

# A.I.D. EVALUATION SUMMARY PART I

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

PO-MAV-777  
ISM = 50491

A. REPORTING A.I.D. UNIT (Mission or AID/W Office) **USAID/India**  
(ES # )

B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN?  
yes  slipped  ad hoc

C. EVALUATION TIMING  
interim  final  ex post  other

IDENTIFICATION DATA

D. ACTIVITY OR ACTIVITIES EVALUATED (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report)

Project #	Project/Program Title (or title & date of evaluation report)	First PROG or equivalent (FY)	Most recent P&D (mo./yr.)	Planned LCP Cost ('000)	Amount Obligated to Es ('000)
386-0469	PVOH Project Mid-term Evaluation Report	FY81	09/89	20,000	20,000

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

Action(s) Required

Name of officer responsible for Action

Date Action to be Completed

- |  |                                |   |
|--|--------------------------------|---|
| 1. Workshops for orientation training and communication among PVO subgrantees.   | E.G.P.Haran                    | One or two per year. First to be completed in FY87. |
| 2. In collaboration with GOI arrange for technical assistance to subprojects.  | E.G.P.Haran                    | Continuous Initial phase by Dec. 31, 1987           |
| 3. Discuss with MOHFW and NIHFW towards strengthening project assistance component as part of NIHFW's monitoring responsibilities. | E.G.P.Haran<br>S.M.Silberstein | Oct. 31, 1987                                       |
| 4. Develop a PP for a follow-on PVOH II Project.   | Steve Frenlich<br>E.G.P.Haran  | June 31, 1987                                       |

ACTIONS

F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION:

mo 12 day 18 year 1987 Report Date: mo DAY '87

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

Signature  
Typed Name  
Date 04/30/87

Project/Program Officer  
E.G.P.Haran

Representative of Borrower/Grantee

Evaluation Officer  
Peter Amato

Mission or AID/W Office Director  
Owen Cyike

SIGNATURES

The PVOH project through the MOHFW is designed to support the expansion and improvement of health, family planning and nutrition services for the poor by strengthening private voluntary organizations working in this area. After a long history of health and population assistance to the public sector, this project seeks to expand the previously under-utilized capacity of PVOs. USAID committed \$20 million in 1981 to be disbursed over six years, but the PACD has recently been extended for two years. This mid-term evaluation was conducted by a team including a health management consultant, a public health doctor, and an AID officer. The team visited seven sub-projects, interviewed project personnel and clients, reviewed project reports, and held discussions with GOI and AID officials. The major findings and conclusions are:

- Organizational delays in start-up and the current administrative structure of the project were reviewed. At the central level an efficient mechanism for project management appears to have been developed; at the subproject level, there are still delays in proposal review and approval, project establishment and implementation, and reporting of service delivery statistics.
- The original project paper specified that up to 15 subprojects would be funded; however in 1984 the maximum number of projects was increased to thirty. At the time of the evaluation, 22 PVOs were delivering primary health care services throughout India.
- The project has avoided duplication of GOI services through close contact with the state governments. In general, state governments recognize the potential contribution of PVOs and some have delegated primary health care responsibilities to PVOs in their respective areas.
- The needs of the PVOs for technical assistance as they expand and improve their coverage is great. Initial proposal review should identify technical and administrative assistance that is needed.
- NIHFV has successfully provided technical assistance in the area of financial accounting and management by contracting with a chartered accounting firm. Additional mechanisms should be developed for provision of technical assistance in other administrative, management and service delivery areas.

The evaluators noted the following lessons:

- Subproject design, approval, establishment and initiation of service delivery requires a substantial amount of time. Efforts should be made to streamline the process, but also to allow for longer project duration.
- The structure of this project (funding a large number of small projects) is "management-intensive"; as the number and size of projects grow, the need for increased technical and management assistance will grow as well. The possibility of regional PVOH support centers should be considered.
- The monitoring and technical support cell in NIHFV should be encouraged to view its role as that of project assistance rather than simply inspection.
- The large number of PVOs working in health and family welfare, and the demand for their services justified consideration of a follow-on project.

## I. EVALUATION COSTS

### 1. Evaluation Team

Name	Affiliation	Contract Number <u>OR</u> TDY Person Days	Contract Cost <u>OR</u> TDY Cost (US\$)	Source of Funds
Mr. P. Subramaniyam	Development Consultant	386-0000-C-00-6066	\$5,802	PD&S
Dr. Abraham Joseph	Christian Medical College, Vellore	PO:IN-P-6-275	\$5,830	PD&S
Mr. John Grant	FVA/PVC	21 days	TDY	

2. Mission/Office Professional Staff Person Days (estimate) 60 days

3. Borrower/Grantee Professional Staff Person-Days (estimate) 15

2

# A.I.D. EVALUATION SUMMARY PART II

## **J. SUMMARY OF EVALUATION FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (Try not to exceed the 3 pages provided)** Address the following items:

- o Name of mission or office
- o Purpose of activity (ies) evaluated
- o Purpose of the Evaluation and Methodology Used
- o Findings and Conclusions
- o Recommendations
- o Lessons learned

### 1. USAID India PVOH Project

Project Number 386-0469

### 2. Purpose of the Activity: To reduce mortality, morbidity, and fertility in India by assisting PVOs to design and expand projects aimed at the provision of basic and special preventive health, family planning and nutrition services for the poor.

### 3. Evaluation Purpose and Methodology

The purposes of this evaluation were as follows:

- to assess the progress of subproject implementation activities towards achieving objectives of the PVOH Project as stated in the Project Paper and the Grant Agreement;
- to assess the adequacy and effectiveness of administrative monitoring and technical assistance aspects; and
- to document lessons learned and their implications on future directions of the Project and/or additional inputs under bilateral agreement.

The evaluation methodology included the following activities:

- review of the documents of 22 subprojects and other related papers;
- site visits to 7 selected subprojects;
- interviews with responsible officials in the MOHFW, NIHFW, DEA, USAID, and the subproject organisations;
- interviews with functionaries of the subprojects at the grass-root level and at the supervisory level;
- interviews with selected beneficiaries at the grass-root level; and
- internal discussions including team planning, site visits, planning and review of work done.

### 4. Findings and Conclusions

- The PVOH is an effective and appropriate mechanism for involving PVOs in delivery of primary health care, family planning and nutrition services.
- The administrative mechanism selected for the project, a special grants program coordinated by the MOHFW is consistent with the GOI's public commitment to increase support to PVOs.
- The project is targeted at high priority areas of interest of both the USAID and GOI, which has had a positive involvement in all aspects of the project.

- The project has increased the awareness of state governments of the role of PVOs in primary health care. A number of the states have provided material support to the projects and some have delegated primary health care responsibilities to PVOs in their respective areas.
- The administrative structure which has evolved over the duration of the project has increased efficiency of proposal review and project management.
- Further refinements in processing the large number of proposals which are now received and in providing technical assistance to projects will be required.
- Site visits indicated that projects which have been operating for two years or more have successfully initiated outreach activities and/or delivering basic child survival services to needy segments of the population.
- The PVO subproject activities compare favorably with government health services and have introduced innovative approaches and promoted community participation.
- Although the project has made substantial progress, technical assistance, training, and other needs must be met if the PVOs are to be fully successful in achieving their objectives.
- The question of sustainability has been identified as a key issue to be addressed if health services are to continue after the end of the PVOH Project.
- An effective collaborating relationship has been developed between USAID, MOHFW, and NIHFV after a long organisational period in the early years of the Project during which some difficulties were encountered.
- The system of review, appraisal and approval of the subprojects has resulted, for the most part, in the approval of sound subprojects.
- The financial administration of the Project is strong, with adequate controls in place.
- The current system of program monitoring by NIHFV ensures adequate government supervision and control; however, program monitoring should be improved so that it becomes more supportive of the subprojects in their day-to-day operations.

### Recommendations

- The most important additional input required at this time is an expanded technical assistance capacity for the subprojects. Expertise will be required in training, data collection and analysis, personnel management, and service delivery strategies. A regional support facility for the PVOs should be considered.
- Visits to potential and functioning subprojects by NIHFV need to be increased and the emphasis shifted from inspection to assistance.
- Communication among PVO subprojects should be encouraged through the support of workshops and perhaps a newsletter.

- The proposal solicitation, review, and appraisal process needs to be further streamlined and standardised.
- The measurement of subproject impact needs to be improved in general by revising, simplifying, and standardizing the baseline survey, providing training to the subprojects in utilization of that data, and analyzing trends from bi-annual reports.
- Subprojects require continual assistance in financial accounting and management, as well as an initial orientation to the funding procedures.
- The "gestation period" for subprojects is relatively long and this fact needs to be taken into account in project planning, budgeting and evaluation.
- The role of family planning in the total package of maternal and child health care should be clarified.

### Lessons Learned

- Subproject design, approval, establishment and initiation of service delivery requires a substantial amount of time. Efforts should be made to streamline the process, but also to allow for longer project duration.
- The structure of this project (funding a large number of small projects) is "management-intensive"; as the number and size of projects grow, the need for increased technical and management assistance will grow as well. The possibility of regional PVOH support centers should be considered.
- The monitoring and technical support cell in NIHFV should be encouraged to view its role as that of project assistance rather than simply inspection.
- The large number of PVOs working in health and family welfare, and the demand for their services justified consideration of a follow-on project.

SH:abw:5/1/87:3353C

**K. ATTACHMENTS (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier)**

PVOH Project (386-0469)  
Mid-Term Evaluation Report  
November 1986

ATTACHMENTS

**L. COMMENTS BY MISSION, AID/W OFFICE AND BORROWER/GRANTEE**

This exceptionally well-done evaluation confirmed our intuitive sense that the PVOH project, considered by many to be a failure, had turned the corner into a very successful activity with high potential impact. It is rewarding to see a joint team of Indian and U.S. experts produce so excellent and useful a report. We are building on their recommendations very directly in our effort to develop a follow-on project. A job well done and a good model of objective and effective evaluation work.

MISSION COMMENTS ON FULL REPORT

XD-ARV-77-A  
LSN = 50493

REPORT OF MID-TERM EVALUATION  
OF  
THE PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH PROJECT  
(No. 386-0469)

SEPTEMBER - NOVEMBER, 1986

Mr. P. Subramaniam  
(Team Leader)  
Dr. Abraham Joseph  
Mr. John Grant

386-0000-C-00-6066-00

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## ACKNOWLEDGEMENT

This mid term evaluation would not have been possible without the full cooperation and support provided by the Government of India (GOI) and the United States Agency for International Development (USAID), New Delhi. The team wishes to thank in particular the officials of the Ministry of Health & Family Welfare (MOHFW), the National Institute of Health & Family Welfare (NIHFW), the Department of Economic Affairs (DEA) and the Office of Health and Nutrition of USAID/New Delhi for valuable briefings and background materials.

We especially thank Mr. P. Mohandas (Joint Secretary and Chairman of the PVOH Special Grants Committee), Mr. M.R. Bhagwat (Director) and Mr. G.N. Sreekumaran (Under Secretary - VOP) of MOHFW for their participation and support. The team expresses its appreciation and thanks to Prof. P.P. Talwar, Prof. Y.P. Gupta and their colleagues of NIHFW for sharing their experiences and providing valuable information. The team wishes to thank Dr.E.G.P. Haran for his invaluable efforts and support throughout the evaluation. We acknowledge the logistic support provided by Dr. Thomas Philip and editorial assistance provided by Dr. Sarah Harbison.

The members of the staff, volunteers and participants of many of the PVO subprojects which we visited extended their hospitality and explained their work to us besides providing whatever information we wanted from them. We wish to thank all of them for the excellent support they have given us in completing these tasks.

## GLOSSARY

AVRV	:	Arya Vaidyan Rama Varier
BLS	:	Baseline Survey
CMA	:	Christian Medical Association
DEA	:	Department of Economic Affairs
DPT	:	Diphtheria, Pertussis and Tetanus
ICDS	:	Integrated Child Development Scheme
ICH	:	Institute of Child Health
ICMR	:	Indian Council of Medical Research
MIS	:	Management Information System
MOHFW	:	Ministry of Health and Family Welfare
NIHFW	:	National Institute of Health and Family Welfare
OPV	:	Oral Polio Vaccine
OR	:	Operations Research
ORT	:	Oral Rehydration Therapy
PACD	:	Project Assistance Completion Date
PHC	:	Primary Health Care
PIL	:	Project Implementation Letter
PVO	:	Private Voluntary Organizations
PVOH	:	Private Voluntary Organizations for Health
SEWA-Rural	:	Society for Education, Welfare and Action - Rural
SKGUS	:	Sidhu-Kanu Gram Unnayan Samiti
SPKS	:	Sarvajanic Parivar Kalyan Samiti
TA	:	Technical Assistance
TB	:	Tuberculosis
USAID/AID	:	United States Agency for International Development
VHAI	:	Voluntary Health Association of India
VHS	:	Voluntary Health Service

## I. EXECUTIVE SUMMARY

### A. Background

After a long history of bilateral assistance to the Government of India in support of primary health care and family welfare activities, AID initiated the Private Voluntary Organizations for Health (PVOH) Project in order to expand and improve both basic health care services and special preventive services in India by developing the underutilized potential of nongovernment organizations and private medical practitioners. Through strengthening the private and voluntary sector, the project seeks to reduce morbidity, mortality, and fertility. Originally funded in 1981, by the time of the evaluation there were 22 projects spread throughout India providing community-based primary health care and family welfare services. The project document provides support for up to 30 PVOs, but it has become clear over the duration of this project that there are many more PVOs capable of expanding their activities and there is clearly a demand for services which they are providing.

The PVOH project represents the joint effort of the the Government of India, U.S. Government and private voluntary organizations working in health and population in several ways. First it represents the consensus among these three groups that PVOs can and should play an expanded role in improving health services. Secondly, financial support for these activities comes both from AID and from the subprojects themselves. They are "co-financed" in the sense that AID provides 75% of the total budget and the remaining 25% is raised by the PVOs themselves as a matching contribution. Funds are used to expand and improve the quality of services by hiring additional field workers, providing training, technical and management assistance and improving physical facilities. USAID committed \$20 million in August, 1981 from a special foreign currency appropriation which amounted to Rs.167.4 million. The original period of disbursement was six years, but the Project Assistance Completion Date has recently been extended for two years i.e., up to September 1989.

### B. Purpose and Methodology

The overall objective of the Mid Project Evaluation is to assess the progress towards attainment of the goal and objectives of the project as specified in the PVOH Project Paper, the Grant Agreement, and the Implementation Letters and to make recommendations for further improvement of the project. The Mid Project Evaluation focusses on the following three broad areas: a) assessment of subproject implementation activities, b) assessment of the adequacy and effectiveness of administrative, monitoring and technical assistance aspects and c) documentation of the lessons learned and their implications for future directions of this project and/or additional inputs on a bilateral agreement. The fieldwork for this review was conducted from the 22nd of September, 1986 to the 25th of October, 1986. This was followed by further discussions with the officials of the Government of India and USAID. The findings were presented to the NIHFW and the Government of India officials on October 30, 1986 and to the USAID officials on October 31, 1986.

C. Evaluation Findings

1. The PVOH Project provides an effective structure for appraising and approving subgrants to voluntary agencies and an efficient approval process is now in place. Despite initial delays in the appraisal and approval procedures these have been streamlined over the last five years and in the process some aspects of the original design have been modified to make the project more effective. A very positive collaborative relationship has been developed between USAID, MOHFW and NIHFW after a long organizational period in the the early years of the project.
2. The PVOH Project is an appropriate mechanism for supporting private voluntary organizations in providing primary health care and special preventive health services.
3. The project design includes a number of elements which are increasingly recognized as important by the Government of India and USAID, including (a) the need to strengthen the role of the private voluntary organizations in the delivery of basic health services, particularly in under-served areas, (b) a strong emphasis on community-based PHC outreach services, (c) a stress on key PHC interventions for the reduction of infant mortality, including immunization, ORT, maternal and child health, nutrition, and family planning as well as on promotion of an integrated approach to the delivery of these services, and (d) emphasis on a high risk approach to providing services.
4. The project has assisted in the establishment of a new support cell in the MOHFW for administering this grants program and a new unit in the NIHFW with responsibility for providing technical support, monitoring and evaluation of PVOH subgrantee activities.
5. This has helped to bring into focus the need for systematic monitoring and evaluation of other government programmes like area projects and to recognize the need to further strengthen NIHFW's technical assistance capabilities.
6. The project avoided duplication of public sector services through full participation of government officials in an assessment of the relationship between PVO services and existing government primary health services.
7. The subprojects funded by this project are providing a wide range of primary health care services to a growing number of people. Technical assistance currently being provided will contribute to improved collection of statistics which will document in a quantitative way the contribution of these projects.

8. On the basis of site visits to seven subprojects, it is clear that after an organizational phase many projects have initiated outreach and/or delivery of basic child survival services to needy segments of the population.
9. The problem of financial sustainability of subprojects at the end of the grant period has been identified as a key issue to be addressed.

D. Recommendations & Needs for the Future

1. As the number of subprojects grow and as the volume of services provided by the individual organizations increases, it is crucial that proposal guidelines be simplified, that technical assistance is provided at the state of proposal development, and that the review and approval process is streamlined.
2. There is a need for substantially increasing technical assistance and training to the subprojects. While NIHFV should continue to play an important role, alternative mechanism of providing technical assistance should be explored and instituted. The possibilities of establishing a network of appropriate regional institutions, panels of local technical experts and regional training workshops should be considered.
3. As the role of the special unit within NIHFV expands with the growth of the project and the need for improving data collection, ways should be explored to provide additional inputs to this unit. The NIHFV's technical assistance needs further strengthening. Particularly, their programme monitoring should be improved so as to make it more supportive of the subprojects, in their day-to-day operations. For implementing this role effectively, external technical support could be obtained.
4. The successful role of the chartered accountants in monitoring and providing assistance on budgetary and accounting matters should be expanded. More frequent visits focussed on training in financial management as well as monitoring of accounts should be planned.
5. The upcoming mid term evaluation of subprojects by NIHFV should be planned with the participation of the PVOs themselves and should focus on ways in which service delivery can be improved after completion of the evaluation. A workshop should be organized with the PVO to discuss evaluation results.
6. Communication among PVOH subprojects and sharing of experiences should be encouraged and financially supported. Organization of workshops and perhaps a monthly or quarterly newsletter should be encouraged.

7. The establishment of quarterly review meetings between MOHFW, NIHFW and USAID should be regularized. These meetings will provide the opportunity for dialogue among the three groups, indepth reviews of progress during the quarter, discussions of problems and identification of technical assistance needs. Issues such as high priority projects to be funded, modifications in financial arrangements, etc. as well as the overall direction and success of the project should be discussed.
8. Experience gained by USAID, MOHFW and NIHFW in the implementation of the PVOH Project should be utilized in responding to the demand which has already been generated for new subprojects. Development of a follow-on project should be seriously considered.

## II. INTRODUCTION

This is the first Mid-Project Evaluation of the PVOH Project of the USAID Mission to India. The overall objective of the evaluation is to assess progress towards attainment of the project goal, objectives, and outputs as specified in the PVOH Project Paper, Grant Agreement, and Implementation Letter No.3, and to make recommendations for further improvement of the project. In support of the goal of reducing mortality and fertility in India, the PVOH project provides funding to established private voluntary organisations working in the fields of health and family welfare in order to increase their effectiveness. At the central level, the project is managed by a special cell of the MOHFW in coordination with the USAID office in New Delhi. The 22 subprojects are managed by the individual PVOs which are monitored and receive technical assistance from a special unit in the NIHFw.

This evaluation focusses on

- a) progress of sub-project implementation activities toward achieving objectives of the project as stated in the Project Paper and the Grant Agreement,
- b) the adequacy and effectiveness of administration, monitoring and technical assistance on the central and the field levels, and the lessons learned thus far and their implications for future directions of this project, and
- c) the lessons learned thus far and their implications for future directions of the project.

The evaluation was conducted by Mr. P. Subramaniam, Management Expert and Team Leader, Dr. Abraham Joseph, Community Health Expert and Mr. John Grant, USAID/Washington. In addition, representatives of the Government of India, Ministry of Health and Family Welfare (Mr. M.R. Bhagawat/Mr. G.N. Sreekumaran) and representatives from the USAID Mission in New Delhi (Dr. E.G.P. Haran/Dr. Thomas Philips) also participated.

The evaluation was carried out during September and October, 1986. Prior to visiting projects in the field, the team reviewed documents and held discussions in Delhi with AID officials and GOI officials in the MOHFW, the NIHFw, and the Department of Economic Affairs. The purpose of these meetings was to understand the perceptions of these various key organisations/individuals about the PVOH Project, its contributions, the constraints in project implementation, and to consider suggestions for improvement.

On the basis of a detailed review of the files of the 22 subprojects which have been funded, seven were selected for field visits and evaluation. In selecting the subprojects for evaluation a number of factors were considered, including project duration, size and design. With respect to duration, five out of the twelve projects which had been functioning over two years were selected. Two additional projects were selected for evaluation from those sanctioned in 1985. With respect to size, small, medium and large projects were represented in those selected. Finally, various components of project design were considered, including:

- a) those which were integrating primary health care with special preventive health care;
- b) those that were innovative;
- c) those with a base hospital with outreach services;
- d) those without any base hospital, but having only outreach services; and
- e) regional location.

Projects included in the evaluation were :

<u>Project Size</u>		<u>Rs. Budget</u> (In Millions)
1. VHS, Madras	: Large	: 14.6
2. SEWA Rural, Gujarat	: Medium	: 4.0
3. AVRV, Coimbatore	: Medium	: 5.8
4. ICH, Memari, West Bengal	: Medium	: 3.9
5. Streehitakarini	: Small	: 2.9
6. Sarvajanic Parivar Kalyan Sewa Samiti, Gwalior	: Small	: 3.2
7. New Century Welfare Society, Madras	: Medium	: 5.9

The classification of the size of the PVO's into large, small or medium has been done taking into account both the size of the subgrant and also the size of the outreach services. (The site visit schedule is shown in Annex I and the list of persons contacted is shown in Annex II.) During the field visits, questions such as how effective the subprojects have been in achieving their objectives, how well they have been managed by the PVOs and how well they fit into the purpose of the overall AID Project were examined.

The time spent in the field for any individual subproject was short, in most cases 2 days. The team had general discussions and worked out the programme of action before making site visits. Similarly, at the end of each day's work the team again met and had a review of the day's work. For general discussions with senior project staff, the entire team participated. However, for detailed examination of aspects of work during field visits, the team broke up into two or three groups, each group looking into particular aspects of the activities of the subproject such

as the maintenance of records and registers by the field workers, the quality of field worker training provided, the management and reporting systems, the drug supply position, the maintenance of growth cards, the facilities available, and the general impact of the project. For assessment of quality of training and the quality of services rendered, project field workers were interviewed. For assessment of impact of the project, the beneficiaries were interviewed. Following completion of site visits, the data which had been collected were tabulated and analyzed, discussions were held by the team and this report was drafted. (See Annex III for the list of the major components of the PVOH Project which have been reviewed by the team.)

### III. PROJECT OVERVIEW

#### A. Background and Purpose of Project

The purpose of the PVOH project is to expand and improve basic health, family planning, and nutrition services, as well as special preventative services for the poor in India by strengthening the private and voluntary sector. This purpose was designed to contribute to achievement of the USAID/India goals for the health, population and nutrition sector, shared by the Government of India, which are to reduce fertility and mortality. To accomplish these goals, AID assistance has focussed on expansion and improvement of services in the previously underserved rural areas. The current project increases the number of channels through which assistance is provided by capitalizing on the strength of private voluntary organizations already working in this area.

This is a country wide project being financed by the U.S. owned rupees under a Special Foreign Currency Appropriation. The total cost of the project is Rs.224 million, of which AID contribution is Rs.167 million (\$20 million) at the time of signing of the Grant Agreement. The remaining Rs.57 million is to be borne by the subgrantees themselves. It provides subgrants to 30 private and voluntary organizations. About 80 percent of the project funds are to be spent in rural and small town settings. Rs.4 million was allocated for monitoring and evaluation.

Voluntary organizations and private practitioners represent a major untapped potential for the promotion of health, nutrition, and family planning awareness and services. PVOs are respected for quality services, a commitment to the poor, and for innovative programming. The Government of India has increasingly emphasized their potential. In addition to these organizations, there are a large number of private medical practitioners of various backgrounds (both allopathic and indigenous systems) which also represent an underutilized resource for providing better health and family welfare services to all of India.

The initial GOI/AID thinking on this project was occasioned by a large grant made by AID in 1977 to St. Johns Hospital and Medical College in Bangalore. The current project was designed to complement that single institution's building effort by providing subgrants to a wide variety of groups working in the private and voluntary sector throughout the country which were providing basic health, family planning and nutrition services as well as to groups providing special preventive services.

Basic health services include immunization, care for pregnant women, and treatment of common diseases such as diarrhea, respiratory problems, and parasitosis malaria. Basic family planning services are based on a cafeteria approach; that is, the provision of information and supplies for all contraceptive methods in a culturally acceptable way. Nutrition services focus on maternal and child malnutrition, anaemia and common vitamin and mineral deficiencies. Organizations which proposed to provide integrated

health, family planning and nutrition services were given preference in funding. The project also included funding for special preventive services. Service programs which prevent the occurrence of a problem and those which, through early case detection and treatment, limit the severity or extent of a problem are included. Examples of special preventive services include early identification and treatment for leprosy, tuberculosis, blindness, deafness, and accident prevention and treatment programs.

Projects were to be selected primarily from the relatively underserved rural areas. It was planned that services of all types could be made available to the largest number of people through expanded outreach into the community and community based distribution of services. More specifically, project assistance was designed to strengthen voluntary organizations' participation in:

- a. organized outreach service delivery;
- b. initial and/or continuing education and training of indigenous practitioners, paramedical, and community volunteers and continuing education for medical doctors serving the rural or urban poor;
- c. management training in support of improved basic health, family planning, or nutrition services; and
- d. innovative activities that test new approaches to service delivery.

Originally, it was planned to fund ten to fifteen subgrants over a six-year time span. The Project also planned to fund an expanded "secretariat" in the Ministry of Health and Family Welfare (MOHFW) to administer these subgrants and to enhance the ability of the MOHFW to aid voluntary organizations in the future.

#### B. Project Chronology and Current Status

Table 1 summarizes the major events in project development and implementation. The project agreement was signed in August 1981. Despite a slow start, PVOH project has shown steady growth over the past three years and a progressive streamlining of project monitoring and management. It has become apparent that there exists both the demand and the capability for a much larger project than was originally envisaged. During the first two years of the project the organizational structure for project administration was developed in the MOHFW, criteria for project approval were designed, and the initial approval of three subprojects was

Table 1: Chronology of Project Design and Implementation

<u>Date</u>	<u>Event</u>
August, 1981	Signing of original project agreement.
Mid 1982	Establishment of special cell in MOHFW to be responsible for project.
December 1982	Project criteria developed and finalized.
Jan. - Feb.1983	Receipt and review of first proposals.
September 1983	Approval of first four proposals.
Jan.- Nov.1984	Approval of eight additional subprojects.
October 1984	Issuance of Project Implementation Letter No.3 defining a three-tier system for approval of grants (see section III C) and establishing a special unit in the NIHFV responsible for monitoring, evaluation and providing technical assistance.
October 1984	Increase in number of potential projects from fifteen to thirty, as defined in PIL No. 3.
Jan. - Dec.1985	Approval of nine additional projects carried out by AID, MOHFW, and NIHFV.
Jan. - Nov. 1986	Approval of four additional projects.
Sept.- Nov. 1986	Mid-term evaluation of PVOH Project.
December 1986	Evaluation by NIHFV of some of early subprojects.

During 1984, the third year of the project, a large number of proposals were received and eight were approved. The need for a more structured review and approval process as well as an expanded capacity for monitoring, technical assistance and evaluation was addressed in Project Implementation Letter (PIL) No.3 (see details in following section). For the purpose of simplifying project approval and management, subgrants were classified as small, medium, or large as follows:

<u>Sub-grant type</u>	<u>Amount of the sub-grant</u>
Small	Rs.80,000 to Rs.2.5 million
Medium	Rs.2.5 million to Rs.10 million
Large	Rs.10 million and above

Of the total AID Grant of Rs.167.4 million, Rs.163.4 million was made available for sub-grants and the balance of Rs.4 million was provided for monitoring and evaluation. The minimum amount of any one sub-grant (AID's contribution) was set at Rs.800,000. It was further decided to finance a maximum of 30 sub-grants under this project rather than 15. (In December, 1986 this was further increased to 32 subgrants.)

During 1985 and 1986 a special cell within NIHFV became fully operational and an additional thirteen projects were approved. As of the time of this evaluation, a total of 180 applications had been received by the MOHFW, 25 had been approved, 117 had been rejected, and 38 were pending final decision. Table 2 presents data on the current financial status of the project:

Table 2 : Financial Status of Project  
(As of November, 1986)

	<u>No.</u>	<u>Amount</u> (Rs. in millions)
1. Total grant	-	Rs.167.4
2. Amount available for Monitoring and Evaluation	-	Rs. 4.0
3. Amount available for up to 30 sub-projects	-	Rs.163.4
4. Total number of projects sanctioned including the 7 sub projects reviewed	22	Rs. 87.2
5. Number of projects recently approved	3	Rs. 17.7
6. Number of projects which are ready for approval	2	Rs. 29.0
7. Funds approved for escalation and revision in costs	-	Rs. 4.5
8. Balance amount available for new sub-projects, technical assistance, etc.	-	Rs. 25.0

### C. Project Management and Administrative Structure

The management and administrative structure as it has evolved is relatively complex and is most clearly understood in terms of levels of bureaucratic relationships and the functions served by the project structure. In terms of the bilateral agreement, USAID/Delhi deals with the Ministry of Finance, Department of Economic Affairs (DEA) (see Table 3 below) for the negotiation of grant agreements and amendments.

Table 3: Inter-relationships Between MOHFW, NIHFW, DEA & USAID

#### Formal Agreements

USAID → DEA, Ministry of Finance → MOHFW

#### Flow of Funds

USAID → MOHFW → Subgrantees

#### Preliminary Screening & Selection of Proposals

By MOHFW with assistance from NIHFW.  
USAID provides comments when requested.

#### Appraisal of Proposals Selected

Small & Medium - By MOHFW with NIHFW  
USAID's participation optional but participates as far as possible  
Large Jointly by MOHFW, USAID & NIHFW

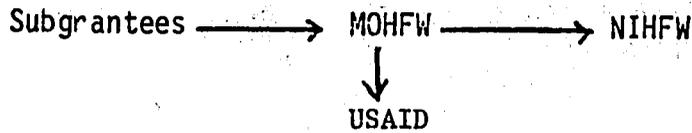
#### Approval

By MOHFW Special Grants Commission  
USAID gives its clearance/comments on small/medium subgrants  
Jointly approves on large subgrants

#### Monitoring

By NIHFW  
MOHFW participates as far as possible  
USAID participates selectively depending on need and resource availability

Subgrantees' Reports



Technical Assistance

By NIHFW to a limited extent

The DEA conveys the specifics of the formal agreements to the Ministry of Health and Family Welfare. However, there is a direct flow of both funds and technical assistance from USAID to the MOHFW.

Figure 1: Flow of Responsibility

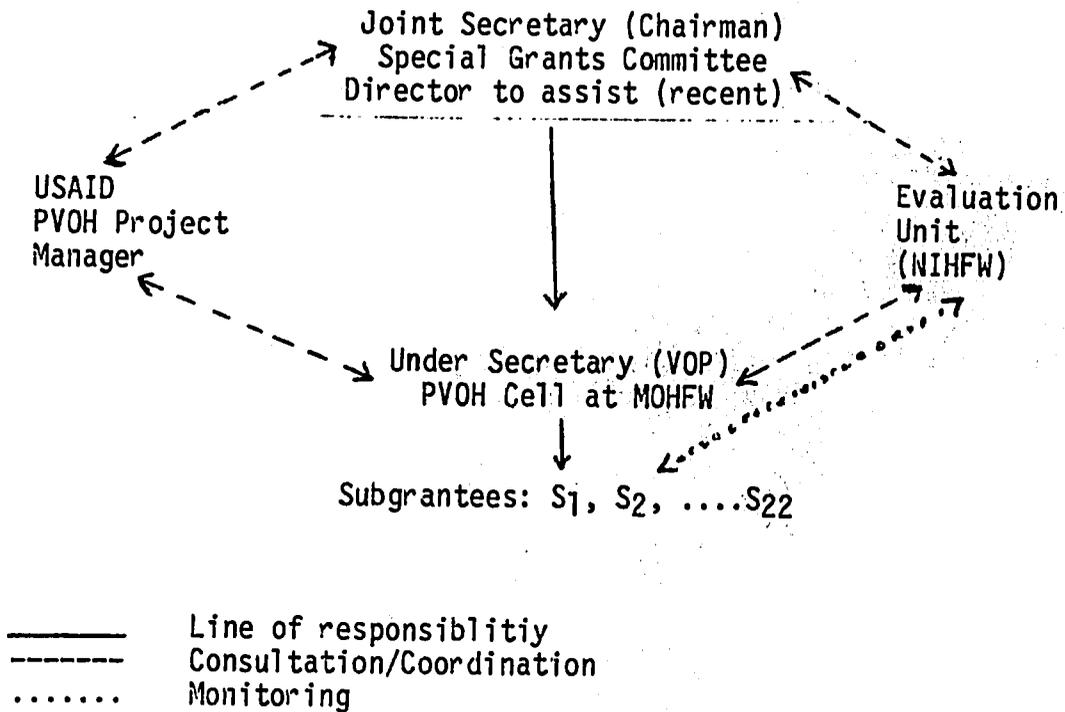


Fig. 1 describes the flow of responsibility in project management. The project design provided that the Indian Government would be responsible for management of the project, including appraisal of proposals for subgrants, approval of subgrants, disbursement of funds, accountability of funds, program and financial monitoring, periodic reports, and technical assistance.

The special cell of MOHFW (comprised of Under Secretary, MOHFW, a technical assistant, a section officer and several support staff) receives all applications for projects (Arrow 1), and screens them for eligibility. At the same time, a copy of the proposal is sent to the state government for concurrence and forwarding to the Under Secretary, MOHFW (Arrows 2 and 3).

After receipt and review of the various application for their completeness, the PVOH cell of the MOHFW selects high priority proposals which meet institutional and selection criteria. Copies of these proposals are furnished to A.I.D. Depending on the size of the project, each of these proposals is appraised for financial and technical viability and for capability of the prospective subgrantee to implement the proposed project and to continue the activities after project financing ends.

The three-tiered procedure as defined in PIL No.3 for appraisal and approval of the subgrants is as follows:

For small Subgrants (Rs.800,000 - 2.5 million)

Appraisals are done by the MOHFW, which may employ consultants or utilize the services of the NIHFW. An appraisal report based on document review and field visit is prepared and submitted to the Special Grants Committee for its consideration with a copy to AID. Approval of the subgrant by the GOI Special Grants Committee and/or MOHFW are in accordance with the institutional criteria and selection criteria stated in the Grant Agreement.

For Medium Size Subgrants (Rs.2.5 million up to Rs.10 million)

Appraisals are done jointly by the MOHFW and NIHFW. The MOHFW informs A.I.D. of the dates of joint appraisal visits at least two weeks prior to the visit. AID's participation in the appraisal visit is optional. The PVOH cell/MOH furnishes A.I.D. copies of the appraisal report and the project proposal. A.I.D. provides comments to the MOHFW within 15 days of the receipt of above document. For this purpose, A.I.D. makes a limited review to ascertain whether the proposed activities are within the project guidelines and whether the prospective subgrantee organization is performing services which are not in violation of A.I.D. policies. The MOHFW furnishes the project appraisal report and A.I.D.'s comments to the Grants Committee for its consideration prior to final approval.

For Large Subgrants (Rs. 10 million and above)

Appraisal and approval of large subgrants is done jointly by the MOHFW and A.I.D. The MOHFW may utilize the services of NIHFW in the appraisal activity.

The Special Grants Committee comprises the following:

- |       |  |                  |
|-------|--|------------------|
| (i)   | Joint Secretary<br>Voluntary Organizations Project, MOHFW                          | Chairman         |
| (ii)  | Joint Secretary<br>(Financial Advisor), MOHFW<br>Or his nominee                    | Member           |
| (iii) | Director General of Health Services<br>MOHFW, or his nominee                       | Member           |
| (iv)  | Joint Secretary,<br>Department of Economic Affairs,<br>Or his nominee              | Member           |
| (v)   | Joint Secretary, ICDS<br>Ministry of Human Resources<br>Development or his nominee | Member           |
| (vi)  | Under Secretary,<br>Voluntary Organizations<br>Project, MOHFW                      | Member Secretary |

Secretary of Health of the concerned State or his nominee and NIHFW shall be co-opted as special invitees in the above Committee.

The National Institute of Health and Family Welfare (NIHFW), under an arrangement with MOHFW, is responsible for the following tasks:

a) Technical Assistance in the Preparation of Subgrant Proposals:

Help potential subgrantees prepare technically and financially sound proposals for funding within the objectives and guidelines of the project. In those cases where project proposals have been submitted for funding, help rewrite the proposals if needed;

b) Appraisal of Proposals:

Provide MOHFW the technical scrutiny and appraisal of subgrant project proposals following the procedures stated in this Project Implementation Letter No.3. Help write joint appraisal reports;

c) Preparation of Procedure Manuals:

Develop procedure manuals required for monitoring of this Project; activity reporting procedures etc. These manuals can be explained to the subgrantees either during the site visits for project appraisal or through separate visits after the awarding of subgrants;

## d) Program Monitoring:

Monitoring the progress of subgrantee activities to ensure the fulfilment of project objectives and the subgrantee's plan of action for which the grant has been provided. Program monitoring will be done based on the information obtained through:

- Quarterly progress reports of the subgrantees;
- Well-planned site visits at least once a year to small and medium size sub-grantees and once every six months to the large subgrantees;
- Repeat visits to subgrantees with special problems or as follow-up visits where specific recommendations have been made.

## e) Financial Monitoring:

Provision has been made for NIHFV to contract with local chartered accounting firms to provide financial monitoring as well as technical assistance in financial management to subgrantees;

## f) Evaluation of Subgrants:

Conduct two evaluations of each subgrantee - a mid-project evaluation and an end-of-project evaluation. The mid-project evaluation will assess how much progress subgrantees have made in their activities with respect to their plan and the objectives of the project. The end-of-project evaluation will assess whether the purposes of subgrant have been achieved and also will consider the impact of the project; and

## g) Technical Assistance to Subgrantees and the Secretariat:

Provide technical assistance to subgrantees and the Secretariat through organizing workshops and seminars. Assist subgrantees in their efforts to compile baseline data and their other training/management needs.

By this arrangement the need for extensive monitoring by A.I.D. has been reduced. A.I.D. continues to retain the right and responsibility to monitor subgrantees if and when necessary. A.I.D. has continued to monitor through selective review of subgrantee selection and subgrantee implementation. The delegation of major responsibility for project monitoring to NIHFV has permitted the expansion of the project to approximately twice its originally planned size.

#### D. Overview of Projects Approved at Mid-term Evaluation

As of the mid term evaluation a total of 22 subprojects providing a wide variety of services throughout India had been approved. Geographically, twelve of the twenty-two states of India have one or more subprojects. Although nine out of the twenty-two projects are situated in what are usually considered the poorer states, all of the subprojects are focussing their efforts on the poorer, less well-served segments of the population. Table 4 below presents basic data on the projects:

Table 4: Basic Data on Projects

##### Distribution by Type of Health Services:

1.1	Special Services (eye)	-	2
1.2	Basic Health Service:		
	a) Allopathy		
	b) Allopathy Integrated with TB & Leprosy		
	c) Non-allopathy (Ayurveda and Homeo)	-	2

##### 2. Distribution by Target Population:

a)	More than 80,000	-	8
b)	50,000 to 80,000	-	3
c)	Less than 50,000	-	11

##### 3. Distribution by State:

Tamil Nadu	-	3
Gujarat	-	4
Madhya Pradesh	-	2
Maharashtra	-	2
Andhra Pradesh	-	1
West Bengal	-	3
Himachal Pradesh	-	1
Haryana	-	1
Bihar	-	1
Punjab	-	1
Uttar Pradesh	-	2
Kerala	-	1

3.	<u>Distribution by Type of Parent Organisation:</u>	
	Hospital	7
	Social Welfare	9
	Socio-Economic Development	3
	Religious	2
	Cooperative	1

The following section presents a discussion of the progress of these subprojects to date in implementation (Annex V presents an overview of these twenty-two projects).

#### IV. PROGRESS OF SUBPROJECT IMPLEMENTATION ACTIVITIES

##### Introduction

Of the twenty-two subprojects included in this evaluation, four were in full operation, eight had most of their infrastructure in place and were starting programmatic activities, and ten were in the initial stages of organization. About half of the projects were approved in the last two years. Annex V provides basic information on the 22 projects included in the evaluation.

The seven projects visited have all successfully completed the organizational stage and six out of seven have successfully initiated outreach activities. All utilize a three-tier approach to providing services, including village level workers, mini health centres/subcentres, and hospital headquarters. The largest of the seven, Voluntary Health Services (VHS) integrates TB and Leprosy control into the primary health care network through a network of 32 mini health centres. Arya Vaidyan Rama Varier Foundation of Ayurveda (AVRV) project integrates traditional systems of medicine, ayurveda and siddha, in primary health care. SEWA Rural has a comprehensive program which includes both the primary health care model and the ICDS scheme of the GOI. Streehitakarini is a women's organization focussing on the urban slum population in Bombay with emphasis on community health workers. Institute of Child Health (ICH) focusses on building up an interface between the Government health care system and the community through extensive training and use of family level workers and mid-level supervisors. The remaining two projects, Sarvajanic Parivar Kalyan Sanstha (SPKS) and New Century provide basic health services through a three-tier system. All seven projects have a training component. Six have mobile units for medical doctors to carry out curative care and field supervision (see Annex IV for detailed project descriptions and field notes). The following description of the progress in development of infrastructure is based on these seven subprojects.

##### B. Development of Infrastructure by the Subprojects

###### 1. Staff Recruitment and Training

Most projects visited had recruited and trained the necessary staff at the time of the evaluation. In a few projects there was either considerable staff turnover (as in VHS, Madras) or difficulty in recruiting and training (as in AVRV and New Century). The reason for the staff turnover in VHS was difficulty in getting people with the salary provided in the project. The salary offered was low compared to similar level jobs in Government service. In AVRV there was a turnover of allopathic physicians and also delay in recruiting low level workers. The reasons cited for the delay were that the project was trying to identify persons who could be true volunteers

and leaders and also to ensure maximum community participation. In New Century there was a delay in recruiting and training staff. The difficulty faced in training the staff was primarily because of the lack of experience of the project holders in conducting training programs. In two projects (SEWA and ICH) the doctors were recruited from medical colleges with which the projects had previous contacts. The motivation of these doctors was greater than those seen in other projects. This is probably because of the exposure these doctors had to the project while they were medical or postgraduate students. These visits motivated them to join the project.

Training of project personnel has proved difficult for a number of the projects. Most of the projects did not have personnel with adequate skills to train their middle and lower level workers. VHS Madras and SEWA Rural are exceptions. VHS conducted training programs for Multi-Purpose Workers (MPW) even before this project started. In SEWA the senior doctors had training in community health and so were able to conduct their own training. The State Government also uses SEWA for the field placement of the MPW trainees. Managers at several of the projects expressed the need for help in conducting training programs and preparing training materials. They did not have experience in syllabus preparation and course design. The field workers in most projects were good and had adequate knowledge of common health problems and their management. Workers had good contacts with the community. The middle and lower level workers seen during the field visits were motivated and had a fairly good knowledge of the immunization schedule, preparation of ORS, nutrition and various aspects of the growth card.

## 2. Equipment Purchase

Except for two projects (ICH and New Century) equipment had been purchased as needed. There was some delay in purchase either because of price inflation or uncertainty about budget adjustments. There was also some problem regarding the payment of sales tax. In general the delay in purchase of equipment did not seem to have affected project implementation.

## 3. Construction of Facilities

Construction is a major component of the total budget in almost all the subprojects. There have been delays in construction in all projects, resulting from

- a) Delays in the community contribution of land,
- b) Increases in land prices and delays in determining whether the Government would accept the new prices as part of the subgrantee's contribution to the project,

- c) Litigation - in the SEWA Rural Project, the land given by the Government to the project was challenged by the local panchayat union and a case was filed,
- d) Difficulty in obtaining construction materials such as cement (VHS, Madras), and
- e) In AVRV and ICH a conscious effort was made to ensure that there was community participation by providing land free of cost; as a result of which the building construction was also delayed.

#### 4. Baseline Survey and Quarterly Reports

The baseline survey as recommended by the NIHFV has been carried out by all the subprojects. However, there were considerable delays due to lack of awareness of the importance of baseline data for planning and evaluation. Unfortunately, subgrantees were not involved in framing the questionnaire and NIHFV had not explained the purpose of the baseline survey to the subgrantees. Only questions which the NIHFV thought relevant were included. This caused a negative attitude among the subgrantees. Subgrantees simply followed instructions from NIHFV and did not consider using the information to plan, modify or evaluate their programs. The data collected is still being analyzed in most centres and hence has not been used till now for evaluating programs or planning work. The subgrantees were not aware of basic epidemiological principles and therefore could not use the data to calculate relevant rates and ratios for their target areas.

The quarterly reports which are being submitted with information regarding number of children vaccinated and pregnant women receiving antenatal care are limited in their utility because the total number of children and pregnant women in the community is not indicated. These denominators would have been available if the baseline data had been collected and analyzed earlier. The subgrantees expressed a desire to have training and guidance in monitoring and surveillance.

### C. Health Service Delivery

#### 1. Primary Health Care Service

All seven subprojects have made a sincere attempt to integrate basic health service with the various components of child survival including Immunization, ORT, Family Welfare, Nutrition and Growth Monitoring. Some have been more successful than others, but all of the projects have at least made a start toward providing community-based primary health care services. Two of the projects which were exclusively doing family welfare work prior to project initiation became multipurpose projects by including primary health

services (Streehitakarini and SPKS). At VHS Madras, a leprosy and tuberculosis control programme was integrated with a primary health care programme by improving "case finding" and "case holding". Short term chemotherapy for tuberculosis and multidrug therapy for leprosy control have also been incorporated into this project. All subprojects except one (New Century) have given priority to preventive and promotive health services. An attempt has also been made to improve the quality of curative services.

a. Immunization

Immunization of children and pregnant women is carried out by all the subprojects as a high priority. BCG, DPT, Oral Polio and TT are included. An immunization programme in action was observed at the SEWA Project. At SEWA, the cold chain was well maintained and the programme was well organized with proper record keeping, health education, and reassurance and advice to the mothers. Over 50 children were immunized in one village alone. The youth of the village as well as the community health volunteers were involved in recruitment for the programme. All projects described the cold chain as well maintained. However, it was not possible to verify this due to lack of time.

Data concerning immunization coverage was obtained from the quarterly reports of the seven projects visited. While the actual number of children vaccinated is available in the records, the percentage of children immunized is not available since the total number of preschool children in the project area is not provided. It is difficult to compare coverage of the PVOH projects with that of the State Health Services because of the lack of proper denominators in both reports. Although some centers report achievement of 100% of their target for immunization of children, the importance of this is difficult to evaluate since targets were not defined in terms of percentage of children receiving three doses of DPT or OPV. Nevertheless data submitted does help to evaluate certain aspects of the immunization programme. Table 5 shows the number of children receiving the 1st, 2nd or 3rd dose of DPT in the 3rd quarterly report of 1986. The number of children receiving the 3rd dose is far less than those receiving the 1st dose. This implies that there are large numbers of children who have not completed the series, and represents a major area for improvement in followup and motivation. Due to shortage of time and limitation of data, it was not possible for the team to verify the accuracy of these data.

It was not possible to compare the immunization coverage of the subproject with that of the State Government figures for the reasons stated earlier. From the field visits it was apparent that the subprojects were reaching out to villages where the Government had not provided these services.

Table 5: Number Immunized in the Quarter July to September 1986

<u>Name of subgrantee</u>	<u>No. of children immunized</u>		
	<u>Ist Dose</u>	<u>IInd Dose</u>	<u>IIIRD Dose</u>
AVRV	191	153	51
ICH	967	447	156
SEWA	105	77	70
New Century	529	375	301
VHS	912	733	809
SPKS		(all doses)	1451

b. Oral Rehydration Therapy (ORT)

ORT also took high priority in almost all projects. The exceptions were New Century and AVRV. During field visits the grass root workers and their supervisors were interviewed regarding their knowledge and use of ORT. They were aware of the danger of dehydration and benefits of giving ORT. They also knew the composition of the solution and how it can be made in the homes. The answers given by the medical officers of some centres (VHS, SPKS, New Century, and AVRV) were disappointing. They indicated antibiotics as the first line of management. This could be attributed to the turnover of medical officers who were not well trained in primary health care. It was not possible to check the practice of ORT in the community due to lack of time.

c. Growth Monitoring and Nutrition

Though growth monitoring was a stated objective of all the subprojects visited by the team, it was not being done in a systematic manner except in SEWA and VHS. Even in these centres the growth charts were not well maintained. There was no information regarding the nutritional status of the community. This information would have helped evaluate the impact of the programme on the nutrition of children. The growth cards were retained in the clinic and so lost their value as a medium of education for mothers. In some centres weights were taken on adult weighing machines which made the weight inaccurate. Staff were aware of the importance of growth monitoring and were able to describe the reasons for growth faltering and the measures to be taken to prevent it. Growth monitoring was not part of the program in New Century and AVRV.

All projects have indicated nutrition education as one of their important activities. In VHS, SEWA, ICH and Streehitakarini, it was possible to observe the education programme which included demonstration, flash card and discussion. New Century and AVRV do not include nutrition education in their programme.

d. Antenatal Care

Antenatal care was also given high priority in all the subprojects visited. Antenatal care included identification of pregnant women by field workers, referral to a clinic for examination, regular monitoring, and provision of health and nutrition information. It was possible to see antenatal clinics being conducted in most of the centres. Quarterly reports indicate that many women have been receiving antenatal care (Table 6). In a few projects more than 100% of the stated target received antenatal care. However, it is difficult to assess the actual coverage because the total number of pregnant women is not known. The quality of the antenatal care (records, examination and laboratory tests) also needs improvement especially in New Century, AVRV and SPKS. The doctors were not familiar with the concept of high risk pregnancies. Only SEWA Rural had home-based antenatal cards. Other centres only have clinic records. The antenatal services included giving iron with folic acid and TT. In SEWA Rural they had produced a special delivery kit which was used in their project area. It was also distributed by UNICEF to other states.

Table 6: Number registered for Antenatal Care  
(From Quarterly reports July-September 1986)

<u>Name of subgrantee</u>	<u>Stated Target</u>	<u>Achieved</u>	<u>Two Doses of TT</u>
VHS	3200	2916	1807 (58%)
AVRV	Nil	273	47
SPKS	50	34 (68%)	29
Streehitakarini	-	103	-
ICH	300	402 (130%)	-
New Century	-	470	120
SEWA	450	407	156

e. Family Planning

Family planning was included by PVOs even prior to the sanction of the USAID project. Two of the subprojects were primarily Family planning projects which have integrated primary health care activities. Though the funds from the USAID projects were not used for sterilization activities, the staff were involved in health education including family planning. Field level workers discussed the concept of spacing and the advantages of a small family with potential clients. They provide supplies for temporary methods and referrals for clinical methods. Although family planning is included in all project designs, coverage appears to be low. This is an area which requires further strengthening.

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**Table 7: Number of Family Planning Acceptors**  
**(From Quarterly reports July-September 1986)**

<u>Name of subgrantee</u>	<u>Tubectomy</u>	<u>Vasectomy</u>	<u>IUCD</u>	<u>OP</u>
VHS	218	21	31	167
AVRV	-	-	-	-
SPKS	13	-	1	-
Streehitakarini	150	-	65	-
ICH	-	-	-	-
New Century	6	-	-	137
SEWA	57	3	31	-

f. Health Education

All subgrantees are carrying out health education activities. The quality of health education varied from place to place. All subprojects are using the traditional methods such as flash cards and posters, discussion and demonstration. Demonstration was used as a method of education in VHS and SEWA. SPKS has provided large volumes of health education materials but it may not be effective because of the large number of messages conveyed. In ICH the Family Level Volunteers were being used primarily for providing education to the community. One of the most effective methods of communication is by using folklore. This method has not been used in the centres that the team visited. No attempts have been made to do a K.A.P. study focussed on health or family planning. The community's knowledge and attitudes should have been assessed initially in order to help prepare suitable health education material. Changes in K.A.P. should also have been measured to evaluate the effect of the education programme.

g. Curative Services

In six of the seven projects visited, the curative system has been improved by incorporating a referral system from the grass root and by improvement of the secondary care facilities. Doctors provide curative service through mobile clinics which are conducted once in a week or fortnightly. The referral facilities were improved by increasing the number of beds, improved laboratory and treatment facilities.

2. Special Preventive Services

There are three eye care projects and one other project (VHS) attempting to integrate public health care with treatment of TB and leprosy. However, since none of these was visited except VHS, little can be said about the quantity or quality of services.

#### D. Subproject Administration and Management

##### 1. Supervision and Staff Management

VHS is a large project whereas SEWA is a medium size project. In both these organisations, the management was found to be satisfactory although staff meetings should be more frequent. Levels of supervision were well defined and the responsibilities of most of the staff were well identified. Financial accounts were also well maintained and there was adequate decentralization of financial procedures. Reports were regularly prepared and reviewed.

ICH in West Bengal and AVRH in Tamil Nadu are medium size projects. These two projects are outreach programmes of two large institutions - the Institute of Child Health in Calcutta and the AVRV Educational Foundation, Coimbatore. These projects are in effect being implemented by the Project Directors. There was little interaction between the Project Directors and the parent organisation. The administration of the institutions did not seem to have the same views as the Project Directors regarding the project goals and objectives, resulting in delays in implementation of the programme. If the projects are to be viable at the end of the grant period they will need the financial and administrative support of the parent body. Hence the parent organisations need to have more interaction with the Project Directors and establish agreement on the policies regarding the programme. Initial attempts have been made in these two projects to identify the responsibilities of the various staff, but more work needs to be done. The financial accounting and reporting were being done fairly systematically. Decentralization was inadequate.

At the Institute of Child Health, attempts have been made to establish a better supervisory system at different levels. Some progress has been made but more should be done. The job descriptions of the individual workers need to be more clearly stated. Greater opportunities should be provided for the various levels of staff to meet together to discuss and take decisions regarding field problems.

Sarvajanic Pariwar Kalyan and Sewa Samiti (SPKS), Gwalior; Streehitakarini, Bombay, and New Century, Madras were included under the small projects. In these three projects the programme revolves around a charismatic leader. The management and supervisory system is poor. The responsibilities of various staff have not been well-identified. Decisions are made almost exclusively by the Project Director. In the absence of the Director, decisions are delayed. Financial accounting was poor in the initial stages of the projects but with the help of the Chartered Accountants contracted by NIHFV this has been improved. The reporting system has also shown some improvement after visits of the monitoring team. However, staff meetings are not held periodically. Such meetings would enable the various members of the team to be involved in decision making.

## 2. In-service Training

In-service training is being given in five of the PVOs visited through periodic training or review sessions. However, the following aspects need further strengthening:

- a. Understanding of the problems and perceptions of the community before the training programme is given so that these aspects could be adequately covered;
- b. Understanding the concepts of primary health care. Basic concepts of primary health care are still not well understood by the PVOs. Technical assistance and training need to be provided;
- c. Assessing the training needs based on the evaluation of the knowledge and skills of the workers. A more systematic method needs to be adopted to identify the weaknesses of the peripheral staff in terms of knowledge and skills and then make a programme so that these deficiencies are overcome;
- d. In almost all the PVO projects visited there has been a very deliberate attempt to improve the health education component. Many of them had good audio-visual aids bought from other centres or prepared at their own centres. However, the skills in communication seems to be poor. Very few were using the traditional folklore methods and the involvement of the community was also not adequate. There is a need to impart these skills to the PVOs so that they can carry out this aspect of the job much better;
- e. The staff of AVRV, New Century Welfare Society, and SPKS need training in conducting ante-natal clinics, growth monitoring and immunization. Hardly any PVO was doing anything systematically in environmental sanitation and they need training in this area too. ICH was found using JALASUDDHI, a chlorine compound for water purification.

## 3. Coordination

While most groups have good coordination at the top level there is considerable scope for improvement at the mid-supervisory and field levels. For example, workers tend to coordinate only with workers doing the same job. At SEWA Rural the child care (Anganwadi) worker and the health supervisor did not interact systematically. They both reported to their concerned supervisors who then interacted at their level. At the VHS Madras the leprosy workers responsible for ensuring that the drugs were given correctly and the primary health care workers did not interact adequately, nor did they share their responsibilities. Better coordination would enhance integration of the service and improvement in their work. There should also be better planning in this area.

#### 4. Reporting

Most of the PVOs need to improve their reporting systems. Duplication was found in one of the PVOs (SEWA Rural). The same information was being reported by the Anganwadi workers, the health supervisors, and the trained dais. Better coordination would decrease the work load and improve the quality of the information reported. In most other PVOs there was inadequate reporting of essential data, especially high risk pregnancies, high risk children, weights of children were not adequately recorded and the findings of the antenatal clinics were not well documented. Births, deaths and pregnancies also need to be documented well. Most of the data collected was not properly utilized for planning, review and revision of the programmes. Unless there is a purpose in collecting the data and this is made known to those who collect it, the quality of the data is not likely to improve.

Home-based records were generally inadequate. Except in one centre there was no home based record for mothers. Most centres had accepted the concept of growth monitoring but the charts or the records were not with the families but were kept at the centres.

While the field level workers have been responsible for collecting most of the vital data, there has been no system by which this information which has been collected at the centre is fed back to the field level functionaries. Graphic presentation of data was also found to be deficient in all centres. Such presentation will help to identify trends in the community. The above deficiencies clearly indicate that there is a need to provide technical assistance to all the PVOs in the areas of reporting, data analysis, and data utilization.

## V. SUBPROJECT NEEDS FOR TECHNICAL ASSISTANCE AND TRAINING

Initially most sub-grantees had considerable needs for technical assistance in administrative and financial matters. These are now being adequately met through existing appraisal and monitoring mechanisms of NIHF staff and through the technical assistance provided by the chartered accountants. However, there are some key areas in which PVOs most need assistance. These can be broadly classified into project planning and project implementation.

### A. Technical Assistance needs for Project Planning

In the project design it was noticed that no attempt was made by the PVOs to identify priority health problems of their area and to design appropriate strategies based on these problems. They had a tendency to adopt the priority problems stated in the guidelines of the book provided by the Government and also the strategy stated in the Government of India's publications "Health for all, an alternative strategy."

Very few projects had carried out a baseline study before the project was proposed or even after the sanction of the project. Without such a baseline study it is not possible for the PVOs to assess whether the project is achieving its objectives or to identify the areas in which modifications are necessary. PVOs need training in the collection and use of program relevant data. Many of the PVOs were not aware of the various rates and ratios which could be calculated with the data which was being collected, and hence data were not being used most effectively for target setting and development of work plans.

### B. Technical Assistance for Project Implementation

Technical assistance for project implementation to the subprojects needs to be strengthened. In the following section specific substantive areas on which assistance is needed are discussed in detail. However, there is one project which, because of its institutional links, has been able to fill many of its needs for technical assistance. This project is discussed here since it may provide a useful model for other PVOs. In SEWA Rural there has been an ongoing association with the Medical Colleges in the area. Post-graduate students have been posted to the project. The M.D. community medicine student who was posted at SEWA from Surat Medical College was largely responsible for organising the community programme in a systematic way - conducting meetings of the supervisors and ensuring that the reporting was well done.

At the Institute of Child Health the posting of post-graduate Paediatric students has also helped in motivating staff and has been instrumental in encouraging doctors to join the project. The two young doctors have shown a very keen interest in improving the entire supervisory system and giving technical guidance to the field workers. They indicated that they needed help in community health. The experience in SEWA Rural suggests that an attempt should be made by the PVOs to have a link with the local medical college since this can improve the technical inputs available to the project, and can orient the medical students and postgraduate students toward primary health care programme implementation.

In general the PVOs need technical assistance and training in the following areas:

#### 1. Selection and Training of Staff

While the selection process was satisfactory ~~the training of~~ staff needed much more improvement. The jobs of the various staff were not adequately described. Without a proper job description, training cannot be well designed. The curriculum for the training programme was also not well prepared. Training methodologies and materials need further improvement.

#### 2. Primary Health Care

Most of the PVOs could benefit from training workshops on key primary health care interventions and on how they could be implemented. This could specifically focus on the key child survival strategies including immunization, ORT, and birth spacing. Such training workshops may have to be followed up with site visits by local experts to provide subgrantees specific project assistance through training of their staff and helping design implementation strategies.

#### 3. Design of MIS

Records, registers and progress indicators also need to be improved. Records frequently were too cumbersome with too much information or were inadequate. Data were not systematically verified by the supervisors. The system of review was absent in almost all centres. The data were collected and collated and sent to NIHFV without adequate review or evaluation of the progress of the work of the PVO. This could also include simplified monthly and quarterly reporting systems at various levels.

#### 4. Financial Management

The chartered accountants under contract with NIHFV are already providing some assistance in this area. This role could be further expanded to include follow-up site visits to assist the subgrantee staff in clearly understanding and implementing proper accounting systems.

## 5. Development of a Good Referral System

Though patients were being treated in the community and then referred to the higher centres like base hospital or district or taluk hospital, there was no good referral system developed as yet. An attempt should be made to develop a system which will enable the PVO to know the number of patients who have been referred, how many of them have reached the referral point, and what action has been taken.

## 6. Use of Appropriate Technology in Health

As indicated earlier much more needs to be done in the area of environmental health, such as construction of appropriate latrines, chlorination of water, promotion of the smokeless chula, soakage pits, etc. Appropriate technology could also be used in the maintaining of cold chain, use of solar energy, biogas etc. Since most of the PVOs are not presently working in this area, they would require technical assistance and training in starting up these activities.

## 7. Knowledge, Attitude and Practice (KAP)

KAP studies need to be done to plan the education programme as well as to measure the effect of these programmes on the community.

## 8. Strategies for Financial Sustainability

Since the projects need to be viable at the end of the grant in 1989, the PVOs need to get some income from the health activities or generate other sources. To enable them to make a correct estimate of expenses and explore alternative source of funding, they could use training workshops.

## 9. Operation Research

With the innovative interventions that are being introduced in several projects unless operation research is carried out systematically, it will not be possible to make any conclusions. PVOs need help to do operations research using the facilities available at their centres.

These technical assistance needs could be met through different mechanisms. These include, for example, (a) training courses and training workshops for PVOs by NIHFV and other institutions (b) tailor-made training program to groups of PVOs, regionally, through local institutions or team of local experts and (c) panels of experts made available to PVOs to obtain specific project assistance on their individual problem areas.

VI. ADMINISTRATION AND MANAGEMENT OF THE PVOH PROJECT INCLUDING MONITORING AND TECHNICAL ASSISTANCE TO SUBPROJECTS

A. SUMMARY: Effectiveness of the Collaborative Relationship Between USAID, MOHFW and NIHFV.

The Evaluation Team has found that this project represents a logical and complementary relationship between the donor agency, the host Government, and the technical backstop agency; that is, between the USAID, the Government of India in the Ministry of Health and Family Welfare, and NIHFV. During the initial 4 years of the project, a positive collaborative working relationship has gradually been developed among these three partners. It has become a very solid and useful relationship, resulting from the personal efforts of the officials responsible in these three organisations. There has been a conscious effort to clarify the respective roles as reflected in the Project Implementation Letters (PIL's).

There have been some problems in the initial start-up stage of the project. It has taken between three and four years to evolve the current collaborative system. The NIHFV was brought into the picture three years after the inception of the project, necessitating an expanded period of adjustment. Delays have also been noticed in delineating responsibilities of the Ministry of Health and Family Welfare and the USAID in the matter of the approval of projects. The fact that there are three key factors in this project has meant certain inherent difficulties in smooth collaboration.

The Team also noticed that there has been considerable confusion in the minds of the private voluntary organisations as to the relative lines of authority and areas of jurisdiction of the three agencies. For instance, some of the PVOs were not sure as to which advice they should follow when receiving instructions from representatives of the three agencies who happened to visit them.

Initially there were delays in reviewing the subprojects. There were also difficulties in coordinating appraisal visits and monitoring visits. In some cases, there was a time lag of 1<sup>1</sup>/<sub>2</sub> to 2 years from the date of receipt of the project to the date of sanction of the project. Similarly, there were delays in sending monitoring reports. There were delays in approval of budget revisions, and communication to the subgrantees. Such delays have been noticed in the early phase, particularly during 1981 to late 1984. During late 1984, these things have been streamlined to a great extent, particularly with the introduction of Project Implementation Letter No.3, introducing the 3-tier system for review and approval of projects. It is noteworthy that it was at the same time that the decision to bring in NIHFV for providing technical assistance in appraisal and monitoring was also taken.

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The involvement of the NIHFV was expected to provide much needed technical assistance to the PVOH subprojects in key areas like project preparation, designing of baseline studies, reporting systems, management systems and overall project monitoring and evaluation. Some of these areas where the subprojects need inputs have been discussed elsewhere in this report. It is the impression of the Evaluation Team that there is considerable scope in improving and strengthening NIHFV's role and contribution in better understanding the objectives of the subproject holders, analyzing their weaknesses, and then trying to help them in areas requiring technical assistance. In many of the medium and small PVOs visited, we found that there is a feeling that the monitoring checklist used by NIHFV is not helpful in identifying their actual needs in terms of technical assistance. On the other hand, it should be noted that NIHFV has succeeded in setting up a structure which assures regular contact with subgrantees and has implemented a standardized format for collection of program data. The challenge now is somehow to make this structure more sensitive to project needs.

B. The Effectiveness of Subproject Selection, Appraisal and Approval Procedures:

The Evaluation Team feels that this is an important area in the overall context of the implementation of the PVOH Project. Under the three-tier system, as explained in Chapter III, Section C, the selection and approval procedures of subprojects were streamlined. Projects which were less than Rs.2.5 million were authorised to be cleared by the Grants Committee without any reference to the USAID Mission. Projects of Rs.2.5 million to Rs.10 million were required to be sent to the USAID for comments on the appraisal reports. If no comments were received within 15 days, the Ministry could go ahead with the appraisal and place it before the Grants Committee. Projects above Rs.10 million were required to be circulated to the USAID and their concurrence had to be obtained prior to approval.

It is a positive aspect of the project to note that since its joining the project, the NIHFV has given valuable help in the appraisal of all subgrants. However, we feel that the appraisal missions should have focussed more on programme and technical aspects and identified areas needing modification and strengthening, as was done on the administrative and financial aspects.

An important constraint complicating the appraisal visits has been found to be the Government regulations with regard to travel and per diem applicable to the staff of the NIHFV. When such visits are organised, the team including the staff of the NIHFV have to make visits and do the work together. When other members of the team travel by air, it becomes difficult for staff members of NIHFV also to travel by air because in the normal circumstances they are not eligible for such air travel (except for full professors). Similarly, when they have to visit major metropolitan centres they find it difficult to meet the living expenses with the comparatively low per diem allowance they get according to the Government rules. This aspect requires careful consideration and decision to make such visits by NIHFV staff easy and useful.

Attention should be devoted to proper preparation of the project proposal by the PVOs. It is necessary to introduce a good package of technical assistance to the PVOs during preparation of the project proposal as well as during project implementation. Similarly, to make the appraisal visits more purposeful, the site visits should be better planned. Monitoring visits should provide needed technical assistance to the PVOs and also give decisions on problems that are placed before them on the site itself. In short, there should be more interaction between the NIHFW teams and the PVOs and more time should be spent on technical aspects of project preparation, project appraisal and project implementation.

### C. Financial Administration and Monitoring

There are two levels in the flow of funds and financial management. The first is from the USAID to the Government of India (MOHFW). After the Project Agreement was executed and the Conditions Precedent were satisfied, AID releases an advance to the GOI for start-up expenses (administration costs for the first project year). AID then releases a second advance to the GOI for advancing funds to the subprojects, after approval of the first three proposals by the GOI's Grants Committee and concurred by AID. In practice, AID has been releasing advance to the GOI equivalent to the estimated first year budget of the subprojects. This advance is replenished by AID on an imprest fund basis, half-yearly or more often if necessary, to the extent eligible, expenses are incurred by the GOI and the subgrantees in the implementation of the project.

The second level of flow of funds and financial management is from the MOHFW to the individual PVOH subprojects. After approval of a subproject, the MOHFW releases an advance up to the amount of projected expenses for the first six months. The advance is replenished by MOHFW against quarterly or semi-annual expenditure claims from the subgrantees until the unexpended balance in the subgrants is equal to the advance amount. Despite this seemingly straightforward procedure, there have been some delays in the flow of funds to subprojects. Most projects experienced a delay of one to three months. The main factor contributing to these delays is the fulfilment of bonds and other documents by the subgrantees.

Once the initial funds have been released to the subproject, the NIHFW is responsible for financial monitoring. In order to fulfil this role, they contracted with two chartered accountant firms. The chartered accountant visits the voluntary organization soon after the approval of the subgrant to review and provide technical assistance to each subgrantee on how it should manage the funds provided under the subgrant. The following assistance is provided :

1. Instructions to subgrantees on what records are to be maintained and how.
2. Review of subgrantee's internal controls and procedures relating to cash management, bank reconciliation, procurement of goods and services, stores maintenance, inventory controls, etc. When these controls and procedures are found deficient, advise subgrantees on what actions are to be taken.
3. Advise subgrantees on how reimbursement claims are to be prepared and how supporting documentation is to be maintained for verification.
4. Explain to subgrantees how periodic reports are to be prepared and how records are to be maintained for verification.

After the initial visit, the chartered accountant deputed by the firm makes periodic visits as a part of the monitoring team of NIHF to review and verify whether the subgrantee maintains adequate records, maintains internal controls, prepares reimbursement claims properly, prepares reports accurately, and complies with AID procurement requirements.

Financial monitoring and technical assistance on financial management as carried out by the chartered accountant is seen to be one of the strong aspects of project management. The PVOs also felt that monitoring by the chartered accountant had assisted them in strengthening their internal financial controls and accounting procedures particularly in areas like inventories, petty cash management, payment procedures (through cheques), expenditure control protocol, etc. Financial and programme monitoring has played a positive role by recommending budget adjustments, waivers for vehicle purchase where appropriate etc. in order to maximise the use of project funds.

During field visits, the evaluation team examined the issue of proper utilization of funds and proper cost accounting. Funds appear to have been utilized properly. Initially, many PVOs had difficulties with the financial procedures and reporting. These were however largely overcome by visits of the chartered accountant to the PVOs and also thanks to the workshop which was organized by NIHF in October 1985.

#### D. Programme Monitoring by NIHF

NIHF is responsible for monitoring the progress of subproject implementation. This task is carried out through periodic monitoring visits and collection of quarterly reports. The NIHF has prepared an overall Administrative Manual which was distributed to the PVOs and explained to them in the workshop held in October 1985. They have also prepared the Monitoring Protocol, the Quarterly Report Format and Baseline Survey Proforma. While these proformae have their own merits, we feel that there is need for developing project-relevant protocols. In the present set of proformae, there is little

scope for reporting of issues or problems unique to a specific PVO.

We also noticed during our field visits that most of the PVOs did not understand the purpose of the baseline survey or of all the information that is requested in quarterly reports. We feel that this should be rectified and the PVOs should be told about the purpose of these studies/reports and the information requested. The focus is on quantitative data. Very little emphasis is given to qualitative aspects of service delivery. Similarly, the information system is also inadequate on monitoring the processes of project implementation that are in evidence in the PVOs. Because of this, there is little provision for discussion of problems of implementation and strategies to resolve them.

A good thing about the present monitoring system is that the NIHFV has instituted a regular system of quarterly reports which is strictly followed. The team felt that there is duplication between the quarterly reports and the monitoring protocol. We recommend that these could be synthesized and simplified into one set of project specific half-yearly activity reports. Only financial reports need to be required on a quarterly basis to expedite disbursement. The challenge now is to make those reports more useful to the projects themselves. Site visits are being made regularly at intervals of six months and one year. These visits are focussing more on quantitative targets and administrative aspects. We found that the PVOs felt a need for greater interaction with the monitoring team, including an opportunity to receive feedback and to discuss problems of implementation and would appreciate additional attention on technical issues. The PVOs did comment favourably on aspects like the guidance received by them on staffing, and on budget revisions (capital and recurring) and on accounting procedures. Such repeat visits could not be more frequent and prolonged probably because of NIHFV's pre-occupation with appraisal/monitoring visits and their other responsibilities in the Institute.

#### E. Evaluation

The NIHFV has already scheduled five or six Mid Term Evaluations and has already started developing their proformae and doing the site visits for evaluation. NIHFV should spend some time with each subproject being evaluated before finalizing the tools for evaluation. The questionnaires will have to be designed carefully to assure that the actual innovation of each of the subprojects is focussed on. The evaluation should be supportive in spirit and try to offer solutions for the areas where the subprojects are experiencing difficulties. It should be kept in view that the main objective of the Mid Term Evaluation. The purpose of evaluation should be to assess the performance of the subproject with reference to the subproject's objectives and its needs, to suggest mid-course corrections wherever there have been difficulties in achieving the objectives and to document successful approaches. Such an approach to evaluation will be of immense help to subgrantees in implementing the activities during its second phase more successfully and will also be useful for developing new projects.

## VII. SPECIAL AREAS OF INTEREST WITH RESPECT TO SUBPROJECTS

### A. Relationship of PVOs to Government Health Services

In general, the quality of services provided by the PVOs seemed to be as good if not better than the services provided by the Government in those areas. The best example is immunization coverage. PVOs had better coverage in general and better retention for the second and third dose. There was also better registration of pregnancies (including high risk cases) by PVOs. The registration system for vital events was also found to be better in the PVOs. Greater efforts were evident in providing health education to the community especially the use of ORS. Though the team made an effort to find out to what extent these programmes were covering the community, verification was difficult partly because of the lack of proper records and also because of lack of time to visit individual homes and interview the various beneficiaries.

The reasons for the better services provided by the PVOH could be attributed to :

- i) Better initial and inservice training - most projects had a training programme of one to three months and a monthly inservice training programme;
- ii) The PVO field workers are visited in the community by the supervisory staff and given the necessary support;
- iii) Greater continuity of staff is also important. In all except one organization, the staff seem to have been fairly stable;
- iv) PVOs seem to have higher motivation of all staff and better staff support systems; and
- v) Finally, there seems to have been a greater concern for qualitative and quantitative reporting. However, this needs to be verified by actual field surveys which were not carried out by this team.

There appeared to be very little duplication of services of the PVOH projects and the Government. State Government officials were frequently present during appraisal visits and made an active effort to see that no Government programmes were duplicated by the PVOH. There are two instances where the Government made a request to the subgrantees to change the site of the construction of their centre so that it was not too close to the State Primary Health Care Programmes. In SEWA Rural, the Government went to the extent of handing over the entire ICDS and health programmes to the PVO. Unfortunately, the same enthusiasm was not seen in other states.

There are numerous examples of cooperation between the PVOH and the Government. In Bombay, the project referred the pregnant women to the Municipal Hospitals. Almost all PVOs obtained vaccines from the Government free of cost. For family welfare, the Government provided both financial and material support. Finally, in the Tuberculosis and Leprosy Programme in VHS, Madras, the National Control Programme were integrated with the primary health care programme which enabled the subgrantee to obtain the necessary drugs free of cost from the Government.

In some cases, there has been formal delegation of responsibilities for better health services and ceding of staff by Government to PVOs. In SEWA Rural, the Government subcentres and ICDS projects including their staff have been ceded to the SEWA by the Government. The Government also wanted to cede the Community Health Centre, but the SEWA Rural did not want to take it on immediately to avoid overloading its capacity. At VHS, Madras over 30 mini primary health centres and the entire tuberculosis and leprosy control programme have been handed over to the VHS by the State Government. At Coimbatore, the AVRV has been given one of the subcentres situated in the tribal area so that the AVRV could conduct its clinics from this centre. In Bombay, the Streehitakarini has been given all the provisions for carrying out the feeding programme for the children of that area. The funds are being provided by Social Welfare Board. In Calcutta, the Institute of Child Health is in the process of getting the adult education centres and the ICDS under their control from the State Government.

Almost all the PVOs have set up coordination committees which consist of the Government representative, local community representatives and the PVO. Unfortunately, these committees have not met on more than two or three occasions at any one centre and in many places they have not met at all. The reason for the inactivity of the coordination committees is that the State Government officials have not been able to attend the meeting whenever it has been called or only junior officials have attended the meetings. This was unfortunate because the purpose of the coordination committees was to look at the various programmes that are being implemented, identify areas where there could be greater coordination or identify problems and discuss solutions and also enable the State Government to make requests to the PVO for certain activity. The coordination committees should meet more regularly in future. Their potential contribution to effective project management and good relationships between the PVO and Government programs is great.

#### B. Degree of Innovativeness of PVO Projects

AVRV is integrating the Ayurvedic System into Primary Health Care by stressing preventive aspects of the Ayurvedic and Siddha systems. Though the project has been going on for over two years, it was not possible to assess to what extent this was being

successfully done. A major deficiency in this project was the lack of good data which would help assess the effectiveness of such an integrated programme. SEWA Rural has developed and is manufacturing an innovative delivery kit. This was found to be very popular among the Dais of that area and has been distributed to other parts of the country through a major funding organization.

The Institute of Child Health, Calcutta has developed and is manufacturing water chlorination compound known as Jalasuddhi. This solution is added to water which is kept in the drinking water containers and not in the well as is normally done. The solution can be kept for over 6 months unlike bleaching powder which easily loses its potency. The Institute of Child Health also has a systematic training programme for housewives for preventive and promotive health care - this includes a six months' course covering 20 key subjects. These housewives are true volunteers because they do not get any honorarium except for the expense which they incur during the training period. No other expenses are reimbursed. VHS, Madras is integrating the National Tuberculosis and Leprosy Control Programme into the primary health care programme.

Some of the other subprojects not visited by the team also have innovations. These are given in Annexure V giving a summary of the 22 subprojects.

### C. Role and Effectiveness of Community Participation

Most of the PVOs made a conscious effort to involve the community in planning and implementation of the projects. The one exception is again New Century, Madras. AVRV, Coimbatore and ICH, Calcutta were particularly strong in this. The community through its leaders were actively involved in selection of project volunteer staff, in the selection of the most appropriate location of health centres, and in contribution of land. In three PVOs there were some efforts to involve the community but this aspect could be further strengthened. In New Century, community participation was negligible. In Streehitakarini, Bombay, members of the community were formally included in the general body of the association. In three other groups, PVOs have active village health committees and/or Mahila Mandals. Four groups have involved the community in income generating activities to complement their health programmes. This, however, was on a very small scale and needed to be expanded further. In Streehitakarini, this included screen printing of health education material which is used in the slums.

D. Interlinkage among PVOs Subprojects

In October 1985, a Workshop was conducted at the National Institute of Health & Family Welfare, where all the PVOs had an opportunity to share their experiences. In this Workshop, project management details were explained and the problems discussed. Most PVOs were very appreciative of the Workshop because it gave an opportunity to meet the other PVOs who were carrying out similar projects. It also helped to clarify the rules and regulations and reporting requirements. However, there were many recommendations on how the Workshop could be conducted in future. The PVOs were of the strong view that the links should be strengthened. At present, there is no communication or interaction with other PVOs. Some of the suggestions given by the PVOs are:

1. Annual workshops be conducted either in Delhi or regionally which will give an opportunity for the various PVOs to present short papers describing their activities, their achievement, their problems so that they could benefit from one another's experience.
2. Visit to other PVOs with similar activities could be arranged.
3. Regional meetings could be conducted. Since it may be difficult to meet often at a national level, the recommendation was that regional groups could meet more frequently to share experiences and learn from each other.
4. Linkages with other PVO umbrella organisations like VHAI - the possibility of all the PVOs being linked with the VHAI of the state so that they could get some inputs from the VHAI as well as share their experience.
5. Routine sharing of information through periodic PVO newsletter. It was felt that a newsletter to which each PVO could contribute whatever has been learned could be circulated. An attempt was made by one organization to do this without much success.
6. Documentation of experiences and success stories - such a documentation could also be circulated and would be a learning experience. Both successes and failures should be documented.

E. PVO Capability to Generate Private Resources and to meet 25% Match Requirement

As explained earlier, each subgrantee was expected to contribute 25 percent of the total subproject cost. We find that the principle of requiring a private match is sound. In fact, it is recognized as such by the PVOs themselves. There are several advantages of such a recognition. For instance, it helps protect

the PVOs autonomy and their volunteerism. It also helps them in establishing a basis for sustainability of the project. Most of the PVOs which we have visited had already started a system of raising contributions from the community with a view to sustaining this project even after the period of the present subgrant. For example, SEWA Rural has devised an appeal for donations in which they are making it very clear to the donors that every Rs.25 they contribute will attract Rs.75 matching grant from the donor. This concept of matching also promotes a sense of partnership. We feel that the present attempts made by some organizations like SEWA Rural to raise funds using this matching condition may ultimately help them in establishing a system of fund raising. However, we are of the opinion a 25% match is rather high and is difficult for many PVOs to meet. We feel that the 25% match requirement coupled with the preference for family large size budgets had the effect of restricting some of the potential applicants. Even with the present minimum budget size of Rs.800,000 we feel the 25% requirement has discouraged some good PVOs from applying. For many small PVOs raising of a 25% match may pose a lot of problems.

It is a fact that most subgrantees are currently meeting the 25% match in cash and kind. They also answer in the affirmative when we asked them about their ability to raise the 25% match. In actuality, it is found to be difficult for many of them to do so. Many of them seem to be doing it only in letter and not in spirit. For instance, some of the PVOs have agreed to raise the 25% match perhaps because they have been keen on getting the subgrant and initially felt that somehow they could raise this 25% match. Later on, they tried to do this by taking advantage of escalation in land values. In other words, after the sanction of the subgrant, when they look around for some way of raising this 25% match, perhaps, they suddenly realize that there is a piece of land which was bought by them years ago, and whose value has tremendously appreciated over the years. Therefore, they have tried to set this off against the 25% match. Some other PVOs are reported to be using various other strategies such as donation of part of the staff salaries to the organization, which is set off against the 25% match. One fortunate thing is that this seems to be a voluntary decision on the part of the staff members and does not seem to be forced on them.

In every case, this requirement has posed a problem. In order to help PVOs with meeting their 25% match requirement, the scope of allowable counterpart contributions was broadened to include even host Government grants. This, we feel, is technically not a private matching contribution. When we discussed this with the concerned officials of the Ministry of Health & Family Welfare, we found that they also felt that this match limit was too high and were considering the possibilities of reducing this quantum.

F. Sustainability

Most of the PVOs have given serious thought to this question of sustainability of the project after the present subgrant ends. It is clear that most of them will face a major challenge in continuing the project at the current planned level of health services after the PVO grant ends. We feel that the PVOs with high capital budgets in relation to recurring expenses, may find it easier than those who are heavily depending on the grant for salaries and other day-to-day expenses. Projects with large parent institutions (VHS, ICH, AVRV) are likely to find it easier to sustain their activities after the subgrant ends than those PVOs without such a support.

Some PVOs have made a deliberate attempt to keep the recurring expenses at the minimum level. Some of them have even resorted to avoiding increases in salaries of staff members. Some PVOs have made a deliberate attempt to meet the recurring expenses by charging fees for services rendered. However, we feel that there is considerable scope for improvement in this area. We find that the fees charged are very nominal which may not be very helpful in sustaining the project. They may charge more reasonable rates and thereby start the process of fund raising towards achieving self-sustainability.

We also find that most of the PVOs are counting on Government support to sustain their activities beyond the present subgrant period. While the PVOH Project is definitely helping to strengthen the linkages between PVOs and the public sector and will in some cases result in such financial support, in many cases such support may not materialize due to resource constraints and other factors.

## VIII. CONCLUSIONS AND RECOMMENDATIONS

### A. Conclusions

#### 1. Appropriateness of PVOH as a mechanism for involving PVOs in primary health care and preventive health services

The evaluation findings indicate that PVOH is an appropriate and effective mechanism for involving PVOs in primary health care. The project design has encouraged the PVOs to broaden their activities beyond curative care and to initiate and expand primary health care outreach activities. The programme has been successful in supporting primary health care projects of a broad range of types and sizes including many smaller PVOs as well as established organisations. PVOH has also supported primary health care projects of PVOs in a large number of states including some of the poorest states with more serious problems including Uttar Pradesh, Bihar and Madhya Pradesh.

It was more difficult for the Mid Term Evaluation to assess the effectiveness of PVOH with respect to support of special preventive services (eye care, TB and Leprosy) because only two of these projects (eye care) had been approved at the time of the evaluation and neither of these was visited by the Evaluation Team (excepting VHS which combines TB and leprosy programmes with primary health care). Nevertheless, quarterly progress reports indicated that these projects were progressing well. Two more large special preventive service projects had just been approved for major PVOs working in leprosy and TB. This aspect will have to be more fully assessed at the time of terminal evaluation of the Project.

The administration mechanism selected for the project - a special grants programme coordinated by MOHFW - is appropriate and timely, given the GOI's public commitment to increase its support of PVOs for delivery of health services. The involvement of the Government of India in all aspects of the Projects and the establishment of a special cell in the MOH, has helped to mobilise GOI administration and technical resources in support of the PVOH project. The need to strengthen the role of the PVOs in the delivery of basic health services, particularly in under-served areas is an important element. Similarly, there is a strong emphasis on PHC out-reach services. Priority is given to the key PHC interventions in the reduction of infant mortality, including immunization, ORT, maternal and child nutrition and family planning, as well as promotion of an integrated approach to the delivery of these services. The project design also included provision for operations research for the strengthening of technical and management support systems and for evaluation of innovative approaches.

Although PVOH has developed a number of effective procedures, there are still many steps that can be taken to improve procedures further and to make PVOH a more effective mechanism for support of expanded health activities. These steps relate to future improvements in the field of proposal solicitation, the review and approval process, the monitoring mechanism, and also the need for additional inputs (technical assistance).

## 2. Project Progress to date toward Objectives

The Project was slow starting because of organization difficulties and PACD has already been extended by two years, i.e. up to September 1989. However, the Project is now making excellent progress. 25 of the projected 30 subprojects have been approved and several others are nearing approval at the time of this evaluation.

The progress of the subprojects toward their individual objectives is discussed in Chapter IV and Annexure V. It is difficult to assess the progress of many of the subprojects towards their objectives because they are still in an organisational stage. However, it is clear from site visits to the 7 subprojects that the subprojects which have been operating for two years or more have successfully initiated outreach activities and/or delivery of child survival services to needy segments of the population. In order to measure the degree of progress towards the achievement of objectives in quantitative terms, indicators will have to be defined more clearly. However, we have made an attempt to include as much quantitative data as possible in the project descriptions (See Annexures IV and V). There are strong indications that the quality of service is high and that coverage is increasing. We find that the PVOs have been highly successful in providing immunization, ante-natal care, and child care. They have been somewhat less successful in providing family planning services. PVO projects compare favourably with Government health service in coverage, they are introducing innovative approaches, and they are successful in promoting community participation.

It is clear from the above that the PVOH Project is successfully achieving its purpose of expanding and improving basic and special preventive health, family planning and nutrition services for the poor by strengthening the private and voluntary sector. It is not possible at this stage to measure the impact of services delivered on mortality and fertility among rural and urban poor in India. In spite of good initial progress of many subprojects, the evaluation identified a number of key technical assistance, management and training needs which must be met if the PVOs are to be fully successful in achieving their objectives.

### 3. PVOH Programme Management; Effectiveness of the Collaborative Relationship between AID, MOHFW and NIHFW

An effective collaborative relationship has been developed between USAID, MOHFW, and NIHFW after a long organisational period in the early years of the Project in which some difficulties were encountered. The Project Implementation Letter #3 in late 1984 (described in Chapter III, Section c) played a key role in clarifying the respective roles of the three participating agencies. Positive efforts by the responsible officials in these agencies in the last two years have contributed further to an effective partnership.

The inclusion of the NIHFW in late 1984 was critical to the effective management of the Project. The externalisation of the monitoring of the subprojects through NIHFW has made excellent sense given the operational and staff limitations of both USAID and MOHFW. It is an appropriate and functional way to monitor the 30 subgrants to be approved by this project. The concept of full-time professional staff who can make regular monitoring visits and ensure adequate controls is one of the strong aspects of this Project.

This Project has clearly strengthened the Government's capability to support PVO Health Project and has improved collaboration between the GOI and the PVOs. The Project has helped to create a new unit for PVO Health Projects in the MOHFW and has provided an impetus towards strengthening the MOHFW's PVOs support structures. It has also led to the establishment of a new unit in NIHFW with a core group for technical support, monitoring and evaluation of PVO health activities. This has helped to bring into focus the need for systematic monitoring of other Government programmes (including the GOI Area Projects) and to recognise the need to further strengthen NIHFW's technical capabilities. The system of actively involving GOI and State Officials in the Project appraisal and monitoring visits has helped to avoid duplication of PVO and Government health services.

The system for the review, appraisal and approval of the sub projects has resulted, for the most part, in approval of good Projects. Project review and appraisal was relatively weak at the outset but these procedures were suitably strengthened by PIL No.3 and the involvement of NIHFW in 1984. However, there are still many aspects that can be improved further.

The financial administration of the Project appears strong, with adequate controls in place. Financial monitoring of the subprojects by NIHFW and the auditing firms is one of the strongest aspects of the Project. One of the weakest aspects of the system is the lack of timely reimbursement to some subprojects, resulting in delays in subproject implementation.

The current system of programme monitoring by NIHFV ensures adequate Government supervision and control. However programme monitoring can be improved so that it becomes more supportive of the subprojects. The NIHFV has provided some useful technical assistance and training to the PVOs. For instance, we can refer here to the holding of a workshop for the PVOs. However, this question of providing better technical assistance to PVOs is one aspect of the Project that needs to be strengthened the most, if the subprojects are to be successful in achieving their objectives.

## B. Recommendations

### 1. Additional Inputs Required for Successful Completion of the Subprojects

- a) The most important additional inputs required at this stage are technical assistance, training and new mechanisms for providing backup to the subprojects.
- b) A participatory Mid Term Evaluation be carried out in all the projects based on which modifications will be made on the objectives and programme plans (including identification of areas needing strengthening for successful completion). Special emphasis has to be laid on providing technical assistance and training to the weakest PVOs.
- c) The concept of a revolving fund should be made fully operative and be better explained to subgrantees.
- d) The PVOs need clarifications on budget adjustments procedures.
- e) Modest budget increases should be anticipated in some cases to meet increased and anticipated expenses.
- f) On the question of sustainability, some technical assistance and training may have to be provided to the PVOs during the remaining period of the grant in terms of alternative strategies, minimising recurring costs and increasing their revenues. The Government of India may also consider the possibility of continuing support after the initial grant period. The financial assistance may continue as a part of the grants-in-aid programme.

### 2. Recommendations for Future Improvements in the Proposals Solicitation, Review and Approval Process

- a) For future subprojects, proposal solicitation can be improved by more effective dissemination of information about the Programme with

- particular emphasis on personalized encouragement of applications from the PVOs. If the Project wishes to give special emphasis to particular kinds of PVOs - such as large PVOs, or PVOs from poorly served states, - an effort should be made to improve dissemination of information to them and to encourage them to submit proposals.
- b) All applications should be reviewed by a technical team with representatives from MOHFW, NIHFW, and USAID, which meets periodically and reviews the proposals received during the previous period. Systematic administrative and technical criteria should be developed for assessment and ranking.
  - c) For proposals recommended for further processing, the review committee should identify technical and administrative areas needing strengthening and the degree of assistance required for proposal finalization. With a good technical rating system, the three-tier system of proposal classification should become unnecessary.
  - d) Field appraisals should focus more on technical and programme aspects and identify areas needing revision/strengthening during the start-up phase.
  - e) In addition to NIHFW, other sources of technical assistance should be utilized in proposal development and in preliminary technical review of proposals.
  - f) Reasonable time periods for the different phases of the review and approval process should be determined and every effort should be made to adhere to them.
  - g) Proposal guidelines should be simplified. Some of the information requested like blue prints, certified cost estimates etc. need not be insisted upon at the initial application stage. Additional guidance materials should be prepared in project design and proposal preparation.
  - h) The issue of whether to reduce the matching contribution required from the subgrantees should be investigated.

### 3. Recommendations to NIHFV for Improved Monitoring, Evaluation and Technical Assistance Support to the Subprojects

#### a) Early Stages of Subproject Planning

There is a need for heavy investment in needs assessment, technical assistance and training in the early phase of subprojects. Additional assistance for conducting baseline studies and explaining their relation to project design is necessary. It will be necessary for the NIHFV to adapt its standard baseline survey proformae to meet individual subproject objectives and needs. It would be advisable for the NIHFV to consult the PVOs on designing the proformae. The NIHFV would do well to spend considerable time with the PVOs on interpretation of data and for project redesigning.

#### b) Site Visits

The PVOs felt the need for greater interaction with the Monitoring Team and additional attention by the Monitoring Team to technical issues. In the circumstances, we feel that the Monitoring Protocol should undergo major revisions. Repeat visits to subgrantees with problems are important and we recommend that once the appraisals are completed in December 1986 these visits be accorded high priority.

#### c) Programme Monitoring

As far as as Quarterly Reports are concerned, there is need for shift in favour of semi-annual reporting system. The monitoring system could be improved in terms of:

- i) deleting items which are irrelevant to the different subprojects,
- ii) including items which are related to the specific project objectives, using indicators identified by the subgrantees,
- iii) including information on processes and qualitative aspects, for example, content of training courses, training methodologies and involvement of the community,
- iv) discussing implementation problems and remedial measures,
- v) relating half-yearly activities to medium and long term objectives/programme plans as required, and
- vi) providing regular feedback to the PVOs from the NIHFV.

With a fairly accurate semi annual activity reports, there may not be a need for PVOs to file a separate monitory proforma. However, the financial reports should continue to be prepared on a quarterly basis to expedite disbursements to subgrantees.

d) Financial Monitoring

We feel that the Chartered Accountants wherever possible should accompany the appraisal teams with a view to assessing the book keeping/accounting soundness of the PVOs and to identify areas needing strengthening. The Chartered Accountants should also visit the PVOs shortly after the project is sanctioned to identify weak areas and to help them learn the required accounting procedures - rather than the present initial visits which takes place 4 or 5 months after the approval of the Project.

To maximise the effectiveness of such monitoring visits, the period of visit should be increased from 2 to 3 days and it would be better if the Chartered Accountants arrive in the field before the arrival of the Monitoring Team. This will facilitate free access to project personnel. The Chartered Accountants should have opportunities of repeat visits to the PVOs with weak accounting systems, upto a week's duration.

e) Evaluation

The NIHFV has already scheduled 5 or 6 Mid Terms Evaluations and has in fact started the development of the necessary proformae. The PVOH Mid Term Evaluation Team suggests that the NIHFV takes the following points into consideration in carrying out their evaluation:

- i) The NIHFV may make site visits to subgrantees to explain the purpose of evaluation and to obtain their suggestions regarding items to be included in the evaluation. We feel that such pre-evaluation visits would be useful in making the evaluations more objective,
- ii) The NIHFV may co-opt a representative of each PVO to help implement the Evaluation and to improve the internal evaluation capability of the PVO. This step will ensure a better PVO participation in the process of evaluation,
- iii) Whenever possible the Evaluation Proformae may be pre-tested for each PVO area.
- iv) As soon as the evaluation results are tabulated, NIHFV may organise on-site workshop to discuss the results of the evaluation for future project direction,
- v) The NIHFV may also try to involve regional and local institutions in the evaluations as much as possible. It should consider the possibility of contracting out some of these evaluation responsibilities to local institution.

f) Training Workshops

We recommend that there should be more workshops in future since most of the PVOs have felt that these workshops have been of use to them. Future workshops may be as participatory as possible with the PVOs sharing their problems, strategies, and successes. There could be workshops based on regional locations, or on programme objectives (shared), and on themes such as primary health care, child survival strategies, project management, operations research, MIS, Community Participation, IEC and Training. Outside experts may be invited to participate in such workshops. There could also be special workshops on themes of special interest, or with focus on specific programmes.

g) Technical Assistance:

The activities relating to programme planning and implementation will be strengthened by continuous review of the original objectives and strategies and formulation of more detailed activity plans during the first year of the subprojects. This should include field based training needs assessment. In view of the magnitude of the efforts required, including long field stays, continuous and regular followup, and also in view of the NIHF's heavy commitments to this and other MOHFW projects, there appears to be a need to explore alternatives for providing additional staff and resources.

- i) The NIHF could add full time training staff to become more involved in field based assessment of training needs during appraisal and project "start up" stages, and set up funds to permit contracting of individual technical experts and trainers. The team should also include a full time community health expert. Considering the level of expertise required and magnitude of work load, the Monitoring Cell may be elevated into a full fledged department headed by a full professor.
- ii) Another way of increasing resources is to contract with institutions/agencies like PVO umbrella groups, specialised technical agencies, medical colleges, universities, etc. for the establishment of suitable panels of resource groups for specific technical assistance needs. These groups would assume responsibilities for identifying technical assistance/training needs and for adequate provision of services. The assistance of these groups would focus on technical interventions, project design, and field based training expertise including services of doctors in community medicines.

As the number of projects grows, and as projects mature and increase the services they are providing, it is likely that substantial additional resources for technical assistance and project coordination will be required. We recommend that a combination of points i) and ii) above in some form be considered.

#### 4. Recommendations to AID, NIHFW and MOHFW for Streamlining and Strengthening Overall Project Coordination

The overall project coordination work has now to concentrate upon the provision of adequate and timely technical assistance to subgrantees. If a system of semi-annual reports is adopted and if the quality of these reports as also the monitoring reports are improved the need for making field visits may be considerably reduced. Establishment of quarterly or monthly review coordination meetings as already suggested elsewhere (between MOHFW, NIHFW and USAID) should improve project management and its efficiency. These reviews will lead to an indepth examination of the performance of individual PVOs. These meetings will also provide opportunities for dialogue among the three groups for indepth reviews of progress of implementation during the period, and for discussion of problems and decision making. To simplify review and approval of budget adjustment requests, increases up to 10% of already approved line items could be delegated to the Ministry of Health and Family Welfare with proforma approval by USAID.

#### 5. Some Special Aspects

The Mid Term Evaluation can be looked at from two angles namely,  
 (i) what is to be done in the next 3 years, and  
 (ii) what are the long-term possibilities?

In the Mid Term, that is, the next 3 years or so, the USAID can stimulate technical assistance and play a more dynamic role by providing funds for innovative activities like organising workshops, carrying out field studies, etc. The role of the NIHFW can be further streamlined focussing more on a "project assistance" role and consideration of using external technical support for implementing these activities. The MOHFW can help in the administrative areas particularly in making it clear to the subprojects that there is enough flexibility between line items of the budget and that the subprojects can make effective use of them.

As far as the long-term possibilities are concerned, the capacity for providing adequate technical assistance to the subprojects in project preparation needs to be strengthened. There is also need for providing technical assistance to the Ministry of Health and Family Welfare in the initial screening of subproject applications and in the initial selection process. The possibility of having the initial screening done by some regional institution should be considered. This would enable the identification of good proposals from good organisations. It is possible that some of the good organisations with good proposals are not able to apply for the grants because they are not aware of the existence of the PVOH project. This could be remedied by giving the responsibilities for initial identification and screening of project proposals to regional institutions. The GOI Special Grants Committee has been playing a key role in the approval of the Projects and that should continue in the future also.

Another point worth mentioning is that most of the projects seem to have a need for longer project duration because they require a longer gestation period. It is also necessary to develop suitable management systems for these smaller projects. For instance, development of Management Information System for all sizes of projects has been found to be an absolute necessity for the effective management of the subprojects. This work could be assigned to consultants who have specialised expertise in Management Information Systems for such projects. The Team has also noted that the existing Project brochure which deals with financial assistance to voluntary organisations can be modified and made into a Project Preparation Brochure which will contain some case studies so that it would be of much more help to the subgrantees to prepare project proposals. Similarly, the Evaluation Team feels that the experience of some of the bigger subprojects in the area of sustaining the project beyond its period of assistance by USAID, should be passed on to smaller organisations and newer organisations, so that they can benefit by them.

In the context of future projects, there are certain points which might be examined further in the light of experiences gained in the implementation of the present project. It may be, for instance, considered whether the future projects should be only service delivery oriented or whether they could include other related areas like training, nonformal education of women. Again, the future projects may perhaps think in terms of prescribing a certain percentage ceiling for construction component under the project.

Annexure ISCHEDULE OF TEAM ACTIVITY INCLUDING VISITS MADE BY THE MID TERM  
EVALUATION TEAM

Sep 22	:	Briefing in USAID Office, New Delhi
Sep 23 to Sep 25	:	Reading of Documents
Sep 26	:	Briefing in USAID Office, New Delhi
Sep 26 & Sep 28	:	Reading of Documents
Sep 29	:	Briefing in USAID Office, New Delhi
Sep 30	:	Discussions at NIHF, New Delhi
Oct 1	:	Discussions at USAID Office and at the MOHFW, New Delhi
Oct 2 to Oct 5	:	Reading of Documents
Oct 6 to Oct 7	:	Visit to VHS, Madras including field visits
Oct 8	:	Visit to New Century Welfare Society Medical Centre, including field visits
Oct 9 & Oct 10	:	Visit to AVRV Education Foundation for Ayurveda, Coimbatore, including field visits
Oct 11 & Oct 12	:	Reading of Documents
Oct 13 & Oct 14	:	Discussions resumed at NIHF & MOHFW; Internal Meetings; and Discussions at USAID Office
Oct 15 & Oct 16	:	Visit to SEWA-Rural, Jhagadia, including field visits
Oct 17 & Oct 18	:	Visit to Streehitakarini including visit to their field services
Oct 19	:	Travel from Bombay to Calcutta and then on to Memari in Burdwan District
Oct 20 & Oct 21	:	Visit to ICH Project in Memari including field visits
Oct 22 to Oct 24	:	Reading of Documents

- Oct 25 : Visit to Sarvajanic Parivar Kalyan Samiti, Gwalior, including field visits
- Oct 26 : Internal Meetings
- Oct 27 to Oct 29 : Discussions continued at NIHFW; USAID Office; DEA; MOHFW; and Internal Meetings; & discussion of points for basis draft report.
- Oct 30 : Presentation at NIHFW
- Oct 31 : Presentation at USAID Office
- Nov 1 to Nov 13 : Preparation of the Draft Evaluation Report

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Annexure II

## PERSONS CONTACTED

The following is a list of persons contacted in the course of the Mid-Term Evaluation conducted by the Team:

USAID, American Embassy, New Delhi

1. Mr. Owen Cylke, Director
2. Dr. Richard Blue, Deputy Director
3. Dr. Peter Amato
4. Dr. Rogers Beasley
5. Dr. Jon E. Rohde
6. Ms. Mary Ann Anderson
7. Dr. E.G.P. Haran
8. Dr. Thomas Philip
9. Dr. Meera Chatterjee
10. Mr. Spencer Silberstein
11. Dr. P. Diesh
12. Mr. John Rogosch
13. Mr. Christopher Crowley
14. Dr. Zarina Bhatti

Ministry of Health & Family Welfare, Government of India, New Delhi

1. Mr. P. Mohandas, Joint Secretary
2. Dr. Bhagawat, Director
3. Mr. G.N. Sreekumaran, Under Secretary
4. Ms. Anita Puri, Section Officer
5. Mr. Jagadessh Kumar, Assistant
6. Mr. P.R. Das Gupta, Joint Secretary

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11. Dr. P. Diesh
12. Mr. John Rogosch
13. Mr. Christopher Crowley
14. Dr. Zarina Bhatta

Ministry of Health & Family Welfare, Government of India, New Delhi

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2. Dr. Bhagawat, Director
3. Mr. G.N. Sreekumaran, Under Secretary
4. Ms. Anita Puri, Section Officer
5. Mr. Jagadessh Kumar, Assistant
6. Mr. P.R. Das Gupta, Joint Secretary

Department of Economic Affairs, Ministry of Finance,  
Government of India

1. Mr. Sudhakar Rao, Director
2. Mr. Krishnamurthy, Under Secretary

NIHFW, New Delhi

1. Dr. P.P. Talwar, Professor
2. Dr. Y.P. Gupta, Project Coordinator, PVOH Project
3. Dr. K.K. Verma, Assistant Professor
4. Mr. J.N. Varshney, Research Officer
5. Mr. M.M. Mallick, Assistant Research Officer
6. Mrs. Dushaj, Statistician
7. Mr. A.K. Goel, Computer Programmer
8. Mr. D.K. Ahuja, Research Analyst
9. Prof. Dr. R. Sapru, Professor
10. Dr. Amita Bardhan, Associate Professor of Social Sciences
11. Dr. A.K. Agarwal, Associate Professor, Hospital Administration
12. Mr. R.N. Bansal, Chartered Accountant
13. Mr. J.C. Gupta, Chartered Accountant

VHS, Madras

1. Dr. N.S. Murali, Secretary
2. Brigadier Dr. M.A. Ramaswamy, Additional Director (Community Health, VHS, Madras)
3. Dr. K. Venkateswara Rao, Joint Director (Community Health, VHS, Madras)
4. Dr. Sampath, Project Coordinator, PVO Project, VHS, Madras)
5. Dr. U.V. Ramakrishnan, Supervisory Medical Officer, PVO Project
6. Dr. Anandan, Supervisory Medical Officer, PVO Subproject

New Century Welfare Association, Madras

1. Mr. Kader Sultan, Vice President
2. Mrs. Sreelatha Sugumar, Project Co-ordinator
3. Mr. M. Subramaniam, Additional Secretary
4. Dr. Kamalammal, Vice President
5. Mr. Jayachandran, Treasurer
6. Mr. R. Radhakrishnamurthy, Secretary

AVRV Education Foundation of Ayurveda, Patanjaliapuram, Coimbatore

1. Mr. Bijoy, Project Director
2. Mrs. Seethalakshmi, Programme Officer

SEWA-Rural, Jhagadia, Gujarat

1. Dr. Anil Desai
2. Dr. Latha Desai
3. Dr. Pankaj Shah
4. Dr. J.B. Shah
5. Dr. Sridhar
6. Dr. Rajesh Mehta
7. Ms. Geetha Parmar, ANM

Streehitakarini, Bombay

1. Mrs. Prema Rangnekar
2. Dr. Veena Mulgaonkar
3. Mrs. Karkare
4. Dr. Potdar
5. Dr. Gore, Assistant Director, Health Services, Government of Maharashtra, Bombay
6. Dr. Vijaya Taskar
7. Mrs. Veena Pradhan
8. Mrs. Jayashree Jhadav
9. Ms. Urmila Warty

ICH Subproject, Memari, West Bengal

1. Dr. Sachin Chaudhuri, Project Director
2. Dr. Chanchal Batra, Programme-in-Charge (Medical)
3. Mr. Monotosh Dutta, Medical Officer
4. Mr. Asit Chaudhuri, Officer-in-Charge, Administration and Statistics
5. Mr. Ajit Sen, Finance Advisor
6. Mr. Narayan Mandi, President, SKGUS
7. Mr. Lakshmiram Mandi, Secretary, SKGUS
8. Mr. Badal Kisku, Member, Central Committee, SKGUS
9. Dr. Devasis Dikshit, Medical Officer, ICMR Project
10. Mr. Dipak Bhadra, Co-ordinator, ICH Subproject

Sarvajanic Parivar Kalyan Samiti, Gwalior

1. Dr. B.S. Verma, Founder Secretary
2. Mr. Nanda Kumar Pandey, President
3. Mr. Vimal Kumar, Vice-President
4. Dr. K.N. Dabhade, Treasurer
5. Mr. O.P. Chawla, Joint Secretary
6. Mr. Rajan Singh Tomar, Joint Secretary
7. Dr. Anwar Hussain Rizvi, Vice-Chairman
8. Dr. Sinha, Joint Director, Department of Public Health - Government of Madhya Pradesh

Other Donor Agencies/Voluntary Organizations:

1. Dr. Saroj, Ford Foundation, New Delhi
2. Mrs. Natty Chen, OXFAM America, New Delhi
3. VHAI, New Delhi
4. Mr. Rolf Carriere, UNICEF, New Delhi

Besides the above officials, executives, doctors and field workers, we also met a number of paramedical workers, social workers, village level workers, community health workers, dais, and also several beneficiaries like mothers, and children, besides some Panchayat Officials and opinion leaders. It is not possible to list all their names but we take this opportunity of gratefully acknowledging the cooperation of all of them as also of all those listed above in responding to our enquiries.

**PROJECT COMPONENTS REVIEWED BY EVALUATION TEAM**

The following are the major components of the PVOH Project which have been reviewed by the Team:

**A. Administrative, Monitoring and Technical Assistance Arrangement**

1. Adequacy and effectiveness of the organisation and management of the subprojects by the subgrantees - project management, special supervision, financial accounting, and reporting.
2. Timely disbursement of funds to subgrantees and their proper utilisation and reporting.
3. Effectiveness of the project organisation in terms of collaborative arrangement and responsibilities between MOHFW, NIHFW and USAID.
4. Review of NIHFW's role, contribution and effectiveness in terms of its responsibilities as stated in Implementation Letter No.3.
5. Adequacy of finance and programme monitoring to ensure proper use of the Government funds.
6. Needs and adequacy of technical assistance to subgrantees.

**B. Subproject Selection and Progress of their Implementation**

1. The effectiveness and appropriateness of the procedure followed in the selection, appraisal and approval of subprojects and whether it was in accordance with established criteria and procedure.
2. How far have the subgrantees been able to implement the subprojects consistent with the approved plan (Appraisal report)? What are the achievements as well as constraints - in construction, procurement of equipment, staff recruitment, training and services activated?
3. Progress and contribution of subprojects towards the achievement of the objectives and purposes of PVOH Project. What is the progress towards preventive/promotive aspects of health care versus curative/treatment aspects, specifically, progress towards improvement of child survival including maternal care, family planning, immunization, promotion of ORT and health education?

4. Contribution of the subprojects towards providing basic health services and improving health care of the poor and needy segments of the target population.
5. Role and effectiveness of community participation in these subprojects.
6. To what extent have the subgrantees been able to develop innovative approaches? How do the subproject activities compare with Government services in the area in terms of services and their quality?
7. How can the project promote interlinkages among subprojects towards achieving the overall objectives of the PVOH Project? (Eg: information dissemination, workshops, field visits, etc.)?
8. Review of NIHFV's role, contribution and effectiveness in terms of programme monitoring and technical assistance (as stated in PIL No.3.
9. Needs and adequacy of technical assistance to subgrantees.
10. Adequacy and effectiveness of field supervision, technical guidance/on the job training, coordination and reporting by the subgrantees.

C. Lessons learnt and future directions

1. Is the PVOH Project an effective method of appraising and approving the subgrants to voluntary agencies?
2. Is externalization of monitoring of subprojects as in the PVOH Project (through NIHFV) an appropriate mechanism to adequately monitor a large number of subgrants?
3. Is this an appropriate mechanism to involve voluntary agencies in primary health care and special preventive health services (such as TB, Leprosy, and eye care)?
4. Are the subgrantees able to share 25 per cent of the subproject cost? Is it a realistic expectation?
5. Are the activities initiated under the Project likely to be sustained by the subgrantees after the Project ends?
6. What is the optimum level of funding that could be efficiently utilized by PVO's?
7. What additional inputs are required to improve the performance of subprojects towards meeting the project objectives?

8. How could we further simplify project management as part of mid-course corrections?
9. If we are to do it again, how could we finance PVO's more effectively but at the same time ensuring proper accountability for the Government funds?

#### D. Methodology of Work

The team started its work with a briefing in the USAID Office in New Delhi on 22nd September, 1986 and further briefings, preliminary discussions with the Ministry of Health & Family Welfare, and the National Institute of Health & Family Welfare in New Delhi. The following documents were made available to the team:

1. PVOH Project Paper
2. Grant Agreement and Project Implementation Letter
3. Subgrantee Appraisal Reports
4. Monitoring reports by NIHFV
5. Quarterly reports by subgrantees

The team held planning meetings both in New Delhi as also in the field before the start of visit to each PVO subproject. There were also daily internal meetings after each field visit. Such meetings enabled the team to properly understand the responsibility of each member and to identify the key issues affecting the assignment, to plan the work and also to jointly exchange notes and to ensure that the whole exercise was proceeding according to the objectives of the evaluation.

Mr. John Grant was able to participate in the field visits in respect of the SEWA Rural, Streehitakarini, ICH, and Sarvajanic Parivar Kalyan Samiti subprojects. He was, however, with the team throughout the final discussion, preparation of the outline report for presentation and through the presentation itself. There was an initial presentation on 30th October, 1986 at the NIHFV and another presentation on the 31st October, 1986 at the USAID Office in New Delhi.

The Team members generally, worked as a team and looked into all aspects of the subgrantees' work. However, in some areas they also had to split into smaller groups with a view to expediting the work. Each member focussed on certain areas. Mr. P. Subramaniam, as the management expert in the team, concentrated on the management aspects, namely assessment of the adequacy and effectiveness of administrative, monitoring, evaluation and technical assistance aspects of this project. In addition, he has also documented lessons learnt and future directions with specific recommendations to improve/simplify management of this project. Specifically, he has focussed on the tasks listed in Section A

above. Dr. Abraham Joseph, as a community health expert, concentrated on an evaluation of the subgrantees' health service delivery, staff recruitment, training of personnel, community participation and other community health issues. Specifically, he has assessed progress of subproject implementation activities towards achieving the objectives of the project as stated in the Project Paper, Grant Agreement and subproject appraisal reports. In addition, he has also focussed on lessons learnt and future directions with specific recommendations to improve/strengthen successful implementation of health services/ training activities by the subgrantees. (Focus on section B above.) Mr. John Grant, because of his previous experience with PVO's and AID policies, reviewed progress of this project from AID's perspective and focussed on the questions listed in Section C above. Before the arrival of Mr. John Grant, these aspects were looked into by the other two consultants. Mr. Grant also assisted in synthesising overall findings of the consultants and he participated in the report presentations and briefings with the Government of India and USAID staff.

## DESCRIPTION OF THE SEVEN SUBPROJECTS VISITED\*

1. Voluntary Health Services Medical Centre, Adayar, Madras  
(established in 1957)

The voluntary Health Services - VHS Medical Centre, Adayar, Madras is a registered non-profit society working on many modern ideas of improving the existing facilities for medical relief, education and research. The institution gives emphasis to preventive and promotive health care to the community by involving them in the form of family units. The curative services are provided through a 50-bedded hospital, having all major specialities/diagnostic centres, etc. The centre also carries out a clinical research programme, student health programmes and has a medical insurance scheme for the community. The institution has a separate family welfare unit which runs a family welfare centre in Madras city.

One of the most important activities of the VHS is the community health programmes undertaken in the rural areas of the St. Thomas Mount Panchayat Union through 32 Mini Health Centres. These centres are functioning on the pattern of the Government programme, each centre covering a population of 5,000 or 1,000 families. These centres provide comprehensive preventive and curative care to the rural population. This system is in substitution for the Village Health Guide Scheme of the Government of India. The staff at each Mini Health Centre consists of a part time doctor (1 for 4 centres), Multipurpose Worker (male), Multipurpose Worker (female) and Lay First Aiders (village level workers - at 3 per centre). The medical component consists of treatment of minor ailments, domiciliary treatment of TB, screening for hypertension and diabetes, early detection of anaemias and toxaeemias among pregnant women and referrals of special cases to the nearest hospitals.

The Community Health Department of the VHS, in addition, conducts Multipurpose Workers Training at the Medical Centre and undertakes research programmes in epidemiology and nutrition.

The objective of the present subproject is to provide comprehensive and continuous primary health care, nutrition, and family welfare services through the infrastructure of Mini Health Centres, integrating TB and Leprosy control into a single horizontal programme. The main diseases in the project area identified are malnutrition, TB, Leprosy, diarrhoea, parasitical infections, etc. The proposed services will be provided through 3 levels namely, 1. Mini Health Centres, 2. Middle Level Supervision of Mini Health Centres and 3. Referral Centre at VHS.

The subproject covers rural population numbering 1,60,000. The life of the project is 5 years and the total project cost is Rs.1.46 crores. The size of the total grant from USAID is 1.06 crores. Of this, Rs.26 lakhs are towards capital costs and Rs.80 lakhs are towards

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Note: In this Annexure, funds are specified in term of 'crore and 'lakh'.  
One Crore = 10 million and one lakh = 100,000

recurring costs. The application for the grant was made in March 1983 and the project was approved in November 1983. The first instalment was released in May 1984. Till date, they have spent an amount of Rs.29.04 lakhs. The project is in full operation. The innovativeness of the project is that they are trying to integrate TB and leprosy control in PHC. Incidentally, it may be noted that this is the only large project and is progressing quite satisfactorily.

Following are the major findings of the field visit:

#### Staff

Almost all the staff were recruited and trained. There was a fairly high turnover of MPW who were trained by VHJS, since they were able to get higher salaries elsewhere. The community health volunteers interviewed were well motivated and had a good knowledge of ORS, Immunization, Antenatal Care, Family Planning, etc. They were able to describe how ORS is prepared. They also seem to have a good rapport with the community. Secondary level workers - multipurpose female and male workers also had a good knowledge of ORS, Antenatal Care, High Risk factors in pregnant women and children. They also maintained good records of the various events taking place in the community. Treatment Supervisors had a good knowledge of Tuberculosis and Leprosy. These workers however seem to have a vertical approach confining themselves to these two diseases. Doctors are working in a part-time basis. There was a high turnover. The two doctors interviewed were not familiar with the principles of community health, their emphasis being more on curative services.

#### Programmes

Leprosy and tuberculosis control programmes have been carried out with good 'case finding' and 'case holding' mechanisms. There was a low compliance from patients who were referred to the centre for X-ray. Attempts have been made to improve this. The compliance of the leprosy patients for the multi drug regime good (ever 854). As mentioned earlier, female and male Multi-purpose Workers and Treatment Supervisors need a more integrated approach to service delivery.

#### MCH

MCH services were again effectively carried out by the community health volunteer and female Multipurpose workers. Doctors had the antenatal cases at the mini health centres. Their knowledge of high risk factor is poor.

#### Immunization

Immunization is done through the mini health centres. Door-to-door contacts are made and the mothers are advised to bring their children for immunization. If necessary, immunization is carried out in various village street-corners to make it easier for the mother to avail themselves of the services. The cold chain and records were well maintained and sterilization of the syringes and needles was good. All the staff are aware of the procedure for maintaining cold chain and the side effects of the vaccine.

Family Welfare

Tubectomy was the predominant method accepted although information and motivation for all family planning methods was provided. Sterilization was carried out in the VHS hospital.

ORS

Management of diarrhoea through the use of ORS was given high priority. The field workers were familiar with the composition of ORS, its preparation at home and gave this impression that they were able to motivate the mothers to use it. The doctors however preferred to use antibiotics.

Health Education

Many audio-visual aids were used (16 mm projector, slide projector, overhead projector, etc.) They also used visual aides such as flash cards, flip charts and flannel graph. Demonstration were also used. A cooking demonstration was being carried out during our visit.

Records

Family Folders are being well maintained. There was a good system for the information to be processed from the periphery to the centre. However, there is not enough feed back from the (VHS Hospital) centre to the community.

Meetings

Meetings were held periodically but tended to be vertical in nature, e.g. Multipurpose worker female and male rather than the whole team coming together for review sessions.

## 2. Society for Education, Welfare and Action - Rural (established in 1980)

This society was established to provide assistance to the marginal income families of Jhagadia taluk in the State of Gujarat. SEWA - Rural leased the Kasturba Maternity Hospital and converted it into a general purpose hospital and operational base for their community extension activities. To complement their diagnostic and curative services, SEWA initiated a community based out-reach service, after conducting an intensive survey of the areas to identify the health problems.

SEWA - Rural is providing integrated, village-based health care to 10 villages within Jhagadia Taluk, Bharuch District. SEWA-Rural requested and received permission from the Government of Gujarat to place the Community Health Volunteers, (CHV's) and Anganwadi Workers (AWW's) under SEWA-Rural jurisdiction. Dais were included in the programme in early 1983. This decision derived from several conferences with the District and the State health officials and constituted a major change in the Government's health care programme. However, it was agreed that SEWA-Rural would include District officers on its Advisory Committee to assure proper coordination and avoid duplication of effort.

Authority over the CHV's and the AWW's enabled SEWA-Rural to develop a model of health services in which primary health care and nutrition are integrated into a single unit, instead of separating AWW and CHV activities, as per the Government's operations. This unit, housing both AWW and CHV activities, receives technical support from a mobile advisory team. This system has been functioning for several months, SEWA-Rural using weekly meetings with the village level workers to provide guidance, motivation, and conduct in-service training on important topics.

Under this subproject, SEWA-Rural proposes to expand its coverage from 10 to 30 villages. Approximately, 32,000 people are placed under the jurisdiction of SEWA-Rural medical facilities by the Government of Gujarat. The Government has also granted SEWA-Rural jurisdiction over the complete range of personnel from CHV's to multi purpose workers. The entire area forms an administrative unit equivalent to PHC, with SEWA-Rural Hospital serving as the base.

Jhagadia is included under USAID's Area Project in the support of an accelerated Model Plan for Health. SEWA-Rural has been in communication with the Area project staff in Bharuch. The expanded project presents an opportunity for effective collaboration between Government and the private voluntary sector. Towards this end, it has been agreed that the Government sub-centres will be turned over to SEWA-Rural. Multi purpose health workers will also fall within their supervision. Supervisory staff will be selected by SEWA.

The major health problems identified for focus under the proposed project are : Infant Mortality, Malnutrition of children under 6 years of age, and TB. Other major causes of morbidity and mortality among children which are addressed by the project are anaemia, malaria, upper respiratory infections, diarrhoea and high fertility rate. Family planning programmes emphasises non-terminal methods. A four level health programme has been established to provide the rural tribal population of Jhagadia with preventive and curative services. The four level health care system consists of: 1. peripheral level workers including community health volunteers, Anganwadi workers and Dais; 2. Village health posts/sub-centres; 3. Mobile service - supervisory team; and 4. Referral headquarters. Physical infrastructure in support of the 4 tiers includes 10 Government sub-centres, 15 constructed health posts, 7 rented health posts, and the referral hospital at headquarters.

It may be seen that the type of the organisation is basically one of social welfare. It caters to the population. Under the present project, it will cover an additional 32,000 population over a period of 5 years. The total project cost is Rs.40 lakhs, Out of this, Rs. 30 lakhs is the USAID Grant. Of this again, Rs. 16 lakhs are towards capital costs and Rs. 14 lakhs are towards recurring costs. Application for the project was made in March 1983 and the subproject was approved in November 1983. The first instalment of the subgrant was released in April 1984. The organisation has so far incurred an expenditure of Rs. 14.14 lakhs. The project is in full operation. The innovation of this project is its attempt to integrate health services with ICDS services. They have also introduced an innovative pre-packed safe delivery kit.

There is a high level of cooperation noticed with the State government. The project is well managed by a team of young professionals. Recently, they have received the WHO Sasakawa Award for excellence in community health.

Following are the major findings of the field visit:

#### Staff

Staff were all in place and they were all highly motivated especially the senior doctors. Doctors were also well versed with the concept of community health, probably because of the links with the medical colleges. The CHV, Anganwadi worker and MPW(F) were interviewed in the villages. They were confident and knowledgeable especially of antenatal care, high risk pregnancies, malnutrition and environmental sanitation.

#### Programmes

Antenatal Care: Antenatal services were well organized. Patient retained cards were being used for antenatal care. High risk patients were identified by community health volunteers and angwadi workers and referred to the hospital. All the staff were aware of the high risk factors and the component of the antenatal clinic.

Immunization: Immunization was carried out very systematically and we were able to see one programme. The maintenance of cold chain, sterilization of syringes and needles and the administration of the vaccine in the village was done in a very systematic manner, with good record keeping and health education.

Growth Monitoring: Growth Monitoring was also being carried out and the records were maintained well. However, no effort was being made to identify those who were malnourished and nor were they given special care.

Family Welfare: Family welfare was also being implemented well. Tubectomy was being done in the base hospital and temporary methods in the sub-centres. The coverage did not seem to be high, but showed improvement over the quarters.

ORS: ORS was being used extensively and the staff were knowledgeable about its component and its preparation.

Health Education: Health Education was done through individual and group methods.

Records: Records were very well maintained but there was some duplication. The same event was recorded by several people (e.g.) Anganwadi, Health Volunteers and Multipurpose Worker recorded pregnancies. There was a good two-way flow of information and review sessions were being periodically conducted.

They have produced a delivery kit and distributed it to the trained dais. It is also being distributed by UNICEF to other centres.

Other Programmes: The State Government had given the project complete control of the area. They were also posting their MPW trainees in SEWA rural for their field training. (SE programmes were also being integrated into this programme.

3. Arya Vaidyan Rama Varier (AVRV) Education Foundation of Ayurveda, Patanjaliapuram, Coimbatore, Tamil Nadu

The AVRV Education Foundation of Ayurveda consists primarily of an ayurvedic college in Patanjaliapuram, 30 km from Coimbatore. The school runs a seven year course to prepare ayurvedic physicians. About 90 students are enrolled in this course. Tuition, lodging and boarding are provided by the Foundation free of cost. The Foundation publishes a quarterly bulletin on ayurveda and has plans to establish a college of Siddha medicine. The Foundation was established by the AVRV Pharmacy in 1978. There is also an AVRV Trust which runs a hospital (about 100 beds) and two dispensaries in Coimbatore. Till the establishment of this project, the health services offered by this institution had been clinic oriented. The Trust conducts research on ayurvedic treatment supported by grants-in-aid from the Department of Science and Technology and the Indian Council of Medical Research. Physicians from the College and the Trust have participated in Government sponsored district comp site health camps.

The AVRV Pharmacy, based in Coimbatore, has a production plant in Kerala and distribution centres for selling their products throughout the country. The Foundation feels confident that the preventive and prospective aspects of ayurveda can obtain recognition and acceptance if due emphasis is placed on this neglected aspect. This philosophy has stimulated the organisation to take up an out-reach programme to the community to increase the use of culturally acceptable low cost health care.

The major health problems of the community in the outreach area have been identified as diarrhoeal diseases, respiratory infections, malnutrition, anaemia, skin diseases and industrial health problems. The health infrastructure facilities in the area are deficient and the PHC's/ sub-centres are at distant places and not accessible due to lack of transport facilities.

Under the subproject, the AVRV proposes to provide a package of health, nutrition and family welfare services through integration of ayurveda and siddha systems in primary health care. The services proposed are preventive, promotive and curative. This is in keeping with the AVRV's overall philosophy of promoting ayurveda as an alternative to modern medicine. The project seeks to establish an equilibrium between the systems of ayurveda, siddha and allopathy. The activities under the project are: 1) survey and collection of data on the community's health status; and collection of data on the community's health status; 2) imparting of health education; 3) imparting of nutrition education; 4) immunisation; and 5) environmental sanitation. The outreach services are provided through Rural Health Centres; 4 satellite health units, a mobile supervisory team, and village health posts. The Rural Health Centre is located near the ayurvedic college and is the administrative centre for the project. The satellite units are being established in phases covering a population of about 26,000. These units are supervised by the referral health centre. A team of physicians and para-medical staff visit satellite units and village health posts at frequent intervals. The functions of this mobile unit are supervisory, treatment and identification of referral cases, besides providing health education.

Trained health promoters use their homes as village health posts which are peripheral service units to identify and assist families requiring treatment at the satellite unit. These promoters also educate the community in the cultivation and preparation of simple herbal medicines. They receive the support supervision from the ANM and the Mobile Health Team.

This organisation is basically an ayurveda college and hospital and its out-reach services cover about 26,000 rural population. This life of the subproject is 4 years and the project cost is Rs.58 lakhs. The USAID Grant for this subproject is Rs.44 lakhs. Of this, Rs.22 lakhs are on capital costs and Rs. 32 lakhs are on recurring costs. The organisation had applied for the subgrant in August 1983 and the subproject was approved in January 1984. The first instalment of grant was also released in January 1984. The expenditure incurred by organization till date is Rs.14.53 lakhs. The project infrastructure is mostly in place. The innovative aspect of this project is that they are trying to use ayurveda and siddha systems in primary health care.

Following are the major findings of the field visit:

Staff:

The Project Director and the assistant, though highly motivated for social and economic development, were not committed to the objectives of this project. Most of the Ayurveda and Siddha practitioners were in place. There was no allopathic physician when we visited the centre. One person had just resigned. The selection of community health volunteers was deliberately delayed because they wanted the community to identify the true workers. However, this process was not indicated in the project proposal.

Programme:

The main emphasis of this project was the integration of Ayurveda and promotive services. It was very difficult to assess the impact of this because the records maintained were not appropriate.

Antenatal Care: The pregnant women were given Garbhachurnam prepared by the centre. Due to the increased cost of this, it was temporarily discontinued. There was no information regarding Hb.value pre- and post-administration of the drug. No efforts have been made to study the traditional methods of management of women when pregnant during delivery and post partum period.

MCH: Except for one multipurpose worker who had training elsewhere others were not familiar with various components of MCH services and the concept of "high risk" care. The Siddha practitioner did not seem to be keen on using preventive methods. He was also unfamiliar with record keeping which made it difficult to assess the utilization of his health services as well as the outcome of their therapy.

Immunization: It was not possible to comment on the coverage and the quality of their services. The project Director indicated that the coverage had improved after initiating this project and that areas never immunized earlier by the Government were being covered. The cold chain was maintained well as per their comments.

Growth Monitoring: Growth Monitoring was not being done systematically.

Family Welfare: Family welfare activities were also poor. No traditional methods were being used even though there are methods in the ayurvedic and siddha system.

Health Education: Health education was being given in the schools and in the group meetings.

School Health: Medical check up for the school children by the Siddha and Ayurveda practitioner was carried out systematically. They had grown herbal garden. The drug manufacturing unit was functioning. All the drugs used at this centre and periphery was manufactured at this centre which kept the cost low.

Records: Maintenance of records were very poor. The various members did not understand the importance of records. The staff were not able to correlate the diagnosis and treatment part of the indigenous system with the allopathic system. The Project Director did not give any importance to this aspect. This was unfortunate because this project was expected to evaluate the effect of integrating traditional system with the modern system.

#### 4. Institute of Child Health, Calcutta

The Institute is a trust registered under the Societies Registration Act, in Calcutta. It is running a children's hospital since 1956. The hospital has 95 beds and provides services in all child care specialities. It also runs Post-Graduate courses such as D.C.H., M.D. (Paediatrics) and diploma in Laboratory Technology in affiliation with the Jadavpur University and the Calcutta University. The Institute also provides facilities for pursuing Ph.D. in Basic Sciences.

It is a pioneer in child care in the eastern region, including the neighbouring countries. The Institute has been experimenting on a holistic approach in interface operation for bringing the out-reach health benefits (available under the State Government's Programme) to the families at the grass-root. The experiment was done on a pilot basis in a rural community under the Memari Blocks about 80 kms. north west of Calcutta in Burdwan, West Bengal. The experimental module included 10 villages and involved about 600 tribal families in this pilot block in that the tribals are known to have some social discipline and homogenous community sense and opinion, enunciated by their social hierarchy to whom they look up for guidance. The Memari Blocks are in the District of Burdwan and have a busy market centre on wholesale grains and cash crops. The area has a population of nearly 3,00,000. Nearly 40 per cent of the population belongs to the Scheduled Castes and Scheduled Tribes. Diarrhoea seems to be the biggest single killer claiming children's life largely. Other diseases like worm infestation, TB, leprosy, and STD

are reported to be common. The ICH decided to utilise its interneers in the site as animators to teach mothers on aspects like nutrition, infection, sanitation, immunisation, child weaning, diarrhoea, worm infestation, personal hygiene, home remedies, etc. The Institute started operating in the experiment on a three-tier nstructure. At the base level, the mothers and house-wives were selected as Family Level Volunteers (FLV's). These volunteers were supervised by Village Level Volunteers (VLV's) who, in turn were coordinated by two coordinators, one male and one female. These VLV's and coordinators constituted the second tier and formed a link between the PLV's and third top tier of professionals - the Doctors, Dais and the dispenser. Weekly classes helped to motivate the family level volunteers. 20 topics were selected by the faculty of the Institute to cover the basic essentials of child care for the rural communities. Every 6 months, the batch of the FLV's was turned over with a new one.

The ICH has been able to organise clientele families under the umbrella of a registered organisation named Sidhu-Kanu Gram Unnayan Samiti (SKGUS) which spearheaded participatory interventions while the women have been organised under Mahila Samities. An action programme for safe water system with the help from UNICEF was operated from 1981-'84. This is at present completely self-sustaining. It is understood that chlorination of domestic water stores is carried out by the mothers. This has brought about a marked improvement in the morbidity of the children. This interface linking with the outreach services has facilitated the State's ante-natal, and other maternal and child care and family planning programme.

Under the present subproject, the Institute expands the coverage of the programme to 60 villages covering a population of nearly 35,000. The objectives of this sub projects are to set an organisational structure of the people's forum to enable it to participate in the Health out-reach service with the particular reference to maternal and child health; to improve the logistics of the out-reach services to ensure a more equitable distributrion of such services; to disseminate health education to the ncommunity on important aspects; to develop a data system for health information, its storage and retrival; to set up training facilities for the health functionaries; and to evolve a self-supporting mechanism to include sanitation practices in the health out-reach system.

This organisation is a teaching hospital which is also doing social welfare work. It is located in the Memari Blocks of Burdwan District in West Bengal and covers about 35,000 rural and tribal population. The life of the subproject if 4 years. The total cost of the subproject is Rs.39 lakhs. The USAID Grant is Rs.25 lakhs. Of this, Rs. 6 lakhs are on capital costs and Rs. 19 lakhs are on recurring costs. The application for this subproject was made in May 1983. It was approved only in June 1985. The first instalment nof the subgrant was disbursed in August 1985. The organisation has incurred an expenditure of Rs.3.08 lakhs till date. Most of the infrastructure is found to be in place. The innovative feature is that they are trying to establish an interface between the Government health facilities and the community through the family level workers. Similarly integration of non-formal education and chlorination of water in this interface system appears to be an innovative feature. In short, it appears to be a grass-root level project complementing Government's health infrastructure.

Following are the major findings of the field visit:

Staff

Most of the staff were in place and well motivated. Because of the difficulty of getting middle and supervisory workers, those who have worked with them for several years have been promoted and given additional training. The doctors were well motivated but needed help in administration. The family level workers were working very effectively and the few volunteers who were interviewed were very knowledgeable and motivated and were able to bring women to antenatal clinic as well as for family planning and children for immunization.

Programme

Antenatal Care: Antenatal clinics were being conducted in the various sub-centres. High risk factors are being identified. But this needs some improvement.

Immunization: Immunization was also being carried out but we did not have an opportunity to check the cold chain. Actual coverage could not be estimated from the records due to lack of a denominator.

Growth Monitoring: Growth monitoring was also being carried out. No special care was given to the high risk children.

Family Welfare: Family Welfare was also being carried out using the volunteers. Patients were referred to Government hospitals.

Health Education: Health Education was being done using posters, flashcards and the traditional methods. The family level workers were the chief resource persons for educating the rest of the village and this seemed very effective by the response from the community.

Records: Record keeping was not very satisfactory and needs improvement. Two-way flow of information is not being carried out.

Other Activities: The Institute had manufactured a special solution which can be used for chlorination of water in the homes. An acute care centre is being constructed. This will only look after patients during the crisis period. After a day or two they will be referred to other hospitals.

## 5. Streehitakarini, Bombay

This is a registered voluntary organisation under the Bombay Public Trust Act 1950 and it was established in 1964. It has its headquarters in Dadar, Bombay. It has its own building with all the physical facilities and its Executive Committee consists of prominent social workers, doctors, college professors, etc. The organisation is involved, inter-alia, in preventive, promotive and curative health and medical services consisting of family welfare, nutrition, MCH programme as well as adult literacy, informal education classes for women, and a few income generating projects. They were initially covering a population of about 50,000 in the lower socio economic groups, mostly slum dwellers, and providing services without any distinction of religion, caste, creed or colour. The important feature of the organisation's functioning has been the participation of the community itself in planning and implementing the programmes and welfare schemes. In addition to its own buildings, the organisation has been rendering services through slum huts made available and in the open space made available in the crossings during fixed hours/days.

Under the present subproject, the organisation has intensified its service activities in the existing 50,000 population coverage. Even though they originally proposed to extend their activities to another 50,000 population in Prabha Devi area, they have not yet started on this. The programme includes provision of package of integrated services including basic health, family planning and nutrition especially for women and children for a slum population of about 50,000 and training of women Voluntary Health Workers for this purpose, including a baseline survey. It is observed that the organization is committed to development work and to the idea of serving the slum population through its comprehensive health care programme. It has also evinced great interest in the preventive, promotive and curative care of the people along with the implementation of its socio-economic programmes.

The organisation is basically doing social welfare work and income generating activities for the women living in slums located in Bombay. It hopes to cover one lakhs population. The life of the project is 4 years. The total project cost is Rs.29 lakhs. The total grant of the USAID for this subproject is Rs.22 lakhs. Of this, Rs.4 lakhs are towards capital costs and Rs.18 lakhs are towards recurring costs. The organisation sent its application for the subgrant in September 1983. It was approved in March 1984. The first instalment of the subgrant was released to the organisation in May 1984. Till date it has incurred an expenditure of Rs.10.25 lakhs. It is seen that most of the project infrastructure is in place. The innovative aspect of this Project is its involvement of women, and inclusion of community members on its general body.

The following are major findings of the field visit:

Staff

The staff were all in place. Most of the senior staff were volunteers who spent 2 to 3 hours per day. The grass root workers Women Voluntary Health Worker (WVHW) who were paid only a honorarium, were highly motivated and had adequate knowledge about family planning, MCH, Immunization. The senior volunteers were also very motivated. However, they were not functioning in a systematic manner but more on an ad hoc basis.

Programme

Antenatal Care: They were providing antenatal service in the slums areas and referred high risk cases to the Municipal hospitals.

Immunization: Immunization was being carried out but the number immunized in the previous quarter was 145 only. Because of lack of proper denominator no comments can be made on the coverage.

Family Welfare: The strength of this programme was the health education given to motivate women to accept tubectomy or temporary methods by the women voluntary health workers (WVHW).

Feeding Programme: Feeding programme for the underfive children was carried out in several centres and the growth of the children were recorded. However, no effort was being made to improve those who were severely malnourished. The feeding was equally distributed among each children. High risk children were not given any special care.

ORS:  
and

ation regarding ORS and they knew the composition

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project evolved certain health education materials including units and these were being used extensively. Charts and flannel graph.

Workers had information of pregnant women and children in the area was not satisfactory and the denominators were not correct. Flow of information was inadequate.

Other Programmes: They also had income generating projects for the girls of these slums, one of which was screen printing, the other was embroidery.

## 6. Sarvajanik Parivar Kalyan Samiti, Gwalior

This organisation was established in 1965 and registered in 1968 under the Madhya Pradesh Societies Registration Act of 1959. Its governing/ executive body consists of 17 members. The Secretary of the organisation is mainly responsible for running the activities of the organisation and the various other bodies under it. Its area of operation is considered to be the whole of Madhya Pradesh with its headquarters at Gwalior. The main objectives of the organisation are: (1) to promote family planning through mass education, motivation, etc.; 2) to provide free medical facilities to the needy poor; and 3) to implement various social welfare programmes. These services are provided to all sections of population without any discrimination on the basis of religion, caste, creed, colour or sex. The organisation has been running two full fledged urban family welfare centres which are financed under the National Family Welfare Programme. The Organisation has also been providing health, MCH, and family welfare services to the people including health education and family welfare exhibitions. The Organisation also looks after the following institutions: Health and Family Welfare Training Centre; Leprosy Welfare Centre; Special Nutrition Programme Centre; Rural Research Centre; Homeopathy Dispensary; Welfare of the Physically Handicapped; and Youth Welfare and Rural Development. This Organisation is also institutional member of the Indian Red Cross Society; the Hind Kusht Nivaran Sangh, the Madhya Pradesh Blind Welfare Association; the National Society for the Prevention of Blindness; and the National Mother and Child Welfare Organisation.

Under this present subproject, the organisation is to cover 34 villages consisting of 15 Patwari Circles with a population of 33,645 out of which 10,000 belong to the Scheduled Castes, and the Scheduled Tribes. 93% of this population is said to be economically backward and below the poverty line.

Some of the health problems identified are as follows: in most of the villages, there is scarcity of drinking water. Because of the poverty and bad living conditions, diseases like Jaundice, Cholera, Tuberculosis and Trachoma are found commonly occurring. A good number of the population particularly children are suffering from Scabies. The Primary Health Centre is at a distance of about 20 km. from the area covered by the sub project. Under this subproject, the organisation is trying to provide a two tier system of service facilities through the main services and Coordination Centre at Sahona and through the 5 village health posts.

This organisation is basically a social welfare organisation. With its headquarters in Gwalior, it seeks to reach health services to 33,645 rural population over a period of 4 years. The total project cost is Rs.32 lakhs. The total subgrant from the USAID is Rs.24 lakhs. Of this, Rs.8 lakhs are for capital costs and Rs.16 lakhs are towards recurring costs. The organisation sent its application for the subgrant in June 1983. It was approved in May 1984. The first instalment of the subgrant was released to the organisation in May 1984. Till date, an expenditure of Rs.19.03 lakhs has been incurred. Most of the infrastructure is found to be in place. The organisation is working with very backward and poor tribals.

Following are the major findings of the field visit:

#### Staff

Some of the staff were in place. Some of them were seen at the sub-centre during the visit. Multipurpose workers male and female were fairly knowledgeable and vocal. Doctors were rather timid and ignorant of the various components of preventive and promotive services. The Project Director was very enthusiastic but did not seem to transfer this to other members of the society or to the staff.

#### Programme

Antenatal Care: They did not have any concept of high risk clinic nor did they know the various components of a good antenatal clinic or the reasons for the activities or for implementing them.

Immunization: Due to lack of time it was not possible to check the cold chain and the immunization methods. The number quoted in the reports did not indicate the actual coverage as the denominators were not known.

Family Welfare: Family planning was one of their activities prior to the USAID project. But this was done mainly in the city. They are now extending it to the rural areas.

Growth Monitoring: Growth Monitoring was not done.

ORS: The doctors were not aware of the ORS and its components and how it is produced. But the multipurpose workers were more familiar regarding this. The doctors preferred to give antibiotics to the child who come with diarrhoea.

Health Education: A lot of emphasis has been given to health education using charts. However, these charts were not ideal for effective health education as the pictures were small and too many messages are conveyed at one time. Quantity rather than quality seem to be their emphasis regarding health education.

Records: Records were poorly maintained. Since the centre had only started functioning recently it was not possible to see how the record system functioned. The Labour Room and Theatre were the same room and this is an unsatisfactory arrangement. This project need a lot of help in health planning and implementation and data management.

#### 7. New Century Welfare Society, Madras

This is a registered Society which was established in 1979. The objectives of the society are: to run medical centre, clinics poly-clinics and other institutions to provide medical facilities to the people living in rural and industrial areas. It has been running its medical centre at Varadarajapuram, Ambattur, in Madras city. This centre has been rendering health and nutrition services to the people of Ambattur and its

neighbouring areas particularly Attipattu and other small villages in the area. The services include out patient general health care, MCH, Ophthalmology and dental care. The centre has been catering to a population of about 1,50,000. It is also running a school at Attipattu and an evening dispensary in the school building which operates after the school hours. The area surrounding the medical centre is habited mostly by weaker sections of population including the Scheduled Castes and the Scheduled Tribes, casual labour, artisans, industrial labourers, etc. The area is semi-rural in part, semi-urban in part, and urban slums in the remaining parts. The area has practically not much of medical facilities and the nearest hospital is at about 7 kms away.

Under the proposed subproject, it is proposed to cover a population of about 1 lakh. The subproject aims at providing comprehensive health care including basic health, preventive and promotive health care, MCH, family welfare, and nutrition services to the poor and weaker sections of the society who are less well served. Detection and treatment of Tuberculosis, leprosy, malaria and filaria are also to be undertaken by the subproject. The organisation proposes to achieve the objectives through preventive, promotive and curative health care. The primary health care services are provided through Mini Health Centres with health workers and female, supported by a doctor who will visit the centre twice a week for three hours. For special care and cases needing hospitalization, the organization proposes to construct a health care centre at Attipattu, with 20 beds, which will serve as a referral hospital for a population of about 1,50,000 and 10 Mini Health Centres will take care of about 1,00,000 population for intensive coverage. The Health Care Centre will also provide orientation training to doctors, para-medical staff and community members including school teachers, private medical practitioners, local leaders and Community Volunteers who can spread the message of MCH, nutrition, family planning, distribution of iron folic acid tablets, vitamin A, ORS, spacing contraceptives, chloroquine tablets, etc. They have also conducted a baseline survey which is being tabulated, right now.

The organization is basically a hospital service organisation located in Madras city and catering to the needs of the urban and slum areas. The subproject proposes to cover a population of 1,00,000 over a period of three years. The total project cost is Rs.59 lakhs. The total subgrant of the USAID is Rs.44 lakhs. Of this, Rs. 21 lakhs are towards capital costs and Rs.23 lakhs are towards recurring costs. The organisation applied for the subgrant in May 1983. The subproject was approved in July 1985. The first instalment of the subgrant was released to them in August 1985. They have incurred an expenditure of Rs.3.67 lakhs so far. The project is still in its initial phase. The organization appears to be primarily interested in establishing a hospital in suburban Madras. They need back up on the community health expertise aspects.

Following are the major findings of the field visit:

#### Staff

Many of the staff were not in place, especially the female and male multipurpose workers. They had just begun the training for the MPW female and male workers. Training was given by doctors from medical colleges and the Government Service. The syllabus and training objectives were not adequately developed. Almost all staff were more interested in curative service than preventive service/ There was a request from the project holders for an increase in support for curative services. Only one person (the coordinator) had a fairly good knowledge of community health work because of the training she had obtained elsewhere. All the other staff came from an exclusively clinical background.

#### Programmes

Antenatal Care: The quality of the antenatal care was very poor. No proper records were maintained. High risk factors were not recorded. The multipurpose female worker interviewed in one of the centres was not familiar with the various aspects of antenatal care.

Immunization: The immunization coverage as per the records was satisfactory, and the project holders indicated that there is a considerable improvement after their involvement in this programme. It was not possible to estimate the actual coverage of immunization as the denominator was not known.

Growth Monitoring: Growth monitoring was not being attempted.

Family Welfare: Tubectomies being done in their main centre but the acceptance of temporary methods was low. Records showed 17 tubectomies, but these could have come from non-project areas.

ORS: The peripheral staff were not aware of ORS and its composition or how to prepare it at home.

Health Education: No organized health education was being carried out in the community.

Records: Records were of a very poor quality except for a few items like number of pregnant women, number receiving immunization and family welfare. No other relevant information was recorded. There was no two-way referral system.

## AN OVERVIEW SUMMARY OF THE PVO SUBPROJECTS

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)*	USAID Grant		Recurring Cost	Date of Application	Date of Approval
								Total Grant	Capital Cost			
1.	Voluntary Health Services 1957	Hospital	Madras Tamil Nadu	Rural	1,60,000	5 years	146	106	26	80	3/83	11/83
2.	Society for Education Welfare & Action-Rural 1980	Social Welfare	Bharuch Gujarat	Rural	32,000	5 years	40	30	16	14	3/83	11/83
3.	Bharatiya Gramreen Mahila Sangh 1958	Social Welfare Women's Groups	Indore, M.P.	Rural	40 Villages	5 years	17	12	2	10	3/83	11/83

\* Note: Lakh = 100,000

Annexure V-1

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
5/84	29.09	In full operation	Integrating TB & Leprosy care in PHC through Mini Health Centre.	Strengthening of base hosp. for TB Leprosy referrals Middle level supervision & 32 Mini being first	-TB & Leprosy through MDT -MCH-FP -MIS using family folders	Integration of TB and Leprosy in PHC	This is the only large project and is progressing satisfactorily.
4/84	14.14	In full operation	Community Health Care. Integration of PHC & ICDS type nutrition services through anganwadi	-Referral Hospital -Mobile team -Subcenters -Village health posts integrated with Anganwadi centre. -CHI, AWW.	-MCH -Immunization -Preschool education -Nutrition services	Integration of health services with ICDS service, introduction of prepacked safe delivery kit, high level cooperation with the state government	Well managed by a team of young professionals, Awarded WHO-Sasakawa award for excellence in community health.
1/84	5.33	In full operation	Integrated Health Care through Women's group	Referral Centre 10 beds, Mobile team 8 village health post, 40 depot holder	Services against: malnutrition, MCH-FP, infectious diseases control through immunization	Involvement of women's group in rural health care	This is the smallest grant.

Annexure V-2

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	USAID Grant		Recurring Cost	Date of Application	Date of Approval
								Total Grant	Capital Cost			
4.	Arya Vaidyan Rama Varier Educational Foundation of Ayurveda 1978	Ayurveda College and Hospital	Coimbatore Tamil Nadu	Rural	26,000	4 years	58	44	22	32	8/83	1/84
5.	Streehitakami 1964	Social Welfare & income generation for womens uplifting.	Bombay Maharashtra	Urban slums	1,00,000	4 yers	29	22	4	18	9/83	3/84
6.	AWARE Action for Welfare & Awakening in Rural Environment 1975	Social Welfare	Khanmam A.P.	Rural	40,000	4 years	62	46	16	30	7/83	3/84

Annexure V-4

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
1/84	14.53	Project Infrastructure mostly in place.	Integration of Ayurveda & Siddha into PHC.	Rural Health Centre (6 beds) Village Health Post, Mobile Unit.	Ayurvedic and Siddha Health Care nutrition allopathic services in immunization. Mobilising Community to participate in health delivery.	The primary medical system in use is Ayurveda and Siddha, not allopathic	Workshop on traditional systems of medicines PHC.
5/84	10.25	Project Infrastructure mostly in place.	Basic health and nutrition services for the urban slums.	-base dispensary feeding centres Community health workers.	Feeding of Children under six 6, MCH, immunization, Household level health education and referral by CHs, training of CHs.		
4/84	10.00	Project infrastructure mostly	Floating Health centres for inaccessible tribal people along the banks of river Godavari	Base Health Centre with 5 beds. 2 floating Health centre with motor boats. 5 health posts.	Medical care, training of village functionaries, mobilising community participation.	Floating health centres with the use of motor boats.	This is a flood prone inaccessible tribal area where continuous activities through the year is a problem. Weak project management with key people located at Hyderabad.

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Annexure V-6

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	Total Grant	USAID Grant Capital Cost	Recurring Cost	Date of Application	Date of Approval
7.	Child in Need Institute 1977	Social Welfare	W.Bengal	Rural	80,000	4 years	55 lacs	31	4	27	4/83	3/84
8.	Sarvajanik Pariwar Kalyan and Seva Samiti	Social Welfare	Gwalior Madhya Pradesh	Rural	33,645	4 years	32	24	8	16	6/83	5/84
9.	Chimaya Tapovan Trust 1977	Religious	Kangra, H.P.	Rural	28,000	4 years	41	31	15	16	6/83	9/84

Annexure V-6

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
4/84	19.07	In full operation.	Comprehensive care for children in need.	1 HC with 8 beds 3 HC with 4 beds 20 low cost centre village H.posts. Mahila mandals.	Child care include growth monitoring, feeding with the use of nutrimix, rehabilitation centre. Training of dais CHs, Mahila mandal women.	A very comprehensive integrated child care program including the use of nutrimix.	CINI was awarded the national price of excellence in 1986.
5/84	19.03	Most infrastructure in place.	To promote 6 planning, provide health care facility.	1 six-bedded HC . Village Health posts with 2 MPW each	Basic health services patterned after the GOI model.	Working rural tribal infested area.	
4/85	13.50	Most infrastructure in place.	Providing basic health care especially MCH service Training Centres for ANMs/MPW.	Establish in a new base hospital. 6 village H posts mobile teams. Training Centre.	Basic health care with out-reach, MCH Immunization Training of ANMs.	The only sub-project with a major training component.	

## Annexure V-7

Sl. No.	Name of PVU	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in Lakhs)	USAID Grant		Recurring Cost	Date of Application	Date of Approval
								Total Grant	Capital Cost			
10.	Red Cross Homeopathic Council 1980	Social Welfare Homeopathic Promotion & Ayurveda	Gurgaon Haryana	Urban & Rural	69,000	4 years	38	28	10	18	6/83	10/84
11.	Sevadham Trust 1978	Community Health Care Organization	Pune Maharashtra	Rural	21,000	4 years	29	22	10	12	5/83	10/84
12.	Krishi Gram Vikas Kendra 1971	Social Welfare	Ranchi Bihar	Rural with 55% tribal	70,000	4 years	48	36	15	21	11/83	11/84

Annexure V-8

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
11/84	9.57	Most infrastructure in place.	Extending Homeopathic care to people. Family welfare & nutrition also covered.	5 bedded referral care, 19 HC Centre	Homeopathic medical care Allopathic for MCH and Immunization.	Integration of homeopathy in PHC.	
1/85	7.06	Most infrastructure in place.	Preventive and curative health services to the Community.	1 MCH centre. 7 subcentres with ICHW. 60 Child Health Workers.	Community Volunteers to provide comprehensive preventive care.	Training of tribal women from the local village ANMs to staff the subcentres because of non-availability of fully trained ANMs.	
4/85	5.81		Provision of Basic health services	3 main centre four bedded. 20 Subcentre	Immunization Screening for TB & Leprosy MCH.	Sponsored by an industrial firm (Usha Martin); other development activities such as milk coop, cattle breeding, agriculture & social forestry.	

Annexure V-9

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	USAID Grant			Date of Application	Date of Approval
								Total Grant	Capital Cost	Recurring Cost		
13.	The Guru Cooperative Milk Producers Union Ltd. 1978	Milk Cooperative	Bhatinda Punjab	Rural	1,20,000	4 years	98	68	20	48	5/84	1/85
14.	KSDNG College of Ophthalmology 1980	Hospital	Valsad & Ahwa Dist. Gujarat	Rural	1,30,000	4 years	84	63	28	35	2/84	4/85
15.	Baroda Citizens Council 1984	Social Welfare Economic	Baroda Gujarat	Urban Slums	35,000	4 years	33	25	1	24	10/84	4/85

Annexure V-10

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
4/85	10.07	Most of the infrastructure is in place.	Integration of health care with Milk Cooperative Infrastructure.	Health post in each village with milk collection points. Mobile units. A base referral dispensary	Simple & cost effective health care through Coop. network. Use of village committees & health cooperatives.	Health care integrated with Milk Coop. Infrastructure which has milk collection posts in most of the villages.	Long term viability of health cooperation is an interesting question. Emphasis is more on mobile units and doctors.
7/85	3.81	Initial phase	Eye care services for the rural people.	5 Rural Eye Care centre with 10 beds each. 2 mobile ophthalmic units. 20 Ophthalmic assistants attached to Govt. PHC's.	Basic Eye Care services. Surgical facilities for glaucoma & Cataract Education for prevention of blindness, school exam.	Rural Eye Care Centres with 10 beds each with to PHCs three Ophthalmic Assistants	Difficulty of recruiting ophthalmic assistants. Start up problems. Subgrantees primary interest is in a sophisticated eye hospital
7/85	2.13	Initial Phase	Health Care for the Urban slum	10 health centre under slums committees	Health Education Nutrition Diarrhea control, Immunization, MCH.	Involvement of local citizen groups.	

Annexure V--14

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	USAID Grant			Date of Application	Date of Approval
								Total Grant	Capital Cost	Recurring Cost		
16.	Institute of Child Health 1956	Teaching Hospital/Social Welfare	Burdwan West Bengal	Rural/Tribal	35,000	4 years	39	25	6	19	5/83	6/85
17.	BAM India 1978	Social Welfare	Calcutta West Bengal	Urban	26,000	4 years	19	14	4	10	3/83	6/85
18.	Nootan Bharati 1958	Social Welfare Agriculture Handicrafts Education Medical	Banaskantha Gujarat	Rural	60,000	4 years	26	19	5	14	6/84	7/85

Annexure V- 12

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
8/85	3.08	Most of the Infrastructure in place.	Education of Community to use out-reach services Preparing a balanced diet. Training in informal sector.	1 Crisis Care Centre 3 Health Units Village level volunteers, Family level volunteers.	Training of family level workers on a continuing basis at the ratio of one per 20 families. Health/non-formal education, training of informal leaders Immunization, MCH, chlorination of water.	Establish an interface between the govt. health facilities and the community through the development and use of family level workers. Integration of nonformal education, chlorination of water.	This is a really a grassroot level project complimenting Government health infrastructure.
8/85	1.92	Initial Phase	Basic health & family welfare services with focus on child care	3 under 5 clinics	Nutrition surveys care of L.B.W. infants Immunization & MCH.	Has management difficulties.	
7/85	5.14	Initial Phase	Reduction in the incidence of TB, eye infection, ORT, high birth rate.	Main centre 10 beds MHC. 3 health posts with 2 MPWs.	Comprehensive Health Care Family Welfare		

Annexure V - 13

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	Total Grant	USAID Grant Capital Cost	Recurring Cost	Date of Application	Date of Approval
19.	New Century Welfare Society 1979.	Hospital	Madras T.Nadu	Urban/Some Slums	1,00,000	3 years	59	44	21	23	5/83	7/85
20.	Khairabad Eye Hospital 1942	Hospital	Kanpur U.P.	Rural	21,00,000	4 years	87	65	26	39	2/84	8/85
21.	Moradabad Charitable Trust & Health Research Centre 1985.	New Hospital	Moradabad U.P.	Rural	37,000	4 years	72	52	28	23	8/84	12/85

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Annexure V - 1A

Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
8/85	3.67	Initial Phase	Basic Health Care services	25 bed base hosp. 10 MHC	Base medical care. MCH immunization. Training of local women as A.M.S & CHMs		Appears to be primarily interested in establishing a hospital in sub-urban Madras. Lacks community health expertise
9/85	13.43	Initial Phase	Rural Eye Care Services	Base hospital. 5 eye care centres with 10 beds each. Eye Care units with ophthalmic assistants	Basic eye care services. Surgical services for cataract & glaucoma. Health education, school examination.	Rural Eye Care centres with minimum in-bed facilities and ophthalmic assistants linked to Govt. PHCs.	Initial difficulty in recruiting ophthalmic Assistants.
12/85	7.46	Initial Phase	Basic health care Services	30 bed base hosp. 7 subcentre	Basic medical care. MCH immunization.		Establishing a brand new hospital appears to be the primary interest. Lack of expertise in establishing a hosp. as well as community health services. Lack of proper staff.

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Date of First Disbursement	Expenditure to-date	Current Status of Project	Project Purposes	Project Structures	Key Services	Innovations & Special Features	Comments
		Initial Phase	Extension of MCH health care to out-reach areas.	Base hosp. with additional 15 bedded maternity units, RHCC, 7 MHCs 200 Village volunteers.	Basic health care MCH immunization	3 months training of village women (5 per village) in health and social welfare activities. Establishment of village level voluntary organization for health as social welfare activities.	

Sl. No.	Name of PVO	Type of Organization	Location	Type of Population Urban/Rural	Population Covered	Life of Project in years	Total Project Cost (in lakhs)	USAID Grant			Date of Application	Date of Approval
								Total Grant	Capital Cost	Recurring Cost		
22.	Sri Ramakrishna Ashram Rural Health Service 1909	Hospital Religious Mission	Trivandrum Kerala	Rural	1,29,000	4 years	48	36	24	12	3/84	3/86



UNITED STATES AGENCY for INTERNATIONAL DEVELOPMENT

NEW DELHI, INDIA

June 12, 1987

MEMORANDUM

TO: ANE/DP/E Room 6663, NS, AID/W

FROM: Peter W. Amato - PD&E/USAID/India 

SUBJECT: AID Evaluation Summary (ES) PVOH Project (386-0469) -  
(Mid-term report)

Attached are the original face sheet of AID ES Part I and Evaluation Abstract, and Part II Summary of Evaluation Findings and Mission comments. Also enclosed is a copy of the Evaluation Report.

Encl. a/s

cc: PPC/CDIE/DI/Acquisitions  
ANE/PD  
SER/MO/CPM/P