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PVOs REACH OUT

A Summary of Thirteen

Primary Health Care Project Evaluations

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SUMMARY EVALUATION REPORT: 13 PVO PRIMARY HEALTH CARE PROJECTS

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FOREWORD

This third and final summary report synthesizes the findings of 13 AID-funded evaluations of PVO projects in health and nutrition which have received Matching Grant funds from AID. Questions or comments are welcome and should be addressed to Nick Danforth, Management Sciences for Health, Suite 700, 1655 North Fort Myer Drive, Arlington, VA 22209 (703/841-0680).

Thanks are due to the evaluators and the many PVO staff members who collaborated in these evaluations, particularly those listed in Appendix 3, and to the staff of AID/FVA, particularly Hope Sukin and John Grant, for their helpful comments. Special thanks also to Lisa Kramer for editorial and administrative support.

ABBREVIATIONS

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

I. EXECUTIVE SUMMARY

This report is a summary of the major findings of evaluations of 13 PVO health projects supported by AID Matching Grants. The evaluations were performed for AID/FVA from 1983-86 by teams from Management Sciences for Health in close collaboration with PVO staff members.

The evaluations have pointed up the breadth of diversity which exists within the PVO community. Some PVOs are moving from a more traditional relief or curative orientation to the provision of primary health care (PHC). Others have been established for some time in the PHC field and are at the forefront of innovative approaches to the delivery of PHC services. While some PVOs have their own health infrastructure, including networks of clinics and hospitals, others work within the ministry of health on planning and training but have no facilities of their own. Such diversity builds strength, but also makes comparisons of PVO projects more difficult. For the seven PVOs whose field projects were evaluated, we identified three distinct strategic approaches to PHC:

- PHC outreach from the PVOs' own clinics
- assisting the government to develop PHC
- PHC in community-based integrated rural development.

All 13 projects have succeeded in using these approaches in different settings, providing new, basic health services, usually to poor, rural families, most of whom would not otherwise have access to them. Analysis of results (Section III) indicates, particularly in the more mature Matching Grant (MG) projects, that most plans for delivering health services or training health workers were being met or exceeded.

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

The effectiveness of PVO projects could be heightened further if improvements were made in their design and management (Section IV). Sometimes project countries and sites within countries are selected for public relations or fund-raising purposes, but are too varied or too far apart to be managed efficiently. Often plans were drawn hastily, lacked measurable objectives or technical analysis,

and involved little or no participation of the host government or beneficiaries. The Matching Grant approval process could benefit from a more rigorous review by FVA of areas in which PVOs required strengthening. In particular, monitoring and information systems used by most PVOs were rudimentary and need upgrading if a project's contribution to well-being is to be accurately measured. At the same time, FVA needs to clarify its responsibilities in Washington and overseas in monitoring and evaluating PVO programs. A scientific assessment of the impact of those projects on morbidity and mortality was not possible because many projects were not collecting or analyzing adequate baseline or monitoring data. This was due, in part, to fact that AID did not require such monitoring in their MGs. This problem is now being addressed in current Child Survival programs managed by the same PVOs, often in the same country projects reviewed during the evaluations.

PVO projects have not been effective at documenting, replicating, and sharing their experiences. Lessons learned by project managers are often lost to the wider national and international health community because the PVOs, host country institutions, and USAIDs are not exchanging project information.

AID and USAID missions must ensure that the PVOs have adequate time not only to plan but also to achieve realistic objectives. In particular, the PVOs and AID should agree on specific measurable objectives, activities, schedules and deadlines. In addition to the more traditional criteria for evaluation of quantitative outputs, evaluation procedures should be designed which will improve program institutionalization, sustainability, and replicability. As discussed in Section V, some PVOs have not had as a major objective the development of local capabilities leading to sustainability and replicability in the host country. The constraints to such development are significant in some countries, but building local capacity should be a greater concern in PVO planning and implementation. The three year time frame for grants leads to pressure to emphasize immediate outputs of health services instead of collaborative institutional development and training which might lead to longer term sustainability and replicability.

Our evaluators' conclusions are summarized in Section VII. They reinforce the findings of previous PVO evaluations which have emphasized the importance of planning systematic steps toward building local capacity. Practically any expatriate organization can make short term improvements in the health status of small unserved communities by using foreign manpower and money to make temporary changes in the environment or in health behaviors. The real challenge for PVOs--and for FVA--is to launch self-reliant local health care systems which begin to recover costs locally, and eventually continue with little or no expatriate support. Increasing project self-reliance is necessary because relatively few people currently benefit from PVO projects. PVOs must mobilize local resources in order to replicate PHC projects in new unserved areas just as deserving of help.

The true test of success in an AID-assisted PVO health project, then, is not how many communities depend on it for health care, but how many communities have been able to develop improved health systems with training and technical support from the PVO, yet no longer depend on that support. Success would then be measured not by how much money the PVO spends on the community, but on how little it had to spend to develop local capacity and self-reliance. Instead of being proud of its long history in a particular community, a successful PVO would publicize how little time it took to help the community set up its own self-managed and self-financed PHC system, and how rapidly it was able to move on to other needy areas, leaving a self-sustaining PHC system in place.

PVOs evaluated here are far from reaching that goal of being able to "phase over" PHC project responsibility, but it is encouraging (partly to FVA's credit) that all of them have begun to move toward it, and that such steps are now being planned explicitly in child survival projects.

In summary, these evaluations have revealed a number of PVO attributes in the health and nutrition sector:

- Most PVOs which had previously devoted a majority of their resources to clinic-based curative care are now, with support from AID/FVA, emphasizing community-based PHC.
- Many PVOs are providing appropriate, and effective health services, sometimes within the context of broader multi-sectoral development.
- PVOs often reach areas unserved by governments.
- PVO staff tend to be highly committed, culturally sensitive and in many cases more respected for their health care skills than their public sector counterparts
- Many PVO projects concentrate on developing small, intensive community-based primary care systems.
- Different PVOs use different strategies, introducing PHC from the top down, the inside out, the bottom up - or several at once. Such variety limits comparability but increases the lessons learned about what works and what does not.
- Most PVOs evaluated work to improve PHC directly with government ministries of health in regional or national offices.
- Other PVOs have an extensive health infrastructure well established in the country on which new PHC programs can be built.
- At least one PVO demonstrated that health status can be improved by integrating health and health related development programs.

The evaluations also revealed several important areas for improvement; many of which are being addressed in the new Child Survival Fund programs:

- PVOs will continue to have only a limited effect on national health status, strategies, and programs as long as their projects continue to directly benefit relatively few people.
- PVO health information systems are inadequate. There is great need to fully document health needs and progress toward meeting those needs.
- PVO staffing patterns and skills are variable. Some PVOs are significantly understaffed, especially at home offices, and only a few PVOs provide specialized technical support to the field in PHC subsystems.
- Some PVOs' priorities are unclear regarding host country institutional development and phasing over to local control.
- AID/Washington's leadership in technical review and monitoring in support of PVO projects has been lacking.
- The AID project design process forces PVOs to promise unrealistic accomplishments, often in too short a time. Not enough attention is given in design to developing realistic workplans.
- USAIDs generally lack knowledge of PVO health activities in their country, except where there is a PVO or PL-480 office.
- Some PVOs fail to work effectively with host country public and private sector organizations.

This report concludes (Section VIII) with recommendations to AID/FVA and the PVOs themselves for addressing these problems.

II. PROJECT DESCRIPTIONS

In June 1983, FVA contracted with Management Sciences for Health (MSH) to:

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

The centrally-funded Matching Grant (MG) program, administered by FVA in collaboration with AID's Regional Bureaus, provides MGs to a "limited number of PVOs of recognized standing with discrete programs in high-priority sectors."

Thirteen projects of seven PVOs in twelve countries were evaluated by October 1986:

- Adventist Development and Relief Agency (ADRA), Haiti and Tanzania
- Helen Keller International (HKI), Philippines
- International Eye Foundation (IEF), Honduras and Malawi
- Meals for Millions/Freedom from Hunger (MFM), Honduras and Thailand
- Project Concern International (PCI), Belize, Bolivia, The Gambia, Guatemala
- Salvation Army World Services (SAWSO), Pakistan
- Save the Children Federation (SCF), Bangladesh.

See Appendix 1 for a description of the evaluation process and Appendix 2 for a flow chart of evaluation procedures.

A. Health Activities

Of the projects evaluated, ten are "horizontal" projects in PHC. They are designed to improve PHC systems which can provide poor families, particularly infants and children, pregnant women, and mothers of young children, with simple, low cost preventive and curative health and nutrition services. Services are provided by community-based health workers in or near the home, with referral to secondary (clinic) or tertiary (hospital) care if necessary. These projects are basically similar in their goals and strategies: they usually seek to reduce maternal and child mortality by training,

supervising, equipping, and supplying village health workers and traditional birth attendants (VHWS and TBAs) who provide standard PHC. One PVO, MFM, concentrates on applied nutrition programs which are closely tied to the PHC activities described here.

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

When evaluated, most projects were in their second or third year of operation; a few were five to ten years old. Several projects had collected limited baseline data, but only one had used it in measuring project progress. All had developed monitoring systems to keep track of outputs, and several have collected data suggesting intermediate indicators of impact on health standards. The projects are small in AID terms, costing annually an average of \$96,000 (in-country costs excluding expatriate salaries) and reaching an average target population of under 60,000 (including both direct and indirect beneficiaries living in the impact areas.)

B. Project Strategies

The PVO projects which MSH evaluated differ in many respects (e.g., their locations, objectives, and strategies). Yet they tend to fit into a general grouping of PVO strategies which is probably representative of most AID-supported PVO activities in health and nutrition. The projects can be categorized roughly into three types, all of which involve training of health personnel at different levels:

1. Hospital and Clinic-Based Services (ADRA, SAWSO)

For many years these have been traditional missionary organizations with long histories of health and nutrition assistance to the Third World, large numbers of deeply committed expatriate staff, and well-organized curative health systems. They have provided clinical care to many unserved areas, often providing more and better quality health services than the public sector, through networks of hospitals and satellite clinics. The clinics are often located in small towns, usually near mission churches; they treat patients or refer them to their mission's hospitals in cities. In the past, health activities, frequently tied to missionary work, were centered in populated areas and were mostly curative; community participation in PHC, water, and sanitation was minimal.

These organizations have changed dramatically in the last two decades. They have realized the inefficiency and ineffectiveness of repeatedly treating the sick, particularly infants and children, who are chronically debilitated by poor nutrition, limited and

polluted water, and preventable or immunizable diseases. These PVOs are committed increasingly to balancing clinical solutions with health education and community action. They are now training and supporting community-based health workers who know and are trusted by their neighbors, to help them with nutrition, water supply, sanitation, and basic health care with minimal training, equipment, and cost. Supported by AID, SAWSO, ADRA, and other missionary organizations began in the 1980s to design increasingly sophisticated procedures for the training, supervising, supplying, and financing of VHWs and TBAs. Many of these village men and women are unpaid part time volunteers, others receive stipends. Some are church members, but more and more are not. They all help provide basic but usually reliable services.

These PVOs are increasingly providing those services outside their traditional catchment areas to rural populations often a considerable distance from their clinics. Although the selection of those service areas is not always based on efficiency, and the costs of training and supervising VHWs in remote areas can be high, these PVOs are now in a position to learn useful lessons about improving the cost-effectiveness of PHC outreach.

AID funding and technical assistance in project design and evaluation is making an important contribution to this switch in orientation. Mission hospitals are a unique local resource; strengthening their outreach activities may be one of the most cost-effective investments which AID could make in the health sector, particularly because AID matching grants to these church groups often stimulate additional private donations. These PVOs have the potential, because of their health infrastructure, to reach many thousands of currently unserved people by expanding their PHC coverage to new rural catchment areas, and selecting new target areas in which VHWs can be supervised and supported effectively--avoiding the temptation to select project sites which are difficult to manage solely because they appeal to donors. FVA's responsibility, we believe, is to support that continued expansion beyond traditional catchment areas, and to encourage these PVOs to interact more with other private organizations, and with the host government (which some mission organizations have traditionally been reluctant to do.)

2. Catalyst with Government (HKI, IEF, MFM, PCI)

These four PVOs represent another large segment of the AID-supported PVO community which also has the potential to effect public health improvements on a wide scale. This type of PVO works directly with ministries of health to provide technical and managerial assistance in PHC to public sector health programs.

Unlike the church-related groups, they have no infrastructure of their own to support PHC. Some, like PCI, work in a single region in some countries or on a national level in others. Some focus on a single PHC intervention. For example, with government support and a close working relationship, MFM tested its Applied Nutrition Program on relatively small target groups (about 4-12,000 people) in Honduras and Thailand. HKI has developed primary eye

care programs in two regions in the Philippines; IEF helped the Malawi government to develop a national blindness prevention plan while testing it in one region. In such projects one or two expatriates paid by the PVO have offices in the MOH and usually act as advisors to local counterparts.

The goals of PVOs which advise governments directly differ from the goals of PVOs which are expanding their own PHC infrastructure. The former seek to increase the effectiveness and impact of government PHC by strengthening PHC planning, training, supervision, supply, and reporting systems by helping to build the capacity of government institutions and staff at all levels, from the ministry to the community, to become more self-reliant in managing and financing those systems. In some respects the objectives of these PVOs are similar to church-related PVOs: both are building the components of community-based primary care systems which depend on supervision and supplies from existing clinics. But PVOs working with governments face problems of interagency coordination and political pressures which PVOs developing their own internal PHC systems are less likely to encounter. For example:

- in Bolivia and Thailand, PCI and MFM respectively devote much of their time to coordinating public and private regional health planning and management by the various ministries whose programs affect nutrition and maternal/child health (e.g., agriculture, education, labor);
- in the Philippines, Malawi, and Honduras, HKI and IEF have worked hard to ensure that health workers trained in eye care are properly supervised and supplied by the MOH;
- in Guatemala, PCI is forced to balance its program, sometimes precariously, between working with the local MOH office in order to build a sustainable program which can be replicated in other areas, and maintaining its traditional arms length policy with the government.

While church-sponsored groups can more easily point to their own internal "success stories", PVOs working with governments have a harder time measuring and publicizing their effectiveness since credit must be shared with the government. FVA and USAID missions need to remember this point when monitoring the PVOs' effectiveness by tracking progress made in public sector PHC programs.

3. Community-Based Integrated Rural Development (SCF)

A third approach worth special mention does not fit easily into either of the other two groups. SCF's program in Bangladesh does not work within the MOH, nor does it grow out of a pre-existing clinic system. Instead, its' health program, like MFM and other PVOs, grew from the principle of integration: that health is inseparable from economic and social improvements. SCF organizes village development committees which in turn develop agriculture, income generation, women's groups, and schools, as

well as providing health, nutrition, and family planning services. It has begun to discuss plans for what it calls "phasing out" of selected villages, preferably when they are able to generate enough income from cooperative projects to pay for village health and development workers. SCF's institutional development efforts focus on building village institutions as well as its own national office in such a way that encourages local self-reliance at both levels.

The SCF system, known as CBIRD (Community-Based Integrated Rural Development), is not easy to replicate and its various activities are costly because they cover many sectors. SCF's independence from government is an advantage, enabling it, for example, to integrate different sectors. But it is also a disadvantage at times; for example, SCF must rely on the MOH for immunizations or tertiary care. Moreover, the time has come to convince the MOH that it can and should adapt the CBIRD model to other areas lacking PHC, but the MOH has not been involved in the SCF projects enough to replicate them easily.

Nonetheless, the SCF strategy may be at least as cost-effective in improving health as other strategies which focus more on health alone (see below). SCF, like the other PVO types, also faces obstacles to reaching its goal of integrated, self-reliant programs. Implementing the CBIRD system to the point of phase-out is time consuming (taking at least a decade in Bangladesh) and complex. But because the SCF system carefully constructs a strong, multisectoral foundation within the beneficiary community, and is beginning to generate income from small businesses to defray some health costs, it may result eventually in the most lasting health impact.

III. RESULTS

A. Improved Health Service Outreach

All projects have succeeded in increasing the availability and utilization of some basic family and community health services. In many rural areas the PVOs brought modern health, nutrition, family planning, or sanitation services to villages on a regular basis for the first time ever. Even where governments had previously been providing some services, the PVOs helped to significantly improve the quantity and quality of such services.

Every project evaluated depended ultimately on the village health workers to deliver services. These VHWS and TBAs are the front line health workers supported by the MOH, by the PVO itself, or a combination of both. They usually have training in both preventive and curative care. They make simple diagnoses and treatments or refer patients to the nearest clinic or hospital (which is frequently their base of operation and supervision). VHWS also provide preventive services ranging from health education in pre- and post-natal care, nutrition, hygiene, family planning, and sanitation. Most VHWS provide families with ORT for diarrhea and contraceptives for family planning, and participate in immunization programs for infants and children. Some VHWS provide food supplements with complimentary PL 480 foods, some assist in water and sanitation improvements. TBAs are trained to do aseptic deliveries and prevent neonatal tetanus.

In several cases the results of such primary care programs were dramatic. Some examples:

- In Honduras, Meals for Millions runs successful applied nutrition programs for nine villages, with approximately 18,000 residents within a regional office of the MOH without long-term expatriate staff. In Thailand MFM assists in government programs in two districts reaching, among others, 12,000 children under five. It accomplishes its objectives by coordinating many public and private nutrition-related activities in the region, training staff at all levels in improved nutrition strategies, and fostering better planning and monitoring.
- In Belize, Bolivia, The Gambia, and Guatemala Project Concern International increased significantly the use of government PHC services by improving health planning and training within regional and national MOH offices. In Belize, VHWS trained by PCI and paid by the MOH are raising health awareness in a remote district with 14,000 residents. In Bolivia, PCI has brought the MOH into closer contact with traditional healers and launched an efficient new drug supply system in two regions. In The Gambia, PCI launched a national PHC worker training program in villages totalling 120,000 population and recently withdrew from it when the national government was able to adopt and sustain it. And in Guatemala PCI nutrition centers had an unusually high success rate in assisting malnourished children and their families in an area of 35,000 people.

- In the Philippines, Helen Keller International has demonstrated that primary eye care training to prevent and cure blindness can be integrated into a PHC training program and can enhance the program.
- In Bangladesh, Save the Children Federation trains village women as all-purpose development workers with a major emphasis on maternal/child health, and requires the involvement of active, representative village development committees. Small businesses, many run by women, have also been assisted by SCF to strengthen programs in health and agriculture.
- The three eye care projects in Honduras, Malawi, and the Philippines have increased eye treatment for thousands of inpatients and outpatients. The eye projects are both curing blindness by extracting cataracts and preventing blindness. They offer extensive outpatient care and early diagnosis--particularly of Vitamin A deficiency from poor diets and trachoma from poor hygiene and polluted water. Many patients treated in these projects do not and cannot pay for services and would not otherwise be cured.

In at least half of the projects, health worker training outputs were the major ones being measured, and they had been reached. Consequent outputs--the health services to be offered by those trained--were more difficult to measure. Increases in the quantity of health services were not reported regularly or accurately, and were not compared to baselines. Evaluators often found VHWS trained and at work in their communities, but few records of their activities (outputs) were kept, either by them or by the clinics to which they often report.

B. Contribution to Improved Health

In a strict epidemiological sense, it is difficult and costly to measure the impact of one or several public health interventions. Since most PVO MG projects were not started with impact evaluations in mind, baseline data upon which such judgements can be made were not collected. Even if the data are present, it is often difficult, if not impossible, to isolate the effectiveness of public health programs when so many other factors affecting general health and well-being are also at play.

Nevertheless, several of the projects evaluated appear to be making significant contributions to the health well-being of the populations they were serving. They provided health and basic services, to rural families who previously had no modern health care. One project measured a drop in infant and child mortality, while other projects have reduced child malnutrition. At least half the projects have increased mothers' use of curative and preventive maternal/child health services. Some examples:

- In Bangladesh, SCF's four impact areas recorded an aggregate 25% decrease in infant mortality and a 13% drop in child mortality during the first two years reported (although such improvements could not be attributed solely to the project and were unlikely to be sustained).³
- In Haiti, ADRA's project in maternal/child health and nutrition produced substantial nutritional impact among its client children. Nearly all children suffering extreme (third degree) malnutrition, and three-fourths of children suffering moderate malnutrition, were recuperated or showed significant weight-for-age improvement, and attendance at follow-up weighing after "graduation", a definite result of the ADRA project, was very high, producing what the evaluators described as "unusually good results for improving child growth compared to other similar programs."
- In Honduras, MFM's Applied Nutrition Program combined nutrition and health education, water and sanitation, and income generation activities which decreased serious (second and third degree) malnutrition by one-fourth. While the project did not track changes in infant mortality, many children who might have died did not - thus doubling the pre-project child morbidity rates apparently⁴ by increasing child survival and improving reporting.
- In the Philippines and Malawi the increased cure and prevention of blindness could be attributed directly to HKI and IEF action.⁵
- In Guatemala, PCI's nutrition centers may have reduced the local prevalence of severe child malnutrition by as much as two-thirds.

C. Cost-Effectiveness

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

The evaluation teams found cost-effectiveness difficult to measure and to compare between programs because the costed components and accounting categories of the different programs evaluated varied widely, and because many costs were not recorded accurately, if at all. Overall, if everyone living in the project is assumed to be the project beneficiaries, then project in-country costs averaged under \$2.00 per inhabitant. But a smaller segment of the target population actually receives health services first hand, and these PVO projects generally focus on small populations (under 60,000), thus increasing per capita costs. In-country costs per direct beneficiary ranged from \$30 per direct participant (anyone who was actively involved in education, food aid, income generation, or agricultural activities) in MFM/Honduras up to the \$3,700 per physician trained in tertiary eye care by IEF/Honduras. It cost \$55 per child in the ADRA/Haiti growth monitoring program, \$89 per child admitted to a clinical program, and over \$100 for each participating family or mother continuing in the longer-term MCH program. The cost of training each paramedical in primary eye care in the Philippines was about \$54, but more complete eye care training in IEF/Honduras costs about \$113 per capita.

MSH did not compare the costs of these projects with costs of other private or public sector health programs, so it is unfair to draw general conclusions about the field project expenses of all PVOs. The field operations of PVOs sometimes appear to be costly when compared to governmental programs which count large populations as beneficiaries (when, in reality, few people benefit). Compared to bilateral AID programs managed by contractors, PVO costs appear low, largely because dedicated PVO personnel work at low pay scales without costly home office supervision. But home office technical support and management of some PVOs is under-funded and given too low a priority in the PVOs' budget process. In such cases, management's effectiveness and efficiency might be increased by increasing its share of program funds.

PVO project management at home and field offices would also be more efficient if each PVOs' projects were located more rationally in countries and communities selected according to developmental rather than geographic considerations. The next step would be to build upon a local success and expand outward to adjacent villages rather than moving on to another region or continent. Local health needs should be at least as important as the PVO's need for publicity. It makes little sense for a PVO to invest as much money per beneficiary in a tiny country overrun with other PVOs where infant mortality is 25 per 100 as it invests in another country where infant mortality is four or five times higher - particularly when neither the communities nor the MOH in the country with low infant mortality show particular interest in PHC.

Projects should also be located closer together. Managing many small projects in far flung Third World countries, and in many small, widely separated corners of those countries, increases costs of travel and administration. More and varied staff are required with different cross-cultural and language skills:

Unfortunately, wide dispersion of PVO projects is nearly universal among PVOs. There is no easy or immediate solution to this problem, given publicity and funding requirements, but it needs to be faced if cost-effectiveness of PVO programs is to be improved over time.

IV. MANAGEMENT

A. Planning

Careful planning is obviously vital to PVO health project management--particularly in innovative, experimental PHC projects. PVOs usually work in areas unaccustomed to public participation in health planning; their approach usually requires some level of community and MOH participation (frequently a slow and difficult process) as well as multisectoral coordination and cooperation.

In fewer than half the projects, project designs were drawn up after careful assessments of local health problems. These were done in collaboration with local institutions, particularly with the Ministry of Health, before project activities got under way. This process helped ensure not only that the projects' goals were appropriate and realistic from a public health viewpoint, but also that potential administrative and political problems would be avoided. Only a minority of PVOs, in these projects at least, seem aware that effective institution-building begins with collaborative planning by all those who have a stake in the project (or in its replication).

When all 13 projects are considered together, it is clear that the process of planning individual country projects needs improvement. Several plans were vague and/or unrealistic in their objectives, strategies,⁶ and tasks, and remained so even after the projects got under way. Few of the PVOs based their plans on careful data collection and analysis. Even those PVOs which utilized annual anthropometric surveys in the design and evaluation process, planned various interventions (health education, agricultural training, etc.) without adequate analysis of data to determine what specific behaviors needed to change, and which of those behaviors could be changed through education alone. None of the PVOs which did baseline surveys predicated site selection on those surveys, but rather on mixed, largely subjective criteria. They also failed to base their educational materials or strategies on analysis of data.

The varied approaches to planning and design by the seven PVOs illustrate the importance of project-specific planning. The few PVOs which began their projects with thorough assessments of local health problems drew up project plans including objectives, outputs, and work schedules. But most project planners did not draw up specific work plans or schedules, and did not target specific outputs. Partly as a result of the evaluation, one PVO recently introduced a list of specific, measurable objectives, other PVOs are now undertaking or analyzing baseline surveys to prepare for future measures of impact.

The constraints to effective planning may have arisen partly from limitations in AID's system for reviewing Matching Grant applications. AID approves a single proposal from each PVO which embraces activities in a number of widely different countries. MG proposals may be presented without country

specific plans and logical frameworks usually required in AID project documents. Most PVOs do not submit more than the briefest country or project specific plans to AID for approval.

Because an AID Matching Grant lasts only three years, FVA has put pressure on PVOs to begin implementation quickly in order to demonstrate activity and produce early results. More often than not, PVO staff have had neither the time nor the resources to do the background analysis in each project site which would enable them to plan each project in detail before beginning implementation. In addition, because of the short funding period, PVOs find it difficult to revise plans and make the mid-course corrections which are appropriate even in well-planned projects.

B. Staff Performance

Detailed analysis of staff effectiveness should distinguish among various types of key personnel: home office from field staff, paid staff from volunteers, expatriates from nationals, project managers from health specialists, and clinic-based from community-based health workers. In the absence of such analysis, generalities about the performance of PVO staff are difficult.

Generally PVO projects are small enough that the staff who manage them at home offices and implement them in the field play an unusually important role in determining those projects' effectiveness. Dynamic, charismatic field project directors are often the reason why particular projects are seen to be "successful." However, some projects suffer because an energetic expatriate does not train local staff or does not delegate effectively, or if generalist project managers do not have the specialized technical assistance in PHC which they require. In such cases, project leadership seems impressive but opportunities for developing sustainable and replicable PHC subsystems may be lost.

PVO health services and personnel are frequently compared to those of the public sector. Many public sector health program staff often do appear less skilled, motivated and committed. Often PVO in-country personnel seem more dedicated to their work, more willing to make extra effort. Several evaluators remarked on the extraordinary devotion of some outstanding PVO staff. At community level, health workers sponsored by PVOs sometimes appear to be more respected by the community for delivering quality health services than their public sector counterparts.

However, such comparisons are misleading. PVO staff are usually able to concentrate their efforts in relatively small target areas - which governments cannot do. Also, because PVOs can normally spend more per beneficiary than the government (see above, page 13), PVO staff may have better support, supervision, supplies, and facilities than public sector health workers. The PVOs' superior services and special commitment may reflect higher costs which prevent replication on a large scale.

Nonetheless, at higher professional levels several evaluators found that the expatriates and nationals who manage PVO projects are usually respected, hard-working, and, for the most part, technically competent. Many have graduate or nursing degrees, some have medical degrees, and most expatriates have several years' experience in developing countries. For example, IEF's only staff in Malawi were two highly specialized surgeons who did most of the eye surgery in that country; PCI's Medical Director in Guatemala was one of very few women physicians in that area.

Some PVO management staff in the field tend to be either development generalists who need technical assistance from health specialist, or experienced clinical practitioners who need more training in PHC management. In both cases, the evaluators generally agreed that many PVO managers need technical support in designing specialized subsystems such as VHW training and supervision, drug management, community participation, and information. PVO health professionals sometimes seemed overworked at providing hands-on care and did not pay adequate attention to planning and monitoring projects. Even the most experienced PVO doctors and nurses rarely had the training or experience needed to implement all the specialized components of a complete PHC system.

Despite their skills and personal qualities, some PVO staff sometimes seemed overworked and unable to pay adequate attention to planning and monitoring projects. Some seemed inexperienced in the management of institution building; for example, some do not work closely with local or national government officials or are not training local counterparts to eventually take their places. They often complain that adequately trained nationals willing to work in remote areas are difficult or impossible to recruit and retain.

Some PVO staff still see their work more from a traditional missionary perspective, as short-term, temporary "relief," rather than as long-term development in collaboration with host-country counterparts who should take over project management. While medically experienced, they were not accustomed to managing a PHC development process based on community participation and aimed at eventual self-reliance. The traditional PVO desire to "do good" and stay indefinitely (instead of transferring technical and managerial skills and low-cost technologies to the host country within a limited time) is fading, but it has not disappeared entirely.

C. Infrastructure

Some PVOs have a large staff and infrastructure (buildings, vehicles, etc.) already in country, usually involved in secondary or tertiary hospital-based care, which can be mobilized quickly for new PHC activities.

- In Tanzania the Adventists have three large hospitals plus over a dozen clinics throughout rural and urban areas with doctors and in-patient services; these are now the base for community outreach activities into adjoining communities. VHWs are supervised and supplied by these clinics, where they spend a day or two each week, and to which they refer patients.
- In Haiti, Adventist clinics in poorer towns are the focus of maternal/child health activities which would not otherwise be available, supplementing under-funded, poorly staffed government hospitals.
- In Pakistan all of SAWSO's seven health centers are now, with both Matching Grant and Child Survival funds, the base of operations for VHW activities in outlying areas. Unfortunately, many project villages are so far from these clinics that travel time and costs present a major constraint. However, to SAWSO's credit, health workers from outside do visit these villages often, and SAWSO is working to recruit village-based workers where possible.

PHC projects built on this existing staff and infrastructure are probably far less costly than setting up new PHC systems from scratch. Some expatriate staff have lived in the project area or country for years and are comfortable with the local language, culture, and living standards. But to change from a hospital-based to a community-based PHC system is not accomplished easily. Organizations like SAWSO and ADRA face special problems in expanding their PHC outreach. For example, experienced expatriate nurses, who are working up to 60 hours a week in stressful clinical work must in addition train and supervise PHC workers. While a public health planner from the home office may be convinced that a nurse's work-load will lighten if she can train VHWs to screen out patients with minor problems, the nurse often believes it is more urgent and important for her to cure the sick. A few of the high level health professionals contacted during these evaluations were so immersed in curative care that they were unable or unwilling to find time to train others to help them.

Nearly all project directors and (in over half the projects) their national counterparts were carefully selected, competent, and committed. The PVOs vary in their balance of expatriate and host country staff. One end of the staffing spectrum was represented by the two MFM₈ projects which have no full time expatriate staff in country. The other end of the staffing spectrum is represented by SAWSO/Pakistan, where only two of the project's 15 top staff members were nationals. SAWSO staff have not been able to recruit or train host country counterparts to replace them, and plans for building a strong indigenous institution are unclear. Most of the PVO projects, however, have one or two expatriate staff working with local counterparts and other officials. Most are making progress toward training host country managers, though a few do not see "nationalization" of staff as a high priority.

D. Monitoring and Information Systems

Poorly defined objectives and data deficiencies have affected the design, implementation, and evaluation of most projects. As mentioned, very few projects utilized baseline data to design appropriate interventions. Several PVOs appeared weak in ongoing project monitoring, their only means of knowing whether their training of PHC staff was effective. Some collected excessive data and did not analyze it appropriately. Others collected too little. In few cases were data used to provide useful and timely feedback to managers or staff about project strengths and weaknesses. In only two projects were data used to build public awareness. Too often, monitoring and evaluation were seen more as a liability, an obligation required by headquarters or by AID, instead of an asset, a tool for management to improve effectiveness. Less than a third of the projects had outside evaluations during the last grant period. Even when outside evaluations were done, few of those evaluations' recommendations seem to have been acted upon.

Some projects, including those which seemed well planned, did not reach some output targets. Often this was a result of a deliberate and appropriate change of plans, to the benefit of project recipients. However, AID/Washington was rarely kept informed of such changes. The PVOs and AID do not have in place an effective information system for monitoring and documenting changes in outputs planned and achieved. This is unfortunate because these changes often reveal important findings about what does or does not work in PHC, and about PVO effectiveness.

In ADRA/Haiti, for example, the number of mothers receiving food aid was less than expected, as was the number of income-generating projects being established--largely because ADRA/Haiti was still experimenting with the optimal mixes of target population size and program cycle duration, and was also re-examining its capacity to do an effective job with income-producing activities. In MFM/Honduras Applied Nutrition Program (ANP), similar planned outputs--mothers and children participating in nutrition programs and mothers' groups organized--generally exceeded plans. These are typical examples of the kinds of changes taking place in all PVO projects which might improve project planning and replication if they were better understood.

Time-consuming record-keeping often burdened the PVO staff who resent it particularly because they get no feedback from program managers about their work or progress. They rarely saw any useful purpose in filling out forms, and in fact there often was none. Medical Assistants in Malawi and VHWS in The Gambia and Pakistan, for example, complained to evaluators that reporting took up a substantial amount of their busy day, that they never heard from their supervisors about the data they collected, and that they know of no project planning which had resulted from it. Sometimes the amount of data being generated could not possibly be analyzed by the small staff available.

In short, most PVOs need timely, accessible, and agile data which might constitute indicators for project management and evaluation without major demands on personnel time. Such monitoring systems would not only generate appropriate reports to management, but would also ensure that information is fed back to front line staff, especially VHWs. Reporting to the general public a few selected statistics to which will have meaning to them like the number of malnourished children, infant deaths or births, or the number of latrines or water pumps - also makes health workers more likely to take an interest in collecting and reporting data.

V. BUILDING LOCAL CAPACITY

To increase the long-term effects of their pilot programs, PVOs should not be concerned solely with the provision of health services. The building of local capacity to provide health services on their own, phasing out foreign assistance is perhaps equally important but often is given low priority in the face of immediate needs. Two concepts are important to the attainment of this objective. The first is sustainability: the project must have managerial, technical and financial resources to maintain itself. The second is replicability: strategies learned and insights gained by the PVO can be adapted and expanded to new target areas or nationwide.

PVOs differ widely in their approach to building local capacity. Some PVOs, particularly the traditionally missionary groups with existing clinic systems (in this report, ADRA and SAWSO), are to develop their own internal organization's PHC system, and replicate projects in new areas under their own management. Others attempt over time to develop external indigenous institutions, public and private. Examples include MFM, PCI, and, SCF. Each of these organizations have stated a commitment to ensuring the project's ability to maintain itself after foreign PVO support has been phased out; however, success with this objective is still very limited.

Both internal and external approaches to local capacity building are important; the most appropriate approach will depend on each local situation. Mission hospitals in many developing areas need AID support to build PHC outreach, while ministries of health need specialized PVO assistance in improving PHC subsystems. In both approaches, the PVO needs to train local staff to replace expatriates, build community participation and support, and control costs in order to have maximum effect.

The highly desirable development objective of building local capacity through sustainability and replicability can be a difficult one to accomplish. At a minimum it requires: (a) effective training of host country nationals at all levels including management, (b) installing appropriate systems of financial control, (c) effective linkages with other organizations, (d) meaningful community participation and (e) payment of salaries adequate to maintain staff continuity. Progress toward this objective will depend to some degree on specific country conditions with factors such as the level of human resource development, the financial ability of the community to offset costs and the community's isolation all being important.

However, in most cases these constraints can be challenged if the PVO begins at the outset to build institutional development objectives into its program plans and sets a target date for the transfer of responsibility to local managers. Few PVO projects have taken such specific steps.

Progress toward local capacity building has been reviewed in terms of three critical aspects: training, relations with other institutions and community participation.

A. Training

All PVOs working in remote areas faced shortages of trained host country manpower willing to work in rural project sites. They therefore placed strong emphasis on training local recruits. They recognize that the first step to developing local capacity is to train local counterparts who can eventually replace expatriates. Several excellent training programs make outstanding contributions to local capacity building as well as to the communities served. For example, in projects run by HKI, IEF, MFM, and PCI, selected regional health management staff and support staff, nurses, and VHWs under the MOH received coordinated training under PVO guidance. Training outputs in some projects exceeded project plans and exceeded the MOH's ability to employ all those qualified. Other projects (ADRA, SAWSO, SCF) trained their own health or multipurpose development workers in particular impact areas, sometimes in collaboration with training programs of the host government or other PVOs.

HKI/Philippines and MFM in Honduras and Thailand designed exemplary training for government management and technical staff. In those projects expatriates were involved in training only as short term trainers. MFM projects, the only ones evaluated which have no long term expatriate staff, nonetheless reached their training objectives. HKI/Philippines developed a superior eye care training program for primary health workers, now functioning without expatriates, using only MOH trainers and local materials. The training can be sustained at low cost without HKI support and will be replicated in other regions of the Philippines in the future.

B. Relations with Other Institutions

In most cases the replicability and sustainability of PVO projects depends partly on the PVO's ability to work in collaboration with either the host government, indigenous PVOs, or other health-related institutions. Ministries of health can often learn PHC strategies from PVOs which have been able to test those strategies independently. PVOs may need to collaborate with both governmental and nongovernmental institutions in other sectors (such as agriculture, water and sanitation, and education) which have a direct effect on health standards.

The PVO projects studied varied significantly in their relationships with governments. Both MFM projects, three of the four PCI projects, and the SCF and HKI project all collaborated very effectively with regional MOH officials, with staff actually working in office space in the regional office alongside staff paid by the MOH. IEF works closely with central MOH offices, and uses offices in the governments' main hospitals. These PVOs' projects are likely to be replicable on a large scale because of their efforts to collaborate with local and national officials who learn (and take responsibility for) the PHC methods used. On the other hand, PVO experience shows that working closely with the MOH does not guarantee that it will adopt effective PHC strategies.¹⁰

MFM, PCI, and HKI all worked effectively with governments because a major goal of their efforts was to improve the capacity of those governments to create and sustain their own PHC systems. Both ADRA projects and SAWSO/Pakistan, in contrast, were working to strengthen their own PHC capability in order to supplement MOH services and were not providing the MOH directly with technical assistance. Both those PVOs seemed to prefer a certain separation from government, while the other four see greater coordination as integral to program success.¹¹

These projects also differ sharply in their relationships with other PVOs; while all PVOs claimed to be concerned to some degree about cooperation among private sector groups, the efforts they actually made to share in project planning or implementation, or to compare project results and learn from each others' experiences, were generally limited. PCI, MFM and the eye care groups are among the types of PVOs more likely to have interorganizational coordination as one of their major organizational goals or strategies, while other PVOs appear to tend toward greater independence, even isolation.

Again such differences seem to stem from different organizational traditions and philosophies. Older, clinic-oriented organizations like the Salvation Army are accustomed to operating comprehensive self-reliant systems, complete with their own subsystems for staffing, transport, drug supplies, housing, and the like. They do not usually put as much emphasis on collaboration with other PVOs as the younger PVOs, which seem more concerned about building up local capacities by sharing project management responsibilities with other private institutions including indigenous PVOs.

In some cases self-interest has prompted these PVO projects to cooperate: where they are active government assisted associations of health sector PVOs like those in Belize, Guatemala or Malawi, meetings with other private groups are a regular and important opportunity to do business. Sometimes one PVO relies on another to provide certain specialized training. But the degree of actual cooperation between the projects evaluated and other non-government health or development organizations is sometimes limited.

The result is that PVO projects sometimes fail to learn from each other and may miss the opportunity to build a stronger private health sector because they are reluctant to see health systems development as a team effort.

C. Community Participation

Participation of beneficiaries in the design and implementation of PHC projects is important if the beneficiaries are to accept, support, and sustain them. The evaluators were concerned whether participation is a reality in most PVO health sector activities.

Ten of the thirteen projects evaluated involved community-based services. The most effective participation was being implemented by MFM, PCI, SAWSO and SCF. Many people in the community were directly affected by these projects. Nearly everyone was at least indirectly affected by them, and all were aware of them. In the SCF and MFM projects, a wide range of people had participated from the beginning in research and planning and continued to work actively for the program. The effects of that high level of participation were evident everywhere. Self-supporting womens' groups planned, managed, and funded their own income generation projects. Farmers, midwives, school teachers, as well as community health workers of both sexes, gave and received health-related education and had regular contacts with local PVO staff.

SCF/Bangladesh's Integrated Rural Development approach had the most highly developed system for ensuring community participation. Village development committees (VDCs) are required for SCF "impact areas" and must include such frequently neglected groups as women, the poor, and the landless. VDCs seem active and effective; in fact, the evaluators recommended that SCF could phase over project control to the VDC in at least one of SCF's 17 villages.

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

PCI also achieved high participation levels in The Gambia, where active village health committees chose, monitored, and occasionally fired VHWS; and in Guatemala, where mothers' and fathers' committees acted as low profile health workers when political violence threatened the lives of high profile VHWS.

Other projects appear to have had mixed results in involving their beneficiaries.¹² HKI/Philippines, a project totally integrated into the government's PHC program, utilizes community health committees which the MOH has set up but which do not appear very effective. There are few indications that the committee members encouraged the use of eye services or

played any role in planning or monitoring eye health activities. SAWSO/Pakistan also worked with community groups in some of its villages, but in most villages these groups were being informed of the project's activities without becoming participants in them. In one village the committee was very active and raised money; in another, the committee was critical of SAWSO. These projects, like most of the projects evaluated, did not have a systematic strategy for monitoring VDCs (as did SCF) or for involving traditional practitioners in VDCs (as did PCI).

D. Findings

The projects evaluated which seem to have the best chance of continuing without foreign assistance are those which were designed to strengthen and expand existing health activities. They focus on training host country staff, and on strengthening collaboration between private and public sector organizations. Most work closely with local or national governments. Most have plans to recover an increasingly large share of project costs from the beneficiaries or from government. The projects of MFM, PCI, and HKI were all planned from the start to build on existing health programs and to train existing health workers. Each improved upon a system already in place, combining both private and public sector resources, and generally avoided creating new structures or new recurrent costs. Each is likely to expand to new areas in the next year or two and each would probably be continued indefinitely by the MOH if the PVO ended its involvement.

A good example of such a self-sustaining project is PCI/Gambia. PCI provided technical assistance to the MOH for five years to develop an impressive PHC system of trained VHWs, active VDCs, frequent supervision by nurses, and patient referral to clinics. Host country nationals were trained as health trainers and project managers on regional and national levels. Villagers participated in selecting and monitoring health workers, and paid for drugs

PCI in The Gambia was not without problems; the MOH had a low budget and appealed to the World Bank to strengthen PHC. But the PHC system was established; it demonstrated effectiveness in providing first-line care to unserved areas; it won wide support from the village to the MOH; and it began to recover some of its costs. Although the project could have benefitted from PCI's continued presence, the effort nevertheless demonstrated that at least one PVO was able to help an MOH develop and expand to remote areas a functioning PHC system.

Other projects appeared less sustainable. SCF's careful creation and supervision of VDCs in Bangladesh, for example stood out as a promising approach to truly representative village participation, with women and the poor required to be represented. Yet this VDC system took many years to develop. It required continuous oversight - and occasional control - by SCF headquarters in Dhaka. None of the SCF impact areas in Bangladesh was considered by headquarters to be ready for self-management or self-financing. Of 17 SCF villages, not one was phased-over to local control;

all remain under SCF tutelage and sponsorship. In ten years, not one new impact area had replicated the SCF approach.

Development of a self-sustaining system did not appear to have high priority at SCF's national office. An SCF committee set up to monitor "phase-over" had become inactive. In short, although the SCF strategy is very effective in building local participation, it appeared unlikely to become managerially self-reliant for some time to come.

The SCF strategy also raises questions which need further study regarding the sustainability of its costs. Because of SCF's fully integrated multi-sectoral approach, the average in-country expenditure per beneficiary of SCF/Bangladesh was more than three times higher than the average of all projects evaluated. The project as a whole cost \$238,000 (in-country costs only), twice as much as the average annual in-country project cost for all projects evaluated (\$96,000). Thus at both the village and national levels, SCF's CBIRD system, though progressive and promising, appears relatively costly. None of its impact areas seem likely to become self-financing in the near future. Nonetheless it may be a cost-effective approach to improving health and nutrition in the short term despite its costs because of its high level of local participation. Comparative financial analysis of these and other PVO strategies would be very useful.

The ADRA and SAWSO projects were focusing on building their own internal capacity; they do little to train staff from other organizations or government in their target areas. While the three projects are quite "sustainable" as long as foreign support continues to flow, there is no evidence of progress toward phasing out foreign funding or technical assistance. The ADRA projects have been more effective in recruiting and training host country managers, but none of the three projects worked closely with the MOH. The ADRA and SAWSO projects will replicate their own strategies by expanding PHC to new areas where they already have health activities under way; but they have done very little to replicate their approaches in other institutions.

These projects did not focus enough on building local capacity partly because FVA had not strongly encouraged them to do so. Future MG reporting requirements could include specific information indicating the project's progress toward local institution building. Reports could include, for example, a specific timetable for phasing over control by a certain deadline; monetary and other indications of beneficiary and public sector support; adequate quality and quantity of national counterparts; building on existing infrastructures and avoiding the creation of new or overlapping systems. FVA has rarely been concerned about tracking such indicators of local capacity building in the past. The time has come for both FVA and the PVOs to realize their often professed goal of building self-reliance.

VI. SPECIAL ISSUES

A. Constraints

Most of these projects faced formidable barriers to improving health and well-being. A major constraint in most projects involving rural PHC outreach was the lack of trained host country and expatriate manpower, particularly in the areas of PHC management and training, as well as in several specialized technical fields. The top staff of most projects are expatriates who have heavy responsibilities and few local staff to whom they can delegate. For example, PCI/Belize and SAWSO/Pakistan face great difficulties recruiting qualified local nurses. In ADRA/Tanzania, the Tanzanian Project Director has no support staff; he relies on his wife who volunteers to help keep the project's books and health service data. In many projects it is difficult to recruit and retain trained health workers for rural posts, even if qualified candidates and funds are available, because they prefer urban posts. Single women are reluctant to move from their homes to remote areas, and married women need to stay with their husbands.

All projects also confronted serious national economic situations--particularly in Bolivia, Guatemala, Haiti and Tanzania, where food, fuel, and medical supplies often ran dangerously low. For example:

- In Bolivia, PCI worked with the eighth new government in six years, an average of 23 strikes per month, and annual inflation between 300% and 2000%.
- In Haiti crushing poverty and unemployment limited the chances of ADRA's nutrition program recovering its costs through service fees or income generation.
- In Tanzania, ADRA's top staff were unable to visit remote project sites because of fuel shortages. VHW Supervisors' motorbikes were grounded at least one-third of the time, preventing proper supervision, while the project director was forced to spend hours queuing for fuel rations each week.

A lack of effective governmental organization and support or a government's limited ability to support multisectoral programs obviously makes institution-building difficult.

- In Honduras, the MOH did not establish a system for assigning and utilizing nurses trained in eye care by the IEF. The results were that many trainees were reassigned to other health work, their specialized skills often wasted; program effectiveness could not be measured (except indirectly in terms of increased utilization of eye clinics); and IEF eventually terminated the project.
- In Belize, PCI organized an active District Health Committee which met monthly to coordinate primary care activities in Toledo District. In contrast, the National

Primary Health Care Coordinating Committee, in which PCI actively participates, has not been effective in developing concrete plans and adequate budgets to replicate PCI's Toledo PHC program throughout the rest of Belize.

- In Pakistan and Tanzania, SAWSO and ADRA respectively run multisectoral programs which integrate health into other sectors; yet both ministries of health typically do not coordinate their programs well with other ministries, thus complicating coordination with the two PVOs.
- In the Philippines cuts in MOH drug supplies meant shortages of essential eye drugs for HKI.

Religious and cultural friction present barriers as well. In Pakistan tension between Moslem and Christian communities caused difficulties for SAWSO staff working in both while political violence threatened health workers in the Guatemalan and Philippines projects:

- In Guatemala, PCI's VHWS resigned when community leaders and development workers were threatened by extremists for attempting community organization, resulting in the creation of community "committees" of numerous health volunteers who could not be singled out for retaliation by either political extreme.
- In the Philippines the anti-government forces limited the effectiveness of some government health activities, but it was a sign of the degree of local support for HKI's primary eye care program that eye care activities were always permitted, if not encouraged, by the rebels.

B. Benefit Distribution

All projects studied were faced with the difficult problem of reaching those too poor, too remote, or too sick to visit VHW posts, health clinics or food distribution points. These projects must make difficult decisions between clinic based demands for curative care, often more likely to help better educated or healthier families, and home visits which take more time per family but often attend to the needs of the most marginal portions of the population.

All projects seek to make their services accessible to the poor, illiterate, or elderly members of their communities. Most showed clear evidence of reaching some of the most needy segments of their communities. All PHC projects had begun to demonstrate effectiveness in stimulating improved nutritional knowledge and behavior among the poorest families. All PVOs work in poor areas, some with villagers who have been completely cut off from government health services. All community members were being treated equally and seemed to have the opportunity to benefit equally.

C. Innovation and Technology Transfer

These PVOs share several innovative features. Foremost is their PHC approach, which fits AID priorities by emphasizing disease prevention through basic health education, immunization, nutrition, and sanitation, and by focusing maternal/child health care (MCH) on infants, children and women. In countries where hospital and clinic-based care is the rule, and a small proportion of the health budget is spent on community-level public health, these PVOs set an important example by reversing that imbalance.

All projects evaluated were using proven health and nutrition technologies already tested elsewhere in the same countries or in other countries, so in that sense they were not now considered innovative. Yet in all projects evaluated, most of the PHC or nutrition approaches being introduced were new to the local community. The need to innovate responds partly to the recognition of the special problems of remote, rural locations which public-sector PHC programs reach with difficulty, if at all. The innovativeness is also a result of most PVOs' multisectoral approach to development, which is hard for government entities to implement, even where the concept is accepted in principle. The PVO ability to at least attempt this "horizontal" approach results in predominant preventive health and nutrition activities being combined with secondary activities in such sectors as agriculture, irrigation, sanitation, family planning, and PL 480 food aid, which expand or supplement more traditional curative, clinic and hospital based programs. All projects provided good examples of such innovation through integration.

Unlike most other PVOs which emphasized health and nutrition for more than other sectors (and were selected in this evaluation series because of that emphasis), SCF/Bangladesh emphasized such sectors as agriculture, small enterprise, womens' groups, and education equally with health. Only 13% of total project activities were directly related to health. While SCF's strategy of Integrated Rural Development put less emphasis on PHC than some other PVOs' approaches, it nonetheless came closer than other organizations to actually demonstrating its impact on infant and child mortality. SCF's innovativeness was found in its rigorous balancing of sectors, preventing health work from absorbing more than its share of resources. Further evaluation is encouraged to determine whether SCF's fully integrated approach, though more costly, is, as discussed above, more cost effective in improving health.

Many other PVO programs have introduced special innovations suited to particular areas:

- o In Tanzania, ADRA's nutrition program organized volunteers in several villages to rebuild a broken irrigation system, and is providing integrated health, sanitation and nutrition education to families to ensure that the irrigation will lead to better health.

- In Honduras, MFM helped the government and private firms to introduce new types of smokeless cooking stoves and family-size silos in addition to new farming methods, all of which are likely to have an impact on family nutrition.
- In Guatemala, PCI provided seed money for revolving loan funds to small business cooperatives which sell smokeless ceramic stoves that pay for themselves by saving on costly firewood, and benefit health by decreasing smoke inhalation and preventing burns. The cooperatives also sell and help build specially designed health-promoting composting latrines which pay for themselves by producing valuable fertilizer for growing food.
- In Bangladesh, SCF village workers have introduced new types of water pumps for drinking and for irrigation, new seeds and fertilizers, and new breeds of fish and livestock, in collaboration with the MOH and UNICEF.
- In many countries, HKI and the IEF provide primary eye care treatment and Vitamin A capsules to children who might otherwise go blind. This low-cost technology may also protect children from both lung and gastro-intestinal problems.

D. Policy Dialogue

Many developing countries' health ministries cling to inefficient health policies, but these PVOs are demonstrating to governments that it is more efficient and effective to develop alternative PHC delivery systems which are community-based, not hospital-based. PVOs which work within government offices appear to have the most direct effect on local and national government policies: organizations like HKI, IEF, MFM, and PCI not only demonstrate systems for developing primary care programs and training primary care staff and supervisors; they actually provide long-term, day-to-day assistance within the ministries of health, to ensure that plans are implemented and sustained over time.¹⁴

Other PVOs which do not have staff working within MOH offices affect health policy changes less directly by setting up demonstration projects which show governments the strengths of the PHC approach. ADRA projects are good examples of that demonstration approach. Other PVOs affect health and nutrition policies by closely involving health ministries in different aspects of their programs. SCF/Bangladesh relies heavily on existing government hospitals, clinics, immunization teams and reporting systems, thereby strengthening those public sector activities, while simultaneously demonstrating bottom-up approaches at the village level.

These seven PVOs vary widely in their ability to communicate with public policy makers. The evaluators normally gave highest marks to those PVOs which work most directly with local governments. But it is also important to recognize the vital policy dialogue being carried out within PVOs themselves. PVOs like ADRA, IEF, and SAWSO, which continue to provide urgently needed clinical care to millions throughout the world, are now making a slow, unavoidable transition toward increased community-based primary care. That change is taking place far more rapidly because of AID's support, and represents a significant policy dialogue in its own right.

E. Unplanned "Spin-Offs"

Several projects report useful initiatives which were not originally planned but emerged as a result of local circumstances. Some examples:

- PCI/Bolivia's drug supply system, a component of its PHC project in Oruro, proved so effective that the MOH asked PCI to replicate it in Cochabamba, and perhaps nationwide.
- ADRA/Tanzania's irrigation scheme in Parane grew out of discussions with village leaders about their food needs.
- IEF's physicians in Malawi trained eye care specialists from southern and eastern African nations while developing a local blindness prevention program.

PVO projects often have a flexibility to deal with unforeseen events which is lacking in large government projects. As mentioned, PCI/Guatemala's VHWS became inactive when threatened with retaliation by extremist groups so PCI created "committees" of mothers and fathers who volunteered to lead health and nutrition discussions among their neighbors and refer malnourished children to nutrition centers. The energy and enthusiasm of those committees are evident; they illustrate the importance of mobilizing citizens to support PHC as well as the ability of most PVOs to react creatively to changes in the project environment.

F. Private Sector

PVOs promote the private sector role in public health simply by providing better health services independently from the government. But several projects involved in policy dialogues within governments have been instrumental in encouraging health ministries to seek fuller participation of the private sector in health and nutrition programs. For example:

- Meals for Millions' Applied Nutrition Programs in Honduras and Thailand involve many private organizations such as agricultural and marketing cooperatives, farmers' and womens' groups, religious organizations, trade unions, plantations and shopkeepers, in joint efforts to improve local nutritional standards. In the process, new small enterprises have grown up in the region and the program has improved several existing businesses.
- Helen Keller International has helped the MOH in one region of the Philippines to establish a cooperative surgical system in collaboration with local private ophthalmologists: the surgeons use otherwise underutilized hospital wards and the government's expensive surgical equipment for their private patients, and in return operate on indigent patients without charge.
- Save the Children in Bangladesh has begun to demonstrate how private sector collaboration in community development can improve the financial sustainability of health services while increasing profits to small enterprises. Village development funds are loaned to small businesses (e.g., food processing or fish ponds) which eventually return profits to the village development committee, which in turn pay stipends to community health workers.

VII. SUMMARY OF CONCLUSIONS

A. PVO Strengths in Health and Nutrition

1. PVOs which had previously devoted a majority of their resources to clinic-based curative care are now, with support from AID/FVA, emphasizing community-based primary health care.

These evaluations reveal that the past decade has brought major changes in the health strategies of AID-assisted PVOs. Many of them, like HKI, MFM, PCI, and SCF, were founded decades ago to provide emergency relief to refugees or disaster victims, or food to victims of famine. Church-related organizations like the Salvation Army and the Adventists, in addition to providing relief, concentrated on developing a network of mission hospitals and clinics, staffing them with expatriate doctors and nurses, and training local staff in curative care. For decades these missions have continued to be a vital part of national health systems in many countries.

Since the mid-1970s, however, there has been increased recognition among all these PVOs of the inefficiency of health systems in which medical personnel wait passively behind clinic walls for patients needing treatment. There has been concern among many PVOs that emergency relief and feeding programs must be recognized as temporary solutions to long term development needs. And there is a clearer sense of the range of economic, political, and socio-cultural factors affecting health.

The result, spurred on by funding from AID/FVA, has been the emergence of the new PHC strategies analyzed in this report, emphasizing a low-cost combination of preventive health education, basic curative care, and referral--all centered on community health workers and community development committees, supported by community contributions. PVOs have not yet documented the impact or cost-effectiveness of PHC during this first decade; however, great improvement can be made in the future if more funding is available to be allocated to this task. More importantly, PVOs have already sufficiently demonstrated the effectiveness of PHC to convince many ministries of health to initiate PHC programs of their own.

2. Many PVOs are providing appropriate and effective health services, sometimes within the context of broader, multisectoral development.

Each of the 13 PVO projects was providing appropriate low cost rural, PHC services focused on maternal and child health and community based prevention. Three projects focused on strengthening secondary and tertiary eye care. All seven organizations evaluated had successfully introduced new low cost health technologies such as ORT, growth monitoring, cataract extraction, family planning, clinic record systems, water and sanitation systems, training methods, literacy classes, even an agricultural loan fund. In nearly all cases, interventions are targeted directly at the village level.

The effectiveness of the projects has varied, and is difficult to measure. In most cases, it was difficult for the PVOs to devote resources to measuring impact, but the projects have definitely improved the quantity and quality of PHC services in many remote areas. In several projects reduced levels of malnutrition, and in one project reduced infant mortality, could be demonstrated statistically. Overall, the seven PVOs clearly serve a useful purpose in training health workers and improving the quality and quantity of health services. These projects are particularly valuable if seen as pilot tests of new PHC approaches which other private and public sector organizations can replicate elsewhere.

3. PVOs often reach areas unserved by governments.

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

4. PVO staff tend to be highly committed, culturally sensitive and increasingly likely to be technically well qualified.

PVOs share strong traditions of service and dedication, some dating back decades. Many staff members have intimate knowledge of the developing areas, cultures and languages where they work and live. Compared to many other Americans in comparable non-PVO, non-Peace Corps technical assistance positions overseas, PVO staff are more willing to live less expensively and in rural areas. Because they are, in general, less susceptible to political vicissitudes, most PVOs have the organizational sustainability and public support which governments do not always enjoy. Some PVO staff are highly skilled health professionals, and those who are less experienced or specialized in particular PHC subjects or subsystems are steadily learning those specialities.

5. Many PVO projects concentrate on developing small, intensive community-based primary care systems.

Most of the projects evaluated have limited target areas where close ties were being built with community groups. Neglected groups like women and the very poorest families were often reached. Few bilateral AID projects have achieved such lasting, direct grassroots action.

6. Different PVOs use different strategies, introducing PHC from the top down, the inside out, the bottom up, or several at once. That variety limits comparability but increases the lessons learned about what works and what does not.

The three types of PVO strategies described above (hospital and clinic-based services, catalysts to governments, and integrated rural development) all seek to improve the quality and reliability of PHC services. But strategies for reaching that goal differ. Some, like SAWSO and ADRA, are building PHC out from their own base of curative oriented clinics and hospitals. SCF is working up from communities where it is refining its integrated development approach to health without much government involvement. The others work up, down, and out simultaneously, with government ministries as their major focus but involving other private organizations and testing pilot schemes in selected communities. All face different obstacles, but are increasing the availability of PHC services nonetheless.

7. Most PVOs evaluated work to improve PHC directly with government ministries of health in regional or national offices.

In such cases the PVO staff is located within the ministry of health, but a few PVO staff are closely tied to such ministries as agriculture, public works, or education. In these projects PVOs work as a catalyst for change within the public sector where, like it or not, most health services in most developing areas get their managerial, technical, logistical, and financial support. The PVOs help these governments develop PHC subsystems in such areas as training, drug supply, or nutrition, and often involve other private sector groups in the process.

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

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

9. At least one PVO demonstrated that health status can be improved by integrating health and health related development programs.

Through building water supplies, stoves, and latrines, improving farms and gardens, teaching literacy to women and nutrition to fathers, PVOs have tested a wide range of indirect strategies to improve family health. SCF in particular seeks to demonstrate the power of an integrated system to improve health.

B. Areas for Improvement

1. PVOs will continue to have only a limited effect on national health status, strategies, or programs as long as their projects continue to directly benefit relatively few people.

PVOs are commonly the first line providers of health care in their communities, testing preventive and primary level interventions which, though usually not new to international health planners, are innovative in those communities. Thus PVOs are uniquely able to experiment, and to report failures and successes in PHC to other institutions and other countries. But many PVOs do not recognize the need to document their findings and share lessons learned. Some PVOs see their health activity solely as an end in itself, when in fact it is at least as important as a pilot test from which other health planners can learn and other programs can be spun off, replicated or adapted. This lack of information sharing seems particularly true of those PVOs which concentrate their resources on internal policy dialogue and capacity building instead of collaborating directly on joint operations with local governments.

2. PVO health information systems are inadequate. There is great need to fully document health needs and progress toward meeting those needs.

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

PVOs have the potential to document their effectiveness particularly because they concentrate on small target areas where accurate data can be collected. Individual households can be surveyed for baseline data on the prevalence of diseases and on health related knowledge

and behavior. The results of projects can be monitored to determine the cost-effectiveness of various PHC interventions. In some cases, these experiments can be controlled. Research opportunities are numerous in these settings (though most PVOs fail to take advantage of them).

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

3. PVO staffing patterns and skills are variable. Some PVOs are understaffed, especially at home offices, and do not provide specialized technical support to the field in primary health care subsystems.

PVO staffing patterns vary according to the size and activities of the project. Overseas, most projects relied primarily on host country staff, few on expatriates; all but three were making progress toward the nationalization of top staff. Project management capabilities varied considerably among the projects. PVOs seem best at providing community-level health care; they are generally weaker in planning and technical analysis, information systems, financial management, management training and supervision. A few programs had inadequate administrative personnel in the field. Many PVOs did not provide specialized training to field staff in technical and management areas.

Home office support capabilities also vary among the PVOs evaluated. Many have been understaffed, technically and administratively. It has been difficult for them to give adequate support to their country programs, especially in primary health care subsystems such as community financing and participation, drug supply, and reporting systems. Field staff rarely call on home office staff or consultants to help them with specialized PHC problems, for three reasons:

- they tend to be independent and used to "making do" with what they have, without relying on outsiders;
- they are often told that the home office has no money to pay for consultants;
- they do not always recognize that specialized experience-based skills are increasingly required to design effective health projects.

Some of these barriers to increased home office support appear on their way to being solved by the recent infusion of AID Child Survival grants, enabling PVOs to hire more specialists in international maternal/child health.

4. Some PVOs' priorities are unclear regarding host country institutional development, and phasing over to local control

AID's policy framework encourages and supports projects which build self-reliance in the host country. Some PVO projects do substantially more than others to help local institutions and individuals help themselves: they train local counterparts who can replace expatriates; they develop health systems which mobilize local resources; and they replicate PHC projects in new areas. AID/FVA needs to decide how much emphasis the PVO projects it supports should put on such institutional development.

If AID considers it essential for AID-assisted health programs to "phase over" control of the project from expatriate to host country control so that the project will become self-sustaining and replicable, it should seriously consider a new emphasis in project monitoring and evaluation.

In addition to closely monitoring the outputs (increased health services) and impact (improved health status) of projects, AID/FVA should develop a formal system to monitor and evaluate institutional development. PVOs would then be required to report to FVA not only essential information on operations, -- how effectively a project improves health standards, -- but also on how much progress is being made toward phasing over to local self-reliance and "scaling up" from small pilot projects to regional or national programs. Along with such periodic reports as numbers of health workers trained, numbers of children immunized, and changes in morbidity and mortality, PVOs could report progress on such activities as community participation, cost recovery, and phase-over to host country management.

Currently these indicators of progress toward institutional development are rarely reported by PVOs with any degree of specificity to FVA: FVA has not yet shown much concern for monitoring such progress, much less requiring phase-over to be completed within a certain period. This is partly because it is considered easier to quantify measures like infant mortality than community participation, and because AID and the US Congress both want simple short-term formulas to gauge PVO effectiveness. Unfortunately the bottom lines in evaluating Third World health systems are not only how well they work, but also who runs them, how much they cost, whether they can be expanded, and how long they last.

5. AID/Washington's leadership in technical review and monitoring in support of PVO projects should be improved.

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

Are FVA staff members responsible for making sure that progress is being made in every country project toward the goals of each Matching Grant? Should the FVA Project Officers be AID's "institutional memory," documenting and disseminating ideas about PVO strengths, weaknesses, and lessons learned? If so, Project Officers need to be able to monitor progress in all sectors in every project in every country of every PVO -- clearly an impossible task.

Given the wide-range of the many centrally funded health-related PVO projects, it is not realistic to expect Project Officers who have many other responsibilities -- and are not trained in PHC -- to monitor the outputs and impact of activities in health. Project Officers do not have the time to review each PVO's annual reports as they should be reviewed, in light of the original proposal, changes in plans, progress reports etc. Major changes are needed in FVA's information system.

The best way to ensure that the AID-PVO partnership improves PVO effectiveness and efficiency is to build an information system which will allow Project Officers to keep abreast of the quantity and quality of project activities (outputs), the effects of those activities on beneficiaries (impact), and related costs (cost-effectiveness). Measures of "phase-over", "scaling up", and institutional development should be as important as measures of health services and status.

To monitor progress in the health sector, a health information system should be set up, and eventually computerized. Moreover, to be effective, it must be at least as useful to the PVO reporting as it is to AID and other donors.

6. The AID project design process forces PVOs to promise unrealistic accomplishments, often in too short a time. Not enough attention is given in design to developing realistic workplans.

The proposal development process tends to produce over-optimistic expectations while, at the same time, leaving gaps in program design. This is particularly the case where new countries are contemplated. No provision is made in the MG proposal process for assuring the development of country-specific plans, though

some of the PVOs produce them on their own initiative. Insufficient time is allowed to develop such plans in the field before completing the project design.¹⁶ Management systems and strategies for community involvement and local institution-building are not adequately addressed, especially in light of the goals of self-financing, cost-effectiveness, sustainability, and replicability. Among the PVOs evaluated, none of their MG proposals addressed these goals with specific plans.

7. USAIDs generally lack knowledge of PVO health activities in their country, except where there is a PVO or PL-480 office.

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

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

8. Some PVOs fail to work effectively with host country public and private sector organizations.

PVOs have had varying degrees of contact with host governments; the advantages of close ties to the host government can vary. Two PVOs (ADRA and SAWSO) tended to limit such contacts.¹⁷ As a result, institutional responsibility and government commitment to supporting those projects had not been established. ADRA and SAWSO are also relatively distant from indigenous PVOs--other than their own affiliates. While they do work with private organizations in some training activities, they do not appear to actively collaborate in implementation. SAWSO does work through an "indigenous" PVO (The Salvation Army of Pakistan). However, that PVO is managed mostly by expatriates and is largely dependent on overseas funding.

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

VIII. SUMMARY OF RECOMMENDATIONS

A. To AID/FVA

1. AID should continue to support, selectively, PVOs working in the health and nutrition sectors and expand that support in well-defined areas.
2. Both AID and the PVOs should recognize, in scheduling and in budgeting, the technical and financial costs of adequate program planning. Time should be allowed for detailed in-country analysis and design to determine proposed objectives, inputs, activities, and outputs. Proposed program design should specify strategies for institution-building and post-MG sustainability, including eventual host country management and cost recovery.
3. Both the PVOs and FVA need to recognize the importance of institutional development, enabling host country individuals and institutions to take over responsibility for each project and scale it up to cover larger areas. AID needs to establish specific measures to monitor institutional development, sustainability, and replicability, and support PVOs which progress accordingly.
4. FVA should require each PVO to demonstrate, through its policies and its actions, a commitment to phasing over control of the project to the beneficiaries and moving into new, needier areas.
5. PVOs and USAIDs should determine with host country institutions how to improve discussion, documentation, and dissemination of project findings and lessons learned to other PVOs, health planners, and host government and AID officials, both locally, nationally and internationally.
6. The unmet need for health care is so widespread that current PVO activities cannot hope to meet it except in a relatively few limited areas. Therefore PVOs need to recognize their responsibilities toward the wider national and international PHC community as well as the community in which they are immediately involved. PVOs in health need to recognize that their work will be most useful if it is replicable, and if their findings are recorded and disseminated. This requires that they communicate with other deliverers of health care, particularly the host government.
7. A simplified health management information system, including specific design criteria and operational guidelines, needs to be developed for PVO, AID, and USAID project planning, monitoring, and evaluation. Categories of quantifiable data and non-quantifiable project information to be reported to AID need to be agreed upon by the PVOs; such information needs to be at least as useful to the PVOs themselves as it is to AID.

B. To PVOs

1. Each PVO evaluated needs to strengthen efforts and tighten schedules to build the skills of nationals, to phase over control of projects to local individuals and institutions, and to scale up from small pilot schemes to large programs. Usually this calls for increased MOH involvement.

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

3. More communication and coordination is needed among AID/ Washington, USAID Missions, host government ministries, and PVOs in the planning and follow-up of projects. PVOs should work more closely with private and public host country institutions to coordinate, monitor, publicize, and replicate projects. American PVOs' ties to indigenous PVOs should be strengthened.

4. Health needs and efficient management, as well as fund-raising requirements, should be considered when PVOs select project sites and countries.

C. Lessons Learned About Evaluation

1. Useful evaluations need measureable objectives. Most PVO projects evaluated by MSH were planned with very general objectives which were difficult to measure. Often objectives were changed during the evolution of the project. Field staff often failed to monitor progress toward objectives, if indeed they were aware of them at all. The evaluators sometimes had to act as policy analysts, helping PVO staff rethink project goals and refine project objectives - not always an appropriate task for an outsider superficially observing parts of the project for only two or three weeks.

Evaluations would be greatly facilitated if in the future, much greater precision is introduced to discussions of evaluation during the design period. The outcome of these discussions should then be formalized in the grant agreement citing in as much detail as possible the measures against which the project will be evaluated and the date(s) for such evaluations. Prior to undertaking the evaluations, the evaluators should meet with technical representatives from the PVO's home office and the FVA Project Officer to agree on the objectives which the project is supposed to have achieved, and on what other issues should be examined which would be of particular interest to the PVO or FVA. Such preparations were unusual in this evaluation series but should be emphasized in future to ensure focus and efficiency during field visits.

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

3. The variability among the PVOs evaluated (e.g., vertical or horizontal programs, health-focused or multi-sectoral) was informative as part of a first effort. But the variations complicated efforts to compare PVOs, especially in the calculation of impact, costs, and cost-effectiveness.

4. Such comparisons were the most difficult aspect of these 13 evaluations. Moreover, the evaluators did not have the time or the authority to compare the results of comparable public and private sector health projects. As a result, it has not been possible to measure objectively the comparative advantage of PVOs in health. To establish the "special niche" of PVOs in the health sector, it will be necessary to focus on more detailed comparative analysis of data, grouping projects to be evaluated which have more uniform portfolios, and comparing them to projects managed by other types of institutions.

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

5. The inclusion of an economist or financial analyst in future evaluations would permit (a) the testing of existing models for cost-effectiveness analysis; (b) comparisons of per unit delivery costs within the private sector and between the private and public sectors; and (c) studies to improve public-private sector collaboration.

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

NOTES

- 1 "AID Partnership in International Development with Private and Voluntary Organizations," AID Policy Paper, Bureau for Program and Policy Coordination, September 1982. In selecting PVOs for the program, FVA considers each PVO's related experience; financial management capability is of prime importance. PVOs applying for an MG must provide general plans for new projects in the countries where they currently work or in new countries. To ensure both program effectiveness and compatibility, AID's stated goal is to include PVOs with MGs into its total planning process so that all such programs are coordinated and do not diverge too far from current AID priorities and sectoral strategies. At the same time, the MG program leaves PVOs ample scope and encourages flexibility in program design and implementation at the country level.
- 2 PCI/Bolivia succeeded in training more health workers at various levels than expected, but systems designed for evaluating that training and for systematic collection of project data were not yet fully operational. In IEF/Honduras many nurses who received training were no longer in contact with either IEF or the MOH, so their effectiveness was not being measured. In HKI/Philippines, because all VHWS in the region are being trained in eye care, there was no control group against which HKI could compare the VHWS' outputs.
- 3 Despite a drop in the average infant and child mortality rates between 1983 and 1984, these health improvements were not reliable indicators of the project's effectiveness because the project had been under way for years before the improvements occurred, the sample population is small (about 150 infant deaths per year), results varied in each impact area, with infant and child mortality increasing in some areas, there was no control group, and because the results covered only one year.
- 4 MFM/Honduras produced excellent results in reducing second- and third-degree malnutrition nearly 25% in all ANP communities: in 1983, after five years of MFM's ANP (including two years under the MG), the proportion of malnourished children in the two communities where the greatest reduction occurred (about half the ANP's population of children under five) was reduced from nearly 50% to 31%. (Regrettably, the ANP is not collecting data on its two other major goals: improvement of nutritional status of pregnant or lactating women and decreased infant and child mortality). Similarly, in PCI/Bolivia we can safely assume that the project significantly lowered infant and maternal morbidity and mortality because of the increase in use of health services, but this cannot be measured scientifically.

- 5 The three eye care projects showed indications of intermediate impact (which cannot reliably be identified as the result of program activities). For example, with hundreds of VHWS being trained in eye care by HKI/Philippines and with increasing numbers of eye patients being referred to clinics, HKI is likely to make inroads into the high rates of blindness in that area. IEF did not do any baseline surveys and has not systematically collected data on the prevalence of blindness in Honduras or Malawi, so the impact of its projects on blindness cannot be measured. Under the assumption that the nurses and doctors trained by HKI and IEF are better able to detect eye pathology and refer patients, the evaluators analyzed changes in the hospital discharge data. During the first two years of IEF/Honduras (1980-82), there had indeed been substantial increases both in the number of cases of tertiary eye care and in the prevalence of cases among the population. HKI project doctors in the Philippines had also increased the availability of eye surgery. Thus both projects seemed to be increasing the use of eye care facilities and the identification of eye problems.
- 6 For example, both ADRA country-specific project plans, approved by AID/Washington after the multinational MG had been approved, were overly ambitious: they needed to be rewritten, cut back, and rescheduled in both countries. IEF had no country-specific work plans or schedules for Honduras or Malawi, only a general multinational proposal for an MG with a logical framework and a wide range of program options including community-level primary eye care training and tertiary eye care training in hospitals. ADRA/Tanzania demonstrated that successful planning can take time. It took the better part of a year after the project began to develop the goals, purposes, and strategies in its plan.
- 7 Two examples of this type of PVO are ADRA and SAWSO. In Haiti, Adventists have been present for decades; recently ADRA's central staff of nearly 40 people have managed PL 480 programs, outreach grants, and other activities. Efficient management and accounting systems which predated the MG have made it much easier for ADRA to monitor and supervise MG activities. In Tanzania, ADRA was also able to build on longstanding experience in rural health; the MG enabled ADRA to build a community outreach program based on its network of rural clinics and managed from its Tanzanian headquarters by a Tanzanian Adventist physician. In both countries ADRA would have been much less effective if it had not built on existing staff and other resources already available in country. Similarly, SAWSO's experienced expatriate staff in Pakistan had been there for at least five and as many as 16 years.

8 The IEF/Honduras project, which involved only one part-time expatriate staff member who visited every few months, had no fixed local staff. Program cost was correspondingly low. (Unfortunately, the expatriate, although very competent as an eye-care trainer, had no other appropriate experience and no local counterpart. Her effectiveness in areas other than training was limited, and the project's possible impact on eye health care was not measured.)

MFM/Honduras was very effective in reducing malnutrition without any long-term expatriate staff. All MFM/Honduras in-country staff were nationals, although MFM headquarters in California provided regular, competent technical assistance and management support to them. There was a high degree of program coordination and integration between MFM headquarters and staff in Honduras. The flow of new technologies from home to field office, with support for their testing, was steady and consistent. Yet it is primarily by mobilizing existing community, government, and private sector organizations, not by providing its own money or material, that MFM/Honduras was effective.

9 HKI/Philippines and SCF/Bangladesh post health status indicators (e.g., infant deaths) and health-related targets (e.g., latrines built) on the walls of health posts for people to see both targets and achievements.

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

11 ADRA projects in Haiti and Tanzania were not closely coordinated with host governments. In both countries Adventist activities in health and nutrition were long established and traditionally independent; in Tanzania, Adventist clinics had been functioning for many years and were commonly known to be more popular than the few existing government clinics. ADRA/Tanzania staff may have concluded, with some justification, that they can be effective without relating more to government.

Similarly, SAWSO/Pakistan had a tradition of strict independence from the Pakistan government, and its clinics and services in villages were more available and of better quality, particularly in drug supplies, than the government's clinics.

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

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

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

In the IEF projects, few attempts were made to work directly at the community level in primary eye care as originally conceived in the MG proposal. According to IEF staff, their initial concern was to provide eye care training to health professionals (which they did successfully) and to improve national eye care policy and planning (which they were not able to do). It was their view that these two activities must precede the introduction of community level eye care, and that community participation was therefore unnecessary. Both projects tested community level interventions (training school teachers in Honduras and TBAs in Malawi) but only on a very small scale.

13 MFM projects brought together in many communities several disparate health, nutrition, and agriculture organizations, both governmental and non-governmental. MFM interventions included various health, nutrition, agriculture, and sanitation programs such as home gardening and small animal production, family-size silos, new kitchen utensils, and "smokeless" stoves and potable water systems. All these activities were carefully coordinated, while health and nutrition changes were carefully monitored, itself an innovative activity in the program area.

PCI was also technically innovative, introducing new types of cooking stoves and latrines, particularly in Bolivia and Guatemala. PCI was particularly innovative in its approach to traditional medicine in Bolivia. By integrating new PHC technologies such as immunization and ORT through long standing cultural practices, institutions, and authorities, PCI was effective in introducing change.

ADRA/Tanzania also integrated its programs in an innovative way: in one of its two sites, VHWS worked closely with ADRA agricultural training officers on irrigation ditch renovation likely to lead to better farming, improved diets, and maternal and child health improvements which may be measurable soon. The program was evaluated in its first year, however, so these links between community leaders, VHWS, clinics, and agriculture were still weak and needed to be developed. An innovative dimension of the ADRA/ Haiti program is the increasingly apparent role for growth surveillance, with and without the PL 480 food incentive, as an important health intervention.

14 Some examples:

- Ophthalmologists representing the IEF were members of the National Blindness Prevention committee in the Ministry of Health in Malawi, where they determined nationwide eye care policies and were moving Malawi toward a comprehensive primary eye care system, while they built the planning and monitoring capabilities of the committee itself.
- The American director of PCI in The Gambia was a member of the national Primary Health Care Working Group, where he played a key role in coordinating PHC training.
- PCI staff in Bolivia worked in a regional MOH Office of Planning and Supervision where they assisted a dozen government agencies and private groups, even traditional healers, in setting up a coordinated health and nutrition planning system.

- o In Thailand, the seven staff members of MFM, all Thai, coordinated the Applied Nutrition Program activities of the provincial departments of health, education, agriculture and community development and several private agencies into a collaborative and efficient nutrition system.

15 Such indicators could include for example:

Community Participation

- communities with representative, active health/development committees
- roles of local citizens in specific health activities
- building latrines, clean water supplies, refuse pits
- coordination with other local development and traditional groups

Cost Recovery

- community contributions (fees for service, drug sales, prepayment schemes, non-monetary help for VHWS, small business income)
- contributions of funds, drugs, infrastructure, training by MOH
- schedule for phase-over to local financing

Host Country Management

- counterparts in training to replace expatriates
- schedules and budgets designed to phase over to local management
- close organizational ties established to other private or public sector groups
- plans for scaling up to new areas, adapting to new conditions

16 The initial matching grant planning and design process, prior to the formal establishment of a program, was usually of short duration and lacked detailed analysis of programmatic and organizational issues. Proposed activities tended to be

vague, often idealistic, and incomplete; project objectives were often not quantified, and proposed budgets were frequently unrealistic. For the most part, real planning and design were accomplished during the first year or two that staff are in the field, usually precluding any measurable results by the third year of "operation." Pre-proposal project analysis and development costs were kept to a minimum, even in a country that was new for the PVO. Little attention was given to developing specific criteria and interventions for achieving long-term institutionalization.

- 17 Their host governments have little or no role in monitoring and evaluating activities, limiting the likelihood of their projects becoming institutionalized into host government services or being sustained by host government financing. Those host governments tend to show little interest in project activities, perhaps because they are generally excluded from project design and monitoring (except when they are asked to sign an agreement with the PVO). These two PVOs come to host governments with pre-determined strategies: once a formal agreement is signed with the host government, there is little subsequent involvement in operationalizing government participation in such areas as financing and training.

APPENDIX 1: The Evaluation Process

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

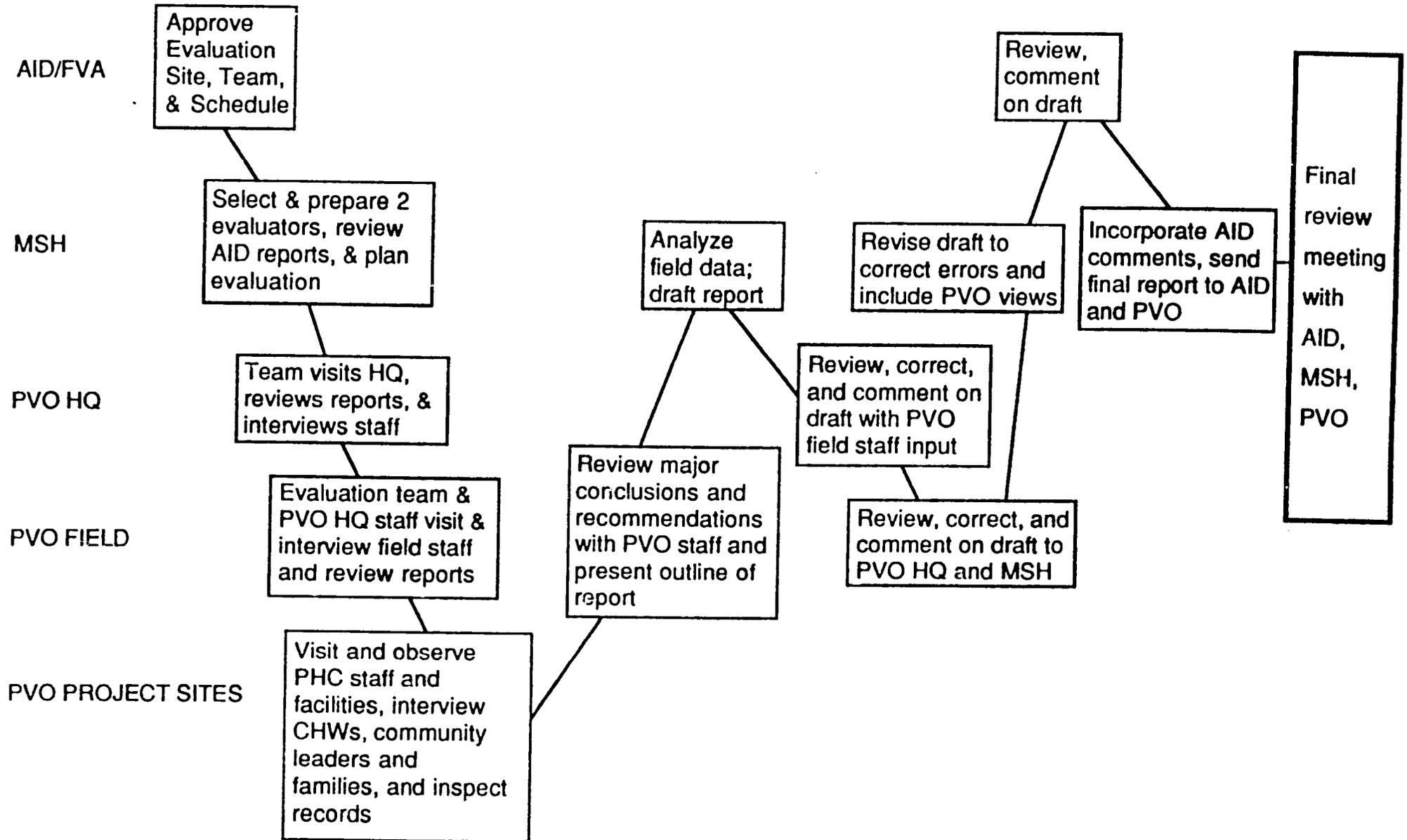
The method used to evaluate each project varied according to the nature and location of the project, the particular concerns of AID/FVA or the PVO home office about the project, and in some cases, the objectives of the local USAID mission (which always approved and sometimes participated in the evaluation). For example:

- In Guatemala, the evaluators focused particularly on the problem of balancing hospital services and costs with community outreach;
- In Bangladesh, the evaluators (including one Bangladeshi) concentrated on measuring the project's impact on child survival and family planning, and the project's effectiveness in promoting community participation;
- In the Philippines, Malawi, and Honduras, the teams were concerned with how well the projects had integrated eye care into national primary health care programs.

A flow chart showing the procedures used by MSH in these evaluations is shown on the following page.

Field visits of two to three weeks each were made by two-person teams of MSH evaluators: one an evaluation specialist, the other a specialist in the technical area of greatest importance to the program. Each PVO except one provided at least one home office representative to the evaluation teams. Review and revision of reports by the PVOs concerned and by FVA, as well as their ongoing participation, was considered central to the process of analysis and to project improvement.

EVALUATION PROCEDURE



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TIME



approximately 3 TO 6 months elapsed time



APPENDIX 3: CONTRIBUTORS: MSH Evaluators and PVO Participants

Conclusions and recommendations in this report resulted from collaboration between independent evaluators and PVO headquarters and field staff, and are based on 13 evaluation reports of primary health care and eye care projects written from 1983 to 1986, copies of which are available from MSH. Key participants included:

PVO	PHC Projects		MSH Evaluators	PVO Participants
Adventist Development and Relief Agency (ADRA) Washington, DC	Maternal and Child Health and Nutrition	Haiti July 1983	Polly Harrison, PhD Evaluation Specialist and Medical Anthropologist Joyce King, MA, Applied Nutrition Specialist	James Fulfer, Haiti Program Director Olive Fulfer, RN Haiti Director of Community Health Richard O'Ffill, International Executive Director
ADRA	Community Health and Nutrition	Tanzania September 1983	John LeSar, MD, MPH Evaluation Specialist and Public Health Physician (Project Director) Nicholas Danforth, MIA, EdM, Evaluation Specialist and Health Planner (Project Manager)	David Syme, MPH, RN International Director for Program Planning and Evaluation Norman Bunker, Tanzania Program Director Godfrey Chamba, MD, Tanzania Medical Director
Meals for Millions/Freedom From Hunger Foundation (MFM) Davis, CA	Applied Nutrition Program	Honduras July 1983	James Becht, MPH, Public Health Eval- uation and Information Specialist Reinaldo Grueso, MD, Public Health Nutritionist (Honduras)	Richard Redder, MFM Vice President for Program Zoila Alvarez, Honduras Program Director

PVO	PHC Projects		MSH Evaluators	PVO Participants
MfM	Applied Nutrition Program	Thailand January 1985	James Becht James Pines Nutrition Planning and Evaluation Specialist	Richard Redder, Kathleen Stack, EdM, MPH Director of Planning and Evaluation Naiyana Khomson Program Manager (Thailand)
Project Concern International (PCI) San Diego, CA	Primary Health Care Development and Training	Bolivia March 1984	James Becht Jaime Bravo, Primary Health Care and Community Development Specialist (Bolivia)	Tom Bentley, Regional Program Director for Latin America and the Caribbean Greg Rake, PCI/Bolivia Program Director
PCI	Primary Health Care Training	The Gambia October 1985	Nicholas Danforth Donald Chauls, EdD, Community Health Education and Training Specialist	Paul Dean, MD, MPH PCI Medical Director Fred Shaw, DrPH PCI Africa Regional Dir. Anthony Nathe, MPH PCI/Gambia Director
PCI	Toledo District Primary Health Care	Belize February 1986	Nicholas Danforth Robert LeBow, MD, MPH Primary Health Care Specialist	Rene Salgado, MD, MPH PCI/Mexico Director Robert Tucker, MPH PCI/Belize Director
PCI	Santiago Atitlan Primary Health Care	Guatemala March 1986	Nicholas Danforth Eugene Boostrom, MD MPH PHC Design Specialist Irene Jillson- Boostrom, PhD, Health Information Analyst	Rene Salgado Robert Tucker Betsy Alexander, RN PCI/Guatemala Director

PVO	PHC Projects		MSH Evaluators	PVO Participants
Salvation Army World Service Office (SAWSO) Washington, DC	Comprehensive Primary Health Care Project	Pakistan	Nicholas Danforth Andrew Haynal, MD MPH Primary Health Care and Family Planning Specialist	Doug Hill, PhD, SAWSO Asian Regional Director Sister Sue Allibone, RN Salvation Army - Pakistan PHC Training Director Captain David Burrows Project Administrator
Save the Children (SCF) Westport, CO	Community-Based Integrated Rural Development (Health, Nutrition and Family Planning)	Bangladesh January 1986	Nicholas Danforth Wasim Zamin, PhD, Specialist in Community Participa- tion in Primary Health Care and Family Planning Programs in Bangla- desh	Gretchen Berggren, MD, MPH Maternal and Child Health Specialist and SCF Deputy Medical Director Afzal Hussain, MD, SCF/ Bangladesh Medical Director

PVO	Eye Projects		MSH Evaluators	PVO Participants
International Eye Foundation (IEF) Bethesda, MD	Primary Eye Care Delivery and Training	Honduras August 1983	James Becht, MPH, Public Health Evaluation and Information Specialist Luis Figueroa, MD Ophthalmologist (Guatemala)	Tamara Oberbeck RN, COT IEF/Honduras Eye Care Trainer
IEF	Blindness Prevention and Treatment	Malawi October 1984	Nicholas Danforth James Sprague, MD Pediatric Ophthalmologist and Primary Eye Care Specialist	Larry Schwab, MD IEF/Malawi Co-Project Director and Primary Eye Care Specialist Tef Tezazu, MD, Ophthalmologist and IEF/Malawi Co-Project Director
Helen Keller International (HKI) New York, NY	Integrated Primary Eye Care and Blindness Prevention	Philippines November 1985	Nicholas Danforth James Sprague	Edward Glaeser, HKI Associate Director Jeffrey Watson, EdM, HKI/Philippines Project Director and Health Education Specialist