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FOUR PVO PROGRAMS
IN HEALTH AND NUTRITION
Interim Summary Evaluation Report
March 1984

Final Report

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I. EXECUTIVE SUMMARY

This report summarizes four evaluations of country programs in health and nutrition which are sponsored partly by the three private voluntary organizations (PVOs) which manage them, and partly by Matching Grants from the U.S. Agency for International Development (AID). Performed between June 1983 and January 1984 by teams from Management Sciences for Health in collaboration with the PVOs involved, these were the first evaluations in a series designed to analyze in depth the progress of a representative sample of PVO health and nutrition programs.

The goals of this series are to improve PVO health and nutrition activities and to contribute to improved AID policies toward PVOs. The evaluations, funded by AID, are strongly supported by the three PVOs involved. All three are making progress in changing their traditional health emphases from medical relief toward training and technical assistance, from cure toward prevention, and from clinic-based toward community-based care.

The PVOs selected represent both horizontal programs (integrating training in health and nutrition, agriculture, family planning, and sanitation) and vertical programs focused on one health problem (eye disease). The country programs visited were in Africa (Tanzania) and Latin America (Haiti and Honduras). The evaluators, from the US and developing countries, represented various disciplines; they included a public health information specialist, two nutritionists, a public health physician, a health educator, a medical anthropologist, and an ophthalmologist.

The evaluations to date indicate that all the PVOs studied are providing very useful, innovative health and nutrition services -- often in underserved areas -- particularly maternal and child care. Most of the PVOs' planned outputs are being met or exceeded. Two of the four PVOs have dramatically improved nutrition standards of children in their communities, and are assumed to have significantly lowered morbidity and mortality. The other two have been effective in training health workers, one at the community level, the other at the clinic and hospital level. All PVOs are introducing some health and nutrition technologies new to their communities such as oral rehydration and contraception, and all are attempting to reach poor and remote families.

Some PVO program activities and costs are not being monitored regularly or carefully. Baseline studies and management information systems are often inadequate or non-existent. Thus it is very difficult to measure accurately the cost-effectiveness of impact of these programs on the health standards of their participants. PVOs need technical assistance to improve staff skills in program design, management, information systems, and evaluation, and they need support in documenting and disseminating their valuable experiences for national and international audiences.

X Both expanded PVO home office support and in-service training of field staff including host country nationals seem essential before these and other improvements can be made.

X Regarding the role of AID, the evaluators are concerned about the need to clarify the responsibilities of AID in Washington and USAIDs overseas in approving, monitoring, and evaluating PVO programs. AID and USAID must ensure that the PVOs have adequate time not only to plan but also to achieve realistic objectives. In particular, AID and USAID staff need to pay attention to specific PVO activities, often neglected, which will improve program institutionalization, sustainability, and replicability. Some PVOs have failed to fully recognize the importance of training counterparts and building indigenous capabilities so that local staff and funding will increasingly, to the extent possible, replace the Americans and the dollars now essential to many PVO activities. Host governments, as well as the U.S. Government, must do their part to encourage institutionalization and to discourage dependence on PVO manpower and money from overseas.

X MSH recommends that these PVOs should definitely continue to expand their health and nutrition outreach activities, and that AID should expand, selectively and with certain conditions, its Matching Grant support. In addition, it is recommended that these evaluations must be continued, allowing more time and more participation by the PVOs themselves, in order to explore in depth several specific issues. These issues include the cost-effectiveness of PVO health programs, the institutionalization process, self-financing, conditions under which replication or "spread effects" are likely to occur, and environments where PVOs seem most effective. Such focused analyses will help to strengthen further the vital, unique, and growing importance of health and nutrition programs of PVOs in U.S. foreign assistance.

II. INTRODUCTION

A. The Evaluation Process

The AID office of Food for Peace and Voluntary Assistance (FVA) is responsible for the planning, monitoring, and evaluation of centrally-funded Matching Grants to PVOs. In June 1983, FVA contracted with Management Sciences for Health (MSH) to:

"design, carry out and synthesize a series of evaluations of AID-supported PVO health sector programs in order to provide information that should lead to improvements in the impact of PVO activities and assist AID and other national and international organizations with policy and program guidance in relationship to PVO health sector projects."¹

Four PVO country programs were evaluated under this contract: two Seventh-Day Adventist World Services (SAWS) programs in Haiti and Tanzania; Meals for Millions (MFM) in Honduras; and the International Eye Foundation (IEF) in Honduras. Field visits of 2-3 weeks each were made by twoperson teams of MSH evaluators: one an evaluation specialist, the other a specialist in the technical area of greatest importance to the program (see Appendix C). Each PVO contributed at least one representative to the evaluation teams. This series of evaluation reports (see report outline in Appendix D) was viewed as a sequence of field tests of methodology and of some basic hypotheses² about PVOs in general and in specific relation to the health sector. Review and revision of reports by the PVOs concerned and by FVA, as well as their ongoing participation, was considered central to the process of analysis and to program improvement. This interim summary report synthesizes the findings and recommendations of the four evaluations.

There are several criteria for deciding which PVOs, and which of their country programs, to evaluate (see Appendix E). Programs selected must be focused primarily or substantially on health and/or nutrition activities; they should normally have progressed far enough to demonstrate outputs and if possible, measurable impact. Programs should not have been over-evaluated and must want to have an evaluation, which should be seen by PVO headquarters and field staff as a joint, collaborative effort with AID and MSH to improve future planning by understanding the strengths and weaknesses of current programs.

¹ See Appendix A for a list of 12 PVOs currently receiving AID centrally-funded Matching Grants in health and nutrition, and Appendix B for an outline of standard evaluation procedures.

² See, for example, J. Tendler, Turning Private Voluntary Organizations into Development Agencies: Questions for Evaluation, Washington, D.C. AID, April 1982

R. The Matching Grant Program

The centrally-funded Matching Grant (MG) program, administered by FVA in collaboration with AID's Regional Bureaus, provides MGs to a "limited number of PVOs of recognized standing with discrete programs in high-priority sectors."¹ Twelve PVOs with major health and nutrition activities now receive MGs totalling about \$25 million (see Appendix A). In selecting PVOs for the program, FVA considers each PVO's track record, and PVO's financial management capability is of prime importance. PVOs applying for an MG must describe their general plans for expanding their programs in the countries where they currently work or in new countries where their services are needed. To ensure both program effectiveness and compatibility, AID's stated goal is to include PVOs with MGs into its total planning process, so that all such programs are coordinated and do not diverge too far from current AID priorities and sectoral strategies. At the same time, the MG program leaves PVOs ample scope in program design and implementation at the country level.

C. Country Program Descriptions

1. Seventh-Day Adventist World Service/Haiti

SAWS, experienced in Haiti after years of relief work, seeks in its MG program to improve the health of Haitian mothers and children by decreasing malnutrition of children under 5 through child growth monitoring and prompt intervention and by using PL 480 food aid as an incentive to train and encourage mothers in growth monitoring, nutrition education, home gardening, and other health-related activities. SAWS has done nutrition baseline surveys, developed training curricula for trainers and mothers, given training courses, established demonstration gardens and fostered home gardens, and opened nutrition centers. Total funding over the life of the project (LOP, 1981-1984) will be \$325,000, half from SAWS and half from AID.

2. Seventh-Day Adventist World Service/Tanzania

Building on its established network of Adventist Churches and rural health clinics, SAWS has recently begun (after considerable rethinking and revision) a community health promotion program in two rural sites in northeastern and northwestern Tanzania. At each of the two sites about 15 Community Health Promoters (CHPs), selected by their community leaders and trained for a month in basic primary health care, work in four communities to improve health, particularly among children under five and mothers. CHPs are in theory supervised and supported by the local Adventist clinics and by two SAWS Training Officers. The CHPs have been asked to do household surveys and home visits to

¹ "AID Partnership in International Development with Private and Voluntary Organizations," AID Policy Paper, Bureau for Program and Policy Coordination, September 1982.

promote basic sanitation, MCH, health education, and family planning. In one of the two sites, the health program is linked to an irrigation program costing \$130,000 (half from AID), in which local volunteer laborers participate and which is designed to improve farming and nutrition practices. The SAWS/Tanzania program was just beginning community-level activity when evaluated. Total LOP funding (1982-1985) is \$273,000, half of which comes from AID.

3. International Eye Foundation/Honduras

The stated goal of IEF's Matching Grant was to prevent blindness and treat eye disease by developing the eye care capacity of the government, by training health professionals at all levels to be eye care trainers, by surveys, and by program planning activities. Its country-specific strategy in Honduras was to upgrade tertiary and secondary care first, before addressing primary eye care, so that in future, when primary care is improved, eye care referrals can be absorbed at the secondary and tertiary levels. Total LOP program cost (1980-1983) is over \$200,000, including non-MG funds; of that total, AID contributed 88%.¹

4. Meals for Millions/Honduras

The MFM overall goal is to reduce malnutrition in children under five and in pregnant and lactating mothers through an Applied Nutrition Program (ANP). MFM also seeks to strengthen the capabilities of the host-country government, indigenous PVOs, and community groups to coordinate their health and nutrition delivery systems. It emphasizes mobilization of community groups to implement self-help projects which generate income, raise nutrition standards, and improve health. Total LOP (1982-1985) funding level, including non-MG funds, is \$420,000 (only 6% from AID).

¹ Each PVO contributes half of the total (worldwide) costs of its Matching Grant Program, but the percentage of each PVO's contribution to any country program varies. For example, in Honduras IEF's contribution was 22%, while MFM's contribution was 94%. Because these MG programs were integrated into other AID or PVO funded activities, it was useful to analyze country programs in health as a whole, including non-Matching Grant activities if they were closely related to the Matching Grant.

III. GENERAL FINDINGS

A. Program Results

1. Outputs

All PVOs evaluated have met or exceeded most of their planned outputs. In both the SAWS/Haiti and MFM/Honduras programs, where many communities, local groups, and families are in the target area, some adjustments in target sizes have been made and a few outputs have not been reached. In Haiti, the number of mothers receiving food aid was less than expected, as was the number of income-generating projects being established--largely because SAWS/Haiti was still experimenting with the optimal mixes of target population size and program cycle duration and was also re-examining its capacity to do an effective job with income-producing activities. In MFM's Applied Nutrition Program (ANP), similar outputs--mothers and children participating in nutrition programs and mothers' groups organized -- generally exceeded plans.

In IEF/Honduras and SAWS/Tanzania, training outputs were the only major ones being measured, and they had been reached. Consequent outputs -- the services to be offered by those trained -- are either not being measured effectively, are not compared with a baseline, or show no results. In Tanzania, for example, SAWS Community Health Promoters (CHPs) are all trained and at work in their communities, but few records of their activities (outputs) are being kept, either by them or by the clinics they report to. Thus there is no evidence yet of change from baseline in MOH clinic referrals or attendance, children immunized, building or maintenance of latrines, etc. Similarly, in IEF, many nurses who received training are no longer in contact with either IEF or the MOH, so their effectiveness is not being measured either. In both these programs, the most evident problem is not that the PVO is failing to produce results on schedule, but that program management information systems do not exist to monitor results and to assist in the continuous planning, control, inservice training, and evaluation which are all vital to program success.

2. Impact

In an innovative health program lasting only three years, it is not realistic to expect a substantial and easily measurable impact on morbidity and mortality - particularly because all the evaluations in this series were interim. Nevertheless, two programs - SAWS/Haiti and MFM/Honduras - have begun to show intermediate signs of impact after about two years of MG activity. SAWS/Haiti, whose stated goal was "to decrease nutrition- and sanitation-related morbidity and mortality in target communities," has saved the lives of almost all child program entrants in

third-degree malnutrition (considered as at risk of death) and has improved the weights-for-age of significant proportions of all entrants in some degree of diagnosed malnutrition. Rates of follow-on attendance at growth monitoring sessions after program "graduation" are also suprisingly high. These results were viewed by the evaluators as "unusually good," especially compared to other national programs for improving child growth.¹

MFM/Honduras has also produced excellent results in reducing second-and third-degree malnutrition dramatically in all ANP communities: in 1983, after five years of MFM's ANP (including two years under the MG), the proportion of malnourished children in the two communities where the greatest reduction occurred (about half the ANP's population of children under five) was reduced from nearly 50% to 31%.²

The other two programs evaluated show only vague signs of impact (which cannot reliably be identified as the result of program activities). IEF has not done baseline surveys and has not systematically collected data on the prevalence of blindness in Honduras, so the impact of its program there cannot be measured. Under the assumption that the nurses and doctors trained by IEF should be better able to detect eye pathology and refer patients, the evaluators analyzed changes in the hospital discharge data and found that during the first two years of the IEF/Honduras MG program (1980-82), there had indeed been substantial increases both in the number of cases of tertiary eye care and in the prevalence of cases among the population. Thus the program may be increasing the use of eye care facilities and the identification of eye problems, but because of inadequate data it is not clear how much of this improvement resulted from IEF's training.

SAWS/Tanzania has just begun community health promotion activities and no substantial impact is likely for at least a year or two. The promise of improving health standards at low cost is very high nonetheless, if certain program improvements are made. SAWS CHPs may be able, despite brief training and currently weak supervision, to introduce such technologies as ORT, immunization, improved latrines, contraception, and simple medications which should dramatically improve infant and child health in their communities (where no primary care has ever been attempted by the government, and little outreach has been attempted

¹ Unfortunately, SAWS/Haiti did not collect baseline infant mortality data as planned so that overall impact measurement is hampered in that area.

² Regrettably, the ANP is not collecting data on its two other major goals: improvement of nutritional status of pregnant or lactating women, and decreased infant and child mortality.

by SAWS in the past.) If the CHPs can be better trained, managed, and supplied, if they are linked carefully to the relatively efficient Adventist clinic system, and if community leaders become directly involved in selecting, controlling, and supporting CHPs, then impact is possible in time. However, lasting impact after the MG program ends is highly unlikely without stronger community participation.

B. Program Analysis

1. Planning, Design, and Approval Process

All evaluation teams and PVO staff were in general agreement that the process of planning individual country programs needed improvement. With the exception of MFM, all plans were vague and/or unrealistic in their objectives and their strategies lacked specifics about who would do what, where, when, and how. Both SAWS country-specific program plans, approved by AID after the multinational MG had been approved, were overly ambitious: they needed to be rewritten, cut back, and rescheduled in both countries. IEF had no country-specific plans, only a general multinational proposal for an MG with a wide range of program options including both community-level primary eye care programs and tertiary eye care training in hospitals. Only MFM initially, and SAWS/Tanzania later, had a clearly integrated and articulated set of goals, purposes, and strategies in its plan.

None of the three PVOs based their plans on adequate data collection and analysis: even MFM, which utilized annual anthropometric surveys in its design and evaluation process, planned its various interventions (health education, agricultural training, etc.) without adequate analysis of data to determine what specific behaviors needed to change, and which of those behaviors could be changed through education or training alone. SAWS/Haiti, which did do baseline nutrition status surveys, did not predicate its site selection on either its own or national survey data, but rather on mixed, largely pragmatic criteria. Like MFM, it also did not predicate its educational content or strategy on analysis of new or existing data.

The constraints to effective planning arise from limitations both in AID and in each PVO. AID's Matching Grant policy is to approve a single proposal from each PVO which embraces activities in a number of widely different countries. MG proposals may be presented without country-specific plans which would include logical frameworks and other details usually required in AID project documents. Some PVOs do submit country program plans to AID for approval but this is not required.

Because an MG lasts only three years, there has been substantial pressure on PVOs to begin implementation quickly without further planning or baseline research so as to demonstrate activity and produce early results. More often than not, PVO staff have neither the time nor the resources to do the background analysis in each MG country which would enable them to plan each country's program in detail before beginning

implementation. In addition, because of the three-year funding limit, PVOs find it difficult to revise plans and make mid-course corrections (changes which are inevitable even in well-planned projects).

AID, in its approval process, looks primarily at the overall track record of the PVO applying for the MG without paying adequate attention to how each country program will be implemented. During this critical initial phase AID is not able to provide technical support to PVOs which might compensate for the pressures of time.

2. Management and Staffing

All PVO staff involved or contacted in this evaluation were highly motivated and committed; both field and home office personnel in all three PVOs appeared to be competent, hard workers. Despite their skills and personal qualities, PVO field staff sometimes seemed overworked and unable to pay adequate attention to planning and monitoring program details. Some seemed inexperienced in the design and management of health programs requiring the institutionalization of change; many are not training local counterparts to take their places. Some see their work as "relief" for the recipients of aid, not as "development" in collaboration with host-country counterparts who should be trained to take over as rapidly as possible. Some were not accustomed to managing a development process which was based on local community participation and aimed at eventual self-reliance. In short, the traditional desire to "do good" and stay indefinitely (instead of transferring technical and managerial skills and technologies to the host country within a certain period) is fading rapidly, but it has not disappeared entirely.

Another significant variation in the PVOs' management and staffing patterns was the size and mix of field, central, and headquarters staff, and the degree to which the PVOs were able to build on existing staff skills and numbers. In Haiti, Adventists had been present for decades; SAWS' central staff of nearly 40 people managed a large PL 480 program, including MCH, Food-for-Work, and Outreach Grant activities. The MG program generated 30 field workers but funded only a small central-office staff. Well-functioning management and accounting systems which predated the MG permitted effective monitoring and supervision of the MG activities which helped the project adapt to local needs and resources. In Tanzania, SAWS was also able to build on long-standing experience in rural health; the MG enabled SAWS to build a community outreach program based on

its network of rural clinics and managed from its country program office by a Tanzanian Adventist physician. Although it lacks adequate management and has little of the management information system so helpful to SAWS in Haiti, the SAWS/Tanzania program would be much less effective if it had not built on existing resources.

The other end of the staffing spectrum was represented by the IEF/Honduras program, which involved only one parttime expatriate staff member and no fixed local staff. Program cost was correspondingly low. Unfortunately, the expatriate, although very competent as an eye-care trainer, had no experience in Latin America, eye care policy, project planning, or institutionalization strategies, and had no paid, in-country staff and no local counterpart. Her effectiveness in areas other than training was limited.

MFM/Honduras occupied a middle position between these extremes. All MFM/Honduras in-country staff are nationals; MM headquarters in California provides very regular, competent technical assistance and management support to the field. There is a high degree of program coordination and integration between MFM headquarters and staff in Honduras. The flow of new technologies from home to field office, with support for their testing, is steady and consistent.

3. Monitoring and Evaluation

Data deficiencies have affected the design, implementation, and evaluation of PVO MG programs. All country programs were weak in their monitoring and data collection activities: two of the four collected excessive data and did not analyze it appropriately; the other two collected too little. In no case was the data transformed into indicators which could provide timely feedback to program managers or staff program strengths and weaknesses. Data was never even considered to be used to build public awareness. Too often, monitoring and evaluation were seen more as a liability, an obligation required by headquarters or by AID, instead of an asset, a tool for management to improve effectiveness.

Time-consuming record-keeping often overburdened staff, who resent it particularly because they get no feedback from program managers about their work or progress. They rarely saw any useful purpose in filling out forms, and in fact there often was none. Sometimes the amount of data being generated could not possibly be analyzed by the small staff available, requiring either more staff or less data, depending on management priorities. In sum, appropriate, well-conceived, timely, accessible, and agile sets of data which might have constituted indicators for project management and evaluation without major demands on personnel time, are largely non-existent in the PVOs studied.

4. Interagency Coordination

The effectiveness and replicability of any PVO primary health care program depends partly on the PVO's ability to work in collaboration with the government, with AID, and with other health-related institutions in the pertinent geographical area. Institutions in other sectors such as agriculture, water and sanitation, and education, have a direct effect on health standards in the PVO program areas; PVOs, in many cases, should be planning and working together with these public and private agencies, as well as with AID, but do they?

This sample of PVO health activity shows wide variation in most interagency relations. With regard to USAID relations, only SAWS/Haiti was in continuous or close contact with the USAID, primarily because the USAID was well staffed to allow such contact. Nevertheless, all four PVOs were fulfilling the terms of their MGs and were well within the guidelines of AID Health Sector Strategy and the USAID Country Development Strategy. Regarding PVO relations, only MFM was working in close collaboration with other PVOs in its program implementation; SAWS/Haiti was an active participant in national PVO consortia activities, but these were only incidentally linked to its MG program.

Host-country relations varied greatly by country and by PVO. For example: IEF worked closely with the Ministry of Health (MOH) in Honduras because IEF's initial activity was training the Ministry's primary and tertiary level health professionals, all paid and originally trained by MOH. Unfortunately, IEF was not able to expand that collaboration in such a way as to institutionalize eye care at any level.

In contrast, MFM collaborated effectively with all relevant Honduran government agencies and with PVOs in its field program but not directly with the central MOH. Its strategy was to play the role of catalyst organization, directing and managing a range of activities in its Applied Nutrition Program (ANP).

MFM and IEF both put major emphasis on collaboration with the Honduran government, but with different objectives and using different methods. MFM's successful coordination was well planned and managed, utilizing host country staff, sustaining some contact at the central MOH, but making most of its efforts at the regional level in the field site, a rural area where the government welcomed and needed assistance. IEF's essentially successful coordination with the host-country government was made by one part-time American trainer who had no experience in such management tasks as PVO government coordination. It appears that one reason the MOH was not persuaded that a national primary eye care program was feasible was because IEF failed to demonstrate in a pilot project how it might work. In contrast, the Honduran MOH does seem convinced of the value of an Applied Nutrition Program because it has seen MFM's successful ANP in operation.

SAWS programs in Haiti and Tanzania, countries with different political and economic systems, evidenced low levels of coordination with host governments. In both countries Adventist activities in health and nutrition were long established and traditionally independent; in Tanzania, Adventist clinics had been functioning for many years and were commonly known to be more popular than the few existing government clinics. SAWS country staff may have concluded, with some justification, that they can be effective without relating more to government. In sum, SAWS seems more disposed to a certain remoteness from government involvement, while MFM and IEF see greater coordination as integral to program success (although that coordination is not always adequate.)

5. Major Constraints

As in all development projects, these four country programs were faced with major environmental barriers to success on several levels. All faced serious national economic situations--particularly in Haiti and Tanzania, where food, fuel, and medical supplies often run dangerously low. A lack of governmental organization and support, as in the case of IEF/Honduras, or a government's limited ability to support multisectoral programs, as in MFM/Honduras, can make institution-building difficult.

The greatest constraint in all four programs, however, was the lack of trained manpower, particularly in the areas of primary health care management and training, as well as in several specialized technical fields. The top staff of the two SAWS programs, for example, are mostly expatriates who have very heavy responsibilities, little time, and few trained support staff to whom they can delegate responsibilities. In Tanzania, the Country Program Director badly needs an Administrative Assistant; he relies on his wife who volunteers to help keep the program's accounts and to contact staff by two-way radio each day. SAW's Director of Health Services, a Tanzanian, asked his wife, a nurse, to "volunteer" to process survey data--an important job which should be done by a specialized researcher.

Both SAWS programs have had brief, general orientation programs for senior staff but seldom arrange specialized technical training for any level staff. In Haiti and Tanzania, technical staff skills are particularly weak in the fields of clinic management (supervising health workers, improving patient flow, etc.) and pedagogy (training all levels of health workers more effectively and reaching mothers with motivational and educational messages). In Tanzania, other skills required (in addition to program management, training and data analysis) are financial planning, and drug logistics--both sorely needed if the CHP is to become a viable community service. All programs were, in greater or lesser degree, lacking in the skills needed for the design and use of suitable information systems.

IV. SPECIAL ISSUES

A. Community Participation

One of the most common claims made for and by PVOs is that they enable whole communities, especially the poorest strata, to participate in programs. They describe themselves as particularly apt at enabling poor people to gain control over their own lives and over the programs meant to benefit them. Participation of client populations in the design and control of primary health care programs is obviously necessary if those people are to accept, support, and eventually sustain their programs. The evaluation was concerned about whether this PVO "article of faith" has become reality in PVO health sector activities.

In all three community-based programs (IEF/Honduras was not community-based), the potential for community participation was great. Still, effective participation was being implemented in only one program, MFM/Honduras: large numbers of people were directly affected by the ANP, nearly everyone in the community was at least indirectly affected by it, and all were aware of it. A wide range of people had participated from the beginning in research and planning and continued to work actively for the program. The effects of that high level of participation were everywhere in evidence: self-supporting women's groups planned, managed, and funded their own income generating projects. Farmers, midwives, school teachers, nutritionists, and sanitarians gave and received training, and had regular contacts with the ANP staff.

The two SAWS programs were less effective in building community participation. In Haiti, the nutrition program was initially generated more by a small group of Adventist Church leaders than by community leaders. The SAWS Country Directors designed and managed most aspects of the program, while local levels of participation varied from site to site: people's contributions of labor, cash, and materials to the program appear to have been greater in rural than urban areas, although no records were kept. Nutrition agents/health care workers and their assistants, both important in encouraging participation, differed in their levels of commitment to it. Even mothers' attendance at clinics varied considerably among sites and was inconclusive as a measure of participation.

In Tanzania, a few community leaders had apparently selected the Community Health Promoters to be trained by SAWS, but it was not clear how well those leaders or the CHPs they selected had represented their communities. In general CHPs appeared young and inexperienced. In any case, the communities' role in the program seemed to end with the selection of CHPs--hardly a hopeful sign for significant, long-term participation in program management. Despite the lack of clear evidence of participation, however, SAWS field staff in both programs expressed concern about increasing participation, and in both cases progress was being made. In Tanzania, Community Health Committees are required

by government, and everyone is required to contribute one day's labor a week (usually Thursday) to public services such as road maintenance. These requirements, sometimes honored in the breach, should contribute to increasing participation in SAWS MG communities.

In Haiti, substantial material contribution by participants is limited by the depth and extent of poverty; however, a tradition of community labor exchange and community councils offer some models for participation. Mothers' attendance at surveillance weighing demonstrated a commitment on which SAWS can build increased participation. Moreover, there is no evidence either in Haiti or Tanzania, that such participation or any benefits would be limited to Adventist Church members; SAWS local staff, including some devout Adventists, apparently treat all community members equitably and apparently do not proselytize.

In the IEF program, no attempt was made to work directly at the community level in primary eye care as originally conceived in the MG proposal. According to IEF staff, their initial concern was to provide eye care training to health professionals (which they did successfully) and to improve national eye care policy and planning (which they were not able to do). It was their view that these two activities must precede the introduction of community level eye care, and that community participation was therefore unnecessary.

R. Benefit Distribution

All programs were faced with the difficult problem of how to reach those too poor or too sick to visit clinics or food distribution points, and how to make their services as accessible to the poor, illiterate, elderly, or remote members of their communities as to others. Yet all programs except IEF showed clear evidence of reaching some of the most needy segments of their communities. SAWS/Haiti and MFM/Honduras in particular were stimulating improved nutritional knowledge and behavior among the poorest families.

In both Haiti and Tanzania SAWS has suffered the same stress as have many other primary care programs between clinic demands and home visits which attend to the needs of the most marginal portions of the population. SAWS/Haiti is currently considering the relative merits of weighing rallies and home visiting and will select one of these options soon.

SAWS/Tanzania program benefits were potentially available to all families in the target areas. All community members were being treated equally and seem to have the opportunity to benefit equally from the CHPs' health education and primary care services. However, the CHPs had not yet demonstrated

either their teaching skills or their willingness to actively assist the poor or visit remote families. Benefits to the poor derive from improved access rather than from attempts by CHPs to stimulate widespread community participation or empower the poor.

Similarly, IEF's program in Honduras was not concerned with testing any interventions to reach underserved populations with primary eye care. Instead, IEF opted for a trickle-down approach by training nurses and doctors (mostly for urban or peri-urban areas) who would provide the general population with secondary and tertiary eye care. IEF had no pilot program in primary eye care or in rural areas which might have demonstrated effective preventive outreach. IEF did introduce eye health curricula in schools, which had the potential of reaching out beyond the clinic and hospital audience to the wider public, but no data was collected about the number of teachers or students involved in eye care activities or about the impact of the experiment on the students' eye health.

C. Innovation and Technology Transfer

All PVO country programs evaluated are using health and nutrition techniques and technologies developed and proven elsewhere in the same countries or in other countries, most of which are not now considered innovative. Yet in three of the four programs evaluated, some primary health care or nutrition technologies being introduced are new to the local community. The need to innovate responds partly to the recognition of the special problems of remote, rural locations which public-sector PHC programs reach with difficulty, if at all. The innovativeness is also a result of the PVOs' multisectoral approach to development, which is hard for government entities to implement, even where the concept is accepted. The PVO ability to at least attempt this "horizontal" approach results in preventive health and nutrition activities being combined with activities in such sectors as agriculture, irrigation, sanitation, family planning, and PL 480 food aid, which expand or supplement more traditional curative, clinic and hospital-based programs.

MFM/Honduras is an informative example of such innovation through integration: it brings together in nine communities several disparate health, nutrition, and agriculture organizations, both governmental and non-governmental. MFM interventions include various health, nutrition, agriculture, and sanitation programs, such as home gardening and small animal production, building family-size silos and kitchen utensils, introducing smokeless stoves and potable water systems, etc. All these activities are carefully coordinated, while health and nutrition changes are carefully monitored, itself an innovative activity in the program area.

SAWS/Tanzania has also integrated its programs in an innovative way: in both sites, SAWS community health committees are developing and have the potential to become increasingly responsible for the supervision, support, and supply of these CHPs (in collaboration with Adventist clinics.) In one site, CHPs also work closely with SAWS' agricultural training officers in an irrigation ditch renovation program which promises to lead to better farming, improved diets, and maternal and child health improvements which may be measurable in about two years. Because the program is only in its first year, however, these links between community leaders, CHPs, clinics, and agriculture are still weak and need to be developed.

The innovative dimension of the SAWS/Haiti program has evolved, rather than having been frankly intended: this is the increasingly apparent, perhaps independent, role for growth surveillance, with and without the PL 480 food incentive, as an important health intervention. The very best clinic trials, those that produce the most clear-cut results, make use of high-risk populations; this explains some of the dramatic results in the SAWS/Haiti program. It also suggests that PVOs can be laboratories for innovation, which does not necessarily limit their potential to the pilot level.

D. Cost-Effectiveness

The evaluation teams found cost-effectiveness difficult to measure and to compare between programs because the costed components and accounting categories of the different programs evaluated varied widely, and because many costs were not recorded accurately, if at all.

Program costs ranged from MFM/Honduras' \$30 per direct participant (anyone who was actively involved in education, food aid, income generation, or agricultural activities) up to the \$3,700 per physician trained in tertiary eye care by IEF. It cost \$55 per child in SAWS/Haiti growth monitoring program, \$89 per child admitted to a clinical program, and over \$100 for each participating family or mother continuing in the longer-term MCH program. The cost of training paramedicals in SAWS/Tanzania had not yet been calculated, but in IEF/Honduras it was about \$113 per capita.

Generally, despite the wide range of costs for some activities, the evaluators were impressed by the low administrative expenses of all PVOs. In several cases, nevertheless, the costs of management, both in the PVO headquarters and in the field, seemed much too low--to the point where some home and field office managers were less effective than they might have been, all things being equal, because they were underfunded. Several were overworked, their offices were understaffed, and their ability to pay for technical assistance, travel, and communications was limited.

Sometimes they suffered from the same time and resource limitations as the managers of the public-sector PHC programs they can or should supplement, a condition which downgrades PVOs as alternative health services.

In sum, the direct field operations of PVOs seem to be low-cost when compared to governmental programs or other health programs funded by AID, largely because dedicated personnel work hard at normal or low pay scales. But management of some PVOs is underfunded and given too low priority in the budget process: in such cases, management's effectiveness and efficiency could be increased by increasing its share of program funds.

E. Sustainability, Institutionalization, and Replicability

Real development means that programs initially funded and controlled from outside by foreign donors will eventually be funded and controlled, to the extent possible, by the program's beneficiaries. Are the PVOs taking steps to ensure that their programs will be institutionalized into local plans and organizations, then sustained, expanded or replicated with local funding? What approaches to institutionalization are most effective?

The evaluators agreed that none of the PVOs are paying enough attention to building the institutions which will sustain their programs after they depart. Three programs (not IEF/Honduras) plan to continue after AID funding in the MG ends. They have general plans for their activities to become institutionalized, with either governmental, community, or other outside support. But none of them have specified or tested which mechanisms they will use to ensure program self-financing, expansion, or replication.

MFM had considered such mechanisms, but had only just begun discussions with government officials and community leaders about the problem of program sustainability. MFM is prepared to continue funding the program itself, without AID funds if necessary, and to act as a catalyst to build future support for the program from many sources. However, this approach may encourage dependence on foreign aid indefinitely, instead of putting pressure on local and national leaders to mobilize their internal resources for development.

SAWS was vague about plans for post-MG sustainability. In Tanzania, the program was just beginning, and there were no plans to generate funds locally to support CHPs. Moreover, no attempts had been made to test whether CHPs need to be paid (despite the view of many PHC experts that outside financing of community health workers discourages community participation.)

In Haiti, the MG program documents are quite specific in rejecting the possibility of eventual self-sufficiency because of the extreme poverty and worsening national food shortfalls,

a position also espoused in the USAID CDSS and Title III documents. At the same time, there are signs that growth surveillance can achieve some autonomy. The role of nutrition and health education in eventual diminution of dependence is barely explored (although this can only go so far where the basic issues are hunger, poverty, and non-productivity.) SAWS/Haiti has demonstrated that its program design, with simplification and modification, is replicable but only with continued external funding.

The four evaluations indicate that, to be effective in institutionalization and institution-building, different PVOs may work best at different levels of the health care system, depending on the nature of the program. A "vertical" program like eye care seems more likely to become institutionalized into national health plans and programs if it is introduced into a Ministry of Health, where programs are usually organized vertically. For example, IEF/Honduras attempted to work closely with its host government. Although IEF's effectiveness in institution-building (introducing primary eye care programs into national primary health care plans and programs) was limited, because of staffing difficulties, the important point here is that its training activities were carried out through the MOH, in accordance with its goal of increasing the eye care skills of government doctors and nurses.

On the other hand, a multisectoral program like PHC or APN (e.g., MFM/Honduras) may be more effectively institutionalized at the field level where the central MOH bureaucracy is less able to impede integrated, "horizontal" planning and implementation. Clearly a case can be made for different PVOs to work in both situations (provided they all continue to build local participation and control.) Both approaches deserve AID's continuing support, but AID must at the same time encourage all PVOs to move as rapidly as possible toward the institutionalization and replication of programs which have proven to be cost-effective.

V. FINDINGS AND RECOMMENDATIONS

This interim report on the country programs of three PVOs was based as much on personal observations as on hard data, which was often not available. Thus it contains tentative and subjective conclusions which do not necessarily apply to other PVOs, other countries, or other health programs. The evaluations are continuing and the findings will be updated.

Meanwhile, preliminary findings have emerged which appear to show trends, and which may have policy implications. They begin to answer some of the many questions have implicitly guide the evaluators: are the PVOs doing well in health? Are they progressing in the right directions? Do they have a comparative advantage in the health sector? In what areas do they perform best? Does their effectiveness (or cost-effectiveness) depend on having existing facilities on which to base community outreach, or being able, unlike government health services, to collect fees for service?

Such questions cannot be answered accurately for the average health sector PVO without further study, but some possible answers to be explored in future evaluations were suggested by the findings of this report. Major findings and related recommendations about PVOs in health, including findings about the evaluation process itself, are summarized here.

A. PVOs

1. Finding: PVOs are performing useful health services in areas often underserved by other providers.

All of the organizations evaluated to date have successfully introduced health technologies--including ORT, growth monitoring, clinic record systems, water and sanitation systems, training methodology, and an agricultural loan fund--according to specific program needs. In three out of four cases, program resources and interventions are targeted directly at the village level. The overall impact of the four programs has varied: in one case (SAWS/Tanzania), it was too early to detect improvements; in another (IEF/Honduras), the lack of institutionalized follow-up has dissipated the residual effects of training; in two programs (MFM/Honduras and SAWS/Haiti), a direct impact on reducing levels of malnutrition can be demonstrated statistically. Overall, the PVOs appear to serve a very useful purpose both in improving health status in the communities they serve, and in improving--often as a catalyst--the effectiveness and efficiency of U.S. foreign aid programs in primary health care.

The evaluation teams concluded that PVOs can and do have a special niche in the health sector, primarily in geographical or substantive areas where public sector services cannot,

will not, or do not go. In this role, they can be seen as extending the reach of the public health sector and, correspondingly, reducing the recurrent cost burden on that sector.

PVOs also share strong traditions of service and dedication, some dating back decades and some having intimate knowledge of the developing areas where they work and live. Because they are, in general, less susceptible to political vicissitudes, they also offer the reliability and durability which the public sector does not always enjoy.

Recommendation: AID should continue to support, selectively, PVOs working in the health and nutrition sectors and, expand that support in well-defined areas.

2. Finding: PVOs are important laboratories for development in health, a fact often unrecognized even by themselves.

PVOs are commonly the first line providers of health care in their communities, testing preventive and primary level interventions which, though usually not new to international health planners, are innovative in those communities. Thus PVOs are uniquely able to experiment, and to report failures and successes in PHC to other institutions and other countries. But many PVOs do not recognize the need to document their findings and share them with others; they often see their health activity as an end in itself, when in fact it is just as important as a test or laboratory from which other planners can learn and other programs can be spun off, replicated or adapted.

The unmet need for health care is so widespread that current PVO activities cannot hope to meet it except in a relatively few limited areas. Therefore PVOs (as well as AID) need to recognize their responsibilities toward the wider national and international PHC community as well as the community in which they are immediately involved. PVOs in health need to recognize that their work will be most useful if it is replicable, and if their findings are recorded and disseminated.

Recommendation: AID should determine with PVOs how they can improve discussion, documentation, and dissemination of PVO findings and lessons learned to other PVOs, health planners, and AID officials, both in-country and internationally.

3. Finding: PVO staffing patterns are variable and some are significantly understaffed, especially at home offices.
4. Finding: PVOs need more planning and management skills, especially in technical analysis, information systems, financial management, and supervision.

PVO staffing patterns vary according to the size and activities of the program. Three of the four programs relied heavily on host country staff and sparingly on expatriates. Program management capabilities varied considerably among the four programs. PVOs are good at field level programming and execution; they are generally weak in planning and technical analysis, information systems, financial management, training and supervision. Three of the programs had adequate administrative personnel at the country offices; only MFM provides specific training to its field staff in technical and management areas. Home office support capabilities also vary among the PVOs evaluated: SAWS and IEF are understaffed, technically and administratively, to give adequate support to their country programs: MFM, on the other hand, is well staffed quantitatively and qualitatively at the home office and all professional staff regularly visit the field.

Recommendation: PVOs, with some exception, need to give more attention to the appropriate size of home offices and diversity of skills (functions) to adequately support and supervise field operations.

Recommendation: Specific training programs, in-service, and interprogram workshops, should be designed and executed by PVOs for their field staffs regarding program administration as well as specific technical issues such as program design, information and evaluation systems, financial management, training and supervision, and local institutional development. AID should promote increased technical assistance in these areas.

B. AID and USAID Relationships with PVOs

1. Finding: There is a lack of clarity about the specific role of AID/Washington the MG process.

AID/W's participation in the Matching Grant program has concentrated for the most part on the proposal development and approval phase. This is due in part to personnel and financial (travel) limitations; there is also, however, an apparent lack of definition as to the specific role of AID/Washington throughout the MG process--program design, monitoring, review, and evaluation--within the above constraints.

Recommendation: Specific criteria and operational guidelines need to be developed for PVO project planning, monitoring, and evaluation. Also, more time should be devoted to monitoring progress in the field to supplement written reports and gain valuable insight into operational constraints and decision-making.

2. Finding: The AID MG design process forces PVOs to promise unrealistic accomplishments, often in too short a time.

3. Finding: More attention is given to technical issues in design than to issues of institution-building necessary for sustainability, replicability, and self-sufficiency.

The MG proposal development process tends to produce over-optimistic expectations while, at the same time, leaving gaps in program design. This is particularly the case where new countries are contemplated. No provision is made for assuring the development of country-specific plans, though two of the three PVOs produced such documents on their own initiative. Insufficient time is allowed to develop such plans in the field prior to finalizing the specific design and required inputs of the country program. Most attention is given in the MG proposals to technical issues encompassed by the program. Management systems and strategies for institution-building are not adequately addressed, especially in light of the goals of sustainability, and replicability (which MG proposals rarely address with specific plans.)

The initial planning and design process, prior to the formal establishment of a program, is usually of short duration and lacks detailed analysis of programmatic and organizational issues. Proposed activities tend to be vague, often idealistic, and incomplete; proposed budgets are often found to be unrealistic. For the most part, real planning and design are accomplished

during the first year or two that staff are in the field, after the budget has been determined, thus precluding any real results by the third year of "operation." Where external funding is involved, pre-proposal program analysis and development costs are kept to a minimum, especially in a country that is new for the PVO. Also, during this phase little attention has been given in general to developing specific criteria and interventions for achieving long-term institutionalization. Both AID and the PVOs should recognize, by word and budget, the technical and financial costs of adequate program planning. Time should be allowed to facilitate detailed in-country analysis and design prior to the determination of a fixed set of proposed inputs, activities, and outputs. Proposed program design should explicitly include specific strategies for institution-building and post-MG sustainability.

Recommendation: Specific time should be allowed, in the MG proposal, for country-specific analysis and design, prior to submission of a final plan and budget. Expected results need to be more consistent with human and financial resources available to each program, and more time is needed--three to five years--to allow PHC programs to mature and produce impact.

Recommendation: Specific criteria and guidelines urgently need to be developed by which to focus and monitor the development of appropriate and useful management systems-- personnel, accounting, information, etc.--and the process of institutionalization, whether this be within the host government structures or in the private sector.

4. Finding: USAIDs generally lack knowledge of MG activities in their country, except where there is a PVO or PL-480 office.

USAID Missions have deliberately had minimal if any contact with centrally-funded PVO programs. USAIDs have not been involved in either planning or monitoring MG activities, except where they were preceded by an OPG; even then, MG activities have generally been considered as a low priority by USAID. Where PVO or PL 480 offices exist in the country, contact has been greater but monitoring guidelines like those mentioned above have been lacking. Most PVOs, for their part, prefer to maintain this independence. As a result there is no in-country support or monitoring of MG programs (outside the PVO itself.)

The specific and appropriate role of USAID vis-a-vis centrally-funded programs, particularly in field supervision and support for institution-building, needs to be better defined--taking into consideration both USAID and PVO resistance to increased coordination--to improve communications between organizations and between sectors, to avoid duplication of AID-funded activities, and to increase program replicability.

Recommendation: More communication and coordination is needed among AID/Washington, USAID Missions, and PVOs in the planning and follow-up of PVO MG programs.

C. Host Government Relationships with PVOs

1. Finding: PVOs have minimal contact with host governments during implementation and evaluation.
Host governments have little presence in the monitoring and evaluation of PVO activities, limiting the likelihood of PVO programs becoming institutionalized into host government services or being sustained by host government financing.

PVOs have had varying degrees of contact with host governments. One PVO (SAWS) tended to limit such contacts, another (MFM) actively pursued coordination, and the third (IEF) worked through the MOH structure but rather independently. Host governments, for their part, tend to have minimum knowledge about (and little control over) PVO activities. A lack of time and personnel is one reason for this; also, host governments are generally excluded from real involvement in the program design phase until they are asked to sign an agreement with the PVO. PVOs come to host governments with pre-determined strategies, even if specific components are to be developed in the field. More importantly, time and effort are not taken on either side (nor required by AID) to analyze and program the content and levels of government contributions. Once a formal agreement is signed with the host government, there is little subsequent involvement in operationalizing the government's participation, in budgets as well as personnel. As a result, institutional responsibility and real government commitment is generally not established. (A significant exception to this is the MFM program, where coordination has been promoted at the regional level and integration has been established at the local health center.)

Instead, specific government offices could be assigned to monitor and support PVOs, perhaps by sector or by location, under appropriate guidelines and regardless of the level of direct government participation. The degree of PVO autonomy

from the host government should be decided in the field to the agreement of both parties. AID and USAID should insist that the decision-making process be faithfully carried out in the best long-term interests of the host government and the USAID country development strategy. Distinction can be made between administrative and technical aspects of PVO programs subject to host government control or influence; however, long-term institutionalization objectives as well as shortterm expediency have to be considered. "Successful" PVO programs, in other words, are not fully effective until the host government knows, supports, and eventually replicates them.

Recommendation: AID and USAID should consider promoting, to host governments, the establishment of a system whereby PVO activities in each country can be better planned, coordinated, monitored, publicized, and replicated when successful.

D. This Evaluation Series

1. Finding: Early PVO evaluations (e.g., SAWS/Tanzania) and mid-term evaluation (e.g., SAWS/Haiti) can be useful in correcting problems before they grow.
2. Finding: All PVOs benefitted from the evaluation process because it clarified many special issues and increased awareness of the complexity and importance of program management.

The design of the evaluation process, which included at least one PVO representative on each team and included ample opportunity for feedback from PVO headquarters and field offices on the draft reports, made it possible for program modifications to be made both early and in mid-stream as issues and problems were clarified. Because they were participatory, the evaluations were seen not as adversary proceedings but as management tools. However, greater involvement of the PVOs in future evaluation report writing process will further enhance this effect.

Recommendation: The PVOs should be the equal, if not the prime beneficiary of the evaluation process as a whole. Thus, more time should be allowed in future evaluation schedules for fuller participation of the PVO in the writing process and for a full cycle of comment and editing to occur.

3. Finding: The time allocation per program evaluated was insufficient overall and it was insufficiently synchronized with PVO program needs and personnel availability.

Recommendation: Future evaluations should allow for one work week of preparation time, two to three weeks in the field, and four weeks for analysis, write-up, reviews, revisions, and follow-up meetings.

4. Finding: For the sort of qualitative evaluations that were carried out, two-person evaluation teams (the evaluation specialist and the technical specialist) plus a PVO participant, worked well. Furthermore, continuity across the series of evaluations has been extremely important.

Recommendation: Team structure and staffing patterns should be maintained.

5. Finding: The variability among the PVOs evaluated (e.g., vertical or horizontal programs, more or less integrated and multi-sectoral) was informative as part of a first effort but complicated comparability, especially in the calculation of comparable costs.

Such calculation was the least consistent aspect of the first four evaluations. One of the major dimensions of assessing the comparative advantage of PVOs is cost. For this to be more consistently evaluated, it might be helpful to perform subsequent evaluation series among groups of programs with more uniform portfolios, whether or not these were MG programs. For example, programs attempting to build preventive community based outreach systems utilizing an existing network of clinics (e.g., SAWS and SAWSO) could be compared. Further comparability might be achieved by using specific hypothesized success criteria for selection of PVOs to be evaluated. (For example, in the case of SAWS and SAWSO, AID can compare the average cost of training and supporting each community health worker.)

The inclusion of an economist in some evaluations would permit the testing of existing models for cost-effectiveness analysis; comparisons of per unit delivery costs within the private sector and between the private and public sectors; and the building of qualitative and quantitative models of optimal program mixes, including the benefits of public-private sector collaboration in health and nutrition services delivery.

Similarly, most health sector PVOs share a common problem of inadequate information systems (not unlike public sector programs.) The inclusion of a health management information specialist would allow comparisons of systems and the development of plans for upgrading them, so as to improve the PVO program management and AID/UASID monitoring and communication with PVOs.

Recommendation: Future evaluation series should group PVOs with more comparable portfolios. For example, some evaluations could focus on cost-effectiveness of PVOs, gather more extensive and uniform cost data, and include an economist. Others could focus on management information systems. The scope of work for such a series should be precisely stated so that the desired sorts of comparability can be attained, particularly in areas of special interest to AID.

APPENDIX A

AID Centrally-Funded Matching Grants to PVOs with Major Health and Nutrition Activities

	PVO	Years of Current Grant	AID Funding Planned in thousands of dollars	Major Activities
1)	Save the Children (SAVE)	1983-85	4,500	Integrated Community-Based Development
2)	Salvation Army World Service (SAWSO)	1984-86	3,600	Comprehensive Health Care Services
3)	Foster Parents Plan (PLAN)	1984-86	3,500	Integrated Community-Based Development
4)	Lutheran World Relief (LWR)	1983-85	2,400	Integrated Community-Based Development
5)	International Institute for Rural Reconstruction	1984-86	2,375	Health Activities within Integrated Rural Development Program and Training
6)	Adventist Development and Relief Agency (ADRA) formerly SAWS	1981-84	2,150	Community-Based Health and Nutrition Programming
7)	Meals for Millions	1982-84	1,850	Applied Nutrition Programs and Appropriate Food Technology
8)	Helen Keller International (HKI)	1981-84	1,500	Integrated Primary Eye and Health Care
9)	Catholic Relief Services (CRS)	1983-85	1,250	Food Aid, Nutrition and Health Services
10)	Project Concern International (PCI)	1983-85	1,200	Primary Health Care Training and Services
11)	International Eye Foundation (IEF)	1981-84	900	Training and Services in Blindness Prevention and Cure
	TOTAL		\$25,225	

APPENDIX B

PVO EVALUATION PROCEDURES

Washington

1. Meet AID project officer to discuss the PVO, country program, and the home office. Obtain MG documents.
2. Request PVO for specific information and documents (see list below).
3. Visit to PVO home office to discuss field visit, country program background data, and home office management; obtain available documents.
4. Review of background documents and data.
5. Select two-person evaluation team including evaluation specialist with PVO health sector evaluation experience and a technical specialist with evaluation experience in appropriate technical areas. Evaluators should contribute cultural perspective in addition to technical balance, and should preferably have local language skills and in-country work experience. A PVO home office staff member should take an active role in designing the field visit in Washington, leading the team in the field, and reviewing the draft evaluation report.

Field Visit

1. Initial orientation and planning session in-country with evaluation team, PVO home office participant, and PVO country program director to finalize arrangements, discuss travel and writing schedule, plan meetings, and outline evaluation report. (Note that occasionally field interviews may require confidentiality, without presence of PVO personnel.)
2. Brief protocol meetings or fact-finding interviews with appropriate Ministry of Health and USAID officials.
3. Meetings with all levels of program staff, to discuss such issues as:
 - history and description of program
 - description of project sites, including significant program and cultural features

- program progress and constraints
- reports and records of outputs, indicators of impact
- selection of sites to visit
- finalize schedule

4. Helpful hints:

- MSH evaluators may divide up occasionally to save time and increase coverage
 - one evaluator can take notes while other leads discussion or interview
 - one or both evaluators, with PVO participant if appropriate, should set aside one day every three or four days to write, review, synthesize, and adjust plans
5. Visit sites, conduct interviews, and review documents (including program data not available at home office).
 6. Collect whatever information is easily available on public sector (or other PVO) activities which can be compared to the PVO's activities.
 7. Detailed debriefing with program personnel prior to departure (based on "Analysis of Results" section of report).
 8. If possible, outline of debriefing points and copies of tables should be left with country program director.
 9. Summary (shorter) debriefing with Ministry of Health and USAID officials.

Washington

1. Summary debriefing with PVO home office, if feasible and necessary, and AID project officer.
2. Write first draft of evaluation report (less than 40 double spaced pages).
3. Send draft copies for review, comment, additions, and corrections to:
 - PVO home office (with extra copy to be forwarded to PVO Country Program Director)
 - Second MSH evaluator
 - MSH Project Director
4. Incorporate corrections in second draft as appropriate.
5. Send second draft of report to AID for comment.

6. Incorporate AID comments in final report.
7. Send copies of final report to:
 - PVO (5 copies)
 - AID (10 copies)
 - Second evaluator (one copy)

INFORMATION REQUESTED FROM PVOs

1. Matching Grant Proposal and/or Agreement with AID
2. Country program (health and nutrition related) plans, schedules, budgets, job descriptions, or other program design documents--including revisions made during the program.
3. Copy of the original program agreements with the host government: resolutions, implementation plan; modifications to the original agreements.
4. Details of country program expenditures by year and line item for both the field and home offices; show amount of AID contribution by year.
5. Copies of annual program reports.
6. Copies of baseline surveys, special epidemiological resource inventories, or other studies which may have been done in the program area.
7. Counts of activities and outputs realized by program site and year under the Matching Grant. If these are not summarized, then source data from which they can be tabulated.
8. Copies of any previous internal or external evaluations which may have been conducted of the program.
9. List of all PVO and MOH personnel directly related to the program, hired during the life of the program, including positions, dates of service, salaries or salary ranges.
10. List of contributing or cooperating agencies, indicating the timing and nature of their input.

APPENDIX C

EVALUATION FIELD VISITS, PERSONNEL, and ITINERARIES

PVO PROGRAM	DATES	ITINERARY	NSM EVALUATORS	PVO PARTICIPANTS
Seventh-Day Adventist World Service, Haiti	July 1983	Port-au-Prince, Roulin, Ranquette, La Fossette, Diquin	Polly Harrison, PhD, Evaluation Specialist and Medical Anthropologist Joyce King, MA, Applied Nutrition Specialist	James Fulfer, SAMS/Haiti Program Director Olive Fulfer, RN, SAMS/Haiti Director of Community Health Richard O'Fili, SAMS/International Executive Director
Seventh-Day Adventist World Service, Tanzania	Sept. 1983	Arusha, Ikizu, Busungu, Bwasi, Pare Mountains, Suji, Gcha, Dar es Salaam	John LeSar, MD, MPH, Evaluation Specialist and Public Health Physician (Project Director) Nicholas Denforth, MIA, EdM, Evaluation Specialist and Health Education Planner (Project Manager)	David Syme, MPH, RN, SAMS/International Director for Program Planning and Evaluation Norman Renker, SAMS/Tanzania Program Director Godfrey Chamba, MD, SAMS/Tanzania, Medical Director
Heals for Millions/ Freedom from Hunger Foundation, Honduras	July 1983	Tegucigalpa, Juticalpa, Zopilotepe	James Becht, MPH, Public Health Evaluation and Information Specialist Reinaldo Grueso, MD, Public Health Nutritionist (Honduras)	Richard Redder, MPH Vice President for Program Zoila Alvarez, MPH/ Honduras Program Director
International Eye Foundation, Honduras	July and August 1983	Tegucigalpa, Choluteca, San Lorenzo, Comayagua, San Pedro Sula, La Ceiba, Juticalpa, Zopilotepe	James Becht, MPH, Public Health Evaluation and Information Specialist Luis Figueroa, MD, Ophthalmologist (Guatemala)	Tamara Oberbeck RN, COT, IEF/Honduras Eye Care Trainer

APPENDIX D

SAMPLE EVALUATION REPORT OUTLINE

- I. EXECUTIVE SUMMARY
 - II. BACKGROUND
 - A. Description of this Evaluation
 - B. Description of the PVO
 - C. The PVO Matching Grant
 - D. Program Environment in Country
 - E. Relevant AID and USAID Policies and Strategies
 - III. THE COUNTRY PROGRAM
 - A. Goals, Purposes, and Strategy
 - B. Planned Outputs and Inputs
 - C. Proposal Development Process
 - IV. ACTIVITIES AND RESOURCE UTILIZATION
 - A. Summary of Activities
 - B. Actual Inputs
 - C. Integral Relations
 - V. PROGRAM RESULTS
 - A. Outputs by Component
 - B. Planning and Design Process
 - C. Program Management
 - D. The Importance of the Program Environment
 - E. The Importance of Financial Constraints
 - VII. CONCLUSIONS AND RECOMMENDATIONS
 - A. General Conclusions
 - B. Special Areas of Interest
 - C. Recommendations
 - D. General Lessons Learned
- APPENDICES
- A. Tables and Figures
 - B. Bibliography
 - C. List of Persons Contacted
 - D. Itinerary of the Evaluation
 - E. Map

APPENDIX E

PVO and PROGRAM SELECTION CRITERIA

A. Program Focus

1. Does the program have substantial health and/or nutrition related activities?
2. Does the program demonstrate any of the relative advantages of PVOs in the health/nutrition sector over other public or private health programs?
3. Is the program typical of the type of health/nutrition activity done by this PVO (or other PVOs) in other countries? If so, is it likely to demonstrate some typical attribute(s) of health/nutrition sector PVOs?
4. Is the program atypical or unique in its approach? If so, is it likely to demonstrate the effectiveness of this special approach? Can it demonstrate a unique approach to such special issues as technology transfer, cost-effectiveness, institutionalization, or benefit distribution?
5. Does the program demonstrate the PVO's Matching Grant Program strategy as set forth in the Matching Grant Proposal?
6. Does the program demonstrate particular health-related activities, technologies, or interventions, possibly new to the area involved, which AID, USAID, the host government, or the PVO itself wants to analyze (e.g. oral rehydration, water and sanitation, agriculture, family planning)?
7. Does the program further the objectives of the USAID Country Program Strategy?
8. Are these unique or special activities important enough for AID or the PVO to replicate elsewhere?

B. Program Timing

1. Does AID require an external evaluation at this time?
2. Has the program been evaluated too recently (within the past year) or too frequently (twice or more)? (If so, do not select.)

3. Is the program mature enough to have demonstrated and measured significant results (outputs, even impact)? (In health programs this may take three years or longer.)
4. If not, is the program at an early or interim stage when an evaluation would help the PVO to make appropriate policy, budgetary, staffing, technical, or other program changes?
5. Is the PVO facing a particular difficulty in the program which it would like to have analyzed by objective, specialized, "outside" observers?
6. Is the PVO planning any expansion or replication which would be improved by an analysis of current activities?
7. Is the program about to end, or has it already ended? If so, does the PVO want to document, disseminate, or publicize its results?
8. Does the home office and/or country program staff have the time to assist the evaluation team by showing them program activities and program data, reviewing the draft report, providing information, etc.?

C. Other Criteria

1. Does the PVO want an evaluation?
2. Is sufficient data available on program outputs, impact, costs, and other important management information?
3. Is the program located in a region, country, culture or economic system of particular interest to AID, USAID, or the PVO?

APPENDIX F

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