

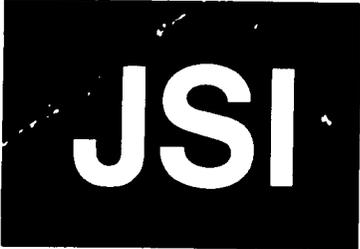
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CARE PRIMARY HEALTH CARE UNIT REVIEW

FINAL REPORT

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The logo for JSI, consisting of the letters "JSI" in a bold, white, sans-serif font, centered within a solid black rectangular background.

Acknowledgement

Everyone at CARE involved in the evaluation was most cooperative, candid and willing to take time out of busy schedules to meet with evaluation team members. The PHC Unit staff were very open and spent a great deal of time locating documents and meeting with team members. It is to their credit that this evaluation was undertaken and a tribute to their professional commitment to excellence.

The Evaluation Team submits the findings and recommendations in this report to the PHC Unit staff as a basis for discussion, reflection and future decisions. Team members are available for clarification and discussion.

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EXECUTIVE SUMMARY

CARE's Primary Health Care Unit (PHC) based in New York commissioned an evaluation team, comprised of consultants from JSI and World Education, in July and August, 1989 to review the effectiveness of its management approaches and strategies to servicing overseas staff and projects and to review its current health programming portfolio. With these two goals providing direction for the evaluation team's analysis and discussion, the following key findings and recommendations are offered in this summary. Other findings and recommendations are included in the main section of the report. These recommendations are made with the understanding that they will provide input for further discussions on how best to position CARE's PHC Unit in the next decade and as input for the PHC Unit's next planning cycle. Data was collected via interviews primarily conducted in New York with CARE-New York and field staff, questionnaire analysis, and document review.

Key Findings

1. Organizational members tended to experience some frustration or tension with how primary health care "fits" within their view of CARE, its role in development and the outcomes of development. (This finding was based on impressionistic data and, therefore, may not be valid. If there is some validity to the finding, this finding might also be generalizable to organizational members' perceptions of other units as well.)
2. The PHC Unit (NY) has been very effective in their present support and advisory capacity to overseas offices and staff as reported by Country Directors, RTAs, and Project Managers who have had direct contact with them. Whereas, some Program Department staff, Country Directors, and Project Managers, who had minimal or no contact with the Unit, were relatively unaware of the quality of the Unit's work and its services.
3. The Country Directors are particularly interested in increased knowledge and access to funding sources.
4. Although the organizational structure in New York tends to be hierarchical, CARE's overall organizational structure is decentralized with considerable authority vested in Country Directors. To a great extent, because of this structure, planning mechanisms provide for the consolidation of plans (country plans and Unit plans) and not integrated plans.
5. Child Survival projects have strengthened CARE's PHC expertise both by virtue of their rigorous design, planning, and evaluation demands and by the addition of technical staff.
6. Child Survival projects provide a rich source of data which to date has been underutilized for reasons related to the management intensive nature of the projects, the fact that the costs for the design and conduct of analytical studies are not covered by the grants, and the failure to sufficiently involve social scientists/writers. Thus, there is a missing

step, i.e., sufficient research data from these projects, that needs addressing before CARE's (or other PVOs involved in Child Survival projects) PHC Unit can more fully apply learnings from previous CS project experience to new ones and other health projects.

Key Recommendations

1. Formulation of a small group (consisting of a cross section of program department staff) to explore answers to these questions:

- a. Why primary health care? How does it fit in CARE's portfolio?
- b. What is CARE's role? (versus competition)
- c. How do you resolve the conflict between a need for definition and evaluation in a field that is hard to evaluate?
- d. How do you target PHC ? (integration, specific programs, use of networks, etc.)
- e. How do you give PHC, given its characteristics, sufficient status within the organization?

(This activity could be beneficial for all sectors to engage in since this recommendation might reflect the needs of other unit staff as well.)

2. The PHC Unit (in New York and RTAs) should be recognized by the organization for its dedication and commitment to providing quality service and the PHC Unit staff should maintain their level of dedication and commitment. Additionally, the PHC Unit needs to make its services and successes more visible to others, particularly, to those field staff who are not informed about their work.

3. PHC Unit staff might consider spending more of their time on donor relations and seeking out funding opportunities. A review of the time log analysis could serve as one source of information as a basis for making decisions regarding allocation of time and tasks. Additionally, a time log could be kept for longer periods of time and/or kept periodically during different "work seasons" to glean a more complete picture of how staff spend their time.

4. The results of the questionnaire could be used as a "springboard" to revisit a participatory planning process with the RTAs for determining PHC Unit priorities, in terms of technical assistance and priority countries. Some countries such as, the Philippines, have significant resources available in country and/or have TA needs that may not suit the skills of the RTA. Additionally, with a new emphasis on integrating population messages into CARE's programs (ANR, SEAD, and PHC), the Program Department may want to consider experimenting with integrating planning processes across units. Within CARE's organizational structure with Country Directors holding considerable control over programming options and priorities, how much integrated planning can be realistically accomplished by NY staff (without

substantial re-structuring in field offices to reflect an integrative process) is difficult to assess.

5. CARE is in a good position to consider three, mutually reinforcing options through which to carry out its PHC work into the next decade. These are; continue to develop and maintain AID Child Survival projects as a major activity, develop intersectoral health-related activities initially by piggy-backing, and explore the use of women as producers, not just consumers of health as an integrating program theme.

SECTION 1: INTRODUCTION

Rationale

Since 1985, the CARE-NY PHC Unit has grown from one professional staff and one support person to four professionals and one support staff person in New York and four Regional Technical Advisors overseas. In addition to this growth in staff, the number of PHC projects and management responsibilities increased considerably. Part of this growth is attributed to CARE's involvement in the AID/W Child Survival initiative. Additionally, a new theme has been incorporated into CARE's vision for the 1990's - the integration of a population agenda into CARE's programs. Potentially, the responsibility for the realization of this vision could have far greater impact on the PHC Unit than other units.

To address this expansion, PHC Unit management systems have had to be modified and, in some instances, new ones added. As CARE prepares to enter the 1990's, the PHC Unit has through this evaluation reviewed its present management approaches and strategies and their effect on providing services to overseas projects. In addition, the effect the Child Survival projects have had on CARE's PHC programming have been examined as part of this evaluation. The purpose of this evaluation is to assist the PHC Unit in their effort of organizational improvement.

Evaluation Design and Team Composition

CARE's PHC Unit assembled an evaluation team to:

- 1) conduct a management review of its current operation,
- 2) assess CARE's overall primary health care program portfolio in relation to the support PHC provides, and
- 3) explore whether CARE projects are tackling the "right" problems for the 1990's.

The results of this evaluation are to be used to improve the PHC Unit's support to CARE's overseas offices in meeting the health needs of poor people in less developed countries. The evaluation team included members from three organizations including CARE: Ellen Lieber, Training Unit, CARE, Dr. Norbert Hirschhorn and Joel Lamstein of John Snow, Inc. (JSI), and Nanette Brey Magnani of World Education, Inc.

Based on an initial review meeting between the PHC Unit staff and evaluation team members, the overall thrust and approach of the evaluation were agreed upon. The following objectives served as a guide:

1. To enable the PHC Unit in CARE-NY to provide more effective and efficient support for PHC programming;

2. To evaluate the impact of the AID/W-supported Child Survival Program on CARE's overall PHC programming;
3. To identify issues and options for consideration in the promotion of CARE PHC programs.

A detailed design was developed (Appendix 1). The data collection process was comprehensive. Team members, to various degrees, participated in reviewing critical planning and program documents (Appendix 2), and interviewing key managerial staff throughout the Program Department, Senior Management, Country Directors during a work week group meeting which also included a few other field staff (Appendix 3), Board members and one RTA via the phone. Feedback was also sought from PVC/AID office in Washington and the Child Survival technical assistance office at Johns Hopkins University. Team members also surveyed field staff, via questionnaires, and analyzed its results (Appendix 4).

Interview notes, documents, and questionnaire responses were analyzed using standard qualitative approaches, such as, calculating frequency of responses and analyzing data for general themes. For questionnaire responses that could be quantified, averages and percentages were computed.

Consulting Team's Roles and Activities

The consulting team, comprised of management consultants, Joel Lamstein and Nanette Brey Magnani, and CARE's representative, Ellen Lieber, met with the PHC Unit staff on June 14th and 15th for an orientation to CARE and to finalize the evaluation design. Documents were identified and sent to JSI and World Education in Boston for review. Dr. Norbert Hirschhorn was subsequently hired as the PHC consultant and spent July 6th and 7th at CARE interviewing key staff. Mr. Lamstein and Ms. Magnani returned to CARE for additional meetings, interviews and questionnaire development on July 17, 18 and 19. The management consultants and the PHC consultant met several times in Boston for information sharing, planning, and data analysis. Ms. Magnani was responsible for coordinating consultants' input to the final report.

Ms. Lieber was invaluable as a provider of a CARE perspective throughout each phase of the evaluation - design, implementation, reporting, and presentation of results to CARE. Additionally, she arranged interview schedules, participated in some interviews, facilitated communication between team members in Boston and CARE New York, and was responsible for sending the questionnaires to all Country Directors, PHC-RTAs, and PHC-Project Managers.

SECTION 2: SUMMARY OF FINDINGS

The major findings of the evaluation are categorized into two sub-sections. Sub-section A: Strategic View (See Appendix 5 for Definition of Terms) provides findings which respond to a strategic question - Is the PHC Unit doing the "right" thing from an organizational viewpoint? Therefore, in this sub-section, the findings were drawn from information gathered on how various members throughout the CARE organizational structure both in New York and Overseas envision CARE and the role of primary health care in that vision. As mentioned previously, the major thrust of this evaluation was more operational than strategic and, thus, the evaluation team offers these findings based on impressions drawn from the interview results.

Whereas, the findings presented in Sub-section B: Operational View constitute findings which were consistent across field staff categories in the questionnaire analysis and/or findings which consistently emerged in the documentation review and analysis of interviews. Findings that were not consensual are listed in Section 5: Additional Findings. Also, the findings in Sub-section B are categorized by major questions the evaluation was designed to address under the umbrellas of Management Review and Health Programming Assessment.

Sub-section A: Strategic View

How do organizational members view CARE, its role in development, and the outcomes of development?

1. Generally, throughout organizational levels, CARE leadership and management viewed CARE as an organization of excellence and a leader in development.
2. Generally, throughout organizational levels, CARE leadership and management viewed development in terms of concrete, definable outcomes and impact (Appendix 5).

How do CARE staff feel about primary health care?

1. Organizational members tended to experience some frustration or tension with how primary health care "fits" within their view of CARE, its role in development and the outcomes of development.

Sub-section B: Operational View

1) Management Review

To what degree has the PHC Unit been effective in supporting overseas missions?

1. The PHC Unit has been very effective in their present support capacity to overseas offices and staff who have had direct contact with them. Most of the questionnaire respondents who had little or no contact with the

PHC Unit staff did not answer questions related to type and effectiveness of PHC Unit support or answered "not applicable." The Unit has been particularly effective in their support to RTAs by being responsive and supportive, by providing competent technical advice backed up by experience, and by being committed to their work.

2. The PHC Unit staff are well respected throughout the CARE organization by those who have worked directly with them. PHC Unit staff are viewed as technically very competent and experienced, committed, and responsive to field requests and to AID.

3. Some Country Directors, Program Department staff, and Project Managers were relatively unaware of the quality of work that is performed by the Unit or the type of services provided.

4. Missions which received TA provided by PHC Unit staff (as opposed to outside consultants) tended to view their TA as more beneficial to the mission if it resulted in funding or increased the mission's chances for funding.

5. While the PHC Unit does publish the "PHC Exchange" and has organized cross visits, field staff (CDs, PMs, RTAs) generally wanted more information about funding opportunities, both large and small, and increased information about other country's project experiences.

6. Within and across regions, requests for TA varied considerably depending on the type of TA needed and the perceived service that could be [A]provided by NY staff and/or RTA.

To what extent is the PHC Unit's work supported organizationally?
(Also see findings listed under Health Programming.)

1. Organizational support to the PHC Unit has grown considerably since 1985 -from one professional staff person and one support person to four professional staff persons and one support staff. Additionally, for more than 3 years, four PHC-RTAs have been working from bases in each of CARE's geographic regions to provide more technical service to the missions and project managers.

2. The PHC Unit's budget for FY'90 is \$244,675.00. The sources and amount of funding are as follows:

<u>Source</u>	<u>Amount</u>	<u>Percentage</u>
Child Survival (II, III, IV)	\$119,830.	49
CARE-USA	95,945.	39
PG I	28,900.	12
	<u>\$244,675.</u>	<u>100</u>

3. In terms of Child Survival support, 40% of CARE-New York PHC Unit time is spent on managing Child Survival-related activities, while 12% of the PHC projects for FY'89 were Child Survival ones. Forty nine percent of CARE-New York's PHC budget for FY'90 will be contributed from AID/Child Survival grants.

4. Within CARE's senior management there was no apparent "champion" for primary health care.

5. Some Program Department staff view the PHC Unit's approach to program development as too "ideological." On the other hand, interviewees who had this opinion believed that approaches, in addition to a community needs-based approach, were also valid.

To what extent do the PHC Unit's planning systems help the Unit achieve its objectives?

1. For the past two years, the Unit has accomplished more than was proposed in their annual unit plans.

2. The Unit manages a considerable work load.

3. The planning system followed by PHC Unit is part of CARE's overall approach to annual planning which is tied to the budget cycle. While MBOs (Management by Objectives) are established on an individual basis, each Unit submits individual unit operating plans and missions submit MYPs (Multi-Year Plans). The planning mechanisms indicate that units and missions plan in isolation of each other although there is a consolidation of unit plans into a program department plan for presentation and approval from CARE-USA Board.

4. The greatest amount of PHC staff time (10%) was spent on communications with field staff. (See Appendix 6 for analysis of time log.) However, the results may not accurately reflect work periods during which time other activities, particularly Child Survival ones, may take precedence such as reporting and proposal writing.

To what extent are the roles and relationships between the CARE-NY staff and RTAs clearly defined and appropriate for the accomplishment of their plans?

1. RTAs understand and agree to a great extent on their role in providing TA to missions. They would like to see that role generally continue as is.

2. Three out of four RTAs reported improved job performance via feedback and support from the PHC Unit/NY when asked to report the concrete results of the PHC Unit TA.

2) PHC Programming Assessment

PHC Portfolio (strengths, unique niche)

Two relatively new growth areas in development in general and for CARE programming specifically are Agriculture and Natural Resources (ANR) and Small Economic Activity Development (SEAD). Primary health care is not a new sector area, but special projects funded by AID in Child Survival have considerably strengthened CARE's technical expertise in PHC. The expertise came with new staff, but was also enhanced by the Child Survival grant's rigorous requirements for design, implementation planning, and detailed evaluation. In at least one country the Child Survival projects was the entry point for subsequent CARE PHC activities.

Quite a number of other PVOs are also carrying out Child Survival projects, and provide much useful materials and stories for fund-raising. CARE has widely advertised its experience in oral rehydration therapy, for instance. Child Survival projects could provide PVOs with an extraordinary opportunity to study what works in PHC, what is sustainable, and how communities and families react. Internal documents at CARE (and other PVOs) are a rich source of such data, further strengthened by the variety of projects in different settings. However, little solid writing has come out of these projects. This is because, at CARE at least, the projects are too management intensive, costs for design and careful analytic studies are not covered by the grants, and the populations under the project often are too small for statistically valid assessments of impact on mortality. (Although for other indicators -- acceptance, continuation, understanding, and use, they are.)

Some other concerns at CARE about the Child Survival grants include their requirement for matching funds that, if raised by donations, are no longer discretionary; and, because of the amount of time the projects need in technical assistance, documentation, and accounting, the PHC staff is less able to develop new directions in health. One strategic desire expressed by senior management is for CARE to be at the cutting-edge of development, to be a leader in new approaches. Given the number of PVOs doing Child Survival projects, and their fairly uniform nature (ORT, EPI, nutrition, health education), no PVO can be said to be at the cutting edge.

The Medico Advisory Board (MAB) seems to represent a model of health care out of step with primary health care which stresses community participation, auxiliary health workers, simple technologies, and preventive care. The MAB wishes to conduct physician-oriented, hospital-based (and training intensive) technical assistance; this view reflects the opinion of a segment of the Board of Directors and creates a source of pressure on the time and energies of the PHC unit in responding to these individual concerns.

SECTION 3: SUMMARY OF RECOMMENDATIONS

Sub-section A: Strategic View Recommendations

1. CARE needs to further examine or substantiate what the evaluation consulting team believes may be the root cause of CARE frustration: an incomplete picture of how primary health care fits strategically within CARE's self-image as an organization of excellence and a leader and as an organization which values definable outcomes.
2. Questions that need further discussion and answering are:
 - a. Why primary health care? How does it fit in CARE's portfolio?
 - b. What is CARE's role? (versus competition)
 - c. How do you resolve the conflict between need for definition and evaluation in a field hard to evaluate?
 - d. How do you target PHC? (integration, specific programs, use of networks, etc.)
 - e. How do you give PHC, given its characteristics, sufficient status within the organization?

Sub-section B: Operational View Recommendations

1) Management Review Recommendations

Effectiveness of Support To Overseas Missions

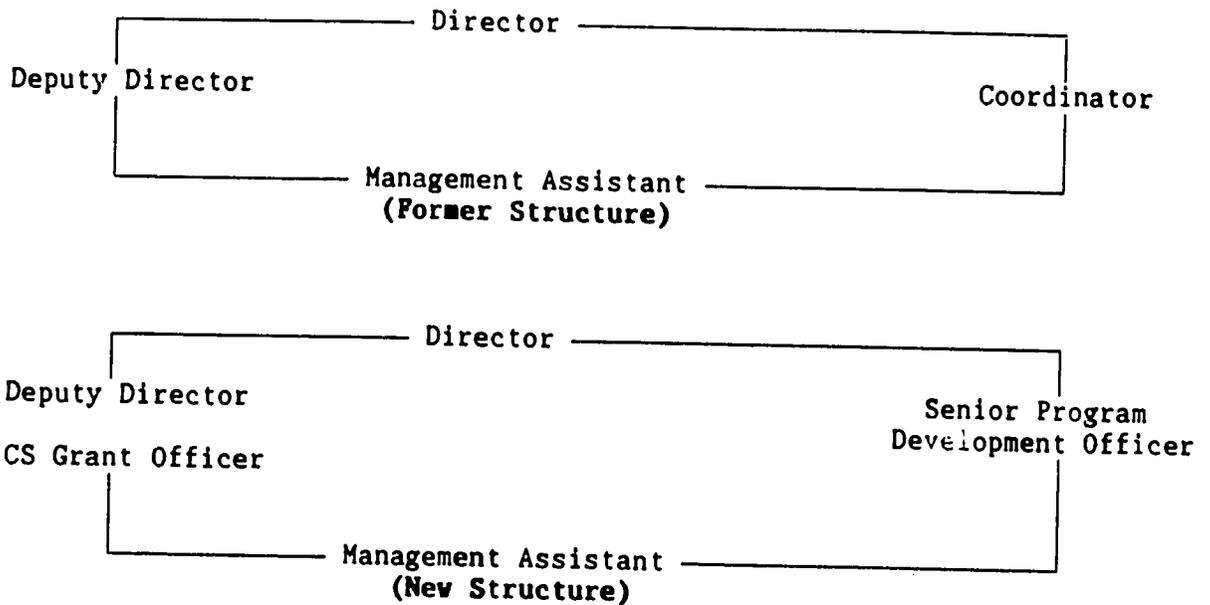
1. PHC Unit staff might consider spending more of their time on donor relations and seeking out funding opportunities.
2. Although the PHC Unit disseminates yearly highlights, the results of the interviews and questionnaire analyses suggests a need for the PHC Unit to make its services and strengths more visible to others.
3. An area of strength for the PHC unit is its responsiveness to field staff. Thus reducing the time allotment spent on field communication needs to be considered carefully before any changes are made. However, there may be a need for one staff person to coordinate Unit communications that include disseminating information for public relations and for sending and tracking correspondence or visits to missions/staff who receive minimal contact from the NY office. For example, the questionnaire analysis revealed that some Asian countries reported minimal or no contact with the PHC Unit. It would be interesting to learn why.
4. The "PHC Exchange" needs to be assessed in terms of its distribution and content and how it might be used to meet needs expressed by Country Directors, RTAs and PMs for further information regarding other missions'

experiences, and on possible funding sources and requirements. Other vehicles could also be considered.

5. The results of the questionnaire could be used as a "springboard" to revisit a participatory planning process with the RTAs for determining PHC Unit priorities, in terms of technical assistance and priority countries. Some countries such as the Philippines, Kenya and others have significant resources available in country and/or have TA needs that may not suit the skills of the RTA.

Organizational Support

1. An additional professional staff person has been hired by the Primary Health Care Unit. Below is a diagram of the former structure and the new structure as illustrated in the Child Survival '89 Annual Report.



Planning Mechanisms

1. The objective-setting process and objectives need to be reviewed. Unit-level decisions need to be made on objectives that would be both challenging and fulfilling for staff. Analyzing the time log can provide a basis for determining how appropriate current time allocations might be.

2. Project managers and RTAs who either are doing integrated projects or who expressed it as a future "programming area" were identified in the questionnaires. The PHC Unit could follow-up and ask them in what ways and how their efforts could be further supported.

3. The results of this evaluation and process could be used as a basis for establishing a participatory planning system by integrating, to the extent possible, the results of the questionnaires (eg. see pt. 4 under Effectiveness of Support above) into Unit plans. The process could offer an additional way to share plans across countries, regions, and units.

Roles and Relationships

1. The PHC Unit staff have established wonderful relationships with the RTAs. As part of the yearly joint planning session between the Unit staff and the RTAs, group objectives could be established so that RTAs not only work on their individual plans, but also work on group/team goals. If truly joint goals can be set, this could not only strengthen the overall TA service, but could increase the teamwork already begun.

2) PHC Programming Assessment Recommendations

CARE is particularly well situated to consider three options to carry its PHC work well into the next decade. The options are not exclusive; indeed, they may be mutually reinforcing.

Option 1. Continue to develop and maintain AID Child Survival projects as a major activity.

The evaluation team believes that USAID Child Survival programming is likely to continue for another 5-10 years, with emphasis shifting to cereal-based oral rehydration therapy and new approaches to weaning foods, acute respiratory illness, and vitamin A supplementation. Given CARE's excellent experience with the grants, CARE ought to continue on this line but with more resources put into documentation, analyses, even designed comparative studies of different approaches. We see no PVO hiring social scientists and researchers who devote full-time to such activities.

Option 2. Develop intersectoral health-related activities by initial piggy-backing.

CARE is also in a unique position to design intersectoral approaches that include health. It would be a useful exercise for a PHC staff to study how health activities could, as a beginning to intersectoral development, be piggy-backed onto existing CARE programs in the other technical units. (In the course of preparing such an internal briefing paper, the PHC unit and the other units would benefit from collaborative discussions.) We can list some possibilities for piggy-backing, just as illustrations.

With Food Distribution programs

- teach mothers how to make cereal-based oral rehydration therapy;
- distribute standard mixing containers for oral rehydration therapy;
- do simple arm circumference measurements in sample of children to monitor communities' nutrition;
- provide tetanus toxoid vaccinations to women coming for food;
- monetize food to purchase essential drugs and vaccines (and syringe and needles, etc.);
- promote family planning by training food staff in the issues, who would then talk to mothers (perhaps).

With ANR

- vegetable production for vitamin A, medicinal seeds;
- a review of portfolio to show how agroforestry projects could lower unnecessary calorie wastage by women, and ways to increase their calorie intake;
- ORT for domestic animal young to improve farmers' economy.

With SEAD

- set up revolving drug funds;
- teach village practitioners essentials of ORT, tetanus toxoid vaccinations, treatment for pneumonia, contraception and set them up in business;
- market line of essential drugs (including contraceptives in market town pharmacies).

Simple, field-based evaluation techniques would need to accompany any piggy-backed activity. Much of the study of possible linkage should focus on need, cost, ease of start-up, feasibility to beginning in existing projects, and community desires. Cross-training of CARE staff in the field will be needed as well for any piggy-backed activity.

The new sustainability grants (once approved) might be used to develop intersectoral activities, particularly as it applies to local NGOs which tend to work in one area only.

Option 3. Use "women" as producers, not just consumers of health as a programming theme.

This interesting new theme could emerge from the current portfolio and successful piggy-backing activities. Although much has been written about this subject, we are unaware of integrated programming on any scale by US PVOs or other agencies implementing health projects (JSI's "Mother Care" project emphasizes prenatal care; Save the Children in Bangladesh combines income-generation and health education among landless women).

The growing body of evidence is that women who control at least some income within the family or have some other basis for confidence and personal capacity, have healthier children. It emerges that even the correlation of years of schooling and lower infant mortality does not -- even at the level of the first four primary grades -- require literacy! (Apparently some confidence and socialization is acquired just by attending school.)

Each of CARE's technical sectors does something that affects women, whether intentionally or not. Many of the piggy-backed activities suggested above involve women's health and capacity in several ways. Family planning (or "birth spacing") is, in many countries, a woman's concern, and her ability to control her own fertility is another element in health and capacity. If a particular theme was wanted that summarized CARE's work in development, this might be a good one to attract donors (individual and organizations). However, this option is still something to examine even as the others proceed.

SECTION 4: DISCUSSION OF FINDINGS AND RECOMMENDATIONS

Sub-section A: Strategic View Discussion

The Evaluation Team started this evaluation with an operational focus to evaluation design and data collection. Thus, this particular sub-section on strategic view is an unintended outcome of the review process and is, therefore, based on impressions derived from the data once the data collection process had been fully underway. Additionally, evaluation team members recognize that since this is not a comparison between units, staff members or organizational members from other units may have similar perceptions and feelings regarding other technical units, i.e., SEAD, ANR or Food.

Once into the data collection process, evaluation team members believed that staff in both the PHC Unit and other Units felt somewhat frustrated with the degree to which primary health care "fit" with CARE's overall vision and strategic plan. Evaluation Team members believe this frustration may be the result of a possible incompatibility or lack of strategic definition between CARE's vision and its present health programming focus on primary health care.

Without more in-depth information, team members suggest that the following areas be further examined to determine if they are causal or non-causal factors and, then, resolved in order to best position the PHC Unit within the wider organizational context and culture of CARE and to best position the Unit to address the needs of its program beneficiaries.

1. A diverse primary health care portfolio and an organizational self-image as an organization of excellence and as a leader in development. How can the organization achieve excellence and become a leader in primary health care with a diverse portfolio? What is the PHC focus? In light of the organization's recent policy decision to integrate population into CARE's programs and discussions concerning AIDS as a new or expanded program area, the direction of the PHC Unit seems to be expanding its portfolio which could make it increasingly more difficult for CARE to become leaders in a primary health care area and, thereby, increasing organizational tension rather than reducing it.

2. Given an organizational culture that values programs that have definable outcomes and wants to achieve an impact, how does primary health care fit within this organizational culture? Primary health care is not easily measured and it is difficult to measure a program's impact even over a period of time. This value conflict can, then, result in organizational members throughout the structure not knowing quite how to feel about primary health care.

Although PHC Unit members clearly are committed, believe deeply about their work, and are doing a good job (as the evaluation results show), their work is still not highly valued by the organization at large which could be attributed to the underlying value conflict just described and a vision incompatible with the Unit's portfolio.

Sub-section B: Operational View Discussion

1) Management Review Discussion

Overseas Support

Evidence from the questionnaire results and from direct interviews with field personnel at the NY office suggests that the service provided by the PHC Unit (New York and RTAs) is excellent. The Unit staff were consistently described as technically competent, responsive, professional, and committed. Given the nature of CARE's programming as field-based, providing quality TA to 65 PHC projects and country missions with a wide range of needs is not easy and has proven frustrating for many TA staff.

The PHC Unit has essentially 4 functions: 1) to provide program support to PHC projects, 2) to oversee the management of CARE's Child Survival program, 3) to manage RTAs-PHC, and 4) to represent CARE's PHC sector within CARE and to PVOs, donors and others external to CARE. The majority of staff time is spent on the first three functions.

The results of this evaluation suggests that Country Directors, Project Managers and RTAs have a need for more assistance with the fourth function, particularly, donor relations and funding. Given the current demands on staff time, more time designated for this function means less time given to the other three functions. Re-allocation of time to certain activities, nevertheless, must be done if these needs are to be addressed. Before making such decisions an examination by the PHC Unit and Program Senior Management of the following would be helpful:

- o next year's plans - '90 - '91,
- o the staff's time log analysis, and
- o the health programming priorities and service needs of field staff as reported in the questionnaire results.

This discussion should also address other findings and recommendations that are related to allocation of staff time and prioritizing activities, time spent on field communications, how to increase the Unit's visibility, etc.)

Given the uneven nature of development, CARE staff will be challenged trying to keep up with country-specific and project-specific demands for technical assistance. Many countries have a great need for all the help that the RTAs and PHC staff can give them. However, some countries have technical assistance needs that are not best provided via the current system. Policies need to be formulated to: 1) Allow the RTA more time to focus his/her time on countries that have the greatest need and not feel "guilty" about not servicing the other countries and 2) To communicate to those "other" countries with different needs that the TA system is not designed to meet their needs, thus altering the mission's expectations of the TA system.

Planning Mechanisms

It is obvious from the PHC Highlights that the PHC Unit staff accomplished a great deal. When compared to the years' objectives they achieved more than planned. The Unit is therefore to be commended.

However, as the Unit looks toward organizational improvement, its planning process should be re-examined both in terms of the actual objectives set and the process for setting those objectives. Challenging objectives and group participation in setting those objectives will result in greater group commitment to the achievement of those objectives and a motivated staff.

The PHC Unit staff are in a very good position to modify its planning process by trying certain planning tools, such as group goal and objective setting, participatory planning and integrated planning. Since there is greater commitment to integration, there is a need to create mechanisms to make it happen.

Modifications might include: joint planning sessions with RTAs and setting objectives as a TA Unit; strategizing how to get input from mission staff and PMs systematically so that their input gets reflected in the Unit's plans (eg. "what gets priority?," etc.); determining how best as a Unit to implement the vision of integrating population and family planning into CARE's programs.

RTA Roles and Relationships With PHC Unit

Given the results of the questionnaire analysis, RTA roles are very clearly defined and the RTAs support the definition of their roles. The relationship with the PHC Unit is very strong. It could be even strengthened by implementing some of the suggestions described above.

One outstanding issue for the organization is how to address the needs of those projects that have technical needs beyond the capabilities of the RTAs. Another is to decide whether the organizational needs (CARE) are more technical or managerial? The evaluation results seem to suggest that they are both.

2) PHC Programming Discussion

The following is an outline of resources needed for the various options recommended in the previous section:

Option 1. Continue to develop and maintain AID Child Survival projects as a major activity.

Resources needed: Additional management help to release the technical staff for more technical work; a skilled researcher-writer to work up "lessons learned" from ended and ongoing projects, and to design new studies.

Option 2. Develop intersectoral health-related activities by initial piggy-backing.

Resources needed: The time of staff in the other technical units and representative field directors to explore the possibilities, probably extra field staff and some RTA time needed once an activity has been selected.

Option 3. Develop a new CARE theme around enhancing women's health and capacity.

Resources needed: For now, a position paper outlining the options within CARE, as review of the literature on the subject, a review of who else is doing what in this area, and, perhaps, an initial market survey to determine how this would be regarded by CARE's donors.

SECTION 5: ADDITIONAL FINDINGS - QUESTIONNAIRE RESULTS

The additional findings listed in Section 5 are presented under two sub-sections: A. Specific Findings - Management Review and B. Specific Findings - Health Programming. Both sub-sections present data from the results of the questionnaire analysis by perspective, i.e., Country Director, RTA, and Project Manager. Questionnaires were sent out to all Country Directors, Health-RTAs, and Health-Project Managers. The return response - 22 Country Directors, 4 RTAs, and 25 Project Managers (5-AFR, 11 LAC, 9 ASIA), in a relatively short period of time, indicated a high degree of field support for this review.

Specific Findings - Management Review

Country Director's Perspective - PHC Unit/NY and RTA TA and Support Service

1. The PHC Unit's greatest strengths are its high degree of professionalism, competence and experience; its responsiveness to mission requests and follow through; its high degree of commitment to PHC and their work; and access to other agencies, funding sources, etc.
2. To some extent, they would like to see the PHC Unit increase information given to missions regarding funding opportunities, increase its cross country exchange of mission's experience and increase visits to projects and missions to help with proposal development. Countries from Asia tended not to request additional services - only the Philippines suggested help with attracting financial support.
3. Countries in Asia did not have the same degree of contact with the PHC Unit as did other countries in other regions and, thus, did not respond to questions related to PHC Unit support and services provided to the same extent as countries in other regions. However, given their limited exposure, Asian countries tended to request TA services less than countries in Latin America/Caribbean region and East and West Africa.
4. TA services tended to be viewed as much more helpful to the missions in Central America and East Africa which rated their services above average.
5. All missions which received TA reported concrete results. Generally, those missions which tended to rate their services on the high end of the continuum reported more concrete results and/or results that realized a real benefit to the mission, ie, secured funding or increased mission's chances to get funding.
6. In terms of additional services from PHC Unit, the most frequently mentioned requests across regions were increased communication with Country Directors regarding funding possibilities both large and small, donor requirements, etc. and sharing of project successes.

7. Most countries within each region have requested RTA services primarily for proposal preparation and project design, implementation and evaluation. Some countries reported budget constraints which prevented them from requesting more services.

8. In terms of helpfulness resulting from RTA service, ASIAN countries reported the services were moderately helpful (5); LAC countries reported above moderate (6.3); and AFRICAN countries reported to a fair extent (8.2) on a scale of 1 - 10 with 1 being to a minimal extent and 10 being to a great extent.

9. Although most countries listed how the RTA could help them further, there was no consistency in their responses. Each request was dependent on the particular needs of a mission.

10. In terms of strengths, CDs tended to report the RTA's availability, knowledge of the area and responsiveness and, to some extent, experience, technical understanding and project management skills.

RTA Perspective

1. RTAs understand, to a great extent, their role in providing TA to missions. They would like to see that role not change significantly.

2. They reported that the PHC Unit/NY responds to their needs to a very great extent and believe the PHC Unit's greatest strengths to be responsiveness and support with excellent consulting skills, technical competence and experience, and commitment. Individual RTAs listed additional strengths.

3. Three out of the four RTAs reported improved job performance via feedback and support from the PHC Unit/NY when asked what the concrete results of PHC Unit TA. The fourth RTA is relatively new to CARE.

4. RTAs described the nature of that support as an equal combination of administrative, project management and technical.

Project Manager Perspective

1. The three most requested areas of TA from NY were: project review, technical expertise, and project redesign. Most services requested from RTAs were related to project evaluation although all RTAs' services generally have been requested and provided across regions.

2. RTA services were viewed as fairly helpful with an average score of 7 out of a possible 10 rating (with 1 being to a minimal extent and 10 being to a great extent). The nature of those services were characterized as slightly more technical-oriented than project management-oriented.

3. The average number of concrete results listed per region was 11. The list included a range of services such as assisting with MYPs, baseline

surveys, project evaluations, design of project monitoring systems, assisting with proposal development.

4. They had less contact with PHC Unit/NY than with RTAs; however, for those who responded, they found the degree of helpfulness of the PHC Unit's assistance has been above moderately helpful. (Responses were rated on a scale of 1 - 10 with 1 representing a minimal degree and 10 representing to a great extent.) Concrete results were listed; however, there were no commonalities. The range included feedback on mission proposals which in many instances was instrumental in the mission securing funding for the project; training workshops and cross-visits; project design and advice on staffing patterns.

5. The most frequently mentioned strengths of the TA (RTAs) staff were: high motivation, technical expertise, project design and review, responsiveness, and access to financial and informational resources.

6. Additional services they would appreciate are: the facilitation of information exchange of CAFE's experiences to other missions, increased role in communicating to field staff funding sources/possibilities and establishing contact between field and donors when possible and the offering of more training opportunities.

7. Most project managers spend a minimal amount of time fulfilling PHC/NY's administration matters.

Specific Findings - Health Programming

Results from the questionnaires were analyzed for major themes. In some instances major themes were not evident and are so stated below. The data is organized by perspective.

Country Director's Perspective

ASIA:

- o Bangladesh - Health programming in general.
- o Sri Lanka and Philippines - nutrition programs.

LA/C: No themes.

- o Nicaragua - greatest assistance needs requested.
- o Bolivia - possibly

AFRICA: Not specific to individual countries.

- o Integrated health programming in several areas including AIDS, Family Planning, Community Development.
- o Countries in East and West Africa will probably continue with a high demand for PHC TA services from both RTA and PHC/NY Unit given their current priorities.

RTA Perspective

Health programming priorities as viewed regionally by RTAs: 3 out of 4 reported integration of population issues. Other areas were listed, but were country-specific.

Project Manager Perspective

ASIA:

- o family planning
- o rehydration and diarrhea control
- o immunization
- o nutrition and nutrition education

LA/C:

- o integration of health education into health programs
- o water and sanitation
- o MCH
- o nutrition

Africa:

- o to some extent water and sanitation

CARE PHC Unit Evaluation
JSI/World Education
Results of Planning Session
June 14 and 15

EVALUATION DESIGN

Purpose: To place the PHC Unit in the best possible position to support CARE overseas missions in meeting the health needs of poor people in less developed countries.

Objectives:

1. To conduct a management review of the PHC Unit in CARE-NY by assessing its current strengths and limitations in providing support to the overseas missions and to make recommendations on what actions the PHC Unit could take to build on its strengths and to minimize its limitations.

2. To assess CARE's overall primary health care program portfolio with particular attention to the Care for the Child Program and its impact on programming and on the PHC Unit in general.

Primary and Secondary Questions:

1. To what extent has the PHC Unit been able to achieve its objectives?
 - a. What are the PHC Unit's short-term and long-term plans?
Has planning been effective?

Data source and Instruments:

Documents: MYP (multi-year plans), Organizational Plans, Unit Plans

Interviews: PHC Unit staff

Questionnaires: RTAs (regional technical advisors - 4)

- b. Are the roles and relationships between the CARE-NY PHC staff and RTAs clearly defined? Is there a shared understanding of them?
 - Should they be changed or do they meet RTAs support needs?
What are RTAs support needs?

Data source and Instruments:

Documents: Contact Person (report), job descriptions

Interviews: PHC unit staff

Questionnaire: RTAs, CDs (Country Directors)

- * c. How does the PHC Unit spend its time? Does their time allocation reflect their job priorities? If not, how should their time be re-distributed to reflect their priorities? (How do central grants affect our time?)

Data source and Instruments:

Time log

- d. How effective is the PHC Unit's support to the overseas missions? What kinds of TA does the PHC Unit provide? What mechanisms are available for providing TA? Where should various kinds of expertise be concentrated - increased, decreased?

Data source and Instruments:

Documents: TA evaluations for RTAs and PHC , annual performance appraisals, "alot of documentation"

Interviews: NY staff

Questionnaires: Project and Program Managers
(w/ checklist of types of TA available)

- * e. What are the functional relationships between PHC Unit and others? To what extent does PHC Unit effectively communicate with others? What are the expectations of the PHC Unit as defined by others? (others: program department(*) - RAG, TAG, ISOG; 5th floor - Donor and Public Relations; Board and Exec. Staff and CARE Int'l; Project Managers (*); non-CARE professionals.

Data source and Instruments:

Documents: organizational chart

Interviews:

Questionnaires:

- * f. What additional support does the PHC Unit need to carry out its plan? What types of initiatives have staff members tried? What has been the organizational support for those initiatives?

- 2. Are there certain interventions that are over or under represented in CARE's PHC portfolio? If yes, should this be changed and how? What are the implications for change? ("Are we doing the right thing?")

3. What impact has the CARE for the Child Program had on CARE's PHC projects and on the PHC Unit?
 - a. How do central grants affect CARE's PHC portfolio?
 - b. What are the lessons learned from the CARE for the Child program?
 - c. To what extent have these lessons learned had an effect on CARE's PHC programming?

Other

The results of the above evaluation will be used as input into the PHC Unit's planning on how best to position primary health care and the unit. The group generated the list of questions below as next steps.

Positioning PHC

Decisions: visibility, image creation, increased funding

1. What are PHC strengths?
 - a. Among strengths is there a unique niche?
 - b. Which does PHC want to promote?
2. How is PHC perceived?
 - a. Donors (public, inst. donors)
 - b. within CARE (Board, Sr.Mgt., CDs, DPR)
 - c. within "Health" community
3. How best can PHC communicate who PHC is?
 - a. Reaching people whose perceptions are consistent with reality
 - b. Reaching people whose perceptions are inconsistent with reality
4. How does PHC access additional resources?
 - a. unrestricted
 - b. multi-lateral/bi-lateral
 - c. foundations

Appendix 2

List of Documents Reviewed

1. CARE's 1988 Annual Report
2. Rural Capital Formation - Interim Report (1987)
3. Rural Capital Formation - Interim Report (1988)
4. FY89 PHC Donor Profile
5. CARE-USA - CARE for the Child V - 12/88
6. CARE-Sudan - North Kordofan Child Health Project
7. Categories of Maternal and/or Women's Health Activities included
in PHC Sector Projects
8. Revised Project Proposal Format
9. 1988 Child Survival Annual Report
10. Program Manual - Overseas Operations Manual, Vol. III
11. Memo re Family Planning (from Phil Johnston)
12. CARE Organizational Chart
13. Framework and Guidelines for the Primary Health Care Sector
14. FY 90 Domestic Plan/Budget
15. PHC Sector - Highlights of FY'88
16. Job Descriptions
17. Use of Regional Technical Advisors
18. Technical Assistance Group
19. CARE Latin American Food-Assisted Primary Health Care Workshop -
Draft Report
20. Asia PHC Cross Visit
21. CARE African Water Workshop, Final Report
22. Session Notes, RTAT Teamwork and Cross-Sectoral TA (summarized)

Appendix 3

List of People Interviewed

CARE New York

Phil Johnston
Rudy von Bernuth
Sandra Laumark
Rudi Ramp
Steve Wallace
Tim Aston
Tom Drahman
Sue Greene
Peter Van Brunt
Larry Frankel
Rudi Horner
Sue Toole
Catharine McKaig
Remo Vonk
Lizette Echols
Mara Russell
Helen Seidler
Beryl Levinger (She has since moved to a different job.)

Jaime de Dios
Dan Roth
Walther Msimang
CARE NY-Board
Dr. Siffert, CARE Board
Non-CARE
Susan Morawetz, AID

CARE Overseas

Walter Msimany
Marge Tsitouris
Paul Barker
Jerry Rolls
Carell Laurent

Appendix 5

Definition of Terms

Impact - the degree to which a program or a planned intervention has affected the specified population for which that intervention was designed for. For example, an ORT intervention should lead to lower mortality rates among children.

Operational View - the way in which an organization functions or carries out its plans.

Primary Health Care Unit - the staff located in New York.

Strategic View - the organizational intent to target its resources in a particular way to achieve its mission and goals.