ANNEXES

Taking the Long View: A Practical Guide to Sustainability Planning and Measurement in Community-Oriented Health Programming.

ANNEXES

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Rwanda 2007, photo taken by Virginia Lamprecht
Zambia 2002, photo taken by Jennifer Yourkavitch
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ANNEX 1: TIPS FROM PRACTITIONERS—ANSWERS TO FREQUENTLY ASKED QUESTIONS

Let's be honest. If giving sustainability the place it deserves in our plans, implementation, and evaluation were simple, we all would have been giving it that place a long time ago in all our projects. But although almost everyone agrees sustainability is important, taking it seriously implies dealing with some difficult issues like the following :

- Considering complex systems of local stakeholders and their interactions rather than only a few project partner relations
- Recognizing possible contributions of stakeholders outside the project rather than only dealing with our own contribution which we would like to showcase to donors and other stakeholders
- Taking into consideration agendas that may overreach our project mandate
- Operating within and supporting a local system that might not be as functional as would be ideal rather than "just doing it ourselves" which might please a demanding donor
- Not only showing accountability ourselves but also encouraging others to be accountable with each other for progress on a timeline beyond our effective control
- Going beyond the usual ways of planning a project
- Stretching the scope of our measurement and evaluation models and tools

This manual has tried to outline a concise and conceptually sound process for undertaking this complex task. Ways to make this manageable involve breaking the process into steps, and organizing multiple determinants of long-term success into an evaluation framework where each component can be considered without the complexity of the 'big picture.'

There is, however, no magic formula for sustainability. Implementing the proposed approach ultimately relies on nuance and ingenuity on the part of practitioners and local stakeholders. This chapter seeks to interject as much of the nuance as possible from the experience of those who have led the application and learning from the SF to date. It is strongly recommended that you read this section with care before engaging in your own pro-sustainability project. We present this practical knowledge as a series of FAQs, emphasizing the key principles of pro-sustainability management and measurement in the answers. If you have your own FAQ and response, please post it in the FAQ section of the Sustainability Page at www.childsurvival.com.

"Isn't it better to get my project up and running for a year or so before thinking about sustainability?

The reasoning might be that after one or two years of implementation you will better be positioned to have tangible discussions with partners about how to transition key activities to them at the end of the project. Certainly the quality and depth of your discussions with partners will improve over time as trust is built, but these discussions will be set on stronger footing if you start them on day one. One of the driving forces behind the development of the SF was the discovery that projects often set very vague "sustainability indicators" during their project planning phases, but then became so focused on implementation that discussions about sustainability with partners did not take place until near the end of the project, when it was too late to retrospectively define what was meant about sustainability and assess whether or not there was progress.

The key operating principle is to plan for sustainability from the beginning, not just as an exit strategy.

What actions can you take to follow this principle?

- Use the management tools from this manual (or others like them) starting at the design and planning stages.
- Develop a vision for sustainable health with local stakeholders from the start, even if you and they come to revise the original vision with time and experience.
- At the planning stage distribute responsibilities among stakeholders, rather than take them all on yourself as an "outside project."
- Use the Sustainability Framework to organize how progress will be evaluated and agree upon monitoring signals indicating the need to make programmatic changes.

"Is there any value to applying the SF at the mid-point or end of my project? If so, how would I do it?"

There is certainly a lot of value applying these principles, activities, and tools at any point in your project life. The level of creativity and flexibility this will require from you and your team will simply increase the further down the project timeline you are. Without going into too much detail, here's what we can suggest:

- Read Chapter 2 again carefully. There are a number of tools you can use and adapt, starting with the Sustainability Checklist. You can then design your own review and planning meeting with partners and follow the recommended steps. You will have information already available to help identify gaps that you can then work on filling.

- Read the previous documents referenced in this manual, and notably the 'Lessons Learned'[1] document, which illustrates in great detail how other projects in your situation have gone about applying these ideas at different stages and sometimes very successfully.

- Join the SHOUT Group (List_SHOUT@childsurvival.com). This is a learning community for sustainable health programming and measurement in community-oriented health programs in resource-constrained settings. You will rapidly identify colleagues who have gone through similar if not identical steps as those you want to follow. There is certainly experience out there you can tap into.

[1]Yourkavitch J, Ryan L, Sarriot E (2004), Lessons Learned from Applying the Child Survival Sustainability Assessment to Seven Maternal and Child Health Projects, ORC Macro

"What is the difference between pro-sustainability planning and developing an exit strategy?"

Sustainability planning too often starts when project managers and partners suddenly realize that a project is about to end. Great efforts are then expended in a very short period of time to develop an "exit strategy." This is a natural consequence of the logic of externally funded projects. But as shown on Figure 4.1, this limits the opportunities for local stakeholders to effectively take over and sustain the results which have been achieved. First, there are practical considerations of the time necessary for transfer of responsibility, but additionally there are considerations of whether or not the "receiving institutions" have the capacity and the resources necessary to take on these new responsibilities. Finally, and most seriously, there is the consideration of whether or not the "receiving institutions" even *want* to take on these responsibilities, especially if this has not been negotiated with them previously.

Figure 4.2 contrasts this 'exit strategy' approach, based on the project timeline, with 'sustainability thinking' from the onset of the project. In effect, sustainability thinking starts with the modest realization that social and societal changes (at the heart of the sustainability challenges) have their own timelines. While projects can hinder or facilitate those changes, stimulate them and accelerate them for better or for worse, social development projects are virtually never in a situation to control the timeline. The 'exit strategy' model of Figure 4.1 presumes that the project timeline can dictate how fast the local system can change. Figure 4.2 positions the project to contribute to a local system and to facilitate changes within it. This local system has its own path and speed of change. Both can be influenced positively by a project, but sustainability demands first and foremost a locally owned process. Obviously, conditions outside the control of local system will also have an influence. The SF takes this into account as well. No matter what the environment, pro-sustainability thinking demands building, strengthening and focusing on the processes and structures in the local system. This approach will sometimes conflict with the demands for immediate results that are common to some donors, but it will allow you to provide a more comprehensive ability to articulate progress in multiple dimensions toward the vision of sustained health outcomes.[2]

[2]An analysis (unpublished) based on extrapolating lessons from Save the Children US's experience in Guinea (Mandiana and Kouroussa) suggests that, over long periods, impact—measured as lives saved—could be 2.5 to 4 times greater by adjusting project investments to sustainability signals, rather than by following traditional project cycles.

Figure 4.1
Project 'Exit Strategy' Thinking

Project effort is represented by the pink curve. It rises, reaches a peak, and falls as the project progresses. Activities narrow in focus as the end of project nears, but then we hope that activities will again increase among partners afterwards. Is this realistic?

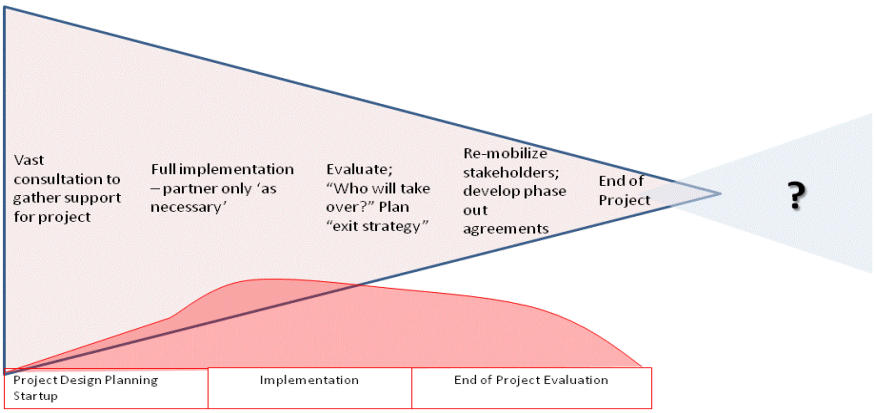
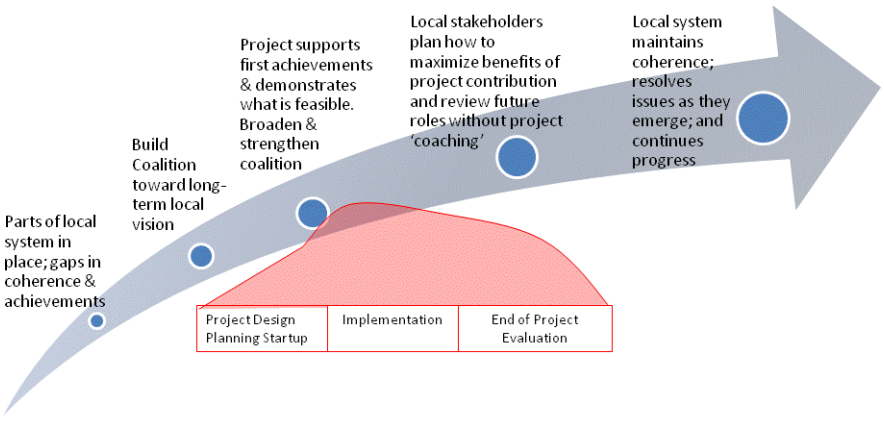


Figure 4.2
'Sustainability Thinking' of Project Contribution to a Larger Local System

Project activities are not the "be all, end all" but rather a catalyst to improve local system functioning. Activities and results may get off to a slower start as problems need to be resolved initially, but then the system gathers momentum that carries through even at end of project as external resources are withdrawn.



"What does it means to 'use system thinking'?"

First, we are quite sure that you've already applied system thinking to many areas of your work. But there are also times when we have not considered enough how change occurs through systems. In our experience, that is a chronic weakness which undermines projects' sustainability efforts.

System thinking can be contrasted with thinking in terms of single solutions. Even in simple systems a solution to a problem often requires multiple interventions at various levels. For instance, if few children with pneumonia are being treated with the appropriate case management protocol within local health facilities, we may decide to train health workers in the correct protocol. But this single training intervention will be ineffective if there are no antibiotics in facilities because of poor logistics management or if few children reach the health centers because of poor geographic access or because mothers are concerned about being treated inhumanely when they reach the facilities. All of these problems will need to be considered and may need to be addressed in order to realize substantial gains in the coverage of appropriate pneumonia case management.

If system thinking is important in this simple example, then it is even more important in a complex local context, with multiple stakeholders, all with current or potential contributions to solving or worsening the health situation. So in pro-sustainability thinking, "single solution thinking" is not appropriate. Consider the following:

- Cause and effect relationships are usually complex, inter-dependent and multi-factorial. Gains in capacity, demand for services, and performance of service providers affect each other and affect health outcomes. Actually, even progress on health outcomes can affect these other factors by making people more motivated to continue their work.

- Some factors are subject to threshold or "tipping point effects," with relative acceleration and stagnation of results along the way. For example if a key local organization has very weak technical capacity at baseline, it may make a large gain in capacity during the project. But this gain still may not be sufficient for it to handle key activities independently after the end of the project. If in fact this organization will be on its own afterward, then all this progress in technical capacity may not translate into an appreciable gain in the chance for sustainability. On the other hand, once a certain level of technical competence (and therefore independence) is reached, then a small incremental gain in capacity may translate into a large gain in sustainability for this area of functioning.

There is also system thinking embedded in the overall structure of the SF. The premise of the SF is that the chances for sustained health outcomes are greatest when the local system partners have sufficient capacity and viability (i.e., are not reliant on insecure inputs) to do their tasks within an enabling environment. The relationships between these various actors and their functions are complex. Failure in any of these areas may be enough to seriously jeopardize the sustainability of the gains made in health outcomes.

An additional complication is that gains in capacity in some areas may be more critical than others, depending on the context. Managers should think critically about the inputs for the key activities needed maintain the specific desired health outcomes. For instance, an intervention that is behavioral and takes place in the household (e.g., exclusive breast feeding) requires different inputs than one that is mainly facility-based and uses higher levels of technology (e.g., emergency obstetrical services). The behavioral intervention may require ongoing social support, a modest amount of ongoing education and training, and little or no financial inputs. On the other hand, a technological facility-based intervention will require secure sources for refresher training, possibly financing for maintenance and replacement of equipment, etc.

Another implication of system thinking is "thinking within the local system." This means that to the extent possible, managers should build on structures and policies already in place, rather than "starting from scratch." There is always a temptation to build a new structure—one that will answer directly to the project, and therefore will probably yield faster results. For instance, there may already be village development committees (VDCs). A project may decide to bypass these as they view them as bureaucratic and cumbersome, instead organizing village health committees (VHCs). Indeed, such a project may be quite successful in the short term in organizing these committees and having them function quite well, especially if the project offers incentives for joining the new VHCs. But if there is no local mandate for the VHCs, they are likely to disintegrate after the end of the project, especially if project-supplied inputs like incentives are terminated. Worse yet, if the VHCs overlapped with the existing VDCs in their activities and personnel, then the project may actually have *weakened* community capacity and lessened the chance of sustaining health gains. If, instead the project had works through the existing VDCs, fortifying their capacity to handle health matters, it is more likely that key activities would be sustained after project end. There would be a trade-off, of course, as health would only be one of several matters that the VDCs handled. But one hopes that the trade-off in terms of short-term efficiency will be offset by the gains in long-term sustainability. This may not always be the case. Such considerations are context-specific, and project managers in consultation with local stakeholders need to analyze the situation to devise the best solution.

The key principle is to work within the local system and consider how change needs to occur at different levels of this system to achieve lasting progress.

What actions can you take to follow this principle?

Design and present the project as a catalytic actor within a local system, which needs to function and maintain itself in its environment.

- Take time to consider all components of the SF in design, planning, and evaluation.
- Involve partners in complementary activities, evaluating and recognizing progress in all relevant areas.
- To the extent possible, build on structures and policies already in place, rather than "starting from scratch."

"What does it mean to 'involve stakeholders in the sustainability process'?"

Most donor-supported projects today are implemented in partnership with the MOH or its district level counterparts, local NGOs, and other local entities. Their success depends, therefore, on the actions of local actors. These actors are already engaged in activities that help or hinder the promotion of health. The project management staff must see themselves as trying to increase the capacity for concerted and unified action within this existing frame of reference. Project effectiveness in the short term and the sustainability of the gains made in the longer term will depend on the effectiveness of these actions to improve the functioning and cohesion of local stakeholders. But not all stakeholders ought to be involved equally in a well-functioning local system. One, or at most several, local organization will be the lead during project period and afterward (i.e., be the owner(s)). Others will supply key inputs, usually technical or financial. Some organizations may only be peripherally involved in the topic at hand (a mayor or a governor) and yet wield much influence over the potential outcome of activities. Project staff, in consultation with other local stakeholders, should think about how such a stakeholder should be involved (or at least not antagonized so that he/she might hinder progress). We will give some advice here. There is also the Stakeholder Analysis tool in Annex 2.2. This can help project managers to work through the process of identifying local stakeholders and thinking about the appropriate level of engagement for each of them. On the Sustainability Page at www.childsurvival.com there is presentation that reviews these issues that can be used in trainings or at a stakeholder workshop.

The necessity of involving stakeholders, not only for the purpose of sustainability but even simply to design an appropriate and effective program is self-evident to most of us. We can dig a little deeper on this topic. The pertinent questions are: (1) How do we identify stakeholders? (2) How are their roles defined? (3) How do we "involve" them in reality?

Being a "stakeholder" means that someone has ("holds") an interest ("stake") in an institution or program. But the interests are not always those a project has in mind. Public servants have a stake in their own career and advancement, trying to gain control over the programs of their departments, and sometimes even trying to gain control over other programs, departments, ministries, and even civil society. NGO staff have a stake in maintaining the income of the NGO which employs them, in addition to an interest in the success of their specific programs. Community members have a stake in maintaining and improving their livelihoods, the education of their children, and the health of community members. They can also have less admirable agendas of their own, based on local politics and social dynamics.

When a project arrives, its first task is to either align its objectives with the existing goals of different stakeholders, or to rally these different groups behind a new set of objectives that they can ultimately be shown to support existing agendas. Based on a commonality of purpose and objectives, projects thus define stakeholders, which will either become explicit partners of the project and "make things happen," or which will take a supportive role (or at minimum, remain benevolently neutral) and allow work to proceed. Those are essential conditions for project relevance and effectiveness.

Involving stakeholders for the purpose of improving sustainability is based on the same reality, but it seeks to move beyond a temporary agreement on project objectives in order to frame a long-term common vision shared by the different stakeholders. Once the project ends or reduces its role and inputs, will these stakeholders have taken ownership of enough of the goals and program activities to ensure continued progress? Will they have a common agenda, or will their respective agendas conflict? Will they get the support they need from institutions in the broader system within which they operate?

To be effective during a project, you can sometimes choose one stakeholder and ignore another, based on shared objectives. But imagine that the ignored stakeholder is a critical player for the long-term because it is needed for a critical input like drug supply, then something more needs to be done than to keep it benevolently neutral. Planning for sustainability, a project will seek to identify the appropriate stakeholders for a range of roles, which are not mutually exclusive (see Table 4.2)—

- From a practical perspective, one or possibly two key stakeholders need to be identified as long-term owner. Much has been written of the need for "champions" to sustain or expand a new activity. This stakeholder has a function like a champion, but even more important. They should not just advocate, but even more actively facilitate, catalyze, and even organize activities after project end. They can mobilize others from the inside, work out cultural and internal political issues. An implementing partner can often play this role, but it is not necessarily the case that the long-term owner is an implementer. They can be a coordinator of others. It is good if they have recognized authority. For IRC Sierra Leone, the Health District led by a particularly visionary Medical Officer played the role of owner. They might be a political authority like a mayor or governor (i.e., they do not even need to be in health). This role cannot be forced upon a partner. If you go back to the "Cautionary Tale" in Chapter 2, you will see that no one took that role. Part of what makes sustainability planning so arduous and time-consuming is that trying to catalyze the development of such a sense of mission in a local stakeholder sometimes takes years. If it never happens, then the design is probably out of sync with local capacity or local expectations. Some places have been so disrupted that local entities simply do not operate as a minimally functional system and will take years to get there. We should measure the capacity and viability of owners in Components 3 and 4.

- There are implementing partners. As the name implies, these partners implement activities or deliver services as part of project implementation. An implementing partner could also be a community-based association or an MOH facility, depending on the design. In Bangladesh, Concern's main implementing partners were Municipalities and Ward Health Committees.

- A key facilitator does not have to be actively present or involved on a daily basis, but has direct responsibility over some local partners. A regional health office, a governorate, an NGO program office can all fall within this category.

- Other stakeholders can be key potential allies. These can be another local or international agency operating on different objectives, but with a mode of operations that can facilitate and/or mesh with project efforts. This could be another governmental institution, UN agency, or other NGO.

- Finally, some stakeholders are even more removed from the local system. Usually a national institution, bilateral or multilateral agency or local NGO headquarters able to set policies,

support and/or resource programs will need to be involved in 'macro' decisions, rather than daily implementation. Involvement of these stakeholders is important, but their involvement will be occasional and focused. We call these key outside influencing agents.

The definition of "involving" can vary. We all know the difference between stopping by an office to shake hands and drop off a report, and sitting down together day in and day out to work things out. In both cases a "stakeholder" has been "involved," but clearly one type of involvement is much more substantial and likely to engage the stakeholder than the other.

Table 4.2 suggests different levels of involvement appropriate for the different types of stakeholders listed above. This is not a black-and-white typology, but it is useful to consider the many groups and organizations (including outside of the health sector) whose roles and actions interface with those of the project, and to question how they are being involved.

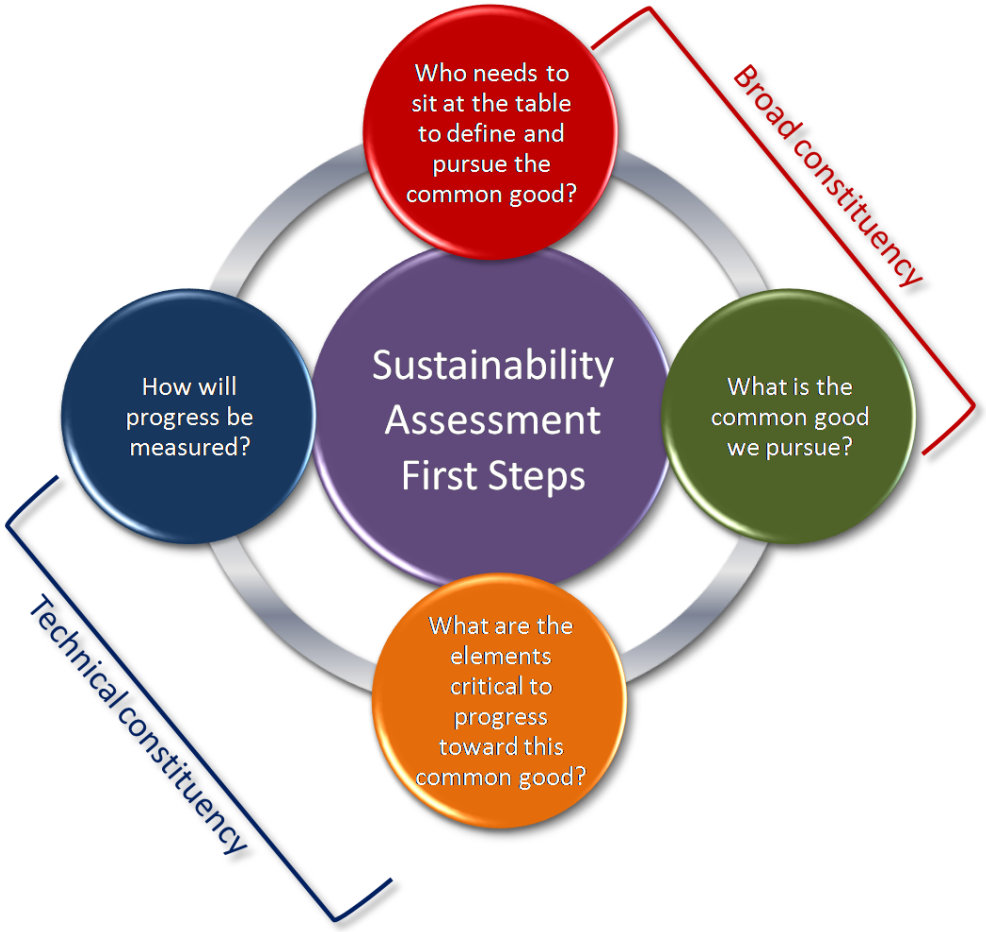
Table 4.2
Role of Types of Stakeholders and Level of Appropriate Involvement in Project

	Inform	Consult	Invite for project design and review	Include relevant activities in sustainability assessment	Co-manage project	Coach and Support
Long-term owner	Very Frequently	Very Frequently	Very Important	Very Important	Very Important	Very Important
Implementing partner	Very Frequently	Very Frequently	Very Important	Very Important	Very Important	Very Important
Key facilitator	Frequently	Frequently	Important	Very Important	Possible	Possible
Key potential ally	Frequently	Frequently (for process issues)	Possible	Very Important	No	No
Key outside influencing agent	At key points	At key points (for big issues)	Possible	Possible	No	No

How we involve stakeholders will be demonstrated from the first day of project design and planning. Figure 4.3 presents some of the first key design questions, which are essential for sustainability planning: What is the common good (vision) being pursued? Who needs to 'sit at the table' in formulating this vision? What are the specific actions which will contribute to producing this vision? How will progress be measured toward this vision? Deciding which stakeholders need to be brought in is critical at this stage since the definition of the 'local system' depends on what common good is being pursued, and different configurations of the 'local system' will affect how the common good is defined.

A final consideration is how to work in a differentiated manner with two distinct groups, which we call "interested parties" and "technical constituencies." The former represents groups of importance because of their societal or political role; the latter have technical contributions to make. Some individuals belong to both groups. For instance, a District Health Officer can make contributions that are both technical and political. Figure 4.3 suggests that design and planning activities should try to differentiate to some extent the different roles of the two groups. Interested parties have political decision and social representation roles, and should be involved in defining the common good, building relations and lines of accountability. Naturally, technical specialists should focus on technical issues. There is a very specific role for M&E specialists. On the one hand, it is not effective to involve everyone in defining indicators. On the other hand, even activities requiring inputs from non-specialists for assessment and measurement purposes will require M&E proficient facilitation and leadership.

Figure 4.3
First Steps of the Sustainability Assessment and Role of Different Constituencies



The key operating principle is to involve stakeholders as much as possible, within the limits of their appropriate role(s). If they are really engaged, eventually stakeholders will involve you in *their* plans!

What actions can you take to follow this principle?

- Consult and if possible work with local stakeholders in early design and planning.
- Map the "local system" at the outset and seek to inform, interest, and possibly involve additional partners.
- Develop an evaluation plan relevant to stakeholders in the local system and not just the project. Review progress together and distribute responsibilities according to 'global partnership' model.
- Advocate with and educate constituents (national stakeholders, donors, your own organization, potential allies).

"Isn't it more efficient for me to develop a draft sustainability plan with my project team and then get the reaction of key partner(s) later?"

We can give a bit of a silly response, but it illustrates our opinion on this topic. Here is our unequivocal response —

No!.....But yes…..But really, no!

No—If the sustainability plan is devised by your team and local partners just give a nod to it, it won't really be meaningful.

But yes—We all know that effective partnership may sometimes mean "priming the pump," so to speak. While you may not want to develop a full plan and submit it to partners, there are times when it is worth advancing ideas—especially new ideas—to help partners see where this is leading to. In our experience it is particularly important not to bother all partners with all questions. It is also true that some partners will evolve in their role and become more involved in key activities prioritized by the project. As discussed under the FAQ of involving stakeholders, you need to adjust the level of involvement as partners/stakeholders evolve in their capacity and interest.

But really no—You cannot come to a new partner and present a fully formed plan for its capacity building to achieve a vision you established on your own and hope to get support. This is where the art of advancing toward sustainability comes into play. There is unfortunately no simple recipe to determine how much you need to do on your own to catalyze action and how much you need to leave to local partners so that they will feel ownership. The proper balance will be different in different contexts and with different partners and at different stages of your relationship with the same partner. You will need to remain flexible and gauge if you have achieved the proper balance from the reactions you elicit from partners.

"What's the best way to communicate this tool to a group that has never heard of it before?"

We recommend two possible approaches for an initial presentation of the SF, depending on your audience:

1. Introduce the ideas of this manual without referring to the Sustainability Framework itself.

   Some have found useful to use a storytelling approach (see below) to convey intuitively the importance of multiple components and long-term planning. This activity can be a bridge to a visioning activity (see Annex 2.3).

   If we imagine a child, we might ask – "When is the child 'sustainable'?" Clearly s/he is not sustainable when she is born as she is completely dependent on parents and others in the outside world for even the most basic things. Later, though, as the child develops, would we say that she is independents (and therefore "sustainable") at the point when she can walk? At the point when she can feed herself? At the point when she can be left alone in the house? When she is financially independent?

   Many participants will find that there really is not a time when we can say that the child is ever completely independent and sustainable on her own. While she certainly is developing more independence, there is no point when she can say she is a **completely** self-reliant entity. Would she ever want to? Would those who have relationships with her ever want her to feel this way?

2. For a more scientifically grounded approach, the Sustainability Page at www.childsurvival.com has an introductory presentation with a few slides, which we have used sometimes to present the evolution of sustainability thinking to partners with a more technical profile.

"How does the Sustainability Framework address the issue of financial sustainability?"

Some discussions of "sustainability" have been limited to the consideration of financial sustainability only. This has frequently been even further limited to thinking about making (usually poor) clients pay for services (i.e., cost recovery) or generating funds locally. This model conceives of sustainability as "total local financial self-sufficiency," ignoring the fact that no health system in the world has achieved the desired health outcomes of equity and universal population coverage without inputs from outside a local system either in the form of public funding or a social insurance scheme, or both.

This conception of sustainability is a reflection of the hope of donor agencies, such as the World Bank or USAID, to see the benefits of their investments maintained beyond project period and the easiest and "most secure" source of ongoing resources are local.[3] On the other hand, there is some evidence that user fees and cost recovery among poor populations limits utilization.[4] The experience with full cost recovery schemes has been mixed, even for fairly simple schemes like community pharmacies in relatively well-off countries like those in Latin America, to say nothing of more complex and costly schemes in the poorer nations of sub-Saharan Africa. Even if services are sustained on a nominally sliding scale, the charges have often acted as a barrier for the poorer members of the community, leading to a situation of inequitable distribution of benefits.

The SF considers financial sustainability issues through several different angles. There are several major levers which we can use to improve this aspect of sustainability (see Figure 4.4) —

- Efficiency gains can make services more affordable and financially accessible, both at the point of service delivery and at a higher system level
- Increased local financial flows for service delivery through user fees, social entrepreneurship and fund-raising to increase local service providers' financial viability (Components 3 and 4)
- Increasing overall national financial flows for the provision of basic services (Component 6)

No project should necessarily work on all these levers, but a rigorous situation analysis and informed visioning activity should help establish which directions are best to pursue. If public and general commitments for essential services are recognized as insufficient, there is only so much a project can do. Whatever it is, it should be done. Being accountable for progress toward sustainability demands that benchmarks be established. Sustainability as a process should then reflect—

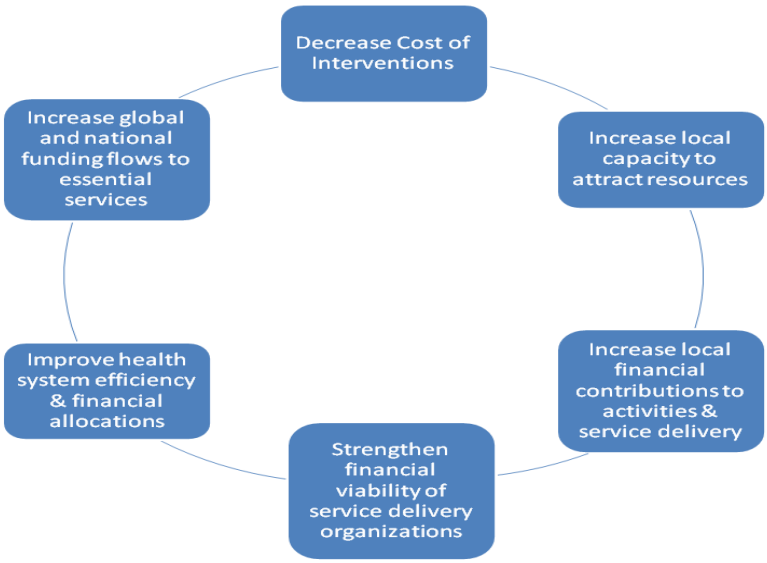
- Either continued progress or at the least maintained level of health outcomes, including and specifically among populations in greater need (in other words, cost recovery is not acting as a significant barrier to services) and
- Decreasing external funding (not necessarily the end of such funding), while

[3] See Bossert, Ibid.

[4] Among others, see Ridde V, Bull World Health Organ. 2003;81(7):532-8. Epub 2003 Sep 3. Evidence of this sort has induced UNICEF and others revise their policies on cost recovery.

- Local and national streams of funding progressively increase toward the desired benchmarks.

Figure 4.4
Financial Sustainability Levers



The appropriate approach will depend on the context and long-term vision. Financial sustainability strategy for community interventions to promote breastfeeding and rehydration therapy will be different from those required to maintain ACTs, bed net, and other commodity supply chains.

The important questions are as follows:

- Does the final vision make sense in the culture, even if changes need to occur for it to be realized?

- Can the project contribute significantly to progress toward that vision?

- What are the mutually agreed-upon responsibilities of each partner to attain that vision?

A final point should be made. That is, total financial self-sufficiency for a key partner may not be a realistic project objective for a 3-to-5-year project. For instance, the level of functioning of the partner may be quite low at baseline. The project may, therefore, need to build a considerable amount of capacity to reach even a minimally acceptable level of functioning. Such may be the case in a post-conflict situation where local institutions have been severely disrupted. In such a case, in order to maintain the new and much higher level of functioning, a considerably increased flow of inputs will be necessary. One should plan realistically in these cases, and not plan on a best case scenario. In this case, a point of 100 percent financial (or also technical or managerial) self-sufficiency will not be the objective by the end of the project period. But planning should not stop there. If the managers are serious about sustainability, then they should think realistically about needed actions beyond the end of the project. That is, they can plan with the recognition of the need for a follow-on project, or for the need of specific follow-on activities, or for developing the grant-getting skills of the main local partner during the project to increase its chance of attracting other

outside resources. The main point is that there are ways to take account of the ongoing needs of a local partner even after a project ends.

The key operating principle is to realistically plan for how the necessary inputs (especially financial) will be obtained after the project ends.

What actions can you take to follow this principle?

- Estimate recurrent costs realistically.
- Use the visioning activity to start planning early for how resources (financial, as well as institutional/managerial and technical) will be acquired after the end of the project. Design the project to contribute to increasing available resources and certainly don't disrupt whatever plans are already in place.
- Total financial self-sufficiency may not be a realistic project objective for a 3-to-5-year project. If so, then think realistically about needed actions. That is, the possible need for a follow-on project, for specific follow-on activities, for a plan during project to increase the grant-getting skills of the main local partner, etc.

"If partners identify a critical activity for realizing the local system vision that is outside of the project's capacity or mandate, is this a sign that my project is being overly optimistic about what can be accomplished?"

The answer can only be made in a specific context, based on experience and sound judgment. We can only suggest an example as illustration of the critical thinking that will be required—

Imagine that a critical part of the vision outside of the project's mandate is that comprehensive primary health care centers need to be staffed by the MOH—as intended by national policies but not achieved in reality—and receive appropriate supplies of drugs and basic commodities from central MOH stores. These issues are outside the authority of what most district-level projects can directly address.

The Sustainability Scenario could be formulated in two different ways depending on the details of the situation. We describe these below, using hypothetical examples.

Situation A

Stakeholders comment that addressing this has failed in the past. Proposals have been made to remedy the situation but that lack of agreement among the World Bank, WHO and bilateral donors has compounded indecision in the MOH. Districts and facilities have sometimes been able to hire staff on contract since skilled human capacity is available in the district. In terms of drug supply, the regional warehousing and distribution system actually works but that central supplies are where the supply chain breaks down. There are other examples of commodity supply management that work in country although lessons and models have not been applied to primary health care. The consensus of stakeholders is that this is not only a critical subcomponent, but one for which there are solutions achievable in country with hard work and determination.

Suggested Sustainability Scenario in Situation A

In this case, it is reasonable for the project to track progress on this issue through the SF in terms of capacity and viability of the health district and policies at national level. Stakeholders should be encouraged to develop a plan for sustainability that demands not only that the project make its own contribution, but that central structures resolve these structural problems. With stakeholders, the project could design advocacy efforts in the capital, based on its area of expertise and mandate. This could start by presenting its sustainability plan and later—perhaps at midterm—presenting progress made and explaining that the sustainability plan requires that central agencies play their role on subcomponents in Component 6 where progress is failing. If stakeholders and project managers repeat the same message, armed with the same evidence, their capacity to encourage national debate and promote change will be enhanced. This is no guarantee that the plan will work, of course, but stakeholders feel that it is reasonable to try this approach.

Situation B

Stakeholders explain that not only can the MOH not pay for staff, but there is a dearth of skilled providers in the district because of its remoteness. Only NGO facilities that train their own providers and ensure a basic compensation package involving community support have been able to contract nurses and midwives for stable periods. The country continues to go through political upheaval and has no stability in leadership at the national level. There is a culture of graft in the public sector. Even regional MOH structures fail to deliver vaccines on time and resist all

accountability. The only commodity supply system operating relies on support from UNFPA contracting with an international NGO for logistics. Stakeholders also think that there currently is not enough structure and stability to determine with whom to advocate. Donors are concerned with other issues, and new models of partnership involving NGOs and private sector are gathering support in the country.

Suggested Sustainability Scenario in Situation B

In this case, one could make the case that the project should not present a sustainability plan relying on a MOH-centered resolution of the problem at the central level. This would not have a reasonable chance of success. Either the project needs to become more modest in what it seeks to achieve and try to sustain, or it needs to work with stakeholders to develop an alternative sustainability scenario, relying on involvement of other stakeholders. This may also require advocacy, and this may reveal a situation that will be far more difficult to sustain than scenario A (even, sadly, by the end of the project). Even in this scenario, benchmarks of progress could be developed for this subcomponent, but it would likely take time to develop after the project begins. The project may have to limit its measurement of this issue to less ambitious items at the beginning. For example it could commit to tracking progress along a pathway like the following:

(i) alternative plans to staffing and supply management developed

(ii) alternate plans accepted by the government and supported by development partners

(iii) alternate plans implemented and tested successfully in the district

(iv) commitment in district to institutionalize alternate plans

At the points when the project staff are reviewing results with partners and possibly presenting them to national authorities, project achievements could be shown alongside progress on this subcomponent, in an effort to show that accountability for sustainability is shared.

ANNEX 2: PROJECT MANAGEMENT TOOLBOX

This annex contains six key tools (outlined in the table below) that are suggested for use by a participatory management team to manage a project in a pro-sustainability manner. These tools are suggested and not required for use by a those interested in basing their project on the SF.

Annex	Tool Name	Description/Use
2.1	Project Planner's Sustainability Checklist	A 39 question checklist to help the project management team ensure that they have thought about the critical areas for managing a sustainable project (there are in-depth tools in this annex for each of the following points): • Defining the local system and involving its stakeholders appropriately • Developing the local system vision • Planning for each of the critical areas for ensuring sustainability • Setting up appropriate measurement systems to assess progress
2.2	Definition of Local System and Stakeholder Analysis	This tool helps the management team get started, by thinking about a coherent definition for the local system; identifying local stakeholders and other important actors; and analyzing the most appropriate way to involve identified stakeholders.
2.3	Facilitating an Exercise to Develop a Local System Vision and Sustainability Scenario	This is a facilitator's guide for use in developing a common vision and sustainability scenario with local system stakeholders.
2.4	Facilitating a Participatory Detailed Project Planning Workshop with Local Stakeholders	This is a facilitator's guide for planning the project in detail so as to contribute in the most significant and feasible way to the common vision. There are subsections for examination of relevant baseline data and for planning the contributions of each of relevant partners.
2.5	A Pro-Sustainability Results Framework	This is a suggested format for developing a project Results Framework that is consistent with the SF.
2.6	Notes for Basing an Evaluation on the Sustainability Framework	Some thoughts on how to structure a midterm, final, or post-project evaluation to yield a solid analysis of issues relevant to sustaining health outcomes.

ANNEX 2.1: PROJECT PLANNER'S SUSTAINABILITY CHECKLIST

Purpose:	39 Questions to Review Project Plans and Processes in Order to Integrate Sustainability in Design, Implementation and Evaluation
When to use:	• Early conception of project • Review of project proposal • Detailed project planning • Before conducting review, self-assessment or evaluation to identify evaluation and research questions
How to use:	• Health programmer, as a thinking tool • Small project team, as basis for brainstorm • Rapid review with stakeholders to identify critical subcomponents for detailed planning • Checklist designed to allow step-by-step review and discussion, but also modular use focusing on one area or another at any point. (You could decide that one question or set of questions is a critical gap and organize partners to specifically work at improving your project planning and implementation processes to resolve those issues.) • Practically: o Check boxes where your state of planning corresponds to the proposed statement. o Take notes as you go, to identify need for further discussions, questions to be answered, and activities/assessments to be carried out—particularly issues where the condition is not met, or where there is lack of consensus.
Time required:	From two hours to two days, depending on intended use
Important notes:	• This is not an M&E tool • Use as a flexible tool to aid in thinking—not holy writ. In context, you will identify important processes—specific processes—your project needs to pay greater attention to. Add and adjust the checklist for your own purpose. The Checklist has to be fairly generic in its language. Make it more specific to your context and targeted interventions, if you are going to revisit key processes over time, as needed. • Some statements are written in terms of developing or "having a plan for," as is fitting at a planning stage. If you use this checklist at a later stage in your project, you should rephrase these statements as "implementing activities to" rather than simply planning for. • Remember to share with us [List_SHOUT@childsusrvival.com] what you learn through your experiences.

I. Definition of the Local System and Involvement of Stakeholders			
#	√	Question	Comments
I.1		You can list all the essential members of the local system [stakeholders] that will have to play a role for positive health outcomes to be sustained 5-10 years after the project ends.	
I.2		You have a plan for approaching or you have already involved the identified stakeholders in your project planning.	
I.3		You have identified an appropriate lead local implementing partner ("owner"), motivated to develop and orient its capacity to achieving the long-term vision.	
1.4		You have identified or have already engaged appropriate implementing partners for those activities that need to be implemented now as well as after the project ends.	
I.5		You can list other local system stakeholders ("key facilitators" and "key allies") and you have a plan to form alliances with them.	
I.6		You have identified the key outside influencers outside the local system who should provide support to health related activities (e.g., national MOH, UN, NGOs, Government); and you can describe how they influence those in the local system.	
I.7		You can list and you have a reasonable understanding of the priorities and plans of the key local system actors and the key outside influencing organizations.	
I.8		Considering the levels of involvement (see Table 4.2 and Annex 2.2) you are achieving the highest appropriate level of involvement for each stakeholder.	

II. Development of Local System Vision and Sustainability Scenario for Long-Term Health			
II.1		Local stakeholders have developed a coherent vision for achieving and maintaining positive health outcomes in the appropriate beneficiary group(s). This vision is a consensus of local stakeholders and is meaningful, coherent, and (eventually) achievable.	
II.2		The long-term core mission of each local partner will support their planned roles in the long-term vision.	
II.3		You have identified potential conflicts between the local system and the agendas of other key local or outside stakeholders. You have a plan to work jointly with implementing partners to resolve these conflicts.	
II.4		The sustainability scenario offers the project opportunities to make a significant and measurable contribution toward the realization of the vision.	
II.5		You have identified implementing stakeholders of the long-term strategies in the sustainability scenario for any activities that are outside the mandate of the project.[5]	
II.6		Implementing partners and/or the owners of strategies have recognizable and increasing roles in making strategic decisions, defining activities and achieving impact.	

[5] See Chapter 4 for a discussion of differences and overlap between implementing partners and owners of the long-term goals/strategies.

III. Operationalization of the Vision (detailed planning and implementation)			
III.1		Project partners and other stakeholders have identified improvements in health outcomes that are— **a.** Meaningful to beneficiaries **b.** Significant in the level of improvement to be achieved **c.** Achievable **d.** Supported by national health authorities	
III.2		Project partners and other stakeholders have identified improvements in health service provision that — **a.** Will help achieve the targeted health outcomes **b.** Address the most strategic subcomponents of quality of care in context (i.e., access, health worker performance, client satisfaction, etc.) **c.** Significant in the level of improvement to be achieved. **d.** Achievable **e.** Are supported by local, regional, and national health authorities	
III.3		Targeted improvements in health services are consistent with targeted improvements in health outcomes (e.g., if case management of pneumonia is targeted, then service provision capacities for this are assessed and targeted for improvement)	
III.4		There is consistency between the objectives for health outcomes, service provision and capacity building of project partners/stakeholders and the plans of the local MOH	
III.5		The long-term plan for financing service delivery is sound and coherent with the long-term vision. It involves or seeks to involve all relevant stakeholders at multiple levels. Inherent tensions between financing services and equity concerns have been clearly spelled out and are being addressed strategically, rather than piecemeal.	
III.6		There is consistency between the objectives for health outcomes, service provision and capacity building of project partners/stakeholders with the plans of key local NGO	
III.7		Implementing partners have a plan, supported by the project or another agency, to bring their capacity to the	

III. Operationalization of the Vision (detailed planning and implementation)			
		appropriate level for advancing the local system long-term vision. The Capacity building objectives are meaningful and relevant to local partners rather than being imposed by the project.	
III.8		The project and stakeholders' sustainability plan considers appropriately, not only basic organizational capacity issues of implementing partners, but also determinants of their viability in the role assigned to them (i.e. considering institutional linkages, visibility, positioning, as well as financial viability).	
III.9		Targeted improvements in community capacity are consistent with targeted health outcome improvements (e.g., if case management of pneumonia is targeted, then community capacities like knowledge of danger signs and health seeking behavior and targeted for improvement)	
III.10		Targeted improvements in health services strengthen linkages and cooperation between community-based and facility-based subcomponents and are coherent with targeted health outcome improvements.	
III.11		Community health competence is being considered from three levels—client/caretaker, household, and local community organization, as required by the targeted interventions.	
III.12		Capacity building at the community level is empowering and coherent with the long-term vision of local stakeholders. It allows space for debate, critical dialogue, consensus building and problem resolution as required.	
III.13		The project and local stakeholders address not only individual demand for services and behavior change strategies but consider social norms, social pressures, and support network to advance sustainability of health promotion approaches.	
III.14		The community health promotion approach is coherent with the service delivery strategy.	
III.19		Community Health Worker and/or Community Volunteer approaches are consistent with the overall vision.	
III.15		The project serves as a catalyst to bring together local stakeholders with key outside stakeholders. *At a minimum* the project serves to spell out what the issues are, and	

III. Operationalization of the Vision (detailed planning and implementation)			
		brings them to the attention of more powerful constituencies.	
III.16		Local stakeholders have included in their sustainability plan appropriate and measurable socio-economic determinants, for monitoring, accountability and advocacy	
III.17		Local stakeholders have included in their sustainability plan appropriate rule of law; legal environment; political stability and transparency issues.	
III.18		Local stakeholders have included in their sustainability plan appropriate health policy and national commitment to health issues.	
III.19		Local stakeholders have identified win-win opportunities to cooperate or integrate with other sector interventions, and improve socio-ecological environmental conditions.	
IV. Monitoring and Evaluation of Progress Toward Sustainability			
IV.1		The project operates with only one Results Framework or Log Frame, that is integrated into the Local System's Sustainability Framework (i.e., the project does not necessarily work on all components of the SF equally, but has taken account of all of them and is consistent with them).	
IV.2		The project M&E plan includes a monitoring plan that involves active stakeholder review of progress toward sustainability in all components of the SF, and not just monitoring of health outcomes and service provision.	
IV.3		Project evaluations have maintained a focus on the local system in addition to the strict requirements of accountability toward the project donor.	
IV.4		Monitoring, evaluation, and sustainability assessment know-how are being developed among local stakeholders themselves. Local stakeholders demonstrate the freedom and initiative to call for review steps.	
IV.5		The nature and involvement of stakeholders is reviewed over time; adjustments are made to project implementation to increase cohesion and ownership within the local system.	
IV.6		The project has shown flexibility to respond to changes, shifts in the environment, and lessons learned.	

ANNEX 2.2: DEFINITION OF LOCAL SYSTEM; PLANNING FOR NATURE AND LEVEL OF INVOLVEMENT OF LOCAL STAKEHOLDERS

I. Defining the Local System

Defining the local system is a critical start to the entire process of planning for sustainability. This is a two step process:

- One should first think about WHAT one is trying to accomplish.
    - What health gain is desired?
    - With what target population?
    - What are the boundaries of this population?
- Then one should think about WHO are the key actors ("stakeholders") that currently or could potentially influence this desired outcome, both those that are within that "system" and those that are outside but influence the local system.

For instance, an answer to the first step might be "Sustainably improve the health of women and children in District x." Then one should brainstorm with a small group of participants about who is currently responsible for making women and children healthy. Within the system, this might be women themselves, MOH centers, private medical practitioners, a local NGO, etc. Key outside organizations with interests/activities germane to this outcome might include WHO, UNFPA, a USAID-sponsored project, etc. As one thinks about the list of stakeholders, one should also consider those who might want to become involved or who implicitly are already involved in affecting this outcome, like religious or community leaders. Brainstorm on this step and be as open and inclusive as possible.

As you brainstorm this with partners, you can create a Venn diagram. Simply draw a large circle on a large sheet of paper which you put on the wall. Give smaller pieces of paper to participants. Have them write down the name of a stakeholder. They should put the paper with the stakeholder name on the wall. If the stakeholder is from within the Local System, they should be put inside the circle. If they are from outside the local system, they should be placed outside the circle. This process should continue until no more stakeholders can be thought of.

This process is presented above as if one goes through these two steps only once. In fact, the process can and should be repetitive. That is, one might generate the initial list of stakeholders with a small group of people. One might then show it to others and add to it. Later, as the planning process for the project gets started in earnest and some currently uninvolved local actors hear about it, they may want to become involved as well. They could then be added to the list of stakeholders. Once one has a reasonable list of stakeholders inside the local system and outside it as well, one can move on to the next stage outlined below ("Planning the level and type of involvement of stakeholders").

II. Planning the Level and Type of Involvement of Stakeholders

Modified from Wageningen International, Multi-Stakeholder Portal
http://portals.wi.wur.nl/msp/index.php?ID=109&IDsub=190

See also the powerpoint presentation on stakeholder analysis on the Sustainability Page at www.childsurvival.com

1. Discuss with the Planning Team the main purpose of the stakeholder analysis. Potential stakeholders will be assessed using the criteria outlined in Chapter 2. That is, do they implement activities directly, support implementation, influence implementation? You could be more specific, if participants find this useful, and divide this into more categories. More specific stakeholder criteria could be "supposed to benefit from the vision", "critical role in ensuring success of vision", "has legal or policy role in attaining vision", "has specific knowledge of processes needed for attaining vision", etc.

2. Review the initial list all the people and organizations the Planning Team generated in Step I, "Defining the local system;" for example, key individuals from the Local System, local leaders and key people from implementing partners such as NGOs and community-based organizations (CBOs), government staff from various agencies and the local administration, local consultants, local businesses and educational/research institutes. This list should be revisited several times to ensure that all key groups and people are included and updated .

3. The Planning Team can then employ various techniques, as appropriate, to finalize the list of stakeholders, such as brainstorming, interviews with key informants or focus groups. Update the stakeholder list by asking key people to look critically at the initial list the Team has produced. You will know that you have finalized the list when it becomes stable; that is, it does not change or changes only slightly with continuing consultations.

4. Classify the stakeholders on the basis of the criteria generated in Step #2 and also on the basis of the type of stakeholder; for instance, the stakeholder is part of the Local System ("primary stakeholder") or is a key outside influencing organization ("secondary stakeholder"). Make a table in which the first column lists the name of the organization; the second column lists the type of stakeholder; and then there is a column for each of the criteria generated in Step 2. Place an "x" in each criterion column that fits a stakeholder. A stakeholder can fit more than one criterion.

5. Prioritize which stakeholders to involve and how to involve them using the Stakeholder Involvement Analysis Matrix on the next page. This matrix maps stakeholders according to their interest in what it is that is being accomplished and by their power/influence over whether this achieved. The matrix gives guidance as to **what** to do with stakeholders that map into the different quadrants by power and by interest.

6. Finally reach agreement on **how** best to involve each of the stakeholders. This is done by asking the different people/groups themselves how they think they can be optimally involved. Remember that participation does not mean involving everybody in all decisions at all times. It means thinking carefully about how to ensure that different interests can best be represented in different phases and forums of the multi-stakeholder process .

Stakeholder Involvement Analysis Matrix

POWER / INFLUENCE		
High	**KEEP SATISFIED** **(e.g., mayor of town)**	**MANAGE CLOSELY** **(Consider making project partner, if not already)** **(e.g., UN agency with project in area, DHO)**
Low	**MONITOR** **(Minimal effort to involve)** **(e.g., local NGO without health activities)**	**KEEP INFORMED** **(e.g., small local startup NGO)**
	Low	**INTEREST IN SUBJECT** **High**

ANNEX 2.3: FACILITATING AN EXERCISE TO DEVELOP A LOCAL SYSTEM VISION AND SUSTAINABILITY SCENARIO

I. Introduction

The concept of establishing a shared vision to guide programming is rooted in the field of management and organizational development, and translated to apply to community-based health programming through the Sustainability Framework. While the process of "visioning" is certainly not exclusive to sustainability planning, it is an integral early step in the planning processes outlined here for the Sustainability Framework.

In the field of management science, a vision is often described as a "picture of the perfect future", agreed upon by board and key staff, that describes the change in condition sought through execution of the mission"[6] Peter Senge, a leading thinker in organizational management, notes that the development of a shared vision "involves the skills of unearthing shared pictures of the future that foster genuine commitment and enrollment rather than compliance".[7]

In the context of the Sustainability Framework, the Vision is a depiction of the preferred future reality for the system and how it will ensure the health of the community. It represents what the local system partners are able to imagine as an ideal long-term sustainable health situation for their community.[8]

This tool presents one approach to undertaking a visioning process as part of a sustainability planning activity. Practitioners are encouraged to adapt it to their own contexts so that the ultimate vision developed fosters ownership and commitment from the key actors in the local system who will be responsible for sustaining health outcomes in the long term. Visions can range from concise, succinct statements to visual depictions of a preferred future (Figure 1 below), depending upon what format most motivates stakeholders to act.

Shared vision statement generated by World Vision and partners for its India CSHGP project:

"All children survive their first 5 years and all mothers survive their pregnancy, delivery and post-partum period. Health services and information are of good quality, are timely, and reach all children."

"Community groups, families, and service providers work together to bring services and the beneficiaries closer to each other. Mothers are empowered to act on the information to care for their children."

"Communities know and exercise their rights to quality health services."

II. Facilitating a Visioning Activity

Time: Approximately ½ day (4 hours) (Note: time below doesn't add up to four hours, but things always take longer than you plan for).

Participants: All key stakeholders in the local system

[7]Senge, P. 2006. The Fifth Discipline: The Art and Practice of the Learning Organization. Random House, New York.
[8]Yourkavitch, J., Ibid.

Process

Introduce the activity (10-15 minutes)

When introducing the visioning activity, it is important to take into consideration the local context and the experience and comfort level of stakeholders with participatory processes. In many settings, it will be difficult for people to open their minds to imagine a "perfect future", as they will understandably feel constrained by significant barriers in their present situation. It is important to encourage participants in this activity to imagine that no barriers exist, and to describe in detail what would be the characteristics of their preferred future. For example, participants may feel frustrated that a lack of commitment at the national level presents significant barriers to supportive policies for community-based distribution of drugs, or other important roles of Community Health Workers. In the context of a visioning activity, if participants feel constrained by this perceived barrier, they may not feel liberated enough to imagine what supportive policies might actually look like.

It is therefore important to remind participants that the vision does not represent "the goal" of their project or the activities that they will carry out. It is instead an ideal that will serve as their starting point for assessing their local situation and then planning how to move from that situation toward the vision.

Brainstorming of a Vision (20 minutes)

Divide the group into smaller groups of 2 to3 people for the first part of the activity. As the groups to imagine a future scenario in which there was a "healthy community."[9] As they think of this future, do not allow present barriers (e.g., lack of funding or political support; poor infrastructure; etc.) to constrain you from imagining the ideal conditions. Assume that no barriers are in place.

> Note: Depending upon the dynamics of the group, it's sometimes helpful to let people reflect individually before the group process, and encourage them to jot down notes or draw pictures of what they would imagine before sharing them with other.

Brainstorming Elements of a Sustainability Scenario (40 – 60 minutes)

- In the small groups, ask participants to describe to each other the future scenarios that they are imagining. Each group can be asked to summarize the key elements identified by its members in a series of notes, or in picture format. (Facilitator's note: It is often helpful to have groups list separate "elements" of their vision on index cards or sticky notes that can be moved around later. This facilitates the grouping and categorization of ideas that is carried out to create a shared vision.

- Ask each group to briefly report back to the large group on the vision its members have articulated. (Note: If there are many small groups, it is useful to choose only 5 or 6 groups to share with the large group, post information about their visions for others to see, and then ask if anyone from another group has something different that was not covered by the groups that presented.)

[9] This term will need to be contextualized culturally. However, the idea here is for people to envision the "ideal," and to free themselves from thinking about the limitations imposed by external factors that presently exist.

(Note: While it is preferable to leave this brainstorming very open so that the ideas come directly from participants, some groups find it difficult to imagine a preferred future in such broad terms. If you feel the group would benefit from a more structured brainstorm to get them started, you can introduce the component areas of the Sustainability Framework to ground the brainstorming. Ask, for example, "In your perfect future, how would we describe health outcomes? Health services? Which organizations would be responsible for supporting these? Etc., In this case, ask people to be specific and descriptive. Simply stating that "there would be high quality health services" is probably not sufficient. You might ask such questions as, "How would you know that the services were of high quality?" Use these responses to fill out the vision in more detail.

Figure 1
Part of a Pictorial Vision Created by a Team with Concern Bangladesh

Creating a Shared Vision and Sustainability Scenario

- Ask the participants to reflect and comment on the elements of a vision and sustainability scenario that were brainstormed by the group.

- As a facilitator, you should have in mind the six components of the SF to probe the group for additional elements that they may not have considered. You can guide the discussion by asking the following questions:

    - What health outcomes do we strive for? This depends on the nature of the health program. It might entail increased contraceptive use, decreased deaths from HIV or TB, increased breastfeeding rates, increased immunization rates, etc. Who will be the beneficiaries of this effort and where are they? **(Component 1).**

    - Who will produce the desired outcomes and how? **(Components 2 and 5)** If the group does not spontaneously think about this, then urge them to consider the roles of community members and of health service providers in producing these outcomes. For instance, if an increased immunization rate among young children is a desired outcome, this will require good quality and accessible vaccination services (Component 2), and also demand by mothers for their children to be vaccinated (Component 5).

    - What resources will those producing the desired health outcomes need (those outlined in the last step) to do their work in the short term and continue to do it over the long term? For instance, health facilities performing vaccinations will need a steady supply of vaccines from the District, etc. Mothers taking their children for vaccination will need support of other household members, community leaders, etc. Who will support them and make sure they can continue to get these needed resources over the long term. Participants often think of material/financial resources first, but what about technical resources (ongoing capacity building) and institutional/managerial resources? **(Components 3 and 4).**

    - Is there anything outside the local system that can help or hinder this process now or in the foreseeable future? Participants can consider policies, governmental effectiveness, natural disasters, etc. **(Component 6).**

- Organize the ideas that the group has generated into logical groupings, based on how these ideas relate to each other. (Note: you may choose to ask the group to identify these logical categories for grouping ideas, or you may suggest some groupings that occur to you as you observe the presentations that each group makes and the ensuing discussion. Usually it's possible to organize the key ideas about a vision and its sustainability scenario into categories that parallel the six components of the SF. If the vision can be organized into these categories, that facilitates the planning processes that follow in terms of the present/future state analysis.

- Task a small group to synthesize the categorized ideas into a vision statement that is clear, motivating, and can be owned by all partners. The more detailed strategies constitute the sustainability scenario. That is, the Vision is WHAT we want and the Sustainability Scenario is HOW we will get there.

Figure 2
The translation of the Figure 1 Pictorial Vision into Categories Paralleling Sustainability Framework Components

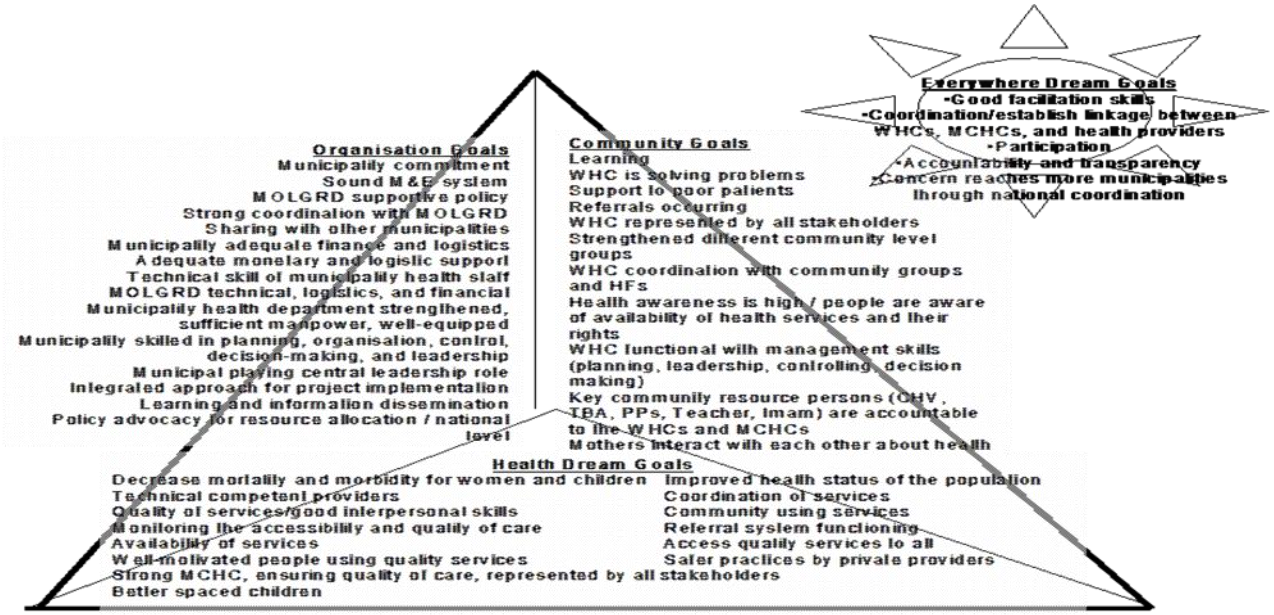


Figure 6: Verbal Diagram of Sustainability Vision for the Project

Placing the Vision in Context (10 minutes)

- Thank the group for its hard work

- Reinforce to the group the importance of the process they just completed, and emphasize the following points about how this process and the vision will be built into the rest of the planning and implementation process:

    - We sought to envision the ideal scenario on purpose—not to discourage us from reaching something that is unattainable, but to ensure that we will always have a target that we are aiming for in whichever activity we undertake. Part of the next part of the process will be to ground us in the present reality in relation to the vision we have just created—how close or far away from the vision are we today? How do we know how close we are? Where do we begin so that that we're moving on the path toward that vision, and not away from it?

During the implementation phase of the project, the vision should serve as an anchor for all staff when they find themselves faced with difficult decisions about which action to pursue or which direction to take. When you find yourself in such a situation, ask yourself "Which choice would help move us toward the vision?"

ANNEX 2.4: FACILITATING A PARTICIPATORY DETAILED PROJECT PLANNING WORKSHOP WITH LOCAL STAKEHOLDERS

If you are a CSHGP grantee, then you probably have held a DIP workshop.[10] This workshop is an opportunity to bring project partners together to review data collected during various baseline assessments and plan activities and assign roles for the project. You may have invited stakeholders (not necessarily project partners) to attend the workshop for a day or two to solicit their input, while not expecting direct involvement in, or accountability for, project activities.

In the past, CSHGP grantees have incorporated the SF into DIP workshops under a few different scenarios. In this annex, we make recommendations for how to incorporate the SF into a 5-day DIP workshop. The recommendations are the result of more than 4 years of concentrated effort with PVO/NGO implementers, namely CSHGP grantees. Descriptions of a few of these experiences are included here. We invite you to consider these recommendations and then adapt and expand your own DIP workshop to plan for sustainability.

If you incorporated the SF in your grant proposal, incorporating it into the DIP workshop will be a straightforward task, and you can use the recommendations below as a kind of checklist to cover all bases. But in case you are introducing the SF to the project team for the first time…these recommendations are for you! For more information on project planning for sustainability, please read Chapter 2 of this document. Various resources for assisting you with the steps below are included in other annexes of this document.

Recommended Steps for projects incorporating the SF into project planning during a DIP workshop—

1. Project team conducts stakeholder analysis before the workshop; then issues invitations as appropriate (see Annex 2.2). Plan for a broad range of stakeholders to attend the first day of the workshop. Project staff can follow up with them later, as needed.

Review and refine first five steps of the SF (Day 1 - #2&3 for large group, #4 for M&E team):

2. Introduce participants; then introduce the SF in the first session. Conduct a visioning exercise with entire group (project partners and other stakeholders). Document the vision and the sustainability scenario. (Estimated time for activity: 4 hours or ½ day).

    - What should health status in the relevant population group look like (e.g., every preventable child death averted)? What improvements in health outcomes will allow the local system to achieve this (e.g., every child vaccinated; every child cared for by informed mothers; every child receiving quality care in health facilities, etc.)? This depends on the nature of the health program. It might entail increased contraceptive use, decreased deaths from HIV or TB, increased breastfeeding rates, increased immunization rates, etc. These are the outcomes you will measure in Component 1.

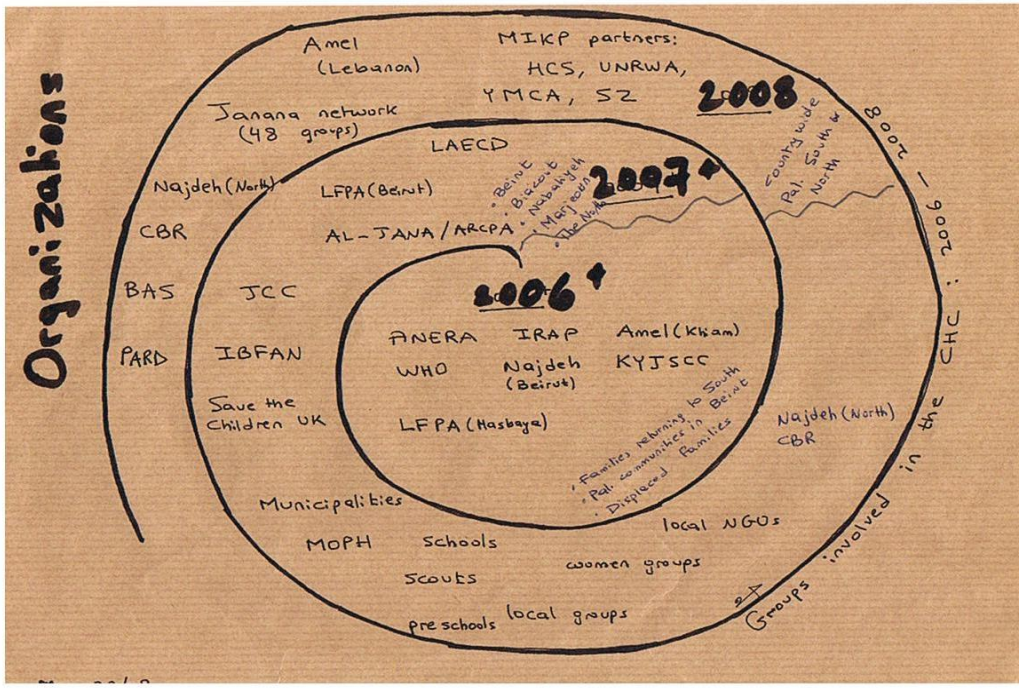
[10] If you are not a CSHGP grantee, then you have probably designed projects with stakeholders and sought their input through some type of meeting or forum. Suggestions made in this annex may be relevant to such meetings.

- Who will produce these outcomes and how? If the group does not spontaneously mention this, then urge them to consider the roles of community members and of health service providers in producing the desired outcomes from Step 1. For instance, if an increased immunization rate is a desired outcome, this will require good quality and accessible vaccination services, as well as demand by mothers for their children to be vaccinated. These are the competencies that health service providers need (Component 2) and communities need (Component 5).

- What inputs or supports will the producers of health outcomes (i.e., those outlined in Step 2) need to do their critical activities in the short term and continue to do them effectively over the long term? For instance, health facilities performing vaccinations will need a steady supply of vaccines from the District, etc. Mothers taking their children for vaccination will need support of other household members, community leaders, etc. (These are the areas of competence that the supporters of health services need (Component 3) and supporters of community competences need (Component 4).

- Is there anything outside the local system that can help or hinder the key processes now or in the future? Participants can consider supportive policies, governmental effectiveness, natural disasters, etc. There are the risks and supports about which planners should be aware and try to influence if possible (Component 6).

- Define the local system with broad range of stakeholder participation and create a graphic to represent it. See the "nautilus diagram" below. List contributions/activities of each main actor in the local system (see Annex 2.2)



Source: ANERA, 2006

4 Day 1 (for M&E team only meeting separately from large group): Identify the data on indicators for each subcomponent of all six components of the SF from the baseline studies (KPC community survey; Health facility and district team assessment; NGO capacity assessment; Community assessment). Discuss the available data. Identify data gaps and develop a plan on how to fill them. Prepare a brief presentation to give to the large group next day.

STEP 6 of the Sustainability Framework (Planning the Programmatic Responses) – Days 2&3)

STEP 6a: Conduct environmental scan activity with stakeholders (See Annex 3 and Sustainability Page at www.childsurvival.com). (Day 2, 2 hours)

- Someone should collect the national data on each of the six sub-components from the websites provided in the Excel sheets in te Environmental Scan tool on the Sustainability Page. This can act as the background when discussing this in the group.. Discuss in turn.

- In a plenary group., consider each of the subcomponents in turn. Consider the national score. Facilitator should give a brief description of why the score was this and what it means.

- Then ask participants: Is the situation the same, better, or worse in the local are? If different, why and because of what factors (list these)?

- Finally, discuss whether any of the identified factors are amenable to improvement by local system stakeholders. Think about the possibility of mitigating the effects of any of the others through project design.

STEP 6b: Conduct a Present/Future Reality Analysis and Refine the Sustainability Scenario for the Local System (Day 2, 6 hours)

With a smaller group of key stakeholders, review the vision and have them think about how they can arrive at it. Do not break it down into too many categories. The six components of the Sustainability Framework provide a useful set of categories into which you can group ideas. You can guide the discussion by asking the following questions:

A central challenge at this point will be to start identifying those parts of the vision/scenario which are within the boundaries of the project resources and mandate. You should also consider those parts that are no less essential to sustainability, but which cannot be shouldered by the project on its own or at all. This brings us back to the tension in planning, which we introduced in this chapter. Given our strong habit and practice of implementing project-centered planning, the tendency will naturally be to dismiss issues that the project will not directly address. We recommend that these issues still be noted and discussed with regards to the role of other stakeholders, including "synergistic agents" (for example complementary projects) and those agencies with decisionmaking potential. These actors may be within the local system or perhaps a step removed from the local system. But remember that a sustainability plan where all the responsibility lies on the project is at best a nice marketing package for an overambitious project and at worse, a promise that cannot be kept.

Once you've grouped the various parts of the vision/scenario, determine what the "present reality" is related to these categories, using the information from your baseline assessments as much as possible. In the absence of data, seek to gain informed opinions about the present situation from key informants. You will want to analyze the most important barriers or challenges to achieving the vision that you have outlined.

For example, if one part of the vision/scenario is "all community members will have physical and financial access to quality basic health services" you might look for data on the present status of quality of health services and access to health services. These data might be available from a recently conducted health facility survey or community assessment related to access.

It will be tempting for partners/stakeholders to view the present reality simply as an absence of the desired outcomes in the future reality. It is important at this stage also to consider not only the problems in the local system, but also its *current or potential assets*. That is, there may be strong religious organizations or mothers' clubs, or a particularly charismatic mayor or motivated District Health Officer. By building solutions based on these assets rather than creating new structures or processes local system actions will be more sustainable (and often more effective in the short term). Another example might be that there are already well-functioning village development committees but they generally do not deal with health issues. But rather than creating a new set of village health committees that have no local history or mandate, it would be greatly preferable to broker an agreement to add health to the mandate of the already well-functioning village development committees.

STEP 6c: Determine what your project can contribute by identifying priority activities (Day 3, 4 hours)

Finally, identify the roles, responsibilities and activities to be carried out by different stakeholders in order to improve the situation represented in the "present reality" toward the "future reality" of the shared vision that you have established. Illustratively, the relationship between vision and sustainability scenario can be represented as follows:

At this point, you can prioritize activities that will provide your project with the best opportunity to improve the present reality in such a manner that your planned health outcomes will be sustained, in a process that also spells out what responsibilities need to be covered by other partners and local system stakeholders, even if not formally part of the project. Consider not only which activities will be most important to ensuring sustained health outcomes, but how feasible it might be to pursue these activities in light of your project's scope, including time and resources. Each project team will establish its own criteria for prioritizing activities.

- **Reality check:** What is the fit of the project? While we have emphasized that the project cannot be responsible for everything, there needs to be a balance between what the project can contribute and how this will create momentum for broader change to achieve sustainability. The scope of the vision should make sense given the scope and breadth of the new resources that are being brought to the table. We can consider the following extreme counter-example:

  A project contributing a piece of medical equipment and some commodities to one health facility will have a very limited mandate in the local system. Such a project should not be in the business of bringing together

stakeholders in the district to build a vision of sustainable health outcomes and facilitating distribution of responsibilities among stakeholders.

- Advocacy: What parts of the sustainability vision/scenario will require the understanding, support and efforts of other actors of the local system? Which parts should be brought to the attention of donors and government in order to support progress toward a sustainable situation? Project and partners are now in a position to have a clear and strategic advocacy agenda and, by assessing progress on the components of the SF, they will have a tool to ask for accountability not only of the project and stakeholders, but all those who affect sustainability, including those in the broader environment.

STEP 6d: Develop a Pro-Sustainability Project Results Framework within the Sustainability Plan of the Local System (Day 3, 4 hours)

- Re-work initial Results Framework according to SF. The initial Results Framework was probably drafted at the proposal stage, but the early implementation stage (i.e., while formulating the Detailed Implementation Plan or DIP) represents an opportunity to make changes based on sustainability considerations. The pro-sustainability project Results Framework only differs from a traditional Results Framework in the following ways (see Annex 2.5):

    - The shared vision is placed at the level above the highest level goal.

    - The project Results Framework is presented with intermediate results that correspond to each of the Components of the SF (see Annex 2.5).

    - The project targets results that are achievable within a specific and tight timeframe, but the SF clearly presents how progress needs to go beyond those levels on some subcomponents. In Figure 2.2, the yellow areas represent progress toward optimal levels on subcomponents that other local stakeholders will be responsible for achieving in order to attain the vision. Being time bound, the project's objectives (green areas) are often less ambitious. In practical terms, it is crucial that local system stakeholders feel as accountable to one another for achievements of these outcomes as project staff feel accountable for theirs. How this accountability is achieved will depend on context, but common organizational forms are either a committee that frequently meets or a locally-recognized authority like a mayor or governor to whom stakeholders agree to report.

- M&E team shows data from baseline assessments arranged by components (45 minute presentation and 45 minute discussion)

1. Fill data gaps in the SF. Create a radar diagram (best done by the M&E team which then presents to whole group for discussion). Conduct Enabling Environment Analysis (see Annex 3 for Excel sheet to help do this). Create a Project Management Plan to match the Results Framework. (Day 4, 2 hours)

2. Identify activities and actors to match Results Framework. Consider dividing into groups based on intermediate results or technical intervention areas. (Day 4, 6 hours)

3. Day 5: Catch-up or spill-over day. Review project plan; review SF. Determine next steps for collecting more information and/or completing DIP.

Outcome: At the end of the DIP workshop the project team should have accomplished the following objectives:

- Oriented partners and other stakeholders to the SF
- Defined the local system
- Completed visioning exercise and created sustainability scenario
- Created an Results Framework and Project Management Plan for project
- Created a Sustainability Framework radar diagram for the local system
- Identified project activities and assigned responsibilities.

Additional Considerations

If this is the first time your organization is using the SF, consider holding a tutorial for project staff before the DIP workshop and hiring an external facilitator (with experience with the SF) to assist with the tutorial and the DIP workshop. Examples: Plan Kenya and PCI Indonesia

In 2004, PLAN hosted a DIP workshop (4 days) followed by a sustainability workshop (4 days). The sustainability workshop was opened to a broad range of Plan staff with expertise in cross-cutting areas like community capacity. PLAN had not used the SF before, and Michel Pacqué from CSTS+ provided technical assistance to the team in Kenya. Two separate workshops made the exercise lengthy and it was difficult to secure consistent participation of key representatives.

PCI submitted a proposal to the CSHGP in 2003 which included a Results Framework not designed around the SF. After introducing partners to the SF at the DIP workshop, Michel Pacqué from CSTS+ led the team through a simple exercise to slightly reorder IRs to fit into the SF and identify components/ subcomponents that were missing. Additional objectives and appropriate activities and indicators were developed.

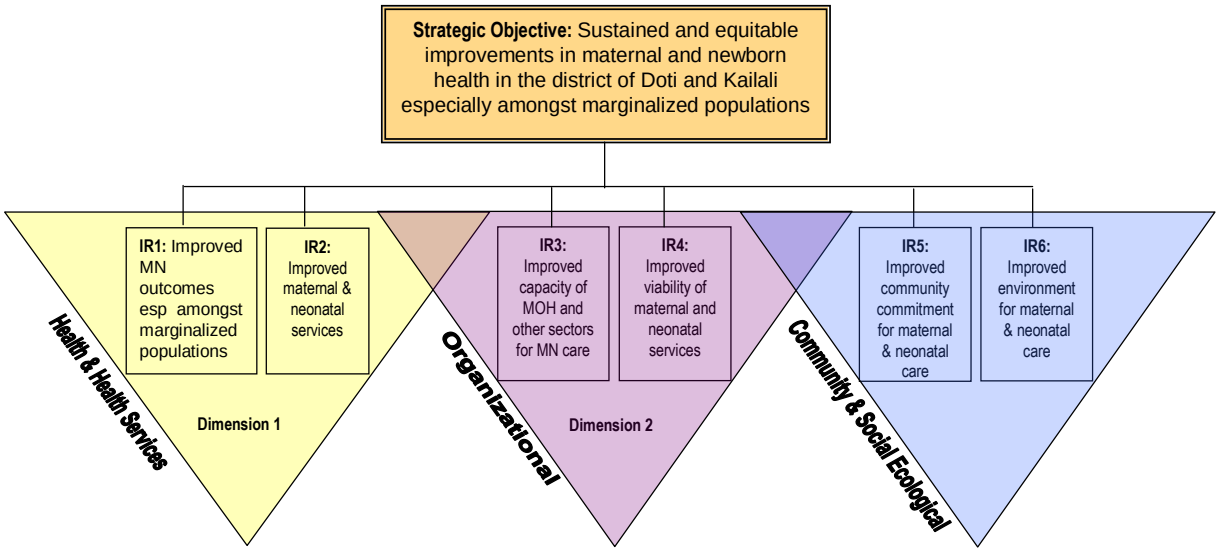
Make it your own. The SF has to be meaningful to the local system in order to be useful. (Example of CRWRC Bangladesh)

In 2005, CRWRC received its first CSHGP grant and held the DIP workshop with project partners in Bangladesh. CRWRC introduced participants to the SF and completed a visioning exercise together. CRWRC identified an additional dimension to their SF: community values. The project team conducted focus group discussions (FGDs) to further explore this topic."From the FGDs, CRWRC partners found that the values of justice and equality were distorted in certain communities. This has led to health care discrimination based on gender, race, and socioeconomic status. If positive values are distorted or a community embraces values that prevent positive change, then positive health outcomes will be difficult, if not impossible, to sustain. By assessing values and as

part of the CSSA, CRWRC hopes to improve the likelihood of sustainability by celebrating values that promote sustainable health and challenging values that prevent sustainable health."—CRWRC, first annual report to CSHGP, 2005.

Using the SF in a Proposal (CARE Nepal)

USAID/Nepal introduced its implementing partners, including CARE, to the SF in 2004. By the time CARE submitted its proposal to the CSHGP in 2008, its project team was familiar with the framework and had measured project results in the components and mapped dashboards. Their proposal effort included an SF, indicating a commitment to planning sustainability from the beginning. The Results Framework in their DIP includes an IR for each component of the SF. Their programming takes place within this Sustainability Framework. See figure below (this is quite similar to the suggested Pro-Sustainability Results Framework in Annex 2.5).



ANNEX 2.5: PRO-SUSTAINABILITY RESULTS FRAMEWORK: A SUGGESTED FORMAT FOR INTEGRATING PRO-SUSTAINABILITY THINKING INTO A PROJECT'S RESULTS FRAMEWORK

In traditional project planning using a Results Framework or a Log Frame, the management team focuses on the outcome/impact of project activities and how this will be achieved by direct project partners. While planning with the SF is not entirely different from this, it is important to expand one's point of view. The following table summarizes the key ways in which an SF is more expansive than traditional project planning. We can see that the SF is much the same as an Results Framework, but a traditional Results Framework takes account of what would be Components 1 and 2 of the SF, whereas the SF will also track Components 3 to 6.The project goal should align with the vision that is produced by the Local System stakeholders and simply be an intermediate level of attainment of the long-term sustainable vision.

Sustainability Framework for Planning	Traditional Results Framework
Local System Vision Looks at desired situation beyond project period	No equivalent
Project Goal Describes project contribution to local vision by end of project. Ought to align with the Local System Vision.	Project Goal Describes situation at end of project
Project Objectives Based on SF Components Include not only health service delivery improvement objectives, but also other capacity development objectives	Project Objectives Action-oriented items designed to achieve goal, usually centered on technical and service delivery topics

In traditional project planning and construction of M&E plans, there is a hierarchy of indicators. The highest level (objective) indicators measure project outcomes such as the percentage of children 0-5 months exclusively breastfed. A target will be set. Project plans are then designed to reach the target level for this outcome. For instance, a common strategy to increase the breastfeeding rate is breastfeeding promotion through formation of Breastfeeding Support Groups. To track progress toward the objective of increasing exclusive breastfeeding rates, managers will not perform population surveys for exclusive breastfeeding from quarter to quarter, but neither will they give up on tracking it altogether and simply wait until the end of the project to find out if the target for this objective was reached. First, they must trust that their chosen strategy (formation of breastfeeding support groups) is, in fact, effective at reaching their objective. If so, then tracking the outputs and processes showing progress on the chosen strategy will be a good barometer showing progress toward the objective. So the M&E system can be designed to track the things like the number of mothers' groups formed, the number of Mothers' Group meetings held, and onward to the number of mothers with positive attitudes and knowledge about breastfeeding. If there is a problem in implementing the strategy, then it will become apparent before it is a crisis, as project managers discuss monitoring reports generated on a regular and frequent basis.

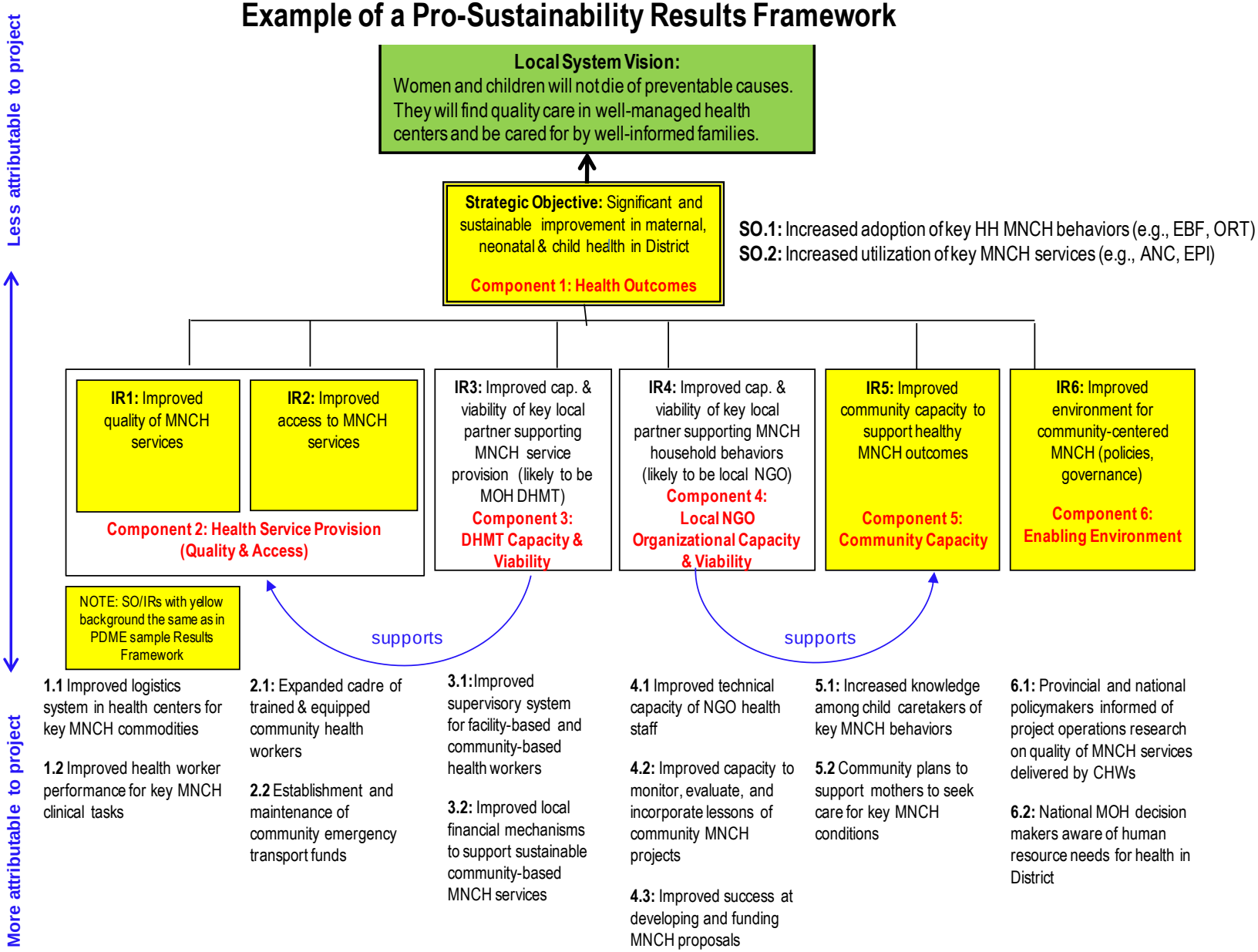
We should use the same reasoning in projects using the more expansive SF. If the project managers have designed their project plan with pro-sustainability thinking, then the SF will have traditional objectives not only for coverage with services or key behaviors but, but also will have objectives for

viability/capacity/performance improvements for local system partners. The following table gives an idea of a hierarchy of indicators one could follow for typical capacity or viability indicators, comparing these to the hierarchy of indicators that might be used for the example of exclusive breastfeeding covered above.

The indicators in the table under outcome/performance should be evaluated, at least at baseline and end line. They will be more complicated to gather and analyze. In the case of EBF, this will likely be done through a population KPC survey. In the case of the organizational capacity/viability indicators in the table—networking, financial management, and supervision—they will be collected through an organizational capacity assessment tool (e.g., the OCVAT or various others). The results of these assessments can be combined into indices and mapped onto the SF radar diagram. The indicators for outputs, processes, and possibly inputs should go into the regular project monitoring plan. This is as true for the indicators that correspond to key project activities for Components 3 to 6, as it is for indicators corresponding to tracking progress on Components 1 and 2.

	Breastfeeding	**Networking**	**Financial Management**	**Supervision**
Outcome/ Performance	% infants 0–5 months who are exclusively breast fed	% projects jointly conducted	% recurrent costs covered by cost recovery	% HW performing tasks correctly
Output	# mothers with positive knowledge and attitudes about EBF (post-test)	# agreements for joint action signed	# health facilities with specified level of funds in bank account	# HW with performance improvement plans based on supervisory visit
Process	# Mothers' Groups meeting held	# meetings with other organizations	# health facilities regularly collecting user fees	# supervisory visits conducted
Input	# Mothers' Groups formed	Work plan to meet with other organizations	# health facilities with cost recovery plan	# supervisors at District office

Example of a Pro-Sustainability Results Framework



ANNEX 2.6: METHODOLOGICAL NOTES FOR BASING AN EVALUATION ON THE SF

I. Introduction

It is impossible to treat in a few pages the essence and fundamentals of evaluation. The reader is referred to evaluation treatises and literature, as well to his/her own experience to understand the purpose and parameters of evaluation, as a science and a little bit of an art. As shown in Table 1, a sustainability assessment based on the SF is simply another evaluation exercise, albeit with very specific parameters in terms of—

- Boundaries (the object) of the evaluation
- Dimensions of the evaluation (range of evaluation questions)
- Timescale of analysis (retrospective; prospective).

This annex will provide a short discussion of these three important parameters in a sustainability assessment[11], and provide some practical examples for implementing the assessment based on past experiences, notably that of Concern in Bangladesh. Box 1 provides valuable references for the reader wanting to delve in depth into this experience, which remains still relatively unique.

Table 1
Contrasting Traditional Project Evaluation and Sustainability Assessment

	Traditional Evaluation	Sustainability Assessment
Boundaries (object) of the evaluation	Project from an 'input-process-output-outcome' perspective. Establish attribution of results to project's strategies and implementation.	Local system of stakeholders, agencies and communities. Establish contribution of project to locally owned process.
Dimensions of the evaluation	Achievement of knowledge, practice and coverage project targets; changes in health service delivery. Broad narrative about capacity building and community processes.	Systematic focus on six inter-related components of evaluation.
Timescale of analysis	Retrospective (what has been achieved?)	Retrospective (what has been achieved?) and Prospective (what does the current situation in the local system predict for the future, notably post-project?)

We start however, with making a few basic points, which should be of value regardless of the type of evaluation being considered, and need to be clearly in mind before considering the specificities of sustainability evaluation.

[11]The terms "assessment" and "evaluation" are used somewhat interchangeably in this section. Practice has made the term "sustainability *assessment*" common. We consider here sustainability assessment as an *evaluation* activity, structured and directed by the model and process of the SF.

Box 1: References on Concern Saidpur and Parbatipur Experience with the Sustainability Framework—

- Initial sustainability assessment: Initial IJHPM paper available at www.childsurvival.com
- The 3-year post-project evaluation: Full report available at www.childsurvival.com

II. Important Principles and Practical Lessons for Establishing Evaluation Findings

Evaluations too frequently cut short important steps in establishing a trail of evidence to support findings and conclusions.

The SF is first and foremost an attempt to bring systematic thinking and evidence to an area plagued with subjectivity. Experience shows that a key weakness in managing and implementing evaluations of any kind is a failure to properly manage the link between data, information, analyses, and conclusions of an evaluation. For this reason, it is important to restate some simple but essential and frequently neglected logical steps in implementing an evaluation.

Table 2 offers a simple presentation of how evaluation seeks to build a trail of evidence to establish findings, conclusions and make recommendations. A frequent shortcoming of evaluation is when an evaluator fails to distinguish between his/her personal opinions (for which there is room at the conclusion stage) and a clear exposition of what the data say (findings). When program managers fail to understand the links between all levels, they are also susceptible to over-reliance on an evaluator's opinion, or on their own subjective opinions. While managers have to make many decisions without the hard evidence they always would like to have, it is not wise to do overstate the range of validity of a specific evaluation to support a decision which will remain subjective. Too often, "evaluation findings" are little more than "opinions formed in parallel to an evaluation exercise," because the steps schematized in Table 1 are not followed rigorously in implementation of an evaluation.

Table 2
From Data to Recommendations—The Evaluation Trail of Evidence[12]

↓ ↓ ↓ ↓ ↓ ←Planning of evaluation ↓ ↓ ↓ ↓ ↓

↑ ↑ ↑ ↑ → Implementation ↑ ↑ ↑ ↑ ↑

Recommendations	Evaluator's best advice to managers/decisionmakers.				
↑	↑				
Conclusions	Statements about value of project, its strategies and activities, based on analytical findings, and expanding based on evaluation team's experience.				
↑	↑				
Analytical Findings	Correlating and linking data and findings, to infer causality and establish relationships				
↑	↑↕			↑↕	
First Level Findings (Data Reporting)	First explanation about the meaning of the data			Evaluator's/expert conclusion on document or process review Qualitative textual analysis	
↑	↑	↑	↑	↑	↑
Data (hard to soft)	Externally verifiable measures	Externally verifiable facts	Quantified measures of qualitative and/or complex information	Qualitative records of opinions/ perception; narratives/ interviews	Record of process or document review by expert/ evaluator

Shortcomings in implementing an evaluation frequently stem from failure to properly plan for it.

This is an artifact caused by the frequent absence of the right data and right information. And this in turn comes from the fact that the questions were not identified in a timely manner. In the case of Concern in Bangladesh, the best evidence established in 2007 was in response to questions clearly laid out in 2003. The evaluation time was thus four years (collecting the data), plus four weeks (reporting the findings) plus four days (cross-tabulations, developing composite measures, seeking correlation), and finally four minutes to form conclusions (progress on health outcomes had stopped, but health indicators had been maintained to a large extent).

The value of an evaluation framework is often underappreciated and this contributes to insufficient planning.

Planning for an evaluation requires looking at Table 1 from the top down: What types of conclusion do we seek? What kind of analyses will it require? What will be the information basis for these analyses? And finally, what data will need to be collected and when?

The role of an evaluation framework (see box) in forming these questions is essential. The most basic one is presented in Figure 1 as a chain from inputs to impact, and is frequently referred to in public health program evaluation. It continues to be extremely useful.

Figure 1
Basic Input-Output Chain of Results Framework in Public Health Programs

It is obvious to many that, even in public health, things are not as simple as Figure 1 makes it out to be. Complexity is inherent in the world and by definition only approached with difficulty by humans. Complexity refers, according to Rihani[13] to "certain systems that have large numbers of internal subcomponents that interact locally to produce stable, but evolving, global patterns." Consequently an important function of an evaluation framework is to simplify complexity to allow breaking down questions and analyses to a manageable level.

By starting with a simplified model, evaluators can establish at which level their evaluation questions lie and examine what data are available or can be produced (and what it will cost). It is thus important to know upfront what the evaluation will and will not answer. An evaluator should not elaborate or write his/her findings outside of his/her model (for example by assessing processes but drawing conclusions on impact, which was not examined). Obviously, there is room for conclusions, where, findings having been established properly, an evaluator can expand based on personal experience (i.e., according to the model, success or challenges in delivering on processes (actual findings) are in turn promising or not with regards to prospect for outputs, outcomes and impact).

> An evaluation **framework** is a ***frame*** of analysis, ***which works*** (well enough) to explain the processes under investigation, as well as the subcomponents and linkages which will be analyzed.

The SF is similar to any framework a simplification of complex interactions of cause and consequence. Proper understanding of this proposed model for how "sustainability happens" is essential to framing the terms of reference of a sustainability assessment.

There are two particular challenges of sustainability evaluation that need to be kept in mind with modesty by every evaluator.

Timeframe—The evaluator is trying to anticipate future situations in an environment that is extremely uncertain and unpredictable. Sustainability evaluation is more than a comparison between a past situation and a present situation (classical evaluation of a project). The evaluator is trying to predict future changes or at least form evidence-based hypotheses about how this future is going to unfold.

Attribution—The evaluator will have many difficulties to provide solid evidence on the degree of contribution of the project towards the sustainability of the local system. As explained earlier, the complexity of local systems is such that the evaluator will only partially prove that the project has had a positive impact on the sustainability of the local systems.

[13] Rihani S (2002), Complex Systems: Theory and Development Practice, Zed Books, London, 2002`

III. Specific Methodological Components of a Sustainability Assessment

Multiple dimensions of evaluation

The SF provides guidance to the evaluator on the areas (components) that need to be investigated. Figures 2 and 3 present the six components, which need to be examined.

- Change in each component can be analyzed through an input-output model as in Figure 2 above, but the consideration of what can be predicted post-project (right side of Figure 2) requires a review of the balance of achievements across all six components (left side of Figure 2).

- There are multiple interactions between all these components, but the SF does not suggest what they are (once again it is a simplification of complexity). It simply posits that if certain levels of achievements (not necessarily known yet) in the six components are achieved, a successful local process (midsection of the diagram) will allow maintaining progress and responding to new crises and threats and finally lead to sustained positive health outcomes.

Figure 2
Traditional Presentation of the Sustainability Framework

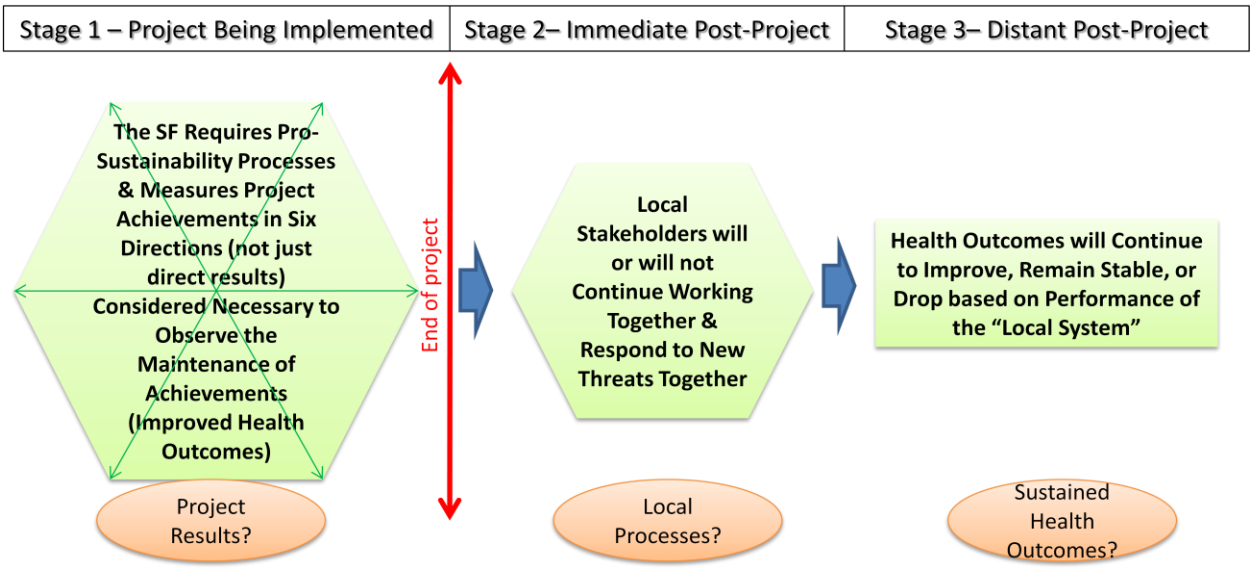
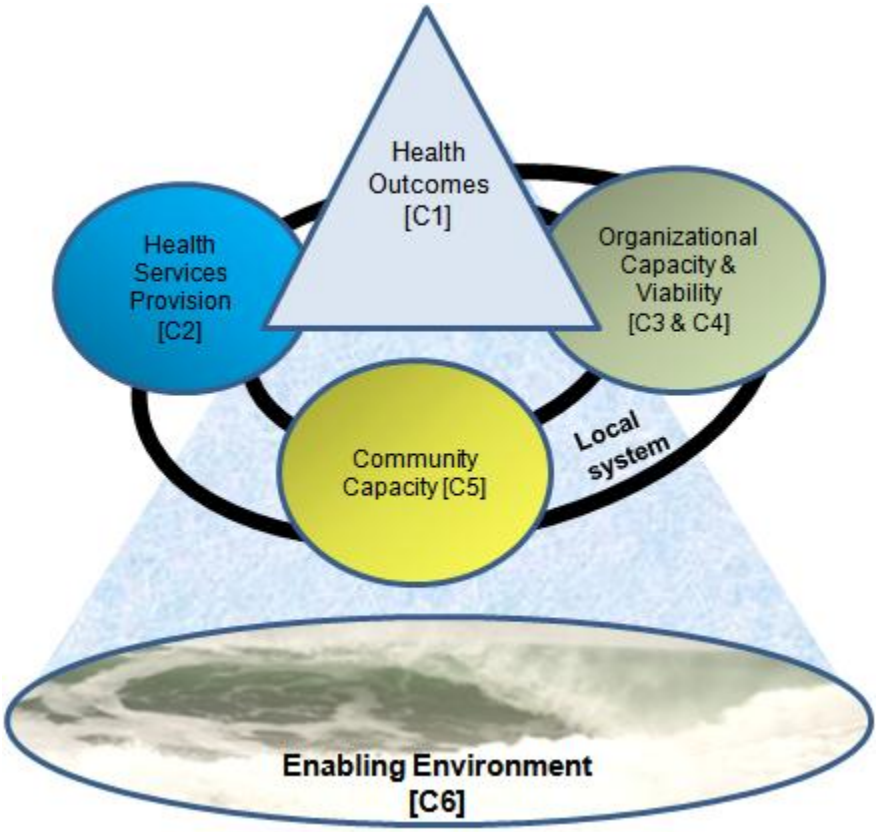


Figure 3
Alternative presentation of the SF's Evaluation Components (left side of Figure 2)



Timescale of evaluation questions

Because sustainability is about an ability to maintain something in time, its assessment needs to be defined within a determined timeframe. Referring back to Figure 2, the nature of a sustainability assessment can be framed in reference to different timelines (Table 2).

The emphasis of an assessment—from prospective to retrospective—will evolve over time. At the onset of the project, the object of the evaluation is to understand the situation in all its components, starting with how coherent a local system is and its capacity to conceive an inspiring long-term vision. On the other side of the model (still in Table 2), post-project evaluation is mostly retrospective in focus, trying to verify initial hypotheses and assumptions.

The greatest challenge in framing the focus of the evaluation lies in the midlevel of the model, as both retrospective and prospective questions can be asked. It will be entirely left to the parties involved to define what their questions are, but they should understand clearly the nature and focus of their questions. An end of project or immediate post-project assessment will most likely combine retrospective and prospective subcomponents. To add to the confusion, the same data and information basis might be used for both. For example, assessing health district capacity at the end of the project or in the immediate post-project period will provide one set of indicators, which can help answer three types of questions:

1. What is the current capacity of the Health District to fulfill its Mission? [A static assessment.]

2. How has this capacity evolved since (1) as a response to project efforts, or (2) since the end of project? Have the project and district been successful in reaching their objectives during the life of the project? Was the district successful in maintaining its capacity and continuing to strengthen it after the end of the project? [Those questions all require retrospective analyses, but start with the static assessment of the district's capacity.]

3. Will the current capacity of the district allow it to promote further progress in the health situation of its population? Will the district be able to strengthen the coherence of the local system and its efforts to advance toward a 'sustainable health vision'? [Those questions are prospective, and generally lead to formulating hypotheses about future trends based on the observed current situation.]

It is strongly recommended to any project contemplating such an exercise to distinguish retrospective and prospective analysis questions. This means that the evaluation plan should not be based on the data collected (in our example a district capacity assessment in both cases) but on which piece of the framework will be used to carry out analyses, as suggested in Figure 2 and Table 2.

In a perhaps reductive summary, one could state that prospective assessments are about forming hypotheses about what needs to happen and what is likely to happen in the future, while retrospective assessments allow verifying assumptions and testing whether hypotheses were demonstrated. It is essential to bear in mind—once again—that robust answers about sustainability can only be provided in the end-of-project or post-project phases if the questions were asked early in the design. Evidence requires data; data collection takes time and needs to be planned for at the onset of the project, or at least early in implementation. Many interesting sustainability assessments

are not carried out, not because the ideas are not there, but because they were not developed in a timely manner (allowing data collection).

Table 2
Level and Focus on a Sustainability Evaluation Over Time

	Project		End of Project	Immediate Local Process	Long-term Local Result
Focus of evaluation	Prospective	Prospective and Retrospective			Retrospective
Initial assessment • Local system: Health situation, coherence, long-term vision, status of other SF evaluation components in support of vision • Project: Identify best and most strategic opportunities to contribute to sustainable health in local system	*				
Midterm/Ad Hoc Evaluation • Evolutions in the local system and among stakeholders • Achievements of project and of stakeholders • Adjustments required in the vision, by stakeholders, by project?	*				
Final Evaluation • Evolutions in the local system • Achievements of project and of stakeholders • Expected sustainability post-project based on achievements and resulting local system conditions	*				
• **Immediate Post-Project Assessment** (i.e., 3-12 months post project) • Effective response of local system (evaluation) after project's pull out or reduction of inputs. (Were end of project hypotheses verified?) • New situation demonstrated in local system; responsibilities of local stakeholders; long-term prospect?	*				

	Project		End of Project	Immediate Local Process	Long-term Local Result
Post-Project Assessment (2-4 years) • Progress on health outcomes and sustainability components post-project? Trend in external inputs versus maintenance of outcomes and continued progress? • Was the project and partners 'sustainability scenario' verified? • How did the local system evolve and respond to new threats/shifts in the environment? • Overall progress toward vision, cohesion of stakeholders? • Needed response of stakeholders (new prospective stage)?	*				
	* *Time of evaluation design*				

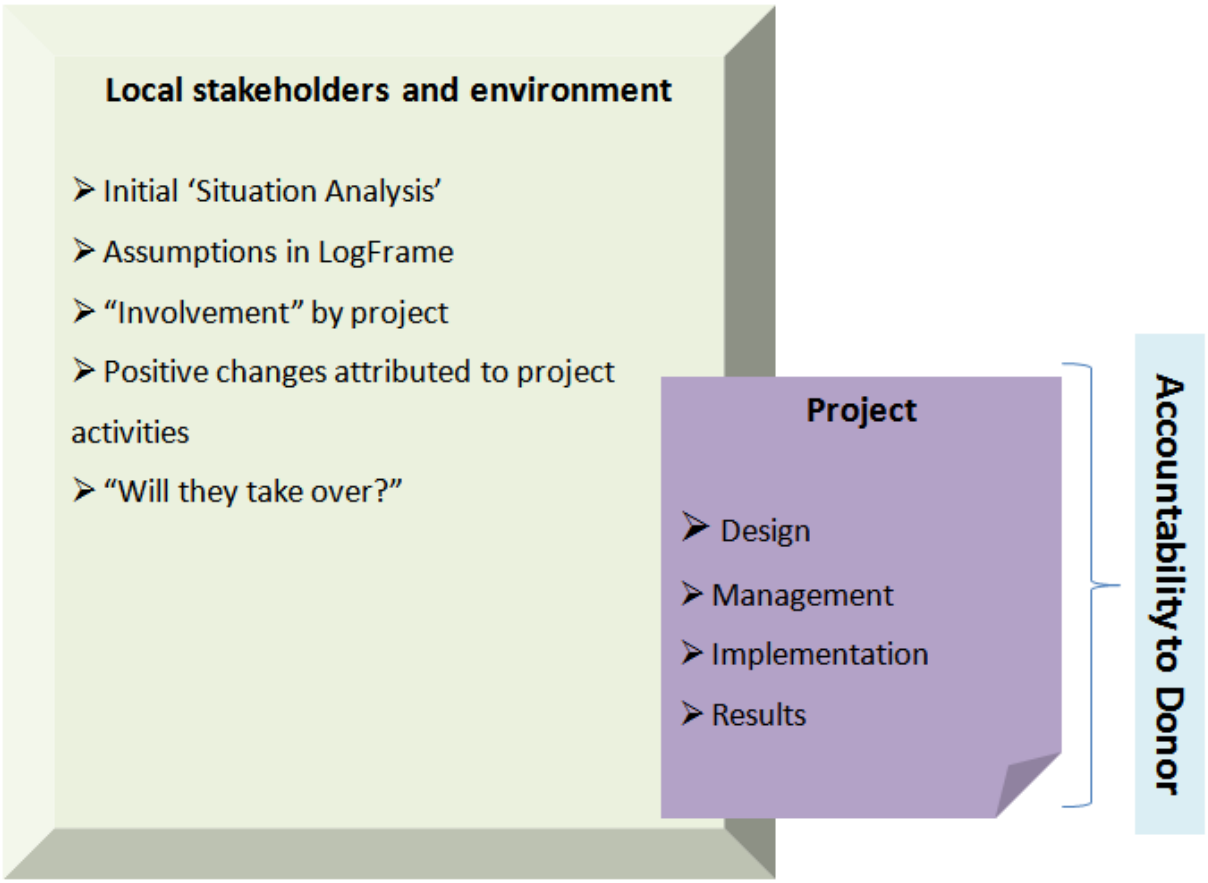
Boundaries of the evaluation

The final and possibly most challenging aspect of a sustainability assessment lies in defining the boundaries of the evaluation. What exactly is being analyzed in an evaluation based on the SF? Answering this question creates some tensions with traditional project evaluation design, and deserves some explanation.

Figures 4a and 4b contrast some of the differences introduced in evaluation approaches between a traditional project evaluation (from formative to summative stages) and a sustainability assessment.

In the traditional model, the focus is on attribution of results to project's efforts, in order to be accountable to the project sponsor (donor). While local stakeholders are expected to be consulted and involved, the local system is implied, very much in the background, and subcomponent to be considered in the Log Frame, or one including the beneficiaries of the project's interventions. The boundaries of the evaluation are however and quite reasonably those set by the project's planning documents, its goals and objectives.

Figure 4a
Place of Project and Local Stakeholders in Traditional Project Evaluation

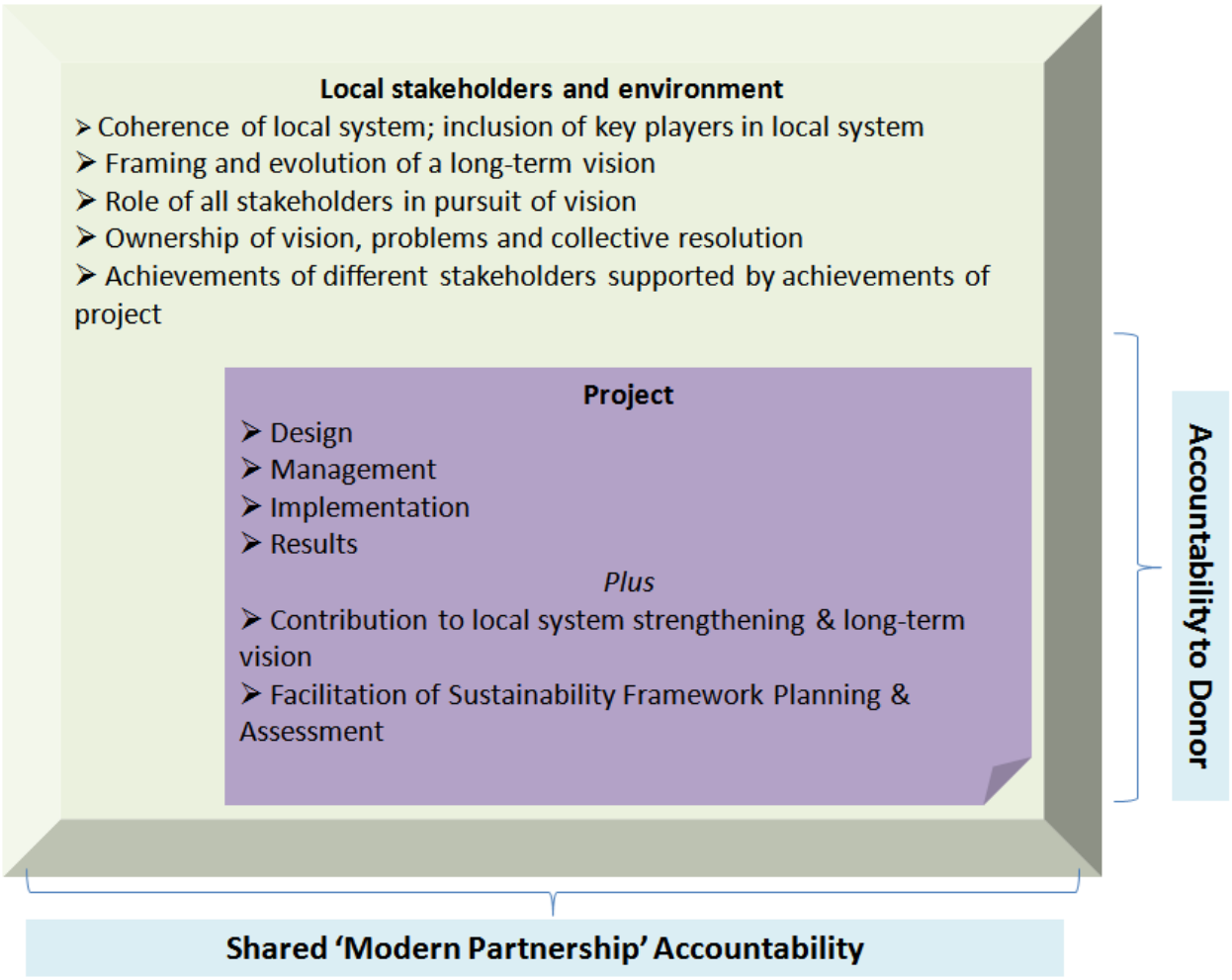


The boundaries of a sustainability assessment are broader, because the organization, vision and roles of local stakeholders are the subcomponents which will determine the long-term sustainability of any achievements. The project is a transient added subcomponent in the local system, and questions are as much about what can be attributed to its design and diligence as about its contribution to the local system, which is now the central reality and focus of the evaluation. The subcomponents of project accountability to its donors remain; they cannot and should not be erased, but more is asked in terms of the local processes supported by the project. Even more is asked of local stakeholders.

Finally, if local stakeholders are going to successfully transition toward a process of 'shared accountability,' the project would not play its role if it engaged its proportionally considerable resources to strictly measure what it manages, without supporting the local system in learning how to measure its own progress.

In the case of Concern in Bangladesh, the sustainability assessment underlined the evolution in needs for a Medical Officer at the Municipality level, and through the evaluation engaged partners in discussions about the importance of this position and its nature. This was part of the sustainability assessment, even though Concern had no specific role, mandate or objective relating to filling that position. But the examination of what it would take to continue improving health outcomes of children and mothers in the reality of the local system demanded that it be addressed. One cannot pretend to care about sustainability, engage stakeholders in critical thinking and then refuse to play an added-value role in system evaluation.

Figure 4b
Place of Project and Local Stakeholders in Sustainability Evaluation



IV. Suggested Steps

Beyond the subcomponents above, we can provide some suggested steps for carrying out a sustainability assessment. We will consider here evaluation as including both retrospective and prospective subcomponents. Each context, program, and specific purpose for the evaluation will impose its own format, so we will provide general recommendations only here. The steps below borrow heavily from the three year post-project sustainability assessment that was carried out in Bangladesh with Concern. Many will call "sustainability assessment" a step where a consultant is brought in to implement a formal assessment. This can take anywhere from 2 weeks to 1 month, depending on the scope of work. In our understanding, this is only the last of a series of steps, which must start much earlier and are described below:

Develop and draw the evaluation model and its major components

Without completing this step and completing it early on, evaluation will be confused and confusing.

This user's guide provides guidance on how to use the SF at different stages of project life; those same steps will allow defining the local system, its vision, and the major components under examination. In the thinking of the SF, it is quite reasonable to identify some of these components as being under the responsibility of one or another implementing partner, while the project has chosen another one to make its effort. But all components are required to think of the long-term and must be presented together. Defining these lines of responsibilities is part of setting up the boundaries of the evaluation.

It is also possible that over time—for example at a midterm review—lessons will have been learned by all and the model will evolve. This evolution is not in itself a problem; actually it is often a very positive thing which needs to be documented (for example because the voice of the key stakeholder has now been heard more clearly). In terms of evaluation methodology, the main challenge is that subcomponents defined late in the life of a project will usually not have been included in the M&E plan, and data may be unavailable to base the assessment on evidence. It is however better to at least consider an issue for which evidence is lacking, than ignore a salient issue, just because measurement systems are a step behind. When time for the final stages of an evaluation comes, the model should be revisited and discussed as part of kickoff for the evaluation. Forming evaluation questions will flow naturally from defining the boundaries of the evaluation, the parts of the model you are considering (subcomponents and linkages), and your timeframe focus.

Develop and implement a data collection plan

As discussed elsewhere in this manual (see Chapter 3 and Annex 3) specific data collection and measurement tools are appropriate to each component of the SF. The timing of data collection steps will be defined by the evaluation questions. Any question about "change," "pre-post differentials," and "evolution" in any component will require collecting data at the onset and after a set period (traditionally pre-post design). It is highly recommended to leverage other ongoing data collection efforts to measure status and changes in components not directly affected by the project. Sustainability evaluation is also an opportunity to broaden the basis of information shared among stakeholders.

Final evaluation phase ["sustainability assessment"]

Finally, having laid the methodological and foundation and collected essential data, the project and partners are ready for a "sustainability assessment." But once again, this is a misnomer: the sustainability assessment starts years before with Steps A and B. Customarily, a consultant will be brought in to pilot this last phase. But the project team can gain in time and efficiency if it has the benefit of a solid M&E team of its own. Implementation steps and final evaluation activities will vary based on context, but the steps below will normally have to be considered. Figure 5 suggests a timetable for completion of steps 1 to 8, which follow conceptually the steps of Table 1.

Step 1—Consolidate Information from the Different Data Sources and Establish the Basic Facts about the Situation at the Time of Observation

Who:	Most of this step should be completed by the project's M&E team along with appropriate implementing partners' staff if there is sufficient capacity. The evaluation consultant should start being involved from a distance at this point, and kept abreast of study reports being produced.
What:	Establish first level findings from essential studies (KPC, HFA, capacity assessments). Identify and collect data from secondary sources (national / regional surveys; governmental and UN reports; relevant research studies; etc.). Inventory additional monitoring data, which can be reported or analyzed further. Start describing basic time trends (increase, decrease, stability in indicators).
How & When:	In practice, step 1 is rarely fully completed by the time of the final evaluation kickoff, and the evaluation team usually navigates between steps 1 and 2. This is not however the best way, nor the more efficient in carrying out the assessment. All that is required to come to step 2 with better formed first-level findings is: (i) a clear and early definition of the evaluation model; (ii) timely data collection in the different components; and (iii) a project and partner M&E team skilled enough to produce basic analyses and summary reports. If this can be done, steps 2 and following can start on a much more informed basis and lead to deeper probing. Alternatively, if this has not been possible, the evaluation kickoff meeting can structure work teams to complete step 1.

Practical example—In the case of Concern Bangladesh, this step was initiated prior to the evaluation consultant's arrival but completed during the evaluation workshop (step 2). The first level findings discussed then were:

- To what extent the two municipalities had maintained health outcomes from 2004 to 2007 (KPC data)?
- To what extent had they maintained their capacity and viability in health promotion according to completed capacity assessments (HiCAP surveys)?
- To what extent had WHCs maintained their capacity to mobilize for and to promote health, according to the completed assessments (WHC capacity assessments)?
- To what extent had the environment conditions evolved over the past 3 years and what major events had taken place?

Step 2—Final Evaluation Workshop

Who:	In a participatory approach, an evaluation team is formed involving key technical staff of the project, implementing partners and local stakeholder groups. Decisionmakers can sometimes be included in the evaluation team; frequently their time availability is more limited but they should take part in kickoff activities, on special occasions and at the time of review of the conclusions. The consultant facilitates the process along with the project team.
What:	This is not different from any evaluation workshop, with the caveat that different components, levels and timeframes need to be considered. The first sections of this document should guide setting up the agenda of the evaluation workshop, depending on the precise nature of the evaluation, how much of step 1 has been completed and the time available. At a minimum, the evaluation kickoff should start with: • Reviewing and agreeing on the purpose of evaluation; • Reviewing the evaluation model and the "sustainability scenario" it forms; • Reviewing and agreeing on the evaluation questions; as well as on the plan for completing the evaluation.
How & When:	Depending on how much of step 1 needs to be completed (for example by setting up small work groups to review data and present findings), the evaluation workshop can take about 3 to 5 days.

Practical example—After a brief discussion of the purpose of the evaluation, the model established by Concern in 2003 with partners was presented in terms of two questions: (1) What story does the model tell? (What scenario did it present? See Figure 5 about how phasing out was meant to take place.); and (2) How did project and partners implement (aka measure/assess) it?

The final post-project evaluation plan included three phases (see also Figure 6 below), which were discussed during the evaluation kickoff. The workshop focused on Phase 1 and on planning for the other ones.

Phase 1 (desk review / evaluation workshop): Where are we now?

- Were benefits lost? Maintained? Improved over the 3-year period?
- What is the current operating architecture of the local system and its actors?
- How have the different areas of capacity considered by the model evolved?

Phase 2 (evaluation workshop / additional data collection and analysis): What happened between then and now?

- Coherence of the system and cooperation of actors?
- Response to threats?
- Did identify strengths and weaknesses in capacity act as expected (according to the sustainability scenario)?
- Were there any unexpected synergies, challenges, or results?

Phase 3 (synthesis and debriefing): What conclusions and recommendations can be made? What can be predicted about the future? What are the main risks and opportunities that may affect the sustainability of the local system?

Figure 5 Visualizing phase-out plans with and without the Sustainability Framework

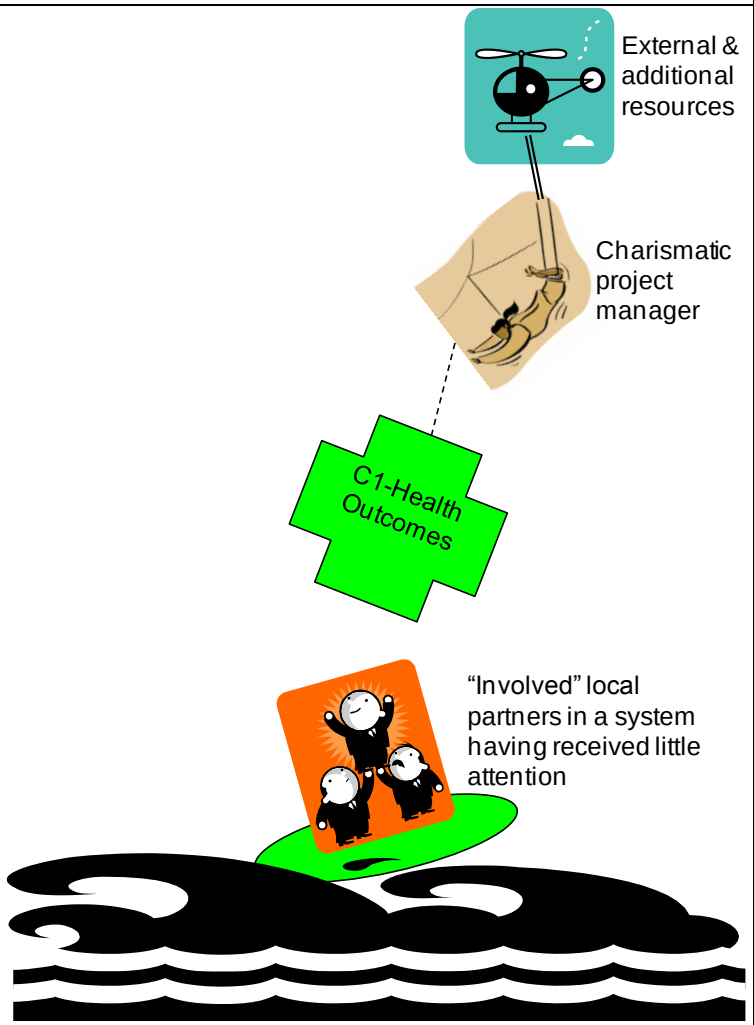
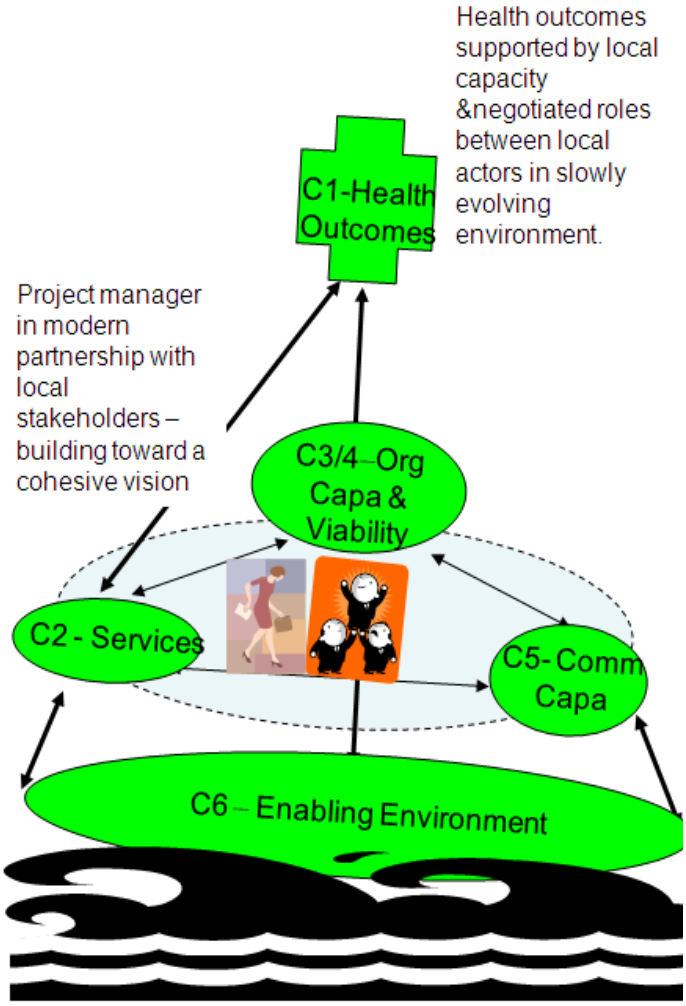
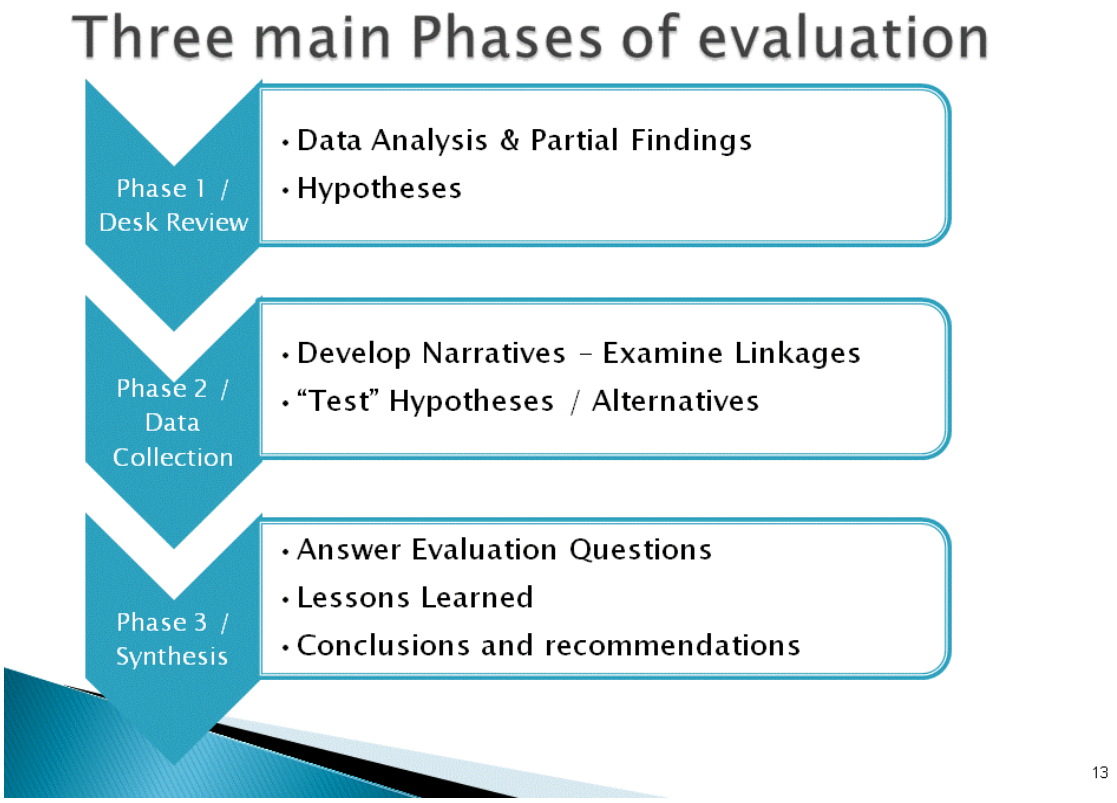
Classical phasing out approach External funding allows projects to raise some health outcomes. These achievements define "success" and initiate the perilous exercise of transferring a range of new procedures and systems over to local partners.	**Phasing out according to the SF** Phasing out is progressive and is based on signals not only about achievements in health outcomes, but also based on information about processes and capacity areas developed in the local system.
	

Figure 6
Presentation of the last Phases of Evaluation to the Concern Bangladesh Evaluation Team



As Step 1 had not been completed (Phase 1), small teams were set to review the findings of the different studies and to present them back to the evaluation team during the initial evaluation workshop.

Step 3—Make Comparisons and Develop First Analytical Findings

Who:	Evaluation team. Possibly advanced work by M&E team.
What:	Step 3 is in the continuation of 1; it remains in the field of presentation of the basic findings, but places emphasis on making comparisons: • Comparing one geographic area with another; • Comparing a set of indicators with another (i.e., by intervention areas); • Comparing indicators between two periods; • Comparing the assessment of different areas of capacity. This step is an essential analytical step, in the development of further questions; it should include: Brainstorming and questioning observed differences; suggesting explanations to be verified, hypotheses to be tested.
How & When:	Evaluation workshop or preliminary M&E work; presenting comparative tables and graphs and summary statements.

Step 4—Identify Resolvable Data Gaps and Additional Questions (Mostly Qualitative)

Who:	Evaluation team with facilitation and *leadership* of consultant.
What:	Analyses and draft conclusions from Step 3 may suggest required additional data mining (for example extraction of M&E data) and questions about Phase 2 of the final assessment ("What happened between now and then?") become critical. Specific questions will suggest interviews of stakeholders, peer organizations, theme group or focus group discussions. By having followed steps 1 to 3, the evaluation team will avoid an abundance of unstructured ad hoc meetings and interviews, but focus data collection on answering useful questions. A plan for data collection must be established by the end of Step 4 and before concluding the initial evaluation workshop. It would be conceivable, but surprising, that no additional data collection be required.
How & When:	Evaluation workshop—This step is in practice very closely linked to the preceding and sometimes implemented through a sequence of steps during the same work sessions.

Practical example—For Concern Bangladesh, a range of questions emerged in the following directions:

1. How did the local stakeholders function as a system and how did this system evolve?

2. What events shaped the evolution of Municipalities and Ward Health Committees (WHCs)? What unforeseen factors/threats/stakeholders came into play?

3. What has been the effective role and investment of Concern in the post-project phase?

There were in addition observed differences between Saidpur and Parbatipur. Reasons for these differences were discussed with the evaluation team but provided additional subcomponents to investigate or simply verify with the municipalities themselves. Data gaps were identified in terms of services delivered in the municipalities, and a small group extracted what information could be found from past KPC surveys, monitoring data and limited studies from other agencies.

Steps 5, 6, and 7 – Data Collection, Analysis, and Presentation

Step 5—Implement Final Field Data Collection

Who:	In a participatory approach, the evaluation team can complete this step.
What:	In addition to additional data mining (monitoring data, further KPC analyses, etc.), this involves implementing field visits, interviews, group discussions and assessment activities planned for in step 4.
How & When:	The evaluation team should have sufficient skills to conduct qualitative interviews and required tasks. Focus groups can be useful—though overrated—but also thematic discussion groups with stakeholders of different background. Observations are too often neglected as an investigative technique, and should be considered. In a sustainability assessment, members of the evaluation team are sometimes themselves key informants on some processes. The consultant and evaluation team need to be aware of the risk of bias and seek ways to decrease this risk.

Step 6—Develop Final Analyses, Draft Conclusions and Recommendations

Who:	With strong leadership from the consultant, this process can involve stakeholders broadly but risks being too time consuming. A small nucleus from the evaluation team (preferably representing different partners) working closely with the consultant is probably preferable. Their work will be validated/amended during the next step.
What:	Going back to the evaluation model and evaluation questions, present information, analyses and synthesis coherently. The consultant should pay particular attention to: Presenting clearly the difference between established facts and suggested findings. Based on the scope of work received for example for a final evaluation, the consultant may draw a distinction between (1) what the project has achieved in terms of its identified objectives (for which there is direct accountability to the donor), and (2) how the local system is progressing toward sustainable health outcomes for beneficiaries. If a project has been designed as suggested in this document, this is only a challenge of presentation of the findings as the former includes the latter. What support there is for final conclusions and recommendations: science and best practices; direct evaluation findings; personal professional conclusions of the consultant based on the evidence available and his/her experience.
How & When:	Consultant with small nucleus from the evaluation team.

Step 7—Presentation of the draft findings and recommendations

Who:	Evaluation team leaders from different constituencies. Distribute roles between consultant, project team members and partners based on skills, role in evaluation, and local political consideration for the future of the beneficiaries. Involve stakeholders very broadly.
What:	Usually implemented first at a local level and then at regional or national level. The first helps strengthen the second and 'test' some recommendations.
How & When:	Can be combined with brainstorming on recommendations requiring wide consensus and response from stakeholders. Should be followed by discussion and/or possibly 'next step' planning activities with stakeholders.

Step 8—Reporting

Reporting is the last step and should allow for time to circulate and review drafts. Conclusions and even recommendations can sometimes be substantially refined during this period. Figure 7 below suggests a timetable for completion of all steps, 1 to 8.

Figure 7
Suggested Illustrative Timeline for the Final Steps of a Sustainability Assessment or Project Evaluation Based On the Sustainability Framework

Week

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Step1	X	X	X	X	X	X	X	X	X	X	X	X							
Step2													X						
Step3													X						
Step4													X						
Step5														X					
Step6														X	X				
Step7															X				
Step8																X	X	X	X

Conclusion: Ten Do's and Don'ts of a Sustainability Assessment

Do	Don't
Design evaluation from the onset. [An early plan—even an imperfect early plan—is better than no evaluation plan at all.]	Confuse indicators with opinions.
Invite peer-organizations / NGOs to learn about areas of assessment you are less comfortable with.	Ignore meaningful information just because you don't have an indicator for it.
Work with stakeholders. Involve stakeholders. Find ways to transfer to stakeholders the capacity to request, manage and/or implement key assessments.	Ignore narratives in evaluation.
Encourage critical thinking. Identify old patterns and debunk them.	Build your evaluation from the data you've collected. (Instead collect data based on an evaluation model.)
Use small successes and limited scale experience to demonstrate how sustainability is built.	Accept assumptions unsupported by evidence.
Use an evaluation framework to focus the sustainability assessment.	Overreach findings beyond what the data say.
Find ways to make data informative.	Ignore your own or your own team's biases.
Think critically and ask questions.	Practice token involvement of stakeholders.
Be specific: how much was sustained under which conditions is more useful of a finding than a personal opinion about "it" being "sustainable" or not.	Confuse evaluation and marketing.
Draw conclusions and recommendations from your experience but only after rigorously exposing the information collected and analyzed.	Overestimate the powers of consultants.

ANNEX 3: SUSTAINABILITY FRAMEWORK MEASUREMENT TOOLBOX

This annex presents and/or links to suggested tools to measure progress in each of the six components of the Sustainability Framework. All the tools can be found on the Sustainability Page at www.childsusvival.com. This annex starts with a summary of the components and subcomponents in Table A3.1; then a summary of the indicators and analyses in Table A3.2. There is a summary table of the suggested tools in Table A3.3. There are then separate sections on the measures describing the suggested tools for each of the six components.

Table A3.1
Components and Subcomponents of the SF

Component	Subcomponent
Health Outcomes	**Neonatal/Child Health** 1.1NC NC Newborn Health 1.2NC Measles and other Vaccine-Preventable Diseases 1.3NC Diarrhea 1.4NC Pneumonia 1.5NC Malaria 1.6NC HIV/AIDS 1.7NC Child Spacing 1.8NC Breastfeeding 1.9NC Nutrition **Maternal Health** 1.1M Hemorrhage/Anemia 1.2M Hypertension/Eclampsia 1.3M Sepsis/Infection 1.4M Obstructed Labor 1.5M Abortion 1.6M HIV/AIDS **FP** FP has no additional subcomponents **TB** TB has no additional subcomponents **HIV/AIDS** 1.1H Prevention of Child HIV (PMTCT) 1.2H Prevention of HIV in Adults/Adolescents (e.g., ABC programs) 1.3H Adult Treatment (ART and OI) 1.4H Palliative Care (e.g., home-based care) 1.5H Care of OVC

Component	Subcomponent
Health Service Provision (Quality and Access)	**Access** 2.1 Geographic Access/Availability of services **Quality** 2.2 Staffing 2.3 Infrastructure 2.4 Supplies 2.5 Drugs 2.6 Infection control 2.7 Community-provider relations 2.8 Health worker technical performance (assessment, treatment, counseling) 2.9 Client satisfaction
District Health Office Capacity and Viability	**Capacity** 3.1 Planning 3.2 Budget management 3.3 Guidelines/Norms 3.4 Training 3.5 Supervision 3.6 Data for decisionmaking **Viability** 3.7 Financial Resources 3.8 Coordination with key actors
Main Local NGO Capacity and Viability	**Capacity** 4.1 Governance and legal structure 4.2 Human resources and administration 4.3 Management systems and practices 4.4 Financial management 4.5 Technical capacity 4.6 M&E/Organizational learning 4.7 Organizational leadership 4.8 Equity and empowerment (focusing on gender equity) 4.9 Organizational performance **Viability** 4.10 Resource mobilization 4.11 Networking and external relations 4.12 Institutionalization of key competencies
Community Capacity for Health	5.1 Community Organization for Health 5.2 Participation/Mobilization 5.3 Key Attitudes (fatalism, resilience, openness to change) 5.4 Awareness/Knowledge 5.5 Programmatic Involvement 5.6 Linkages 5.7 Resource Mobilization
Enabling Environment	6.1 Health policy and Government commitment to health 6.2 Governance and stability 6.3 Strength of civil society 6.4 Human development 6.5 Women's empowerment 6.6 Natural environment

Table A3.2
Indicators/Tools, Transformations for Subcomponent Index Scores, and Analyses/Combinations to Calculate Six Component Index Scores

Component	Step 1: Measure indicators	Step 2: Transform to Subcomponent Scores	Step 3: Combine to get Component Index Score
1. Health Outcomes			
Neonatal/Child Health	KPC/CATCH	Standard transform in Annex 3 or LiST	Average of all 16-20 subcomponents
Maternal Health	KPC/MNH Module	No transformation or LiST	Average of 4 indicators
FP	Met Need (various tools)	No transformation	N/A
TB	MOH/NTP data	No transformation	TB Outcome Index (CDR estimate × TSR)
HIV/AIDS	Key coverage indicators (various tools)	No transformation	Average of relevant subcomponents
2. Health Services (Access and Quality)	CSTS Rapid Health Facility Assessment Tool	No transformation	Quality Score × Access Score Quality Score = Average of all subcomponents Access Score = Geographic Access
3. DHO Capacity and Viability	CSTS Rapid Health Facility Assessment (R-HFA), DHO module	Ordinal transformation for some indicators	Average of 9 subcomponents
4. NGO Capacity and Viability	SHOUT OCVAT	Ordinal transformation	Average of 12 subcomponents
5. Community Capacity	Modified HCP Community Capacity Tool	Ordinal transformation	Average of 7 subcomponents
6. Enabling Environment	Standard indices (after adjustment for local system)	Data already transformed	Average of 6 subcomponent indices

Table A3.3
Summary of Suggested Tools for Measurement

Component	Tool(s)
Component 1. Health Status Neo/Child Health Maternal Health FP TB HIV/AIDS	Neo/Child: Rapid CATCH Maternal: KPC, MNH module FP: Modern Contraceptive Prevalence (from Flex Fund Survey) TB: Case Detection Rate and Treatment Success Rate (from Nat'l TB Pgm.) HIV: Key indicators in various tools
Component 2. Health Service Provision	Rapid Health Facility Assessment (R-HFA)
Component 3. DHO Organizational Capacity and Viability (in support of Component 2)	Rapid Health Facility Assessment (R-HFA) – DHO Module
Component 4. NGO Organizational Capacity and Viability (in support of Component 5)	SHOUT OCVAT
Component 5. Community Capacity	Health Communication Partnership tool from Mobilizing Communities from Health and Social Change Malaria/AIDS Competent Communities tool (PLAN/SAWSO/ Constellation for AIDS)
Component 6. Enabling Environment	*a. Health Policy* MNCH: Countdown to 2015 Policy Index; available at http://www.countdown2015mnch.org/reports FP: FP Effort Index TB: Summary of indicators of Political Commitment to DOTS; available at http://www.stoptb.org/wg/advocacy_communication/assets/documents/Compendium%20of%20Indicators%20for%20Monitoring%20and%20Evaluating%20NTP.pdf HIV: UNGASS Commitment Indicators *b. General Governance and Stability* World Bank Governance Index; available at http://info.worldbank.org/governance/wgi/index.asp c. *Strength of Civil Society* Civicus Civil Society Index *d. Human Development* UNDP Human Development Index; available at http://hdr.undp.org/en/statistics/www.civicus.org/csi *e. Gender Development Index* UNDP's Gender EDI; available at http://hdr.undp.org/en/statistics/indices/gdi_gem/ *f. Environmental Stability /Disruption* Local participant scoring, but also can consult UNEP: EVI, especially the sub-index on disaster; available at http://www.vulnerabilityindex.net/EVI_2005.htm

Component 1—Health Outcomes

Neonatal and Child Health

The CSHGP's 16 Rapid CATCH indicators are listed in the table below. Analyzed together, they give a comprehensive "snapshot" of key behaviors and levels of coverage of important services, which gives a good sense of the state of health of the population of 0–5 month olds in the local system. The materials for implementing this population-based survey tool can be found at www.child survival.com. Two alternative ways to summarize this data are presented:

1. Transformation of the data for the CATCH Index:

   Using the parameters in the table below, the data are transformed and then combined as an unweighted average. If this alternative is chosen, the transformations in the last column of the table is used. This will convert the coverage levels obtained from the survey to scores. These scores are then combined as an unweighted average to give the Component 1 Index Score.

Subcomponent	Indicator	Cutoff Values for Transformation Bands	
Newborn Health	(1) Maternal TT Vaccination: Percentage of mothers with children aged 0v23 months who received at least two Tetanus toxoid vaccinations before the birth of their youngest child	Measured Value	Transformed Value
		0	0
		35	20
		55	40
		75	60
		90	80
		100	100
	(2) Skilled Delivery Assistance: Percentage of children aged 0–23 months whose births were attended by skilled personnel	Measured Value	Transformed Value
		0	0
		35	20
		55	40
		75	60
		90	80
		100	100
	(3) Post-natal visit to check on newborn within the first 3 days after birth: Percentage of children aged 0-23 who received a post-natal visit from an appropriate trained health worker within 3 days after the birth of the youngest child	Measured Value	Transformed Value
		0	0
		35	20
		55	40
		75	60
		90	80
		100	100
Breastfeeding	(4) Exclusive breastfeeding: Percentage of children aged 0–5 months who were exclusively breastfed during the last 24 hours	Measured Value	Transformed Value
		0	0
		35	20
		55	40
		75	60
		90	80
		100	100

Subcomponent	Indicator	Cutoff Values for Transformation Bands
Nutrition and Vitamin A	(5) Infant and Young Child Feeding: Percentage of infants and young children aged 6-23 months fed according to a minimum of appropriate feeding practices.	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(6) Underweight: Percentage of children aged 0-23 months who are underweight -(-2 SD for the median weight for age, according to WHO/NCHS reference population)	Measured Value / Transformed Value 0 / 100 10 / 80 20 / 60 35 / 40 50 / 20 100 / 0
	(7) Vitamin A Supplementation in the last 6 months: Percentage of children aged 6-23 months who received a dose of Vitamin A in the last 6 months: card verified or mother's recall	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
Vaccine Preventable Diseases	(8) Measles vaccination: Percentage of children aged 12–23 months who received a measles vaccination	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(9) Access to immunization services: Percentage of children aged 12-23 months who received DTP1 according to the vaccination card or mother's recall by the time of the survey	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(10) Health System Performance regarding Immunization services: Percentage of children aged 12-23 months who received DTP3 according to the vaccination card or mother's recall by the time of the survey	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100

Subcomponent	Indicator	Cutoff Values for Transformation Bands
Malaria	(11) Treatment of Fever in Malarious Zones Percentage of children aged 0–23 months with a febrile episode during the last 2 weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(12) Child sleeps under an insecticide-treated bed net: Percentage of children aged 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night. This indicator should be used for programs in Africa. In Asia, this indicator should be used in specific geographic areas where bed net use is recommended. In Latin America this indicator should not be used because bed nets are not effective because of the biting patterns of the vector.	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
Diarrhea	(13) ORT Use: Percentage of children aged 0–23 months with diarrhea in the last 2 weeks who received oral rehydration solution (ORS) and/or recommended home fluids.	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(14) Point of Use (POU): Percentage of households of children aged 0–23 months that treat water effectively.	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
	(15) Appropriate Hand Washing Practices: Percentage of mothers of children aged 0–23 months who live in households with soap at the place for hand washing	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
Pneumonia	(16) Appropriate Care Seeking for Pneumonia: Percentage of children aged 0–23 months with chest-related cough and fast and/ or difficult breathing in the last 2 weeks who were taken to an appropriate health provider.	Measured Value / Transformed Value 0 / 0 35 / 20 55 / 40 75 / 60 90 / 80 100 / 100
Child Spacing	Met Need for Modern FP (see FP subsection below)	No transformation
HIV/AIDS*	PMTCT coverage (see HIV/AIDS subsection below)	No transformation

*Include only where HIV/AIDS is a major cause of child mortality

2. Component 1 score as an estimate of under 5 mortality (U5MR)

The level of under 5 mortality does not need to be measured directly to use this method. At baseline, we use the best estimate available for U5MR in the project area and then for the final U5MR, we use a tool called the Lives Saved Tool, or LiST, available at www.childsurvival.com. The LiST tool has an instruction sheet contained in it, giving a detailed explanation for its use. It converts the coverage changes for 20 key life-saving neonatal-child health behaviors and services into an estimate of child mortality reduction. So the same population outcome data shown in the last table can also be analyzed with the LiST tool—an updated version of the analytical tool used for the 2003 and 2005 Lancet articles on Child and Neonatal Survival. The output will also be a single number as in Option #1; however, in this case, the index value has a specific meaning. It is a measure of how the estimated U5MR compares against "international standards."

Here is an example of how this method of calculating the Component 1 Index Score works. At baseline, either the national level or preferably regional data can be used to get the estimated U5MR in the project area. Demographic and Health Surveys data available online can be used (http://www.statcompiler.com/). If no recent DHS has been done, then the UNICEF website can be checked which has an up-to-date estimate for all countries, www.childinfo.org/. The U5MR is converted to a 0 – 100 score by using the following assumptions:

- The best under five mortality that developing countries have is about 20 per 1,000 live births.
- The worst that developing countries do in terms of under five mortality is over 200 per 1,000 live births.

So if we give the worst case scenario (U5MR $\geq$ 200) an index score of 0 and the best case scenario (U5MR $\leq$ 20) an index score of 100, and then connect these two extremes with a smooth linear curve, we get the following formula to convert a U5MR to a 0 – 100 index score:

$$\text{Component 1 Index Score} = 111 - (0.556 * \text{U5MR})$$

As an example, if the baseline U5MR in the project area was estimated from national U5MR data to be 80, then we would give a baseline Component 1 Index Score = 111 - (0.556 * 80) = 67. At the end of the project, we do not need to have measured U5MR directly. Instead, we plug the project population coverage data for the key interventions in Component 1 into the LiST calculator (the same data as in the last table). Say that the coverage rates for pneumonia treatment, EBF, and ORT are plugged into the LiST tool and that it estimates a 20% drop in U5MR to 64. This would give a final Component 1 Index Score = 111 – (0.556 * 64) = 75.

Maternal Health

For Maternal Health, we use the same logic as for Neonatal/Child Health. That is, the subcomponents of Maternal Health are the main causes of maternal health/illness, as seen in the table below. Ideally, we would have the coverage indicators for evidence-based interventions to combat these six main causes of maternal death, as with child health. Unfortunately, coverage information is not readily available in most countries for these key indicators, so instead it is suggested that Skilled Birth Attendance and Met Need for Essential Obstetric Care stand in as proxy indicators for basic services to cover many of the main causes of maternal mortality (i.e., hemorrhage, hypertension, sepsis, obstructed labor, and abortion).

Subcomponent	Suggested Indicator*	Transformation
Hemorrhage/Anemia	Home birth by Trained Attendant, coverage Skilled Birth Attendance coverage Met Need for Essential Obstetric Care Met Need for modern FP	No transformation
Hypertension/Eclampsia		
Sepsis/Infection		
Obstructed Labor		
Abortion		
HIV/AIDS**	ARV coverage, female-specific, if available	No transformation

*All indicators listed here are explained in Bertrand J., and Escudero G. 2002. Compendium of Indicators for Evaluating Reproductive Health Programs. MEASURE Evaluation **Only in high HIV seroprevalence settings

The LiST tool mentioned in the Child/Neonatal Health subsection will be updated in 2009 to include maternal health. That is, it will add a calculation that will convert population coverage data for evidence-based life-saving interventions into estimates of reductions in the Maternal Mortality Ratio. This might be an alternative way to transform maternal health coverage data in the near future.

Family Planning

"Met need" for modern contraceptive methods is the opposite of the very commonly used FP indicator of "Unmet need." That is, Met Need = 100 – Unmet Need

In other words, if Unmet need is 70 percent, then Met Need is 30 percent. Putting the indicator in this positive way gives a "barometer" of how well the overall local system is functioning in terms of meeting the need for FP, as it is a "functional coverage indicator" for FP in the local system. That is, if this number is zero, then no one who wants FP is getting it and if it is 100 percent, then everyone who wants it is getting it. Below are the instructions from USAID's Flexible Fund survey on how to calculate Unmet Need, available at http://www.flexfund.org/resources/grantee_tools/tab_plan.cfm. To get Met Need, subtract Unmet Need from 100 percent. The percent of Met Need is reported as the FP Outcome Index score.

Indicator	How to Calculate the Indicator
Unmet Need for FP % women of reproductive age (15-49 years) currently married or in union who are fecund (not pregnant or unsure if they are pregnant and not sterilized) who desire to have no more children or postpone childbearing, and who are not currently using a method of FP	$\frac{\text{Number of women 15-49 married or in union (currently married or living with a man) AND who are not pregnant or unsure AND who are not sterilized AND do not want any more children at all or are unsure OR do not want any more children for at least 2 more years AND who are not currently using a method of FP}}{\text{Total number of women 15-49 married or in union (currently married or living with a man) AND who are not pregnant or unsure AND who are not sterilized AND do not want any more children or are unsure OR do not want any more children for at least 2 more years}} \times 100$

Tuberculosis

The suggested Component 1 Tuberculosis Outcome Index is a single number that is meant to give an overall impression of the functioning of TB control in the local system. It is the product of the two standard outcome indicators that are regularly collected and annually reported by the National Tuberculosis Program (NTP). These two indicators are:

- Case Detection Rate (CDR) under DOTS
- Treatment Success Rate (TSR)

When one multiplies these two numbers together, one gets a number that can be interpreted as the "percent of all TB cases in the population that are successfully treated." The catch here is that the CDR is a number based on national data and may be higher or lower in a local area; however, it will usually not be known with certainty what the actual local case detection rate is, so the national estimate is the best that can be feasibly obtained. Fortunately, it will usually give a fairly good sense of the situation with case detection in the area.

This is similar to the MDG Indicator 6.9 which is the "proportion of tuberculosis cases detected and cured under DOTS." The Stop TB Partnership has endorsed the targets, linked to the MDG, to diagnose at least 70 percent of people with sputum smear-positive TB (i.e., under the DOTS strategy), and cure at least 85 percent of these. These are targets set by the World Health Assembly of WHO.

TB detection rate under DOTS (CDR)—Definition and explanation of significance

The term case detection, as used here, means that TB is diagnosed in a patient and is reported within the national surveillance system, and then to WHO. The proportion of estimated new smear-positive cases of TB detected (diagnosed and then notified to WHO) by DOTS programs provides an indication of the effectiveness of national TB programs in finding and diagnosing people with TB. The case-detection rate is calculated as follows:

$$\text{CDR} = \frac{\text{\# of new smear positive cases notified}}{\text{\# of new smear positive cases estimated for that year}} \times 100$$

TB treatment success under DOTS (TSR)—Definition and explanation of significance

TSR is the percentage of new smear-positive TB cases registered under DOTS in a given year that successfully completed treatment, whether with or without bacteriological evidence of success ("cured" or "treatment completed" respectively). At the end of treatment, each patient is assigned one of the following six mutually exclusive treatment outcomes: cured; completed; died; failed; defaulted; and transferred out with outcome unknown. The proportions of cases assigned to these outcomes, plus any additional cases registered for treatment but not assigned to an outcome, add up to 100 percent of cases registered.

Treatment success is an indicator of the performance of national TB control programs. In addition to the obvious benefit to individual patients, successful treatment of infectious cases of TB is essential to prevent the spread of the infection. Detecting and successfully treating a large

proportion of TB cases should have an immediate impact on TB prevalence and mortality. By reducing transmission, successfully treating the majority of cases will also affect, with some delay, the incidence of disease.

HIV/AIDS

The 5 main outcome (coverage) indicators listed in Table 3.3 on page 47 are in various tools. They should be combined into a single average number to give the HIV/AIDS Outcomes Index Score.

Component 2—Health Service Provision (Access/Quality)

The CSTS Rapid Health Facility (R-HFA) automatically calculates the value of the Component 2 index. It can be found at www.childsurvival.com. There is no transformation of the indicators. They are indices of attainment of the subcomponent. For example, the Drugs indicator has 5 main drugs. If the health facilities assessed, had 3.0 of these essential drugs, on average, then the percentage of attainment is 3/5 = 60% attainment. Each of the indicators on the R-HFA is calculated this way. The R-HFA data sheets then automatically calculate a Quality Score which is an average of ten of these indicators (note, health worker performance combines three separate indicators):

- Staffing
- Infrastructure
- Supplies
- Drugs
- Infection control
- Community-health facility relations
- Health worker technical performance (assessment, treatment, counseling)
- Client satisfaction

This is the average Quality Score for the assessed health facilities. This Quality Score is multiplied by the Geographic Access Score to give the overall Component 2 score. The Geographic Access score is calculated by the R-HFA tool using the standard WHO definition of Geographic Access. That is, members of a community have geographic access to services if they are within 5 kilometers and no more than 1 hour by means of local transport year-round. There is a mapping exercise in the R-HFA to calculate the Geographic Access Score. It can also be estimated by knowledgeable informants from the local system. As an example of the calculation of the Component 2 index score, imagine that the Quality Score for the assessed group of health facilities is 65 percent and that there is 70 percent geographic access, the Component 2 Index Score would be 65% × 70% = 46. The meaning of this score is that 46 percent of the population has access to services *of sufficient quality*.

NOTE: The R-HFA calculates a separate Quality Index and Access Score for Community Health Workers. This can be added to the Health Facility Index to give a total score. As an example, imagine that the date in the example above is the baseline Component 2 score (i.e., 46) and that a project decides to increase access through trained CHWs. Say that they reached the remaining 30 percent of the population without access to services with CHWs. Imagine also that the Quality Score was 55 percent, then the CHW Index would be 30% × 55% = 17. Then the overall Component 2 Index Score would be the sum of the Health Facility Score and the CHW Score. In this case, it would be 46 + 17 = 63.

Component 3—District/MOH Organizational Capacity and Viability (support for service provision)

The R-HFA DHO module automatically calculates the value of the Component 3 index. It can be found at www.childsurvival.com. The DHO Module of the R-HFA calculates the Component 3 District/MOH Capacity and Viability Index Score from the following six capacity subcomponents and two viability components. A capacity score is calculated as an average score of the six capacity subcomponents. A separate viability score is calculated as an average of the two viability subcomponents. Averaging these two scores gives the Component 3 Index Score.

Capacity

- Structure and Administration
- Planning
- Budget management
- Guidelines/Norms
- Training
- Supervision
- Data for decisionmaking

Viability

- Financial Resources
- Coordination with key actors (civil society, donors, technical agencies)

Component 4—NGO Organizational Capacity and Viability (support for community capacity)

The SHOUT OCVAT automatically calculates the value of the Component 4 index. It can be found at www.childsurvival.com. The tool measures attainment of 46 indicators on a 0 to 100 scale. The scores of three to five indicators per subcomponent are combined to yield the following nine subcomponents of capacity and three subcomponents of viability:

Capacity

- Governance and legal structure
- Human resources and HR management
- Management systems and practices
- Financial management
- Technical capacity
- M&E/Organizational learning
- Organizational leadership
- Equity and empowerment (focusing on gender equity)
- Organizational performance

Viability

- Resource mobilization
- Networking and external relations
- Institutionalization of key competencies

The nine subcomponent scores under Capacity are averaged to give a Capacity Score, and the three subcomponents of viability are averaged to give a viability score. These two scores are then averaged to give the Component 4 Index Score.

Component 5—Community Capacity

The Health Communication Partnership Community Capacity Assessment tool and the PLAN Malaria Competent Communities tool (based on a previous AIDS Competent Communities tool developed by SAWSO) are recommended for the measurement of Component 5. The HCP tool is available at http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/ cac.htm; the PLAN tool is available at www.childsurvival.com. The following table shows the seven subcomponents of Component 5 and where they can be found in each of the recommended tools.

Component 5 Subcomponents	Health Communication Partnership Tool	Malaria/AIDS Competent Communities Tool
5.1 Community Organization for Health	Organization	Ways of deploying our strength
5.2 Participation/Mobilization	Participation	Gender-driven response Inclusion of vulnerable
5.3 Awareness/Knowledge	Needs assessment	Malaria is a fact of life Acknowledgement Adapting our response
5.4 Attitudes (Openness, Resilience)	Consciousness	Learning and transfer Adapting our response
5.5 Programmatic Involvement	Programmatic involvement	Measuring change
5.6 Linkages	Linkages	TOOL DOES NOT HAVE ANYTHING FOR THIS SUBCOMPONENT
5.7 Resource Mobilization	Financial Management	Mobilizing resources

Both tools use scales of 1–5 for all their indicators. The scores that you get for each indicator should be converted to scales of 0–100 in the following way, and then averaged to get a Component 5 Index Score:

Tool Score	Transformed Score
1	10
2	30
3	50
4	70
5	90

Component 6—Enabling Environment

Component 6 describes the enabling environment. It is important to remember that the radar diagram a project creates is a snapshot of one point in time. To get an idea of trends in the key indicators, a project can take measurements at various points in time, but observing trends related to Component 6 is probably only possible every 5 years or so, given the macro nature of some of the measures (e.g., HDI, etc.).

Unlike other components, health projects do not usually directly affect the subcomponents of Component 6. The exception to this may be Health Policy. A project may be able to advocate effectively for changes in policy that can affect the sustainability of key interventions. Another consideration is that an NGO may be involved programming in the project area in other sectors with health effect (e.g., income generation, education). Including personnel from these other sectors in planning and indicator measurement would almost certainly be beneficial.

Even though the project does not have the power to affect some of the subcomponents of the enabling environment, these subcomponents still affect project achievement and the potential for sustaining health gains. Therefore, an "environmental scan" with valid measures of this component is still important for making programmatic decisions, especially for actions to mitigate risk. Different aspects of the environment will continuously facilitate or inhibit the potential for sustainability. The environment constantly exerts pressure on the local system, requiring it to adapt to or try to mitigate the situation. In short, one cannot describe the prospects for sustainability without accounting for subcomponents of the enabling environment. One should do an "environmental scan" to see if there are any threats in specific areas with the most effect on health outcomes The environmental scan should include the following six general areas (the content of each area may vary from project to project):

6.1 Health Policy and Government Commitment to Health

The specific policy issues to be addressed will depend on the technical focus of the project. But clearly, the level of commitment and resources devoted to health will be a major factor in what is possible to implement and sustain.

6.2 Governance and Civil Stability

There are various measures to ascertain whether government institutions function and are trusted. This is critical for support of government-sponsored health services and for the climate in which civil society operates. Specifically, in terms of civil stability, in areas where there is disruption because of war or insurrection, there will be disruption of services, strains in social networks, and in the extreme physical displacement of people. Disruption of this sort makes gains in health tenuous at best. When the situation is at its worst, maybe immediately post-conflict, projects will have to be cautious in what they promise with regards to sustainability.

6.3 Strength of Civil Society

Gains in specific local organizational capabilities (captured in Component 5 for community-based associations) can be supported, maintained or hindered by the social environment in which civil society operates overall. The World Bank and others have summary national measures for this.

6.4 Human Development

Large swings in the economic and development landscape can make for shifting priorities among organizations and individuals that may threaten health gains. For instance, in a situation of drought or even famine, subsistence will predominate over health in terms of national, local, and household priorities. The UNDP (UNDP) computes a summary measure of human development—the HDI—for all countries on a periodic basis. UNDP country offices sometimes compute this score for subnational regions as well. Progress on the HDI (which includes summary measures about education standards) certainly supports greater expectations for what can be sustained. In the Americas, PAHO uses a similar summary measure known as Unfulfilled Basic Needs (NBI, in Spanish).

6.5 Gender Empowerment

The role of women is critical in population health gains, as they are the main caregivers for themselves and their family members. Values related to women, in terms of their decisionmaking authority and power within the household will either endanger or solidify their ability to act in order to effect positive health changes. This correlates with their level of education and literacy.

6.6 Natural Environmental Factors

Many areas can be hit by natural disasters, quickly wiping out gains in health and development. Obviously, some geographic regions are more prone than others to disruptive natural phenomena. The profile of vulnerabilities will vary as well—some areas are prone to drought, thus affecting food security and nutrition; others to quicker onset disasters causing massive service disruption and/or displacement of populations (e.g., earthquakes, tsunamis, hurricanes, flooding, etc.). Unfortunately, the poor are always disproportionately affected by natural disasters. There are indices of environmental vulnerability at the national level, for instance that of the UNEP, known as the EVI.

Whatever you decide, in terms of measures, be sure to document it clearly and then consistently measure the same subcomponents in the same way throughout the project and possibly beyond. Here are a few specific recommendations on how to go about doing the environmental scan:

Do a scan across all six of the subcomponents and use the most appropriate measure for each (the main suggestions for tools are in Table 3.9 in Chapter 3; there are additional measures in the table in this chapter):

6.1 Health Policy and Government Commitment to Health
6.2 Governance and Civil Stability
6.3 Strength of Civil Society
6.4 Human Development (i.e., socioeconomic status, education, and health)
6.5 Gender Empowerment
6.6 Natural Environmental Factors (i.e., vulnerability to disasters)

National-level data will most likely be available, but the results they give should be inspected and adjusted to fit the local context. For instance, the HDI might be in the moderate range, but the district in which the project is located is known to be worse than the national average. This should be taken into account and the score downgraded. Remember that using standard and consistent

measures is necessary for validity and comparability. Specific suggested measures are given in the table in Chapter 3 in the subsection for Component 6. Some additional measures are shown in the table below. But adaptation to local circumstances will make the information the most useful to your situation.

As with the components within the SF, the subcomponents of Component 6 are not completely mutually exclusive or independent. Rather, they can be interdependent. You should describe the situation as best you can, by scanning these six main subcomponents. There is not an exact or infallible measure of this component. There may be more appropriate measures for any of the subcomponents to best describe the local situation. Below is a table with some additional suggestions beyond those given in Chapter 3.

Subcomponent	Index	Data Source
a. Health Policy and Government Commitment to Health	Commitment to Health	Center for Global Development http://www.cgdev.org/content/publications/detail/10016
b. Governance and Civil Stability	Voice and Accountability	World Governance Indicators http://info.worldbank.org/governance/wgi/index.asp
	Political Stability and Absence of Violence	World Governance Indicators http://info.worldbank.org/governance/wgi/index.asp
	Government Effectiveness	World Governance Indicators http://info.worldbank.org/governance/wgi/index.asp
	Regulatory Quality	World Governance Indicators http://info.worldbank.org/governance/wgi/index.asp
	Rule of Law	World Governance Indicators http://info.worldbank.org/governance/wgi/index.asp
	Corruption Perception Index	Transparency International www.transparency.org/policy_research/surveys_indices/cpi
c. Strength of Civil Society	Civil Society Strength Indicator	Freedom House www.freedomhouse.org
	Indicator of Civil Liberties and Political Rights	Freedom House www.freedomhouse.org
d. Human Development	Human Development Index	UNDP http://hdr.undp.org/en/
	Human Poverty Index[14]	UNDP http://hdrstats.undp.org/indicators/18.html
	Progress toward Millennium Development Goals (MDGs)	UNDP www.mdgmonitor.org
	Gini Coefficient (Measure of Income Inequality)	World Development Indicators www.worldbank.org/data
	Equitable Access to Education and Health	World Development Indicators www.worldbank.org/data

[14]The Human Poverty Index is an indication of the standard of living in a country, developed by the United Nations. For highly developed countries, the UN considers that it can better reflect the extent of deprivation compared to the Human Development Index. It is a measure of the extent to which people in a country are not benefitting from development. Where HDI consists of three main components; longevity, knowledge and standard of living, and assesses these components as development. HPI assesses the same three components from an opposite point of view to take into account factors that HDI does not include.

Subcomponent	Index	Data Source
e. Gender Empowerment	Gender-Related Development Index	UNDP http://hdr.undp.org/en/statistics/indices/gdi_gem/
	Gender Empowerment Measure	UNDP http://hdr.undp.org/en/statistics/indices/gdi_gem/
	Share of women in political office	UNDP
f. Ecological Environment and Natural Factors	Environmental Risk Index	United Nations Environment Programme (UNEP)—Environmental Vulnerability Index (EVI), especially the questions related to disasters): http://www.vulnerabilityindex.net/EVI_2005.htm
General/Cross-Cutting	Quality of Life Index	The Economist's Intelligence Unit www.economist.com/media/pdf/quality_of_life.pdf

Some local-level factors to consider when discussing national data to determine if it should be adjusted to fit local situation

6.1 Health Policy and Government Commitment to Health

- State of decentralization (e.g., share of central budget transferred to local authorities)
- Is access to care in the local area better or worse than the average national situation?

6.2 Governance and Civil Stability

- Existence of regular and free local elections
- Share of population voting in local elections
- Citizen participation in local government meetings
- Any localized civil instability?

6.3 Strength of Civil Society

- Membership in voluntary organizations
- Density of networks and associations
- Presence of a particularly strong NGO/CBO/FBO in the area?

6.4 Human Development

- Is the local area generally better or worse off than the national average in terms of socio-economic status, access to education?

6.5 Women's Empowerment

- Are there any local cultural patterns that make things significantly worse or better in the area for women than generally?

6.6 Natural Environmental Factors

- Local vulnerability to disasters, because of specific local ecological conditions or population-specific factors (e.g., location in flood plain)

Notes on calculations for transformation of indicators

By way of review, the steps involved in data analysis for the each of the six components of the SF are as follows:

STEP 4: Adapt tools/indicators to local context and measure indicators for all 6 components and the 50 or so subcomponents of the SF
STEP 5a: Transform indicator values to scores
STEP 5b: Average transformed scores into subcomponent indices
STEP 5c: Average subcomponent indices to construct component indices

Steps 4, 5b, and 5c are all fairly straightforward (adapt, measure, average, average). It is Step 5a that may be unfamiliar. First, the reason why this is done is so that data can all be combined and compared on the same type of scale. This allows us to examine and present a large diversity of data in a simple way, which, in turn, makes it easier to discern patterns and make programmatic decisions. If you use the tools suggested in this manual and available at the Sustainability Page at www.childsurvival.com, you will not need to transform any of the indicators; however, if you are using other tools, you will need to do this step yourself. This discussion will allow you to do that.

Simple (linear) transformation

The default transformation is this one shown here. That is, in the absence of some compelling reason to change the data, an indicator that can take on continuous values from 0 to 100 percent is "transformed" by simply putting it on a 0 to 100 index scale with exactly the same value. The principle of this type of transformation will also work when the indicator might only be able to take on values of, say 0 to 50, but we still want to transform to a 0 to 100 index score. We will simply say that the minimum indicator value of 0 maps to an index score of 0 and that the maximum indicator value of 50 will transform to an Index Score of 100 (i.e., the indicator value must be multiplied by 2 to arrive at the Index Score.)

Indicator Status	Range of Score Values for each Band	Indicator Benchmarks
Strong	81–100	81–100
Promising	61–80	61–80
Intermediate	41–60	41–60
Emerging	21–40	21–40
Poor	0–20	0–20

Transformation of categorical (ordinal) data

What should be done with data such as those produced, for instance, by many organizational capacity assessment tools? For many such tools, respondents are asked to rate attainment of an indicator on a scale of 1-to-5. A "1" means no attainment of the attribute, and a "5" means perfect attainment. So, when we go to map this onto a 0–100 index scale for the subcomponent score, a "1" (no attainment) is equivalent to a 0, and a "5" to 100. We could just multiply the value of the indicator by 20. That is, a 1 is a 20, 2 a 40, 3 a 60, 4 an 80, and 5 a 100; however, you can see that no one could ever get a socre of 0 with such a transformation. So, to give a slightly better approximation, we transform in the following way: "1" = 10, "2" = 30, "3" = 50, "4" = 70, and "5" = 90. This is how we transform the two tools suggested for Component 5.

Non-linear transformation

Sometimes we will not want to transform quantitative data exactly linearly. There should be a rationale for this. In the example here, the data in the table below show the transformation for measles immunization coverage data. You will notice that the data is not transformed linearly. That is, to attain a score of 20, immunization coverage has to reach 40. The index value then rises in fairly steady steps up to full coverage. The rationale for this transformation is from categorization of performance of country EPI programs done by WHO. More in-depth discussion of the reasons for transforming non-linearly and how to do this are in the references on the Sustainability Page at www.childsurvival.com.

Indicator Status	Indicator Values	Index Score
Strong	90.1–100	80.1–100
Promising	80.1–90	60.1–80
Intermediate	60.1–80	40.1–60
Emerging	40.1–60	20.1–40
Poor	< 40	0–20

"Reverse" transformations

What should you do with data on such topics as on malnutrition or stock-outs? That is, the lower these indicator values go, the better, which is the opposite direction from that of the usual situation, where higher values are better. In this case, we need to do a "reverse transformation." This might be linear or nonlinear. If such reverse transformations are needed, we subtract the maximum value the indicator can take from the measured value and then take its absolute value before transforming it.

A final word

So, we've covered all the possibilities: linear or nonlinear, forward or reverse, continuous or ordinal data. If you use the tools suggested in this manual for the measurement of each of the components, then most of the transformation work is already done for you, as these tools perform the transformation or suggest how to perform it. The following table summarizes this process.

Component	Step 1: Measure Indicators	Step 2: Transform to Subcomponent Scores	Step 3: Combine to get Component Index Score
1. Health Outcomes			
Neonatal/Child Health	KPC/CATCH	Standard transformation in Annex 3 or LiST	Average of all 16-20 subcomponents
Maternal Health	KPC/MNH Module	Standard transform (Annex 3) or LiST	Average of 4 indicators
FP	Met Need (various tools)	No transformation	N/A
TB	MOH/NTP data	No transformation	TB Outcome Index (CDR estimate × TSR)
HIV/AIDS	Key coverage indicators (various tools)	No transformation	Average of relevant subcomponents
2. Health Services (Access and Quality)	CSTS Rapid Health Facility Assessment Tool	No transformation	Quality Score × Access Score Quality Score = Average of 10 subcomponents Access Score = Geographic Access
3. DHO Capacity and Viability	CSTS Rapid Health Facility Assessment, DHO module	Ordinal transformation for some indicators	Average of 8 subcomponents
4: NGO Capacity and Viability	SHOUT OCVAT	Ordinal transformation	Average of 12 subcomponents
5. Community Capacity	Modified HCP Community Capacity Tool	Ordinal transformation	Average of 7 subcomponents
6. Enabling Environment	Standard indices (after adjustment for local system)	Data already transformed	Average of 6 subcomponent indices

For those using these tools but still interested in how the transformations are done or for those choosing other tools and having to do these transformations themselves, the following illustration shows the general function for performing transformations, based on the idea of linear interpolation:

Calculating a score from an indicator value:

When the scale goes up (higher score for higher indicator values)

$$\text{Score} = \text{Base score for indicator status band} + \left[\frac{(\text{Measured value of indicator}) - (\text{Minimum indicator value for band})}{(\text{Maximum indicator value for band}) - (\text{Minimum indicator value for band})} * 20 \right]$$

When the scale goes down (lower score for higher indicator values)

$$\text{Score} = \text{Base score for indicator status band} + \left[\frac{(\text{Maximum indicator value for band}) - (\text{Measured value of indicator})}{(\text{Maximum indicator value for band}) - (\text{Minimum indicator value for band})} * 20 \right]$$