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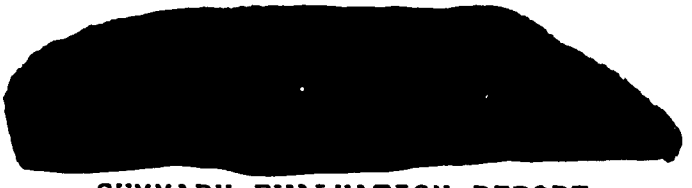

SUMMARY EVALUATION REPORT

EIGHT PVO PROJECTS

IN HEALTH AND NUTRITION

March, 1985

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SUMMARY REPORT: EIGHT PVO HEALTH PROJECTS

March, 1985

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ABBREVIATIONS

ADRA	Adventist Development and Relief Agency (formerly SAWS, Seventh Day Adventist World Service)
AID	Agency for International Development
ANP	Applied Nutrition Program
FVA	Bureau for Food for Peace and Voluntary Assistance, AID
HKI	Helen Keller International
IEF	International Eye Foundation
MFM	Meals for Millions/Freedom from Hunger Foundation
MG	Matching Grant from AID
MOH	Ministry of Health
MSH	Management Sciences for Health
OMA	Ophthalmic Medical Assistant
ORT	Oral Rehydration Therapy
PCI	Project Concern International
PHC	Primary Health Care
SAWSO	Salvation Army World Service Office
TBA	Traditional Birth Attendant
USAID	AID Missions Overseas
VHW	Village Health Worker

FOREWARD

This second interim report summarizes the findings of eight evaluations of PVO projects in health and nutrition by the PVO Evaluation Project of Management Sciences for Health, which is solely responsible for its contents. It was sponsored by the AID Bureau for Food for Peace and Voluntary Assistance. Questions or comments are welcome and should be addressed to Nicholas Danforth, Project Manager, PVO Evaluation Project, Management Sciences for Health, Suite 700, 1655 North Fort Myer Drive, Arlington, VA 22209, (703/841-0723).

I. EXECUTIVE SUMMARY

This report is a summary of the major findings of evaluations of eight PVO health projects funded partly by AID Matching Grants. The evaluations were performed in 1983 and 1984 by teams from Management Sciences for Health for AID/FVA in close collaboration with PVO staff members.

All eight projects have succeeded, in different settings and using varied approaches, in providing modern, low-cost health services, usually to poor, rural families, most of whom would not otherwise have access to them. Analysis of results (Section IV) indicates, particularly in the more mature Matching Grant projects, that most targeted outputs (primarily health services delivered or health workers trained) are being met on schedule or exceeded. The impact of those outputs on morbidity and mortality was less evident because many projects do not collect or analyse adequate baseline or monitoring data. However, two projects have dramatically reduced child malnutrition and at least half the projects have demonstrated intermediate indicators of impact on maternal and child health such as increased utilization of curative and preventive services.

The management of PVO projects needs improvement (Section V). Plans for specific Matching Grant projects in each country were drawn hastily, often without measurable objectives, technical analysis, understanding of the existing local conditions, and without the participation of the host country government or, in some instances, the beneficiaries. Also, the Matching Grant approval process could benefit from a more rigorous review by AID of specific areas in which PVOs would require strengthening (eg. planning, monitoring, evaluation, etc.). PVO health information systems, which are essential for effective performance by health workers at all levels, are usually rudimentary and need upgrading in order to explain and verify project impact. Pressure on the PVOs to show early results, with grants up for renewal every three years, leads to an emphasis on immediate outputs of health services instead of collaborative institutional development and training which might lead to longer term sustainability and replicability (Section VI).

Despite such difficulties and formidable socio-economic constraints, these projects were able to provide innovative health services such as oral rehydration, immunization, and blindness prevention in some of the Third World's poorest, most neglected, and most remote rural areas (Section VII). Although PVOs reach only a small proportion of the needy in any country, they often try new approaches requiring a level of independence and creativity not found in public sector projects. They are able to test and demonstrate imaginative, cost-effective primary health care strategies, primarily because of the hard work of their devoted staff members and their ability, in some projects, to work closely with individuals and communities in small, focused, controlled interventions.

Unfortunately most of the PVO projects have not been very effective at documenting and replicating their innovative experiences. Lessons learned by a few project managers are often lost to the wider national and international health community because the PVOs, host country institutions, and USAIDs are not sharing project information. Improved monitoring and information systems and dissemination will reveal findings about the PVOs' effectiveness and efficiency which may have very useful implications for other private and public sector health planners.

Regarding the role of AID, the evaluators are concerned about the need to clarify, simplify, and facilitate the responsibilities of AID in Washington and USAID missions overseas in approving, monitoring, and evaluating PVO programs. AID and USAID missions 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. Host governments, as well as the U.S. Government, must do their part to build cooperation and institutionalization.

MSH recommends that these PVOs continue to expand their health and nutrition outreach activities and that AID expand, selectively and with certain conditions, its Matching Grant support. In addition, it is recommended that these evaluations be continued, allowing more time for revision of draft evaluation reports by the PVOs themselves. The review and revision of draft reports is a lengthy but essential part of the learning process which should be encouraged. Several specific issues should be explored in depth. They include the impact and cost-effectiveness of PVO health projects, 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 unique and growing importance of health and nutrition programs of AID-assisted PVOs.

II. BACKGROUND

A. The Evaluation Process

The AID Bureau for Food for Peace and Voluntary Assistance (FVA) is responsible for the planning, monitoring, and evaluation of centrally-funded Matching Grants to PVOs. Twelve PVOs currently receive Matching Grants totalling over $25 million focussed primarily on health and nutrition (see list at Appendix A). 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]

To date, eight country projects of six PVOs have been evaluated:

- Adventist Development and Relief Agency (ADRA), Haiti and Tanzania
- Helen Keller International (HKI), Philippines
- International Eye Foundation (IEF), Honduras and Malawi
- Meals for Millions/Freedom from Hunger (MFM), Honduras
- Project Concern International (PCI), Bolivia
- Salvation Army World Service Office (SAWSO), Pakistan

Field visits of two to three weeks each were made by two-person teams of MSH evaluators: one an evaluation specialist, the other a specialist in the technical area of greatest importance to the program. Each PVO except one provided at least one home office representative to the evaluation teams. 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 project improvement. This interim summary report synthesizes the findings, recommendations, and lessons learned, from the eight reports. (See Appendix B for a summary of basic facts about each of the projects evaluated).

There are several criteria for deciding which PVOs and which of their country projects to evaluate. 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. Projects should not have been over-evaluated and must want to have an evaluation; the evaluations are, and should be

seen by PVO headquarters and field staff, as a joint, collaborative effort between each PVO and AID and MSH to improve future projects by understanding the strengths and weaknesses of current projects.

B. 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] In selecting PVOs for the program, FVA considers each PVO's related experience; financial management capability is of prime importance. PVOs applying for an MG must provide general plans for new projects in the countries where they currently work or in new countries. 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 and encourages flexibility in program design and implementation at the country level.

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

III. PROJECT SUMMARIES

Of the eight projects evaluated, five are "horizontal" projects in primary health care (PHC). They are designed to provide poor families, particularly children, pregnant women, and mothers, with simple, low cost preventive and curative health services in the home or community with referral to secondary (clinic) or tertiary (hospital) care if necessary. These projects are basically similar in their goals and strategies: they seek to reduce maternal and child mortality by training, supervising, and supplying VHWs who provide standard PHC interventions.

Village health workers (VHWs) are the front line health workers who usually have training in both preventive and curative care. They make simple diagnoses and treatments or refer patients to the nearest clinic or hospital (which is frequently their base of operation and supervision). They also provide preventive services ranging from health education in pre- and post-natal care, nutrition, hygiene, family planning, and sanitation. Most VHWs provide families with ORT for diarrhea and contraceptives for family planning, and participate in immunization programs for infants and children. Some are trained as birth attendants, some provide food supplements with complimentary PL 480 foods, and some assist in water and sanitation improvements.

The remaining three projects are eye health projects focused on a single health goal: the prevention and cure of eye problems and blindness at all three service levels (primary, secondary, and tertiary).

When evaluated, all eight projects were in their second or third year of operation (except MFM/Honduras which was in its fifth year). All projects have utilized or collected some baseline data; some of it is limited, inaccurate, outdated or not yet analysed. All have developed at least rudimentary monitoring systems to keep track of outputs, and several have collected data suggesting intermediate indicators of impact. The eight projects are small in AID terms, costing in the range of $100,000 to $200,000 annually. Each project is described briefly below.

A. Primary Health Care Projects

1. Adventist Development and Relief Agency (ADRA)/Haiti

ADRA, highly experienced in Haiti after years of relief work, seeks in its MG project to improve the health of Haitian mothers and children by decreasing malnutrition of children under five through 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. ADRA 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. This project proved very successful in helping malnourished children.

2. ADRA/Tanzania

Building on its established network of Adventist Churches and rural health clinics, ADRA has recently begun (after considerable rethinking and revision) a community health promotion project in two rural sites in northeastern and northwestern Tanzania. At each of the two sites about 15 VHWs, 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. VHWs are in theory supervised and supported by the local Adventist clinics and by two ADRA Training Officers. The VHWs have been asked to do household surveys and home visits to promote basic sanitation, MCH, health education, and family planning. In one of the two sites, the health project is linked to an irrigation project costing $130,000 (half from AID), in which local volunteer laborers participate and which is designed to improve farming and nutrition practices. The ADRA/Tanzania project was just beginning community-level activity when evaluated.

3. Meals for Millions (MFM)/Honduras

The MFM overall goal is to reduce malnutrition in children under five and in pregnant and lactating women 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.

MFM was effective, without a single expatriate full-time in Honduras, at integrating various health and health related services in the project area and building community participation (particularly among women's groups). Hundreds of children and women benefitted directly from new health and nutrition programs, with a 24% decrease in 2nd and 3rd degree malnutrition over five years. Applied Nutrition Program concepts and processes were introduced and are likely to be replicated by the government, but improved information systems are needed.

4. Project Concern International (PCI)/Bolivia

Like MFM/Honduras, Project Concern in Bolivia has been instrumental in increasing the quantity and quality of the government's own health services, simply by helping to improve health planning, training, and administration. PCI's successful "regionalization" effort in Oruro, Bolivia, is managed by two expatriates (a project director and a trainer) who work in the regional Office of Planning and Supervision of the MOH to develop its administrative and information systems and to train all levels of health workers. PCI also coordinates research on and experiments with continuing traditional and modern medicine and encourages the spread of new but appropriate health related technologies. The PCI approach has brought significant increases in access to and use of health services and has strengthened community-level

preventive health promotion. The Bolivian Government is anxious to expand the PCI approach into new areas and is very supportive of PCI's integrated innovative role.

5. Salvation Army World Service Office (SAWSO)/Pakistan

Approximately 20,000 poor Pakistanis living in villages which have never had any modern health sanitation services are now served by visiting teams of nurses, village health workers, environmental health workers and literacy teachers of the Salvation Army of Pakistan. The teams provide not only the basic package of material and child health services including immunization and family planning, but also TB screening and treatment for all ages, sanitation education and assistance, and basic literacy training for girls and young women to improve their health knowledge and behavior. One site provides rehabilitation for handicapped children.

These services are innovative, not only in the lives of the beneficiaries but also within the tradition-bound Salvation Army, which has for nearly a century provided Pakistanis with curative care from its network of ten clinics throughout the country. With Matching Grant support and helpful guidance from SAWSO/Washington, "The Army" is now working hard to emphasize outreach and prevention focused on health, nutrition and sanitation education. The Government of Pakistan has appointed the Salvation Army to provide immunization; the Family Planning Association provides the Salvation Army with contraceptives. Salvation Army health teams are generally welcome in Moslem as well as Christian villages. It is too early to measure impact, but the Salvation Army is reorganizing its information system to ensure services are provided, and that other outputs can be measured accurately.

B. Eye Care Projects

1. Helen Keller International (HKI)/Philippines

This successful project provides training in eye care and supervision of 400 village health workers. The project:

- is fully integrated into and controlled by the Ministry of Health, which will be able to take responsibility for it when HKI moves on;

- is very low in cost, increasing its chances for sustainability and replicability;

- demonstrates that a vertical (eye care) component can enhance a horizontal (PHC) program, not detract from it.

There are several reasons why this project was well planned and managed and is likely to be cost-effective. It addressed a specific, recognized problem. It was integrated into a successful on-going PHC project. It enjoyed the support of the USAID from the early inception of the idea and it aimed at a relative-

ly modest goal which could be achieved within the three-year MG period. It was carefully planned, with specific, scheduled outputs, and is coordinated by an energetic, effective American manager. He is careful to encourage both local and national government officials to take responsibility for the project, and he ensures that HKI keeps a low profile. HKI is efficiently and rapidly reaching its goal to help local health authorities integrate eye care fully into the PHC system and thus demonstrate a blindness prevention model which can be widely replicated without expatriate help.

2. International Eye Foundation (IEF)/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 strategy in Honduras was to upgrade tertiary and secondary care first by training nurses and later to address primary eye care. In that way, as primary eye care became available in the future, eye care referrals could be absorbed at the secondary and tertiary levels. IEF's training was effective, but without any IEF staff based in Honduras, without follow-up training, and without national eye health planning and policy-making, lasting improvements in eye care cannot be documented.

3. IEF/Malawi

Malawi has 7,000,000 people but only two indigenous ophthalmologists--neither of whom is able to give much time to clinical care. To remedy this, the government relies heavily on two IEF ophthalmologists who have been in Malawi under an AID Matching Grant since 1981. Highly skilled and experienced in African eye care, both ophthalmologists have worked very effectively most of the time doing surgery in Malawi's two central hospitals. IEF has no other support staff there, and its home office plays a minimal role in the project.

In addition to their major emphasis on surgery, the IEF physicians have made important contributions in training Malawians in eye care at the secondary and tertiary levels. They provide in-service training to more than a dozen eye care workers in the two central hospitals and to 26 medical assistants in the central and southern regions of Malawi. IEF also organized a nine-month international eye care training course for 22 medical assistants from Malawi and five other African countries, and an eye survey of 7,000 people in the southern part of the country. IEF began to experiment with primary eye care by training TBAs to prevent and detect eye problems in newborns, and by testing a system for Medical Assistants to visit rural health posts. However, PHC was at an early stage in Malawi and the MOH had discouraged IEF from attempting to integrate eye care into the VHW's tasks to avoid overloading them. Unfortunately national eye health policy and planning activities have not been undertaken in this project, and there are no plans to decrease Malawi's dependence on expatriates.

IV. RESULTS

A. Outputs

All eight projects were generally achieving or exceeding planned outputs of health and nutrition services on schedule, although start-up time had often taken longer than expected. Three projects (ADRA/Tananzia, SAWSO/Pakistan, and HKI/Philippines) had only recently completed health worker training and were just beginning to deliver services, thus showing few outputs. All projects, however, succeeded in increasing the availability and utilization of certain health services. In many rural areas the PVOs brought modern health services to villages on a regular basis for the first time ever. Even where governments or indigenous PVOs had previously been providing some services, these PVOs helped improve the quantity and quality of services significantly. PCI/Bolivia, for example, helped increase the utilization of regional health services by about 60%, while also improving the quality of those services and exceeding its training objectives.

The three eye care projects appear to have increased eye treatment for both inpatients and outpatients. All three eye projects are curing blindness by extracting cataracts and preventing blindness through extensive outpatient care and early diagnosis--particularly of Vitamin A deficiency from poor diets and trachoma from poor hygiene and polluted water. Patients treated in these projects do not and cannot pay for services and would not otherwise be cured. HKI/Philippines' primary (village level) activities are handicapped by a delay in receiving essential drugs; and IEF/Malawi is unable to provide primary eye care because Malawi has no primary health care system. Nonetheless, both groups were able to help health workers build stronger eye treatment and referral systems.

In some projects, including those which seemed well planned, and which had quantified their planned outputs, some output targets were not achieved. Usually this was a result of a deliberate and appropriate change of plans, but in only one case (ADRA/Tanzania) was AID/Washington told of the change. It is unfortunate that the PVOs and AID do not have in place a more effective information system for monitoring because changes in outputs planned and achieved often reveal important findings about PVO effectiveness.

In ADRA/Haiti, for example, the number of mothers receiving food aid was less than expected, as was the number of income-generating projects being established--largely because ADRA/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/Honduras Applied Nutrition Program (ANP), similar outputs--mothers and children participating in nutrition programs and mothers' groups organized--generally exceeded plans, perhaps because MFM has developed its system for two more years than ADRA in Haiti.

In five projects, training outputs were the major ones being measured, and they had been reached. Consequent outputs--the services to be offered by those trained--were more difficult to measure effectively or were not compared with a baseline. In ADRA/Tanzania, for example, VHWs 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. PCI/Bolivia has succeeded in training more health workers at various levels than expected, but systems designed for evaluating that training and for systematic collection of project data are not yet fully operational. In IEF/Honduras many nurses who received training are no longer in contact with either IEF or the MOH, so their effectiveness is not being measured. In HKI/Philippines, because all VHWs in the region are being trained in eye care, there is no control group against which HKI can compare the VHWs' outputs. In several projects the problem is not that the PVOs are failing to produce results on schedule but that project monitoring systems do not adequately measure results.

B. Impact

In low cost public health projects which have been under way for less than three years, it is not realistic to expect a significant impact on morbidity and mortality. Nevertheless, several projects show intermediate signs of impact after about two years of MG activity. ADRA/Haiti, whose stated goal was "to decrease nutrition- and sanitation-related morbidity and mortality in target communities," has saved the lives of almost all children in the program suffering from third-degree malnutrition (considered as at risk of death) and has dramatically improved the weights-for-age of most of the 10,000 children in the program suffering from some degree of 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. (Unfortunately, ADRA/Haiti did not collect baseline infant mortality data as planned so that overall impact measurement is hampered in that area.)

When evaluated in 1983, ADRA/Tanzania had just begun community health promotion activities and no substantial impact is likely for two more years. The promise of improving health standards at low cost is very high nonetheless, if certain program improvements are made. VHWs 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 by ADRA in the past.) If the VHWs 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 the VHWs, then impact is possible in time.

MFM/Honduras has produced excellent results in reducing second- and third-degree malnutrition nearly 25% 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%. (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). Similarly, in PCI/Bolivia we can safely assume that the project has significantly lowered infant and maternal morbidity and mortality because of the increase in use of health services, but this cannot be measured scientifically.

The three eye care projects show indications of intermediate impact (which cannot reliably be identified as the result of program activities). For example, with hundreds of VHWs being trained in eye care by HKI/Philippines and with increasing numbers of eye patients being referred to clinics, HKI is likely to make inroads into the high rates of blindness in that area. IEF did not do any baseline surveys and has not systematically collected data on the prevalence of blindness in Honduras or Malawi, so the impact of its projects on blindness cannot be measured. Under the assumption that the nurses and doctors trained by HKI and IEF are better able to detect eye pathology and refer patients, the evaluators analyzed changes in the hospital discharge data. During the first two years of IEF/Honduras (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. HKI project doctors in the Philippines have also increased the availability of eye surgery. Thus both projects seem to be increasing the use of eye care facilities and the identification of eye problems.

C. Cost-Effectiveness

Ideally PVOs should monitor health related costs of each project and count the people who benefit from it. This monitoring would reveal the per capita costs of health services, and would enable the PVO to compare its cost-effectiveness in different areas or in using different approaches. Unfortunately most projects find it difficult to estimate how much expenditure is directly related to health because of their multi-purpose, horizontal nature. Is irrigation or income generation to be considered a health intervention or not? Both have important effects on health, nutrition, and family planning, but neither is normally considered a health project output. Moreover, most

projects have trouble either in defining or in counting their target populations and their actual beneficiaries: is a mother who sees only one nutrition demonstration a "beneficiary"?

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. Project costs in Honduras ranged from MFM's $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 the ADRA/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 ADRA/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. The direct field operations of PVOs appear 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 as explained in the following section, management of some PVOs is underfunded and given too low priority in the budget process. In such cases, management's effectiveness and efficiency might be increased by increasing its share of program funds.

V. MANAGEMENT

A. Planning

Whether it is done before or after the MG award, careful planning is obviously a vital part of PVO health project management--particularly in innovative, experimental PHC projects which explore uncharted waters, and which may require both community and MOH participation (frequently a slow and difficult process) as well as multisectoral coordination and cooperation. In three projects, MFM/Honduras, PCI/Bolivia, and HKI/Philippines, detailed designs were drawn up after careful assessments of local health problems. These were done in collaboration with local institutions, particularly with the Ministry of Health, before project activities got under way. This process helped ensure not only that the projects' goals were appropriate and realistic from a public health viewpoint, but also that potential administrative and political problems would be avoided. These PVOs, in these projects at least, appear to be well aware that effective institution-building begins with collaborative planning by all those who have a stake either in the initial project or in its replication.

Nonetheless, when all eight projects are considered together, it is clear that the process of planning individual country projects needs improvement. Several plans were vague and/or unrealistic in their objectives and strategies and remained so even after the projects got well under way. For example, both ADRA country-specific project plans, approved by AID/Washington after the multinational MG had been approved, were overly amibitious: they needed to be rewritten, cut back, and rescheduled in both countries. IEF had no country-specific work plans or schedules for Honduras or Malawi, only a general multinational proposal for an MG with a logical framework and a wide range of program options including community-level primary eye care training and tertiary eye care training in hospitals. ADRA/Tanzania demonstrated that successful planning can take time. It took the better part of a year after the project began to develop the goals, purposes, and strategies in its plan.

As in many developing country health projects, few of the six PVOs based their plans on careful 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. ADRA/Haiti and SAWSO/Pakistan, both of which did baseline surveys, did not predicate site selection on either their own or national survey data, but rather on mixed, largely pragmatic criteria. Like MFM/Honduras they also failed to base their educational materials or strategies on analysis of new or existing data.

The constraints to effective planning may have arisen partly from limitations in AID's system for reviewing Matching Grant applications. AID approves 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 and logical frameworks usually required in AID project documents. Most PVOs do not submit more than the briefest country project plans to AID for approval.

Varied approaches to planning and design by the eight PVOs illustrate the importance of country-specific planning (discussed in first Interim Report). Both PCI/Bolivia and HKI/Philippines began their projects with thorough local assessments of relevant health problems, then drew up careful project plans including objectives, outputs, and work schedules. IEF did not draw up specific work plans or schedules in Malawi, and has not targeted specific outputs. SAWSO/Pakistan has recently introduced a list of specific, measurable objectives, and is refining its baseline data to prepare for future measures of impact.

Because an MG lasts only three years, there has been substantial pressure on PVOs to begin implementation quickly without further planning or baseline research in order 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 project in detail before beginning implementation. In addition, because of the three-year funding limit, PVOs find it difficult (as in the cases of ADRA/Tananzia and SAWSO/Pakistan) to revise plans and make mid-course corrections and changes which are appropriate even in well-planned projects.

AID, in its approval process, has looked primarily at overall past performance of the PVO applying for the MG and does not have the staff or the time to study how each country project will be implemented. During this critical initial planning phase, AID has not been able to provide technical feedback to PVOs which might compensate for the pressures of time.

B. 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, some PVO field staff sometimes seemed overworked and unable to pay adequate attention to planning and monitoring project details. Some seemed inexperienced in the design and management of health programs requiring institution building; some do not work closely with local or national government officials (see below) and some are not training local counterparts to eventually take their places.

Some see their work more as temporary "relief" for the recipients of aid, less as long-term development in collaboration with host-country counterparts who should take over project management. As in many other AID-funded health programs, some PVO staff were medically experienced but were not accustomed to managing a PHC development process based on local community participation and aimed at eventual self-reliance. The traditional PVO desire to "do good" and stay indefinitely (instead of transfering technical and managerial skills and low-cost technologies to the host country within a limited time) is fading, but it has not disappeared entirely.

Some PVOs have a large staff (and infrastructure of buildings, vehicles, etc.) already in country who can be mobilized for new PHC activities very quickly and inexpensively. Some staff members are expatriates who have lived there for years and are comfortable with the local language, culture, and living standards. Two examples of this type of PVO are ADRA and SAWSO. In Haiti, Adventists have been present for decades; recently ADRA's central staff of nearly 40 people have managed PL 480 programs, outreach grants, and other activities. Efficient management and accounting systems which predated the MG have made it much easier for ADRA to monitor and supervise MG activities. In Tanzania, ADRA was also able to build on long-standing experience in rural health; the MG enabled ADRA to build a community outreach program based on its network of rural clinics and managed from its Tanzanian headquarters by a Tanzanian Adventist physician. In both countries ADRA would have been much less effective if it had not built on existing staff and other resources already available in country. Similarly, SAWSO's experienced expatriate staff in Pakistan have been there for at least five and as many as 16 years.

Each of the project directors were carefully selected, experienced, competent, and committed. The PVOs vary in their balance of expatriate and host country staff. One end of the staffing spectrum was represented by the two PVO projects in Honduras, IEF and MFM, which had no full time expatriate staff in country. The IEF/Honduras project, which involved only one part-time expatriate staff member who visited every few months, had no fixed local staff. Program cost was correspondingly low. (Unfortunately, the expatriate, although very competent as an eye-care trainer, had no other appropriate experience and no local counterpart. Her effectiveness in areas other than training was limited, and the project's possible impact on eye health care has not been measured.)

MFM/Honduras has been very effective in reducing malnutrition without any long-term expatriate staff. All MFM/Honduras in-country staff are nationals, although MFM headquarters in California provides regular, competent technical assistance and management support to them. 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. Yet it is primarily by mobilizing existing community, government,

and private sector organizations, not by providing its own money or material, that MFM/Honduras has been effective.

The other end of the staffing spectrum is represented by SAWSO/Pakistan, where only two of the project's 15 top staff members are nationals. SAWSO staff have not been able to recruit or train host country counterparts to replace them, and plans for building a strong indigenous institution are unclear. The remaining three PVO projects, however, have one or two expatriate staff working closely with local counterparts and other officials; most are making progress toward training a host country replacement.

C. Monitoring and Information Systems

Data deficiencies have affected the design, implementation, and evaluation of some projects. Several PVOs appeared relatively weak in their monitoring and data collection activities; some collected excessive data and did not analyze it appropriately; others collected too little. In few cases were data used to provide useful and timely feedback to managers or staff about project strengths and weaknesses. In only one of the projects (HKI/Philippines), were data 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 burdened the PVO 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. Medical Assistants in Malawi and VHWs in Pakistan, for example, complained to the evaluators that reporting took up a substantial amount of their busy day, that they never heard from their supervisors about the data they collected, and that they know of no project planning which had resulted from it. Sometimes the amount of data being generated could not possibly be analyzed by the small staff available.

In short, most PVOs need well-conceived, timely, accessible, and agile sets of data which might constitute indicators for project management and evaluation without major demands on personnel time. Such monitoring systems would not only generate appropriate reports to management, but would also ensure that information is fed back to front line staff, especially VHWs. Reporting the most important and interesting statistics to the community--as VHWs in HKI/Philippines do by posting charts of service and morbidity and mortality statistics on the walls of their health posts--also makes health workers and the public more likely to take an interest in collecting and reporting data.

VI. INSTITUTIONAL DEVELOPMENT

To increase the long term effects of their pilot programs, PVOs should not only be concerned with the immediate provision of health services in the initial target areas, but they must also be committed to building the capacity of local organizations to provide health services on their own in the future, phasing out foreign assistance. It is a well known AID policy that AID-assisted PVOs should help people in developing countries develop their own skills and capabilities to address their development problems.

However, this form of institutional development is not easy to implement or measure. It requires effective training of host country nationals at all levels, including management. It requires a certain degree of financial management so that costs can be controlled and increasingly recovered so that projects can become self-financing. The project needs to be closely linked to national objectives. It also requires good, collaborative relations with governments and other private groups so that both government officials, local leaders, and direct beneficiaries are all committed to project continuation.

Eventually, the result of effective institution-building, including training, cost-effective implementation, and building community support, should be project sustainability (the project having the managerial, technical, and financial resources to maintain itself) and replicability (so that it can be adapted and expanded to new target areas, or nationwide). While skilled expatriates are usually needed to set up new projects, in most cases their primary role should be to train local people to run those projects as early as possible.

This section reviews the PVOs' progress toward sustainability and replicability in the context of such institutional development. However, institutional development means very different things to different PVOs. For some PVOs, particularly the religious groups with existing clinic systems (in this report, ADRA and SAWSO), institutional development is internal: their goals are to sustain indefinitely their own organization's primary health care system, and to replicate pilot projects in new areas under their own auspices.

For other PVOs, institutional development refers to development of indigenous local institutions, public and private. For them, sustainability refers to the project's ability to maintain itself after foreign PVO support has been phased out; replication means that the government or other private organizations apply the PVO's model in new areas under new auspices and separate from the PVO.

Both types of institutional development are viable; the most appropriate approach will depend on each local situation. In both the internal and external approaches, a PVO needs to train local staff to replace expatriates, build community

participation and support, and increase cost effectiveness if it seeks to have maximum effect. In these respects, several of the PVOs evaluated are setting outstanding examples.

A. Training

All PVOs face evident shortages of trained host country manpower; most of those evaluated recognize that the first step they need to take to develop local capabilities is to train local counterparts who can eventually replace expatriates. That recognition is reflected in several excellent training programs which are among the most outstanding contributions of these PVOs to the communities they serve.

PCI/Bolivia is perhaps the best example of a project carefully designed to build the capability of host country staff at all levels to run the entire gamut of project operations with expatriate assistance at a minimum. All regional health management staff and support staff, nurses, and VHWs received coordinated, "regionalized" training under PCI guidance. Training outputs exceeded project plans and the MOH's ability to employ all those qualified and scheduled to be hired.

MFM/Honduras also designed exemplary training for management and technical staff, using expatriates as trainers but only on a short term basis. This project is the only one evaluated which has no long term expatriate staff; nonetheless it has apparently reached its training objectives. HKI/Philippines also developed a superior eye care training program for primary health workers, now functioning without expatriates, using only MOH trainers and local materials. The HKI/MOH training can be sustained at low cost without HKI support and will be replicated in other regions of the Philippines in the near future. The two ADRA projects have put major emphasis on training VHWs and host country project management staff and are making major improvements.

IEF's training in Honduras and Malawi, on the other hand, has also been of high quality but is completely dependent on expatriates and is not institutionalized into the MOH. Similarly, SAWSO/Pakistan training of VHWs is largely done by expatriates and is in need of improvement.

B. Relations with Institutions

The PVO projects evaluated provided health care to relatively small numbers of beneficiaries. While these health systems appear to be efficient and cost-effective on a limited scale, they should be expanded and replicated on a large scale if they are to maximize their own (and AID's) investment. In many cases the replicability of PVO projects depends partly on the PVO's ability to work in collaboration with either the host government, indigenous PVOs, or other health-related institutions. Ministries of Health can often learn PHC strategies

from PVOs which have been able to test them without the constraints of a large bureaucracy. PVOs may need to collaborate with both governmental and nongovernmental institutions in other sectors (such as agriculture, water and sanitation, and education) which have a direct effect on health standards. In most cases PVOs need to plan and work together with these public and private agencies.

The eight PVO projects studied varied significantly in their relationships with governments. MFM/Honduras, PCI/Bolivia, and HKI/Philippines all collaborated very effectively with regional MOH officials, while the other two PVOs have been able to work closely with both central and regional MOH offices. These three PVO projects are more likely to be both replicable and sustainable because of their efforts to collaborate with local and national officials who learn (and take responsibility for) the PHC methods used.

Working closely with the MOH does not guarantee that it will adopt effective PHC strategies. In both Honduras and Malawi IEF worked within the MOH but did not help in the establishment of needed primary eye care policies because IEF staff were oriented toward training, not policy and planning, and were not able to demonstrate, as HKI did in the Philippines, that primary eye care can strengthen a PHC program.

MFM/Honduras, PCI/Bolivia, and HKI/Philippines all worked effectively with governments because a major goal of their efforts was to improve the capacity of those governments to create and sustain their own effective and efficient PHC systems. Both ADRA projects and SAWSO/Pakistan, in contrast, were working to strengthen their own PHC capability in order to supplement MOH services and were not even attempting to assist the MOH directly.

ADRA projects 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. ADRA/Tanzania staff may have concluded, with some justification, that they can be effective without relating more to government.

Similarly, SAWSO/Pakistan had a tradition of strict independence from the Pakistan government, and its clinics and services in villages were more available and of better quality, particularly in drug supplies, than the government's clinics. Both those PVOs seemed to prefer a certain separation from government, while the other four see greater coordination as integral to program success.

C. Community Participation

One of the most common claims made for and by PVOs is that they enable whole communities, including the poorest strata, to participate in programs. They describe themselves as particularly apt at enabling the poor to gain control over their own lives. Participation of beneficiaries in the design of PHC projects is obviously important if the beneficiaries are to accept, support, and eventually sustain these projects. The evaluation was concerned about whether this PVO "article of faith" has become reality in PVO health sector activities.

Six of the eight projects evaluated were community-based (neither IEF project had reached the village level). The most effective participation was being implemented by 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 generation projects. Farmers, midwives, school teachers, nutritionists, and sanitarians gave and received training, and had regular contacts with the ANP staff.

Another effective project in eliciting community support was PCI/Bolivia, where a major focus in the target region was to utilize existing traditional structures to deliver PHC. Traditional healers, herbs, legends, and relationships are all studied and, if appropriate, incorporated into daily routines of the projects' VHWs, nurses, and trained TBAs. This innovative project reveals that bridging the gap between modern and traditional cultures may be the most important step in increasing participation and service utilization.

Two other projects appear to have had mixed results in involving their beneficiaries. HKI/Philippines, a project totally integrated into the government's PHC program, utilizes community health committees which the MOH has set up but which do not appear very effective. There are few indications that the committee members encouraged the use of eye services or played any role in planning or monitoring eye health activities. SAWSO/Pakistan also worked with community groups in some of its villages, but in most villages these groups were being informed of the project's activities without becoming participants in them. In one village the committee was very active and raised money; in another the committee was critical of SAWSO.

The two ADRA projects 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 ADRA Project 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 such participation. 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 VHWs to be trained by ADRA, but it was not clear how well those leaders or the VHWs they selected had represented their communities. In general VHWs appeared young and inexperienced. In any case, the communities' role in the program seemed to end with the selection of VHWs--hardly a hopeful sign for significant, long-term participation in program management.

The evaluators were concerned whether the religious PVOs (ADRA and SAWSO) might have had limited results in stimulating community involvement because of the target populations' possible perception that these PVOs were either proselytizing or restricting services to Church members. There was, however, no evidence in either Haiti, Pakistan or Tanzania, that participation or benefits were limited to Adventist Church members or Salvation Army members. Both ADRA and SAWSO staff, including some very devout members, apparently treat all community members equitably and do not proselytize. In Pakistan, although the Salvation Army often helps the small minority of Christians in its villages, most beneficiaries are Moslems in the majority of project villages.

In the IEF projects, few attempts were 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. Both projects have tested community level interventions (training school teachers in Honduras and TBAs in Malawi) but only on a very small scale.

D. Sustainability and Replicability

Ideally, projects which begin with PVO aid should eventually be replicated without that aid, and should in the long run become self-financed and self-managed, sustaining themselves without depending on expatriate support. Normally, for any project to be sustainable and replicable, its costs must be low enough to be assumed locally, its management and staff must be capable of administering it effectively, and its beneficiaries must appreciate it. Predictably, these PVO illustrate different levels of sustainability; they teach a variety of lessons about how PVOs can best ensure that their activities will be appreciated and eventually carried on by beneficiaries.

The projects evaluated which seem to have the best chance of eventually continuing without foreign assistance are those which were designed to strengthen existing health activities. They focus on training, on strengthening collaboration between private and public sector organizations, and they work closely with local or national governments. Most have plans to recover an increasingly large share of project costs from the beneficiaries or from government.

Good examples are MFM/Honduras, PCI/Bolivia, and HKI/Philippines--all of which were planned from the start to build on existing health programs and to train existing health workers. Each has improved on a system already in place, combining both private and public sector resources, and has avoided creating new structures or new recurrent costs. Each would probably be continued indefinitely by the MOH if the PVO were, for any reason, to end its involvement. And each is likely to expand to new areas in the next year or two.

Other projects appear less sustainable. The two IEF projects were effective in training staff of existing MOH programs but remained fully dependent on expatriate trainers. IEF was unable to strengthen the two countries' eye care policies, plans, and management systems; for example, Malawi had no plan to increase the number of Malawian ophthalmologists from its current level of two. The ADRA and SAWSO projects are focusing their institutional development on themselves; they do little to train staff from other organizations in their target areas. While the ADRA and SAWSO projects are sure to continue for some time under PVO sponsorship, there is no evidence of progress toward phasing out foreign funding or technical assistance. The ADRA projects have been more effective than SAWSO/Pakistan in recruiting and training host country managers, but none of the three projects worked as closely with the MOH as the other five projects evaluated. The ADRA and SAWSO projects will replicate their own strategies by expanding PHC to new areas where they already have health activities under way; but they have done very little to replicate their approaches in other insitutions.

The eight evaluations indicate that different PVOs may be most effective in institution-building at different levels of the health care system. A "vertical" program like eye care might be easier to institutionalize into national health plans and programs if it is introduced differently than multisectoral programs like PHC or applied nutrition. Clearly a case can be made for PVOs to work in many situations, provided they all continue to build local participation and management. Not all PVOs are moving as rapidly as possible toward the institutionalization and replication of projects.

VII. SPECIAL ISSUES

A. Constraints

These eight projects faced formidable barriers on several levels. All confronted serious national economic situations--particularly in Haiti and Tanzania, where food, fuel, and medical supplies often ran dangerously low. A lack of effective governmental organization and support, as in the case of IEF/Honduras and SAWSO/Pakistan, or a government's limited ability to support multisectoral programs, as in MFM/Honduras, can make institution-building difficult. Religious and cultural friction in Pakistan caused difficulties for SAWSO, and cuts in MOH drug supplies in the Philippines meant shortages of essential eye drugs for HKI.

The greatest constraint in all eight projects, however, was the lack of trained host country and expatriate 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 ADRA, SAWSO and IEF projects, for example, are mostly expatriates who have very heavy responsibilities, little time, and few staff to whom they can delegate responsibilities. SAWSO/Pakistan faces great difficulties recruiting qualified Pakistani nurses, particularly Salvationists. In ADRA/Tanzania, the Tanzanian Project Director has no support staff; he relies on his wife who volunteers to help keep the project's books and service data.

Both ADRA projects and the SAWSO project have brief orientation programs for senior staff but little or no specialized administrative technical training for any level staff. Thus ADRA and SAWSO staff skills are particularly weak in the fields of clinic management (supervising health workers, improving patient flow, etc.) and adult education (for training all levels of health workers more effectively and for 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. All projects were more or less lacking in the skills needed for the design and use of suitable information systems.

B. Benefit Distribution

All projects we studied were faced with the difficult problem of reaching those too poor, too remote, or too sick to visit VHW posts, health clinics or food distribution points. All projects seek to make their services accessible to the poor, illiterate, or elderly members of their communities. Most showed clear evidence of reaching some of the most needy segments of their communities.

ADRA/Haiti, MFM/Honduras, PCI/Bolivia, and SAWSO/Pakistan in particular were stimulating improved nutritional knowledge and behavior among the poorest families. These four, particularly ADRA and SAWSO, work in extremely poor areas with many

villages which have been completely cut off from government health services. These programs must make difficult decisions between clinic based demands for curative care, often more likely to help better educated or healthier families, and home visits which take more time per family but often attend to the needs of the most marginal portions of the population.

ADRA/Tanzania, HKI/Philippines, and both IEF projects' benefits were potentially available to all families in the target areas. All community members were being treated equally and seemed to have the opportunity to benefit equally. However, benefits to the poor derive from improved access rather than from attempts by VHWs to stimulate widespread community participation or empower the poor.

IEF's projects in Honduras and Malawi were not concerned with testing interventions to reach underserved populations with primary eye care. Instead, IEF opted for a trickle-down approach by training Honduran nurses and doctors (mostly for urban or peri-urban areas) and Malawian medical assistants who provide the general population with secondary and tertiary eye care. IEF had no pilot programs in primary eye care or in rural areas which demonstrated effective preventive outreach. IEF/Honduras 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 were 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. IEF/Malawi trained TBAs but had no data on the effectiveness of the training or on TBA activities.

C. Innovation and Technology Transfer

These PVOs share several innovative features. Foremost is their primary health care approach, which fits AID priorities by emphasizing disease prevention through basic health education, MCH, nutrition, and sanitation, and by focusing on children and women. In countries where hospital and clinic-based care is the rule, and a small proportion of the health budget is spent on community-level public health, these PVOs set an important example--particularly when they can document cost-effectiveness in lowering mortality and morbidity.

All eight projects evaluated were using proven health and nutrition technologies already tested elsewhere in the same countries or in other countries, so in that sense they are not now considered innovative. Yet in all projects evaluated, some primary health care or nutrition approaches 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 in principle. 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 and PCI/Bolivia are good examples of such innovation through integration. MFM/Honduras 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, kitchen utensils, and 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.

PCI/Bolivia has also been technically innovative, introducing new types of cooking stoves and latrines, but is particularly innovative, ironically, in its approach to traditional medicine. By integrating new PHC technologies such as immunization and ORT through long standing cultural practices, institutions, and authorities, PCI has become very effective in introducing change.

ADRA/Tanzania has also integrated its programs in an innovative way: in one of its two sites, VHWs work closely with ADRA agricultural training officers on irrigation ditch renovation which promises to lead to better farming, improved diets, and maternal and child health improvements which may be measurable in about two years. The program was studied in its first year, however, so these links between community leaders, VHWs, clinics, and agriculture were still weak and need to be developed.

The innovative dimension of the ADRA/Haiti program is the increasingly apparent 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 ADRA/Haiti program.

VIII. CONCLUSIONS

A. PVO Strengths

1. PVOs are providing innovative, appropriate, effective health services.

Each of the eight PVO projects was providing appropriate low cost rural, PHC services focused on maternal and child health and community based prevention, three projects also strengthen secondary and tertiary (eye) care. All six organizations evaluated have successfully introduced new low cost health technologies such as ORT, growth monitoring, cataract extraction, family planning, clinic record systems, water and sanitation systems, training methods, literacy classes, even an agricultural loan fund. In six out of eight cases, interventions are targeted directly at the village level.

The impact of the eight projects has varied: in three cases, ADRA/Tanzania, HKI/Philippines and SAWSO/Pakistan, it was too early to measure impact but the projects have definitely improved the quantity and quality of PHC services. In the two IEF projects the lack of institutionalized follow-up may have dissipated the effects of excellent training. But in at least two programs (MFM/Honduras and ADRA/Haiti), a direct impact on reducing levels of malnutrition can be demonstrated statistically. Overall, the six PVOs appear to serve a useful purpose in training health workers and improving health services. The projects are particularly valuable if seen as pilot tests of new PHC approaches.

2. PVOs often reach areas unserved by governments.

PVOs have a special niche in the health sector by serving selected geographical areas where public sector services cannot or will not go. They extend the reach of the public health sector, correspondingly reducing the recurrent cost burden on that sector.

3. PVO staff tend to be highly committed, technically competent and culturally sensitive.

PVOs share strong traditions of service and dedication, some dating back decades. Many staff members have intimate knowledge of the developing areas, cultures and languages where they work and live. Some PVO staff are highly skilled health professionals. Compared to many other Americans in comparable jobs overseas, most PVO staff are more willing to accept living less expensively and living in rural areas. Because they are, in general, less susceptible to political vicissitudes, most PVOs have the durability and even public support which governments do not always enjoy.

4. PVO projects usually concentrate on small target areas.

Most of these pilot projects have limited target areas where close ties can be built with communities, and accurate data can be collected. Individual households can be surveyed for baseline data on the prevalence of diseases and on health related knowledge and behavior. The results of projects can be monitored to determine the cost-effectiveness of various PHC interventions. In some cases, these experiments can be controlled. Research opportunities are numerous in these settings (though the PVOs often fail to take advantage of them; see below).

5. Some PVOs have an extensive health infrastructure well established in the country on which new PHC programs can be built.

Older PVOs with traditional missionary programs, such as the Adventists and the Salvation Army, have often built close cultural and spiritual ties to communities; they have established hospitals and clinics, staff housing and vehicles; and they have trained their followers primarily in curative health care. AID funding enables those PVOs to expand out from their existing base of operations to rural households, upgrade staff skills in PHC, and reorient activities toward more cost-effective preventive care. As such, the Matching Grant can multiply the benefits of non-AID American assistance programs.

B. PVO Weaknesses

1. PVOs have a limited effect on national health standards unless they can develop innovative models to be replicated. Yet some PVOs do not document and replicate their methods.

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 lessons learned. Some PVOs see their health activity solely as an end in itself, when in fact it is at least as important as a pilot test from which other health 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 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. This requires that they communicate with other deliverers of health care, particularly the host government.

2. PVO health information systems are inadequate.

Despite increased concern among donors about the cost-effectiveness of PVO activities, and increased talk about monitoring and evaluation among PVOs themselves, many PVOs are still unable to measure the effects or impact of their programs on the health of the beneficiaries, e.g. lower mortality and morbidity rates of infants, children and women, or lower fertility. Some are unable to monitor project outputs (health, nutrition, or family planning services provided). Very few have been monitoring project costs in such a way as to prove to donors and to governments that their approaches are more efficient as well as more effective.

3. Few PVOs have performed and utilized adequate baseline surveys of health needs.

Accurate, comprehensive baseline health surveys of beneficiaries are necessary for (a) planning, deciding priorities for using limited resources and setting measurable objectives; (b) implementation, helping health workers find and work with those in greatest need; and (c) monitoring, as a benchmark to measure progress. Some PVOs fail to do a thorough sample survey or census; some fail to use baseline information to plan or monitor activity.

4. PVO staffing patterns are variable; some are significantly understaffed, especially at home offices. Home and field staff need more planning and management skills.

PVO staffing patterns vary according to the size and activities of the project. Overseas half the projects relied primarily on host country staff, half primarily on expatriates; all but two are making rapid progress toward the nationalization of staff. Project management capabilities varied considerably among the eight projects. PVOs are good at field level programming and execution; they are generally weak in planning and technical analysis, information systems, financial management, management training and supervision. One fourth of the programs had inadequate administrative personnel in the field. Many do not provide specific training to field staff in technical and management areas.

Home office support capabilities also vary among the PVOs evaluated. ADRA and IEF are understaffed, technically and administratively; it is difficult for them to give adequate support to their country programs. The other PVOs are generally well staffed quantitatively and qualitatively at the home office.

C. PVO/AID Relations

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

AID/Washington's participation in the Matching Grant process 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 rest of the MG process: program monitoring, review, and evaluation. Are FVA staff members responsible for making sure that progress is being made in every country project toward the goals of each Matching Grant? Should the FVA Project Officers be AID's "institutional memory," documenting and disseminating ideas about PVO strengths, weaknesses, and lessons learned? If so, Project Officers need to be able to monitor progress in all sectors in every project in every country of every PVO, an impossible task at present.

Given the heterogenous nature of the many centrally funded health-related PVO projects, it is not realistic to expect FVA Project Officers who have many other responsibilities - and are not trained in PHC - to monitor the outputs and impact of activities in health or any other sector without major changes in AID's information system. Project Officers do not have the time to review each PVO's annual reports as they should be reviewed, in light of the original MG proposal, subsequent changes in planned outputs, and progress reported previously.

The best way to ensure that the AID-PVO partnership improves PVO effectiveness and efficiency is to build an information system which will allow Project Officers to keep abreast of the quantity and quality of project activities (outputs), the effects of those activities on beneficiaries (impact), and related costs (cost-effectiveness). For monitoring progress in the health sector, a simple health information system should be set up. To be effective, it must be at least as useful to the PVO reporting as it is to AID and other donors.

2. The AID Matching Grant design process forces PVOs to promise unrealistic accomplishments, often in too short a time. Not enough attention is given in design to issues of institution-building and community participation.

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 some of the PVOs produced them on their own initiative. Insufficient time is allowed to develop such plans in the field before completing the project design. Management systems and strategies for community involvement and local institution-building are not ade-

quately addressed, especially in light of the goals of self-financing, cost-effectiveness, sustainability, and replicability (which none of the MG proposals 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; project objectives are often not quantified, and proposed budgets are frequently unrealistic. For the most part, real planning and design are accomplished during the first year or two that staff are in the field, usually precluding any measurable results by the third year of "operation." Pre-MG proposal project analysis and development costs are kept to a minimum, even in a country that is new for the PVO. Little attention has been given to developing specific criteria and interventions for achieving long-term institutionalization.

Both AID and the PVOs should recognize, in scheduling and in budgeting, the technical and financial costs of adequate program planning. Time should be allowed for detailed in-country analysis and design to determine proposed objectives, inputs, activities, and outputs. Proposed program design should specify strategies for institution-building and post-MG sustainability, including eventual host country management and cost-recovery.

3. <u>USAIDs generally lack knowledge of MG activities in their country, except where there is a PVO or PL-480 office.</u>

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 USAIDs. 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 communication between organizations and between sectors, to avoid duplication of AID-funded activities, and to increase project replicability.

D. PVO/Host Country Relationships

1. Some PVOs fail to work effectively with host country organizations.

PVOs have had varying degrees of contact with host governments; the advantages of close ties to the host government can vary. Two PVOs (ADRA and SAWSO) tended to limit such contacts. Their host governments have little or no role in monitoring and evaluating activities, limiting the likelihood of their projects becoming institutionalized into host government services or being sustained by host government financing. Those host governments tend to show little interest in project activities, perhaps because they are generally excluded from project design and monitoring (except when they are asked to sign an agreement with the PVO). These two PVOs come to host governments with pre-determined strategies: once a formal agreement is signed with the host government, there is litle subsequent involvement in operationalizing government participation in such areas as financing and training. As a result, institutional responsibility and real government commmitment has not yet been established.

ADRA and SAWSO are also relatively distant from indigenous PVOs--other than their own affiliates. While they do work with private organizations in some training activities, they do not appear to actively collaborate in implementation. SAWSO does work through an "indigenous" PVO (The Salvation Army of Pakistan); however, that PVO is managed mostly by expatriates and is largely dependent on overseas funding.

In contrast, the four other PVOs have worked more closely with local and national government offices and truly indigenous PVOs. For example, all have promoted cooperation at the regional or national level. HKI, IEF, and PCI expatriate staff all have offices within the MOH; MFM has no in-country expatriate project staff at all. All four have also established major links with local PVOs and have encouraged them to take over many project responsibilities.

There may well be situations where closer PVO links to governments or to private groups are neither wanted nor needed. In most cases, however, it seems desirable for local governments to know more about or to monitor and support these PVO projects under appropriate guidelines. The degree of American and indigenous PVO autonomy from the host government could be agreed upon by all parties. AID and USAID should insist that PVO projects be implemented in the best long-term interests of the host country and the USAID country development strategy. Different components of MG projects could become subject to indigenous control or influence; in any case, long-term as well as short-term expediency should be considered. Although there may be exceptions, most evaluators believe that successful PVO projects are not fully effective until the host country's private or public sector organizations know, support, and eventually replicate them.

E. Recommendations

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

2. PVOs and USAIDs should determine with host country institutions how to improve discussion, documentation, and dissemination of project findings and lessons learned to other PVOs, health planners, and host government and AID officials, both locally, nationally and internationally.

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

4. Specific training programs should be designed and executed by PVOs for their field staffs. Topics to be defined would be in areas of project administration as well as specific technical issues such as project design, information and evaluation systems, financial management, training and supervision, and local institutional development. AID should promote increased technical assistance in these areas.

5. A simplified health management information system, including specific design criteria and operational guidelines, need to be developed for PVO, AID, and USAID project planning, monitoring, and evaluation. Categories of quantifiable data and non-quantifiable project information to be reported to AID need to be agreed upon by the PVOs; such information needs to be at least as useful to the PVOs themselves as it is to AID.

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

7. USAIDs should consider promoting to host country institutions the establishment of a system whereby PVO activities in each country can be better planned, coordinated, monitored, publicized, and replicated.

8. American PVOs' ties to indigenous PVOs should be encouraged.

9. Future evaluations should group PVOs with more comparable portfolios and focus on selected topics in greater depth. For example, some evaluations could focus on management information systems, cost-effectiveness of PVOs, cost-effectiveness of health only vs. integrated programs, etc. (see below).

F. Lessons Learned About Evaluation

1. Early and mid-term PVO evaluations can be useful in correcting problems before they grow, although more mature projects tend to reveal more substantial findings.

2. All PVOs benefitted from the evaluation process because it clarified special issues and increased awareness of the complexity and importance of program management.

3. 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.

4. 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 the variations complicated efforts to compare PVOs, especially in the calculation of impact, costs, and cost-effectiveness.

5. Such comparisons were the least consistent aspect of these eight evaluations. Moreover, the evaluators did not have the time or the authority to analyze the results of comparable public and private sector health projects. As a result, it has not been possible to measure objectively the comparative advantage of PVOs in health. To establish the "special niche" of PVOs in the health sector, it will be necessary to focus on more detailed comparative analysis of data, grouping projects to be evaluated which have more uniform portfolios, and comparing them to projects managed by other types of institutions.

6. The inclusion of an economist or financial analyst in some evaluations would permit (a) the testing of existing models for cost-effectiveness analysis; (b) comparisons of per unit delivery costs within the private sector and between the private and public sectors; and (c) building models of optimal program mixes which maximize including the benefits of public-private sector collaboration.

7. 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 information systems and the development of plans for upgrading them. The results should be improvements in PVO program management and AID/USAID monitoring of PVOs.

8. More time should be allowed during evaluations for the evaluators to provide technical assistance if requested.

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)	1981-84 formerly SAWS	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	

A P P E N D I X B

SUMMARY REPORTS OF INDIVIDUAL PVO PROJECTS

Adventist Development and Relief Agency, Haiti

Adventist Development and Relief Agency, Tanzania

Meals for Millions, Honduras

Project Concern International, Bolivia

Salvation Army World Service Office, Pakistan

Helen Keller International, Philippines

International Eye Foundation, Honduras

International Eye Foundation, Malawi

SUMMARY REPORT: Adventist Development and Relief Agency, Haiti

Maternal and Child Health and Nutrition

A. PROJECT DESCRIPTION

Goals/Purposes

- increased health status of mothers and children in Haiti
- decrease malnutrition of children 0-5 by early detection and prompt intervention in 10 target areas

Strategies

- use PL 480 food as incentive for mothers to do growth monitoring, nutrition education

Activities

- baseline surveys, infrastructure, curriculum devt,
- training courses
- demonstration gardens
- open nutrition centers
- inservice training
- program monitoring

Inputs

- $325,000 (1/2 from AID) plus food worth $115,000 (2 yrs.)
- ADRA experience and infrastructure in relief in Haiti since 1976
- about 40 "central" staff and 30 "field" staff
- 2 expatriates

B. RESULTS

Planned - Outputs	- Actual
- 10 nutrition centers more established with 1 nutr. assistant at each	- on target for centers, over target for training
- 9000 mothers trained in growth monitoring and food prod/sanitation/preparation at each center	- modified to 5000 mothers; probably on target for 9/84
	- pace behind target
- 3 mother's groups estab. at each	- pace behind target
- all 9000 mothers receive PL 480 food	

Planned - Impact	- Actual
- indicators more specific than originally planned, but impact difficult to measure this early	- outstanding impact on child growth during program and follow-up seems likely

C. MANAGEMENT

Planning

- initial designs were overambitious; needed to be focused, specific
- time needed to refine plans, hire staff, collect and analyze data

Administration/Staff

- large and highly committed staff generally strong
- good collaboration and delegation between expats and Haitians

Relations

- USAID PVO officer and health officer both assist in communication with AID and with host govt, but do not affect internal program effectiveness

Information Systems

- clinic management and data collection weak; excessive data collected; priorities not set

D. INSTITUTIONAL DEVELOPMENT

Training

- competent nutrition assistants doing effective work after both initial and inservice training

Participation

- self-help component with mothers' participation not successful
- but general participation of mothers in growth monitoring worked well

Sustainability

- self-sufficiency not likely because of high levels of rural (90%) and urban (50%) poverty, food shortages, etc.

Replicability

- key interventions only can be replicated:
- growth monitoring
- ORT for diarrhea
- breastfeeding 2 yrs
- immunizations
- FP

(others not as effective)

E. SPECIAL ISSUES

Constraints

- shortage of technical assistance, esp. in specialized technical fields, (e.g. clinic management, adult education)

Benefit Distribution

- widespread benefits being extended to many MCH programs receiving PL 480/ADRA foods
- focus on under age 3 is most effective

Innovation/Technology Transfer

- not innovative (already being done by several PVOs in Haiti) but tries to combine food supplements with other interventions

F. CONCLUSIONS

Strengths

- well integrated MCH and nutrition/education program
- introduced weight-for-age concepts as important intervention

Weaknesses

- needs improved data collection
- community participation can be broadened

Recommendations

- monitor infant mortality to determine overall impact
- strengthen participation

Lessons Learned

- growth monitoring is an effective nutrition education tool

SUMMARY REPORT: Adventist Development and Relief Agency, Tanzania

Community Health and Nutrition

A. PROJECT DESCRIPTION

Goals/Purposes	Strategies	Activities	Inputs
- improve health of children under 5 in 8 communities - design primary health care system by training and supporting community health promoters in each community	- designate communities with SDA clinics and comm. health committees - link CHPs to clinics and CHCs for support	- baseline survey of 2900 families - training of CHPs - household and clinic health promotion - "ditch" repairs (related)	- $273,000 (1/2 from AID) for health only - one expat, country Program Dir. (40%) - SDA Medical Dir. (60%) - 9 SDA staff (part-time)

B. RESULTS

Planned - Outputs	- Actual	Planned - Impact	- Actual
- 30 community health committees established	- leaders appointed to CHC's but limited activities in sites visited		
- 90 community health promoters selected by CHCs	- at least 30 CHPs selected	- not stated	- too early to measure
- 30 CHPs trained	- 29 CHPs trained		
- 30 MCH clinics operating	- programs operating in sites visited		
- 70% MCH attendance of children 0-5	- no data collected		
- 75% immunized	- no data collected	- functioning PHC system including CHPs linked to SDA clinics	- CHPs in place but only weakly linked to SDA clinics
- 6 communities will have 60% of population with access to clean water	- 0% to date in sites visited		
- 40% use of latrines	- 0% to date in sitew visited		

C. MANAGEMENT

Planning	Administration/Staff	Relations	Information Systems
- initial plan overambitious, was revised, cut back - plans were not specific enough on CHP training tasks, supervision, finances - baseline survey done after planning and after training CHPs (should be before)	- good staff but over-worked and lack certain critical skills - weak supervision of field workers by ADRA MG program and clinics - unclear rela. with clinics	- link with SDA clinics weak - nonexistent with nat'l. gov't. - very little with local gov't., AID	- lack of staff to manage, collect, analyse data - data needed to show both outputs and impact

D. INSTITUTIONAL DEVELOPMENT

Training

- needs improvements in some subjects but generally well planned by Tanzanian MD Project Director
- should prioritize more clearly (e.g. anatomy section too detailed for average VHW)

Participation

- community data would improve training/work of CHP
- community groups not yet organized, but have potential

Sustainability

- no plans for program continuation, CHP salary support
- but SLA clinics are nearly self-sustaining

Replicability

- if self-financing system (tax or pre-payment plan) is set up, program can be replicated
- potential great for CHPs and clinics to work together

E. SPECIAL ISSUES

Constraints

- Tanzanian economy in crisis; lack of fuel for support, supervision, supply
- shortage of trained staff

Benefit Distribution

- benefits are likely to reach to poor (CHPs services are free) but not to empower them

Innovation/Technology Transfer

- new program of outreach from clinic improves preventive health education
- not new in intl. context

F. CONCLUSIONS

Strengths

- excellent Tanzanian MD as Project Director (only project evaluated to date with a host country MD as director)
- uses well organized system of rural clinics for supervision and supply of VHWs

Weaknesses

- poor supervision of VHWs in spite of clinic structure
- planning and prioritizing of key interventions in communications
- training not focused on key tasks

Recommendations

- strengthen supervision and supply of VHWs from clinics
- decide specific tasks for VHWs to be monitored carefully
- increase project staff to support Project Director
- select VHWs with more careful criteria

Lessons Learned

- new administrative and monitoring systems for VHWs are vital when systems are traditionally clinic based
- tight supervision is essential when VHWs lack in-depth training and have too many activities to monitor carefully

SUMMARY REPORT: Meals for Millions, Honduras

Applied Nutrition Program

A. PROJECT DESCRIPTION

Goals/Purposes

- reduce malnutrition of children 0-5, pregnant women, and lactating women
- strengthen capabilities of communities and health delivery system
- organize communities to implement self-help projects and participate in health and nutrition programs

Strategies

- applied nutrition program
- catalyst/facilitator
- interagency coordination
- community organization
- program integration

Activities

- agency coordination
- clinical control and supplementary feeding
- nutrition and health education
- training group/project administration
- self-help/income-generation
- water and sanitation

Inputs

- $420,000*
- Apr 78 - Jun 83
- AID contributed 6%
- staff: 8 IEP, all national; 1 MOH

*includes non-MG funds

B. RESULTS

Planned - Outputs	- Actual
- 8 communities organized	- 14 womens groups in 9 communities
- periodic meetings of coordinating committee	- coordinating committee active thru 1981
- 350-400 children in control	- 428 children in 1982 547 children in 1983
- 100 women participating in health/nutrition prog.	- women's group members: 274 in 1981, 256 in 1982, 333 in 1983
- 2 people per village trained in agriculture	- agric. training difficult to quantify; at least 2 per village
- self-help projects: fish ponds, gardens, small animal	- 86 agriculture project in 1983; 59 gardens in 1982, 49 loan recipients
- water projects	- 3 community water systems

Planned - Impact	- Actual
- improve nutritional status of children	- 24% decrease II & III malnutrition children under 5
- improve nutritional status of women	- no data on nutritional status of women
- decrease mortality and morbidity of children	- no mortality data: health center morbidity doubled, 1979 - 82

Costs and Cost-Effectiveness

- $30/year per capita
- provides where govt. does not
- high level of outputs in various sectors for low level of inputs
- major savings from no expatriate staff full-time in Honduras

C. MANAGEMENT

Planning

- community/field based planning
- purpose and objectives well defined
- inadequate analysis to determine most effective interventions; e.g. educ. and agriculture

Administration/Staff

- very capable and mutually supportive field staff
- good technical and admin. support from home office

Relations

- very good inter-agency relations
- mutual collaboration of MOH at region and field
- no USAID involvement

Information Systems

- info system disorganized; lacks certain data, excessive in other areas
- annual anthropometric survey
- no precise plan for program evaluation

D. INSTITUTIONAL DEVELOPMENT

Training

- primarily with womens groups at community level

Participation

- active community participation in identification and execution of projects

Sustainability

- sustainable with MFM presence as catalyst until communities assume role (no date set for MFM pullout)
- MFM incorporated as national agency

Replicability

- no GOH agency to facilitate replication
- role of private sector to be explored

E. SPECIAL ISSUES

Constraints

- no GOH agency for executing multi-sectoral programs
- agricultural component understaffed

Benefit Distribution

- most efforts and impact felt at village level
- other agency technicians oriented to process

Innovation/Technology Transfer

- integrated program
- new technologies
- plant varieties
- silos
- credit system
- health center records and appointment systems

F. CONCLUSIONS

Strengths

- improved integration of health and related services
- new technologies well tested, appropriate, cost effective
- integratee income generation and health
- interagency coordination

Weaknesses

- can improve mgt. information system, collect and analyse useful data
- needs technical analysis of nutrition interventions

Recommendations

- govt. needs to define who is responsible for coordinating and executing intersectoral activities
- MFM should decide how and when the project will become fully self-sustaining

Lessons Learned

- very good example of several AID and PVO goals: inter-organizational coordination; institution building; sustainability; self-managed
- information and evaluation systems are difficult for any PVO given limited budgets, pressure to "produce"

SUMMARY REPORT: Project Concern International, Bolivia

Primary Health Care Development and Training

A. PROJECT DESCRIPTION

Goals/Purposes	Strategies	Activities	Inputs
- Reduce morbidity and mortality, esp. of children and women (no specifics) - Increase access to health services; increase utilization; increase promotion and prevention - Strength MOH planning, management	- Training and support systems development - Regionalization; integration of services, administrative decentralization of subsystems (MCH, nutrition, sanitation, epid, TB, dental).	- Establish detailed plans - Develop support systems - Train supervisors, trainers, support staff - Train CHWs, TBAs - Establish local committees and local trad. medicine	1981-1983 - 385K (43% from AID) spent by PCI. This was 63% of the regional health extension budget; 25% from UNICEF, 10% from MOH (in addition to regular budget), 3% from community. - Two expat. health specialists - 14 local health mgt. professionals, 6 MDs, 42 nurses, 30 CHWs, 15 TBAs, 10 support staff.

B. RESULTS

Planned - Outputs	- Actual	Planned - Impact	- Actual
- Increased health services utilization	- 59% increase in utilization	- Reduced morbidity and mortality, esp. children and women (reduction not specified)	- Increased utilization and quality of health services throughout region is a significant intermediate indicator
- Planning (baselines, interagency coord, etc.)	- Coordinated team planning very effective		
- Training (CHWs, nurses, support staff)	- Training largely exceeded projections; quality of services improved		
- Develop admin. systems (planning, supervision, referral, supply, maintenance, info., evaluation)	- 6 admin. systems all behind schedule (because of MOH internal delays)		
- Develop comm. participation (incl. traditional medicine)	- Research and systems effectively promote both comm. participation and traditional medicines		

Costs and Cost-Effectiveness

- Overall per capita expenditure for 1983 = $3.21 (58% from PCI, 27% from MOH, 14% from UNICEF)
- Project has substantial financial support from local government

C. MANAGEMENT

Planning

- Assessment of health problems in region done first
- Planning was shared, team effort, concensus, guaranteeing commitment

Administration/Staff

- Effective administrative systems were developed in collaboration with government
- Nearly all local staff in regional MOH office; only 2 expatriate PCI staff members
- Project strongly institutionalized

Host Government Relations

- Project is fully integrated into regional MOH office
- PCI Director takes turns running the project planning and supervision on a rotating basis

Information Systems

- Continuous monitoring, and special evaluations (of drug supply, nurse training, traditional medicine) done by Office of Planning and Supervision
- However, systematic data collection and the regional information and evaluation subsystem planned have not been set up yet

D. INSTITUTIONAL DEVELOPMENT

Training

- management training of regional officials popular and apparently effective, induces colaboration
- CHW training integrated with other health-related training
- regional approach leads to much more efficient utilization and supervision of health workers

Participation

- CHW training strongly emphasizes community participation.
- Extensive research and application relating traditional and modern medicine has greatly increased support for the CHWs

Sustainability

- Group process used to develop policies within MOH framework makes this a well integrated, self-sustaining, institutionalized project
- PCI presence needed to reinforce changes made
- All disagreements in project are within MOH, not with outside agency
- Region, not central MOH, will sustain funds and management in future

Replicability

- Special health activities have been developed suitable to this region only - but the process of research, planning, and institutionalization is replicable
- PCI now expanding services to another region; also has been requested to manage other health systems elsewhere in Bolivia using same methods

E. SPECIAL ISSUES

Constraints

- Much progress made despite harsh environment, droughts, floods
- Rampant inflation of 1500%/2 years
- Devaluation of 7000% raises costs of imported health supplies, medicines, (but strengthen PCI dollars)
- Political instability, strikes, etc.
- MOH unable to maintain personnel or budget

Benefit Distribution

- Dramatic increases in CHW services to 7,500 rural villagers, improved drug supplies to 20,000 others, increased services and utilization elsewhere in region - mostly result of PCI.

Innovation/Technology Transfer

- Special cooking stoves introduced for ventilation, and sanitation
- Above-ground latrines used for cultural, engineering, and agricultural reasons
- Integration of traditional and modern medical systems; use of trad. social groups instead of artificially imposed "health committees"
- Folklore for health education

F. CONCLUSIONS

Strengths

- Complete integration of project into the regional MOH plans and operations
- Sharp increases in number and use of health services
- Training exceeded plans
- Traditional and modern medicine combined

Weaknesses

- No major problems
- Minor problem of different perspectives, in the home office and the Bolivia office of PCI about their roles
- Delays in parts of the regional plan due to MOH, not PCI

Recommendations

- Continue to develop program and expand to new areas, especially Cochabamba
- MOH must provide more health personnel
- Encourage multi-sectional development; gardens, water supplies, etc.
- Training improvements
- Place another PHC specialist to help expansion
- Improve home/field office relations

Lessons Learned

- Development of systems like this one require more commitment than money: long-term administration is better than short-term expenditures
- MOH needs better understanding of the PVOs' roles

SUMMARY REPORT: Salvation Army World Service Office, Pakistan

Comprehensive Preventive Health Project

A. DESCRIPTION

Goals/Purposes

- Reduce maternal, infant mortality dysentery, TB, communicable diseases among 100,000 rural poor

Strategies

- VHWS provide ante-natal well-baby clinics; family planning, immunization, TB services; medical treatment; sanitation

Activities

- All baseline surveys done; all strategies implemented in 7 of 10 villages, pop. 20,000
- Literacy classes for 300 young women
- 1 rehabilitation program

Inputs

- $373,000 (2/3 from AID) plus $68,000 worth of HQ support
- 2 full-time managers and several part-time (all expat)
- 3 full-time nurses (expat)
- 12 Pakistani labor workers
- Many consultants (expat)

B. RESULTS

Planned - Outputs - Actual

- Ante/post-natal care to 25% of pregnant women
- Immunize 60% of children
- Treat 25% of TB increase knowledge of 25 staff
- Rehabilitate 100 handicapped children

- "Outreach" outputs varied widely in each village, possibly because of reporting inaccuracies, also because of the priorities of the Nurse-in-Charge, and transport problems
- Poor: Antenatal, fam. planning, TB, sanitation
- OK: immunization, literacy
- Good: Well-baby; curative services

Planned - IMPACT - Actual

- Target: 100,000 people impact goals on infant or maternal morbidity not specified
- Reduce infant mortality by 15%

- Reached: 20,000 people
- Baselines lack key info. related to objectives
- Intermediate indicators (outputs, or services delivered) indicate likely impact in half the outreach areas on some objectives

Costs and Cost-Effectiveness

- Built on existing system low start-up costs
- Low salaries for expats
- Low costs of clinics, literacy, rehabilitation
- High commuting costs for VHWs

C. MANAGEMENT

Planning

- Plans grew out of SAWSO's need to change
- Inadequate definition of objectives and measures
- Inadequate baseline studies, village/VHW selection criteria, and community involvement plans

Administration/Staff

- Large expat mgmt. staff including RNs know Pakistan well, highly committed
- Need for more focused activities in MCH, ORT
- Training is weak, esp. in sanitation

Host Government Relations

- Good communication w/USAID and national government officials
- Local MOH officials not as supportive of SAWSO; better ties needed

Information Systems

- Very thorough records but some key information not collected (e.g., infant and maternal mortality) and some info. excessive
- System being revised to fit new project objectives

D. INSTITUTIONAL DEVELOPMENT

Training

- short courses for VHWs not long enough. Key subjects like ORT, family planning not well learned. Needs improvement
- Sanitation workers trained for only 2 days
- New training officer will be reorganizing curric. and materials using Medex, other improved sources

Participation

- Community groups not receiving enough attention; some villagers alienated by "outsiders" or "Christians"
- Some villages are supportive, involved
- Two villages raised funds and provided free labor for sanitation projects

Sustainability

- Self-financing is increasing thru fees for service, sale of medicines, etc.
- Communities contribute to sanitation (may contribute to PHC, too)
- Project not well institutionalized into MOH plans
- Some villages have no institutions to sustain the project in future

Replicability

- Project can be continued by Salvation Army contributions, but is not likely to become self-financing for years (until community financing and portion increases)
- Salavation Army and its staff are stable, permanent in Pak. (even more sustainable than USAID)
- Model may be very replicable in SA clinics (not clear whether GOP will replicate)
- Future replication not advisable without further testing

E. SPECIAL ISSUES

Constraints

- Extreme poverty limits impact, sustainability
- Socio-religious suspicion of Christians and non-resident outsiders
- Purdah restricts MCH and literacy
- Problems of cooperation with local MOH officials

Benefit Distribution

- Very effective outreach to 20,000
- Remote poor rural villages unserved by GOP
- No organized community participation

Innovation/Technology Transfer

- New services being provided in these villages include literacy classes for girls, thorough immunization, ORT, family planning, sanitation, and rehabilitation (one area only)

F. CONCLUSIONS

Major Strengths

- Very well organized, committed, experienced management team
- Excellent system of clinics and expat Nurses on which to build village outreach
- SA very stable and respected institution in Pakistan

Major Weaknesses

- VHWs and EHWs (sanitarians) not trained or supervised adequately
- Management team is 90% expatriate
- SA not working effectively with village leaders or local health officials
- Innovations, impact not well documented
- VHWs not village-based

Recommendations

- Improve training of all VHWs and sanitarians who need to live in villages
- Improve info. systems to document progress from baseline to reaching new objectives
- Increase Pakistanis in management
- Focus on a few key MCH activities in outreach

Lessons Learned

- Project demonstrates the great potential for transforming traditional clinic based program run by missionaries into village-based program where control is shared by village leaders
- Innovativeness is not enough; it needs to be documented

SUMMARY REPORT: Helen Keller International, Philippines

Integrated Primary Eye Health Care and Blindness Prevention

A. DESCRIPTION

Goals/Purposes

- To integrate primary eye care (PEC) and blindness prevention into the Bicol Integrated Health, Nutrition, and Population Project.
- To demonstrate an inexpensive "value-added" eye care program which might be replicated in other PHC projects in the Philippines

Strategies

- Train Barangay Health Aides (BHAs) to prevent, diagnose, treat, and refer eye problems, and train secondary level workers
- Integrate BHA training into existing training programs, and integrate eye care treatment referral into existing health and rehabilitation services
- Control costs carefully to ensure replicability
- Emphasize primary level
- Eye health education

Activities

- Assess eye problems in region
- Develop curriculum, training, and public education materials
- Train all 400 BHAs in Bicol region, and secondary level (nurses, MDs)
- Provide equipment, supplies, and education materials
- Assist in supervising BHAs and administration of PEC

Inputs

- $192,000 total cost includes:
  - one full time project coordinator, secretary, and driver
  - equipment and supplies

B. RESULTS

Planned - Outputs	- Actual
- Examination of random sample of 1,500 in Bicol for eye problems, eye health knowledge and behavior	- 2000 people examined, many treated or referred
- Training for 400 BHAs and other secondary level health workers	- 280 BHAs, 52 MDs, and 52 Public Health Nurses trained
- Design of low cost eye health training and public education materials	- Materials designed and produced
- Local production	
- Provide eye surgery in both provincial hospitals	- Surgeon flow from Manila monthly provides surgery in one hospital only

Planned - IMPACT - Actual

- BHAs have only recently been trained in PED
- No baseline survey available to measure impact, but the numbers of eye patients treated or referred is growing fast

Cost and Cost-Effectiveness

- Costs are low because HKI project:
  - has minimal staff (one expat)
  - uses no expat MDs, only MDs available locally
  - piggybacks eye care onto an existing PHC system, so requires no special infrastructure or staff
  - designed low cost educational materials which can be produced locally
  - is extremely careful about controlling costs

C. MANAGEMENT

Planning

- Careful planning, involved GOP, AID
- Bicol Project, developed without eye care emphasis since 1978, was the basis for HKI project, USAID/Manila requested HKI proposal
- National Sight Plan (1979) needed to be implemented
- HKI had experience in rehabilitation of the rural blind in Philippines since 1970's
- Detailed, country, specific plan written by home office staff in 2 visits

Administration/Staff

- Very competent (U.S.) Project Coordinator is careful to build GOP responsibility for project, control costs, ensure replicability
- Also competent Admin. Assistant (Filipina) can take over Coordinators responsibilities in his absence

Relations

- Very close and effective ties to the regional office of the MOH, which can soon take over the program
- Very close ties to AID; HKI Coordinator was USAID consultant and maintains contact in Manila (commutes there twice monthly)
- Private MDs, Lions Clubs, other support HKI effort

Information Systems

- Careful color-coded records are kept at every stage of referral system; each form stimulates follow-up
- BHA records, appear accurate and complete
- Information on health problems is used for public education (wall posters, etc.)
- One statistician from Inst. of Ophth. does monthly data analysis at project office

D. INSTITUTIONAL DEVELOPMENT

Training

- Training is very good, the project's major focus. All training methods and materials were carefully pretested with test groups. Materials produced locally at low cost. PDC training at all levels, including nurses and MDs, mainly focused on BHAs.

Participation

- Most BHAs work with some type of Barangay (village) health committee; people becoming aware of eye services available (unclear how effective committees are)
- Private sector involved, refer non-paying patients to the BHA or hospitals
- BHAs try to reach eye patients being mistreated by traditional healers
- BHAs supported by all, even the militant opponents of Marcos

Sustainability

- Costs of HKI project can probably be covered by MOH as part of BHA program, so HKI project can be continued as long as the MOH is able to pay for the BHAs in Bicol
- Cost-effectiveness and cost recovery need to be researched if long-term sustainability is to be assessed

Replicability

- Because BHAs have only recently begun, the Bicol project needs to be studied carefully before replication begins in other regions like Panay
- Because costs are low and the BHA's role is enhanced, HKI approach is likely to be repeated in other PHC projects in Philippines and elsewhere

E. INSTITUTIONAL DEVELOPMENT

Constraints

- Project still very new, difficult to measure effectiveness at this time
- MOH in financial crisis, cut essential drugs including eye ointments and Vitamin A
- Difficult to get MDs out of Manila, or to get MDs to work in public sector

Benefit Distribution

- Poor villages are reached by 400 BHAs providing PEC
- Some older blind cannot be persuaded that cataracts can be removed (but the word is spreading)
- Some poor needing surgery cannot afford to take time off work; some have transport problems (HKI working on this)

Innovation/Technology Transfer

- Project demonstrates that an effective vertical component (PEC) can strengthen a horizontal (PHC) program: BHAs are more respected by community and themselves when they have eye care skills, medication, kits, etc.
- Educational materials are produced locally, low cost
- Discussions under way for involving private MDs part-time in surgery for non-paying patients

F. CONCLUSIONS

Strengths

- Project is fully integrated into MOH program of PHC
- Additional training for eye care takes little time and cost but enhances the BHA status; seems cost-effective
- Project so popular even the revolutionaries back it
- MOH gets full credit and responsibility for project (HKI has low profile)
- HKI developed a clear country-specific plan
- Strong emphasis on information system and accurate monitoring

Weaknesses

- UNICEF has delayed the delivery of essential drugs which are needed for PEC credibility (Vit. A and eye ointment)
- No surgeon is available yet at one of the two main hospitals in the region; some patients have a problem traveling
- HKI project is dependent on continuation by MOH of the BHA's (likely, but not guaranteed)

Recommendations

- After project has matured in Bicol and data proves it cost-effective, continue in another region (Panay)
- Do more focused research on special issues, e.g., cost-effectiveness, nutritional interventions
- Establish a broader and more influential constituency for eye care; build support for the neglected National Sight Plan
- Improve administration of surgery

Lessons Learned

- USAID can be a help, not a hinderance, to a PVO project, and vice versa
- PVOs should try to give the local MOH officials a major stake in their project if the project is to be institutionalized (adopted and adapted) for continuation and replication
- Information system is vital to PVO project sustainability and replicability

SUMMARY REPORT: International Eye Foundation, Honduras

Primary Eye Care Delivery and Training

A. PROJECT DESCRIPTION

Goals/Purposes

- alleviate blindness (reduce prevalence and incidence) by: promotive preventive, and therapeutic services
- develop capacity of MOH thru: surveys and planning, upgrade PEC skills, train trainers

Strategies

- upgrade tertiary care first to absorb demand from subsequent primary eye referrals

Activities

- training auxiliary and professional nurses
- specialized training of opthalmologists
- curriculum development
- commodities

Inputs

- $213,000* Sept 79-June 83. AID contributed 88%. Staff 1 C.O.T. (IEF) 20 + intermittent (MOH)

*includes non-MG funds

B. RESULTS

Planned - Outputs	- Actual	Planned - Impact	- Actual
- training .24 professional nurses .400 auxiliary nurses .opthalmologists	- 118 nurse supervisors trained; 18% current supervisors were trained	- no indicators stated	- no surveys undertaken
- curriculum development in 6 schools	- 27 nurse instructors trained; 32% of current instructors trained		- increase in utilization of tertiary care level
	- 757 auxiliary nurses and students trained		
	- 19 opthalmologists (71% of total)		
	- curriculum good at 3 universities level; very little at 3 auxiliary schools		

C. MANAGEMENT

Planning

- purposes and objectives not well defined
- overall MG proposal on primary care not implemented
- no plan for organ. devel.
- prev. survey not done
- program survey not utilized

Administration/Staff

- IEF trainer not qualified for inst-bldg.

Relations

- inadequate attn' paid to program by MOH, USAID (and IEF)
- private sector not pursued

Information Systems

- information system weak, difficult to evaluate and monitor status

D. INSTITUTIONAL DEVELOPMENT

Training	Participation	Sustainability	Replicability
- high quality training despite (lack of later follow-up)	- primary eye care at community level as envisioned in MG proposal not implemented in final program	- program ending, no effort made to sustain; no institutional structure being left behind	- design can be replicated in private or public sector if MOH will become committed - very little attn' paid to inst-bldg. other than training, to sustain training, or to private sector

E. SPECIAL ISSUES

Constraints	Benefit Distribution	Innovation/Technology Transfer
- MOH disorganization - external "causes" of increased utilization - lack of TA for institution building	- aux. and prof. nurses received training - rural MDs not included - primary eye care not implemented - tertiary care providers	- new for program in Honduras, not elsewhere

F. CONCLUSIONS

Strengths	Weaknesses	Recommendations	Lessons Learned
- good training provided at all levels	- no follow-up to training - no measures by IEF of impact on eye health - no sustainability or replicability planned - project phased out (7)	- work more closely with government in the overall design of project - ensure long-term continuity; plan with all stakeholders	- planning and policy-making are as important in the design of an easily-neglected vertical program, as is quality of eye care training - management of eye care workers is as important as training them

SUMMARY REPORT: International Eye Foundation, Malawi

Blindness Prevention and Treatment Program

A. DESCRIPTION

Goals/Purposes	Strategies	Activities	Inputs
- Primary Eye Care (PEC) delivery and training - reduce curable and preventable blindness - establish an institutionalized capacity for prevention and treatment of blindness and eye disease	The IEF ophthalmologist(s) would: - provide eye care delivery and training in the central hospitals - train medical assistants to provide preventive and curative service in rural areas - supervise all eye care workers in Malawi - formulate a blindness prevention plan for MOH - do eye disease surveys - develop eye health educ. materials	- eye surgery provided in 2 hospitals - Medical Assistants (OMAs) and other health personnel (even some TBAs) have been trained in PEC - 9-month course for OMAs from 6 countries - OMA supervision and inservice training - survey of 7000 people in southern Malawi	- $333,000 (plus $15,000 for survey) - 2 ophthalmologists - administrative and technical backup from home office, esp. for survey - GOM provides housing, office, support staff, local travel, etc.

B. RESULTS

Planned - OUTPUTS -	Actual
- blindness prev. plan	- existing plan strengthened by IEF
- training for eye health personnel	- many personnel from Malawi, elsewhere, received training
- PEC materials developed in local languages	- some produced in English only
- PHC workers trained in PEC	- No, PHC program not developed
- design PEC program	- " "
- 162,000 outpatients	- 180,000 outpatients
- 500 sight-saving operations	- over 2,000 eye operations

Planned - IMPACT -	Actual
- to reduce the prevalence of curable and preventable disease	- no system for measuring is in place (no baseline, inconsistent monitoring of prevalence of blindness or disease) - impact may be measurable later if more studies like IEF's are done to measure prevalence

Cost and Cost-Effectiveness

- surgical and out-patient outputs have been high while IEF administrative costs are very low (having no administrative field staff). Thus cost per patient treated appears low.

C. MANAGEMENT

Planning

- no specific tasks, work schedules, outputs were planned
- no baseline data or surveys were studied to help in planning
- plans based on 1981 eye health assessment and IEF experience in Kenya
- no long term plans for institutionalization
- four different statements of goals, plans, strategies used in planning

Administration/Staffing

- two MDs were the only IEF staff: very competent and experienced in East Africa
- but no staff available to do admin. tasks, information, etc.
- IEF improving admin. of OMAs
- minimal home office support (except during survey) from IEF

Host Governments Relations

- IEF works very closely with MOH Blindness Prev. Comm., and with MOH hospitals and districts
- USAID does no monitoring of IEF (or other centrally funded PVOs)
- IEF has not assisted private hospitals
- collaboration with Lions Clubs, Hopkins, HKI

Information Systems

- outputs not reported to AID
- The Blindness Prev. Program and IEF do not monitor eye care activities carefully; records from OMAs are incomplete and inaccurate
- IEF improving the OMA's info. system as part of better supervision
- eye surgery may provide some baseline info., but more is needed

D. INSTITUTIONAL DEVELOPMENT

Training

- IEF MDs train hospital and clinic staff in 2 regions
- major intl. training program held for 20 eye health workers from 6 African countries
- survey used to train OMA in villages
- TBAs trained in PEC pilot tests

Participation

- little community level activity has begun, but increasing numbers of rural poor are receiving services in central and district hospitals

Sustainability

- Surgical output in central hospitals largely dependent on IEF, 2 Malawian MDs unable to do surgery
- only 2 Malawians (non MDs) able to do some surgery in central hospitals
- OMA system could continue without IEF but needs IEF supervision to ensure quality

Replicability

- Training of non-physicians to do surgery, international eye care course, and training/supervision/referral system for district hospitals - all can and should be replicated throughout Malawi, possibly other African countries
- MOH must develop PHC system before PEC can be tested in a few villages, then replicated

E. SPECIAL ISSUES

Constraints

- MOH has not assigned counterparts to take over IEF role
- lack of Malawian MDs to take over eye surgery
- MOH budget very restricted; OMAs cannot be increased
- IEF deeply involved in hospital care, not able to develop PEC
- PHC program not functioning yet

Benefit Distribution

- planned beneficiaries: 162,000 outpatients and 500 sight-restoring surgeries
- actual beneficiaries: 180,000 outpatients and over 2000 eye surgery patients
- some rural poor have been among beneficiaries in the two central hospitals and the southern and central regions
- TBAs help pregnant women and infants with eye care after IEF training

Innovation/Technology Transfer

- international training course
- IEF is continuing surgical work in hospitals begun by expatriates a decade ago (now new)
- eye surgery (now being analyzed) may be one of the best recent studies in Africa
- PEC is a badly needed innovation but is not yet begun

F. CONCLUSIONS

Strengths

- Highly skilled, productive eye specialists with African experience committed to long term, hard work
- IEF works closely with MOH, activities well integrated into MOH program
- Costs are low, well controlled, little home office expense
- Large survey done, can have important effect
- Training for Africans from 6 countries

Weaknessess

- MOH dependence on IEF: few Malawians are being trained to do eye surgery, and no Malawian MDs are able to take over for IEF staff
- IEF deeply involved in central hospitals, unable to devote enough time to developing district and village level PEC demonstration project
- PHC program of GOM is very small, too early to develop PEC demonstration project
- IEF lacks clear long-term plans for institutionalization of national blindness program, including PEC

Recommendations

- Develop clearer objectives, long-term plans for manpower training, PEC, MOH commitments, etc.
- Require Malawian counterparts to take over IEF roles
- Develop test of PEC systems to be integrated into the PHC program being developed
- Improve data collection and analysis
- Consider non-medical IEF staff, and more home office involvement to improve planning, information, training

Lessons Learned

- AID should ask PVOs for country specific plans with objectives, scheduled outputs, plans for institutional development, etc. (IEF is not building the "institutional capacity" which is the purpose of its matching grant; instead, it has prolonged Malawi's dependency on expatriates). AID or USAID should then monitor progress.