XDAB8418-A
ISN78177

DRAFT - for
discussion only

FINAL EVALUATION

PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH (PVOH-I)

(No. 386-0469)

by

David F. Pyle, Ph.D., Team Leader
Abraham Joseph, M.D.
K.G. Krishnamurthy, Ph.D.
James Pines, J.D.

March 1991

This evaluation was conducted for USAID/New Delhi.

JOHN SNOW, INC.

TABLE OF CONTENTS

Map
Acknowledgement
Glossary
Executive Summary

I. Introduction
   A. Team
   B. Scope of Work
   C. Methodology
   D. Organization of Report

II. Background
   A. NGOs in India
   B. MOHFW's Relations with NGOs
   C. Development of PVOH-I
   D. Summary of Findings of PVOH-I Mid-Term Evaluation by USAID

III. Findings and Lessons Learned
   A. Current Status
      1. National Level
      2. NGO Level
      3. Community Level

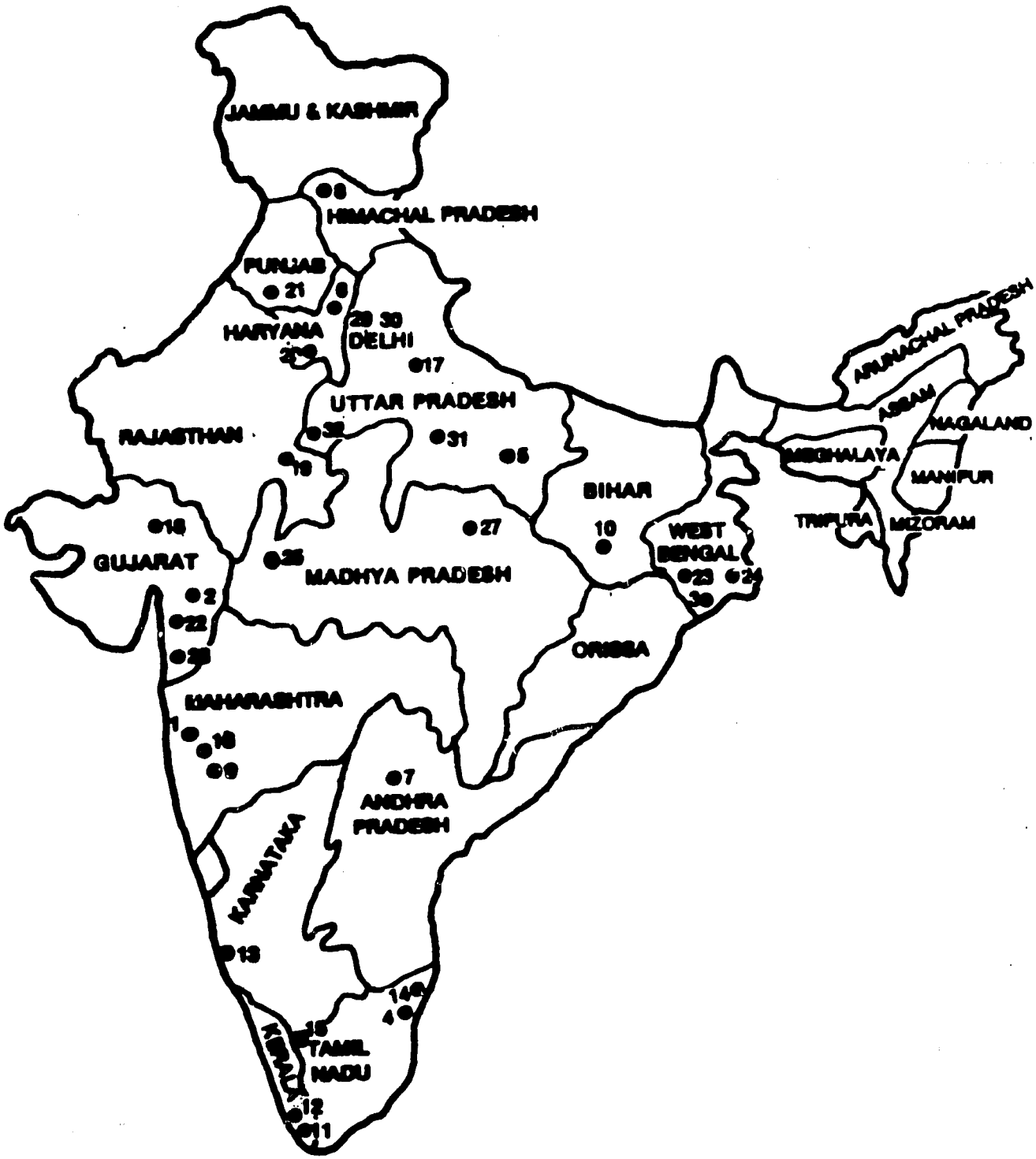
IV. Future Considerations
   A. Programmatic Issues
   B. Sustainability Issue
   C. Structural Issue

V. Recommendations
   A. Policy Directions
      1. Sustainability
      2. Decentralization
   B. Program Issues
   C. Project Management and Administration

Annexes

I. Scope of Work
II. Documents Reviewed
III. List of Persons Interviewed
IV. Sub-Project Data
V. Sub-Project Accomplishments

MAP SHOWING LOCATION OF PVOH PROJECTS



(Names of PVOH-I sub-projects corresponding to numbers listed on reverse side)

Sub-Project List

1. Streehitakarni
2. Baroda Citizens Council
3. BAM
4. New Century Welfare Soc.
5. Kamla Nehru Hospital
6. Maharishi Dayanand
7. AWARE
8. Chinmaya Tapovan Trust
9. Sewadham Trust
10. Krishi Gram Vikas Kendra
11. R.K. Ashram Charitable Trust
12. Sree Sivagiri Narayan Med Mis
13. Medical Relief Society
14. Voluntary Health Services
15. AVRV
16. KEM Hospital
17. Charitable Trust & Health Res. Ctr.
18. Nootan Bharti
19. Bal Rashmi
20. Red Cross Homeopathic Council
21. Guru Coop. Milk Producers
22. SEWA-Rural
23. Sidhu Kanu Gram Unnayan Trust
24. CINI
25. Bhartiya Grameen Mahila Sang
26. SPKSS
27. Children's Welfare Society
28. KSDNG College of Ophthalmology
29. Leprosy Mission
30. TB Association
31. Khairabad Eye Hospital
32. Khurja Eye Relief Society

Glossary

ANC	Ante-Natal Care
BAM	Brother's for All Mankind
BCC	Baroda Citizens Council
CINI	Child In Need Institute
GOI	Government of India
KEM	King Edward Memorial
MCH	Maternal Child Health
MOHFW	Ministry of Health & Family Welfare
NGO	Non-Governmental Organization
NIHFW	National Institute of Health & Family Welfare
PHC	Primary Health Care
PVO	Private Voluntary Organization
PVOH	Private Voluntary Organization for Health
SGC	Special Grants Committee
SKGUS	Sidhu Kanu Gram Unnayan Samiti
SOSVA	Society for Service to Voluntary Agencies
SPKSS	Sarvajanik Parivar Kalyan & Sewa Samiti
USAID	United States Agency for International Development
USFY	United States Fiscal Year
VAFAH	Voluntary Action for Family Welfare & Health
VHA	Voluntary Health Association
VHAI	Voluntary Health Association of India

ACKNOWLEDGEMENT

We don't know what deity Dr. Tom Philip prayed to, but we are impressed with the results. To send two teams off in different directions to observe and discuss project activities with 11 NGOs and to get them back to New Delhi without so much as a minor problem is certainly a major miracle! He deserves our collective thanks for all the logistic support he provided the Evaluation Team and the patience he exhibited in responding to our each and every request for data, appointments, bookings, etc.

John Grant provided the team with the guidance and direction it required. For every thing he did, from reviewing the Scope of Work with the team and ensuring that we understood and were comfortable with it to entertaining us at his home, we are most grateful. We also want to thank Dr. Patil for his efforts collecting the reports and data pertaining to the PVOH-I Project. Most importantly, we would like to thank Rama who served as our computer consultant, making the computers perform and printers behave themselves. Also to Cecilia who labored on several of the more involved charts on the team's behalf.

The Evaluation Team is most appreciative of the time given to us by the NGOs we visited. Without exception, they were very patient, answering all our questions and let us review their records and documents as needed. In addition, their hospitality was most generous and will be fondly remembered. It is meeting and working with committed and highly competent individuals such as we met in the field that renews our collective faith that progress can be made and that solutions do exist.

The officials at the MOHFW and NIHFW were also very helpful. Their participation in the PVOH-I Project gives the Evaluation Team hope that collaboration between the government and NGOs is not only possible but will expand in the years to come.

EXECUTIVE SUMMARY

The Private Voluntary Organization for Health (PVOH-I) Project was launched in the early 1980s by the Ministry of Health and Family Welfare (MOHFW) with Rs. 168 million or $20 million support of USAID/New Delhi. The PVOH-I Project was originally scheduled to terminate in 1987 but was extended until September 1990. This final evaluation was commissioned to review project activities since the mid-term evaluation in late 1986 and to explore mechanisms to institutionalize closer cooperation in health activities between the public and private sectors.

Purpose - The purpose of the PVOH Project was to strengthen the capacity of non-governmental organizations (NGOs) nation-wide to deliver maternal and child health services and to expand their operations to the underserved areas of the country. The project represents the beginning of USAID's effort to develop a closer working relationship between the MOHFW and the NGO sector with the goal of improving the health status and reducing mortality among the vulnerable target population (i.e., infants and children under five).

Methodology - The evaluation was conducted by a four-person team between mid-February and mid-March 1991. In accordance with the Scope of Work, the team examined the impact of the PVOH-I Project at the national, NGO and community levels. The methodology consisted of a review of a large volume of project documents (including sub-project appraisals, annual monitoring reports, mid- and end-term evaluations), interviews with government officials at the Centre and NGO leaders (in New Delhi and in the field) and site visits. The Evaluation Team split into two groups, one visiting five grantees in the north (one each in Rajasthan and Madhya Pradesh, three in West Bengal) while the other saw four sub-projects along the west coast (two in Gujarat, one in Maharashtra and one in Karnataka). In addition, several influential NGO leaders whose projects had received PVOH support were interviewed to discuss their views on the project and to explore ideas about what might be done in the future to expand such efforts and develop ways to facilitate public and private sector interaction.

Findings - The PVOH-I Project funded 32 projects in 13 states of India. They spent all but approximately 12 percent of the programmed funds. Out of the 32 grants made, one was never launched and one terminated early. Of the 30 remaining, 5 were unipurpose (i.e., blindness prevention, leprosy, tuberculosis) and not visited during this evaluation.

The principal finding at the national level was that the MOHFW had developed a much greater understanding of and appreciation for NGOs and what they can accomplish in the health field . The agency responsible for the technical aspect of the project, the National Institute of Health and Family Welfare (NIHFW), also developed a sensitivity and capability to work effectively with NGOs. The NIHFW's appraisal, monitoring and evaluation of each of the PVOH sub-projects was found to be an important ingredient in achieving project objectives.

At the NGO level, the evaluation found that the grantees greatly strengthened their capacities to manage health projects and deliver a quality package of maternal and child health (MCH) interventions, including (but restricted to) immunization, ORT, ante-natal care, vitamin A distribution, health education and family planning. They trained a large number of workers and expanded their operations to cover a significant number of people (over a million and a half) in underserved and isolated areas.

At the community level, the PVOH-I sub-projects achieved some very impressive coverage results. The Evaluation Team focused on three interventions which were common to all sub-projects.

- Family Planning: 8 of 23 sub-projects for which data were available had modern contraceptive usage rates of over 50 percent. Another six projects had rates in the forties.

- Immunization: 18 of 23 sub-projects had DPT III coverage rates above 70 percent.

- Ante-Natal Care: 9 of 23 sub-projects had coverage rates above 70 percent.

In addition, the grantees had placed considerable emphasis on mobilizing the community, involving them in project activities and developing their capability to address and manage their health affairs.

Recommendations - Despite the generally favorable findings, a number of recommendations were made to increase the effectiveness and magnitude of the collaboration between the government and NGOs in the future, especially in the PVOH-II project which is currently being implemented. These are divided into three categories: policy directions, program issues, and project management/administration.

- Policy: The **Sustainability** issue should be given greater attention. For this to be successful, some NGOs (especially the smaller, newer, community-oriented ones) will require additional time, hence requiring longer phase-out periods. Attention to sustainability must be given from the design stage and technical assistance provided if required. Depreciation of capital assets, NGO's core/overhead costs and the validity of the NGO's matching portion must be viewed from a sustainability perspective.

  Decentralization is the other major policy direction. If the level of government-NGO collaboration is to be increased while maintaining the quality of the field activities, a mechanism must be identified, developed and institutionalized. PVOH-I largely ignored the state health departments. PVOH-II should do at the state level what PVOH-I did at the national level. Under PVOH-II an attempt should be made in at least one state to decentralize the grant making and management responsibilities. This process might begin with the technical assistance and auditing functions. To generate interest a workshop should be held for the directors of health services in the PVOH-II states to discuss NGO-government collaboration. In addition, tours for ehalth officials from the PVOH-II states should be arranged to states in western India already

having success state-NGO collaboration to demonstrate what can be achieved and how. USAID should consider hiring consultant services to assist in the development of the state-level association.

- Program: PVOH-II should be concentrated in the states having less NGO activity and lower health indices (i.e., north and northeast). Unipurpose projects should not be funded. Greater attention should be placed on nutrition interventions and temporary family planning methods. New interventions (e.g, ARI) should be added. More "at risk" targeting is needed. Those sub-projects focusing on the development of genuine community involvement require more time and a small amount of unrestricted funds. User fees are important to develop a feeling of ownership in the community.

- Project: Financial procedures should be simplified and improved. The guidelines for length of grants and phase-out period should be flexible. More communication between grantees is encouraged in the form of annual workshops. Monitoring and reporting should be revised to focus on key indicators and include mortality data on the target population (by age).

Lessons Learned - A number of lessons were learned over the past eight years during the implementation of the PVOH-I Project. First, it is clear that the government and NGO sector can collaborate effectively, improving and extending services to underserved segments of the population. Good results and quality cocntrol are attained and maintained by the involvement of an intermediary technical institution (like the NIHFW). The appraisal, monitoring and evaluation of NGO activities by this technical group gave the PVOH sub-projects strong technical capabilities and resulted in high coverage rates for some of the most important MCH interventions. To enable the grantees to continue the work initiated under the PVOH Project, the sustainability issue must be addressed from the earliest possible date during the design stage. Finally, NGOs have different needs and must be considered individually; for example, the newer/smaller/less-well-endowed NGOs, which are committed to a high level of community involvement, will require more time to become self-supporting. Consequently, a more gradual phase out of outside support and funding for such NGOs will help them survive the traumas of sustainability.

I. INTRODUCTION

The PVOH-I Project came to an end in September 1990. At the same time, activities in the PVOH-II Project have begun. Therefore, this evaluation is viewed as an opportune time to review what has been accomplished in the initial effort (PVOH-I), while taking stock of what USAID is doing to strengthen and expand the interaction between the government-Ministry of Health and Family Welfare (MOHFW) and the non-governmental sector, as manifested in the PVOH-II Project.

USAID/New Delhi organized the final evaluation of the first Private Voluntary Organizations for Health (PVOH-I) Project. The evaluation was conducted by four independent experts between 19 February and 18 March 1991. The objective of the evaluation was three fold. First, USAID desired the team to evaluate efforts being undertaken to build support for increased interaction between the government and non-government agencies operating in the health sector to improve the health status of the most vulnerable and underserved segments of the Indian population. In this sense, the evaluation of PVOH-I is a review of broad review of USAID's long-term and continuing attempt to increase the collaboration between the public and private components of the health field. Accordingly, the Evaluation Team looked at the PVOH-I Project activities as part of USAID/New Delhi's larger program to increase the interaction between the public and private sectors in the health/family planning sector in India. The PVOH-I Project can be considered as Phase I of USAID/New Delhi's effort to improve and increase the Ministry's relationship with the NGO community. Therefore, this exercise is both a final evaluation of the PVOH-I Project as well as an interim evaluation of the long-term and on-going effort that USAID and the Ministry of Health and Family Welfare are pursuing.

The second aspect of the evaluation can be referred to as the summative component. The Evaluation Team reviewed the performance of Private Voluntary Organizations (PVOs), or as usually referred to in India, Non-Governmental Organizations (NGOs)[1], that had received grants under the project. Specifically, USAID/New Delhi asked the team to ascertain how well the grantees had done in achieving the goals, objectives and outputs as stated in the Project Paper, Grant Agreement and Project Implementation Letter No. 3. This aspect of the evaluation required the team to review what had transpired over the seven-year project, particularly since the mid-term evaluation (October 1986). Lessons learned were identified so that, where appropriate, the successes can be replicated. In addition, any weaknesses in PVOH-I sub-projects that should be addressed in the current PVOH-II are described and recommendations made to resolve the problem.

---

[1] The term "NGO" in the American context is used to define a broad range of autonomous, privately-managed agencies. However, because this project is carried out in India where the term PVO is not commonly used, the term NGO will be used in this report. The Evaluation Team wonders why the project was not called the NGOH-I Project.

The third major objective of the final evaluation of the PVOH-I is equally important to USAID and involves the future role of Indian NGOs in health and their relationship with the Ministry of Health and the donor community. There is an interest on the part of all concerned to identify and institutionalize a mechanism that will bring about closer cooperation in health activities between the public and private sectors. This comprises the forward looking or formative aspect of the evaluation.

A. Team

The PVOH-I Evaluation Team consisted of four persons who have considerable experience in NGO and health/family planning/nutrition programming. The team leader was Dr. David F. Pyle, who has done research involving NGOs in Maharashtra; Dr. Abraham Joseph, a Professor of community health, Christian Medical College (Vellore) and a member of the PVOH-I mid-term evaluation team; Dr. K. G. Krishnamurthy, an Advisor to the Planning Commission for over a quarter of a century; and James Pines, who has evaluated and provided technical assistance to NGOs in many countries.

B. Scope of Work

The Scope of Work for the PVOH-I evaluation was drafted by USAID/New Delhi and approved by both NIHFW and the MOHFW. The Scope of Work (relevant extract, Annex I) raises issues regarding three levels of operation - national, NGO and community. As mentioned, the evaluation team was asked to review the achievements of the 31 NGOs which had participated in PVOH-I as well as to explore ideas about the future of Indian NGOs in the health field with all those participating in the Project.

The Scope of Work focused on the following issues:

- National Level - To what extent has the MOHFW's policy and attitude regarding NGOs changed?

  - Has the capacity of the NIHFW to deal with NGOs been improved and strengthened?

- NGO Level - How have the sub-grantees expanded or increased the effectiveness of their health-related activities?

  - Have the NGOs developed approaches to ensure that the activities initiated under PVOH-I are sustained?

- Community Level - What impact have the PVOH-I activities had on the health/nutrition status of the target population?

  - How effectively have the communities served by the NGOs

been involved in the implementation of the health/family planning/nutrition efforts?

In order to ensure that each of the levels received proper attention, members of the evaluation team were given responsibility for specific aspects: Dr. Krishnamurthy, with his experience on the Planning Commission, the policy-related national level; Dr. Pyle and Pines, with their associations with NGOs in India and abroad, the NGO level; and Dr. Joseph, with his involvement with community-based programming, the community level.

C. Methodology

In order to gain a complete assessment of the PVOH-I project, the evaluation team employed several methods and procedures. These included the review of relevant documents, interviews with key officials who have played a role in the implementation of the project, and carried out visits to a number of project sub-grantees.

- Document Review - The team collected and read a large volume of project-related documents (Annex II). These included papers presented at workshops on NGO participation in health and on sustainability of NGO-managed health activities. In addition, the team studied policy documents to determine progress over the project period and what direction private-public cooperation might take in the future. At the NGO level the team reviewed a large number of project documents, especially for those sub-projects visited by the evaluation team; these included the original project proposals, the appraisal reports, selected monitoring reports, the mid-term evaluation report, and the end-term evaluation report. Where appropriate and available, the evaluators also reviewed sub-projects' own evaluations and sustainability plans.

- Interviews - The evaluation team devoted considerable time to discussions with the key actors in PVOH-I. The interviewed where conducted at several levels (see list of persons contacted, Annex III). In Delhi, USAID/New Delhi officials, MOHFW and NIHFW officials, and leading authorities on NGO programming were asked about their respective roles in the PVOH-I Project and their thoughts about how the NGO health effort might be strengthened in the future.

- Site Visits - The evaluation team was split into two in order to visit as many PVOH-I sub-projects as possible. The sites were selected taking several considerations into account. First, it was decided that the unipurpose projects would not be visited. The team thought it important that the sites should be representative of the 32 sub-projects that had been funded. This meant that the sample must include the well established NGOs covering larger populations as well as the smaller NGOs launching health activities for the first time. It also meant visiting both rural and urban project sites. In addition, both newer projects (3 to 4 years of

participation in PVOH-I) and older ones (6 to 7 years) were included. Finally, logistic considerations, i.e., time limitations and transportation options, helped determine the sites selected.

The Evaluation Team divided into two subgroups. One team focused on the sub-projects in the north (from Rajasthan in the west to West Bengal in the east). The other two members of the team visited projects along the west coast (from Baroda in the north to Manipal in the south). The resulting list of sites visited is as follows:

- Northern States

Bal Rashmi Society (Jaipur, Rajesthan)
Brothers for All Mankind - BAM (Calcutta)
Child in Need Institute - CINI (Daulatpur, West Bengal)
Sarvajanik Parivar Kalyan and Sewa Samiti - SPKSS (Gwalior, Madhya Pradesh)
Sidhu Kanu Gram Unnayan Samiti - SKGUS (Amadpur, West Bengal)

- Western/Southern States

Citizens Council (Baroda, Gujarat)
Medical Relief Society (Manipal, Karnataka)
Sevadham Trust (Pune, Maharashtra)
SEWA-Rural (Bharauch, Gujarat)

In addition, in the course of the travel, the Evaluation Team met with a number of experienced NGO leaders and former government health officials to explore their thinking on current and future issues dealing with NGO health programming and the issue of how public-private collaboration can be facilitated. These included the directors of Streehitakarni (Bombay) and KEM Hospital (Pune).

The team spent two weeks in the field visiting the sub-projects. Prior to the initiation of the site visits, a protocol was developed identifying issues and questions that would be addressed. This helped ensure that all members of the evaluation team were pursuing the same aspects and that their findings would be comparable. While at the sub-projects, the evaluation team discussed project activities with the managers, staff and community members and leaders. Data collected by the sub-grantees were reviewed.

The PVOH-I evaluation was facilitated by the fact that the NIHFW had conducted a final or end-term evaluation on each of the participating sub-projects. This exercise consisted of a survey of approximately 600 households in each project. Having some data on the impact and levels of coverage when visiting the respective sites proved a helpful starting point for the evaluation team when it arrived at the site. It allowed the team to address a series of other questions of longer lasting consequence, specifically sustainability and the mechanism which might follow PVOH to facilitate collaboration between the MOHFW and the NGO community.

D. Organization of the Report

The report of the evaluation team is organized along the lines of the Scope of Work. Chapter II reviews the background of the PVOH-I Project and how it fits into the Indian context. The role played by NGOs in India in described. The trend indicating greater NGO-government collaboration over the past decade is documented. Finally, the development of PVOH-I and the findings/concern of the PVOH-I Mid-Term Evaluation are outlined.

Chapter III focusses on the findings of the Final Evaluation. It is divided into three sections - the first describing what has taken place at the national level, the second concentrating on the NGO level and the third addressing the community itself and what impact the project has made on the health status of the target population.

Chapter IV responds to USAID/New Delhi's concern that the future role of NGOs and their relationship with the MOHFW be considered. While the PVOH-I effort might have had an impact on a significant number of the poor and underserved in India, it represents only a small fraction of those in need. There is a felt need on the part of all parties concerned (the government, the NGOs and the donors) to identify mechanisms that will lead to greater interaction between the public and private sectors in the health field. In addition, Chapter IV will discuss what might be done in PVOH-II to strengthen the project, benefiting from the lessons learned in PVOH-I.

Chapter V of the recommendations derived from the findings and observations the team made during the course of the evaluation. These observations address the national, NGO and community levels, but are divided into three categories (national directions - sustainability and decentralization; program issues; and project management and administration.

II. BACKGROUND

A. NGOs in India

Since the early 1800s, voluntary organizations have played a small but significant role in the social and economic development of India. The groups are often religious in nature and have been heavily influenced by Mahatma Gandhi's philosophy of community development and voluntary action. After independence, the NGO movement gathered momentum, and there was a gradual shift from charity and social service to welfare and community development.

Over the past several decades, the government support for the NGO sector has increased steadily, from RS. 34 lakh in the Third Five Year Plan (1961-66) to Rs. 150 crore in the Seventh Plan (1985-90). The Seventh Plan contained a separate subchapter on the involvement of voluntary organizations in poverty alleviation. The chapters on Health and Family Welfare also stressed the role of the voluntary sector.

B. MOHFW's Relations with NGOs

It is estimated that two-thirds of the annual per capita health expenditure (Rs. 30) is spent in the private sector. With a significant portion of the population beyond the reach of the government service network, a significant portion of the population relies on private sources, both private practitioners and voluntary health groups.

The exact number of NGOs in India involved in health is impossible to determine; however, the estimate of 3,000 has been given. In 1985, the MOHFW ear marked Rs. 7.2 crore, or a little over one percent, of its total budget of Rs. 630 crore for NGO activities. Over half of the amount allocated to the NGO sector (Rs. 4.5 crore) is from the PVOH-I project itself. In the last three years of the Seventh Plan (i.e, 1987-90), there has been a considerable increase in the flow of funds to the voluntary agencies both in the amount of money programmed and the number of NGOs assisted. Of late, the government has involved NGOs in the implementation of the various national programs (e.g., blindness prevention, family planning, leprosy). The flexibility that characterizes NGO operations and their effectiveness at the community level has encouraged the MOHFW to utilize increasingly the NGOs to reach the underserved areas of the country. Accordingly, the MOHFW has developed a variety of grant-in-aid schemes that fund NGOs provide health and family planning services to portions of the Indian population.

C. Development of PVOH-I

For the first several years after the government adopted a policy to involve voluntary organizations in the health sector in 1982, most of the efforts were institution-based, involving for the most part the operation of dispensaries and hospitals. There was little or no support for innovative project which included outreach and community participation.

In order to strengthen and expand the voluntary organization activities in the remote and underserved areas of India, the Private Voluntary Organization for Health (PVOH) Project was launched by the Government of India with the financial assistance for USAID. The formal agreement was signed in August 1981 for $20 million worth of India rupees (at that time valued at Rs. 16.8 crore). A sum of Rs. 4 lakh was set aside for monitoring and evaluation.

The long-term goal of the project was the reduction of infant mortality and fertility, especially among the poor and disadvantaged sectors of society. This goal was to be achieved by strengthening the private and voluntary sector so that it could expand and provide a basic package of maternal and child health services (especially, immunization, ante-natal care, ORT, nutrition, and family planning).

The PVOH Project was particularly interested in identifying and supporting innovative activities that involved community participation. The

unique features and basic requirements for funding under the PVOH Project are as follows:

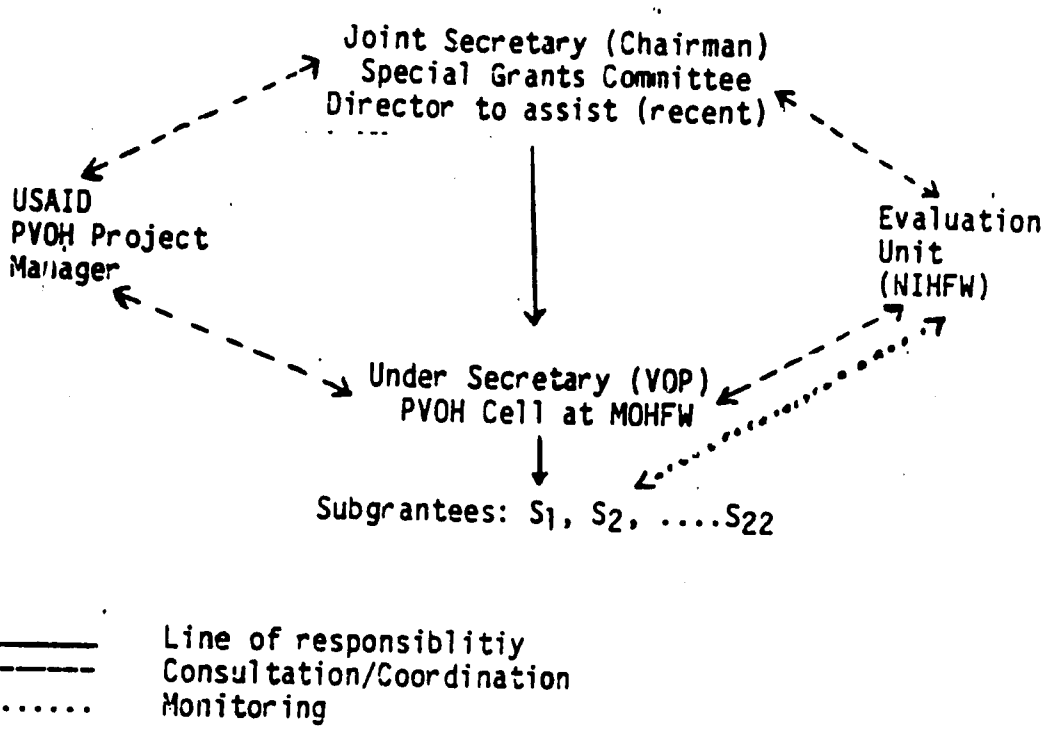
- emphasis on outreach services to less served areas, both urban and rural;
- emphasis on basic and special preventive/promotive health care;
- complementarity and supplementation of other government services in the area;
- replicability of the sub-projects;
- sustainability of sub-project activities after the grant period is over; and
- the NGO has to share 25 percent of the total cost of the project.

Over 150 proposals were received and of these 32 were sanctioned, fully committing the amount of the grant under the agreement. Because of a slow start, the first projects were not approved and launched until late 1983 and early 1984. The last project was not sanctioned until early in 1987.The original Project Assistance Completion Date was September 1987, but this was extended three times up to the end of September 1990.

As shown in Annex IV, the sub-grants ranged from Rs. 1.2 million (or 12 lakh) to Rs. 16.1 million (1.6 crore or approximately $800,000 at the current rupee exchange rate). Approximately 1.6 million people benefited from the NGO project activities. Five of the 32 projects were unipurpose efforts, supporting single services in leprosy, tuberculosis or eye care. Of the multipurpose projects, three were in urban slum areas, three were both urban and rural, four covered predominately tribal areas and 18 were entirely rural. All the sub-projects included maternal and child health (MCH) family welfare, nutrition, environmental sanitation, health/nutrition education and simple curative services. One blindness control project (in Bulandshahar District of Uttar Pradesh) was never launched and the grant was cancelled. The grants were used by the NGOs for a variety of things, including the hiring and paying of additional workers, providing training, the construction and refurbishing of facilities, and the purchase of equipment.

Figure 1 describes the flow of responsibility in PVOH-I Project management. Grant applications were solicited by means of advertisements in the leading newspapers of India. Two copies of the NGO proposal went to the MOHFW and one copy to the respective state government for recommendations to the GOI. The first step of the review was preliminary screening. For most of the projects this was conducted by the NIHFW. The technical feasibility of the project was examined, considering the time frame and cost. All aspects of the proposal were assessed, both medical and non-medical. The NGO's experience in fields related to health and other related background and sustainability were examined. It had to have at least three years of successful programming, and its proposed project had to be innovative and complement existing government activities. Finally, there had to be a 25 percent contribution from the grantee (from indigenous sources). If the proposal survived this phase, it was selected for field appraisal.

Figure 1: Flow of Responsibility



The field appraisals were conducted by a team consisting of MOHFW and NIHFW officials. If the proposed budget was large (over Rs. 1 crore), a USAID/New Delhi representative joined the appraisal team. If medium (between Rs. 25 lakh and 1 crore), USAID may or may not participate in the appraisal exercise. Based on a site visit and discussions with organization officials, the appraisal team made their decision whether the project would be funded.

The Appraisal Report contained a brief introduction to the NGO, its area of operation, an summary of its experience, and details on the project proposed for funding under the PVOH Project. The project details included the area of operation, various activities/services proposed to be provided, implementation strategy to be used, the infrastructure (both physical and human) required to carry out the activities, total project costs (both grant-in-aid and the organization's share), and complete financial plan for the project period. Those proposals recommended for funding were sent for final approval to the Special Grants Committee (SGC). This 6-person committee consisted entirely of government officials, four of them from the MOHFW plus a representative from the Department of Economic Affairs and the Ministry of Human Resources development; a person from the concerned state's Health Department and the NIHFW were special invitees.

Once approved, the grantee received the first installment covering a period of six months. Subsequent installments were released by the MOHFW quarterly on receipt of the NGO's expenditure statement for the previous quarter. The NIHFW had the primary responsibility for monitoring and evaluating sub-project activities. The Institute is the technical arm of the MOHFW and is chiefly involved in training and research activities. The NIHFW conducted annual monitoring visits to each of the sub-projects each years as well as carried out mid-term and final (or as referred to in this case "end-term") evaluations. In addition, the NIHFW provided technical assistance for the preparation of sub-grant proposals, carried out appraisals of the NGOs submitting proposals, and provide technical assistance as required. They also were tasked with monitoring the sub-projects' financial situation for which the contracted chartered accountants who verified grantee fund utilization and, as required, provided guidance on proper financial management. The first monitoring visit took place within the first three months of sub-project approval and, among other things, provided the NGO with guidelines on how to conduct the baseline survey as well as the reporting system. the quarterly progress and expenditure reports follow a structured format developed by the NIHFW.

D. Summary of Findings of PVOH-I Mid-Term Evaluation by USAID

The Mid-Term Evaluation of the PVOH-I Project was completed by November 1986. At the time the evaluation was carried out, 22 sub-projects had been approved. This exceeded the number of projects (15) that were originally planned. Initially it was envisaged that there would be larger grants to fewer NGOs. Experience demonstrated, however, that the NGOs could not absorb such large amount and were particularly constrained by the 25 percent matching requirement. The PVOH Project was modified so that 30 sub-grants would be financed. In the end, this number was raised to 32 in December 1986.

The Mid-Term Evaluation found that the project had developed an effective means for appraising and approving sub-grants as well as an appropriate mechanism for supporting health activities of NGOs. It pointed out that the project had led to the formation of a new NGO support cell in the MOHFW for administering the grants. The project also supported the creation of a new unit in the NIHFW that was to provide technical support to the grantees, review the quarterly reports, and carry out regular monitoring visits and evaluations of the field activities. The mid-term evaluation demonstrated that the sub-projects were providing a wide range of primary health care services to the poor in under-served areas by complementing the government program. The NGOs were placing emphasis on outreach services and community participation as well as the integration of key interventions targeted for the high risk groups (i.e., children under five, especially the under ones, and pregnant and lactating women).

Recommendations from the Mid-Term Evaluation include the following:

- Need to simplify and streamline the proposal guidelines as well as the review and approval process;
- Need to increase technical assistance to the sub-projects;

it was suggested that a network of regional experts and trainers might be developed to respond to this need;
- Need to devote more attention to the sustainability question;
- Need to strengthen the NGO unit in the NIHFW so that it could improve its technical assistance and monitoring capabilities;
- More frequent visit by the chartered accountants to the projects for monitoring purposes as well as training in financial management;
- The mid-term evaluations of the sub-projects by the NIHFW should focus on ways to improve service delivery and a workshop convened to discuss results;
- More communication between sub-projects should be encouraged by means of workshops or periodic newsletters;
- Quarterly meetings between MOHFW, NIHFW and USAID should be held regularly to discuss problems and to identify technical assistance needs; and
- A follow-on project should be seriously considered to respond to the demand for new sub-projects.

III. FINDINGS AND LESSONS LEARNED

A. Current Status

Thirty out of the 32 sub-projects approved for funding under the PVOH Project have been carried out successfully. One sub-project was never launched; this was the Bulandshahar Comprehensive Eye Care Services of Khurja, Uttar Pradesh. One other, the Guru Cooperative Milk Producers Union Limited in the Punjab, ended in 1988 due to a change in leadership. Thus the universe dealt with in this evaluation includes 30 sub-projects. The total population reached by these 30 sub-projects was approximately 1.6 million. Seven of the grantees covered a target population of over 80,000, 7 from 50,000 to 80,000 and 15 less than 50,000 (see Annex IV). There was a broad distribution of project activity, with PVOH sub-projects in 15 different states. Gujarat led the list with 4 sub-projects; Madhya Pradesh, Maharashtra, Tamil Nadu and West Bengal had 3 each; Haryana, Kerala, New Delhi and Uttar Pradesh had 2 each; and Andra Pradesh, Bihar, Himachal Pradesh, Karnataka, Punjab, and Rajasthan had 1 each.

Out of the Rs. 168 million originally obligated, Rs. 20 million were not spent. Of this amount, half has been deobligated and reobligated to the PVOH-II Project. Five million of the rupees is to be added to PVOH-II sub-project support; the other Rs. 5 million is added to the PVOH-II Project Development and Support (PD&S) funds, giving it much needed funds to support project-related activities. What will be done with the remaining Rs. 10 million has not yet been decided.

The PVOH-II Project was authorized in August 1987, with a funding level of $10 million (in dollars). However, it was not launched until the first quarter of USFY-91 because administrative delays, primarily in USAID which was fully occupied in the management of the PVOH-I Project. The latter was

extended annually for three years. It did not come to an end until the end of September 1990.[2]

Discussion of the PVOH-I Project will concentrate on the four years since late 1986, when the mid-term evaluation was completed. The discussion follows the format laid out in the Scope of Work, addressing questions relating to three different levels - the national, NGO and community. It has been noted that several of the concerns identified in this evaluation were addressed as recommendations in the Mid-Term Evaluation of 1986; specifically, simplification of financial procedures,increased technical assistance, more communications between grantees and more attention to the sustainability issue.

1. National Level

In addition to USAID, the major actors in the PVOH Project at the national level have been the MOHFW and the NIHFW. This section examines the respective roles of the two organizations.

a) MOHFW

One of the objectives of the PVOH Project was to foster a closer relationship between the Ministry and the NGO community. The Evaluation Team found that the MOHFW has a positive view of non-governmental organizations. The officials to whom we talked in the MOHFW expressed both their interest and willingness to work with and through them to achieve the goals that have been established for the Ministry and have been spelled out in the most recent Five Year Plan. The MOHFW appreciated the capacity of the NGO sector to reach the needy populations in underserved or, in some cases, unserved, areas of India. This positive attitude represents a dramatic change which, at least to some extent, can be attributed to the PVOH Project - it provided the vehicle for the Ministry and the private sector to learn more about each other by establishing a closer working relationship.

The improved relations and increased cooperation between the government and the voluntary agencies have resulted from a number of factors. One is undoubtedly the increased support accorded NGOs in GOI policy and in the Seventh Plan. While the MOHFW has also increased the amount it programs through NGOs, PVOH still represents a majority of the amount expended by the Ministry. The project been the leading force in the effort to involve NGO more intimately in health care service delivery in India. Discussions with Ministry officials convinced the Evaluation Team that the GOI wants to program

---

[2] Even though it has not affected the project in any way, it should be noted that because the PVOH-I allocation was made in Rupees, the dollar value of the PVOH grant has been gradually eroded in relation to the dollar through the combined effect of devaluation and inflation. The original grant was valued at $20 million; by the time that the PVOH-I Project came to an end in 1990, the same rupee amount (Rs. 168 million) was worth somewhat less than half the original dollar amount.

increasingly greater amounts for health activities through NGOs. The PVOH Project can take at least partial credit for this, having been responsible for increasing and facilitating the relationship between the two groups.

The NGO cell established in the MOHFW has generally been effective in administering the project. As is so often the case, the major problems have involved financial matters. PVOH sub-grantees complained about the cumbersome procedures, the lack of flexibility and the slowness of disbursements, all very common concerns of anyone dealing with any financial bureaucracy. A number of these issues were mentioned in the Mid-Term Evaluation, but have yet to be fully addressed. Among the specific problems identified by the Evaluation Team were:

- delays in disbursements to the NGOs (as much as 9 months, which makes it extremely hard on the small NGOs especially, requiring them to borrow funds);
- holding up reimbursements on account of small discrepancies (as small as 80 paise in one case!);
- no line item flexibility, which makes it impossible for the NGOs to respond to changing environments and situations;
- limitations on the use of contingencies, which precluded the use of the funds for certain kinds of unforeseen expenses[3].

Despite the significant progress made in building a positive relationship between the MOHFW and the NGO community, both parties still feel that there is more room for improvement and a better understanding of the needs of the voluntary sector. More frequent joint meetings and discussions would help improve the mutual understanding and lead to stronger working relationships and collaboration in the future. The more the Ministry knows about how the NGOs function and vice versa, the easier it will be for both sides to join forces to address the health and family planning problems facing India.

T date little effort has been devoted to developing the relationship between the NGO applying for the PVOH grant and the department of health from the state in which the NGO is located. A copy of the proposal was sent to the state government for approval, and in most cases a state representative was on the appraisal team, but the state was not brought into the design or approval phase in a meaningful way. Notable exceptions to this rule were Gujarat and Maharashtra where impressive NGO efforts were launched in close cooperation with the respective state governments. However, in most cases the MOHFW expressed concern about the delay in receiving the necessary approval from the states. To address this problem they established a time limit after which it would automatically be considered that the state consented. This lack of state involvement carried on to implementation of the sub-projects. Most of the departments of health in states where PVOH activities have taken place are

---

[3] One NGO spent Rs. 3000 on cooks for a two-day training session it held for its volunteer health workers. They charged this expense to the contingency line item. This was disallowed because the original budget had identified the contingency to be used for stationary supplies.

not aware of what NGOs can do in health and have little experience in working with them.

b) NIHFW

The National Institute of Health and Family Welfare has carried out its responsibilities of monitoring and evaluation as specified. All mid-term evaluations were carried out, as were the annual monitoring visits. All the final or end-term evaluations have been completed as well, although seven of the reports have yet to be released. In general, 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 made the PVOH Project unique and differentiates it from the other centrally-funded NGO support projects which do not include the technical oversight function. The invaluable role played by NIHFW is one of the chief lessons learned in PVOH-I; if quality programming is the objective, a technical group must be involved to ensure that sub-projects are appraised, monitored, supported and evaluated.

Despite the positive part played by the institute, the Evaluation Team identified a number of issues and concerns relating to the technical role the NIHFW has played in the PVOH Project. These relate to the baselines, the quarterly reports, the mid- and end-term evaluations, technical assistance, the auditing of the sub-grantees, and constraints faced in carrying out the work.

- **Baseline Studies** - The baseline studies reviewed during the site visits were found to be too lengthy and in many cases included unnecessary data. In a few of the early projects, the NGOs surveyed the every household in the project catchment area. This was later changed to include only a sample of the households. A lot of data was collected on socioeconomic status (e.g, age and sex of household members, educational status, number of currently married women by age group). This information was "nice to know" and appropriate if research were to be conducted; however, the data were not useful for sub-project management purposes and was never used during project implementation.

The Evaluation Team also found instances of incorrect information in the baseline studies. In one case, the study mentioned that no pregnant women had received vitamin A supplements. In fact, pregnant women are not supposed to consume mega-doses of vitamin A. In another case, there was confusion as to denominators, but in neither case was there any feedback from the NIHFW pointing out the shortcomings.

- **Quarterly Reports** - The format for the quarterly reports is cumbersome. The reports seen in the field were over 20 pages in length, the first 8 pages being devoted to financial accounts (every single expenditure no matter how small had to be included). The sub-project service delivery data consisted mostly of input indicators. While targets were asked for and coverage rates could be determined, much information asked for was not used by the NIHFW or the project. According to the NGOs representatives interviewed by the Evaluation Team, they were not consulted in determining what data should be collected and how the information would be utilized.

Although the 11 projects visited by the Evaluation Team had population-based (or household) data, they were unable to provide it in a manner that would be useful to the manager, supervisor or community (e.g., coverage rates for the major interventions). Part of the reason for this was the format of the quarterly reports. The projects were not asked to present the data in a form that was useful to the sub-projects. Moreover, there was no reporting of births and deaths in the under five age group. The birth figure can be derived from the number of pregnant women, but the death data are nowhere to be found. Considering that infant and child mortality reduction is the primary goal of the PVOH Project, the Evaluation Team believes that mortality rates of the under fives should be tracked. While the mortality rates derived may not be statistically valid, the data, over the six or seven years of the PVOH Project, could have been revealing. At the very least, they could have shown whether or not there was a downward trend. More importantly, by focusing on deaths of the under fives, the sub-projects would have had a greater appreciation of the causes of death and how under five mortality might be reduced.

One of the more serious concerns was the lack of feedback to the NGOs on their quarterly reports. According to the NGOs, they received no comments or questions, even when mistakes or omissions were made.

- **Mid- and End-Term Evaluations** - The Evaluation Team found it useful to have the results of the NIHFW's end-term evaluations available when it visited the respective grantees. The 600-household surveys made at each sub-project gave us some objective figures on what had been accomplished in the individual efforts. However, the evaluations carried out by the NIHFW became quite rote, each one being almost identical. Whenever a problem or deficiency was identified in an NGO project, there was little analysis or discussion of the reasons for it. In addition, because the focus of the NIHFW was almost exclusively on service delivery activities and coverage, there was virtually no consideration of quality-of-service issues. The quality of the care provided was never mentioned in any of the reports reviewed in the course of the evaluation.

A review of the various evaluations carried out during the course of the PVOH-I Project found that no process issues were included. As in the monitoring aspect, the NGOs said that they had played no role in the formulation of the evaluation proforma. It is possible that this can be explained by the fact that the formats for the monitoring and evaluations exercises were developed in the early stages of the PVOH Project when the NIHFW had not yet developed a close working relationship with the NGOs.

- **Technical Assistance** - The NIHFW is first and foremost a training and research facility. When the institute was involved in the PVOH-I Project, it was to provide the technical aspect to the appraisals and monitoring efforts, something the Ministry was unable to contribute. Originally, the provision of technical assistance was never envisaged as a responsibility of the NIHFW; it was added only when no other agency could be identified.

Prior to the PVOH Project, it had little experience in dealing with NGOs. During the course of the PVOH Project, NIHFW developed considerable expertise in working with NGOs. However, in discussions with institute

officials, they pointed out that NGO activities represent only a fraction of what the NIHFW does, and they are not viewed as a major activity of the institute.

It was pointed out by individuals interviewed that the NIHFW staff has limited experience designing and implementing action-oriented, integrated, community-based projects. This makes it very difficult for them to identify technical assistance needs during their monitoring and evaluation visits to the NGO sub-project sites.

Site visits found that the guidance given by the NIHFW for nutrition programming (e.g., growth monitoring, weaning) was inadequate. Rarely were comments made regarding nutrition data or programming activities. This could help explain why nutrition programming was generally considered to be weak in the projects visited by the Evaluation Team. In addition, technical assistance in such non-health areas as community participation and sustainability were particularly difficult for the NIHFW to relate to since they had no capabilities in these matters.

- **Auditing** - The financial monitoring function was contracted to two chartered accountant firms in New Delhi. This arrangement has been highly successful from everyone's perspective. The MOHFW has been able to maintain the financial integrity and accountability required; there were no reported or identified case of project funds being diverted or misused. The NIHFW was pleased with the service provided by the chartered accountants. The NGOs without exception expressed their satisfaction with the arrangement, finding the chartered accountants to be less rigid than government auditors. In addition, they found very helpful the technical assistance provided by the chartered accountants, especially in developing or strengthening their financial systems.

According to sub-project administrators the Evaluation Team visited, the chartered accountants reviewed each and every receipt. In most commercial audits, only 10 to 20 percent of the receipts are chosen for scrutiny. The cost of the audits could be reduced if the sampling methodology were adopted. Finally, the cost of the financial monitoring function was high, due primarily to the fact that both chartered accountants were located in New Delhi, thus requiring travel and per diem for visits to each sub-project each year.

Another issue that caused concern for the Evaluation Team was the failure to take depreciation into account in the monitoring of the PVOH sub-projects. It is suggested that when considering the long-term sustainability of the project, it is essential that depreciation be included in costs. This is the only way that replacement of capital assets obtained under the PVOH Project can receive explicit attention.

It was also observed that some of the NGOs used questionable means or mechanisms to acquire the 25% match required by the PVOH Project. The authenticity of the matches were not reviewed by the chartered accountants during their sub-project visits. As will be mentioned in the next section, such practices can and do have a negative impact when it comes time for the NGO to sustain itself.

- **Cost** - The aspect that makes the PVOH-I Project unique and is responsible for much of the success it has achieved is the appraisal, monitoring and evaluation role played by the NIHFW. The cost of this activity was Rs. 54 lakh over the six-year period[4]. This amounts to barely 3 percent of the total project budget. The Evaluation Team believes strongly that this investment pays off in the improved quality of sub-projects.

- **Constraints** - Several logistic and cost problems were associated with having the NIHFW serve as the technical support for the PVOH Project. First was the problem associated with travel of some of the NGO cell responsible for monitoring the sub-projects. Because of their rank, government regulations prevented them from traveling by air. Train travel was inefficient and costly in terms of pay and per diem. However, if the monitoring teams were made up only of officials of sufficiently high rank to be able to fly, the cost of personnel would be increased. Moreover, the NIHFW does not have sufficient personnel of such a rank that it can spare for the PVOH Project.

Having to monitor and evaluate all 32 PVOH sub-projects from New Delhi was extremely difficult and time consuming for the NIHFW. It was also very expensive. Approximately half of the budget for monitoring and evaluation activities was spent on travel and per diem costs.

2. NGO Level

The most important issues relating to the NGOs, identified by the Evaluation Team, pertained to capacity building, differences in NGOs, communications among NGOs, use of data, sustainability and phase out, finances, and unipurpose projects.

- **Capacity Building** - The PVOH Project was intended to strengthen the technical and managerial skills of the NGOs. The Evaluation Ream's sub-project visits made it clear that this has been accomplished. A number of the NGOs, especially the smaller ones, mentioned that they did not know how to prepare a project proposal when applying for the PVOH grant. Thanks to technical assistance received from the NIHFW and the PVOH experience, the NGOs now feel comfortable developing and drafting project proposals. This is a skill that will serve the NGOs in the future, enabling them to submit proposals for additional grants from a variety of agencies. The NGOs also developed the ability to manage grants, developing better financial systems and upgrading their project monitoring capabilities.

The NGOs receiving grants under the PVOH-I Project greatly expanded their operations. The individual groups added a large number of staff members at all levels, from physicians to community-level workers. With this staff, the NGOs increased the populations served, in most cases expanding the catchment areas in which they had been operating.

---

[4] The faculty members who serve as PVOH committee members received no pay from the project. PVOH Project funds the salaries of the PVOH cell and the travel and per diem costs for all NIHFW personnel traveling on project business.

As is discussed in the next section, the grantees did a good job at increasing the coverage of the target populations in their respective project areas in the most important child survival or MCH interventions. These include, among others, immunization, ORT, health education, ante-natal care, vitamin A distribution, and family planning.

The Evaluation Team's site visits gave them the opportunity to observe NGO service delivery and determine their knowledge and skill levels in the child survival interventions being provided. In most cases, the NGOs were seen as doing a good job. This included the NGO staff as well as the community volunteers. They had been trained well in the interventions they were responsible for delivering. In term of quality of service, the Evaluation Team was satisfied that the sub-projects were doing well. Several examples include cold chains being properly maintained and instruments sterilized.

During discussions with the middle- and grassroots-level workers and community leaders, it was obvious that they are fully aware of the importance of ORT, its composition and its preparation in the home situation. Apart form the fact that there was a satisfactory ante-natal coverage in many of the projects, the quality of care was good. They had listed high risk factors of which workers at all levels were aware. Based on this information, referrals were made to appropriate levels. Sevadam has introduced non-formal folk media for transmitting health messages through local youth groups. This group was being used not only in the project area, but also being contracted by the government to promote health education in other parts of the state. Besides, both Sarvajanik Pariwar Kalyan and Sewa Samiti and SEWA-Rural are carrying out extensive health education activities using films, charts and graphs.

Several models of community volunteer training were seen. Sidhu Kanu Unnayan Samiti and Bal Rashmi have trained community volunteers who are not paid any honorarium for their services. At the same time, many others have trained part-time paid workers (SPKSS, SEWA-Rural, CINI) who were selected by the community. After initial training, these workers were involved in the periodic review meetings where they had opportunities to discuss, clarify and learn various aspects of project implementation.

The sub-projects developed and were implementing a variety of innovative, and in most cases successful, outreach strategies. For example, CINI had paid mahila mandal members carrying out some of the health activities; Sidhu Kanu Gram Unnayan Samiti trained village women as Family Health Volunteers; Bal Rashmi had a paid male and female volunteer for a group of villages. In Sevadam delivery kits were being manufactured. Besides, health education activities were being promoted through folk media. CINI was using chlorination fluid for disinfection of the village wells. These and other models are worth documenting and sharing with those who are interested in delivering services to the underserved at the community level.

Areas of concern included the general lack of success, in some sub-projects, in programming temporary contraceptive methods. This, of course, is a problem in India that is not restricted to the NGO community by any means. A more general weakness was observed in nutrition programming, a problem that was mentioned in the previous section. Growth monitoring was done poorly in

most of sub-projects visited. In some it has been discontinued. One only recorded weights rather than using a growth chart. Another was using an inappropriate scale (one meant for weighing fish). Of equal importance is the education of the mothers about the need to introduce solid foods around the sixth month. This is very difficult in India where the custom is to wait until the first birthday. There is no more important behavioral change that can be introduced. The sub-projects observed showed mixed success in this regard.

Another general concern was the lack of high risk or at risk programming in several of the projects. The exception was in the case of ante-natal care, where workers frequently identified high risk pregnancies and provided them special attention. The effectiveness and efficiency of the field workers can be dramatically increased by concentrating their energies and limited resources on those who are most in need. This is true in nutrition programming (3rd degree malnourished or not growing), immunization (the one year old not yet completing immunization) and family planning (eligible couples with a child under three, more than three children, the mother under 20 or over 35). While most of the projects maintained lists of eligible couples, none of them focused on the recruitment of high priority couples.

As mentioned in the section on the NIHFW, little technical assistance (either clinical or managerial) was provided to the sub-projects. It is not realistic to think that the NGOs themselves would identify technical assistance needs. Groups rarely see their own shortcomings or aspects that have to be strengthened. Many needs for technical assistance can be identified, ranging from nutrition programming, to methods/techniques for accelerating behavioral change, to monitoring and use of information, to fund raising strategies, to ways to sustain the efforts initiated under the PVOH Project.

- Differences in NGOs - The Evaluation Team observed that there are several clear distinctions to be made among the NGOs involved in the PVOH Project. For one the NGOs in western and southern India can be contrasted with those found in northern India. The former have demonstrated better organizational abilities and in several cases have developed close relationships with their state governments. The NGO tradition is stronger in the western and southern areas of the country. In addition, the health indices are usually better in these areas as well. The reverse is true for the northern states. State governments are less results-oriented and rarely committed to working with NGOs. There is less NGO tradition and development, and worse health and socioeconomic indicators.

Another difference that is noted, and has programmatic implications, is large versus small NGOs. The larger NGOs are usually older and have better resource bases; their experience and high level of expertise make them effective and successful grantees. In many cases the larger NGOs (e.g., KEM, CINI, BCC, SEWA) have multiple sources of support, thus reducing the trauma of sustainability. On the other hand, the smaller NGOs (BAM, Sidhu Kanu, Bal Rashmi, Sevadam) need more assistance in designing and drafting their proposals, strengthening their management and information systems, developing their sustainability plans and strategies for income generation. The latter are less able to survive the delays in financial disbursements that

occasionally occur. There is also a difference between NGOs working in the urban slums and those operating in the rural areas where community involvement and integrated programming involve quite different approaches.

- **Communications** - There has been very little interaction between the NGOs that received grants under the PVOH Project. All grantees were brought together for several procedural workshops in the early years of the project and for the Sustainability Workshop in August 1990, just before the project officially came to a close. The participants we interviewed agreed that the latter workshop was a great success. The exchange of ideas was useful for all concerned. It was also helpful psychologically for the NGOs to see that they were not alone in facing the problems of sustaining the PVOH-funded efforts. The NGOs mentioned that they thought more such workshops during the course of the PVOH-I Project would have been helpful.

- **Data Use** - The Evaluation Team found it frustrating that the PVOH sub-projects had considerable data collected at the household level, but were unable to provide a clear picture of what the coverage was of several of the most important interventions (e.g., immunization, ANC, contraceptive usage). Having failed to consolidate the information in a useful way, the sub-projects had not been tracking the most important indicators of project effectiveness. Nor were they able to identify which project village(s) or field worker(s) required greater attention. In other words, the projects were collecting a large volume of data but were not using it for management purposes. The Evaluation Team identified a general lack of a problem-solving approach in the PVOH sub-projects.

The lack of attention to mortality in the under five age group was also of concern to the Evaluation Team. With the reduction of infant and child mortality as the stated goal of the PVOH Project, it was expected that under five deaths (0-1 and 1-4) would have been tracked. All sub-projects visited were routinely collecting death data on the target population. However, few of the NGOs were using the information. This is a concern, since the projects had not identified the level of infant/child mortality or the leading causes of death. This prevented them from making adjustments in their strategies and interventions to improve impact. The sub-projects were in need of technical assistance on how to make maximum use of the data that they were already collecting.

- **Sustainability and Phase-Out** - The first priority when discussing sustainability is to define exactly what is meant by the term. The Evaluation Team sees it as the NGO continuing the efforts initiated under the PVOH Project, drawing support from any one or more of a number of sources, including:

- patient fees/cost recovery (e.g., drugs)
- government grants-in-aid or service delivery contracts
- income generated from entrepreneurial enterprises
- fund raising/donations (from individuals or corporations)
- local panchayats

It was obvious that the NGOs, especially the smaller ones, had not given sustainability much thought prior to the August 1990 workshop. USAID and the

MOHFW/NIHFW admitted that they did not pay attention to the sustainability issue during the appraisal or, even later, in monitoring exercises. After a slow start, USAID was under considerable pressure to program the PVOH funds and did not feel that it could spare the time to concentrate on development of feasible sustainability plans in the early stage of the project. Experience has shown that sustainability must be a concern from the very beginning of development efforts.

Sustainability was mentioned in the Mid-Term Evaluation as an issue requiring significant attention during the last half of the PVOH-I Project. Still nothing was done to promote the capacity of the NGOs to sustain their efforts once the PVOH funding terminated.

At the 1990 workshop, a number of the grantees expressed their inability to continue with the activities started under the PVOH Project. It was at this point that USAID and the Ministry consented to entertain proposals for two additional years of funding, the first on a shared 50-50 basis, the second with the PVOH Project providing only 25 percent of the total. USAID and the MOHFW are considering 11 proposals for extension at this time.

At the time of the Evaluation Team's site visits, the PVOH-I Project had officially been over for almost six months. Most of the sub-project activities were continuing. However, this appeared to be largely because many of the sub-projects had applied for and expected to receive additional funding under the 2-year sustainability extensions. The team was unable to assess how much of the PVOH-I supported activities would have been continued had it not been for the possibility of receiving additional funding. Already several of the sub-projects visited had reduced their level of effort, e.g., KEM and Sevadam in Maharashtra and the SPKSS in M.P. The latter stopped providing services at two of its five sub-centers that had been started under PVOH-I. This, however, is not necessarily a bad thing since it was made possible because the government had initiated services in these two areas; activating the government resources can be attributed to the SPKSS and is a positive outcome of the PVOH-I Project.

Several of the sub-projects that had contractual relationships with their state governments mentioned the difficulty in getting them to permit the charging of user fees. This is a concern for several reasons. The NGOs require the resources, if the effort is to be maintained. In addition, experience has demonstrated that small charges can have an important impact on the community. Not only do they value the services or drugs more, but the villagers also have an increased feeling of "ownership" of the project. If the people pay for the services, they can make demands. The psychological and political implications are significant. This was confirmed during our discussions with the community leaders in several project areas.

The Evaluation Team's visit to SEWA-Rural made it clear that one factor that has not been understood by the NGOs, or accepted by the government, is the need for the non-governmental agencies to cover their core staff costs or recover overhead. This is a vital concept, if the NGOs are to grow and sustain themselves. Without such support, the more projects or grants the NGOs receive, the worse off they are financially.

Most of the NGOs visited were beginning to explore ways to raise money from the public. Charitable contributions by individuals and corporations in the past have gone mostly to religious causes (i.e., building temples) or to support large hospitals. Usually rural health and development efforts have not been supported. Nor have there been efforts to solicit funds from those in a position to give. This new trend of indigenous fund raising offers many interesting and potentially valuable opportunities for Indian NGOs.

- **Finances** - As mentioned, the sub-projects fail to take into account the depreciation of capital assets received in the PVOH Project. This has serious implications for the long-term sustainability of the NGO efforts, since it produces systematic underestimation of program costs.

The matching portions of some of the PVOH sub-grants visited by the Evaluation Team are questionable. Some use inflated land values as their contributions. One increased the salaries of some sub-project staff, then had them contribute almost half their salaries to the NGO as a donation, which it then counted as part of the match. Efforts such as these are not helpful in the long run. The project has certain recurring costs required to sustain its service delivery activities in the community, and these must be met. Any scheme designed to lessen the burden in the short term will eventually catch up with them and cause problems; it will slow progress toward eventual and effective sustainability.

- **Unipurpose Projects** - The Evaluation Team did not visit any of the unipurpose projects. However, when considering the goal and objectives of the PVOH-I Project, the team feels that it is not appropriate to fund them. It is not possible for such schemes to have significant impact on the health or nutrition status of the target population, nor can they contribute anything to the family planning effort.

3. Community Level

The issues addressed in this section relate to the impact the PVOH-I Project has had upon the communities in which the NGOs carried out the project. The impacts are mainly of two types: the coverage with the basic health services delivered by the NGOs; and the community involvement aspect.

- **Intervention Coverage** - While the goal of the PVOH-I Project was the reduction of infant and child mortality, no data are available on what the NGO sub-projects achieved in this regard. While any such figures would not be considered valid infant or child mortality rates, they would let the project managers, field staff and community members know trends. Moreover, the focusing on the under five deaths would encourage the NGOs and communities to pay attention to each and every death in the target population. The causes of death should be identified. Slowly the project would identify trends and take action to reduce the causes, by adopting new interventions or modifying ones they are already delivering.

The achievements of the sub-projects in three of the major interventions are given in Annex V. Some of the performance figures are very impressive. However, the Evaluation Team was not able to validate this information. Of

particular note are the contraceptive usage figures. The end-term surveys found eight of the 23 projects having contraceptive prevalence rates of over 50 percent; one in Bihar had a rate over 70 percent. Another six had rates in the forties. It should be pointed out that these figures refer only to modern methods. They compare very favorably to national figures which include traditional methods as well. In addition, the PVOH-I figures are very good considering that the sub-projects were carried out in more backward and less served areas. Several projects showed a decrease from the baseline; the explanation is that different denominators were used and hence figures are not comparable.

Immunization coverage is also very good. Many of the sub-projects had rates in the eighties and nineties. For example, 18 of 23 grantees had coverage rates for DPT III above 70 percent. This is particularly impressive when compared to the baseline figures. However, it must be remembered that when the projects began, immunization coverage in India was generally very low. The Universal Programme of Immunization (UPI) had not yet started and measles vaccine was hardly available.

The ante-natal care coverage was somewhat lower - nine of the 23 sub-projects were found to have rates above 70 percent. This is area where the projects could put more attention. Yet at the same time, the inherent difficulty of reaching pregnant women in India must be understood in light of the tradition of women returning to their families for delivery, usually in the 28th month (often earlier for the first pregnancy).

As mentioned in the previous section, ORT coverage appeared to be very good. The sub-project workers and community members interviewed know the recipe and said that they were using it whenever a child had an episode of diarrhea. In addition, vitamin A distribution to the target population was being done on a routine basis in the sub-projects visited by the Evaluation Team. One sub-project, the Baroda Citizens Council, had a very good latrine program. The facilities that were constructed were being used, cost of maintenance being collected and were clean and functioning.

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.

Without control areas, it is not possible to compare the PVOH-I performance with areas not being served by the NGO. If one believes the national figures for immunization coverage, the sub-project areas may not be any better off. The ANC and family planning figures in some of the sub-projects are considerably better than the national averages. When compared to the areas surrounding the PVOH grantees, the Evaluation Team had the impression that they had significantly better coverage in the important MCH interventions. This is substantiated by the fact that several of the sub-projects mentioned that a considerable number of people from outside catchment areas availed themselves of the project's services. It must also be recalled that PVOH activities were carried out in underserved areas, meaning that they were considerably worse off than most of the country.

The absolute number of population served by the project is large, over 1.5 million people. However, relative to India's total population, it is insignificant. The team's site visits made it clear that the poorest and neediest of the target populations were being served, and that most areas where the projects were being carried out had indeed been underserved.

However, 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 about this strategy and the procedures developed in the PVOH Project will serve as the model for a broader NGO-government linkage in the health sector in the future.

- **Community Involvement** - Generalizations about community participation in PVOH-I sub-projects are difficult, because the term received many interpretations and grantees differed substantially in their approaches to it. As might be expected, the specialized health NGOs (such as the large hospitals) gave less attention to community involvement than did the community development agencies (such as Streehitakarni in Bombay and Sidhu Kanu Gram Unnayan Trust in West Bengal).

Because the history of primary health care in India has led to very passive attitudes among the people, and the expectation of free services, health has not been an easy area in which to introduce the broader participation characteristic of the community development approach. That approach also emphasizes addressing priority "felt needs" and, especially in urban areas, water, sanitation and income generation often took precedence over health, even among mothers. For example, in CINI, BCC, and SEWA-Rural the introduction of income generating activities and other development programs (e.g., water supply and sanitation) has lead to better rapport and acceptance of the health program by the community. It is for this reason that integrated programming should be encouraged in the PVOH-II Project. To be able to respond to community priorities, it is helpful if the project has a small amount of unrestricted funds. The PVOH-I sub-projects did not have the benefit of such resources.

The evaluation visits to PVOH-I Project sites made several things about community involvement clear. There are ways that the community can be stimulated to take an active role in health. One is to institute user fees or charges, as practiced by virtually every sub-project visited to a greater or lesser extent. This gives the community members a feeling of ownership, that, in turn, makes the health providers more accountable. It is seen as an indispensable part of community participation, over and above the income generation and sustainability aspects usually cited. The community accepts the small charges for services with little or no objection, if they perceive them to be of high quality. A problem arises, however, in sub-projects working under a contractual relationship with the government (e.g., SEWA-Rural and KEM). In these cases, the government objected to the charging of fees, but eventually consented.

The use of community members as health workers is another important component of community involvement. Again, all the PVOH-supported NGOs utilized community workers. More than reducing the personnel costs, which it certainly does, local personnel provide the project with high quality

workers who are loyal to the project, dramatically reducing turnover to very low levels. In the projects visited, the only significant personnel vacancies were in the physician positions. In one case (SEWA-Rural), the state government objected to the use of personnel from the area who did not meet the minimum educational standards for a particular position. In the end, the government agreed and the community workers were accepted.

Where community groups are well organized, the health services become one of many self-help, problem-solving activities. Volunteer health committees were found in all the PVOH sub-projects visited. With appropriate guidance from the PVOH grantee, these committees perform useful services - motivating and mobilizing beneficiaries, channelling community perceptions of service quality to managers and generating resources that contribute to the support of the project. Several projects (e.g., CINI in West Bengal, Streehitakarni in Bombay) make very effective use of the women's organizations or mahila mandals in the villages.

Although there is a reluctance in the development community to rely upon volunteers to deliver services, the PVOH sub-projects prove that volunteers can play a role. Some of the volunteers receive a small monthly salary (Rs. 100 - 250) and apparently do a respectable job in serving the community. Most of these are women who provide outreach services and regularly call on families in their areas of responsibility to do such things as educate, mobilize for health services, follow-up on missed appointments. As the PVOH Project came to an end and resources were not available, many of the sub-project staff continued to work without pay, because of their high level of commitment to the community and to the project.

For genuine community participation to take place, considerable time is required. Several of the PVOH grantees found that months had to be spent in sensitizing, orienting and involving the community. It is during this time that the community is organized, a partnership is developed and demand for services is built. The initial investment in sensitization, education and training can yield important long-term returns and in sustaining the effort once the outside funding is no longer available.

While the grantees in PVOH-I have made a start in the community involvement aspect, a number of them, especially those with a narrow health orientation (SPKSS, BAM, Sevadam) could benefit from some technical assistance in this area. Working with a community, mobilizing it to action, and eliciting the proper support are technical skills as much as agriculture, education or health care. Very little technical support to help NGOs design community involvement strategies and strengthen such efforts was available through the PVOH-I Project.

IV. FUTURE CONSIDERATIONS

This chapter is based upon the evaluation findings as detailed in the previous chapter. It also responds to USAID/New Delhi's request that the team consider what USAID and the GOI should do in the future, to promote greater public-private cooperation in the health sector. The Evaluation Team views

PVOH-I as having been highly effective in increasing MOHFW awareness and support for NGOs. However, it is not clear what would happen if the PVOH-II Project did not exist. For example, the level of MOHFW funding of NGOs in health would drop by approximately half and there would be no readily identifiable mechanism or structure through which the NGOs could receive support from the government. Only grants-in-aid would continue, with no formal appraisal, no monitoring, and no technical assistance. Therefore, the team saw an important need for the PVOH-II to do more than fund another 30 NGO health projects. USAID and the MOHFW demonstrated that they could do that quite effectively in PVOH-I. The issue is how USAID can assist the MOHFW to establish a permanent structure for programming funds to the NGO community, to serve the hardest to reach and underserved populations, in the future. If the project is to have a lasting and significant impact, it will have to address and focus on the **PROCESS** issues. This will require a different set of activities and will by no means be easy. If it succeeds, the PVOH-II Project will have made a significant contribution to India and its population.

The issues for future consideration can be grouped into three categories: programmatic, sustainability, and, most important, the structural concerns.

A. Programmatic Issues

There are a series of concerns, raised and discussed in the last chapter, that, if addressed, will help to improve incrementally the quality of the PVOH-II Project, the successor to the successful PVOH-I Project.

These concerns include;

- How to encourage discussion that will help the MOHFW to better understand NGOs;
- How to accelerate the flow of funds;
- How to simplify audits;
- How to simplify monitoring and make it more useful for program management;
- How to monitor quality of services more effectively;
- How to assure that grantees receive prompt and useful feedback on all documents they submit;
- How to encourage communication among PVOH grantees;
- How to provide guidance that reflects adequately the many differences among NGOs;
- How to generate and community participation more effectively;
- How to assure that the health services reflect the felt needs of the beneficiaries; and
- How to get the government to accept user fees and health workers with less than minimum educational standards.

B. Sustainability Issues

Considerable attention is currently being addressed to the problem of how the PVOH-I sub-projects are going to be sustained. In the words of the former project director who was responsible for the implementation during the

early years of the project, little attention was given this important issue when the sub-projects were being designed and appraised. Only very late in the project did sustainability become a major concern. Eleven grantees have applied for two year extensions, that will give them 50 percent of their recurring costs the first year and 25 percent during the second year. The Evaluation Team considers the extension grants as a necessary and worthwhile investment; without them it is very possible that a significant portion of the financial inputs to date might be in danger of being lost. It is understood that five extension grants have already been approved and a workshop is planned for others to assist them to come up with viable sustainability plans.

The prospect of having to survive without the grant has forced grantees to come to grips with what sustainability means, and to develop strategies for covering their operating costs. The grantees have identified a number of innovative and creative ways to raise money. PVOH-I provides several lessons important for any future NGO support project. One is that technical assistance may very well be required by NGOs at the project design and appraisal stage, to help them think through appropriate and feasible strategies for their particular situations.

Each grantee in the PVOH-II Project should have a sustainability plan prepared by the end of the first year. USAID and the MOHFW should review this plan to ensure that it is realistic. Then progress made in developing the strategy laid out in the plan should be assessed during the annual monitoring site visit. Government financial partnership is an aspect of the plan and should be addressed early. During PVOH-II efforts should be made to assure that the grantees absorb recurrent costs are absorbed on a phased manner so that they are able to survive the trauma of funding termination more easily.

There is discussion of reducing the amount of non-recurrent costs allowed in the PVOH-II grants. This could have serious repercussions on ability of some NGOs to generate income. One NGO in PVOH-I plans to derive a major portion of its income from its rural health center built with PVOH funds, by doing a large number of cataract operations there. Being a high priority in the area, patients are willing to pay a reasonable amount for this operation. People are already coming from outside the area for the procedure, thus enabling the sub-project to bring additional resources into the project area. The funds generated will go a long way to paying for the recurring costs of the outreach activities. Without the non-recurrent input from PVOH-I, this would not have been possible.

One problem identified by the Evaluation Team is inability of NGOs to cover their total costs. The NGOs working with government have agreements that do not provide funding for establishment or core costs. Consequently, the more grants the NGO receives from the government, the greater the burden on the voluntary organization. The grantees are generally unaware of this need for increased overhead. To rectify this problem, the NGOs require technical assistance to identify the cost implications of expanded services and to develop strategies to generate funds to cover overhead costs. Secondly, government should be made more aware of the NGO situation and encouraged to consider core costs on the part of the NGOs, or accept the principle that NGOs can include an overhead charge in their contracts.

Another issue that should be addressed in the new PVOH Project is the way depreciation is handled. It is suggested that sub- projects be instructed that all the capital inputs (building, vehicles, equipment) received through PVOH must be amortized. Unless this is done the sub-project will not be accurately reflecting their financial status. They will face problems when, no longer receiving grant funds, they have to replace capital goods. Thus, in the name of sustainability, depreciation should be taken into account from the moment capital items are purchased.

The same principle applies to the need to be stricter with the matching grant component of the grantees. As mentioned, some of the sub-projects have used questionable financial valuations or methods to meet their match. The validity of the NGO's match should be reviewed during appraisal, to ascertain if it is legitimate. The purpose of the match is to aid in sustainability and phasing over. Any effort to get around it only decreases the chances of the NGO to stand on its own when the time comes.

Finally, thought should be given to the phasing out of the PVOH grant. The period is likely to vary depending on the NGO. The smaller/newer community-based NGO will probably require a long period and at a more gradual decline in support. The phase out schedule and rate at which the grant funds will be reduced, should be negotiated during appraisal. In other words, there is a need to tailor the grant to the specific character and capability of the NGO in question.

C. Structural Issue

The structural issue occupied the greatest amount of the Evaluation Team's time. Concern was raised, at the launching of the evaluation, about the overall impact of the PVOH Project. Was the follow-on effort to be nothing more than the funding of another 30 projects? How can the project be expanded and have a greater impact? This question also relates to the long-expressed interest and stated intention of the PVOH Project to regionalize. These points plus what was learned during the course of the interviews in New Delhi and in the field, allowed the Evaluation Team to identify the issue of decentralization as a major concern, and one which should be addressed in PVOH-II. This was considered to be of vital importance since it linked both the issues of sustainability and expansion.

To date, PVOH activity has centered around the MOHFW and the Centre. All grants-in-aid are handled from New Delhi. This being the case, it was appropriate that a project focusing on the funding of NGOs should be run through the Centre and that USAID's efforts to improve government-NGO communications be done in New Delhi. However, such an approach raises several problems. For one, there is a limit to the number of grants the Centre could ever program. Large numbers of grants to NGOs are programmed by Rural Development (over 2,500 between 1985 and 1990), Education and Social Welfare. Unfortunately, however, past experience demonstrates that these arrangements leave a lot to be desired, because they support only those NGOs carrying out prescribed government programs and the programming institutions have no

mechanism to appraise, monitor or support the grantees. Flexibility and innovation disappear as does quality.

Another problem is the fact that health is a state subject. In the PVOH-I Project, the states played only a minor role. The departments of health had to approve the NGO grants in their respective states and state representatives sometimes joined the appraisal teams. However, as a rule they were neither included in any negotiations with the NGO nor involved in any substantive way with the process. Thus, as the NGO implemented the PVOH sub-project, there was little interaction with the state health department.

It became apparent to the Evaluation Team that expansion of the PVOH concept of government-NGO collaboration requires decentralization. The state departments of health must become substantively involved. This means that the PVOH-II Project has to do for at least one state government what PVOH-I did at the Centre with the MOHFW over the last eight years. Having accomplished in one state, the PVOH-II Project will have shown the way for other states to follow. In other words, the first state exercise will serve as the model.

As the NGO directors and Ministry officials were quick to point out, decentralization poses potential challenges. The NGOs are reluctant to have to deal directly with the states. The health departments, in the states selected for programming in the PVOH-II Project, do not have an existing or appropriate mechanism to work with NGOs. It will not be easy, but if large volumes of grants are to be programmed in health, decentralization is one of the few options available. If it is not possible, that is an important lesson to learn as well.

How would the decentralization be done? There are obviously several different models. What is described below is not meant to be a formula or prescription. Rather it is little more than an attempt to address some of the important issues, alerting those concerned with the PVOH-II Project to what might be expected and how the task might be approached. The Evaluation Team has tried to think through some of the more important issues and make suggestions that resulted from the process.

One of the first steps would be to hold a workshop for the directors of health from the northern and northeastern states which have already been selected for PVOH-II programming. The purpose of the workshop would be to orient them to what PVOH is and to begin to increase understanding about how NGOs operate, their activities, needs and interests. A second step, meant to increase their understanding and interest in NGOs, would be visits to outstanding NGO projects in their region and in places like Gujarat and Maharashtra that have valuable models of how governments and NGOs can work together to achieve shared objectives.

The transfer of the NIHFW responsibilities to the state could be done in phased manner, dependent on the capacity of the local organization to assume the role. One way it might be done is for a group to be identified that would eventually be responsible for all the activities now being carried out by the NIHFW. This would include appraising, monitoring and evaluating projects, identifying and providing technical assistance, maintaining a list

of consultants and contracting those that are required for short-term assignments, lobbying and advocating in support of the grantees.

Ideally, the state-level association would serve as the "honest broker" for health-related NGOs in the state. It would meet with government representatives and identify areas where the government had gaps in service, or where they think they require assistance. The NGOs working in or close to this area would be contacted, to determine their interest in being contracted to carry out a community-based health program there. If no NGO is currently operating in the area, the association would notify the membership, to see if any NGO would expand operations to this new location. The association would not only broker the "deal", but would also assist in negotiating the terms, having good relations with the state department of health and experience in developing such arrangements.

The most difficult aspect of a state-level operation is to figure out how the funding decisions would be made. Having the MOHFW send the money to the states is not likely to work since the government would consider it as part of back payments owed them by the Centre. The local association would also be reluctant to be responsible for this aspect since it consists of NGOs and would find selecting grantees from among them very difficult and politically charged.

The Evaluation Team identified one possibility based upon its discussions with involved and interested parties. For the time being, funds would be held by the NIHFW. In the individual states there would be a panel which would attached to, but be independent of the local association. It would decide which projects are funded. This independent group would be selected by a nominating committee. Each member would serve for a fixed amount of time. The number of people sitting on this panel would have to be determined, but it is thought that it might be approximately nine. At least half of the members would be from the voluntary organizations, the rest coming from the public sector. Although it might take some time to negotiate such an arrangement with the state government, the process might be expedited if a strong local association is put in charge of it.

The association to be chosen cannot be identified at this time since it is not known in what state the decentralization effort might be launched. Several possibilities have come to the attention of the Evaluation Team, including SOSVA (Society for Service to Voluntary Agencies), which is currently only working in Maharashtra but has expressed an interest in working elsewhere in the country. It has negotiated an arrangement with the Maharashtran Government. Moreover, the organization is comprised of senior former officials who know their way around and through bureaucracies. However, one disadvantage is that SOSVA may lack experience and contacts in the state that will be chosen.

Another possibility is Voluntary Health Association (VHA) in the state where decentralization will be attempted. These branches of VHAI are independent bodies that could provide most of the required services. The VHA is often well connected and respected, thus being able to hold its own with the government and make things happen. The biggest question is deciding who

will receive the grants. The organization has justifiably always been reluctant to handle and program money to its member organizations. It has relaxed this to some extent recently, by beginning to program funds. In fact, if the operation works as envisaged, the VHA branch would only indirectly be involved in money matters. The selection panel would be separate and only use the association as a convening center and for logistic support.

The decentralization process can begin with the technical assistance aspect of the PVOH-II Project. The VHAs in states where PVOH-II sub-projects are being implemented could be contracted to provide technical assistance. This is something that the organization is already doing at the central level. The association with the PVOH-II Project would enable it to develop this capability further and strengthen operations at the state level. Because this is one of the identified concerns in the PVOH to date, a duel benefit will be derived. First, the quality of technical assistance would be improved. Secondly, it would reduce travel costs. It would also enable the MOHFW and USAID to develop relationships with the VHAs and get them involved in the PVOH Project. At the same time, the VHAs would have the opportunity to work with the state governments, which could prove important as the VHAs become more involved in PVOH programming.

The state-level body will require a central organization that represents its interests and those of its members with the bureaucracy in New Delhi. This central organization need be nothing more than a small secretariat, consisting of a few individuals with experience in dealing with the government machinery. As the state associations are being formed, the NIHFW could serve this function. In the future, a new group would be required to carry out this function. One group with the title of Voluntary Action for Family Welfare and Health (VAFAH) has been mentioned and has received some support among decision makers in the MOHFW and the government. It is interesting that the formation of such a central organization is currently being discussed in New Delhi prior to any effort at decentralization being made.

If such an central organization were formed, there are several concerns. Based on interviews and discussions at both the Central level and in the field, concerned individuals stressed that it was important to prevent it from repeating problems that have plagued other central bodies formed in recent years to program funds to NGOs in others sectors (e.g., rural development). The tendency is for these groups to become extensions of the bureaucracy, and ending up programming money for existing government programs. At the same time, they often become highly political. It is said that such groups are often dominated by government officials rather than by the NGOs that they are meant to serve. All these factors taken together make it difficult for such centralized groups to provide the support required to ensure the level of quality achieved in the PVOH-I Project.

What are the implications of a strategy to develop state-level programming capacity? For USAID it certainly would require considerable effort and time. It would be slow, with numerous hurdles along the way. One concern would be the delay in disbursements of funds, since a year or more might be required to form the association and develop it to where it could operate effectively. It might be possible to obligate funds to the states,

which could only be released when the association is deemed to have reached the point of managing its responsibilities. Secondly, it would require addition manpower to put the state-level operation in place. It is suggested that it the task can and should be delegated to an outside contractor who can be on site over an extended period of time (from one to two years) to assure that the process is proceeding on schedule.

The other implication for USAID/New Delhi, if it is to pursue effectively the decentralization and sustainability initiatives as suggested in the this evaluation, is additional time. As currently scheduled, the PVOH-II Project is to terminate in 1995. Because project initiation was delayed three years, it is unrealistic to think that its objectives could be reached within the next four years. As mentioned, for sustainability and genuine community participation to be done effectively, time is required. The same can be said for decentralization and the establishment of responsible state-level associations to manage and administer PVOH activities in its area. accordingly, the Evaluation Team thinks it is essential that the PVOH-III Project be extended until September 1998.

Advantages can also be identified. First and foremost, the ability of the government and donors to support a larger volume of NGO activity in the health sector, without losing quality, would be established. The operation would be more cost effective, requiring less resources for travel and per diem. Moreover, being local, the state-level body should be able to do more to develop and sustain an effective government-NGO relationship. USAID should eventually be able to decrease its management role by delegating greater responsibility to the state. This will determine how well the system can operate without intensive management from the donor.

What the local association looks like and how it functions cannot be fully described, since no such organization now exists anywhere in India. There is no precedent; the path will have to be blazed. Since there is no mechanism currently existing in any sector at the Centre that effectively serves this function, the PVOH-II Project will have to explore new options.

V. RECOMMENDATIONS

Overall the Evaluation Team was impressed with the achievements of the PVOH-I Project, at the national, NGO and community levels. It has accomplished in a satisfactory manner the objectives established in the project paper. At the national level, the MOHFW has become comfortable and capable of working closely with the NGOs. Moreover, the NIHFW has developed expertise in working with the community-based approaches being implemented by the NGOs. The NIHFW contributed greatly to the PVOH-I Project by its appraisals, monitoring and evaluation of all sub-projects, giving the project a high level of quality and assuring high performance by almost all the grantees.

The NGO used PVOH-I funding to strengthen their capabilities. They increased their management capacity while greatly adding to the staff, both in terms of quality as well as quantity. The NGOs also established a closer

working relationship with the government, developing a better understanding of how an effective collaboration can be realized. The value of the PVOH-I Project was manifested in high levels of coverage in such vital MCH services as immunization, ante-natal care and family planning. Impressive results were also noted in such activities as oral rehydration therapy, vitamin A distribution, and health education. The strategies developed by the grantees were often innovative and paid considerable attention to involving the community.

In the course of the evaluation, the team has developed a number of recommendations. Although PVOH-I has been completed, there are a number of suggestions that might be considered as USAID/New Delhi and the MOHFW implement the PVOH-II Project. These recommendations are divided into three categories: policy, program and project management. The policy recommendations apply to both USAID and the Ministry as they address fundamental aspects of the PVOH Project and have long-term implications. The program issues should be carried out in consultation with USAID as they refer to important substantive matters. The project management concerns are most appropriately handled by the NIHFW in day-to-day implementation of the PVOH-II Project.

These recommendations should not require any additional monitoring or management support from the USAID. Any increased effort required, such as the development of state-level operations, constitutes program implementation and can be contracted to qualified consultant(s). Because of the late start of the PVOH-II Project and because of the need of additional time to develop state-level programming capabilities and effective sustainability strategies, it is recommended that the PVOH-II project should be extended until September 1998.

A. Policy Directions

1. Sustainability

a. Definition - The USAID and the MOHFW should recognize that the sustainability of NGO activities requires that NGOs acquire resources from various sources, including:

- patient fees/cost recovery (e.g., drugs)
- govt. grant-in-aid or service delivery contract
- income generated from entrepreneurial enterprises
- fund raising/donations (from individuals & corporations)
- local panchayats

b. Phasing - The USAID and MOHFW should recognize that sustainability should be considered from the sub-project design stage and that there is a need to build in a phase out PVOH support, while recognizing that the speed and magnitude of increased NGO contributions will vary widely.

c. Technical Assistance - PVOH-II should provide technical assistance to grantees on the development of resource mobilization strategies and specific fund raising and techniques to implement them.

d. Costing - NGOs should be cautioned to include the depreciation of capital equipment, and the increased overhead cost of expanded operations, when calculating financial requirements for sustaining project activities.

e. State Commitment - All grants approved for funding under PVOH-II should reflect dialogue and negotiation between state and government and grantees, to assure consistency between private and public health services agendas.

f. User Fees - User fees for services provided by NGOs should be encouraged. Government should not discourage the practice in areas where NGOs deliver services on a contract basis.

g. Income Producing Assets - PVOH-II guidelines should avoid arbitrary limitations on the financing of capital costs, since income generated through use of capital assets financed under the project, may contribute substantially to sustainability. It should be determined during appraisal if the non-recurring input will assist in income generation or increase the burden of recurring costs flowing from it, thus making sustainability more difficult to achieve.

f. NGO Matching Contributions - The matching portion of NGOs should be reviewed during appraisal to ensure that it meets the spirit as well as the letter of the provision. Unless proposed matches represent real and significant contributions to project support, prospects for sustainability are diminished.

2. Decentralization

a. Transfer of Responsibilities - To increase possibilities for greater participation by NGOs in health service delivery, PVOH-II should begin the process of transferring, to one or two states, the responsibilities now carried out by NIHFW, thereby doing at the state level what PVOH-I did at the national level.

b. NGO Cell - To facilitate dialogue between NGO representatives and government, PVOH-II should encourage and support establishment, in the department of health in each selected states, of a "NGO cell".

c. Workshops - PVOH-II should, early in the project, fund a workshop for directors of health in the target states, to increase their understanding and interest in collaborating with NGOs, to provide them with examples of effective government-NGO relationships, and to develop the attitude and skills needed to work successfully with NGOs.

d. Tours - PVOH-II should include funding of travel by health officials from the target states, to the western and southern parts of the country where NGOs have developed models of collaboration with government suitable for adaptation and transfer.

e. Possible Approach - There are several things that might be done to facilitate the decentralization process:

- State-Level Association - PVOH-II should encourage designation, in the target states, of an association of NGOs, capable of being assisted to appraise, monitor and evaluate NGO projects. The associations would have a number of functions:

  - select and maintain a consultant roster
  - identify consultants and facilitate their project-support work
  - select chartered accountants by tender and oversee their work
  - negotiate service delivery contracts with state governments
  - lobby and advocate for member NGOs
  - receive and distribute funds to member NGOs based on appraisals

- Initial Tasks - As the state-level associations demonstrate their capability, the NIHFW should begin to transfer the responsibility for the provision of technical assistance and the contracting of private auditors.

- Project Approval - Projects to be funded in the selected target states should be chosen by an independent panel, consisting of representatives of both government and NGOs, for which the state-level association will provide administrative support.

- Apex Group - The formation of a central-level coordination group should be deferred until a substantial number of state-level associations are functioning. In the meantime, the NIHFW should perform such functions.

- Contract Consultant - PVOH-II should provide funding for consultant(s) to act as a catalyst, expediting and providing technical assistance in the development of improved state-NGO collaboration.

B. Program Issues

a. Concentration - As proposed, PVOH-II should be concentrated in north and northeast India where health indices are lower and NGOs are less well developed.

b. Unipurpose Projects - Because PVOH-II focuses on MCH services, unipurpose sub-projects should not be funded.

c. Targeted Groups - The PVOH-II Project should give priority to populations in greatest need of the services by identifying at risk groups, especially in nutrition and family planning interventions.

d. New Interventions - As coverage and effectiveness of immunization, ORT and other PHC services improve, PVOH-II should give high priority to introduction of new services, especially ARI diagnosis, treatment and prevention, identifying such interventions by epidemiological analysis.

e. Nutrition - PVOH-II should give special attention to upgrading nutrition components of PHC services.

f. Integration - PVOH-II should integrate its health activities with water, sanitation, non-formal education and other development activities which are high priorities of the community.

g. Unrestricted Funds - PVOH-II sub-projects relying heavily on community participation should include a modest amount of unrestricted funds to enable it to respond to high priority community-identified needs arising during project implementation.

h. Variable Time Requirements - PVOH-II sub-projects having active community involvement as a project objective should be given sufficient time to develop genuine community participation prior to initiation of service delivery.

i. Health Committees - Local health committees should be formed and supported in PVOH-II sub-projects having community involvement as an objective and expecting the community to play a significant role in sustaining activities.

h. User Fees - Because fee-for-service payments strengthen beneficiary sense of ownership, and increase insistence on provider accountability, user charges should be treated as an integral part of the community approach to health services supported in PVOH-II.

C. Project Management and Administration

a. Financial Procedures - Financial Procedures should be simplified and improved:

- by providing sufficient advances to eliminate liquidity problems
- by releasing all reimbursement funds, except for disputed amount
- by providing line item flexibility up to 5% without government approval
- by having a 5% unrestricted contingency

b. Auditing - Private auditors should limit their review to a sampling of receipts (possibly 20-25%) and should provide explicit acknowledgement of the adequacy of depreciation charges shown in NGO accounts.

c. Guidelines - The PVOH-II Project should take into account differences among NGOs and develop appropriate guidelines to work with each. Of special concern is the length of the grant and the phase out schedule. The smaller,

newer, poorer, community-based NGOs are likely to need longer than the four years allotted the PVOH-II Project to develop viable projects and means to sustain them.

d. Grantee Interaction - PVOH-II should arrange for an annual workshop for PVOH grantees. Some possible topics include: outreach strategies; monitoring/recording keeping/reporting; sustainability approaches/techniques/ experience; community participation strategies; income generating experience; fund raising; integrated programming at the community level. and ARI programming.

e. Community Health Workers - Persons with less than the government's minimum educational standard should be encouraged and approved by governments collaborating with NGOs in the PVOH-II sub-projects.

f. Monitoring and Reporting - The PVOH monitoring and reporting should be modified in collaboration with representatives of the grantees. The most important issues to be taken into consideration are:

- a limited number of key indicators should be identified;
- the quarterly reporting format should be simplified, tracking key indicators;
- more attention should be given to births and deaths (0-1,1-4);
- baseline surveys should be limited to collecting data on the key indicators;
- greater emphasis should be placed on monitoring the quality of services; and
- technical assistance to assist sub-projects to strengthen their record keeping should be provided as required.

g. Feedback - Arrangements should be made to ensure that the NGOs receive substantive feedback on their quarterly reports and other project-related reports they are required to submit.

ANNEX I

Private Voluntary Organisations for Health (PVOH)
PIO/T for Evaluation Consultants

SCOPE OF WORK

Background

Private Voluntary Organizations (PVOs) represent a major asset in India for the promotion of health, nutrition and family planning services. Keeping this in mind, the PVOH project was authorized in August 1981 as a 6 year project at the estimated LOP funding level of $ 20 million. The original Project Assistance Completion Date (PACD) of September 1987 was extended thrice to September 1988, 1989 and 1990. The Project funded 31 PVOs and subgrants approved ranged from Rs. 1.2 million to 16.1 million.

Out of the 31 PVOs which received funding, 27 had multipurpose and 4 had unipurpose projects. The multipurpose projects covered basic health, nutrition and family planning services and the unipurpose projects covered single services such as leprosy, tuberculosis or eye care. Out of the former group, 3 covered urban slum areas, 3 covered both slum and rural areas, 4 covered predominantly tribal areas, and 17 covered rural areas. Out of the latter group, 2 focused on health education related to leprosy and tuberculosis and 3 focused on eye care and blindness prevention.

AID funding was primarily used to expand and improve the quality of health outreach "community oriented" services provided by the PVOs by hiring additional workers, providing training, technical and management assistance and by improving physical facilities. For grant management, three institutional mechanisms were created by the Ministry of Health and Family Welfare (MOHFW) i.e. Voluntary Organisations Projects (VOP) section to screen applications, Project Coordination Committee (PCC) to review and appraise the proposals and Special Grants Committee (SGC) to finally approve the grant to selected organisations. In addition to this, National Institute of Health and Family Welfare (NIHFW) was responsible for appraisal, monitoring, evaluation, and special training support to PVOs, as well as financial monitoring and technical assistance.

The selection criteria used for the PVOs included the following i.e. complementarity with existing Govt. activities, consistency with the goals and purposes of the project, 25% contribution from indigenous sources, financial and technical feasibility for proposed activities, innovative approach to health care delivery, atleast 3 years successful track record in health care delivery. In addition sustainability plans beyond the post grant period and plans for serving less well served areas were also included.

The purpose of the project was to strengthen the Private and Voluntary sector so that it could expand and provide improved basic and special preventive health, family planning and nutrition services for the poor with a long term goal of reducing mortality and fertility among them.

A mid-term evaluation of this project was conducted in 1986. This complemented ongoing evaluation/monitoring conducted by the National Institute of Health and Family Welfare (NIHFW) as part of the project implementation. NIHFW has completed mid-term evaluations of all PVO sub-grantees and final evaluation of most of them and reports are available.

The mid-term evaluation by AID revealed that the PVOH project provided an effective system for appraising and approving subgrants as well as an appropriate mechanism for supporting health activities of PVOs. It also led to the establishment of a new support cell in MOHFW for administering the grants and support for a new unit in the NIHFW for providing technical support and carrying out regular monitoring and evaluation of PVO activities. The mid-term evaluation also showed that the sub-projects were providing a wide range of primary health care services to the poor in under served areas by complementing the government program. They achieved this by placing emphasis on community based outreach services, and the integration of key interventions targetted against high risk groups.

Based on the findings of the mid-term evaluation, a follow-on project was developed with increased emphasis on sustainability planning and provision of technical assistance. PVOH-II, which was authorized in August '87 with a funding level of $10 million for 8 years.

ARTICLE I - Title

Private Voluntary Organizations for Health.

ARTICLE II - Objective

To obtain services to assist the Government of India (GOI) in evaluating the PVOH Project.

110

ARTICLE III - Statement of Work

The contractor will provide two members, including the team leader of a four member team which will conduct an evaluation to assess the impact of this project at national (MOHFW / NIHFW), PVO and community levels with a view to highlighting critical factors producing impact. The evaluation will focus primarily at the purpose rather than at the goal level of the project i.e.it will attempt to determine how much impact the project has had on the expansion and improvement of services for the underserved communities and if the PVO sector has been strengthened for providing these services efficiently. The evaluation is expected to bring out lessons learned from PVOH that can be applied to PVOH-II project and some practical and policy oriented recommendations for the USAID.

The issues to be examined at the national, PVO and community levels are as follows:

AT THE NATIONAL LEVEL

A. **Central Issue:** What efforts are being made by the GOI, especially by the MOHFW to tap the potential of PVOs in achieving national health objectives?

Key Questions: To what degree has MOHFW recognized the potential of PVOs in health? Has MOHFW created or does it propose to create new structures and mechanisms at national and state levels to provide necessary support to PVOs in order to tap their potential in achieving national health goals? Are there

41

favourable policy changes reflected in the MOHFW's programs and increased budget allocations for PVOs? Are there any umbrella organizations or networks of PVOs emerging which can or are playing key roles in fostering the PVO role in the health sector? How significant is the shift in GOI attitudes towards the inclusion of PVOs in national health programs?

B. **Central Issue:** What is the extent to which NIHFW has developed institutional capabilities and interest in providing technical and professional assistance, to PVOs in the planning, implementation, monitoring and evaluation (PIME) of health activities?

Key Questions: Has NIHFW's involvement in this activity increased its interest in PVO sector? How far has it developed professional expertise in-house in PIME techniques for the better management of health projects? How effective has been NIHFW's technical, training, monitoring and evaluation support to PVOs in improving their management and delivery of health services?

Has there been any change in the perceptions of the NIHFW team regarding PVO's? Is NIHFW utilising the expertise it has gained from this project for other projects? To what extent are the changes in NIHFW's attitudes and practices towards PVO's due to its involvement in PVOH Project.

AT THE PVO LEVEL

C. **Central Issue:** To what extent have the PVO sub-grantees improved their capabilities to provide basic community health services (outreach) effectively and efficiently to the poor in under served areas?

Key Questions: To what extent have the technical and managerial capabilities of the PVO staff been improved as a result of this project? Have PVOs integrated their health activities with other sectors and coordinated their efforts with existing health delivery systems in project areas so that their efforts are complementing other health delivery systems and are not duplicating them? Have PVOs developed cost-effective and innovative health strategies and interventions which are replicable elsewhere? What is the PVO's perception of the Technical Assistance/monitoring support provided in this project as well as networking between PVOs? Is the level of funding and time frame provided sufficient to improve the service coverage/capability?

D. **Central Issue:** To what extent have the PVO sub-grantees taken effective steps to sustain the activities initiated under this grant?

Key Questions: Are the PVO's seeking ways to be self sufficient at least as far as core funds are concerned? Do PVO's have a long term sustainability plan? What

are the sources and strategies that are commonly being thought about? Which activities have the PVOs been successful in sustaining to date? Which have been discontinued? What are the key factors that have contributed to the success or failure in sustaining these activities. Have the PVO sub-grantees taken on large donor grants (PVOH) without considering the consequences when the grant dries up?

AT THE COMMUNITY LEVEL

E. **Central Issue:** Has the quality and coverage of basic health, nutrition, family welfare and preventive health services provided by the PVO sub-grantees improved significantly during the project?

Key Questions: What is the extent to which the health services rendered under the project succeeded in improving the general health status of the target population in terms of ante natal care, deliveries by the trained birth attendants, immunization and use of family planning methods?

F. **Central Issue:** What is the extent to which communities have participated in the planning and implementation of the health activities and have assumed responsibility for the maintenance management and financing of basic primary health care services on a sustained basis?

-44

Key Questions: Were communities adequately involved in planning and implementing health services supported by the Project? Were community health workers, such as traditional birth attendants,indigenous health practioners, etc. who worked with the project, properly and adequately trained, equipped and utilized in the community-based health programs? Were local groups and organizations given resources and responsibilities to maintain and manage community health services on their own? Have the concepts of revolving health fund and self-financing community health services emerged/proven successful in any project which might offer sustainability models worth replicating elsewhere?

Other Issues and Questions the team believes is important to consider in this evaluation.

IV. Methods and Procedures

In order to examine the above mentioned evaluation issues at national, PVO and community levels in a short period, the following methods and procedures will be followed.

A. Review of Project Documents

1. Five year plans and health policy papers by the GOI

2. Monitoring and visit reports, mid term evaluation reports and final evaluation reports prepared by NIHFW.

-45

3. "Collaborations with voluntary organizations in Health, Family Welfare and Nutrition" by NIHFW, 1989

4. Project Paper of "Private Voluntary Organizations for Health" 1981.

5. "Sustainability of voluntary organizations in Health", Report of the Workshop, August 1990.

6. Midterm Evaluation Report on PVOH-I, September 1986.

7. Quarterly progress and expenditure reports from PVOs.

8. Approved project proposals and appraisal reports on all PVOH projects.

9. Financial monitoring report by Fergusons.

10. Any other relevant documents.

B. The evaluation team will prepare protocols on issues and questions to be probed in meetings with key individuals. They will have meetings and discussions with officials from AID, MOHFW, NIHFW, the academic and voluntary organizations in Delhi such as VHAI, CAPART, PRADAN, Ford Foundation etc.

C. **Use of available data**

The NIHFW was responsible for periodic monitoring and evaluation of PVOH projects. Considerable amount of data has been collected and analyzed. The reports on midterm and final evaluations are available.

This material will be made available to the team on arrival in Delhi.

D. Visits to selected PVOs

The evaluation team will break up into 2 teams of 2 individuals each (one American and one Indian) and each team will visit 3 to 4 PVOs.

A representative sample of PVOs will have to be selected for observations,visits, discussions and validation of available data. Based on the mix of PVOs, their geographical location, and the time and logistic constraint that will face the evaluation team, 10 PVOs have been shortlisted for visits.

The team leader will develop a detailed methodology to be followed during site visits with a common agenda of issues and protocols and each group of 2 will visit 3 to 4 sub-projects within the available time.

Detailed profiles, documents and data related to selected sub-projects will be made available to the evaluation team members in advance, so that they can study them both before and during the field visits.

The team is expected to discuss the evaluation issues with concerned officials and to collect essential information during their meetings. They will also visit the community served by the project for observations and validation of data.

E. Interview Protocols and Summary Data Sheets

Interview protocols and summary data sheets to be used during the field visits will be developed prior to site visits.

ARTICLE V - Reports

1 The contractor will prepare a Draft Report, two (2) copies of which will be submitted to USAID/India at least two (2) working days prior to the presentation by the Evaluation Team.

2 The Contractor will present the findings to appropriate USAID staff.

3. The team members will revise the draft report immediately after the presentation, based on the comments and questions at the presentation.

4. The leader will be provided with written comments by the USAID staff. The report will be modified based on this feed back and will be submitted by the team leader within 10 days of receipt of comments.

5. In addition to standard evaluation report pattern, AID requires the following.

i. Executive summary stating:

-- Nature and purpose of the project evaluated.

-- Purpose and methodology of evaluation actually followed.

-- Findings and conclusions related to major issued examined

-- Recommendations for follow up action or in PVOH-II

48

-- Lessons learned for AID, MOHFW/NIHFW and PVOs in general.

-- Project Design and suggestions for improvement in future projects.

-- Specific inputs/improvements suggested along with financial implications and follow up action.

ii. Project Identification Data Sheet (in a prescribed form)

iii. Table of contents.

iv. Body of the report consisting of required chapters or sections more or less in the same order followed in executive summary. Only the findings and conclusions can be discussed in separate chapters or sections on issues or sets of issues related to the impact at community, PVO and national levels.

v. Annexures containing relevant data labels technical analysis and detailing of specific points made in the report.

ARTICLE VI. A. Relationships and Responsibilities

Team Composition

The evaluation team will consist of 4 members - 2 American and 2 Indian. All members will have extensive experience in policy oriented evaluation and private voluntary organizations in health services, with a sound background in community health, preventive social medicine or related disciplines. Individual members will focus on certain aspects but also be responsible for the overall evaluation objectives as set out above.

VI.B. Responsibilities of the Team Leader

He/she will study and follow the statement of work as set out above.

He/she will coordinate the efforts of 1 senior U.S. scientist and 2 senior Indian scientists.

He/she will take the lead and have the responsibility to:

1. finalise the protocols before the team leaves on its field trip.

2. to finalise the itinerary.

3. to finalise and submit to USAID a draft report 2 days before the presentation.

4. to complete and submit the final report within ten days of receiving USAID's written comments.

5. to finalise the specific responsibilities of each team member as regards report writing as well as aspects to focus upon during evaluation.

Responsibilities of the Senior U.S. Scientist

He/she will study and follow the statement of work as set out above.

He will be specifically responsible for evaluating the information systems that have been utilized in this project. He will evaluate the effectiveness at two levels, namely between the field worker and the PVO management and between the PVO and MOHFW/USAID.

He will examine the technical assistance provided by NIHFW and the perceptions of PVOs about the contribution of NIHFW.

He will analyze and report on other aspects of the statement of work as agreed by the team.

ANNEX II

DOCUMENTS REVIEWED

1. Agency for International Development (AID)- Project Paper, Private Voluntary Organizations for Health-India (386-0469) (AID, Washington, D.C., August, 1981).

2. Chaudhuri, Samir - "Non-Governmental Organizations in Health Care; Current Status and Future Possibilities"- Paper presented at Workshop on Involvement of NGOs in Family Welfare Program, NIHFW (New Delhi, November 1989).

3. Ferguson and Company - "Report on Review of Financial Monitoring Systems Under PVOH-I" (New Delhi, December 1988).

4. Haran, E.G.P.- "Involvement of NGOs in Health and Family Welfare Program - Experience of PVOH Project"- Paper presented at Workshop on Involvement of NGOs in Family Welfare Program (New Delhi, November 1989).

5. Haran, E.G.P.- "NGO-Government Collaboration in Health and Family Welfare: Experiences, Issues and Opportunities"- Paper presented at Workshop on Involvement of NGOs in Family Welfare Program (New Delhi, November 1989).

6. Krishnamurthy, K.G.- "Perspectives and Constraints for the Involvement of Voluntary Agencies in Development Programs"- Paper presented at Workshop on Involvement of NGOs in Family Welfare Program (New Delhi, November 1989).

7. MOHFW- "Collaboration with Non-Governmental Organizations in Implementing the National Strategy for Health for All" GOI (New Delhi, April 1985).

8. MOHFW- "Financial Assistance to Voluntary Organizations for Health, Family Welfare and Nutrition Services" GOI (New Delhi, February 1989).

9. MOHFW- "Private Voluntary Organizations for Health" GOI (New Delhi, undated)

10. NIHFW - "Collaboration with Voluntary Organizations in Health, Family Welfare and Nutrition: An Overview of the Project on Private Voluntary Organizations for Health GOI" (New Delhi, March 1989).

11. NIHFW and The World Bank- "Workshop on Involvement of NGOs in Family Welfare Programme - Introductory Document" (New Delhi, November 1989).

12. NIPCCD - "Grants-in-Aid to Voluntary Organizations - Report of a Workshop" (New Delhi, Janury 1989).

13. Subramaniam, P.A. and Grant, Joseph J. - "Report of Mid-Term Evaluation of the Private Voluntary Organizations for Health Project" (New Delhi, USAID, November 1986).

14. Talwar, P.P. and Goel, O.P.- "Involvement of NGOs in Family Welfare Programmes in India; Some Important Issues" (New Delhi, NIHFW, October 1989).

Project Documents

In addition, the evaluation team reviewed project proposals, appraisal reports, mid-term monitoring reports and final evaluation reports for all subprojects that were visited during the evaluation.

ANNEX III

LIST OF PERSONS INTERVIEWED

Government of India

Ministry of Health:

Ms. L. Sailo - Deputy Secretary, Family Welfare
Mr. Sree Kumaran - Former Undersecretary
Dr. N.S. Deodhar - Former Assistant Director of Health Services

State Ministry of Health, Maharashtra

Dr. Srinavasan - Former Secretary of Health
Dr. Rao - Former Deputy Director of Health Services

National Institute of Health and Family Welfare (NIHFW):

Dr. (Ms.) Sapru - Chairperson, PVOH Working Group
Mr. Y.P. Gupta - Member and Secretary, PVOH Working Group
Mr. C.V.K.V. Sastry - Statistician, PVOH Working Group
Dr. A.K. Agarwal - Member, PVOH Working Group
Mr. M.B. Chanana - " " " "
Mr. P. Talwar - " " " "

USAID:

Walter G. Bollinger - Director
Dale B. Pfeiffer - Deputy Director
Timothy M. Mahoney - Program Officer
James R. Kirkland - Division Chief, HPNS
John J. Dumm - HPN
Thomas Philip - PVOH Project Officer
John P. Grant - PDPS/PPE
Michael Hendricks - Evaluation Consultant
Dr. B.R. Patil - Evaluation Consultant
Dr. E.G.P. Haron - Former Director, PVOH I

CAPART (Council for Advancement of People's Action and Rural Technology) :

S. Gopalan - Director General

Ford Foundation:

Ms. Saroj Pachanvi - Health Program Officer

PRADHAN:

D. Joshi - Director

South Asia Partnership/FORAD:

J. B. Singh - Director

Voluntary Health Association of India:
Alok Mukhopadhayay - Director

In addition, one or more members of the evaluation team visited the following PVOH/I subprojects. Only senior staff interviewed are noted, but, unless otherwise indicated, field visits included observation of operations and interviews with field staff and community members;

1. Bal Rashmi Project (Jaipur) - Ms. Alice Garg, Secretary

2. BAM India (Calcutta) - Dr. A.K. Mitra, Project Coordr.

3. Baroda Citizens Council (Baroda) - Girdhar Vaswani, Executive Director

4. Child in Need Institute Project (CINI, Calcutta)
   Dr. K. Pappu, PVOH Project Coordinator

5. KEM Hospital Project (Pune, Maharashtra)- no field visit
   Dr. Kulkani - Project Director
   Dr. Samir Chaudhri, Director

6. Medical Relief Trust (Manipal, Karnataka)
   Major Chakladar, Project Director

7. Sarvajanik Pariwar Kalyan & Sewa Samiti (SPKSS, Gwalior)
   Dr. B.S. Verma - Secretary and Coordinator

8. Sevadham Trust (Pune, Maharashtra)
   Dr. S.V. Gore, Managing Trustee

9. SEWA Rural (Jhagadia, Gujarat)
   Dr. Anil Desai, Director

10. Sidhu Kanu Gram Unnayan Samiti (ICH, Amadpur, West Bengal)
    Mr. Banerjee, Secretary

11. Streehitakarini (Bombay)
    Dr. (Ms.) I. Parik, Director (no field visit)

ANNEX IV

Sub-Project Data

Sub-Project	Population Covered	Funding Initiated	Amount (Rs.mil.)	Extension Applied For
1. Streehitakarni	100,000	9/85	2.29	No
2. Baroda Citizens Council	35,000	9/85	2.56	Yes
3. BAM	26,000	9/85	1.67	Yes
4. New Century Welfare Soc.	100,000	6/86	4.38	Yes
5. Kamla Nehru Hospital	51,000	12/86	7.66	Yes
6. Maharishi Dayanand	32,000	3/88	1.22	No
7. AWARE	40,000	9/85	4.66	No
8. Chinmaya Tapovan Trust	28,000	9/85	4.22	No
9. Sewadham Trust	21,000	9/85	3.00	Yes
10. Krishi Gram Vikas Kendra	70,000	9/85	3.78	No
11. R.K Ashram Charitable Tr.	129,000	9/85	4.28	No
12. Sree Sivagiri Narayan Med Mis	26,000	3/88	3.07	No
13. Medical Relief Society	62,000	3/88	6.17	No
14. Voluntary Health Services	160,000	9/85	11.29	No
15. AVRV	26,000	9/85	4.31	No
16. KEM Hosp.	35,000	3/88	5.41	No
17. Charitable Trust & Health Res. Ctr.	37,000	6/86	5.02	Yes
18. Nootan Bharti	60,000	9/85	2.50	Yes
19. Bal Rashmi	32,000	3/88	2.80	Yes
20. Red Cross Homeopathic Council	69,000	9/85	2.99	No
21. Guru Coop. Milk Producers	120,000	9/85	6.83	No
22. SEWA-Rural	32,000	9/85	4.61	No
23. Sidhu Kanu Gram Unnayan Trust	65,000	9/85	3.04	Yes
24. CINI	80,000	9/85	5.13	No
25. Bhartiya Grameen Mahila Sang	50,000	9/85	1.63	Yes
26. SPKSS	34,000	9/85	4.02	Yes
27. Children's Welfare Society	38,000	12/86	6.72	No

28. KSDNG College of Ophthalmology	130,000	9/85	5.66	No
29. Leprosy Mission	Unipurpose	3/88	16.09	No
30. TB Association	Unipurpose	3/88	9.00	No
31. Khairabad Eye Hospital	21,000	6/86	7.65	Yes
32. Khurja Eye Relief Society	-----	12/86	- Early Termination	
Total	1,709,000		153.66	

ANNEX II

SUB PROJECT ACCOMPLISHMENTS

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

SUB PROJECT ACCOMPLISHMENTS

S. No.	Sub Projects	Vaccines	Immunization Baseline %	Immunization Final Evaluation %	Antenatal Care Baseline %	Antenatal Care Final Evaluation %	Contraceptive Usage Baseline %	Contraceptive Usage Final Evaluation %
11.	R.K. Ashram Charitable Trust, Trivandarum	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 III	8	82				
18.	Nootan Bharti, Madangarh, Gujarat	BCG	34	92				
		DPT III	30	83	21	49	13.9	29.8
		Measles	0	73				
		TT II	1	75				
19.	Bal Raahari Project Jaipur	BCG	4	95				
		DPT III	15	92	12	88	9.9	49.1
		Measles	0	86				
		TT II	2	72				
20	Red Cross Homeopathic Council Gurgaon, Haryana	BCG						
		DPT III	No Knl Te					
		Measles						
		TT III						

SUB PROJECT ACCOMPLISHMENTS

S. No.	Sub Projects	Vaccines	Immunization Baseline %	Immunization Final Evaluation %	Antenatal Care Baseline %	Antenatal Care Final Evaluation %	Contraceptive Usage Baseline %	Contraceptive Usage Final Evaluation %
21.	Guru Cooperative Milk Producers, Bhatinda, Punjab	BCG	9	81				
		DPT III	29	43	36	58	34.6	48.6
		Measles	1	39				
		TT II	0	94				
22.	Seva Rural Jhagadia, Gujarat	BCG	3	100				
		DPT III	2	82	NA	63	NA	47
		Measles	NA	81				
		TT II	NA	86				
23.	Sidhu Kanu Gram Unnayan Trust Memari, West Bengal	BCG	11	90				
		DPT III	27	86		13.2		44.2
		Measles	0	6				
		TT II	53	87				
24.	Child in Need Institute Calcutta	BCG	52	96				
		DPT III	35	87	NA	84	23.2	51.5
		Measles	0	73				
		TT II	0	78				
25.	Bhartiya Grameen Mahila Sang Indore	BCG	11	89				
		DPT III	4	89	NA	57	NA	56.9
		Measles	0	76				
		TT II	34	72				
26.	Sarvajanik Parivar Kalyan & Seva Samiti, Gwalior	BCG	0	0				
		DPT III	0	83	3	61	10.1	30.3
		Measles	0	0				
		TT III	2	95				
27.	Children's Welfare Society Churhat, MP.	BCG						
		DPT III	Report no					
		Measles						
		TT III						
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				

SUB PROJECT ACCOMPLISHMENTS

S. No.	Sub-Projects	Vaccines	Immunization Baseline %	Immunization Final Evaluation %	Antenatal Care Baseline %	Antenatal Care Final Evaluation %	Contraceptive Usage Baseline %	Contraceptive Usage Final Evaluation %
31.	Khairabad Eye Hospital Kanpur, U.P.	Uni	Purpose	Project				
32.	Khurja Eye Relief Society Khurja, U.P.	Uni	Purpose	Project	Early- Termination			