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PROJECT ASSISTANCE COMPLETION REPORT

THE PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH PROJECT

(386-0469)

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I. INTRODUCTION

From 1947 to the early 1980's, the Government of India's (GOI) policy was such that the responsibility for providing health care to its citizens rested with the State. Although few in number, private voluntary organizations (PVOs), which are respected for quality services, a commitment to the poor and innovative programming, represent a major untapped asset for the promotion of health, nutrition, family planning awareness and services. While the GOI had allowed voluntary organizations to operate in the field of health care, active encouragement and cooperation was not prevalent. Most of the GOI efforts involving voluntary organizations in the health sector were institution based, involving for the most part, the operation of dispensaries and hospitals. There was little or no support for innovative projects which included outreach and community participation. After USAID/I made a large grant to St. John's Hospital and Medical College in Bangalore in 1977, the Private Voluntary Organizations for Health Project (PVOH-I) project was designed and inaugurated in 1981 to complement that sole institution's efforts by providing sub-grants to a wide variety of groups working in the private and voluntary sector which were providing basic health, family planning and nutrition services as well as to groups providing special preventive services.

II. PROJECT GOAL AND PURPOSE

The project goal was to reduce mortality and fertility among rural and urban poor in India. To accomplish the goal, the project purpose was to expand and improve basic and special preventive health, family planning and nutrition services for the poor by strengthening the private and voluntary sector. The PVOH-I project

was particularly interested in identifying and supporting innovative activities that involved community participation. By completion, the project purpose had been achieved as sub-grants had been awarded to 30 voluntary organizations with an accompanying 1.5 million direct beneficiaries.

III. PROJECT HISTORY

After a long history of bilateral assistance to the Government of India (GOI) in support of primary health care and family welfare activities, USAID initiated the PVOH-I Project in August 1981 to develop the underutilized potential of nongovernment organizations (NGOs). USAID committed grant funds of \$20 million in Rupees (i.e. RS. 167,400,000) from a Special Foreign Currency Appropriation for a six year project. It was eventually extended to nine years ending in September 1990 with a total expenditure of approximately \$16.8 million (RS. 141,088,138). At that time, activities in the PVOH-II project began.

The PVOH-I project represents the joint efforts of the GOI, USAID and PVOs working in health and population in several ways. First, it represents the consensus among the groups that PVOs can and should play an expanded role in improving health services. Secondly, financial support is provided by both USAID and the PVOs themselves in the form of matching contributions. USAID provided 75% of the total budget with the remaining 25% raised by the sub-grantees themselves. Funds were used to expand and improve the quality of services by hiring additional field workers, providing training, technical and management assistance and improving physical facilities.

The project initially envisioned 15 sub-grants of about \$1 million

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each. However, in October 1984, the project design was changed to accommodate 30 sub-grants of about \$500,000 each when it was found that the PVOs could not absorb such large funding and were particularly constrained by the 25 percent matching contribution requirement. In addition, it was felt that they would encounter great difficulty in sustaining activities at the higher level once USAID funding was withdrawn. In 1986, the number of sub-grants was raised to 32. At a 1990 workshop, USAID and MOHFW consented to entertain proposals for two additional years of funding, the first year on a shared 50-50 basis, the second year with the PVOH-II project providing only 25 percent of the total. USAID and MOHFW considered 11 projects for extension, eventually awarding a one year grant on a 50-50 basis to six projects.

A midterm evaluation was conducted in 1986 and found that the PVOH-I project was an appropriate mechanism for supporting PVOs in providing primary health care and special preventive health services and that an efficient sub-grant approval process was in place. The project had assisted in the establishment of a new support cell in the Ministry of Health and Family Welfare (MOHFW) for administering the sub-grants program and a new unit in the National Institute of Health and Family Welfare (NIHFW) with responsibility for providing technical support, monitoring and evaluation for sub-grantee activities. An effective collaborative relationship had been established between USAID, MOHFW and NIHFW which aided in implementing the project. In addition, the project avoided duplication of public sector services through full participation of government officials in the assessment of the relationship between PVO services and existing government public health services. The 22 sub-projects which had been funded to that point were providing a wide range of primary health care services to a growing number of poor in underserved areas, placing emphasis on outreach services and community participation.

The evaluation team noted that there was a need to simplify proposal guidelines, provide technical assistance at the point of proposal development and streamline the review and approval process. In addition, there was a need to increase the technical assistance and training to the sub-projects. In particular, the unit within the NIHFV should be strengthened to improve its technical assistance and monitoring capabilities. Chartered accountants should make more frequent visits to the projects for monitoring and training purposes and greater communication between sub-projects should be encouraged via workshops, personal exchanges and newsletters.

IV. PROJECT STATUS AND ACCOMPLISHMENTS

The PVOH-I project approved 32 projects in 13 states of India. Of the 32 sub-projects, one was never launched due to problems at the district administration level and one terminated early when the PVO disbanded with the GOI taking over its activities. Of the remaining 30, four were unipurpose (blindness prevention, leprosy, tuberculosis, etc.) and 26 were multipurpose. Of the multipurpose projects, three were in urban slum areas, three covered both urban and rural areas, four covered predominately tribal areas and 16 were entirely rural. All included Maternal and Child Health (MCH), family planning, nutrition, environmental sanitation, health/nutrition education and simple curative services. Thus, 30 PVOs were strengthened with about 1.5 million individuals in underserved areas benefitting from the project. (A list of the sub-grant projects is given in Attachment 'C'.) Although the number of persons served is quite large, it is insignificant relative to India's total population. However, the final evaluation noted: "What is most important goes beyond numbers. It concerns the process or mechanism that the PVOH-I project established. It is not unrealistic to think that this strategy and the procedures developed in the PVOH project will serve as the model for a broader PVO-government linkage in the health sector in the future."

Since all PVOH-I project applications had been received by the time of the mid-term evaluation, it was impossible to implement all of the recommendations by the end of the project. However, many of them, such as simplified proposal guidelines, increased technical assistance, streamlined review and approval process and more frequent sub-project visits by the chartered accountants were incorporated into the PVOH-II project.

The PVOH-I sub-projects achieved some impressive coverage results. For example, 8 of 23 sub-projects for which data were available had modern contraceptive usage rates of over 50 percent. Another six had rates in the forties. 18 sub-projects had DPT III coverage rates of above 70 percent and nine sub-projects have coverage rates in ante-natal care of above 70 percent. Attachment A provides the subgrant achievements. In addition, while the monitoring and evaluation of the PVOH-I sub-projects focused on the quantity of services provided and paid little attention to the quality of services, the evaluation team was generally impressed with the high standards being maintained in the sites visited.

Voluntary Sector: About 150 applications were received from PVOs during a six year period of PVOH-I, while the same number of applications for PVOH-II were received in a 2 1/2 year period. While this is partly a result of the growth in the number of PVOs working in the health field, it is clear that there has been a positive change in NGOs' voluntary sector's perceptions as well as suspicions about the government's motives.

The final evaluation team found that the sub-grantees had greatly strengthened their capabilities to manage health projects and to deliver a quality package of maternal and child health (MCH) interventions, including immunization, oral rehydration therapy, ante-natal care, vitamin A distribution, health education and family planning. They trained a large number of workers, and increased the number of staff members at all levels - from physicians to community

level workers - and expanded their operations to cover a significant number of people in underserved and isolated areas. They also were able to develop better financial systems and upgrade their project monitoring capabilities. The sub-projects developed and implemented a variety of innovative and successful outreach strategies and all utilized community workers. For instance, village women were trained as family health volunteers, health committees were formed to motivate and mobilize beneficiaries, volunteers received small salaries to provide outreach services and call on families, chlorination fluid was used for disinfection of village wells, and health education activities were promoted through folk media.

Evidence available one year after the project completion indicated that 80-90 percent of the sub-grantees were sustaining at least 75 percent of their activities initiated under the project. In June 1992, almost two years after project completion, USAID sponsored a workshop which was attended by 22 of the 30 sub-grantees, all of which were still sustaining activities. These PVOs have been successful in sustaining and sometimes expanding their activities through self-generated funds, alternate donor funds and/or GOI funds. For example, both Kamla Nehru and SEWA Rural were given funds from the GOI to expand their health care services by doubling the size of the areas they were covering. The final evaluation team found that virtually every sub-project instituted "user fees or charges" which gave the community members a feeling of ownership, contributed to making the health providers more accountable and provided financial support to sustain the project itself.

Government Sector: A very important result of the project has been the increased interaction and collaboration between the voluntary sector and the MOHFW. Between 1980-90 there appears to have been a marked and positive shift in the attitude of the MOHFW towards greater utilization of the voluntary sector and of the voluntary

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sector towards collaborating with the government and accepting government grants. The final evaluation team found that both the MOHFW and the NIHFW had developed a much better understanding of PVOs and what they can accomplish in the health field, as well as a sensitivity and capability to work more effectively with them. As an example, the NIHFW's appraisal, monitoring and evaluation of each of the sub-projects was found to be an important ingredient in achieving project objectives. In fact, this project represents the only MOHFW initiative in which monitoring and evaluation have evolved into a systematic, high profile, essential requirement for grant distribution.

The final evaluation team stressed that NIHFW has played a critical role in the success of the PVOH-I project by assuring the technical quality of the sub-projects. "It is their participation that has made the project unique and differentiates it from other centrally funded PVO support projects which do not include the technical oversight function." In addition, because of the NIHFW experience, other government run academic institutions are realizing that they can provide services to the private voluntary sector to effective ends, whereas they had previously confined their services to the government sector.

The change from a previous MOHFW attitude of having to suffer the voluntary sector, which was seen as intruding into an area of state responsibility, to one in which the MOHFW clearly states that it considers a PVO the best mechanism to reach remote and resistant population pockets with family welfare, preventive and promotive health services, is remarkable. In 1985, the MOHFW committed only 1 percent of its budget to PVOs; in 1990, it set a target of 20 percent of its budget being utilized by PVOs by 1995. How much this change of policy can be attributed to the PVOH project is difficult to ascertain. However, the fact that in years 1984-90, well over 50 percent of the MOHFW disbursements to PVOs were via the PVOH-I

project certainly testifies to the part the PVOH-I project has played.

Given that the MOHFW utilized only 1 or 2 percent of its budget to benefit only 1 to 2 percent of the nation's population within the PVOH-I project, it would require further study to determine whether such a small investment can have a marked effect on government policy. However, the enthusiasm with which the GOI/MOHFW is moving towards 1) broadcasting its policy of collaboration with PVOs through the mass media and policy documents, 2) motivating the state bureaucracies to follow this example, 3) providing a growing percentage of its budget to PVOs, 4) attempting to create a mechanism whereby governmental interference in the voluntary sector is minimized, bureaucratic bottlenecks removed and greater autonomous PVO participation encouraged in programming funds, and 5) involving PVOs in all health policy formation, indicates that the shift is genuine and not superficial.

It must be noted, though, that the changes in the GOI are not fully reflected in the state health ministries. While the more progressive states of Maharashtra, Gujurat and Tamil Nadu have enthusiastically embraced this approach, the areas where these policies could have the most effect, e.g., Bihar, Madhya Pradesh and Uttar Pradesh have been slow to respond. To some extent this reflects the paucity of a strong voluntary movement in those latter areas.

V. LESSONS LEARNED

1. It is clear that the government and PVO sectors can collaborate effectively, and thereby improve and extend services to underserved segments of the population. Good results and quality control are attained by the involvement of an intermediary technical

institution (like NIHFW). The appraisal, monitoring and evaluation of activities by this technical group ensured that those PVOs most likely to succeed were selected, gave the sub-projects strong technical capabilities and resulted in high coverage rates for some of the most important FP/MCH interventions. If quality programming is the objective, such a technical group must be involved to ensure that sub-projects are appraised, monitored, supported and evaluated properly.

2. Comprehensive sustainability planning needs to be incorporated into the initial project design with adequate technical assistance at the project design and appraisal stage. Each grantee should have a sustainability plan prepared by the end of the first year and efforts should be made to assure that grantees absorb recurrent costs on a phased manner to enable them to survive the trauma of funding termination more easily.

3. As a rule, the PVOs were found to have sufficient technical competence in the health and family welfare areas, but could have been more effective if assistance had been provided in the areas of accounting procedures and managerial skills. Technical assistance and training in these areas, initiated early in the project, could provide a general strengthening of the voluntary sector.

4. Due to various USAID and MOHFW policies, small grass root organizations were unable to access grant funds. The grants which USAID makes are too large for the smallest organizations to absorb. However, it is just these types of organizations which work in the most needy areas and could generate the greatest benefits. Mechanisms need to be found which would allow such groups access to funds. In addition, the newer/smaller/less well-endowed PVOs, which are committed to a high level of community involvement, require more time to become self-supporting. Consequently, a more gradual phase out of support and funding will help them to attain long term sustainability.

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5. The lack of trained grass root level workers is an important factor constraining the PVOs from expanding their services and areas of operation. Most training is geared toward the government infrastructure and the output of trained personnel is inadequate to meet even the government's requirements. In addition, most academic and training institutions are in the government sector. Training institutions in the PVO sector should be established and strengthened to make PVOs more self-reliant and sustainable.

6. The PVOH-I project was often seen by state governments as an activity carried out by voluntary organizations with central government assistance and therefore, out of their purview and control. Often state governments put unnecessary obstacles in the way of PVO sub-grantees because of this perception. While the activity should remain outside state government control, closer involvement and cooperation can, and should, be fostered through a continuous dialogue between the voluntary organizations, the state and central governments. This can be encouraged if a policy of cooperation between the health ministries and voluntary organizations is delineated with a senior officer at the state level being made responsible for this liaison.

7. Experience gained from the PVOH-I project indicates that an effective way to influence GOI policy is to design and implement an activity with no overt suggestion of policy changes. Such an approach requires considerable time as the GOI has traditionally been slow to accept change. However, once it is convinced that the new way of doing business can lead to success, it is often quick to change its policies and implement the new measures. This has clearly happened in the PVO health area as a result of the successful implementation of the PVO health project. It can also be seen in the effects which certain other health population and nutrition projects have had, e.g., the Integrated Child Development Services project and the Intra-Uterine Device and Demographic

Research Components of the Family Planning Communications and Marketing project. The lesson from all of these is that successful efforts need longer periods of USAID support in order to become firmly planted in Indian soil. Too often USAID appears to have lost interest just at a time the GOI recognizes and becomes committed to a new innovative approach, and thus is unable to reap the full benefits of its path breaking efforts.

VI. MISSION FOLLOW-UP ACTIONS

The final evaluation was done in March 1991 which provided insight into whether and how well the sub-projects were being sustained. A detailed evaluation of the sub-projects in 1993 could examine the sustainability aspect in greater detail which would provide valuable feedback for the PVOH-II sub-projects.

The GOI has requested that the activities initiated with PVOH-I and continuing with PVOH-II be continued further. In India, USAID is at the forefront and is accepted as the leader in the field of strengthening the private voluntary sector. Efforts thus far have been aimed at individual PVOs, while strengthening the sector as a whole has been neglected. A project which focused on the national sector would greatly enhance the ability of this sector to function as an effective third alternative to the government and commercial sectors in the field of health services. This can be accomplished either by expanding PVOH-II, or by initiating a new project, PVOH-III. A Mission decision on these options will be taken at a later date.

SUB PROJECT ACCOMPLISHMENTS

S. No.	Sub-Projects	Vaccines	Immunization		Antenatal Care		Contraceptive Usage		
			Baseline %	Final Evaluation %	Baseline %	Final Evaluation %	Baseline %	Final Evaluation %	
1.	Streehitakarni Bombay	BCG DPT III Measles TT II	No End Term Evaluation (ended in 1989)						
2.	Citizen Council, Baroda.	BCG DPT III Measles TT II	79 57 32 0	81 68 56 55	NA	84	45.7	35.7	
3.	BAM INDIA Calcutta	BCG DPT III Measles TT II	10 17 0 23	72 76 78	NA	76	5.5	38.7	
4.	New Century Welfare Society Madras	BCG DPT III Measles TT III	24 36 29 97	84 87 86 76	NA	30	NA	44	
5.	Kamla Nehru Hospital, Allahabad	BCG DPT III Measles TT II	11 12 7 25	82 76 71 69	32	36	36.2	20.2	
6.	Maharishi Dayanand Haryana	BCG DPT III Measles TT II	Report	Not	Available				
7.	AWARE, Hyderabad	BCG DPT III Measles TT II	NA	61 32 11 59	NA	100	NA	12	
8.	Chinmaya Tapovan Trust, Himachal Pradesh	BCG DPT III Measles TT II	16 17 0 11	83 80 76 68	NA	63	26.3	61.6	

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9. Sewadham Trust, Pune	BCG	4	83	NA	73	20.5	39.5
	DPT III	6	82				
	Measles	NA	76				
	TT II	4	87				
10. Krishi Gram Vikas Kendra, Ranchi	BCG	NA	0	NA	74	NA	70.3
	DPT III		81				
	Measles		50				
	TT II		72				
11. R.K. Ashram Charitable Trust, Trivandrum	BCG	NA	74	NA	28	NA	75
	DPT III		45				
	Measles		28				
	TT II		25				
12. Sree Sivagiri Narayan Medical Mission, Varkala, Kerala	BCG	NA	70	NA	85	NA	66.6
	DPT III		45				
	Measles		36				
	TT II		43				
13. Medical Relief Society Services of South Kanara, Manipal	BCG	49	78	91	35	19	56
	DPT III	55	78	(3 visits)			
	Measles	3	66				
	TT II	91	100				
14. Voluntary Health Services Madras	BCG		76				
	DPT III	NA	95	NA	64	NA	35
	Measles		72				
	TT III		66				
15. AVRV, Coimbatore, Tamil Nadu	BCG		90				
	DPT III	NA	72	NA	50	NA	48
	Measles		70				
	TT II		79				
16. KEM Hospital, Pune	BCG	56	91				
	DPT III	17	94	36	95	33.6	52.7
	Measles	0	83				
	TT II	31	98				
17. Charitable Trust and Health Research Centre, Moradabad, UP	BCG	3	90				
	DPT III	11	74	55	60	30	33
	Measles	0	91				
	TT II	8	82				

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18. Nootan Bharti, Madangarh, Gujarat	BCG	34	92	21	49	13.9	29.8
	DPT III	30	83				
	Measles	0	73				
	TT II	1	75				
19. Bal Rashmi Project Jaipur	BCG	4	95	12	88	9.9	49.1
	DPT III	15	92				
	Measles	0	86				
	TT II	2	72				
20. Red Cross Homeopathic Council Gurgaon, Haryana	BCG			No End Term I			
	DPT III						
	Measles						
	TT III						
21. Guru Cooperative Milk Producers, Bhatinda, Punjab	BCG	9	81	36	58	34.6	48.6
	DPT III	29	43				
	Measles	1	39				
	TT II	0	94				
22. Sewa Rural Jhagadia, Gujarat	BCG	3	100	NA	63	NA	47
	DPT III	2	82				
	Measles	NA	81				
	TT II	NA	86				
23. Sidhu Kanu Gram Unnayan Trust Memari, West Bengal	BCG	11	90		13.2		44.2
	DPT III	27	86				
	Measles	0	6				
	TT II	53	87				
24. Child in Need Institute Calcutta	BCG	52	96	NA	84	23.2	51.5
	DPT III	35	87				
	Measles	0	73				
	TT II	0	78				
25. Bhartiya Grameen Mahila Sang Indore	BCG	11	89	NA	57	NA	56.9
	DPT III	4	89				
	Measles	0	76				
	TT II	34	72				
26. Sarvajanik Parivar Kalyan & Sewa Samiti, Gwalior	BCG	0	0	3	61	10.1	30.3
	DPT III	0	83				
	Measles	0	0				
	TT III	2	95				
27. Children's Welfare Society Churhat, MP.	BCG			Report not ava			
	DPT III						
	Measles						
	TT III						

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28. KSDNG College of Ophthalmology and Research, Navsari, Gujarat	Uni	Purpose	Project				
29. Leprosy Mission, New Delhi	Uni	Purpose	Project				
30. T.B. Association of India New Delhi	Uni	Purpose	Project				
31. Khairabad Eye Hospital Kanpur, U.P.	Uni	Purpose	Project				
32. Khurja Eye Relief Society Khurja, U.P.	Uni	Purpose	Project	Early-	Termination		

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SPECIAL COVENANTS

Section 5.1. Project Evaluation The Grantee agrees to establish an evaluation program satisfactory to the Parties as part of the Project. Except as the Parties may otherwise agree in writing, the program will include, during the implementation of the Project and at one point thereafter: a) evaluation of progress toward attainment of the objectives of the Project; b) identification and evaluation of problem areas or constraints which may inhibit such attainment; c) assessment of how such information may be used to help overcome such problems; and d) evaluation, to the degree feasible, of the overall development impact of the Project.

STATUS: Mid-term and final evaluation were conducted in November, 1986 and July, 1990 respectively and addressed the above concerns.

Section 5.2. Family Planning Except as A.I.D. may otherwise agree in writing, Grantee will: a) ensure that no portion of the Grant proceeds will be attributed to motivation fees to any person for family planning or attributed to sterilization or abortion-related costs; b) ensure that all family planning services, including sterilization, will be provided on a strictly voluntary basis.

STATUS: This has been complied with.

Section 5.3. Facility Maintenance All facilities financed under the Project will be adequately maintained.

STATUS: This has been complied with.