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FROM PROJECT TO PROGRAM:
STRUCTURAL CONSTRAINTS ASSOCIATED
WITH EXPANSION

by

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**FROM PROJECT TO PROGRAM: STRUCTURAL CONSTRAINTS
ASSOCIATED WITH EXPANSION***

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Development literature is replete with reference to small-scale projects which achieved impressive impact on a modified scale but failed when expanded into large-scale programs. Pilot/demonstration projects have been thought of in mechanistic terms, i.e., assuming that if they work on a small-scale (like a prototype machine), they will succeed when scaled-up. In a few cases, particularly in the more technical interventions like nutritional fortification, an approach has been scaled-up successfully so that a significant portion of a country's population reaps the benefits. However, in programs involving the delivery of services at the community level, the results attained in the project phase are rarely duplicated when the intervention is expanded.

This phenomenon raises important and complex issues. Before we can expect to improve our record in the replication and expansion of successful project experience, we must determine two things: 1) what makes the small-scale projects successful; 2) what are the constraints precluding effective implementation of project-developed interventions on a large scale.

Ask anyone why small-scale projects succeed where their expanded versions fail and the explanation will usually include one or more of the following factors: 1) charismatic leadership; 2) "missionary zeal" of the project staff; 3) generous financial support. Certainly all three can be found to a greater or lesser extent in any successful project. But if we examine project experience closely, we find that while the three conditions are possibly necessary, they are not sufficient to explain what makes projects succeed and what precludes effective implementation on an expanded basis.

*Based on David F. Pyle, "From Project to Program: The Study of the Scaling-up/Implementation Process of a Community-Level integrated Health, Nutrition, Population Intervention in Maharashtra (India)", dissertation submitted in partial fulfillment of the Ph.D. degree in Political Science at the Massachusetts Institute of Technology, Cambridge, Mass., 1981. An earlier version of this paper was presented at the XII International Nutrition Congress, San Diego, California, August, 1981. Revised for inclusion in David C. Korten and Rudi Klauss (eds.), Social Development Theory and Method.

SMALL-SCALE PROJECTS

My research in the Western Indian state of Maharashtra suggests that a process can be identified and isolated which helps explain how small-scale projects achieve their impact. During the 1970s, seven community-based projects (Jamkhed, Kasa, Mandwa, Miraj, Pachod, Padgha, Wadu) operated within Maharashtra delivering an integrated package of nutrition and health services. Six of them were voluntary agency-managed, all but one (Jamkhed) linked to the Department of Health. Padgha was run exclusively by the government. All seven were similar in that they recruited, trained and utilized villagers as outreach workers. The basic model resembled closely the one recommended by WHO in its "Health for all by 2000" campaign.

The Maharashtra projects covered populations ranging from 30,000 to 230,000. The services delivered differed from project to project but generally included nutrition (education, surveillance, some supplementary feeding), primary health care (immunization, ante-natal care, deworming, communicable disease control) and some fertility control services.

Although their cost accounting procedures contained some obvious deficiencies (e.g., no shadow pricing of donated goods and services or amortizing of capital costs), the annual recurring costs per capita were encouraging, ranging from \$.50 to \$1.20 (Pyle, 1979). This represents a four fold increase over government expenditures on rural health care in Maharashtra but is reasonable when considered in terms of cost-efficiency or cost-effectiveness.

While most of the projects were too new or did not carry out formal evaluations, several were able to demonstrate impressive impact. Although fault can be found with certain aspects of their evaluation methodologies, Jamkhed and Miraj results must be noted. Infant mortality rates at Jamkhed (Arole, 1977), for instance, began at 97/1000 live births in 1971; in 1976 the rate was 39 (a 60% reduction) while the non-project area reportedly had an IMR of 90. Miraj (Ram, 1978) reported a 68% decrease in IMR (from 67.6 in 1974 to 23.1 in 1977). Immunization rates reached 98% in Jamkhed by 1978 when 96% of all ante-natal cases were covered (Jamkhed, 1979) compared to 97% at Miraj in 1977. The percentage of eligible couples practicing contraception was particularly impressive - from 2.5% to 50.5% in Jamkhed (versus 10% in the control area); Miraj went from 30.6 to 89.1% (referring to couples having three or more children).

After studying each project and identifying those factors responsible for impact, we can construct a composite or "ideal type" project from the joint experience. The primarily management-related features (orientation, morale, accountability, flexibility,

community participation) provide a standard to which we can compare the implementation process of the expanded program.

The underlying ORIENTATION of a project or program can help explain how results are achieved. Korten (1977) distinguishes between results and procedure orientation:

	<u>Results</u>	<u>Procedure</u>
Objective	Specific	Vague
Target Group	Priorities	All
Indicators	Output	Input
Organization	Team	Specialists
Training	Problem-Solving	Routines

Most of the Maharashtra projects typified the results orientation. Specific objectives included the reduction of child mortality by half and birth rate by 25%. Target groups were explicitly identified. All projects focused their efforts on "at risk" children - i.e., under 65% weight/age standard, no weight gain for 3 months or loss for 2, serious illness like measles or gastroenteritis (Shah, 1976). A similar set of "at risk" factors were identified for pregnant women. The indicators of project success were given in terms of impact as related to their respective objectives. The team work that typified the projects meant that the paramedics and doctors acknowledged the vital role played by the village workers. Finally, the training consisted of several weeks of orientation followed by task-by-task, on-the-job instruction in selected skills and on the identification and solution of problems.

The second factor was good staff MORALE. The need for a job, rather than innate dedication, was found to be the most common reason staff members joined the projects. Moreover, their pay was not significantly higher than government workers with similar responsibilities. Certainly they enjoyed less job security. Yet the project staffs typically had a "can do" attitude and were interested in achieving the project's objectives. Their positive attitude and performance can be explained by good personnel practices, including promotions based on merit, participatory management, job satisfaction (good support and feedback on individual performance).

Thirdly, the Maharashtra projects held both staff and community ACCOUNTABLE for their actions. This complemented their results orientation. A simple yet revealing information system was introduced. Each month the most efficient projects would collect a few impact indicators (e.g., infant and child mortality, births, nutritional status) and intermediate indicators (e.g., percentage of under-five at risk or immunized,

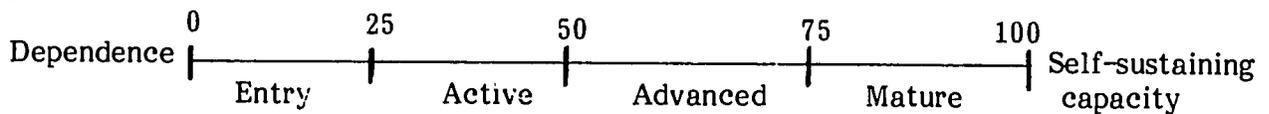
of ante-natal cases seen, of couples contracepting). The managers and supervisors practiced "management by exception", concentrating attention both on those performing below the norm (to identify and rectify problems) as well as those achieving outstanding results (to identify points to be duplicated). In addition, techniques such as surprise visits kept staff members performing well. If workers continued to be unproductive despite extra attention, training and assistance, sanctions were enacted (e.g., reduction in pay, termination). Project communities also had to perform in accordance with mutually agreed upon terms or face termination of project benefits. This leverage prompted community activity where it might not otherwise have existed and reduced the "let-them-do-it-for-me" attitude.

FLEXIBILITY, the fourth element, is essential for the results orientation to function. Local managers had to react to needs and situations as identified. The projects functioned as decentralized operations. The effective delegation of authority gave managers the control over the staff and intervention required to achieve project objectives. Having no time constraints, the projects evolved and developed, the managers learning from their experience and adapting accordingly. This flexibility also permitted sequential programming. For example, water resource development may be the most appropriate entry point followed by nutrition and health services and finally family planning efforts. In other words, felt needs must be addressed and confidence gained before less tangible interventions are introduced.

Finally, COMMUNITY PARTICIPATION is one of the least understood yet most important elements for the impact of voluntary agency-managed projects. To appreciate its role we must subdivide it into five separate actions, some or all of which were found in the respective projects. An initial diagnosis of community needs was carried out in conjunction with the villagers or by an agent who was experienced and capable of identifying village problems, needs, customs and traditions which affected both the design and delivery of the intervention. The closely related second element involved understanding by the community of its roles and responsibilities in the project. The fact that each of the seven Maharashtra projects employed a social scientist (e.g., rural sociologist, community organizer) whose primary task was to establish and maintain relations with the villages indicates the importance of these two elements.

The third element of community participation was programmatic involvement, the active role of villagers in the design, implementation and/or evaluation of the project. For example, many of the schemes depended on villagers to select the local worker and to assist in the evaluation and annual planning exercises. In addition, significant contributions were made by the villagers in the form of funds, materials, produce

and/or labor. Not only did this defray project costs (up to 50% in the case of Jamkhed); it also established "accountability from below" by developing a sense of "ownership" in the project by villagers. Increased self-reliance was an important development objective in and of itself. Similarly, assisting communities to establish or strengthen local organizations (e.g., women's, youth, religious groups) increased the capacity of the projects and people to marshal community energies to achieve specified project objectives and to carry on the approach on their own. Each project's performance was scored on the five elements of community participation and given an overall rating. By rating each scheme on a scale from zero to five on each aspect a "score" (actual versus possible) was arrived at. This made it possible to place each project on a continuum.



The closer a scheme came to the self-sustaining end of the spectrum, the greater its ability to survive the withdrawal of outside support.

GOVERNMENT PROGRAM

In 1977 the new Janata Government launched the Community Health Worker Program (CHWP) based explicitly, according to official statements, on projects such as Jamkhed, Mandwa, and Miraj. This provided an opportunity to study what happened in the process of expansion and why. The research had not progressed very far when it became obvious that the constraints faced in the transition process were too complex to study from only one point of view. Three perspectives or sets of conceptual lenses were required to identify and analyze problems arising in the expansion of the project-developed intervention.

The first, RATIONAL ACTOR ANALYSIS, typified the evaluations conducted by the semi-autonomous National Institute of Health and Family Welfare (1978) and complemented by the state demographic institute in Maharashtra (Dandekar and Bhat, 1978). The questions asked referred to what had taken place and not why things happened the way they did. The issues in this case dealt primarily with logistics, procedures and programmatic inputs. The results were presented in quantitative fashion. The findings provided data on the village workers (socio-economic status, educational background, sex), their training (physical facilities, aids, content, duration, retention), supplies (medicines, equipment, materials) and financial support (salaries, funds for medicines and transport). Most of the problems were of the "teething" variety any new scheme might experience. The impression given is that if the

shortfalls were rectified, the program would achieve impact. Thus, while the analysis of the logistical aspects are of concern, anyone interested in the underlying reasons for the difficulties in expanding small-scale projects into large operational programs must go further and study the organizational and political constraints.

The second perspective, therefore, involves ORGANIZATIONAL ANALYSIS. One of the basic hypothesis of the study was that structural adjustments would have to be made if the radically new strategy were to be implemented effectively (Chandler, 1962). The analysis focused on the same management issues found to be important for the success of the voluntary agency-managed projects. The resulting contrasts make it apparent why the delivery of services under the CHWP will not achieve comparable results.

The official program in the five Phase I districts in Maharashtra (covering 7 of the state's approximately 45 million rural population) was clearly procedure (rather than results) oriented. Its objectives were vague and no priorities were set, either in terms of services or target groups. Nutrition, one of 13 CHW responsibilities, was virtually forgotten about in the field. The indicators used to determine program effectiveness focused primarily on inputs (e.g., number of minor illnesses treated, condoms distributed). Instead of team work we find a highly structured, specialist-dominated organization in which the doctor ruled and the village worker was considered of little value. Moreover, the intermediate-level multipurpose workers never materialized as planned due to a failure to carry out a reorganization within the Health Department, thus maintaining the vertical, unisectoral orientation and making effective supervision and support of the CHWs extremely difficult. The 3-month CHW training, centered in the classroom rather than the field, was overly technical in nature and not oriented to problem-solving as in the projects.

Lack of motivation among government health staffs is a well known phenomenon around the globe. In the CHWP there was little chance for promotion, little support, no positive feedback, no participation in program management. Compounding the problem was the lack of control over the health workers at all levels.* The supervision that existed was restricted to register checking. The lack of any effective information system precluded good management. Despite the existence of over 180 registers in one Primary Health Center, no one could provide information on current birth rates, infant or child mortality rates, percentages of couples contracepting or children immunized.

*The problems associated with the administrative structure at the district level in India are discussed in some detail by Satia (1981).

The highly centralized, hierarchical, top-down structure of the health bureaucracy gave the local managers little opportunity to respond to local staff or programming needs even if identified. The rigidity of the government system contrasted sharply with the flexibility found in the project and greatly detracted from the effectiveness of the community-based program.

Finally, the government's CHWP had none of the elements of community participation found important in the projects. No one from the health staff either carried out community diagnosis or devoted time to ensuring the community understood their role in the program other than distributing a 4-page leaflet on the objectives of the CHWP to the village headmen. Activities involving villagers in programmatic aspects like CHW selection were not actively pursued, nor were villagers asked to contribute toward the support of the CHWP. In fact, no demands were placed on either the community or individuals. Community interaction and organization were not encouraged in either the orientation of the managers or the training of the field workers; there was no evidence that such activities were considered important. The result was a perpetuation of a dependence on others to provide services; none of the self-reliance as promoted in the projects and in official policy statements ("put health in the hands of the people") ever developed.

The third perspective required in the study of project to program transition is POLITICAL ANALYSIS. This element is not a major concern in the implementation of the small-scale projects where the local power structure is generally co-opted and circumvented. In some respects projects operate in a political vacuum. However, as soon as the model is expanded into a national program, politics, both at the macro and micro levels, become integrally and inexorably involved. This is particularly true in social sector programs which deal primarily with the poor as is the case in nutrition and primary health care schemes. While the political issue may be the most difficult to research, its importance in the Maharashtra case demonstrates its role in the scaling-up process cannot be underestimated. The aspects of major concern are commitment, elite/interest group involvement, accountability and self-reliance.

Commitment involves the often used but seldom defined term "political will". Analysis of the CHWP makes it clear that we must consider different indicators of commitment. The most commonly referred to include policy and budgeting support. Both were present in the case of the CHWP, but this was not sufficient to ensure effective implementation. In fact, the political pressure exerted by the Janata Party to launch this program six months after taking office as a symbolic gesture fulfilling campaign promises had a negative repercussion on the program by preventing the

formation of a solid foundation. A deeper level of commitment involving the willingness and capacity to make the necessary structural/organizational changes required to achieve impact (e.g., decentralize and delegate authority, integrate services, reorient high and middle level personnel, etc.) was lacking. The government did not go beyond what might be referred to as "palliatics" (symbolic social programming).

Another vitally important political aspect is the opposition by the various elite and interest groups. Entrenched urban-based vested interests made it very difficult to shift emphasis to the rural areas and to simple nutrition/primary health care as envisioned in the CHWP. The politically powerful elite demanded highly specialized medicine focusing on degenerative diseases, thereby resisting any change in the existing medical curriculum, irrespective of its inappropriateness to the needs of the rural poor. The politically influential opposed any reduction in medical school enrollments, despite the overproduction of doctors, as they aspired to lucrative medical careers for their children. In addition, health professionals, especially physicians, did not support the CHWP. To the contrary, the Indian Medical Association vigorously opposed the CHWP as providing "second class medicine" and creating more "quacks" in the rural areas. Finally, the rural elite also had a negative impact on the transition process, even though more through lack of support (omission) than active opposition (commission). Not suffering from malnutrition or from want of basic health services they had little stake in the program. Their interests entered only in influencing the selection of village workers, a process that became subject to political influence as might be expected given the continuing hold of the patron-client system in rural India.

Political analysis helps explain the lack of accountability in the government health system. A well established network of connections existed between the health staff and the local as well as state level elected officials. Payment for assignments and transfers to preferred health centers plus the widespread use of government time, facilities, and supplies in private practice were the basis for forms of corruption which precluded "accountability from above". Superiors had little interest in the impact of services on the health of the population and never carried out surprise visits; they had no desire to discover problems at subordinate levels which might result in political complications and force them to abide more strictly by the rules themselves. "Accountability from below" depended on village councils (gram panchayats) which proved to be ineffective. Political parties had gained control and corrupted the local bodies. The headmen (sarpanch) were more interested in their own political and

economic advancement outside the village than in local development issues. The villagers, not being politically conscious or organized, did not make any demands on the health system to deliver CHWP services effectively.

Self-sufficiency was discouraged by politicians who saw it to their advantage to maintain the paternalistic approach, hence the dependence of their constituents on the political system for health services. The people interviewed were willing to contribute toward the support of the local worker. The elected officials, however, resisted such an idea even though it would reduce the financial burden on the central government.

CONCLUSION

A number of implications can be drawn from the Maharashtra case on the "trauma of transition" from project to program. First, contrary to accepted practice, planning starts with implementation. The advantage of small-scale projects is that they provide implementation experience. But this is of little help unless it is utilized properly. Policy-makers and program designers must study the process which underlies a strategy's capacity to achieve impact. At the same time, they must analyze the organizational and political structures within which the expanded effort will be implemented, identifying where the strategy and structure "fit" and where they do not.* This exercise will make the program initiators aware of the potential constraints facing successful expansion of the project-developed approach. Rather than discouraging action, a clearer appreciation of the factors affecting implementation should make officials and managers feel more confident to deal with and overcome them by planning accordingly.

If, as is usually the case, the strategy and structure do not match, several options exist. Either the strategy can be modified to fit structure or vice versa. However, radical transformation of either the organizational structure or the strategy is highly unlikely (in the former) and not recommended if impact is to be duplicated (in the latter). More realistic is the adjustment of both so that the structure and strategy are more congruent. Structural modifications include bureaucratic re-orientation which enables the agency responsible for implementing the approach to adopt more of the process factors responsible for project success. It will, in other words, permit the formation of a "charismatic organization" which duplicates the characteristics found in the small-scale projects.

*This supports the findings of Ickis (1981) who studied the influence of strategy structure fit on the performance of rural development programs in Central America.

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