MID-TERM EVALUATION, PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH (PVOH-II)

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At the MOHFW, Mrs. Adarsh Mishra, Joint Secretary, provided our first orientation to the Ministry's commitment and role in PVOH-II. Mr. Bhag Mall, Director NGO, devoted time and attention to answering our questions, and clarifying the intricacies of the project selection process. We express our sincere gratitude to Mrs. Mishra, and her colleagues and staff at MOHFW.

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GLOSSARY

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwives
ARI	Acute Respiratory Infection
CBR	Crude Birth Rate
CHC	Community Health Center
GOI	Government of India
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
LFA	Lady First Aiders
NGO	Non-Governmental Organization
NIHFW	National Institute of Health and Family Welfare
MCH	Maternal Child Health
MIS	Management Information System
MMA	Mahila Mandal Activators
MOHFW	Ministry of Health and Family Welfare
MPHW	Multi-purpose Health Workers
ORT	Oral Rehydration Therapy
ORS	Oral Rehydration Salt/Solution
PCC	Project Coordination Committee
PHC	Primary Health Center
PIL	Project Implementation Letter
PVO	Private Voluntary Organization
PVOH	Private Voluntary Organization for Health
PVOH-I	Private Voluntary Organization for Health Project I
PVOH-II	Private Voluntary Organization for Health Project II
SGC	Special Grants Committee
SW	Social Worker

EXECUTIVE SUMMARY

Private Voluntary Organizations for Health (PVOH) II is a project of the Government of India/Ministry of Health and Family Welfare (GOI/MOHFW) with support from the United States Agency for International Development (USAID). The purpose of PVOH-II is to expand and improve basic and preventive health, family planning and nutrition services for the poor and underserved by strengthening the private voluntary sector. The goal of PVOH-II is to reduce morbidity, mortality and fertility among the rural and urban poor of India, particularly the morbidity and mortality of children under five. PVOH-II began on August 31, 1987 and is funded through August 31, 1997 with a total budget of US$ 13.4 million (a US$10 million grant from USAID in dollars, a US$0.5 million contribution from the Government of India (GOI) in rupees, and a US$2.9 million contribution by the PVO grantees in rupees).

The objectives of PVOH-II are to be achieved through the awarding of sub-grants to two types of PVOs. The first, Outreach Service PVOs, provide direct outreach health and family welfare services to underserved communities. The second, Support Service PVOs, which are usually larger, stronger, more established PVOs, provide technical assistance and support services to smaller/newer PVOs involved in health, training, or development projects. At the time of this mid-term evaluation, a number of the support service PVO's sub-sub-grants had not yet been sanctioned. The responsibility for monitoring and evaluation of all sub-projects has been given to the National Institute of Health and Family Welfare (NIHFW), the technical arm of MOHFW. Under NIHFW, a separate "Evaluation Unit" has been specifically created for this purpose.

PVOH-II got off to a slow start, with the first outreach sub-project sanctioned in April 1990. By December 31,1993, 39 sub-projects, (29 outreach and 10 support service sub-projects), ranging from Rs 1.3 million to Rs 12 million, have been sanctioned. To date, GOI/MOHFW has released Rs 8 crore 65 lakhs (Rs 86.5 million) to the PVOs and NIHFW. A total of US$ 1.4 million (Rs 3 crore and 41 lakhs) of the US$10 million obligated has been claimed by GOI/MOHFW, and disbursed by USAID.

The Mid-Term Evaluation of PVOH-II was undertaken under the aegis of John Snow, Inc. from January 10 to February 9, 1994. The team consisted of four individuals with considerable experience relevant to PVOH-II. The team leader was Dr. Michèle Andina, an independent consultant specialized in MCH and family planning, who has worked extensively with PVOs in both Asia and Africa; Ms. Susan Klein, John Snow, Inc., Program/Health Care Systems Consultant; Dr. C.A.K. Yesudian, Professor of Health Management at the Tata Institute of Social Sciences, Bombay; Dr. K.C. Malhotra Professor of Anthropology at the Indian Statistical Institute, Calcutta. Data for the evaluation was collected via document review, discussion with USAID, MOHFW and NIHFW officials, and through site visits to 11 of the sub-projects and 2 sub-sub-projects.

In the implementation of PVOH-II, the PVOs have shown themselves to be capable, committed and resourceful in the implementation of their sub-projects. The Evaluation Team has noted a number of significant achievements. The PVOs have:

- Expanded their geographical areas of service, added new health related services, and improved the services they offer;
- Developed horizontally and vertically integrated health care delivery systems, including some improvements in the service delivery infrastructure;
- Provided quality health related services to underserved, remote and isolated populations;
- Built their overall capabilities in project formulation, and financial management, and
- Strengthened linkages and working relationships with district and primary health center (PHC) officials to provide complementary and supportive services.

Progress in some areas of the sub-projects was observed to be in need of reinforcement. Innovation in both health care delivery and allied development activities has been limited by the selection process. Only a few attempts at integrating traditional and western systems of health care were observed. Community input into local programming has been largely missing, and while considerable training of village level health workers and volunteers has taken place, it has been uneven. Infrastructure development activities have been delayed, hampering implementation of activities as designed in the original proposals. Record keeping and management information systems (MIS) were observed to be weak in many PVOs. The lack of adequate records and a strong target orientation has contributed to gaps in coverage of the perinatal period (especially labor/delivery, post-partum, and neonatal care). Nutrition services lacked the necessary dietary counseling in conjunction with growth monitoring, and specific treatment modalities, e.g. for acute respiratory illness (ARI) were not evident.

The primary impediment to progress has been a "top-down" approach to overall project management, coupled with the inability of the management system to respond in a timely fashion. Technical assistance, training, and sharing experiences, while meant to be an integral part of PVOH-II, have not been forthcoming. The proposal selection process, as well as the monitoring system, have tended to focus on compliance and achievement of numerical targets. Flexibility and problem solving, hallmarks of PVOs, have not been encouraged, and technical support and guidance required by the PVOs has not been provided. To a large extent, the PVOs have been working on their own, with minimum assistance, in their attempts to implement their programs and expand their horizons.

The prospects for having sustainable health care delivery systems in place, in each of the sub-project and sub-sub-project areas at the conclusion of PVOH-II, are doubtful. Even if the original implementation schedule had been followed, this would have been difficult. Given the delays in project start-up, on-going delays in the release of funds, slow management response, and the limited number of years remaining, the time required to build programmatic sustainability will be woefully short. In terms of financial sustainability, the cost-recovery potential is low. A moderate amount of cross-subsidization from other PVO activities, including income generation, is feasible. However, the bulk of the funds will have to come from donor sources which cannot be projected at this time. Experience from PVOH-I indicates that approximately 30% of the project activities can be sustained.

To enable PVOH-II in the years remaining, to achieve its purpose of strengthening the PVOs' ability to provide basic and preventive health care to underserved populations, and to improve the prospects of leaving sustainable programs behind, the Evaluation Team recommends:

- **An immediate revision of the PVOH-II management system**, facilitating effective and timely response by energizing and expanding the role of the Project Coordinating Committee (PCC), allowing for appropriate programmatic changes and budget flexibility within line items, and developing a mechanism for testing and integrating findings from innovative approaches;

- **Easing the burden of the Evaluation Unit of NIHFW** by contracting with regional experts for the technical aspects of sub-project monitoring and evaluation, facilitating NIHFW's participation by providing adequate financing for travel and per diem, and by restructuring reporting requirements and clarifying evaluation procedures.

- **Activating channels for strengthening PVO capacities** by identifying and providing individualized technical assistance, establishing mechanisms for sharing experiences among participating PVOH-II PVOs, and by giving additional definition and structure to the Support Services component of PVOH-II.

- **Developing an institutionalization plan** which documents how GOI/MOHFW and the PVOs will work together to sustain successful programs after termination of PVOH-II.

In conclusion, this Mid-Term Evaluation revealed that the sub-grantees of PVOH-II are willing and able to provide high quality health related services to underserved, remote and isolated populations. The capabilities and commitment are all there, but the implementation of the project, from PVO selection, to field appraisals, to baseline surveys, to monitoring visits and quarterly reports which are number and target oriented and receive little feedback, to delays in disbursements of funds, all stand to hamper the effectiveness of the PVO's activities. It is therefore imperative that at this time, all parties involved in PVOH-II (GOI/MOHFW/NIHFW, USAID, and the PVOs), continue in a true spirit of partnership and cooperation to smooth the road for the remaining project years.

MID-TERM EVALUATION PVOH-II

INTRODUCTION

The Government of India (GOI)/Ministry of Health and Family Welfare (MOHFW) has made enormous strides toward achieving the goal of "Health for all by the year 2000." Yet, in a country the size and population of India, the government alone cannot assume full responsibility for this enormous task. To complement and share the GOI's efforts, during the early '80s private voluntary organizations (PVOs), with direct links to the community level, were identified as potential partners for health. The flexibility of PVOs, and their capacity to deliver services to remote and under-served populations, encouraged the MOHFW to explore further cooperation.

This mid-term evaluation of Private Voluntary Organizations for Health II (PVOH-II), is viewed as critical to successful completion of PVOH-II. It provides the opportunity for assessing what has been accomplished, as well as for identifying corrective actions necessary for achieving the stated goals. Future collaborative efforts of GOI, USAID, and PVOs for health, will hopefully also benefit from the findings of this mid-term evaluation.

DESCRIPTION OF THE PROJECT

1. HISTORY OF PVOH II

The PVOH-II project follows on the experience and capabilities of PVOH-I, which was implemented from 1980-1990, and evaluated in March 1991. PVOH-I was created to increase the interaction between the public and private sectors of the health/family planning fields in India. In order to strengthen and expand voluntary organization activities, in the remote and under-served areas of India, PVOH-1 project was launched by the GOI with the financial assistance of USAID. In August 1981, a sum of US$20 million worth of India rupees (at that time valued at Rs 16.8 crore) was agreed to, plus an additional 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, by strengthening the voluntary sector so that it could expand and provide a basic package of maternal and child health services (especially, immunization, antenatal care, ORT, nutrition and family planning).

PVOH-II began 8/31/87 and is funded through 8/31/97. The total contribution for PVOH-II is US$ 13.4 million: US$10 million from USAID in dollars, US$0.5 million from

the Government of India (GOI) in rupees, and US$2.9 million from the PVO grantees in rupees.

Because PVOH-II began in 1987, prior to final evaluation of PVOH-I, recommendations made in that final evaluation were not incorporated into the design, implementation and monitoring of PVOH-II. A booklet developed jointly by the MOHFW/GOI and USAID served as the guideline for proposal submission.[1] From 1987-1990 few proposals were received, due to administrative delays at USAID, which was fully occupied with PVOH-I.[2] From 1990-1991, when PVOH-I terminated, the first 42 PVOH-II proposals were received for technical review. The total number of proposals received is unknown, but of the 262 proposals received for technical review, 39 projects have been sanctioned by PVOH-II.

2. PROJECT PURPOSE AND GOALS

The purpose of PVOH-II is to expand and improve basic and preventive health, family planning, and nutrition services for the poor by utilizing and strengthening the private and voluntary sector. The goal of the project is to reduce morbidity, mortality and fertility among the rural and urban poor of India, particularly the morbidity and mortality of children under five.

3. PROJECT OBJECTIVES[3]

Key objectives of PVOH-II include:

- Creating PVO sponsored health outreach activities that are self sustaining
- Supporting and testing innovative approaches to community based health care, family planning, and nutrition programs
- Identifying and strengthening institutions capable of providing technical assistance to health PVOs, and to stimulate their use as a resource by PVOs
- Fostering a system of information exchange by PVOs
- Upgrading the skills of PVO managerial and technical staff
- Improving the quality of community level training for community health workers, volunteers and women
- Supporting special health related activities and preventive programs, such as literacy training for females, sanitation, and low cost methods of providing safe drinking water
- Encouraging and supporting programs to integrate traditional and western systems of health care
- Supporting the dissemination and utilization of the most effective treatment methods such as oral rehydration for diarrhea.

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[1]Financial Assistance to Voluntary Organisations for Health, Family Welfare and Nutrition Services, GOI/MOHFW, New Delhi

[2]PVOH-I Final Evaluation, March 1991, pg. 11

[3]Project Paper, India: Private Voluntary Organizations for Health (PVOH) II (386-0511). Agency for International Development, Washington, D.C. 20523, August 28, 1987

4. PROJECT MODELS AND CURRENT STATUS

To achieve the above objectives two types of PVOs have been identified for funding. The first type, "outreach service PVOs," provide outreach health and family welfare services to under-served rural and urban communities. The second type, "support service PVOs," are usually larger, stronger more established PVOs, which provide technical and support services to PVOs delivering health care services. Sub-sub-grants are given by these support service PVOs to smaller PVOs who are working at the grass roots level in health, training or development activities. Technical assistance provided by the support PVOs may include setting up information systems or surveys, training of health workers and other staff, or assistance in any area which smaller/newer PVOs may require.

Of the 39 PVOs funded by PVOH-II, 29 are providing "outreach services" and 10 are "support service" PVOs. The total population reached by these 39 sub-projects is approximately 2.1 million in 2,160 villages. All 29 outreach projects provide some form of integrated primary health care, and the 10 support projects, fund either integrated outreach or training projects. Geographically the 39 PVOs are spread throughout India, in 12 states (see map, Annex 1).

Although PVOH-II officially began in 1987, the first grant was only sanctioned in 1990 and through 1991 a total of 24 "outreach service" PVOs were operating under PVOH-II. During 1992-1993, 10 "support service" PVOs were sanctioned in addition to 5 outreach service projects. Many of the support service PVOs sub-sub grantees are awaiting sanctioning and have delayed implementing their activities. As seen in Annex 2 the grants range from Rs. 1.3 million (or 13 lakh) to Rs. 12 million (1.2 crore or approximately US$360,000 at the current rupee exchange rate), with some of the support service sub-sub-grantees receiving sums of less than Rs. 100,000 (1 lakh, US$30,000). To date GOI/MOHFW has released Rs 8 crores 65 lakhs (Rs 86.5 million) to the PVOs and NIHFW.[4] A total of US$ 1.4 million (Rs 3 crores and 41 lakhs) of the US$10 million obligated has been claimed by GOI/MOHFW, and disbursed by USAID.[5]

5. PROJECT PROCESS

To fully understand the PVOH-II project one needs a firm understanding of the process by which PVO projects are selected, monitored and evaluated. Each step of this process has significant implications for the overall effectiveness of project design, implementation and evaluation. In this section the process is described as it has evolved. Variation in implementation will be discussed in "Evaluation Findings." (Please see next page.)

Selection

Beginning in 1987 grant applications were solicited by means of advertisements in the leading newspapers of India and by word of mouth. PVOH-II projects were sanctioned by the MOHFW through 12/31/1993. All proposals were to follow the guidelines for submission as

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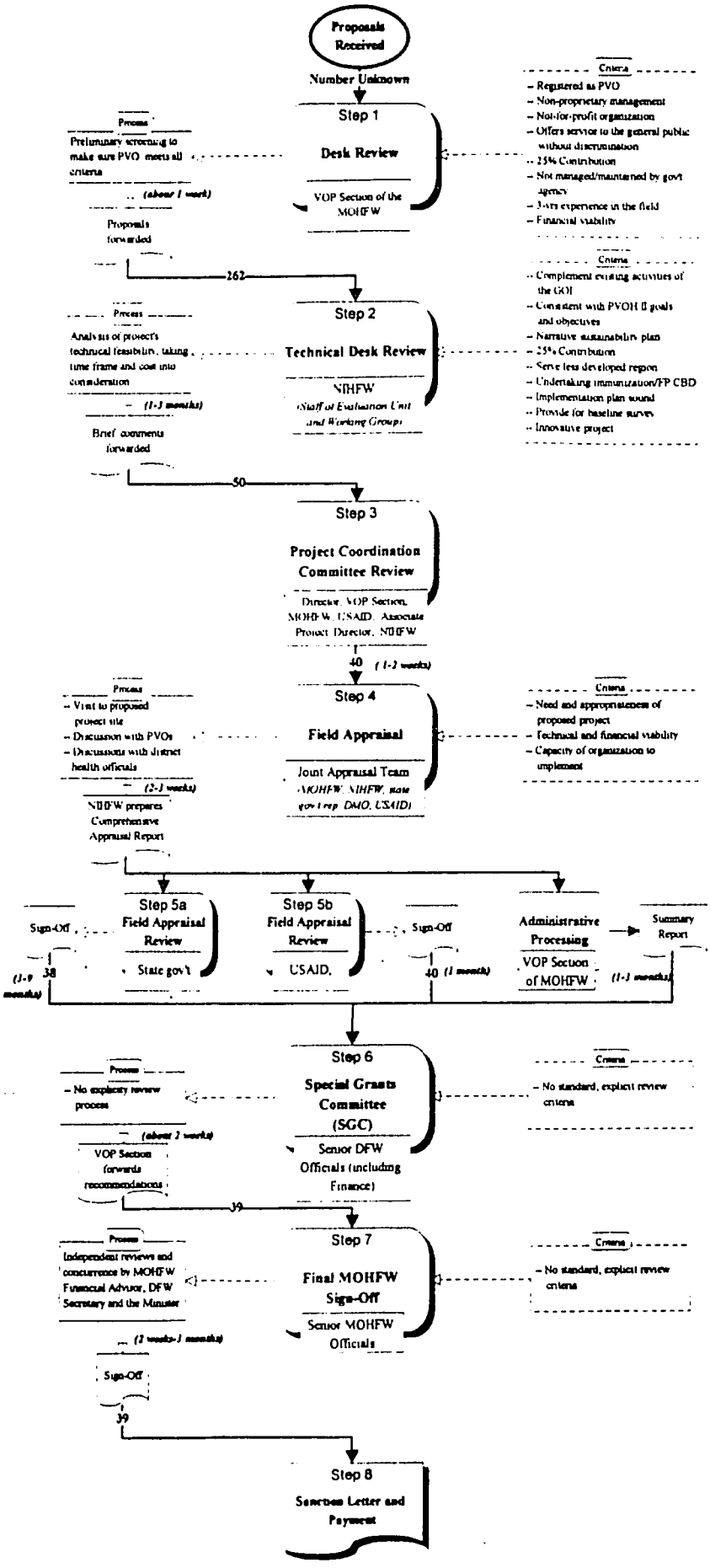
[4]Figures provided by Director, VOP Section.

[5]Figures provided by USAID.

Sub-Grantee Sanctioning Process



stated in the booklet, "Financial Assistance to Voluntary Organisations for Health, Family Welfare and Nutrition Services" prepared by the GOI/MOHFW. Funding was limited to a minimum of Rs 2 million and a maximum of Rs 12 million. A total of four copies of the proposal were submitted by the PVO: two to the MOHFW, one to USAID, and one copy to the respective state government for recommendations to the GOI.

STEP 1 - DESK REVIEW was a preliminary screening by the Voluntary Organization Project (VOP) Section of the MOHFW (Please see next page for MOHFW organizational chart) to determine PVO eligibility. The criteria included:

a) registration as a PVO
b) under non-proprietary management
c) not for profit organization
d) PVO must offer services to the general public without any distinction of religion, caste, creed or color
e) must be sound financial standing and agree to meet 25% contribution with half of contribution in cash
f) must have at least 3 years experience in field
g) not managed and maintained by the state or local government[6]

A total of 262 proposals passed this review and were sent to the National Institute of Health and Family Welfare (NIHFW) for the "technical desk review."

STEP 2 - TECHNICAL DESK REVIEW, was conducted by NIHFW and included examination of project technical feasibility, taking time frame and cost into consideration. Both medical and non-medical aspects of the proposal were assessed, and the PVO's experience and expertise in these areas were examined. Preference was given to those projects which were innovative and complemented existing government activities. Careful attention was given to issues of eventual sustainability, and the PVO's ability to contribute 25% of the project costs. The following selection criteria were also considered as part of the technical desk review:

a) Proposals must complement or supplement existing activities of the GOI
b) Must be consistent with goals and purposes of the project
c) Must describe how activities will be sustained in post-grant period
d) Must include at least 25% contribution from indigenous sources
e) Preference given to PVOs in less developed regions
f) PVOs undertaking immunization programs in urban slums and community based contraceptive distribution given preference
g) Goals, purposes and outputs must be clearly stated, methods to achieve them must be technically sound and implementation plan must be reasonable
h) Must include provisions for a base line survey
i) Innovative projects and those including training, health education, participation of women, non-formal education of women or other promotional activities given preference.

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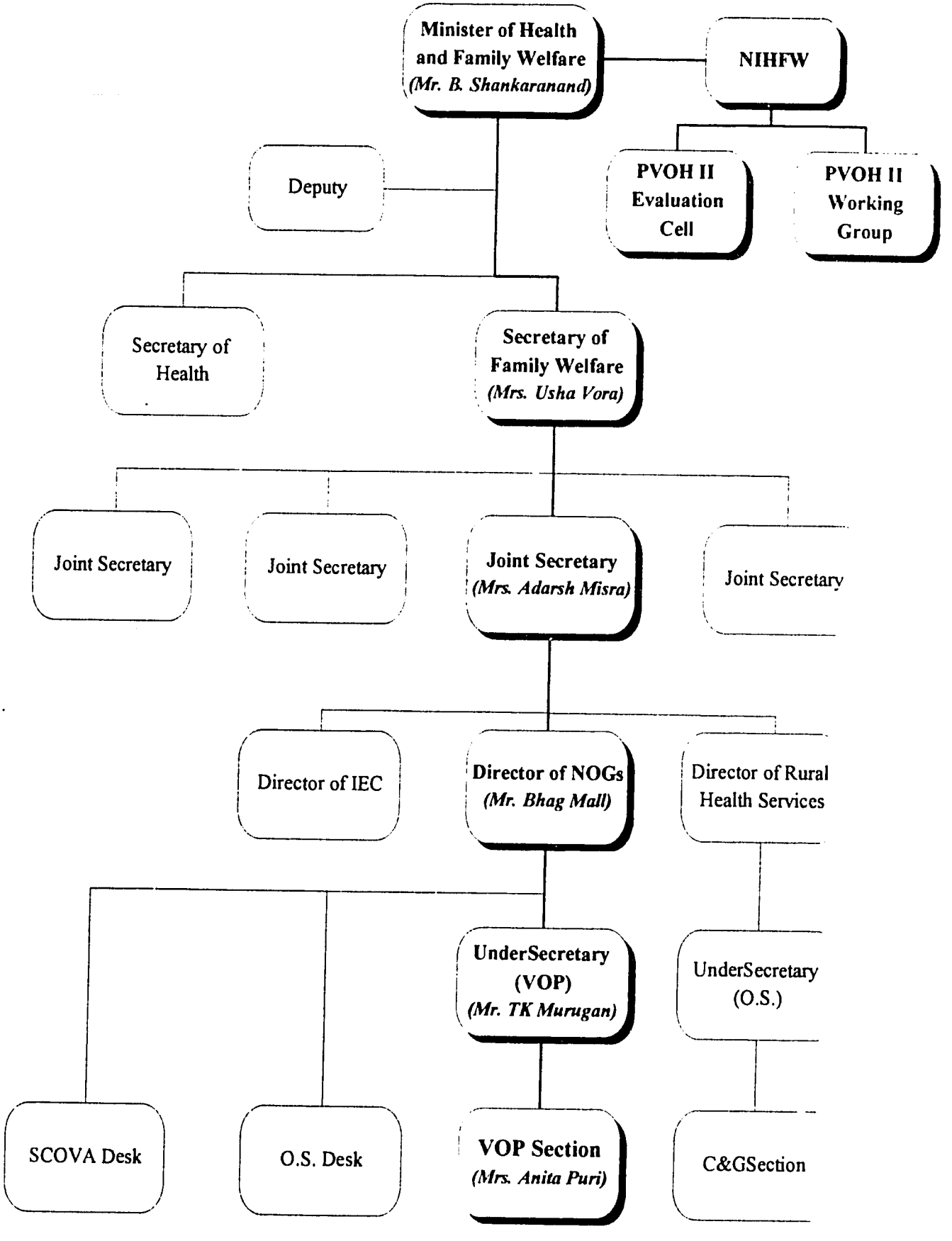
[6] See footnote #1

MOHFW Structure Relating to the PVOH II Project



The recommendation of the technical desk review was sent to the Project Coordination Committee (PCC).

STEP 3 - THE PROJECT COORDINATION COMMITTEE included: the Director, VOP Section of the MOHFW, a USAID representative, the Finance Officer from the MOHFW and the Associate Project Director from the NIHFW. The PCC was responsible for selecting proposals for "field appraisal." It was established by PIL to coordinate project activities, and to identify and resolve problems that arise during project implementation.

STEP 4 - THE FIELD APPRAISAL, a total of 50 were conducted by a team whose membership varied, but usually included: one or two members of the NIHFW, MOH representatives from the respective state government, a state government representative, and the district medical officer of the proposed project area. USAID had the option to join all field appraisals and exercised this option selectively. The objectives of the field appraisal were to:

i) determine the need and appropriateness of the proposal
ii) assess the technical and financial viability of the proposal
iii) assess the technical, managerial and financial capabilities of the organization to implement and sustain project activities

Based on a visit to the proposed project site and discussions with organization officials, the appraisal team decided whether the project would be recommended for funding.

The appraisal report, prepared by NIHFW, contained a brief introduction to the PVO, its area of operation and a summary of its experience. Details of the proposed PVOH-II project included: the area of operation, the various activities/services to be provided, implementation strategies to be used, the infrastructure (both physical and human) required to execute the project, total project costs (both grant-in-aid and the organization's share), and a complete financial plan for the project period.

STEP 5 - FIELD APPRAISAL APPROVAL. Copies of the field appraisal report were sent to: the VOP Section of MOHFW, USAID, the state government and the PVO. Comments and approval of the field appraisal from both USAID and the state government were necessary for the process to continue. The submitting PVO was given two months time to submit a detailed final proposal.

STEP 6 - SPECIAL GRANTS COMMITTEE (SGC). The VOP Section of MOHFW made arrangements for a meeting of the SGC. In preparation, the VOP Section prepared a summary of the longer appraisal report, containing the team's recommendations, broad budget items and implementation strategies, as well as the recommendations of USAID, and State Government approval. This summary report was sent to each SGC member 15 days prior to the meeting. The SGC included: the Joint Secretary of the Department of Family Welfare (Chairman SGC), Joint Secretary Financial Advisor MOHFW, the Director General of Health Services, Joint Secretary Department of Economic Affairs, Joint Secretary Ministry of Human Resource Development, Under-Secretary VOP, MOHFW (member secretary). A state government representative, the director of NIHFW's evaluation unit, and the PVO may also have been specially invited. The SGC is responsible for the overall direction of the project and the approval of all sub-grants.

STEP 7 - SGC RECOMMENDATIONS TO FINANCE SECTION MOHFW AND SECRETARY, DEPARTMENT OF FAMILY WELFARE FOR APPROVAL. Following SGC project approval, the recommendations of the SGC were sent by the VOP Section, to the Financial Advisor of MOHFW for concurrence. The recommendation next proceeded to the Secretary, Department of Family Welfare for final approval.

STEP 8 - SANCTION LETTER AND PAYMENT. Following final approval a sanction letter was sent to the PVO and a copy submitted to the Pay and Accounts Section, MOHFW. This Section prepared the check and sent it to the VOP Section who forwarded the first installment to the PVO. The initial funding covered the cost of a baseline survey, including any required technical assistance; salaries of core sub-project staff; and the establishment of an acceptable accounting system. Further installments were based on completion of the baseline survey, submission of an acceptable operational and sustainability plan. At this time an installment amounting to six months expenditure of the sub-project was released.

Monitoring

NIHFW, the technical arm of the MOHFW is chiefly involved in training and research activities, and has primary responsibility for monitoring both the financial and program sub-project activities of the 39 sub-grantees. Each PVO is responsible for submitting quarterly program and financial reports in triplicate to MOHFW, NIHFW and USAID. NIHFW reviews the quarterly program reports, and the quarterly financial reports are audited by a chartered accountant firm, who has been sub-contracted by NIHFW. Comments related to these quarterly reports are sent by NIHFW to the PVOs.

Monitoring visits were scheduled to occur 6 months after project implementation with subsequent yearly visits. These visits are divided into two areas, program and financial. NIHFW assembles a team including representatives from the MOHFW, USAID and the local State Government to conduct the programmatic monitoring. The financial monitoring, divided into two task areas was the responsibility of the chartered accountant. Task 1 included informing the sub-grantees of the PVOH-II requirements and procedures. Task 2 included annual verification of the PVO's accounts, and the issuance of a utilization certificate saying that the project funds were utilized for the purpose for which they were sanctioned.

Evaluation

NIHFW is responsible for conducting mid-term and final evaluations of the 39 individual PVOH-II projects. It may also contract consultants to conduct these evaluations. To date there have been no mid-term evaluations but an extensive scope and plan of operation has been prepared. No final decision has been made as to how the evaluations will be conducted.

6. PROJECT MANAGEMENT

PVOH-II is jointly managed by USAID and the Ministry of Health and Family Welfare (MOHFW), GOI. The National Institute of Health and Family Welfare (NIHFW), working under the MOHFW, is responsible for monitoring and evaluation. NIHFW has contracted with a firm of chartered accountants to assist with financial monitoring.

Role of Government of India/Ministry of Health and Family Welfare (GOI/MOHFW)

MOHFW is the nodal agency of the Government of India, responsible for implementing PVOH-II. The project comes under the jurisdiction of the Joint Secretary, Family Welfare, where PVOH-II is handled by the VOP Section of the Department of Family Welfare. The Director of the VOP Section is responsible for PVOH-II's day to day management in the Ministry. Under the Director is one Under Secretary and one Desk Officer in charge of PVOH-II with supporting staff.

Role of National Institute of Health and Family Welfare (NIHFW)

NIHFW has been involved in PVOH-II at every level, from sub-project selection, to sub-project monitoring and evaluation. It is officially responsible for monitoring and evaluating the subgrant activities, directly and/or by contract. The Evaluation Unit of NIHFW, created for this purpose, is responsible for coordinating and providing staff support for this activity and draws on other faculty members of the Institute as needed. During the course of PVOH-II, NIHFW has also been involved in the field appraisal process.

Technical workshops have been provided by NIHFW under PVOH-II for "Proposal Development" (July 1991), and for "Conducting Baseline Surveys." Staff of the Evaluation Unit provided advise on programmatic issues to individual PVOs as requested.

NIHFW has prepared standard formats for the quarterly program and financial monitoring reports. The main purpose of the first financial monitoring visit conducted by the chartered accountant was to brief each PVO about the financial procedures and requirements of PVOH-II.

Role of United States Agency for International Development (USAID)

USAID is the primary donor and project designer of PVOH-II. In partnership with the GOI it acts as a co-manager of the project and sits on the PCC. USAID reviews all sub-grant appraisal reports and provides its concurrence to the sub-grants as appropriate. Project funds are also committed for each sub-grant by USAID, after the approval of the SGC is received, and sanction orders are issued by MOHFW. This commitment enables USAID to disburse funds to MOHFW, as per the budget specified in the sanction orders. Further, USAID also concurs to any changes in the budget of the sanction orders, and revises the committed amounts accordingly. All other activities in the project are also reviewed by USAID, and after the concurrence of MOHFW, funds are committed by USAID prior to disbursements. USAID is responsible for the mid-term and final evaluations of PVOH-II.

THE MID-TERM EVALUATION

1. EVALUATION PURPOSE

This mid-term evaluation has four primary objectives:

- To assess progress towards achievement of the stated project purpose and goal
- To track implementation difficulties and constraints
- To identify mid-course corrective strategies
- To recommend a future course of action

2. EVALUATION ISSUES AND QUESTIONS

The Scope of Work for the PVOH-II mid-term evaluation was drafted by USAID/India in agreement with MOHFW. The Scope of Work (relevant extract, Annex 3) raises seven specific issues for consideration:

1) Mechanisms for review and selection of PVO grantees
2) Range and quality of health interventions
3) Community participation and relevance to community needs
4) Effectiveness of activities implemented by PVOs
5) Sustainability of project activities
6) Effectiveness of the management structure
7) Future directions, including corrective strategies

During preparation of the mid-term evaluation draft the Evaluation Team identified another issue, the role of support services PVOs which needed to be addressed.

3. EVALUATION TEAM AND WORK PLAN

The PVOH-II Mid-Term Evaluation was conducted under an Indefinite Quantity Contract (IQC) between USAID and John Snow, Inc., Boston, Mass., U.S.A. The team consisted of four individuals with considerable experience relevant to PVOH-II. The team leader was Dr. Michèle Andina, an independent consultant specialized in MCH and family planning, who has worked extensively with NGOs in both Asia and Africa; Ms. Susan Klein, John Snow, Inc., Program/Health Care Systems Consultant; Dr. C.A.K. Yesudian, Professor of Health Management at the Tata Institute of Social Sciences, Bombay; Dr. K.C. Malhotra Professor of Anthropology at the Indian Statistical Institute, Calcutta.

Between January 10 to February 9, 1994, 23 work days were scheduled for 3 team members and 28 work days for the team leader. The work plan included:

activity	day #
Review of documents, briefings USAID, MOHFW, NIHFW	1 - 3
Site visits - 11 PVOs	4 - 13
Prepare draft - brief USAID	14 - 17
Revise draft - brief MOHFW	18 - 20
Continue revisions - presentations	21 - 23
Finalize and submit report (Team Leader)	24 - 28

4. EVALUATION METHODOLOGY

To achieve a complete assessment of PVOH-II, the mid-term evaluation team utilized a mix of methods and procedures. These included the review of relevant documents, meetings and discussions with key project officials, and site visits to outreach and support PVOs operating under the auspices of PVOH-II.

- Document Review - The team collected and read a large volume of project-related documents and correspondence (Annex 4). These included the PVOH-I Evaluation and all official documentation for PVOH-II. Correspondence between the MOHFW, NIHFW and USAID was also reviewed. At the PVO level the team reviewed a large number of project documents, especially for those PVOs visited by the evaluation team; these included original proposals, appraisal reports, quarterly program and financial reports, program and financial monitoring reports, and correspondence with USAID, MOHFW and NIHFW. Additional project specific documentation was reviewed during the site visits.

- Meetings and Discussions - During the first week in Delhi a considerable amount of time was spent in meetings and discussions with the primary parties involved in PVOH-II: USAID, MOHFW, NIHFW. (See list of persons met, Annex 5). Discussions focused on understanding the implementation, monitoring and management of PVOH-II. Discussions were also held amongst the team members and a protocol was developed identifying the issues and questions that would be addressed (see Annex 6). Upon return from the field additional discussions were held with MOHFW the VOP section, NIHFW and the chartered accountant.

- Site Visits - A total of 13 PVOs (including 2 sub-sub-grantee PVOs) were visited by members of the mid-term evaluation team. Sites were chosen by the USAID Project Dirctor based on the following criteria:
  1) Geographical distribution
  2) Support service PVOs (4) and outreach service PVOs (7)
  3) Urban and rural projects
  4) Sanctioned in Phase 1: 1987-1991 (5)
     and Phase 2: 1992-1993 (6)
  5) Funded under PVOH-I (1)
  6) Logistical considerations: transportation means, time etc.

In order to visit the maximum number of PVOs the evaluation team was split into two. Two visits were made by each team in the North West, after which the site visit protocol was reviewed. For the remaining visits, one team focused on projects in the North and East, while the other covered the Western and Southern areas. The sites visited were as follows:

- Team 1: Klein and Malhotra

Survival For Women and Children Foundation (Chandigarh, Haryana)
Indian Institute of Health Management and Research (Jaipur, Rajasthan)
Women in Social Action (Midnapore, West Bengal)
National Institute of Social Work and Social Sciences (Bhubaneswar, Orissa)
Indian Institute of Youth and Development (Phulbani, Orissa)

- Team 2: Andina and Yesudian

Parivar Seva Sanstha (Gurgaon, Haryana)
Jaipur Rural Health and Development Trust (Jaipur, Rajasthan)
Society for Service to Voluntary Agencies (Pune, Maharashtra) + sub-grantee
Sewadham Trust (Pune, Maharashtra)
Rural Education and Development Society (Sivaganga, Tamil Nadu)
Tamil Nadu Voluntary Health Association (Madras, Tamil Nadu) + sub-grantee

A total of 10 days were spent in the field visiting the projects. The site visit protocol served as a guideline for the two teams, and helped ensure that all members of the evaluation team were pursuing the same areas and that their findings would be comparable.

At the field site, discussions and interviews were conducted with project officials, project workers (doctors, field workers, village health guides etc) and community members. Observations were made of vehicles, supplies and equipment, medicines, building sites, clinics etc. Registers and records maintained by the various PVOs were also reviewed. The evaluators participated and observed programs for service delivery, IEC and training. In the field, written notes were maintained, and upon return these were exchanged among team members for review and discussion.

EVALUATION FINDINGS AND CONCLUSIONS

Many of the problems identified in the mid-term and final evaluations of PVOH-I persist. This is partly due to initiation of PVOH-II prior to completion of PVOH-I, as well as to the failure to implement the recommendations made by these evaluations. This raises considerable concern amongst the present Evaluation Team, as to how PVOH-II can overcome the constraints, in order to implement the changes which everyone acknowledges to be needed. All three parties, MOHFW/NIHFW, USAID and the PVOs, have contributed enormously to the successful implementation of PVOH-II and have demonstrated their commitment to project goals. **In addition to immediate mid-course adjustments, a spirit of partnership and cooperation should be continued and reinforced, for successful completion of PVOH-II.**

During the site visits, it was made clear to the Evaluation Team that the PVOs were providing much needed, quality health services to remote and under-served populations. The following sections will address specific findings in the areas identified as "evaluation issues and questions."

1. MECHANISM OF REVIEW AND SELECTION OF PVO GRANTEES

Introduction

The selection of PVOs is crucial to the success of PVOH-II. A total of 29 outreach service grantees and 10 support service grantees have been selected. This section will review the selection process to ascertain whether the criteria, and review mechanisms have resulted in selection of appropriate PVOs, and the development of proposals that contribute towards the purpose and goals of PVOH-II.

First, the eligibility and review criteria and the mechanism for review, are briefly described and analyzed. Even if the criteria and mechanism were appropriately prescribed, their application was crucial to the selection process. Therefore, the second part of this section will analyze the way the criteria and the mechanism for review and selection were used.

The Criteria

Two sets of criteria were used to select the proposals. The first set of criteria were applied during the desk review to determine PVO eligibility. These criteria included registration as a PVO, good track record and ability to contribute 25 per cent of the total budget. A second set of criteria were framed to technically review proposals submitted by those PVOs who had met the eligibility criteria. These criteria included the ability to supplement and complement government health services, ability to meet the goals and purpose of the project, sustainability, including the capacity to contribute 25 per cent of the total budget, working in underserved or unreached areas, and the ability to use innovative programs and approaches to achieve the goals of the project.

On the whole, the eligibility and review criteria seem to be appropriate except for the criterion of 25 per cent contribution. At Step 1, the desk review, a number of proposals were seemingly rejected because they were unable to make the required 25% contribution. This may well have resulted in the arbitrary rejection of some innovative proposals from smaller/newer PVOs. The exact number of proposals received by the desk review is unknown, therefore no percentage determinations can be made.

The Mechanism

The mechanism for project selection is depicted in the flow chart on page 4. One immediately observes that this is a complex and lengthy process. At every step, contrary to the stated PVOH-II objectives which encourage innovativeness and experimentation, "square pegs were forced into round holes,[7]" resulting in sub-project homogenization. Delays were observed at all decision making levels, leading to increased sub-project costs, and a shorter period available for the PVOs to implement their activities.

The PCC, consisting of the managers of PVOH-II, was observed to serve a crucial role in the selection process. The decision to undertake a field appraisal rested with them, but the PCC lacks the necessary technical expertise required to take a well informed decision. They therefore based their decisions strictly on the recommendations of the technical desk review. The Evaluation Team feels that a broader membership (including PVO representation and an expert in community based health delivery) would enhance the decision making, as well as the problem solving capacity of the PCC. Equally, the SGC, which makes the final sanctioning decision should have a broader membership base to enhance their role.

Application of Selection Criteria and Mechanism

The criteria could not be applied in a holistic fashion. The project design has prescribed appropriate criteria for the review and selection of outreach PVOs, but the goals and objectives of PVOH-II were not kept in mind when these criteria were applied. Too much emphasis was laid on the sustainability of the sub-project, and the criterion of innovation was given little weight. The rigid and technically limited mechanism for project desk review eliminated early on some of the PVOs who were originally targeted for PVOH-II.

The review and selection mechanism prescribed in the design of the project was not applied appropriately. The project design clearly states that PVOs will revise their proposals based on comments given in the field appraisal report, and re-submit their final proposal within two months. In reality, the PVOs were, in most cases, not given the opportunity to revise their proposals. The appraisal report became the final proposal. This contributed to further homogenization of the proposals. Sub-projects visited by the Evaluation Team were noted to have similar kinds of programs, approaches and management structures. It was further observed that some of the PVOs had to accept certain components of the program, which they were

[7]Words of one of the PVOs.

incapable of implementing. Such an application of the review and selection mechanism did not allow the PVOs to include any innovation, nor did it enhance the PVO's capacity to prepare proposals.

A provision for contracting outside experts was not fully utilized to facilitate the review and selection process. In the project design, provision was made for contracting Indian experts for appraisal visits. If consultants, experienced in working with PVOs in community based health delivery, had been included in the appraisal team, the field appraisal report could have been more useful for the PVOs to revise their proposals. Since most PVOs rely on donor funding, they have some experience in proposal writing. This capacity could have been further strengthened by providing proper feed back on the original proposal prepared by the PVOs. In fact, some of the original proposals were better than the appraisal report.

Application of the review and selection mechanism was slow. From 1991-1992, 150 proposals were received by the Evaluation Unit (EU) of NIHFW for technical desk review. Working to their full capacity, NIHFW was able to process these proposals and 23 were recommended for field appraisal. Had PVOH-II begun as scheduled in 1987, this "piling up" of proposals would not have occurred. NIHFW should be commended for their efforts in this strenuous review process. During the same period the EU also conducted 21 field appraisals. After the field appraisal visit, preparation of the appraisal report was often delayed, but given the workload of NIHFW these delays are understandable. The provision of using consultants for the field appraisal was, however, not utilized and could have facilitated the entire selection process. For the selection of the last four support service groups (1993), consultants were hired for field appraisal which decreased the time required for sanctioning of these sub-projects.

After SGC approval, there were also administrative delays. Some delays were due to the PVO's lack of awareness about the procedures to be followed in terms of submission of documents to the MOHFW. Though these administrative procedures were mentioned in the guidelines, they were too cumbersome and numerous for many PVOs to follow.

Based on the above observations and analysis, the following recommendations are made:

(1) The criterion of 25 per cent contribution may be waived/reduced in cases where the potential for increasing sustainability exists.

(2) Increase the capacity of PCC by broadening the membership to include PVO representation and a technical expert in community based health delivery.

(3) Allow the PVOs to finalize their own proposals by providing the support and input necessary to revise the original proposal.

(4) Use consultants for the field appraisal visits and assign them the responsibility of writing short and concise appraisal reports.

2. RANGE AND QUALITY OF HEALTH INTERVENTIONS

Introduction

The primary purpose of PVOH-II is to expand and improve basic preventive health, family planning and nutrition services with the goal of improving the health and welfare of women and children. The evaluation team's observations of 13 PVOs (11 sub-grantees and 2 sub-sub grantees) revealed a vast range of health related interventions. Severe time constraints did not permit a comprehensive evaluation of the quality of services provided, but it was clear to the entire team, that each PVO possessed the capabilities and desire to provide high quality services.

PVOH-II has enabled a number of PVOs to 1) expand their geographical area of service 2) improve the services they offer, especially the service delivery infrastructure 3) add new services and 4) integrate health services into a village level development program.[8] As identified in PVOH-I, family planning, identification of individuals at risk, and nutrition services remain weak, although improvements have been observed in a number of sub-projects. **Like under PVOH-I, little technical assistance has been provided to the PVOs under PVOH-II.** The Evaluation Team agrees with its predecessors, that it is unrealistic to assume that the PVOs themselves, can in all cases identify their technical assistance needs. A few have been able to identify a need for guidance in specific areas such as Management Information Systems (MIS), income generation (sustainability) and Information, Education and Communication (IEC) techniques. Therefore, an important role of PVOH-II is to provide these PVOs, who are willing to deliver services to remote and under-served populations, with the necessary tools and expertise for providing quality health services. **To accomplish this, technical assistance must be provided.**

Service Delivery

The majority of projects provided a three tier system of service delivery:

1) village/community level - non-medical workers
2) sub-center/community level - paramedical workers
3) mobile units/static clinics - medical doctors

The following chart offers an overview of the types of providers at each level and the range of services available.

[8]For this mid-term evaluation an exhaustive review of the extent of these changes was not done.

LEVELS OF SERVICE DELIVERY	
TYPES OF PROVIDERS	RANGE OF SERVICES[9]
Community Level: Village Health Guides (VHG) Lady First Aiders (LFA) Mahila Mandal Activators (MMA) Dais (TBAs) Balwadi (preschool) workers	- motivate for ANC, immunization, family planning by home visiting - maintain village health records - provide basic first aid and curative services (scabies, worms, ORS) - organize community (Mahila Mandals and village health committees) - assist with labor and delivery (disposable delivery kit) - referral - income generation projects - growth monitoring/nutrition programs
Sub-center Level: Multi-Purpose Health Workers (MPHW) Auxiliary Nurse Midwives (ANM) Social Workers (SW)	- record keeping of services provided - antenatal care - immunizations - curative services (ARI, ORS) - motivate and home visits - monitor growth and development - attend deliveries - supervise community level workers - community awareness (IEC) - referral
First referral level: (Static Center/Mobile Units) Doctors	- curative services and referral - some preventive, e.g. ANC, family planning - school health exams - supervise lower level workers

Service Delivery Issues

Under PVOH-II little programmatic innovation was observed, and most PVOs used program models already in existence. The design of PVOH-II stresses creativity and innovation,[10] but the nature of the selection guidelines, baseline surveys and other factors, have hampered this objective. Despite these constraints, a number of creative strategies and approaches were seen.

A critical strength of PVOs is their flexibility to modify and adapt methods of service delivery, to the particular cultural and geographic needs of the community. This was clearly observed in a number of instances. For example, when problems were encountered, such as a mobile unit breaking down, mountains of bureaucratic requisitions and financial approvals were not necessary. A management decision was immediately made to rent a vehicle, so that uninterrupted services could continue. Unfortunately, this type of creative problem solving has encountered roadblocks in PVOH-II, and this expenditure was disallowed both as grant

[9]This is a range of the services provided at each level. It is not necessarily a comprehensive list, nor are all components evident at each sub-project.

[10]Financial Assistance to Voluntary Organisations for Health, Family Welfare and Nutrition Services, GOI/MOHFW, pg.2

expenditures and as a PVO contribution.[11]

In contrast to PVOH-I, all PVOH-II outreach projects provide a broad range of services. The extent of service delivery integration varied from PVO to PVO, but true collaboration was achieved in one sub-project where the village Dais (TBAs), Balwadi workers and ANMs, worked together as a team to provide MCH services. In another sub-project, the doctor from the mobile unit made home visits with the village level worker to high risk families and individuals.

Range of Health Interventions

As stipulated in the project guidelines, the primary areas of health intervention were in basic health, family planning and nutrition. The structure and time constraints of the site visits, did not allow for close scrutiny of individual services provided, but preliminary observations are described below.

Antenatal care was an area of heavy focus for all outreach sub-projects. In addition to registering all antenatal cases, services were to include: a physical check up (minimum of 3), weight and blood pressure measurements (monthly), blood and urine tests, TT immunization (2 doses or booster dose) and iron folic tablets.[12] Target numbers for ANC cases were set for each PVO irrespective of the sub-project's primary area of focus. The village level workers, in several sub-projects, devoted a great deal of time and energy on identifying pregnant women and motivating them to seek ANC services. The emphasis in this area is reflected in the impressive coverage rates.

In contrast the perinatal period - especially labor and delivery - was less well attended to in a number of sub-projects, although one PVO had an excellent program for training village Dais. Identification and referral of high risk women was also hampered by the lack of necessary referral facilities. It was even observed that one government Community Health Center (CHC), with an operating theater, was unable to provide emergency c-sections.

Equally neglected was the post-natal period, birth to 6 weeks. In one sub-project area, during 1993, the records of one village indicated a total of 13 deaths, including 7 infants (3 neonatal deaths) and 4 children under five years of age. In another sub-project area two neighboring villages each had maternal deaths recorded during the previous year - one hemorrhage and the other puerperal sepsis. The local village health workers (responsible for keeping the registers), were aware of these deaths, but the lack of appropriate MIS limited their ability to plan the necessary outreach interventions. In contrast, another sub-project has developed and printed maternal-child health records which are kept at home by the pregnant women, and include color codings for high risk cases, a schedule of post-partum visits, and infant growth and immunization charts. **Such comprehensive and efficient record keeping systems need to be shared among the PVOH-II sub-grantees.**

Immunization is another area of emphasis in PVOH-II. Again, specific numerical targets have been set, based on the baseline studies. While these numerical targets are helpful, the

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[11]Personal communication during site visit.

[12]All components were not covered in all cases.

Evaluation Team felt that **a more sustainable approach for village level workers would be to work toward "percentage covered."** Few of the village level workers can calculate target numbers, but they do understand the need for all children to be fully immunized. Most of the PVOs have done house to house surveys of their service areas, and maintain a separate register of all children aged 0-5. If health workers are taught to think in terms of each child receiving all their immunizations, rather than merely tabulating the number of shots administered (or done by government providers), the need/desire for immunization services will be sustained beyond the PVOH-II period. In those instances where PVOs were actually providing immunizations, careful attention was paid to maintaining the cold chain and to proper infection control. Creative efforts, including providing transportation to government facilities or the "rounding-up" by village level workers of children requiring immunizations were observed.

Nutrition programs, including growth monitoring and counseling about breastfeeding and weaning were addressed by some PVOs and ignored by others. Those sub-projects with Balwadi (preschool) programs did growth monitoring and provided supplemental nutrition. The quality of growth monitoring was observed to range from a well structured program of monthly visits, which included counseling, weight, Vitamin A and Iron Folic supplements, to growth monitoring which consisted of two weights during a 12 month period. **Technical assistance is necessary for assisting PVOs to develop protocols, parameters and appropriate technology, for these types of services.**

Family Planning services tended to be very target oriented. Permanent sterilization (tubal ligation) appears to be the method of choice for most women, but this may be due to the remuneration offered by the government for women choosing this method. Some of the PVOs mentioned difficulties with local government providers who resent having to share credit for any family planning acceptors. Because the salary of some government health employees is dependent upon their meeting acceptor targets, many PVOs only motivate and refer individuals for family planning, without taking any credit for their intervention. It was observed that village and sub-center level workers, devote a great deal of energy to both registering all eligible couples and motivating them to accept family planning. One PVO used male social workers as community level organizers and they also served as male motivators. **Unfortunately no "impact studies" were being conducted, or are planned, of innovative interventions. PVOs require assistance in learning how to determine the effectiveness of these types of creative variations in service delivery.**

Realizing that utilization and acceptance of health related services is dependent upon first meeting the health care needs of the population, PVO activities included curative as well as preventive services. At the village level, minor illnesses, such as scabies and worms were treated. The majority of sub-projects treated diarrheal disease, either using packaged ORS, or locally available home remedies. Some sub-projects treated ARI, but more technical assistance is required in this area. At the sub-center (para-medical) level, a wider range of medicines and services were available, including antibiotics and injections (Vitamin B was especially popular). Mobile units and static centers (often in rented facilities), were staffed by doctors, who in the case of one sub-project, lived in the village static centers. These physicians, some with training in Ayurvedic medicine, all practiced allopathic medicine and were highly committed to their village communities. In one static center it was observed that after only 6 weeks of operation, clinic utilization was high, and fees for service accounted for approximately 5% cost recovery.

In some sub-project areas, attention needs to be given to the specific health needs of individual communities. For example, in one village in Maharashtra, the PVO was recently requested to take over a sub-center which the government was unable to service. When asked by the Evaluation Team about her satisfaction with the services, a village woman immediately said that they needed snake venom and rabies vaccines to handle all the village snake and dog bites. A lack of attention to local needs, was also noted in the baseline surveys which analyzed the same variables and set similar outcome targets for each sub-project. This narrowing of operational targets has tended to limit the range and awareness of potential health interventions.

Health promotion, through IEC was observed to be provided at varying degrees by different PVOs. One PVO had a well developed IEC program, utilizing local folklore groups for the delivery of health messages, in a highly entertaining manner. Other PVOs provide "lip-service" to IEC, but are at a loss as to how to integrate such activities. **Once again, technical assistance is necessary for improving their skills and expertise.**

Environmental health (mainly water and sanitation) was provided by a few of the PVOs. One sub-project had assisted local villages to install hand pumps, while another distributed plastic bottles of chlorine to members of the village Mahila Mandals. The use of spring waters and water filters was also observed. Like IEC, environmental health interventions are viewed by those PVOs with long histories of involvement in the health sector, as a peripheral activity. This is in marked contrast to those PVOs whose backgrounds are more in the field of community development. **The two approaches present an interesting areas of inquiry, as to which approach has the potential for greater sustainability.**

Community development activities included the formation of village health committees, women's groups (Mahila Mandals, Mahila Sangams), and income generating projects. A number of PVOs were actively involved in the formation of Mahila Mandals and one PVO even had a separate village level worker, the Mahila Mandal Activator just for this purpose. Many PVOs are grooming these women's groups to assume responsibility for village health care needs, once PVOH-II terminates. The income generating activities observed in various sub-projects included vocational training for women in tailoring, carpet making, screen printing on textiles and pottery. No literacy programs were observed in any of the sub-projects visited despite its specific inclusion in the PVOH-II objectives as a preventive program for improving maternal and child health.

PVO Accomplishments in Health

Based on the Evaluation Team's observations the following strengths of PVOH-II sub-projects were identified:

1) Strengthening of the community level structures necessary for raising health awareness.

This has come about through:
- the training of village based health workers
- infrastructure additions such as static clinics or mobile units
- IEC
- the formation of community groups such as Mahila Mandals and Village Health Committees

The hope for sustainability of health awareness rests in the hands of the community, to identify their own health care needs, and over time, to be able to address them using existing resources.

2) Providing quality services to remote and hard to serve areas
- through appropriate training and utilization of multiple level health care providers
- flexibility in service delivery strategies and approaches
- ability and willingness to respond to local needs and demands

3) Strengthening linkages and working relationships with district and primary health center (PHC) officials to provide complementary and supportive services.

4) Progressing toward good coverage of ANC, immunizations and family planning acceptors (especially in the South), which will in the long run reflect on health indicators such as CBR, MMR, and IMR.

Constraints Impacting on Health Interventions
**** Suggestions for Improvement**

The following constraints were identified and some preliminary suggestions for improvement include:

1) **Inadequate record keeping systems:**
- no use of denominators for determining percent coverage
- cumbersome, with large number of registers
- ineffective for follow-up and true outreach
- heavy focus on target indicators, especially those developed in the baseline studies which may not have even been appropriate to the PVO's activities

**** Technical assistance is clearly required in this area.**

2) **Lack of functioning government services for referral purposes (high risk perinatal, immunizations), especially in the remote rural areas**

**** Work in cooperation with state and district level health officials to identify and meet the medical infrastructure needs of the area.**

3) **Difficulty maintaining focus on service delivery** because of
- delayed disbursement of PVOH-II funds
- overburdening of staff with PVOH-II bureaucracies (e.g. quarterly program and financial reports, visiting evaluation teams etc.)

**** Simplification (not standardization) of reporting procedures and a shortened period of funds disbursement is required.**

3. COMMUNITY PARTICIPATION

Based on field visits, and discussions held with members of the sub-project teams, local communities, Mahila Mandals and members of the Panchayat[13], the following observations were made with regard to the nature and extent of community participation in the PVOH-II sub-projects. For the sake of brevity the observations are described under the following heads:

Staff hiring

With the exception of a few categories of workers (in particular Doctors, Accountants, Pharmacists, etc), other staff, especially the field level personnel, have been hired from the sub-project areas. The field level workers differently designated as Village Level Health Worker (VLHW), Health Worker (HW), Health Educator (HE), Village Health Guides (VHG), Auxiliary Nurse Midwives (ANM), etc, are invariably recruited from the sub-project area. In addition, in some sub-projects Health Volunteers (HV) from each of the villages covered in the sub-project have also been hired.

The above mechanism has immensely helped the PVOs develop effective rapport with the communities. In addition, it has generated local employment for the population (mostly women) and has resulted in low staff turn over.

Innovations:

- The qualifications of village level health workers vary from PVO to PVO.

- To ensure that the female health workers continue staying in the same village, many PVOs have preferred daughter-in-laws. This is in particular extremely relevant in north Indian States (like Haryana, Rajasthan, Punjab, etc) where the daughters have to be married in villages other than their own (village exogamy).

Village Level Institutions Created

- In many of the outreach sub-projects visited, women's groups designated differently (e.g., Mahila Mandals, Mahila Sangam) have been formed. Some of the women's groups have evolved formal structures with office - bearers and are in the process of formal registration under the Societies Registration Act. The village level health worker is usually responsible for motivating the women to form such groups, and facilitates its periodic meetings. The topics discussed in these meetings are usually related to health awareness, family planning, diseases

[13]Village level self government institution.

prevalent in the area, nutrition, safe drinking water, sanitation, income generating activities.

- Strikingly, there is no evidence in any of the visited PVOs of involving adult males in any organized manner (except in some income generating activities). This is indeed a major lacunae in all the visited sub-projects.

- Although it was intended in PVOH-II to involve teachers in the program, this has largely not been accomplished (one PVO has involved teachers to some extent for the maintenance of Health Cards).

Contribution by the Community

Another way to assess the level of community participation is the contribution made by the community in cash and/or kind to PVOs, as well as the extent to which the community in fact uses the services being provided by the PVOs, and its willingness to pay, albeit partially, for the services.

In several sub-projects the local communities have given land and/or buildings to the PVOs for setting up of MCH Centers and sub-centers. These have been mostly given by the Panchayats.

In some sub-project areas the community has contributed (the extent varies) labor and material for health related activities (e.g., water harvesting systems), and income generating activities.

The Evaluation Team was deeply impressed to observe that the communities were effectively using the services provided by the PVOs. In many cases, the communities were in fact even paying, though partially, towards the services received.

One PVO has introduced a health insurance scheme and presently about 10 percent of the population pays Rs.10 per year.

Involvement of Traditional Health Workers

Typically in a village (often a cluster of village hamlets, especially in remote areas with low population densities) two traditional health workers exist, namely, the Dai (Traditional Birth Attendants) and traditional medicine men.

The extent of involvement of Dais varies between the sub-projects. In general, the sub-project's village level workers assist the dais, but in others, dais have been ignored.

The traditional medicine men have not been involved in any of the sub-projects visited.

Involvement of Local Doctors

In many sub-project areas private Doctors do not exist. However, in one sub-project area, high risk mothers and children are often referred to private Doctors practicing in the sub-project area.

IEC

With a few notable exceptions, the language of health messages have not been effectively adopted to local conditions. In one sub-project, the local media (folk songs and music, folk drama) has been used very effectively. In another, project posters on different aspects of health and family planning have been prepared in the local language and use local idioms.

Appraisal and Monitoring Mechanisms

In general, both at the appraisal and monitoring levels, adequate attention and emphasis has not been paid with respect to the level of community participation.

Recommendations

In order to further strengthen the extent of community participation in the sub-projects, attention should be paid to the following:

- The monitoring should adequately address various aspects of Community participation.

- The Monitoring Team should discuss with the PVOs ways and means of incorporating components of traditional medical systems and involving traditional medicine men.

- Site-specific health related, audio-visual aids need to be developed using local language and incorporating local idioms.

- As noted earlier, the Doctors in the sub-projects are usually not from the same areas, and are often not trained in Community based health services. Training/orientation in this regard should be provided to them (in fact, one Doctor had made this request to USAID officials).

4. EFFECTIVENESS OF OUTREACH ACTIVITIES IMPLEMENTED BY PVOs

Effectiveness of Management and Implementation of Grant Activities

Effectiveness of program planning. The PVOH-II guidelines and proposal development process has tended to impose a prescribed package of services on the PVOs. In spite of this, most PVOs have creatively designed and implemented horizontally and vertically integrated programs. That is, at every service delivery level, personnel address a range of services (horizontal) and, that the different levels of service are tiered in terms of the sophistication of the intervention and linked to each other through an internal referral system (vertical). This represents a vast improvement over PVOH-I, in which single intervention sub-projects were common, and is a major achievement of PVOH-II.

None of the PVOs visited had directly involved their communities in the initial program planning activities. A missed opportunity for later community involvement, was the way in which the baseline survey was designed and conducted--purely an external data collection exercise. This effort could have been combined with a more qualitative needs assessment which included community meetings. As the PVOs undertake efforts towards programmatic and financial sustainability, they will have to involve the community in the program planning process if they are to succeed. The community will have to be made to understand, at a very basic level, that the funds that have supported the program were meant as "seed monies," and that if the services they have come to value are to continue, they will have to join in a partnership with the PVO. **Community input should be solicited particularly with regard to the services and fees for village level activities.**

Ability to set meaningful operational targets. Operational targets were tentatively set in terms of percentages in conjunction with the "Field Appraisal Visit." In some cases, the percentages were revised as a result of the baseline survey. As a result of the baseline survey, percentages were converted into target numbers. PVOs convert annual target figures to monthly and quarterly figures. They are not "empowered" to set their own targets. Operational targets have become the tail that wags the dog. Both government and the PVOs have lost site of the program processes that generate these statistics.

Effectiveness of staff recruitment. PVOs have done an impressive job in staff recruitment. Not only have most positions been filled (some supervisory and doctor positions being an exception), but they have been filled with qualified personnel.

PVOs have been highly successful in recruiting village level health (and in some cases, social) workers. Selection criteria included permanency in the village, commitment and, to some extent, literacy. While a number of the PVOs identified Dais and middle-aged women as the ideal recruit, most ended up recruiting "daughters-in-law." The youthfulness of these workers seems to be a handicap only in their ability to be the primary birth attendant, although some accompany the Dais, and may come to be accepted in time. While many of these workers are called volunteers and are paid small stipends, most are committed and view their work as a full-time job.

PVOs have done a remarkable job in recruiting dedicated doctors, in spite of the low

salaries (compared with government positions) and unfavorable working and living conditions. While there was seen to be significant turnover, the PVOs were able to relatively quickly recruit replacements, this is in contrast to the public sector where rural posts have gone unfilled for months and years. In spite of the difference in social status and urban/rural perspective between the doctors and their patients, the Evaluation Team was greatly impressed with the compassion with which they provided treatment. One PVO used recent medical school graduates as volunteers to staff their mobile units.

Effective design and implementation of supervisory systems. Two supervisory streams were noted: supervision to ensure programmatic compliance, and; supervision to ensure quality of care.

Within the programmatic supervisory stream, two models were seen: one in which there was ongoing field supervision carried out by a designated supervisory position, and a second in which the levels of service of one category of service staff was monitored by another category of service staff, above them in the hierarchy. In the first model, where the supervisor's position was filled, effective supervision was in place; where the position was not filled, the Project Coordinator often stepped in to fill the gap. "Field coordinators" typically have at least weekly contact, and often more, with community-based paramedical personnel and health workers.

In the second model, reporting relationships have been defined, but in most cases, supervision is limited to monitoring whether workers have met their targets. This latter type of "supervision" generally takes place at monthly meetings which are held when workers receive their salaries. In a number of cases, feedback comes in the form of "scolding," (the stick without the carrot). Systems for recognition of a job well-done need to be incorporated into the supervisory process.

While there is certainly an appreciation for the need to maintain quality of care, the control systems to ensure quality are largely lacking. This is seen by the Evaluation Team as a critical area for immediate attention and technical assistance. This is particularly important in light of the fact that an important strategy of PVOH-II is to create health care delivery competence in PVOs which had previously had limited or no experience in providing health care services, i.e., those organizations that had previously concentrated on development or training issues.

Several bright spots with regard to quality monitoring were observed during the field visits. In one sub-project, physicians routinely monitor--via spot-checks--the quality of the antenatal care provided by the paramedical personnel (ANMs). Another PVO has developed, and is using, a color-coded approach to health care records which serves as functional protocol identifying "high risk" (obstetrical and others) cases, and clearly identifies the level of appropriate treatment (village, health center, hospital). The Evaluation Team was greatly encouraged that, **with the proper guidance and sharing of experience among PVOs, more PVOs will be able to implement quality assessment and assurance systems.** In a sub-project focusing on Dai training, weighing scales and resuscitation equipment were checked at monthly meetings to make sure all were in good working order.

Effective collection and use of data to support sub-project activities. As found in both the mid-term and final evaluations of PVOH-I, effective collection and use of data continues to be a problem, although some of the PVOs have made progress in this area. Virtually all the PVOs recognize the need to improve data collection activities, but don't know how to proceed.

Of the three major functions of data in a health care program--patient management, operations management, and program monitoring and evaluation--only the latter has received emphasis from PVOH-II management and thus the PVOs themselves.

The data collection systems are largely borrowed from other sources--MOHFW, UNICEF and others--without the recognition that data is meant to support specific program activities and where activities differ, data needs differ as well. Large volumes of data are collected, much of which is redundant. It is primarily used to tabulate statistics related to targets, but is not set up to do this efficiently. The preponderance of data collection tools are individual bound "registers," one for each activity (immunization register, antenatal care register, etc.) and one for each category of vital statistic which require reporting (birth register, death register). Some are organized on a case basis while others are organized by service event.

A few of the PVOs, mostly on their own initiative, have begun to develop systems for collecting data for patient management/quality of care. Some examples of this are:

- -- a case register for all under 5s in the village, maintained by the village health worker, was used to record all relevant data necessary to identify children in need of immunization, and to follow-up on children who have received curative care
- -- a child health card, held by the mother, which facilitates village-based growth monitoring, and identification of immunization needs when village health workers pay home visits
- -- a Home-Based Mother/Child Linked Record which enables paramedical personnel to clearly identify "high risk" obstetrical cases, low birth weight, and failure to thrive in the offspring resulting from the pregnancy.
- -- a Family Health Folder, which unites the health records of all family members, currently kept in duplicate (one held by the family and one by the PVO).

No work has begun on the development of real management information systems (MIS). Virtually none of the outreach PVOs are familiar with this technical concept. However, some intuitively understand that service data should be used for program management. One of the PVOs was observed to have begun thinking about how to use service statistics to improve the day-to-day management of the program. For example, the Program Officer reviews all cases of neonatal deaths (up to and including "verbal autopsies"), shortly after the close of each month, to determine whether there was any breakdown in the system.

Another start at using data for day-to-day management, is a daily log instituted by one of the PVOs for use by the village health worker, in which each household visit is recorded along with the services rendered and action to be taken. This has significant potential for use as a management tool. Often these workers are doing far more than is reflected in their statistics and such a log would clearly show this. It can also serve as a tool for qualitative supervision by the field supervisor.

Timely and individualized technical assistance in the area of the collection and use of data is urgently needed. Some of the Support Service PVOs may have this expertise to offer the outreach PVOs. While the appropriate consultants are being identified and mechanism for providing this assistance are being worked out, a forum that would enable the more advanced PVOs to share their experience with the others should be created.

Progress in decentralizing management of sub-project activities. While all of the

PVOs have designated Project Coordinators, they typically have little decision-making authority. Important management decisions are often made by the Director of the larger organization who may have little day-to-day contact with the sub-project.

Of the PVOs visited, there did not appear to be any organizational structures in place to decentralize management decision-making below the level of the Project Coordinator.

Quality of Staff Training

Training efforts are concentrated almost exclusively on village health workers. No training or orientation for doctors was noted. One sub-project provided training for Dais, one for ANM-equivalency, and one sub-sub-project trained Lay First Aiders (LFAs). Two of the PVOs had developed training programs for field workers for income generation activities.

The Evaluation Team was struck by the fact that while village health workers in most of the sub-projects were expected to carry out the same tasks, the level of training they received varied significantly--as short as a one-week orientation followed by one-month of antenatal care training at a PHC, to a six-month residential program with an additional two-months supervised practicum.

Several different approaches to training were noted:

-- training organized by the PVO, but inviting local health care experts to speak to trainees leaving the content up to them
-- contracting with another PVO to provide training with well structured curriculum
-- delegation of training responsibilities to selected sub-sub-projects

Only two trainings were observed to follow anything resembling a formal curricula with behavioral objectives (knowledge and skills) specifically related to the tasks that the trainee would be expected to carry out on the job. In the future, "training programs" that are guided only by loose agendas, with content left up to individuals unfamiliar with the tasks the trainees are expected carry out, should be discouraged. **If it is worth holding a training program, it is worth supporting it with a well-structured curriculum.**

No evaluation of the effectiveness of training (pre-post testing or even post-test only) was noted, although this may have been present in the training provided by the outside agency. **At a minimum, each training program should, in the future, incorporate a post-training assessment of its effect on trainees' knowledge and skills critical to the tasks that they are expected to carry out on the job. At a project-wide level, given the wide variation in the actual commitment of resources among the various training programs, and the potential variance in associated training outcomes, it is incumbent on PVOH-II to do some cost-effectiveness comparisons so that lessons can be learned and findings disseminated.**

In some cases, ongoing training sessions were built into the monthly staff meetings--generally, the physicians providing information on a topic they feel relevant. **To strengthen the ongoing training, each PVO should undertake a strategic planning exercise which identifies what tasks village health workers are currently assigned, which they are doing well and**

which they are not, and which others they could be made competent to undertake at the village level. This information would then be used to develop a more formal in-service training program.

As the senior member of the health care team in most field locations, sub-project doctors are called upon to expand program horizons, to undertake managerial tasks, and to innovate outside of the health care field, responsibilities for which they have had little or no previous training. They clearly have the capacity to assume these responsibilities, but they must have the proper tools to do so. **It is recommended that a staff-development program be instituted for PVOH-II doctors. A forum should be established to enable the sub-project doctors to meet at a regional level, to identify their own staff development needs.** Some tentative areas to be considered include: personnel management including training and supervision of subordinate staff, village-level environmental sanitation, appropriate technology in health and development.

Planning and Management of Referral and Transport Systems

Referrals. Many of the PVOs have developed vertically integrated programs, as noted above, which link promotional/motivational activities to services provided by their own staff--village health workers, paramedicals or physicians, as appropriate--and delivered via a tiered service delivery system (individual villages, nodal villages serviced by mobile units, fixed sub-centers and, in a few sub-projects, medically staffed units with beds.) The internal referral systems are working reasonably well.

The effectiveness of internal referral for immunization for the few sub-projects that undertake this directly (if government programs exist, PVOs refer to these programs) is due largely to the efforts of the village health workers who round up the patients and accompany them to the service delivery site. The effectiveness of referral for curative services is probably due mostly to the clear perceived need on the part of the patient.

Although these internal referral systems are designed for the effective referral of antenatal cases, the Evaluation Team could not determine, given the time limitations of the field visits, whether they were actually functioning effectively. Several concerns were noted. First, few of the sub-projects had internal capabilities for high risk deliveries. In the case of sub-projects which had planned to provide services for high risk deliveries, construction funds have been held up, due to a variety of reasons, and it is not clear whether the facilities will be built in time to work out an effectively functioning system, before the end of the sub-project. There was little evidence that sub-projects were involved in either providing or arranging for transport of high risk cases, in anticipation of their delivery.

In the areas in which most sub-projects are functioning, the feasibility of external referral is limited. In most cases, there simply are no services available within a distance one would be expected to reasonably travel for the services. Where a facility exists, it is often unstaffed or understaffed. Even where services are supposed to be available, they sometimes are not (one doctor who had come to a PHC for a sterilization camp refused to do the procedure because the PVO referred patient was the only patient present and he felt it was not worth his while).

Transport. A number of the sub-projects have built a transport component into their sub-projects. Vehicles have been procured with both USAID funds and out of the PVO contribution. These have included bicycles, mopeds, motorcycles, a passenger car, 4-wheel drive jeeps, and mobile vans.

Planning for the type of vehicle, and the way the vehicle was to be used in the program, had a number of inadequacies. Since this is a highly technical area and probably the first experience most PVOs have had with mobile health services, **PVOs should not have been expected to undertake this planning exercise on their own.** Since a number of vehicles were procured through PVOH-II, **expert advice should have been sought to provide planning assistance to both PVOH-II officials and the individual PVOs.** As a result, many of the vehicles were not functioning in the way they were envisioned, and many villages which were supposed to receive services directly, could not be accessed by the sub-project vehicle and were having to feed into nodal villages. Issues that should have been considered but often were overlooked:

- -- in the case of a mobile unit, is the vehicle meant only to transport staff to a site or will the services actually be delivered inside the vehicle
- -- have the type, size, horsepower, transmission, clearance, wheel-base, etc. been matched to the road conditions and the weight that will be transported
- -- does the vehicle have sufficient seating and cargo space to transport the number of staff and volume of equipment needed for its intended purpose

The poor roads over which the vehicles must regularly travel have taken their toll. (Tires typically need to be completely replaced every 4-6 months, springs break, etc.) The high cost of maintaining vehicles was not anticipated. **The project needs to find some mechanism for covering these unanticipated costs.** In the same token, the useful life of project vehicles can be expected to be significantly shorter than under normal conditions, bringing into serious question the sustainability of activities that are built around the sub-project vehicle.

A system for anticipatory transport of high risk obstetrical cases for institutional delivery in advance of the onset of labor, was not noted and may be an appropriate use of sub-project vehicles. A number of the vehicles were designated as ambulances. This notion is ill-conceived and misleading for several reasons. First, there is no communication system to summon the vehicle in emergency situations. Even in cases where communications may exist, the vehicle is used primarily for staff transport to the site of mobile clinics and would rarely be available when an emergency occurred. At best, it is only possible to transport acute and emergency cases when co-incidently encountered in the course of other work.

Few instances of program planning that purposefully capitalized on indigenous transport systems were observed. In one exception noted, to achieve efficient coverage of remote villages, input solicited by the sub-project from the community about the local system of roads, footpaths, public transport and the availability of bullock carts, were among the considerations used to group the outlying villages to feed into nodal communities, which were then targeted for regular visits by the mobile health team.

Progress in Infrastructure Development

A number of the sub-projects visited have included infrastructure projects. For the most part, these involved building, equipping and staffing of clinical facilities, typically including a small operating theater and a few inpatient beds for pediatric and obstetrical emergencies. While the communities' needs for such facilities are not disputed, the Evaluation Team found the sanctioning of clinic infrastructure construction under the parameters of PVOH-II to be of significant concern. The maximum five-year lifespan envisioned for PVOH-II sub-projects is relatively short considering the many stages required to develop a viable facility--planning, land acquisition, contracting, construction, equipping, staffing, and development of operating systems and referral linkages--with the knowledge that there are invariably unforeseen circumstances and slippages in schedule encountered. **Further, even in a project where sustainability is a major emphasis, these are risky ventures without an MOHFW backup plan for continued support.** The direct cost recovery potential is clearly minimal--probably inversely proportional to the need. At the present time, the hope for cross-subsidies and donor support are just that--hopes. **With less than three years remaining in the project, realistic and achievable sustainability plans have not yet been developed.**

The plan of one of the Support Service PVOs to construct a training center is more consistent with PVOH-II. Originally, the PVO had planned to run its training programs from a rented facility. At the first monitoring visit, the Monitoring Team suggested that the goal of the project might be better served by constructing rather than renting a facility, reducing the post-project recurring costs to enhance the sustainability of the training programs developed under PVOH-II. (Also an excellent example of the kinds of positive interactions that should be taking place during the monitoring visits.) This type of infrastructure project, is not as vulnerable to the short project lifespan as a clinical facility, because there is no significant program development that must take place following completion of construction.

Of these infrastructure projects, one has been completed and three are in the stages of clearance or awaiting the release of funds.[14] All have experienced significant delays--some external and some internal. The bureaucratic process leading up to the release of funds is lengthy and complicated, and probably not subject to change. However, more proactive assistance may have been provided to the sub-projects to help them to negotiate the system since it was, no doubt, their first experience with it. In the case of the training center, the programmatic and, more significantly, the budgetary ramifications grow with each month's delay--the need to continue to rent space after the initial projected completion date of the facility will result in budget over-runs. In addition, bureaucratic delays result in higher end costs due to escalation in building costs, as is the case with all of the other projects. How will these costs be borne? Of the external delays, one was due to labor problems; the other because no contractors willing to bid on a project in such a remote area, could be found. This appeared to be an insurmountable problem until USAID intervened, recommending that the PVO be allowed to serve as its own general contractor--another good example of the facilitate role that PVOH-II management should play.

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[14]Based on the 11 sub-projects visited.

Progress in Linking Up with Existing Government, PVO and Private Health Care Systems to Strengthen Program Activities

The development of strong linkages and good working relationships with existing local government health officials and service providers marks a significant accomplishment of PVOH-II over PVOH-I. With only a few exceptions, the PVOs are working cooperatively with government at the local level.

In many instances the PVOs have taken the initiative to establish these relationships. They have established services and undertaken activities that are complementary and supportive, rather than competitive. They strategically give credit for jointly undertaken activities to the government. Some examples of collaborative efforts between PVOs and government include:

- -- PVO-trained and affiliated Dais provide accurate birth registration data to the local health department
- -- PVO village health workers collect and accompany individuals to government immunization clinics, sterilization and eye camps
- -- Use of PVO vehicle and driver to provide transportation to the staff of government health services to field locations, particularly for immunization services
- -- Providing medical coverage (PVO doctor) for government facilities on an episodic or short term basis
- -- Government PHCs will be handed over to a PVO (Maharashtra state)

There were a number of examples noted in which PVOs linked up with other PVOs to strengthen their activities:

- -- One of the PVOs contracted with another sub-project for technical training
- -- In Orissa, at the initiative of NIHFW, all four PVOH-II PVOs meet quarterly to share information of mutual interest

PVO Ability to Undertake Meaningful Self-Evaluation

Many of the sub-projects are undertaken by small, grassroots PVOs which are not conversant, and should not be expected to be conversant, with sophisticated evaluation methodologies. One of the objectives of the PVOH-II is to strengthen PVO competence, especially at a basic level.

The way that PVOH-II has evolved, the PVOs have been generally discouraged from relating evaluation efforts to their specific program activities. Standardization of the baseline survey is a prime example. The same data are collected for each sub-project whether they have activities to impact a particular problem or not. Collection of data, supporting innovative interventions or activities of local interest, was generally not included.

Because a target-oriented system of monitoring and evaluation has been imposed upon them, PVOs have neither learned to set meaningful targets for themselves, nor to really think about the impact their services are having on the communities they serve. For instance, a reduction in neonatal tetanus deaths should be readily observable, even in the absence of

statistics, yet PVOs queried were unable to offer an opinion on the effectiveness of their maternal tetanus immunization activities.

Most of the guidance from the project management level has emphasized output (number of units of service delivered) and impact (change in health status indicators) measures, with no attention given to the process by which the services are being delivered or the short term effectiveness of the interventions. In the end, information may be available about what has changed, but not what was responsible for the change in order to continue and replicate effective program interventions, and discard ineffective ones.

5. SUSTAINABILITY OF PROJECT ACTIVITIES

Capability of PVOs to Sustain Activities at the Organizational and Community Level

PVOH-II seeks to promote sustainability of its sub-projects by requiring PVOs to contribute at least 25% of their sub-project budget, in cash (at least 50% of the contribution) and/or in-kind, over the term of the sub-project, and to develop a plan for sustaining program activities after project termination. Most PVOs come to the table with a "project" versus a "program" mentality. They move from project to project, from donor to donor. Many have not really thought through what taking on a permanent service delivery responsibility entails, nor do they necessarily envision it as a permanent commitment.

The need to focus attention on sustainability was a major finding of the final evaluation of PVOH-I. As was the case of PVOH-I, all parties in PVOH-II continue to struggle with definitional issues. Is the program expected to be entirely self-sustaining? Can a PVO use income generated from another activity or cross-subsidies in determining sustainability? If funding from other donors must be tapped, should the activities still be considered sustainable? What if another organization, such as government, is willing to take over the operation of the services after the project is concluded, has the program been sustained? **The Evaluation Team strongly believes that any combination of the above, which results in effective services being permanently established for the sub-project's target population, should be considered a success in terms of sustainability.**

In discussing sustainability, there also is a need to make a distinction between program and financial sustainability. While they are quite different, they are interdependent. The development of programmatically sound and effective programs during the sub-project period are likely to attract other donors. (e.g. as a result of its participation in PVOH-I, one PVO has been able to more readily attract donor monies and estimates 30% sustainability of PVOH-I project activities).

Community-level activities, while most consistent with the missions of many PVOs, may be the hardest to sustain. Preventive and promotive services are the most difficult to market to the community, in spite of their potential cost-effectiveness. Even curative services provided by community health workers may not be valued enough for the community to be willing to pay for them after the project. These curative services also require medical "backup" for "quality of care assurance." It was disconcerting to learn, that at least one of the PVOs would consider cutting community level services, rather than its newly-developed institutional-based services, should budget cuts become necessary after the close of the project. **The expansion and further strengthening of the capacity of village health workers to provide curative care in addition to perinatal care,** which are generally more valued than preventive and promotive services, and to ease into partial fee-for-service, **is one strategy for sustaining community level services.** Careful attention must be paid to government practices, such as the direct payment to Dais for attending deliveries, which stands to undermine a community's willingness to pay for such services.

Financial Sustainability

Planning for Sustainability. To encourage PVOs to begin thinking about sustainability early in the process, the Project Paper and the sub-grant guidelines, called for a post-project financial sustainability plan. This plan was included in the initial proposal, and consisted of an estimate of annual recurrent post-grant costs, and identification of how these costs will be met. It is also expected, by the final project year, that each PVO will be contributing 70% of the annual recurring costs. These types of financial plans have clearly been a useful exercise for the PVOs, but how realistic they are is another question. **Training and/or technical assistance is necessary for assisting the PVOs in developing realistic and achievable sustainability plans.**

25% Contribution. The concept of 25% contribution has been the subject of quite a bit of confusion to date. During proposal preparation, some PVOs received assistance from NIHFW to better understand what constitutes contribution; the Task I visit from the chartered accountant also included assistance on better understanding the concept of contribution. PVOs were often unaware that in-kind contribution was allowable. Some proposals were submitted with less than 25% contribution; as these proposals were reworked during and after the appraisal visit, the 25% level was achieved. The Project Paper and proposal guidelines clearly state that the contribution need not be equal in every project year, so long as there is 25% contribution to total costs over the life of the project; however, some of the PVOs were not aware of this and became inappropriately locked into a fixed 25% per year.

In the absence of guidelines for selection of sub-sub-projects, the Support PVOs are struggling with a mechanism for addressing this 25% contribution, vis a vis their sub-sub-grantees. Should each PVO come up with 25% per year, or whether there need only be 25% contribution within the sub-sub-project line item, thereby allowing one sub-sub-project to cross-subsidize another, or whether the Support PVO's contribution could cross-subsidize its sub-sub-projects? In most cases, the 25% contribution was made to flow down to the individual sub-sub-project budgets. Since these sub-sub-projects are typically smaller, undertaken by newer PVOs, rigidity in this regard, particularly a fixed 25% per year approach, may be inappropriate. A more flexible approach, more consistent with the goals and objectives of PVOH-II, would be to encourage an increasing contribution over the life of the sub-sub-project. The ability to progressively increase contribution is a much better measure of a program's potential for financial sustainability.

As sub-projects have been implemented, PVOs have picked up many unbudgeted costs (e.g. cost of renting a vehicle for maintaining services when the project vehicle was being repaired, the unbudgeted costs for the maintenance itself, etc.). Conflicting messages have been received by the PVOs as to whether these could be regarded as PVO contributions. Since these items are above and beyond the 25% level, it is peculiar that the PVOs have been discouraged from booking these activities as PVO contributions. The ability to absorb more than a 25% contribution is surely a plus and **PVOs should be encouraged to record them as such. One way of displaying this achievement in a positive light would be to have sub-projects prepare, as part of their mid-term and final evaluations, a type of budget-to-actual report which allowed for the inclusion of items under "actual" that were not in the original**

budget. In this analysis, not only would contribution likely exceed 25%, but the total "actual" costs would most likely exceed the original budget figure, providing all concerned with a more realistic estimate of what it really takes to run a program.

Progress toward financial sustainability and the potential for various approaches to create financial sustainability. Most PVOs are beginning to charge fees for service. Most are charging a Rs 2 registration fee which covers one or two visits. A token fee is often charged for drugs which covers only a small proportion of the costs. These fees seem to be reasonable, given the economic status of the populations served. It therefore should be noted that, even under the best of conditions, the fee-for-service contribution toward cost recovery will be minimal. At one of the clinics that appeared to be doing well at fee collection, an analysis revealed only about a 5% cost recovery.

Community-level income generation activities have been cited as a strategy for increasing financial sustainability, under the dual rationale that as economic status is improved, improvement in health status will follow, and that accessible income will make community members willing to pay for services. Even if these rationale are borne out, most of the community level income generation activities undertaken by the PVOH-II sub-projects, are too small and have not been provided sufficient time, to have an impact. **Their potential could be improved with the provision of technical assistance in market analysis, product development and quality control, and marketing and distribution.** Agricultural income generation projects carried out by one PVO, provide an example of appropriate mechanisms for cross-subsidization of sub-project activities.

Programmatic Sustainability

The Evaluation Team observed that many programs were fundamentally sound and potentially viable, a credit to the ingenuity of the PVOs. The goal of PVOH-II is to supply the inputs to strengthen the PVO's ability to design and implement sustainable programs. Achievements to date are as follows:

-- To the extent that strengthening PVO capacity to design programs and write proposals contributes to programmatic sustainability, interactive assistance provided by NIHFW/MOHFW/Field Appraisal Team to prospective sub-projects, PVOH-II has moved PVOs within its purview in a positive direction. Support Service sub-projects have made significant contributions to their prospective sub-sub-projects in this area.

-- To the extent that strengthening PVO capacity in the financial management of its grant funds and program budgets contributes to programmatic sustainability, PVOH-II has moved further in the direction of programmatic sustainability. The technical competence, sensitivity to PVO issues and consultative style of the chartered accountants during the Task I monitoring visit must be strongly credited for this accomplishment.

-- To the extent that strengthening general PVO management capabilities contributes to programmatic sustainability, PVOH-II has a long way to go in this regard. To

date, there has been little done in this area. Management training and technical assistance is one of the roles of the Support Service PVOs, but delays in sanctioning of sub-sub-projects has not allowed them to implement this task.

-- To the extent that establishing positive, supportive relationships with local health officials and service providers is one strategy to move toward programmatic sustainability, PVOs have moved a long way in that direction.

-- To the extent that publicizing impact is an effective mechanism for "marketing" services to the community and potential donors, PVOs have not yet availed themselves of this strategy. Like many organizations world-wide, they show a preference for showing "infrastructure" such as clinic buildings rather than less visible outreach activities.

The design of PVOH-II largely overlooks the need to provide assistance to sub-projects and sub-sub-projects in the area of service delivery. While one of the strengths of PVOs is that they are creative and innovative, they can always benefit from being exposed to the cafeteria of service delivery strategies, interventions and models that have been successfully implemented in other contexts.

Constraints to Sustainability

Matching services to community needs, and allowing the community to develop a vested interest in the success of these services, are critical factors in the long-term sustainability of PVOH-II-generated programs. Homogeneity imposed from the top in the program design exercise and the baseline survey, have limited the sub-projects' ability to truly respond to the community's needs. Fortunately, there is still time to regroup. **PVOs must be allowed to modify programs in light of experience and the community must be involved in these future strategy formulation and decision-making processes.**

Because of the many delays in sanctioning of sub-project and sub-sub-projects, lags in the release of and withholding of funds, and failure to act on monitoring team recommendations for programmatic and budgetary changes, there is a real potential that PVOH-II may come to an end before activities can reach a level of programmatic sustainability. The Evaluation Team was particularly concerned about the effect of this on sub-sub-projects, that are to be funded under the group of Support Service PVOs whose sub-projects were only sanctioned in December 1993.

Building programs around capital items with high recurrent and/or replacement costs (e.g. vehicles and clinic buildings), is a significant constraint to sustainability. If these post-project costs cannot be met, not only will those services immediately dependent upon them be discontinued, but other aspects of the program can come tumbling down like a house of cards.

As previously mentioned, the potential contribution of fee-for-service to cost recovery is minimal, due to the economic status of the target population. Further, the potential contribution of a few isolated income generation activities to cross-subsidize health services is also quite small. (The few sub-project/sub-sub-project models which integrate health services into a larger village development scheme offer more promise in this area). Thus partnerships with government become critical, and MOHFW's decision that, regarding its own schemes,

PVOs will only be involved in sub-projects that address "small family norms," should be reconsidered.

In India, as in many countries, communities expect government services to be provided free of charge. They have complained that, as a government project, PVOH-II services should also be free. Anything that draws attention to PVOH-II's government sponsorship, such as signboards outside facilities and USAID stickers on vehicles, tends to decrease the community's willingness to pay for service.

6. EFFECTIVENESS OF MANAGEMENT SYSTEM

Introduction

PVOH-II is jointly managed by MOHFW and USAID. At MOHFW the management structure for PVOH-II consists of an administrative arm, VOP Section, and a technical arm, NIHFW. Based on the advice and recommendations of NIHFW, the VOP Section takes administrative steps to implement the project. The role of USAID is at the macro-level management of PVOH-II, as well as to participate in committees like PCC. PVOH-II's management structure is strengthened by two committees, SGC and PCC. While the SGC is responsible for the overall direction of the Project and the approval of all sub-grants, the PCC is responsible for "coordinating project activities and to identify and resolve problems that arise during implementation".[15]

This section, analyzes the project design, to determine whether the management system facilitates project implementation, in such a way as to achieve the stated goals and objectives.

Incompatibility of the Management System

The design of PVOH-II has several unique components that encourage PVOs to participate in achieving national goals in health and family welfare. The guidelines specify that highest priority be given to those PVOs willing to develop, study and test innovative approaches in the delivery of health care. The project design has well recognized the PVO's strengths of innovation and experimentation.

Lack of Flexibility in Sub-Project Formulation: As mentioned earlier in the section "Mechanism of Review and Selection" (pgs 13-15), strict application of the project criteria has limited the innovation and experimentation of many sub-projects. For PVOH-II this is now history, but it is highly relevant to future joint MOHFW/USAID/PVO projects.

Since the management structure of PVOH-II is highly centralized, top-down, and far removed from the PVOs, emphasis has been given to "control," rather than supportive supervision and problem solving. Methods successfully used in managing large government bureaucracies are being inappropriately replicated for PVOs. From field appraisal, to the baseline surveys and project monitoring, the PVOs have had to face a rigid management system, which is only lightened by some individual/personal interactions.

For example, because the field appraisal report has been considered "the final proposal," a number of PVOs realized that they had been sanctioned to conduct a different sub-project than originally intended. The first monitoring visit revealed the PVO's lack of project implementation, which in some cases, sowed the seeds of mistrust. In two specific instances, the Evaluation Team agreed with the PVO's concerns, and felt that weaknesses in the field appraisal process had precipitated the misunderstanding. Monitoring teams had also agreed with one of the PVOs, and recommended the necessary budget sanctions to the SGC. But, to date,

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[15]Project Paper, India: PVOH-II (386-0511), August 1987. p.20

the activities have not been funded.

Baseline surveys were conducted using a fixed format for all sub-projects. Although advised by NIHFW to modify these baselines to include appropriate quantitative as well as qualitative variables, many PVOs were unable to do this, or did not chose to make the necessary changes. These baseline surveys were subsequently used to determine numerical operational targets for each PVO, rather than helping the PVOs to develop a monitoring system, which could have been used for their own project management, monitoring and evaluation.

Quarterly program reports use a lengthy standard format which reflects only some of the PVO's activities, provides little space for narratives (one paragraph on the last page of a multi-page document), and makes each project look essentially the same. The documenting of problems, experiments and innovations is not encouraged. Annually a detailed statistical report is also required. The sheer volume of these quarterly reports hinders timely and productive management response. Given the highly centralized (New Delhi) top-down management structure, it is difficult to provide supportive supervision and the needed technical assistance.

Quarterly financial reports also pose an additional burden on the majority of PVOs. Although most PVOs have hired separate accountants for assisting with PVOH-II, the time required by the project coordinator for compiling these reports is appreciable. Disbursement of installments were withheld on trivial grounds, requiring for clarification of the quarterly reports. These delays have led to innumerable difficulties for some PVOs to continue their sub-project activities. One project director made a trip to Delhi to speed up the disbursement process.

Yearly program monitoring, which includes a team site visit has varied from sub-project to sub-project in terms of its effectiveness and impact. Each sub-project is different. They serve different regions and communities, and provide different services. The PVOs consist of different levels of providers, ranging from those with little experience in health, but extensive community development experience, to former ministry level officials. As a result, the composition, expertise and backgrounds of the monitoring team must also take these factors into consideration. **Field monitoring should serve the dual function of assessing progress towards objectives, as well as providing some of the support and technical assistance necessary to achieve the goals.**

Inability to Make Use of Project Provisions: The design of PVOH-II has clearly mentioned the provision for technical assistance. The evaluation team observed the need for technical assistance in many areas, especially record keeping and MIS. The PVOs also identified their need for technical assistance. However, little has been done in this area. A few broad based and general training programs, in areas like management and accounting, were carried out. The PVOs, however, did not find them useful for solving their specific problems and meeting their specific needs. **Individualized technical assistance programs need to be developed with each sub-grantee.**

The PCC was supposed to prepare a panel of experts/consultants to provide technical assistance to the PVOs. So far this has not been done. It was previously mentioned that the PCC's limited membership does not have the technical expertise nor breadth of experience in working with PVOs to identify experts/consultants who can provide technical assistance.

Lack of Flexibility in Implementation: Since the final project was given to the sub-grantees from "the top" in the form of the appraisal report, some PVOs have not been able to evolve a sub-project program and structure appropriate to their local situation. After running the project for 1 to 3 years, many PVOs have realized that the current method of delivery was

not effective and that change was needed. However, they were not allowed to implement changes even if it did not involve any financial implications. The strength of PVOs is to experiment and change, but the rigid management system does not permit such flexibility. Therefore, while innovation is the hallmark of PVOH-II, the management system hinders innovations.

Evaluation Unit of NIHFW Overburdened. During the early years of PVOH-II, the Evaluation Unit was over loaded with field appraisals. Once a sub-project was launched, the Unit was responsible for all monitoring and evaluation. The staff has to scrutinize all quarterly program and financial reports, conduct annual field monitoring visits, and prepare a report of each visit. During 1994, a number of sub-projects will be due for midterm evaluations. Given the time, staffing and expertise of the Evaluation Unit, this task is enormous. Even with additional inputs from the NIHFW working group, the current management structure is not conducive to successful completion of the monitoring and evaluation needs of PVOH-II. In addition, the staff are not adequately remunerated, in the sense that their allowance for travel does not permit some to travel by air, and does not provide sufficient money for boarding and lodging.[16] **A more appropriate management structure would be to decentralize NIHFW's monitoring and evaluation functions. NIHFW should retain a centralized, supportive role, but with the time consuming and costly tasks of monitoring and evaluation decentralized to capable regional institutions or individuals.** This would enhance the quality of the monitoring visits, allowing them to serve a dual role of PVO strengthening as well as actually monitoring their activities.

At present, the financial monitoring is contracted to Thakur, Vaidyanath Ayer & Co. (TVA) by NIHFW. A need was felt to decentralize financial monitoring by four different chartered accountant firms for the four zones of the country. But, the Evaluation Team believes that this strategy would be ill-advised for a number of reasons. The current firm is well-familiar with the financial reporting requirements of USAID and MOHFW and with the specific accounting requirements of PVOH-II. The firm (TVA) has branch offices all over the country, and assigns senior staff and support services from its main office in Delhi, and from its three branch offices in Calcutta, Bombay and Madras. Thus, the services provided by TVA are already decentralized. The current firm has a 15-year history of working with PVOs, understands the environment in which they operate, and has had a good working relationship with the PVOH-II sub-projects, as attested to by the sub-grantees themselves. **Considering all these factors, it is advisable to retain TVA till the end of the project.**

Analysis

This section discusses the factors found in the design and structure of PVOH-II which have contributed to the above mentioned problems.

Mistake in Project Design: The project design has properly identified the strengths and weaknesses of PVOs and aims to make use of their strengths, and to provide support to over come their weaknesses. It has also identified an appropriate approach to deliver health services

[16]Personal communication Evaluation Unit, NIHFW.

through PVOs, i.e. outreach. However the design did not envisage the appropriate management system to implement the project. **A rigid, top-down structure is not well suited to implement the kinds of programs, activities and approaches under PVOH-II.**

Misinterpretation of Project Design: Certain aspects of the project design have been misinterpreted. For example, the appraisal report was not intended to be a final proposal. This misinterpretation has led to further homogenization of all projects, thereby stifling innovation. Secondly, the project design envisions a much greater role for the PCC. This committee is designed to identify the implementation problems and to assist the PVO to solve them. The PCC also has the responsibility to facilitate PVOs receiving technical assistance by selecting a panel of consultants and institutions. Unfortunately, the PCC has been unable to undertake these roles. The Evaluation Team feels that the lack of PVO and technical representation at this level may have hindered their ability.

Based on the above analysis, the following recommendations are made:

(1) Implement the role (as stated in the project design) and broaden the membership of PCC to include PVO representation and a technical expert in community based health delivery.

(2) Identify technical assistance capabilities to meet the specific and individual needs of the PVOs.

(3) Streamline reporting procedures and provide <u>timely</u> feed-back and support.

(4) Make top management accessible to the PVOs and sensitive to their problems by calling them together and **<u>listening</u>** to their problems.

(5) Ease the burden of the Evaluation Cell of the NIHFW by decentralizing their monitoring and evaluation functions.

7. THE DEVELOPMENT OF SUPPORT SERVICE PVOs AND THE EFFECTIVENESS OF THEIR ACTIVITIES

Evolution of the Concept of the Support Service PVO

The concept of the Support Service PVO has evolved as PVOH-II has taken shape, gaining and changing definition as the project progressed from design, to proposal development, through project implementation.

The concept of a Support Service sub-project is essentially absent in the Project Paper and the Project Implementation Letter (PIL), although the concept is "enabled" in the original project objectives. Definition was first put to the concept in the grant proposal guidelines, when the original enabling objectives were refined into an operational objective:

> "to promote expansion and creation of support services and technical assistance on a sustained basis for upgrading the skills of managerial and technical staff of PVOs working in health care activities" by providing "various types of training and technical assistance to small and weak PVOs and providing liaison services, monitoring and evaluation of the implementation by weak PVOs."

The guidelines make it explicit that Support Service sub-projects need not include a service delivery component, and there is no suggestion that it is the explicit role of the Support Service group to help smaller, weaker PVOs develop project proposals for funding. Several points in the guidelines remain ambiguous: were the strengthening activities to be open to the larger community of health PVOs or targeted to a select group? and; how was the technical assistance to be distributed between the Support Service PVOs and the parallel Technical Assistance component of PVOH-II?

The concept only began to take concrete shape when the first Support Service proposal, sanctioned in March 1992, was submitted. At this point, the four possible functions became clearly differentiated:

1) assistance in project/proposal development
2) support services (training and technical assistance)
3) umbrella (liaison, monitoring and evaluation)
4) direct services

It was not until September 1993, when the second Support Service PVO submitted its first batch of proposals from the smaller agencies, that serious consideration was given to the source of funding for the proposed activities. Would they be funded directly from existing MOHFW schemes, or would they become sub-sub-projects under PVOH-II funding? Ultimately, the latter approach was chosen but, to date, the exact mechanism has not been identified and few of these sub-sub-projects have been sanctioned.

Mechanism for the Review and Selection of Support Services PVOs

Unlike the Outreach Service sub-projects, no guidelines were devised for selecting the Support Service sub-projects. During the site visits, the Evaluation Team visited four support service sub-grantees and found different criteria and processes had been used to review their proposals. Of the ten Support Service sub-projects that have been sanctioned, the process for the first six was initiated by the PVOs, who responded either to advertisements or to word-of-mouth. Field appraisals were made, just as they were for Outreach sub-projects, and in some cases proposals were modified.

In the case of the last four sub-grantees, which were only sanctioned on December 31, 1993, the process was initiated by the PCC which identified and short-listed well-reputed groups, who were then approached and encouraged to submit proposals. Consultants were hired through PVOH-II to make site visits and provide assistance, (where necessary), to develop proposals. This mechanism provided much quicker turnaround, and is believed by USAID, to have resulted in stronger proposals.

During the appraisal and review process, two significant things happened which have impeded the progress of several of the Support Service sub-projects.

Imposition of activities and responsibilities. In one instance, an outreach activity was imposed on the Support Service group. This PVO was asked to include a service delivery component as a condition of grant award, even though it had no experience or interest in working at the community level. This imposition took place in spite of the guidelines which clearly stated that it was not necessary for Support Service sub-grantees to undertake a service delivery program.

Overlap in catchment areas. The Evaluation Team noted considerable overlap in the catchment areas of the Support Service groups. The Team was particularly perplexed when it noted that two states--Haryana and Gujarat--were cut out of the proposal of one of the Support Service groups explicitly because other Support Service groups were already working there, only to find that two new states added--Bihar and Madhya Pradesh--were already covered by one of the very same Support Service sub-projects. The difficulties stemming from this overlap have already manifest themselves during the search to identify potential sub-sub-projects. Fortunately, their target PVOs are somewhat different--the latter has targeted PVOs with less health experience, partially by default. The intensity of the effort now required to identify quality groups has caused the Support Service PVOs to fall behind in their implementation schedule.

Variation Among the PVOs and their Sub-projects

The Support Service sub-projects are perhaps characterized more strongly by their differences than by their similarities, as summarized in the figure on the following page. Clarification on a number of issues and questions is urgently needed.

What type of parent institutions are appropriate as Support Service PVOs? The four Support Service sub-projects visited have been imbedded into four different types of (see pg. 46)

COMPARISON OF SUPPORT SERVICE SUB-PROJECTS

Characteristic	Support Service Sub-projects			
	SWACH	TNVHA	SOSVA	IIHMR
Type of Parent Organization	Institute for applied health research and field projects	Membership organization	Professional group providing technical assistance	Academic teaching and research institute
Responsibilities Originally Proposed	Sub-sub-project development TA and training Umbrella Direct service Information dissemination	Sub-sub-project development Umbrella	Sub-sub-project development TA and training Information dissemination	Sub-sub-project development TA and training Umbrella
Type of PVOs Targeted for Sub-sub-projects	Small, health-oriented PVOs	Institutions training village-level Lady First Aiders	Small, health-oriented PVOs	Small, development PVOs with little or no health experience
Process of Short-listing PVOs for Sub-sub-project Development	Secondary identification, mailed questionnaire, invitation to workshop	Previous knowledge of its members	Resource person selection, invitation to workshop	Identified through local sources, field appraisal, invitation to workshop
Assistance Provided for Program & Proposal Design	Project Formulation Workshop followed by some further interactive development by mail and final editing by SWACH	TNVHA prepared proposal. After proposal approved, the sub-sub-grantees were informed of their participation	Provided technical assistance to prepare proposals	Awareness Creation Workshop followed by intensive interactive development by mail (Some PVOs could benefit from a follow-on workshop to complete proposal)
Sub-sub-project Sanctioning	SWACH recommends to MOHFW. Two batches submitted. None selected yet	Directly approved and passed on to sub-sub-grantees	SOSVA recommends. MOHFW has approved 26	IIHMR will recommend to NIHFW. None submitted yet.
Funds Disbursal to Sub-sub-projects	Directly from MOHFW	From TNVHA	Directly from MOHFW	Directly from MOHFW
Monitoring	Sees monitoring as a problem identification and solving task. Plan not yet developed.	Inspection	Supportive supervision and problem-solving. Holds Monitoring Workshops	Not yet formulated
Method of Providing Managerial TA	Expects to use outside experts. Plan not yet written	No such expertise available	Providing directly	Expects to provide directly through faculty.
Method of Providing Programmatic TA	Expects to provide directly. Plan not yet written.	Provided directly	Providing directly	Expects to provide directly through faculty.

parent institutions:

- -- a foundation which conducts applied health research projects and also maintains an ongoing field program of Dai training and supervision
- -- a membership organization for health PVOs
- -- a health consulting organization
- -- an academic teaching and research institute in the field of health care management

Added to these, are the six Support Service PVOs not visited, a number of which are hospital-based.

The degree to which the sub-sub-project is compatible with the philosophy, overall mission, mode of operation, and resources of its parent is a critical element not only in its successful implementation but to its sustainability as well.

What type of PVOs should be targeted for project development and strengthening? As per the guidelines, all of the Support Service sub-projects target "small" PVOs. However, the definition of small may vary--sometimes defined in terms of budget, sometimes defined in terms of the geographical area/number of villages served, sometimes not defined at all. The majority of the Support Service sub-projects target PVOs that are grassroots organizations that have directly provided health care services in the past. Two exceptions are worth noting. In one case, the target PVOs are those which are normally involved in an area of development other than health. This strategy is aimed at expanding the number of PVOs with a health care delivery focus providing services to underserved areas. In the second case, the target PVOs are training institutions, rather than service delivery institutions--the objective being to strengthen their capacity to do training.

What should be the responsibilities of the Support Service PVOs in:

- -- **Identifying and screening prospective sub-sub-project PVOs?** What are the trade-offs between an arms-length process and a labor intensive field appraisal approach? Under what circumstances is one of these preferable over the other?

- -- **Development of proposals?** What forums are the most effective for developing sound, viable projects for PVOs at different levels of sophistication, experience in health care delivery, etc.? What is the appropriate roles for the Support Service PVOs vis a vis the proposals: writer? editor? consultant?

- -- **What guidelines and criteria should be applied in the selection of sub-sub-project proposals?** This issue has been very problematic for PVOH-II Support Service PVOs. In the absence of guidelines, most Support Service PVOs have assumed that the same criteria that applied to them must flow down to the sub-sub-projects. In the case of the 25% contribution, this may be neither appropriate nor desirable. On the other hand, lack of programmatic guidelines may result in the necessary flexibility to begin to see some innovation in PVOH-II.

- -- **What types of training would be most useful for the smaller PVOs?** Based on the site visits made, the Evaluation Team believes that the service delivery

PVOs will not benefit from broad theoretical training in management. It is therefore recommended that training be more narrowly focused and individualized (e.g. strategic planning, field supervision, development of staff training plans, quality assurance, fund-raising.)

-- **What constitutes an umbrella function?** This function was broadly defined in the guidelines as liaison, monitoring, and evaluation. Does liaison mean fiscal in the sense of being a fiscal intermediary? What is the appropriate monitoring approach given the organizational relationships between the Support Service PVOs and the smaller PVOs? Should monitoring be provided in terms of supportive supervision? Measuring progress against implementation plan and targets? To what extent will the Support Service PVO be responsible for financial monitoring? As the final batch of Support Service Sub-projects have just been recently sanctioned, would it be more appropriate to delegate to them comprehensive responsibility for sub-sub-project sanctioning and funds dispersal, and to what degree will Support Service PVOs be held accountable for the sub-sub-project performance?

-- **Can, should, do Support Service PVOs provide direct service?** If this is appropriate, how can these direct service projects best be used to support the objectives of PVOH-II. For example, one Support Service PVO has developed a field training area at which other PVOs can observe:
- Dai training
- the use of appropriate technology for perinatal care developed by the PVO (measuring sticks for identifying high risk pregnant women, simple tools for resuscitation of the newborn, balances for identifying low-birth weight infants)
- a public/private sector team approach to service delivery in which the Dai, the Anganwadi worker and the sub-center ANM (multipurpose worker) work closely to provide care to pregnant women and children
- a field supervisory system

-- **What information dissemination is going on?** How can PVOH-II capitalize on the information dissemination efforts of the Support Service sub-projects. **PVOH-II would be well-served by wider dissemination of high quality publications produced under the auspices of individual sub-projects. For example, one Support Service PVO has produced a newsletter of such quality that a separate contract might be considered for this PVO to develop the technical content of the planned PVOH-II newsletter.**

Monitoring and Evaluation of Support Service PVOs

Under PVOH-II, Support Service PVOs are subject to the same monitoring and statistical reporting requirements as the Outreach sub-projects. Since the mandate of the Support Service component is broad (the degree to which they have provided support services, the extent to which these support services have strengthened the target PVOs), and lacks specific operational

objectives, evaluation could be difficult. In light of this, the Evaluation Team strongly **recommends a case study approach for the evaluation of these Support Service sub-projects.** The case study methodology is ideal in a situation where the objectives are not explicit and there is so much variation among the sub-projects. There are important lessons to be learned by documenting the processes by which small PVOs are developed and their service delivery capacity expanded. An additional by-product is the opportunity to compare the experiences of health sector PVOs with those PVOs whose prime focus has been in another development sector. Steps will need to be immediately taken to provide Support Service PVOs with the necessary tools for utilizing case study methodology.

Constraining Factors

The two most significant and inter-related factors to successful implementation of the Support Service component is that, 1) no clear functional definition has been provided, and 2) in the absence of a clear, functional definition, a relatively standard package of activities has been imposed on the PVOs.

Conclusions

While resolution of the many above issues is urgently required for successful completion of this project, several are moot with regard to PVOH-II due to the lack of project time remaining. However, there are significant lessons to be learned from this experience, that can benefit both USAID and MOHFW in future activities involving PVOs.

8. FUTURE DIRECTIONS

The preceding sections of the report, have dealt with the various issues as outlined in the Scope of Work. This concluding section draws from the detailed treatment contained the previous sections.

The issues for future consideration can be grouped into two categories:

- Constraints to project implementation, and;
- Recommendations for future course of action.

Identification of the constraints hindering project implementation are crucial to future progress. A clear understanding and comprehension of these constraints is necessary for mid-course strategies to be implemented, and to have the required impact on the day to day activities of the PVOs.

However, before elaborating on the above issues the Evaluation Team would like to **highlight some of the significant achievements made by PVOH-II.**

PVOH-II has enabled a number of PVOs to:

(1) Expand their geographical areas of service, add new health related services, and improve the services they offer, including the service delivery infrastructure.
(2) Develop horizontally and vertically integrated health care delivery systems
(3) Provide services to underserved, remote and isolated populations.
(4) Build their overall capabilities in project formulation, and financial management.
(5) Strengthen linkages and working relationships with district and primary health center (PHC) officials to provide complementary and supportive services.

CONSTRAINTS

Based on site visits and discussions with officials at MOHFW, NIHFW and USAID, and with the personnel of the different PVOs, the Evaluation Team has identified the following four broad areas of constraints which are likely to impact on the ability of PVOH-II to achieve its objectives and goal.

1) **Rigidity of Management System**

The management system being followed to implement PVOH-II appears rather rigid at various levels of Project implementation.

- Criteria of selection for PVOs.

- Homogenization of sub-projects rather than innovation and individualization: The appraisal reports, the baseline data collection format, and the format for quarterly reports, have tended to homogenize the projects, thus severely inhibiting development of innovative approaches, a crucial objective of PVOH-II.

- Budget rigidity: The procedure being followed does not allow for flexibility within line items of the sanctioned budgets to the PVOs.

- Procedures for processing supplemental grants: The various steps through which the supplemental grants recommended by the Monitoring Teams are being processed, are lengthy, rigid, and time consuming (PVO - Monitoring Visit - NIHFW - PCC - SGC).

- Target orientation versus process orientation: It is envisaged in PVOH-II that the sub-projects will "develop, study and test innovative approaches in delivery of health care." Thus the original design laid emphasis on PROCESS orientation. However, the various mechanisms followed in the implementation, have turned the sub-projects into TARGET achieving projects. This has severely affected the innovative capacity of the PVOs.

2) **Inability to Respond in a Timely Manner to:**

- Selection and approval of sub-sub projects (under the support service PVOs)
- Release of sanctioned budget as well as supplemental grants
- Actions recommended by monitoring reports
- Requests, concerns and problems of the PVOs
- Providing substantive response to Quarterly Reports

3) **Failure to Provide Technical Assistance of any Import to PVOs:**

- The procedures being followed for implementation and monitoring of PVO sub-projects, does not adequately address identification of the individualized technical assistance needs of the PVOs.

- Consequently, systematic and directed efforts have not been initiated to identify and document technical resources (technologies, materials, persons) that are critical for building the capacity of the PVOs.

- Mechanisms for effective interaction between the PVOs participating in PVOH-II, and between the PVOs and NIHFW and MOHFW, although strongly emphasized in the Project Implementation Letter (PIL), have not been fully developed and implemented. Consequently, inter-PVO support, which allows for sharing experiences (both soft and hard aspects), has not been meaningfully utilized.

4) **Overburdening of the NIHFW:**

As designed in the Project Paper, the workload of the NIHFW was appropriately spread across the life of the project but, because of start-up delays, this workload has now been heaped in the last four or five years, making it virtually impossible for the staff to accomplish. In addition, during the implementation phase, the concept of sub-sub-projects was introduced, expanding the number of PVOs under PVOH-II many times over.

NIHFW has the responsibilities of technical desk review, annual project monitoring field visits, reviewing quarterly reports, mid-term and final evaluation of all sub-projects. In due course, such procedures will involve well over a 100 projects (including sub-projects and sub-sub-projects).

The resources--staff, technical, financial--available to the NIHFW, and the differential per diem rates for the staff, etc - will not permit it to respond effectively to the various activities noted above, as well as to the other needs of the PVOs.

RECOMMENDATIONS

In order to effectively deal with the constraints noted above, the Evaluation Team makes the following recommendations. Both the first and second area of recommendations must have a high priority for the successful completion of PVOH-II.

I. IMMEDIATE REVISION OF MANAGEMENT SYSTEM

A) Convene top level strategy meeting between USAID and MOHFW

The following priorities for discussion have been identified

1) review resource utilization of project to date
2) re-examine clearance required by each party
3) decide what tasks can be delegated
4) decide what procedures should be streamlined

B) The PCC should be energized and its role expanded

This is critical to breaking up the many log jams that have occurred in project implementation, and to provide a vehicle for the necessary mid-course corrections. To enhance the facilitative and problem-solving role of the PCC, as detailed in the project paper, it is also recommended to:

1) **Expand PCC membership to include representation from PVOs and non-governmental technical experts**
2) **Develop a revised action plan for duration of PVOH-II**

   In this "action plan" some of the issues to be addressed:
   - creation of mechanism for technical assistance along the lines of the description in the project paper (see Recommendation II for suggestions)
   - specify "turnaround times" for as many activities as appropriate. (e.g. time from monitoring site visit to SGC report)
   - determine contents of monitoring reports necessary to meet PCC's specific management needs.

C) SGC membership should be broadened to include PVO representation and non-governmental technical experts

D) **Develop a mechanism for testing and integration of findings from innovative approaches**

1) **Support operations research/case studies**

Different mechanisms are being used at the community level to deliver the same services. Operations Research needs to be conducted to determine the effectiveness and cost effectiveness of apparently comparable systems. (e.g. is growth monitoring more effectively done by a VHW doing home visits or by monitoring in a fixed center?)

2) **Allow for introduction of programmatic changes based on operations research findings and other lessons learned**

Institute mechanisms for programmatic and budgetary flexibility

- **authorize an allowable 10% variation within line items**
- **PCC to streamline supplementary grant requests**
- **recognize the additional "contribution" made in response to needs identified during project implementation above the 25% originally budgeted**

E) **EASE BURDEN OF EVALUATION UNIT OF NIHFW**

The Evaluation Team feels that this is an <u>urgent priority</u> for successful completion of PVOH-II. To accomplish this we recommend:

1) **NIHFW and MOHFW should fix special rates of travel and per diem for different categories of Evaluation Unit staff.**
This is necessary to facilitate monitoring tasks from both a functional and psychological perspective.

2) <u>PROGRAM MONITORING</u> **must be decentralized under NIHFW**

To best achieve this decentralization, and at the same time accomplish the PVOH-II objective of "identifying and strengthening institutions capable of providing technical assistance to health PVOs, and to stimulate their use as a resource by PVOs" we <u>recommend for immediate implementation:</u>

a) Identification by PCC of 4-5 regional institutions, support service PVOs, or individual consultants, for assistance with the yearly monitoring site visits
b) MOHFW to contract with these agencies for services
c) Meeting to be convened by Evaluation Unit with sub-contractors and PCC members to develop "monitoring guidelines" which allow

for individualization based on type of PVO and type of sub-project.

d) Monitoring team must have <u>one</u> NIHFW representative so that complete overview of PVOH-II program activities remain centralized at NIHFW, but workload is eased.

e) Contractor responsible for preparing written monitoring report, including summative findings and recommendations (not to exceed 10 pages)

f) At PCC meeting contractor to present findings of monitoring report

3) **The procedure and process for <u>midterm evaluations must immediately be clarified</u> in light of the above recommendations.**

The Evaluation Team especially recommends that the sub-grantees be involved in this midterm process, so that their institutional capabilities for evaluation, and for planning corrective actions is enhanced.

4) <u>FINANCIAL MONITORING</u>, must also be decentralized but, as with program monitoring, since a "central authority" is required, the Evaluation Team **recommends that the current chartered accountant be retained for the duration of the project.** The present firm has a decentralized regional office structure with central control at its head office in Delhi.

5) **Restructure <u>REPORTING PROCEDURES</u>**

The present burden of reporting procedures impacts not only on NIHFW but on all management levels of PVOH-II from the ministry to USAID to the PVOs. Feedback on these reports from NIHFW is imperative for optimal sub-project functioning. We therefore recommend the following reporting procedures:

a) **Program Progress Reports submitted quarterly, documenting in <u>narrative</u> form** program activities and progress, problems encountered (solutions and unresolved issues), and immediate technical assistance needs

b) **Financial Reports submitted semi-annually** with one copy to NIHFW and one to TVA

c) **Statistical Report submitted annually**
(PVOs <u>must</u> compile their statistics on a monthly basis for their own management purposes)

II. ACTIVATE CHANNELS FOR STRENGTHENING OF PVO CAPACITIES

A) TECHNICAL ASSISTANCE, as described in the Project Paper, should be undertaken immediately

The process of providing this technical assistance must be individualized and relevant to the needs of the individual PVOs.
We recommend the following steps:

1) PCC to IMMEDIATELY develop process for individualizing TA which includes:[17]
   - identifying and contracting regional teams of consultants (with broad based community health delivery experience, not only academic experience) to meet together and develop strategy for assessing needs of each individual PVO
   - site visits by team, which as part of the needs assessment process may include TA in and of itself, and has the goal of working with the PVO to develop an individualized technical assistance plan

Virtually all PVOs require individualized TA in:
- Health records and MIS
- Sustainability plans (realistic and achievable)

2) **Mechanisms for sharing experiences, innovations, technologies, etc. should be instituted immediately**

- Identify well-developed systems, etc. that have been implemented by each sub-projects so that they may serve as consultants to each other
- Conduct regional conferences and an annual PVOH-II wide conference, which include workshops on technical issues (part of the conference should be devoted to updates from NIHFW/MOHFW with opportunities for PVOs to interact with them)
- Conduct study tours and visits to other PVOs
- Develop a resource and dissemination center (one PVO is already doing this)
- Implement Newsletter (one of the existing PVO newsletters can be expanded, via a separate contract, to serve the project-wide function)

[17]If the monitoring visits are conducted with sufficient consultant expertise this could be accomplished at the same time.

III. GIVE STRUCTURE TO SUPPORT SERVICE COMPONENT OF PVOH-II

Evolution of the support service concept has been rapid and specific components will need to be considered. Immediate consideration must be given to:

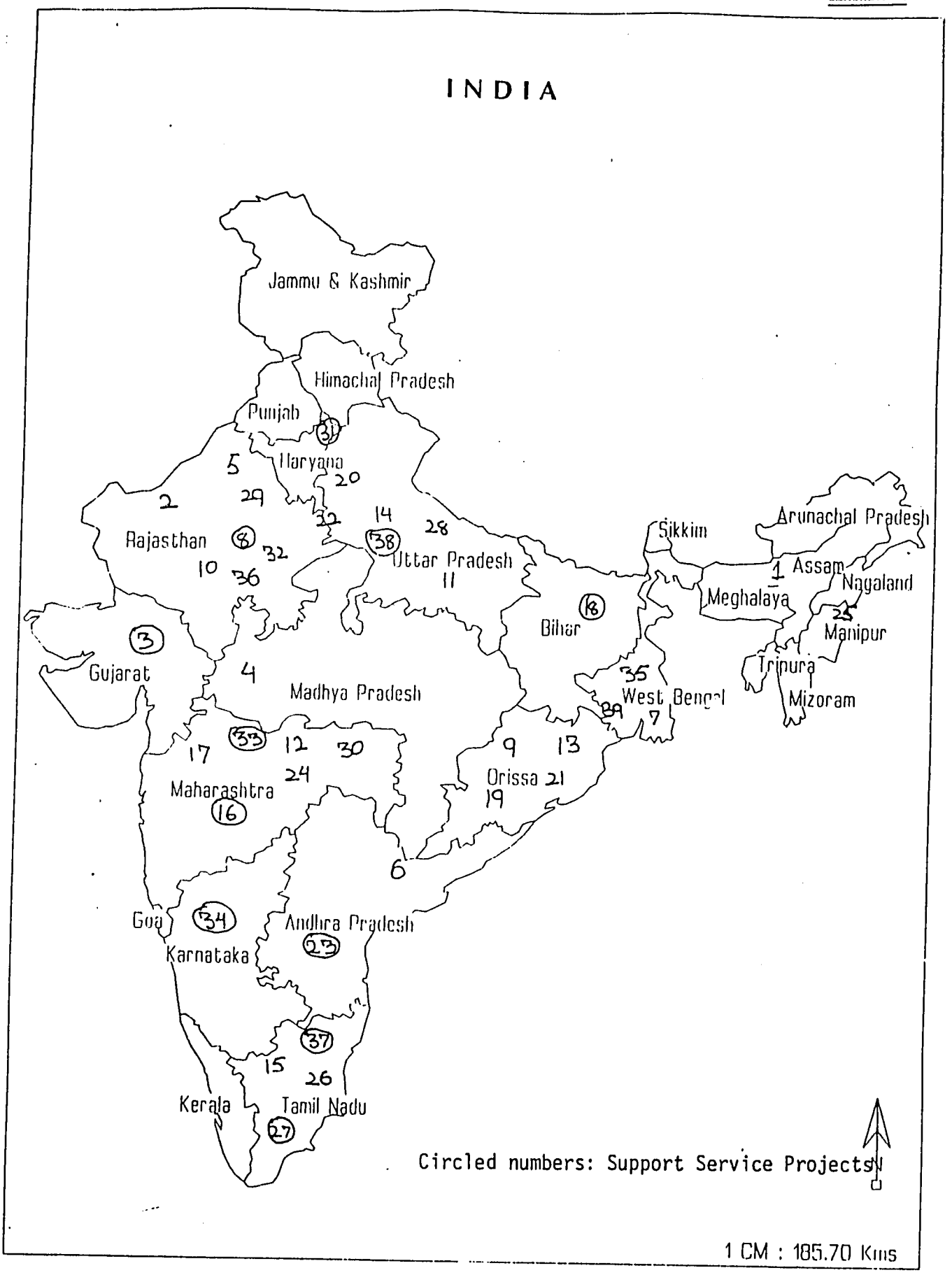
- The selection, monitoring and evaluation of sub-sub-grantees.
- What responsibilities does the Support Service PVO have vis-a-vis their sub-grantees and PVOH-II for financial monitoring?
- What technical assistance and guidance will these Support Service PVO's require to achieve PVOH-II project objectives and goal?

IV. DEVELOP IN COOPERATION WITH GOI/MOHFW AN INSTITUTIONALIZATION/POST PVOH-II PLAN

A. How to incorporate "lessons learned" into future projects and ongoing service systems.

B. Contingency plan for supporting worthwhile activities/infrastructure which may in spite of the PVO's good intentions fail to meet the sustainability acid test.

ANNEX 1


INDIA
Jammu & Kashmir
Himachal Pradesh
Punjab
Haryana
Rajasthan
Uttar Pradesh
Bihar
Sikkim
Arunachal Pradesh
Assam
Nagaland
Meghalaya
Manipur
Tripura
Mizoram
West Bengal
Gujarat
Madhya Pradesh
Orissa
Maharashtra
Goa
Andhra Pradesh
Karnataka
Kerala
Tamil Nadu
Circled numbers: Support Service Projects
1 CM : 185.70 Kms

ANNEX 2

PRIVATE VOLUNTARY ORGANIZATIONS IN HEALTH – PVOH II

ANNEX II

No.	Name of the PVO	Sanction	Headquarter	State	Villages	Population	AID Total	PVO total
1	Assam Imdadiya Hospital Committee	02/19/91	Guwahati	Assam	40	72,000	4,239,417	1,415,550
2	Bal Rashmi Society	10/30/91	Jaipur	Rajasthan	107	67,939	4,914,066	1,638,356
3	Baroda Citizen's Council (30 Sub–Grantees)	07/27/92	Baroda	Gujarat			3,512,150	3,329,400
4	Bhartiya Gramin Mahila Sangh	01/18/92	Indore	M.P.	50	40,000	5,559,321	1,853,120
5	Bhoruka Charitable Trust	08/01/91	Churu	Rajasthan	40	50,000	4,944,251	1,831,000
6	Dr. Ailu Ramalingiah Homoeo. Med.College & Hosp.	09/04/91	Rajahmundry	Andhra Pradesh	40	9,612	5,154,398	1,718,852
7	Gana Unnayan Parishad	11/18/91	24–Parganas	West Bengal	35	58,730	3,307,788	1,104,527
8	Indian Inst. of Hlth. Mgt. & Res. (20/25 Sub–Grantees)	09/29/92	Jaipur	Rajasthan			4,498,990	1,664,965
9	Indian Institute of Youth and Dev.	11/20/90	Phulbani	Orissa	66	10,173	3,080,956	1,066,328
10	Jaipur Rural Health and Dev. Trust	04/23/90	Jaipur	Rajasthan	120	92,511	6,280,900	2,095,000
11	Janhitkari Chikitsalaya	08/01/90	Kanpur	U.P.	92	80,951	3,858,690	1,310,000
12	Jawahar Medical Foundation	05/14/91	Dhule	Maharashtra	67	31,621	4,853,106	1,668,084
13	Jyotirmayee Mahila Samiti	07/13/90	Cuttack	Orissa	118	96,893	4,118,560	1,408,570
14	Kamla Nehru Memorial Hospital	09/25/91	Allahabad	U.P.	40	51,888	4,619,330	1,599,556
15	Karunya Educational Trust	07/18/91	Coimbatore	Tamil Nadu	9	37,664	3,423,374	1,281,585
16	Kasturba Gandhi Health Society (8–10 Sub–Grantees in MP)	12/31/93	Wardha	Maharashtra			3,213,050	1,151,200
17	KEM Hospital	01/29/92	Pune	Maharashtra	68	78,000	3,711,059	1,242,500
18	Kurji Holy Family Hospital (8–10 Sub–Grantees)	12/31/93	Patna	Bihar			2,475,273	3,199,219
19	National Institute of Social Work and Social Sciences	12/30/91	Bhubaneswar	Orissa	103	31,642	5,145,878	1,717,064
20	Naujhil Integrated Rural Project for Health & Development	03/18/91	Mathura	U.P.	73	107,634	5,978,075	1,992,691
21	Orissa Institute of Medical Research & Health Services	10/11/91	Cuttack	Orissa	96	74,547	4,588,842	1,531,449
22	Parivar Seva Sanstha	01/01/92	Gurgaon	Delhi	45	60,000	6,292,210	2,133,310

PRIVATE VOLUNTARY ORGANIZATIONS IN HEALTH – PVOH II

No.	Name of the PVO	Sanction	Headquarter	State	Villages	Population	AID Total	PVO total
23	Praja Sewa Samaj	12/26/91	Kadiri	Andhra Pradesh	15	27,906	3,011,000	1,007,047
24	Pravara Medical Trust	11/06/90	Loni,	Maharashtra	50	125,000	5,245,685	1,785,800
25	Rural Development Organisation	05/02/90	Manipur	Manipur	88	82,505	6,022,200	2,007,400
26	Rural Education and Development Society	11/15/91	Sivaganga	Tamil Nadu	30	19,346	3,455,870	1,159,579
27	Rural Unit for Health and Social Affairs (4 Sub–Grantees in Ori	12/31/93	Vellore	Tamil Nadu			1,767,100	589,100
28	Sarvajanik Parivar Kalyan & Sewa Samiti	10/21/91	Darjioli	U.P.	35	19,784	4,665,500	1,556,269
29	Seva Mandir	07/09/90	Udaipur	Rajasthan	42	60,000	3,368,750	1,128,500
30	Sewadham Trust	01/31/92	Pune	Maharashtra	39	30,000	4,907,102	1,653,800
31	Survival for Women and Children Foundation (20 Sub–Grantees	04/01/92	Chandigarh				5,892,000	1,964,000
32	Social Work and Research Centre	10/23/90	Tilonia	Rajasthan	150	200,000	7,080,000	2,438,000
33	Society for Service to Voluntary Agencies (SOSVA)	03/05/92		Maharashtra	40	55,000	5,767,000	1,930,000
33	Subgrants through SOSVA – 29 Sub–Grantees			Maharashtra			12,000,000	4,000,000
34	St. John's Medical College (4–8 Sub–Grantees)	12/31/93	Bangalore	Karnataka			1,332,900	452,800
35	Tagore Society for Rural Development	07/24/90	24–Parganas	West Bengal	59	105,000	5,211,005	1,740,000
36	Tarun Bharat Sangh	06/24/91	Alwar	Rajasthan	68	30,531	3,605,776	1,281,585
37	Tamil Nadu Voluntary Health Association (4 Sub–Grantees)	04/21/92	Madras	Tamil Nadu			7,407,000	2,510,000
38	Uttar Pradesh Voluntary Health Association (50 Sub–Grantees)	10/27/93	Lucknow	U.P.	250	250,000	5,907,224	2,749,778
39	Women in Social Action	11/20/91	Midnapore	West Bengal	100	29,746	4,106,885	1,376,507

ANNEX 3

ANNEX III

SCOPE OF WORK
MID-TERM EVALUATION
PRIVATE VOLUNTARY ORGANIZATION FOR HEALTH-II (PVOH-II)
PROJECT NUMBER 386-0511

Article-I: TITLE

Mid-term evaluation of PVOH-II project (386-0511)

Article-II: OBJECTIVE

The contractor shall undertake the mid-term evaluation of PVOH-II project and submit the report to USAID/India in accordance with the terms of reference specified here and statement of work (SOW) attached.

Article-III: STATEMENT OF WORK

See Attachment-1.

Article-IV: REPORT

The contractor will prepare a report which will cover all evaluation issues. All team members will contribute to the evaluation report but the team leader will be responsible for producing the final report according to USAID requirements.

The evaluation report will include the following sections:

- Description of the project
- Evaluation purpose
- Evaluation issues and questions
- Evaluation team and work plan
- Evaluation methodology
- Evaluation findings and conclusions (issue-wise)
- Recommendations and lessons learned

The contractor will also prepare a one-page evaluation abstract and a four to five page executive summary giving the gist of all sections of the report in the same order as mentioned above. Besides this the final report will have preface, table of contents, list of tables, acronyms, lists of persons and organizations visited, documents and reports reviewed and relevant technical or analytical annexures supporting the main findings, conclusions and recommendations. Scope of work and project related papers like project identification data sheet, log-frame and profile of

activities supported under the project are also to be included in the final report as per USAID requirements.

The contractor will submit a draft report to USAID. Before finalization of the report, the contractor will informally discuss tentative findings and recommendations and the report structure with USAID officers responsible for project management and evaluation. The contractor will debrief concerned USAID and GOI officials, seek and incorporate their suggestions and comments, revise and submit one original and 20 duplicate copies (along with diskette) of the final report to the Evaluation Officer.

Article-V: RELATIONSHIP AND RESPONSIBILITIES

The contractor will provide a team of four-members with the following nationality, specialty and experience.

1. A US public health expert with extensive experience in health care delivery by PVOs. He/She must be qualified to lead the evaluation team. Must have good report writing skills and will be responsible for the overall coordination of evaluation and finalization of the report. Person must have experience in leading evaluation teams for USAID funded projects.

2. A US public health specialist with experience in planning and providing primary health care services from a PVO perspective.

3. An Indian expert with extensive experience in providing primary health care service delivery and working with grass roots level NGOs.

4. An Indian expert with prior experience of managing community based, financially self sustaining outreach health care programs and developing active community participation in project design and implementation.

Team members will report to the team leader, make contributions in the areas of their interest and seek guidance and support from the Evaluation Officer and Project Officer from the Mission.

Article-VI: PERFORMANCE PERIOD

The mid-term evaluation will begin o/a September 27, 1993 and will take 23 workdays from all team members and 28 workdays from the team leader to complete the following activities:

	Activity	Workdays
i)	Review of documents and team planning	02
ii)	Briefing and discussions with Mission officials	01
iii)	Discussions with GOI officials concerned in Delhi	02
iv)	Planning Meeting	01
v)	Visits to select PVOs and State departments concerned	08
vi)	Preparation of draft report	06
vii)	Debriefings with GOI and Mission officials	01
viii)	Revision of the report by the team	02
ix)	Finalization and Submission of the report by the team leader	05
	Total for 3 team members	23
	Total for the team leader	28

Article-VII: WORK DAYS AUTHORIZED

A six day work week will be authorized for the team, 23 workdays ordered for 3 team members and 28 for team leader giving the total of 97 workdays. The workdays ordered, therefore, would be as follows:

i)	For Team Leader	28 days
ii)	For 3 Team Members	69 days
	Total	97 days

STATEMENT OF WORK

MID-TERM EVALUATION

PRIVATE VOLUNTARY ORGANIZATIONS FOR HEALTH-II (PVOH II), PROJECT NUMBER 386-0511

1. BACKGROUND

The PVOH-II project is a follow on project which builds on the experience and capabilities of the PVOH-I project which was implemented during 1980-90. The life of project (LOP) of PVOH-II is from 08/31/87 to 08/31/97. The total contribution is $10 million from USAID in dollars, $0.5 million from GOI and $2.9 million from the PVO grantees in rupees.

The purpose of this project is to expand and improve basic and preventive health, family planning, and nutrition services for the poor by utilizing and strengthening the private and voluntary sector. The goal of the project is to reduce morbidity, mortality, and fertility among rural and urban poor in India, particularly the morbidity and mortality of children under five.

The key objectives are to:

- Create PVO sponsored health outreach activities that are self sustaining
- Support and test innovative approaches to community based health care, family planning, and nutrition programs
- Identify and strengthen institutions capable of providing technical assistance to health PVOs, and to stimulate their use as a resource by PVOs
- Foster a system of information exchange by PVOs
- Upgrade the skills of PVO managerial and technical staff
- Improve the quality of community level training for community health workers, volunteers, and women
- Support special health related activities and preventive programs, such as literacy training for females, sanitation, and low cost methods of providing safe drinking water
- Encourage and support programs to integrate traditional and western systems of health care
- Support the dissemination and utilization of the most effective treatment methods such as oral rehydration for diarrhea

The project involves two types of generic activities:

- Provision of outreach health and family welfare services to rural communities

- Provision of technical and support services to PVOs which are delivering health care services such as technical assistance for health intervention strategies, health surveillance, setting up information systems, surveys, training of health workers, administrative, and financial staff, monitoring and evaluation, and fund raising and support for economic activities to ensure long term sustainability of PVOs. This type of activity would essentially be services provided by larger, stronger, more established PVOs to smaller organizations working at the grass roots level in health activities.

A total of 40 PVOs can be funded. Thirty-four have been given grants (twenty nine for outreach services and five for support services) and five more (support services) will be funded before December 1993. The project is jointly managed by USAID and the Ministry of Health and Family Welfare. The National Institute of Health and Family Welfare (NIHFW) is responsible for appraisal of PVOs and monitoring of activities and progress. NIHFW has contracted with a firm of chartered accountants to assist with financial monitoring.

The AID grant funds the following activities:

- Sub grants to PVOs
- Technical Assistance and Training
- Monitoring and Evaluation

The state-wise list of organizations providing outreach and support services under the project is given in Table-1 and Map-1.

Table-1: State-wise List of Organizations Providing Out-reach and Support(*) Services under PVOH-II Project

	State/Name of Organization	Location
	TAMIL NADU	
*	*Tamil Nadu Voluntary Health Association*	*Madras*
	Karunya Educational Trust	Coimbatore
	Rural Education and Development Society	Sivagangai
	MAHARASHTRA	
*	*Society for Service to Voluntary Agencies (SOSVA)*	*Pune*
	Subgrants through SOSVA	
	KEM Hospital	Pune
	Sewadham Trust	Pune
	Pravara Medical Trust	Loni
	Jawahar Medical Foundation	Dhule
	ANDHRA PRADESH	
	Dr. Allu Ramalingaiah Homeopathic Medical College and Hospital	Rajahmundry
	Praja Seva Samaj	Kadiri
	WEST BENGAL	
	Tagore Society for Rural Development	24-Parganas
	Gana Unnayan Parishad	24-Parganas
	Women in Social Action	Midnapore
	HARYANA	
*	*Survival of Women and Children (SWACH)*	*Chandigarh*
	Parivar Seva Sanstha	Gurgaon
	MANIPUR	
	Rural Development Organization	Manipur

ORISSA

Jyotirmayee Mahila Samiti	Cuttack
Indian Institute of Youth and Development	Phulbani
Orissa Institute of Medical Research and Health Services	Cuttack
National institute of Social Work and Social Sciences	Bhubaneswar

ASSAM

Assam Imadadiya Hospital Committee	Guwahati

GUJARAT

*	*Baroda Citizen's Council*	*Baroda*

MADHYA PRADESH

Bharatiya Grameen Mahila Sangh	Indore

RAJASTHAN

*	*Indian Institute of Health Management Research*	*Jaipur*
	Jaipur Rural Health and Development Trust	Jaipur
	Seva Mandir	Udaipur
	Social Work and Research Center	Tilonia
	Tarun Bharat Sangh	Alwar
	Bhoruka Charitable Trust	Churu
	Bal Rashmi Society	Jaipur

UTTAR PRADESH

Sarvajanik Parivar Kalyan and Seva Samiti	Darjioli
Kamala Nehru Memorial Hospital	Allahabad
Naujhil Integrated Rural project for Health and Development (NIRPHAD)	Mathura
Janahitkari Chikitsalaya	Kanpur

2. *EVALUATION PURPOSE*

In March 1991, the final evaluation of PVOH-I was conducted to explore mechanisms to institutionalize closer cooperation in health activities between the public and private sectors and bring out lessons learned and implications for the PVOH-II project.

The final evaluation emphasized the need to:

- decentralize both technical assistance and auditing functions of PVOH-II project.
- provide technical assistance to prepare sustainability plans and evolve cost recovery mechanisms,
- concentrate activities in states where the NGO sector needs strengthening and where the health indices need improvement
- simplify and improve financial and monitoring procedures to maintain and retain the focus consistently on the project purpose and goal.

The overall purpose of the mid-term evaluation is to assess progress towards the achievement of stated project purpose and goal, track implementation difficulties and constraints, identify mid-course corrective strategies, and recommend future course of action.

3. *EVALUATION ISSUES*

Issue: Mechanisms for review and selection of PVO grantees

- What criteria have been used and how effective have they been in the review and selection of projects for:
  a) outreach services
  b) support services
- In order to meet project objectives what review and assessment criteria ought to be used to select such PVOs for assistance?

Issue: Range and Quality of Health Interventions

- What is the range and quality of health, population and nutrition interventions planned and delivered by the PVO grantees?
- Are these interventions appropriate and are they responsive to the needs of the community?

Issue: **Community Participation and relevance to Community Needs**

- What innovative mechanisms have been established by PVOs in community participation and in integrating traditional medicine systems with "western medicine". To what extent have health messages been adapted to local conditions? Has the planning of the project been sensitive to local culture?

Issue: **Effectiveness of activities implemented by PVOs**

- How effectively are the PVOs managing and implementing their grant activities including: collecting health data, setting operational targets, planning programs at community level, recruiting, training and supervising staff, decentralizing management and decision making?

- What is the quality of training programs that PVOs offer to workers? What are their systems for on-going training? Do they have mechanisms for supportive supervision?

- How well planned and managed are referral and transport systems for outreach services, particularly for high risk births?

- Are PVOs drawing upon existing Government, voluntary and private sector health resources at the district level to strengthen program activities including referral?

- Have PVOs developed indicators to measure impact? Are they able to evaluate changes in mothers' knowledge and behavior?

Issue: **Sustainability of Project Activities**

- Are PVOs developing capabilities to sustain activities at the organizational level and at the community level? Are they working at building linkages with government and other development agencies? Are they strengthening local capacity to plan, manage, and partially finance services? Do they measure and publicize impact? Are they increasing demand on government services (where existent)? Are they involving the community in problem solving?

- Are PVOs contributing the 25% share to project costs? Are they making efforts to generate sustainable financing? (fee for service, drug sales, cooperatives, income generating activities)

Issue: **Effectiveness of Management Structure**

- Given the goals of the project and the capability of the grantees is the management structure designed for the project, adequate and appropriate to provide the administrative and technical support required by the PVOs?
- What is the perception of PVOs regarding the responsiveness and effectiveness of NIHFW, MOHFW, and USAID in providing the support they are meant to provide?

- How does the existing management structure established compare with that suggested in the project paper and basic PIL?

- What recommendations does the team make for improving the financial administration and technical support rendered by NIHFW, MOHFW, and USAID to the grantees?

Issue: Future Direction

- What are the critical constraints to project implementation and progress?

- What are the key mid course strategies to be implemented so that the available resources can be used effectively?

- What are the evaluation team's recommendations on future course of action in order to meet project objectives and goals?

4. *EVALUATION METHODOLOGY*

In order to examine these issues, an appropriate mix of the following methods will be used.

A. *Review of documents* such as project paper, project agreement, project amendments, project implementation letters, minutes of project implementation review meetings, sub-grant proposals, appraisal reports, field visit and monitoring reports, periodic progress reports, guidelines etc.

B. *Meetings and discussions* with concerned officers responsible for review and selection, implementation and management, monitoring and evaluation of PVO sub-grants at NIHFW, MOHFW and USAID levels.

C. *Site visits and discussions* with project managers of both support service and outreach service PVOs. At least 10 PVO grantees will be visited.

D. *Other appropriate methods* such as case-studies, observation, and anecdotal evidences may also be used by the evaluation team if required.

ANNEX 4

ANNEX IV

DOCUMENTS REVIEWED

1. MOHFW - Financial Assistance to Voluntary Organization for Health, Family Welfare and Nutrition Services (PVOH-II Scheme), GOI, New Delhi, undated.

2. MOHFW - Scheme for promotion of small family norm through innovative methods (revamped), MOHFW, New Delhi, undated.

3. MOHFW - Mini Family Welfare Centre Scheme (revamped), MOHFW, New Delhi, undated.

4. MOHFW - Model scheme for promotion of small family norm and population control, setting up six bedded sterilization ward with operation theater, MOHFW, undated.

5. MOHFW - Model scheme for assistance to Non-Governmental Organizations for promotion of small family norm and population control by encouraging spacing methods and sterilization, MOHFW, undated.

6. MOHFW - VOP Section - PVOH-II Scheme: Statement of Committed Grant and Funds released to Voluntary Organizations during the last 3 years and the current year (as on 31/1/1994), Delhi.

7. NIHFW - Collaboration with Voluntary Organizations in Health, Family Welfare and Nutrition: An overview of the project on Private Voluntary Organizations for Health, New Delhi, 1989.

8. NIHFW - Scope and plan of operation of Mid-Term Evaluation, NIHFW, undated.

9. NIHFW - PVOH-II Project activities (1991-92 and 92-93) - A critical review, Delhi, undated.

10. SHARE - Survival, Health awareness, Resources, Education: A newsletter funded under PVOH-II scheme, SWACH, Chandigarh, undated.

11. SWACH & MOHFW - Directory of Private Voluntary Organizations. Survival for Women and Children (SWACH) foundation and MOHFW, 1993.

12. USAID/India- Private Voluntary Organizations for Health (PVOH-II) (386-0511), USAID, August 28, 1987.

13. USAID/India- Final Evaluation: Private Voluntary Organizations for Health (PVOH-I) (386-0469), USAID/New Delhi, March 1991.

14. USAID/India- Grant Agreement between the President of India and the United States of America for Private Voluntary Organizations for Health (PVOH-II), (386-0511), USAID/New Delhi, August 1987.

15. USAID/India- Private Voluntary Organizations for Health (PVOH-II) (386-0511), Project Agreement, dated August 31, 1987, Project Implementation Letter (PIL) no.7, procedures and guidelines, USAID/New Delhi, march 9, 1989.

16. USAID/India- First Amendatory Agreement to the Project Grant Agreement between the President of India and the United States of America for Private Voluntary Organizations for Health (PVOH-II), A.I.D. Project no. (386-0511), July 27, 1990.

17. USAID/India- Second Amendatory Agreement to the Project Grant Agreement between the President of India and the United States of America for Private Voluntary Organizations for Health (PVOH-II), A.I.D. Project no. (386-0511), August 27, 1991.

18. USAID/India- Third Amendatory Agreement to the Project Grant Agreement between the President of India and the United States of America for Private Voluntary Organizations for Health (PVOH-II), A.I.D. Project no. (386-0511), undated.

19. USAID/India- List of sub-grantees PVOH-II, January 1994.

20. USAID/India- Project Assistance Completion Report: The Private Voluntary Organizations for Health Project, 386-0469, December 1, 1993.

21. ISHA, BANGALORE
Strengthening the Capabilities of Voluntary Agencies in Health and Family Welfare Through the PVOH Scheme, Phase I and II

22. ISHA, BANGALORE
An Assignment of the Impacts Made by the Projects for USAID, New Delhi and MOHFW, New Delhi, April 2, 1992

Project Documents

In addition, the Evaluation Team reviewed project proposals, appraisal reports, monitoring reports, quarterly reports, for all the 11 sub-projects and 2 sub-sub-projects that were visited during the evaluation.

ANNEX 5

ANNEX V

LIST OF PERSONS INTERVIEWED

Ministry of Health and Family Welfare

Ms. Adarsh Misra, Joint Secretary
Mr. Bhag Mall, Director, N.G.O.
Mr. T.K. Murugan, Under Secretary, VOP Section
Ms. Anita Puri, Section Officer, VOP Section
Ms. Jyotna Sokhey, Deputy Commissioner, MCH.
Dr. K. Khehar, Dy Commissioner
Dr. Tripta Bhasin, Dy Commissioner

National Institute of Health and Family Welfare

Program Monitoring
Dr. J.P. Gupta, Director
Mr. K.K. Varma, Associate Project Director (PVOH-II)
Mr. V.N. Tyagi, Evaluation Unit
Mr. Sharma, Evaluation Unit
Dr. N.K. Sood, Associate Professor
Dr. Rajani Bala Chopra, Lecturer

Financial Monitoring
Mr. K.N. Gupta, Thakur, Vaidyanath Aiyar & Co.

USAID

Mr. Walter Bollinger, Director
Mr. Steven P. Mintz, Deputy Director
Mr. Jerry Tarter, Director, Project Design and Implementation
Mr. John J. Dumm, Director, Office of Population, Health, Nutrition (HPN)
Ms. Rekha Masilamani, Chief, PHN, Health Services Division
Dr. K. Sudhakar, PHN/HS
Dr. Rajani Ved, Project Officer, PHN/HS
Mr. N. Ramesh, Evaluation Office,
Mr. R. Kaman, PHN/HS

LIST OF PERSONS INTERVIEWED
TEAM 1

January 12-13, 1994

1. **Survival for Women and Children Foundation (SWACH), Chandigarh.**

Dr. Neena Raina, Director and Programme Coordinator.
Dr. Amrit Syngle, Principal of Training Institute for PVOH-II.
Dr. Satinder Singh Jarri, Programme Officer.

Locations visited

Village Ledi:	Dai monthly meeting with MPHW and Field coordinator.
Village Dadupur:	Integrated Child Development Scheme Center (Dai, MPHW, Anganwadi worker, mothers and children).
Village Tharapur Khurd:	Women's group assembling disposable delivery kits.

Site of proposed training centre.

January 14-16, 1994

2. **Indian Institute of Health Management Research (IIHMR), Jaipur, Rajasthan.**

Dr. G. Giridhar, Director, IIHMR.
Dr. P. K. Mukherjee, Chief coordinator, PVOH-II Project.
Mr. Amitava Banerjee, Senior Research Officer (i.e. program officer).

Locations visited

IIHMR Campus, Jaipur, Rajasthan.

January 19-20, 1994

3. **Women in Social Action (WSA), Jhargram, West Bengal.**

Persons contacted:

Bhakti Barik, Project Coordinator
Abhijit Chowdhury, Medical Officer
Mitali Bera, Medical Officer
Ratan Mallick, Area Supervisor
Surita Nag, Area Supervisor
J. N. Mandal, Lab. Technician
Kajal Barik, ANM
Sabita Mal, ANM
Dipti Sinha, Organizer
Bhupati Mahata, Organizer
Subir Choudhury, Typist
Rinku Chakraborty, Accountant
P. Barik, Advisor

Locations visited

Village Chakua: MCH-Post
Devjani Mahato, Health Worker
Hiramani Mandi, Health Worker
Village Birjania: MCH-Post
Chayya Mahato, Health Worker
Sawarna Sinha, Health Worker
Village Belaihohi

January 20-22, 1994

4. **National Institute of Social Work and Social Sciences (NISWASS), Bhubaneswar, Orissa.**

- Shri. P. Naik, Project Coordinator at Bhubaneswar, and he accompanied us to the project area.

- Dr. I. C. Mohanty, Chief District Medical Officer at Phulbani, District Head Quarter, Phulbani district.

Daringbadi

Dr. G. Harichandan, Senior Medical Officer
Dr. P. K. Subudhi, Junior Medical Officer
Mr. Sunil K. Sahu, Pharmacist
Mr. K. C. Senapati, Pharmacist
Mr. Padma C. Panda, Lab. Technician
Mrs. Surata Hehara, Staff Nurse
Ms. Sabita Naik, ANM
Ms. Dhani Sahu, ANM
Mr. P. K. Lima, Health Educator
Mr. Julian Digal, Driver
Mr. Sudhir Digal, Sweeper-cum-chowkidar
Mrs. Hara Singh, Sweeper

Location visited:

NISWSS, Bhubaneswar
Phulbani
Daringbadi
Village Kandahappa (project Centre)
Village Chadakria
Mrs. Sushil Nayak - Grass Root Heath Worker
Mr. Sujit Nayak - Grass Root Social Worker.

January 22-23, 1994

5. **Indian Institute of Youth Development (IIYD), Kalinga, Orissa.**

Persons contacted:

Mr. P. C. Misra, Project Coordinator
Mrs. Mikhla, Lady Health Worker
Mrs. Jhara Digal, President, Mahila Mandal
Shri. S. K. Savoni, Accountant
Shri. B. B. Das, Pharmacist
Mrs. Kunilata Sahu, Lady Health Worker
Mrs. Prabati Kar, Health Volunteer
Mrs. Anapurna Digal, Health Volunteer

Location visited

Head Quarters of IIYD at Kalinga
Sanatory Sales shop of IIYD at Tikabali
Village Munigia
Village Piplidan
Village Katimatia, sub-center.

LIST OF PERSONS INTERVIEWED
TEAM 2

January 13, 1994

1. **Parivar Seva Sanstha, Gurgaon**

Mr. A.K. Bhagat, Coordinator
Mr. Amal Basak, Consultant
Dr. Moitra, Mobile Unit Doctor
Ms. Fatima, Counsellor cum Junior Administrator
Village Health Promoter
Auxilliary Nurse mid-wife
Village Trained Dai

Locations Visited

Village Sudaka	Mobile unit service, health education, immunization.
Static Clinic construction site	

January 14 and 15, 1994

2. **Jaipur Rural Health and Development Trust, Jaipur.**

Dr. D.D. Nimavat, Project Director
Dr. Jagdev, Formar Project Direct
Mr. Korawalla, Trust Chairman
Static Clinic Doctor
Village Health Guide
PHC Doctors
PHC Male Nurse
CHC Doctors

Locations Visited

Village Mahala	Static clinic
Village Palu Kalan	Village Health Guide and her husband, discussed record keeping.
Village Dudhu	Community Health Center
Village Vichoon	Primary Health Center and meeting with the doctors and male nurse

January 17 and 19, 1994

3. **Society for Service to Voluntary Agencies (SOSVA), Pune.**

Mr. Srinivasan, Project Director
Dr. G.A. Panse, Consultant
Mr. Vaidya, Manager, Human Resource Development
Mr. Manoharan, Manager, Finance
Dr. Kohlapure, Field Officer
Dr. Kale, Field Officer
Mr. Elave, Field Officer

Locations Visited

Pune Mahila Mandal - Sub-grantee of SOSVA

Ms. Chaya Barve, Project Coordinator Clinic Doctor, and Health team

January 18, 1994

4. **Sevadham Trust, Pune**

Persons Contacted

Dr. Gore, Director
Mr. Uttam Rao Jagdev, Project Coordinator

Locations Visited

Village Khed	Mr. M.S. Kalshetti, Block Development Officer
Village Koyande	Static Clinic, Mobile Clinic, Ante-natal check Deshpande, Social Worker, Dr. Shinde, Static Clinic Doctor, Volunteer Doctors and Activator.

January 21, 1994

5. **Rural Education and Development Society (REDS), Tamil Nadu**

Persons Contacted

Mr. S. Alexander, Consultant (founder & former Chairman of REDS)
Mr. B.S.J. Victor, Chairman
Ms. Rachel Rajathi, Project Coordinator
Lady Medical Officer
Mr. Franklin, Communicator

Locations Visited

Village Kootiravupatty	Vocational training center, and Static Clinic.
Other villages	Hand pump, Balwadi, Sub-centre, Sangam members, Village Health Guide, Village Level Organiser.

January 22, 1994

* **ASSEFA, Natham, Tamil Nadu** (sub-sub-grantee of Tamil Nadu Voluntary Health Association)

Person Contacted
Dr. Dutta, Medical Officer

Location Visited
Village Natham LFA and Vocational training center.

January 24, 1994

6. **Tamil Nadu Voluntary Health Association**

Person Contacted
Dr. Sampath, Project Coordinator

Location Visited
Madras City Project office

ANNEX 6

ANNEX VI

Site Visit Protocol

Field notes should be written at end of each day describing activities observed, questions answered etc.

Historical Development of PVO (MA/KCM)

- Early Development--When was it founded, founded by whom, who participated? What was its initial mission, target populations, catchment areas? What were its sources of funding? Initial budget levels? What services did it initially provide? Other key activities?

- Structure--What was its organizational structure? Staffing patterns? Pre-project linkages with other PVOs?

- Project Involvement--How became aware of opportunity? Who/how decided to apply? Why did it apply for the grant? What did it hope to get out of project participation? How decided on what "project" to submit, (especially interested if initiative was truly their's or if project was modified somewhere along sub-grant process - e.g. if NIHWF "rewrote" original proposal - notion of top-down versus bottom-up)? Steps taken to achieve proposal process? Energy/resources required to complete this process

Health Care-Related Services (MA/SFK)

- Services Provided--fp/other MCH, direct services vs. outreach services (IEC, motivation, etc.), service delivery systems/structures

- Expansion of services under the Project--types of services, catchment areas, level of services

- Approach to Service Delivery--integrated/vertical, what innovative approaches have they envisioned/tried and what has been their experience?

- Referral and Transport Services

- Quality of service--how do they define quality? how do they control it (protocols)? how do they know measure/monitor it? do they think quality has improve as a result of the project? If yes, what do they think was responsible for improvement? If no, what do they think the project could have contributed to help improve quality?

Other Related PVO Activities (MA/KCM)

- Types of Activities--literacy, income generation, empowerment of women, water and sanitation

- Relationship to Project Objectives of Improving Health Status

Community Involvement (MA/KCM)

- Mechanisms for Involving the Community--Pre-project? New under the project?

- Adaptation to Local Needs---presence of traditional healers or other medical systems and/or tribal/ethnic/religious variations, is there a formal process for identifying local needs? how have local needs/culture been addressed (messages, approaches to service delivery etc)

TA and Other Activities of Umbrella Agencies (SFK/CKY)

- TA and Consultation Needed by PVOs--methods of needs assessment,

- Services Available--staff technical capacity, capacity to meet actual demand

- Process for Providing--how initiated, venue, fees, follow-up

- (If subgranting umbrella) Subgranting Process--identifying candidates, support for proposal writing, selection criteria and process, proposal review, monitoring and evaluation

Human Resource Development and Training (CKY/KCM)

- Personnel--what categories of personnel are employed to deliver services? what are their backgrounds? prior formative training? selection criteria?

- Training Systems--internal capabilities vs. external resources? who is trained? what types of training is available (pre-service, in-service)? curriculum used? trainers?

- Community-Level Training

- Management Training--what kind of training have they gotten throught the project? what would be helpful?

Organizational Linkages (All)

- Public Sector--what are they? who initiated the linkages? what problems have been/are still being encountered? what are the areas of overlap? of complementarity? in what areas and through what processes can working relationships be improved?

- Other PVOs--collaboration in providing services, technical support, other

- Traditional practitioners--types of practitioners, attitudes towards these practitioners

Financial Issues (SFK/CKY)

- Budget Levels--Prior five years? LOP? Projected annual? Proportion of total budget represented by the project budget?
- Funding--other sources of funding today
- Local Participation--What budget items did they use to satisfy their 25% requirement? How did they decide to use these items? What other items could have been used? How do they feel about this (realistic?, difficult?)?
- Bookkeeping and Financial Reporting--What is done internally and what is done externally? Was training provided/necessary for this? What changes were made because of the project and how do they feel about these changes? Impressions of process. Recommendations/suggestions

Other Management Issues (SFK/CKY)

- Pre-project Management--structure, staff experience, management training
- Project Contribution--changes in structure, training
- Planning Systems--strategic planning, annual workplans
- Managerial Control Systems (for umbrella projects)--how do they manage subgrantees?
- Operational Control Systems--patient referral systems, supervisory systems
- MIS--what is the system? how does it fit into the planning and control processes?

Program Evaluation

- Subproject Goals and Objectives--what are they? how were they developed? have any needs assessments been done? are goals and objectives realistic?
- Evaluation Framework--are the hypothetical linkages between program activities and program goal/objectives explicit and clear?
- Measurement--what indicators are considered important? besides the baseline survey, what sources of data are

available? is PVO able to evaluate effectiveness (are indicators developed?)

- Evaluation Process--is there an evaluation plan? what are the internal staff capabilities for doing evaluation? what options have been considered/chosen for carrying out the evaluation?

- Evaluation Activities--what activities have been carried out to date? what problems have been encountered?

Experience with the Project Process

- Proposal Preparation--"assistance" provided by anyone during proposal process, impression of restrictions imposed in process (e.g. meds, construction, vehicles, abortion) were these problematic? Total time involved from beginning to receiving sub-grant

- Review Process--Assessment of "field appraisal process," impressions of selection process

- Start-up--Notification of sanction, release of funds

- Sustainability Plans

- Baseline Survey--when done? assistance required/received? impressions of process, recommendations/ suggestions

- Experience with CPA firm

- Technical Assistance--perceptions of what TA is available and who to access it? Impression/effectiveness of list of eligible TA organizations (process of PVO contracting directly with them (see Project Paper pg 14). What have they needed, asked for and received? From whom have they received technical assistance? What has been their experience? PVO assessment of TA (who determines if TA has been effective, i.e. does PVO have any recourse if not satisfied?) recommendations, suggestions

- Reporting Requirements--impression of including time & resources necessary to complete this process, technical assistance needed/provided, recommendations/suggestions

- Monitoring Process--who does this? has it been done? impression of this? what received from process (e.g. report, feedback)? Recommendations, suggestions

- Information Exchange between PVOs--what has been their experience?

- Suggestions for improvement of process

PVO's Relations with Project Participant "Agencies"

- State/District Health Govt Level/SCOVA--interaction/involvement with this level (how, when, where), impressions of participation (facilitates or constraints from this level)

- NIHWF--interaction/involvement with them in addition to what mentioned above, suggestions/recommendations

- MOHFW--interaction/involvement with this level (how, when, where), impressions of impact of govt activities in this geographical area, impressions of participation (facilitates or constraints from this level), suggestions/recommendations

- USAID--interaction/involvement with this level (how, when, where), impressions of participation (facilitates or constraints from this level), suggestions,/recommendations

Future Directions

- Plans for own organization
- Impressions of involvement of PVOs in health
- Future cooperation with which type of agency (govt, private other PVO)
- Concerns
- Recommendations, suggestions

Potential for Sustainability

- What does PVO consider sustainability to mean?

- Programmatic Sustainability--are program activities within the ongoing mandate of the organization? what activities are likely to be dropped after project completion? what is their base of support for continuing project activities (community, govt, etc)? organizational structure and management support for continuing program activities? dissemination of lessons learned to other organizations (TA, hand off programs, etc.)? how will liabilities that are being accumlated be sustained (hardware, personnel and salaries, etc)?

- Managerial Sustainability--are managerial linkages established under the project expected to remain? through what mechanisms?

- Financial Sustainability--cost recovery mechanisms envisioned/implemented (fee-for-service, health insurance schemes etc), income generation activities, cross-subsidies,

fund-raising activities/private patrons, identification of organizational donors, grant-writing/self-evaluation capabilities

Documents to Collect

- Proposal
- Sustainability Plan
- Annual budgets
- Quarterly Progress and Expenditure Reports
- Baseline survey protocol and results

List of Contacts

- Names, titles by organization

Acronyms

- For all significant acronyms, identify full name/title etc.