current decisions. If this distinction is acknowledged, much of the understandable resistance to long range planning should disappear.

- Specifically, the evaluation team believes that the PCI planning process should become a routine staff activity with the results and recommendations subject to board comment. While the board should be heavily involved in looking at the implications of alternatives and in raising policy issues, it is impractical and inappropriate for the board itself to do staff work;
- Program planning should flow up from field projects and from other organizational units within the context of a clear set of institutional policies and objectives. In this sense, planning is both decentralized and centralized. In a small organization there tends to be an instinctive understanding of policies and goals. These understandings become much more difficult to sustain in a larger, decentralized operation and places a premium on the use of such standard navigating devices as staff conferences and issuance of annual policy statements;
- Planning in the absence of financial forecasts is frequently a frivolous exercise; PCI has initiated a system of long-range planning, but it should be strengthened and better integrated with the budget process;
- The planning process should focus on the development of alternatives in order to clarify the implications of a chosen course of action.

Increased size and changes in the nature of PCI's project balance (i.e., large, externally funded contracts rather than Matching Grants alone) both require and permit reorganization of authority and operational control for field projects. Administration support is now stronger, but health content (technical) support is weaker, and needs equal weight with administration. To maintain PCI's currently perceived leadership, new emphasis must be placed on upgrading the program operations. Expansion will create new tensions including:

- contract vs. Matching Grant (and private) funding; i.e., all costs covered vs. matching; higher (more openly competitive) salaries vs. volunteer-type salaries which will exist side-by-side between projects;

- career-oriented vs. short-term staffing orientation, creating a revolving door reorientation problem and low commitment to PCI for the long haul; and
- "output oriented" contract relationships vs. "process-oriented" grants where good intentions are sufficient.

c. Information Systems

PCI should continue to develop its program tracking, monitoring and evaluation systems. Like most PVOs, PCI has to date been unable to document accurately the impact of its activities on health standards in communities where it is active. Although PCI's health and management information systems have been strengthened since 1982, PCI recognizes the need for improvements, partly because of PCI's pattern of working with governments (which themselves fail to collect sound impact data), but also because limited resources are available for information specialists and computerization. Better information use could not only help PCI strengthen its programs; it could also demonstrate to the public and to potential donors, the cost-effectiveness of their contributions.

d. Technical Staff Development

PCI needs to strengthen its capacity to provide technical backstopping and high quality design services to its PHC programs in such areas as improved MCH delivery, health information systems, drug logistics, community financing, and other increasingly specialized subsystems. PHC is a multi-sectoral approach to health systems development which requires a range of staff and consultant skills. Where PCI does not have a particular skill represented on the staff (e.g., drug management, health information systems design), it can decide whether to hire a short term consultant, or make a longer term commitment by developing its in-house capability in that particular skill. Such decisions relate to such varied issues as costs, personalities, and work schedules, but they depend above all on PCI's major, long term, policy decisions and organizational direction. Very little staff development and training have occurred in recent years; they are needed if PCI is to remain a dynamic organization, growing in capacity as well as in size.

PCI should continue to strengthen communications with field personnel through an annual staff conference; a regular schedule of periodic visits; increased participation in the budgetary process; decentralization of appropriate decision making; the development and broad dissemination of the long range plan; issuance of an annual policy statement; and an institutional "work plan" for the year. In addition, PCI should increase its

commitment to funding staff development and training both in technical areas and in administration and management to the extent that adequate resources are available.

e. Board Relations

Because the primary focus of this evaluation was on the capacity of PCI to support field activities and an expanded portfolio, and because there was limited opportunity to interview board members, our observations are preliminary. Generally, the PCI board appears to be more involved in operational matters than is currently necessary, particularly in the details of long-range planning as it relates to the redesign of PCI's fund raising strategy. In both cases there is a clear and critically important role for the board. The previous concern should not be interpreted to suggest the board limit its policy and oversight role with regard to fund raising or planning.

However, we conclude that the board would play a much more effective role by focusing its attention on PCI's institutional capacity to perform planning and fund raising processes, as opposed to the impression that the board oversees PCI, particularly with regard to financial matters, in a modestly confrontational manner. In view of the recent financial history of PCI there may be justification for this attitude. However, the current Executive Director has been quite successful in "reversing the tide" and in securing a strong financial base. To the extent that the board can move toward a more collegial and cooperative style of interaction, we believe the organization will benefit.

To the extent that there is significant disagreement with regard to the operational role of the board, PCI should consider the services of a consultant with experience in board training and board/staff relations to help both parties better understand their respective roles.

VIII. RECOMMENDATIONS TO AID

We conclude echoing the view which most observers inside and outside PCI have held consistently: that PCI is a strong organization with an impressive "track record" and proven program strategy that, despite its limited size, resources, and technical skills, would justify sustained or increased AID support. The organization has moved far toward strengthening its general management and administrative systems, and financial base. Now it must do the same in such areas as health sciences and information. The problems identified in this report are already widely known to many closely associated with PCI and were described by them to the review team. All those problems, in time, are correctable, and there is evidence that PCI is sensitive to most of them and responding accordingly.

PCI's reputation in, and contribution to, PHC is good because the program content is good, catalyzed by motivated field staff -- not because PCI is big or promotes itself well. To insure that this continues we conclude that future growth should be adjusted to match the rate that PCI can strengthen its capacities in the critical areas discussed in this report.

Specific recommendations to AID:

1. In light of PCI's established record of administrative, financial, and technical quality, AID should respond favorably to PCI's request for a third Matching Grant.
2. AID should be responsive to PCI's request for an increment in the size of the Matching Grant, provided PCI takes steps to begin to implement at least some of the organization and management recommendations made in this evaluation, particularly those dealing with increased substantive technical capacity and decentralization.
3. AID should be responsive to PCI requests for funding for increased headquarters staff and for the higher salaries for PCI's new field staff in positions and areas identified in this evaluation.
4. AID and PCI should work together to ensure that the annual flow of funds during the forthcoming, three year Matching Grant period is linked to the expansion in the institution's managerial and programmatic capacity. Both should be aware of the dangers of gearing up too many new, ambitious programs too quickly. A gradual increase in the size of each annual tranche during the three year period would, at this point, appear to make the most sense.

## ACKNOWLEDGEMENT

As review team members we have all experienced the financial, management, and time pressures of PVO work and are well aware of the inconvenience caused by external evaluations, reviews, audits, and the like. We appreciate the considerable time and trouble taken by PCI staff members to make available without hesitation their files, their program in Mexico, many of their Board Members, and many of their personal concerns in a sincere, mutual effort to understand the organization's weaknesses and challenges as well as its obvious strengths and opportunities. The energy and commitment of all PCI staff members and its many volunteers, despite limited resources, attest to the basic strength of the organization and indicate PCI's potential for further growth.

## APPENDIX A

### Management Review Team

The three members of the management review team were:

- Ronald O'Connor, MD, MPH, President and founder of Management Sciences for Health (MSH), a Boston-based non-profit foundation involved in international health management and technical assistance, with offices in Washington, DC and five developing countries. Dr. O'Connor, author of Managing Health Systems in Developing Countries, has a degree from MIT's Sloan School of Management and specializes in international health program management.
  
- C. Stark Biddle, MA, MBA, is a management consultant who has undertaken several studies of PVOs. He has worked in both the private and public sector and was Director of AID's Office of Planning and Budget for several years.
  
- Nicholas Danforth, EdM, MIA, the manager of the AID-funded PVO Evaluation Project at MSH, is a specialist in design and evaluation of programs in health and family planning. He has led seven PVO evaluation teams, including evaluations of Project Concern in The Gambia, Belize, and Guatemala and supervised an evaluation of PCI in Bolivia.

## APPENDIX B

### Selected Bibliography of the Types of Materials Reviewed by Team

#### PCI PUBLICATIONS:

PCI: An Approach to Primary Health Care  
Long-Range Planning Goals for Program Operations  
Report to Executive Committee on Progress in Implementing  
Long-Range Plan, 1986  
Executive/Senior Staff Resumes  
Staff Job Descriptions  
Annual Reports (1982, 83, 84)  
Field Notes: A PCI Field Staff Exchange, 1980-85 (2-3/yr  
early, but 1/yr since 1983)  
PCI Videotape and Film Presentations and other fund-raising  
materials

#### PCI TRAINING MATERIALS

##### General:

Health Care Training Manual for Village Health  
Promoters, Instructor's Manual, 1978

##### Bolivia:

National Drug Distribution Program Manual for Drug Purchase  
and Supply Subsystem, PCI/Bolivia, June, 1984

Manual Para el Subsistema De Compras Y Suministros Componente  
Medicamentos, Junio, 1984

##### The Gambia:

Program for Pre-training of Village Health Workers and TBAs,  
Undated

Initial Training of TBAs, Gambia Primary Health Care Program,  
1981

Village Health Worker Training Course, 1983

##### Somalia:

Primary Health Care Training and Development Project, Lower  
Jubba, Somalia, September, 1985

APPENDIX C

Profile of Current PCI Activities

<u>Program</u>	<u>\$(Thousand)</u>	<u>%</u>
Field Projects	1542	50%
Shared Proceeds	127	4%
AMDOC/Option	<u>38</u>	<u>1%</u>
	1707	55%
 <u>Management/Administration</u>		
Program Development	283	10%
Executive Management	54	2%
Administration	145	4%
Finance	<u>115</u>	<u>4%</u>
	597	20%
 <u>Development/Fund Raising</u>		
Public Education	60	2%
Promotion	12	-
Direct Mail	187	6%
Walks	456	16%
Misc. Fund Raising	<u>36</u>	<u>1%</u>
	751	25%
 TOTAL	 \$3,055	 100%

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<sup>1</sup> From 1986 budget presentations.

APPENDIX D

Income Data for PCI; 1984 - 86

	<u>1984 Act</u>	<u>%</u>	<u>1986 Budget</u> <sup>1</sup>			
			<u>Low</u>	<u>%</u>	<u>High</u>	<u>%</u>
<u>Private Contributions</u>						
Walk	950	31	960	27	988	18
Direct Mail	295	9	356	10	356	6
Other	<u>198</u>	<u>6</u>	<u>232</u>	<u>6</u>	<u>300</u>	<u>5</u>
	1443	46	1548	44	1644	29
<u>Grants</u>						
AID	647	21	937	26	2336	48
Other	<u>258</u>	<u>8</u>	<u>241</u>	<u>6</u>	<u>506</u>	<u>6</u>
	905	29	1178	32	2842	54
<u>Health Fees</u>	28	-	12	-	12	-
<u>Misc. Income</u>	9	-	5	-	5	-
<u>Chilchinbeto</u>	32	1	56	1	56	1
<u>Hong Kong</u>	568	19	719	20	719	13
Total	<u>2985</u>	<u>95</u>	<u>3518</u>	<u>97</u>	<u>5278</u>	<u>97</u>
(% from AID)	(22%)		(27%)		(44%)	

NOTE: Only changes are in AID figures.

	<u>Low</u>	<u>High</u>
AID Matching Grant - Extension	150,000	150,000
AID Matching Grant - Addition	<u>-</u>	<u>459,595</u>
Sub-Total	150,000	609,595
Somalia	-0-	615,385
Indonesia - Co-financing	45,000	50,000
AID Management Discernment	33,334	33,000
Child Survival	<u>708,690</u>	<u>1,061,439</u>
	937,024	2,336,419

<sup>1</sup> After this estimated budget was completed in January, 1986, AID renewed PCI's Matching Grant at an annual level of \$400,000 (see Appendix E.)

APPENDIX E

Tentative Five Year Income Projection

1985 Est. Through 1990 Forecast

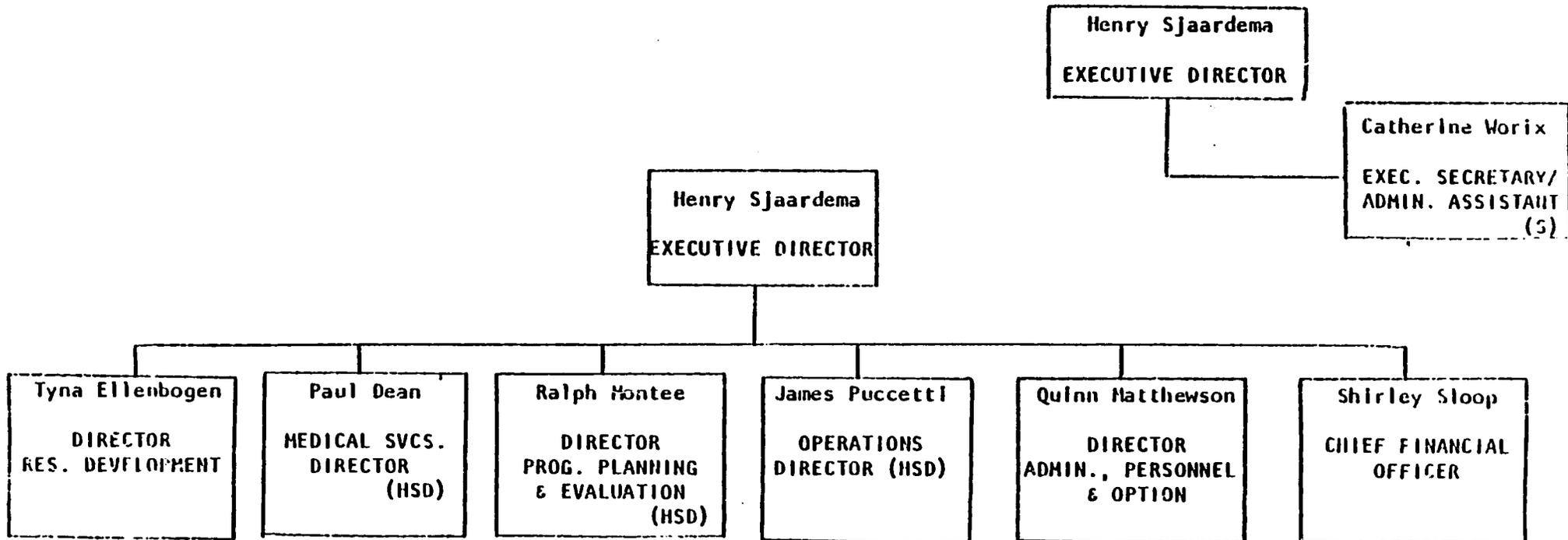
	<u>1985</u>	<u>1986</u>		<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
		<u>Low</u>	<u>High</u>				
<u>Private Contributions</u> <sup>1</sup>							
Walks	915	960	988	1009	1059	1112	1168
Direct Mail	320	356	356	411	462	513	564
Corp./Foundation	93	46	100	110	120	130	150
Other Contributions	180	232	353	423	545	650	621
Total	<u>1508</u>	<u>1594</u>	<u>1797</u>	<u>1953</u>	<u>2186</u>	<u>2405</u>	<u>2503</u>
% of Income	48%	45%	33%	30%	32%	35%	35%
<u>Government Grants</u> <sup>2</sup>							
IHS	110	121	121	120	120	120	120
AID							
Somalia	-	-	750	1600	1600	1600	1600
Bolivia	3	-	-	-	-	-	-
Indonesia	142	45	100	75	75	75	75
Child Survival	200	709	1061	1100	1100	1100	1100
Matching Grant	394	400	400	400	400	400	400
Mgm't Assess.	17	33	33	-	-	-	-
Sub-Total AID	<u>756</u>	<u>1308</u>	<u>2465</u>	<u>3295</u>	<u>3295</u>	<u>3175</u>	<u>3175</u>
% AID	24%	37%	46%	50%	48%	47%	47%
<u>Other Grants</u>	94	88	138	150	175	200	225
<u>Other Income</u>	<u>684</u>	<u>792</u>	<u>800</u>	<u>800</u>	<u>800</u>	<u>800</u>	<u>800</u>
TOTAL INCOME	3152	3532	5410	6573	6831	6701	6823

<sup>1</sup> 5 year projections from Resource Development Department.  
<sup>2</sup> For details of AID income, see Table III.

APPENDIX F

PCI Organizational Chart - Executive Director  
And Senior Staff

S = Salary

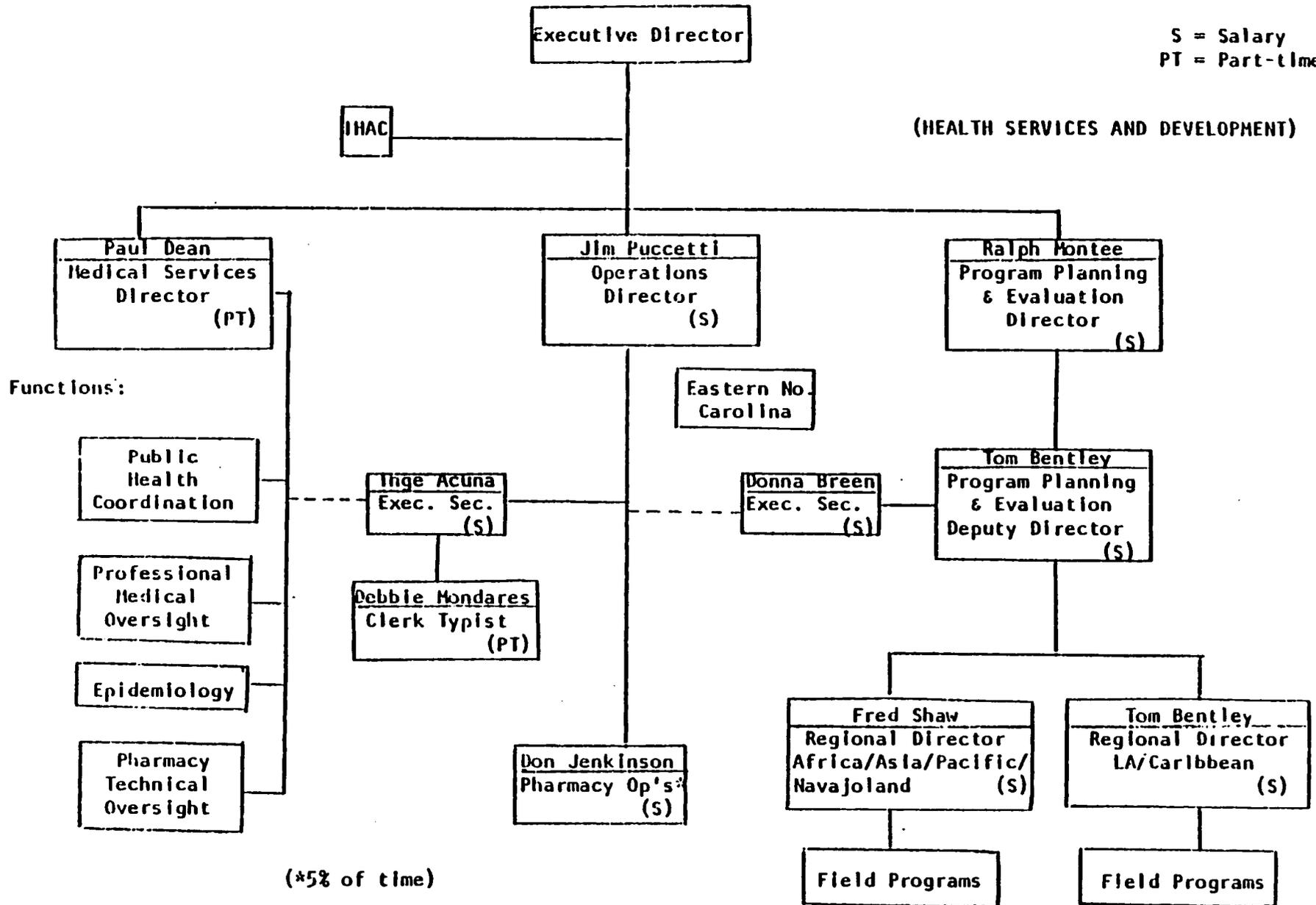


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APPENDIX G

PCI Overall Organizational Chart

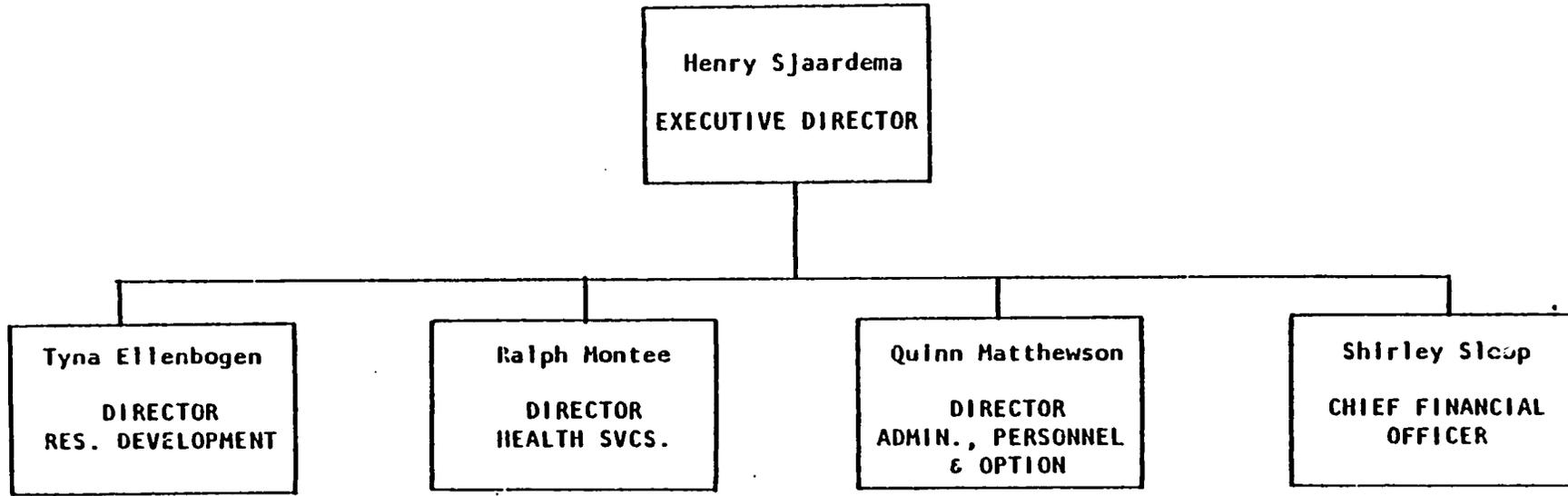
S = Salary  
PT = Part-time



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APPENDIX II

PROJECT CONCERN MANAGEMENT



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