MANUAL

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

MANUAL (WITHOUT ANNEXES)

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This manual represents the "latest chapter" of work that began in 2002 with the Sustainability Initiative at Child Survival Technical Support (CSTS). The original framework was called the Child Survival Sustainability Assessment. As it has become more generalized and applied in a number of contexts, it was renamed the Sustainability Framework (SF). This framework, along with its tools and methods, has evolved over the intervening years through its application in projects and consultations with field and headquarters staff. This manual systematizes and crystallizes that experience. With so much interest in the concept of sustainability, this manual comes at an opportune time. It is not meant to be the definitive statement, but rather serves as a signpost on the long road of learning about this critical topic. We hope that it spurs more advancement in the field and helps those who would like to improve the sustainability of project-initiated health gains.

Many colleagues at Child Survival Technical Support Plus Project, the U.S. Agency for International Development (USAID), and private voluntary organizations/nongovernmental organizations (PVOs/NGOs) have contributed to the development of the Sustainability Framework and of this document. PVO headquarters and field staff contributed directly and through the experiences of their practice. We would particularly like to thank the following PVO staff, who made substantial contributions to this manual—Michelle Kouletio, Will Story, Laban Tsuma, and Rozalin Wise. We would also like to thank Chris Bessenecker and Karl Blanchet, two experienced consultants who have helped refine the thinking by applying the Sustainability Framework and have given great advice on the writing of this manual. We would also like to thank the Adventist Development and Relief Agency, CARE, Concern Worldwide, Christian Reformed World Relief Committee, Doctors of the World, International Rescue Committee, PLAN International, Project Concern International, Project Hope, Save the Children, and World Vision for their work in applying the Sustainability Framework and advancing its development. Several people at USAID/Washington have helped advance the Sustainability Framework then and now—Namita Agravat, Sharon Arscott-Mills, Sheila Lutjens, and Erika Lutz. Sheila and Sharon (as well as Deepak Paudel) also gave substantial support in developing the Sustainability Framework while at USAID/Nepal. Finally, we thank Bart Lawrence, Sheila Lopes and the Macro editing staff as well as Cheryl Deal and the Graphic staff at Macro for their extensive work on this manual.

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For further information about the Child Survival and Health Grants Program, please visit its website at http://www.usaid.gov/our_work/global_health/home/Funding/cs_grants/cs_index.html.

For more information related to sustainability that has been produced by CSTS+ and its partners, please visit CSTS's Sustainability page at http://www.childsurvival.com/documents/CSTS/Sustainability.cfm or e-mail them at csts@macrointernational.com.

We wish you the best in your endeavors to sustain the health gains of your projects. If you want to share your experiences, you can join the Sustained Health Outcomes (SHOUT) Group by sending a message to List_SHOUT@childsurvival.com.

GLOSSARY: COMMONLY USED TERMS IN THE SUSTAINABILITY FRAMEWORK

Capacity	Capacity refers to the ability of an organization, institution, or community to apply skills and resources to accomplish goals and satisfy stakeholder expectations. Components 2, 3, 4, and 5 of the Sustainability Framework (SF) refer to various capacities of actors in the local system—health service deliverers (Component 2), communities (Component 5), and the organizations that support health services and communities (Components 3 and 4).
Component	There are a total of six divisions of the SF (known as *components*): 1. Health outcomes 2. Health service delivery (quality and access) 3. Ministry of Health (MOH) district organizational capacity and viability 4. Main local nongovernmental organization (NGO) organizational capacity and viability 5. Community capacity 6. Enabling environment.
Enabling Environment	To paraphrase the World Bank, an enabling environment is a set of conditions that affect the ability of actors in the local system to meet their goals in an effective and sustained manner. It includes legal and regulatory/policy frameworks and political, sociocultural, and economic factors. This is measured in Component 6 of the SF.
Goal	A higher-level result to which a project contributes, but which lies beyond the responsibility of the project alone; for example, "Improved health outcomes for women and children under five." Within a project using the SF, the project goal should be supplemented with the vision of the local system (see below) in order to encourage local actors to think beyond the project itself.
Health Outcomes	This is a measure of the health status of the appropriate population. This is Component 1 of the SF. The subcomponents of Component 1 are the health conditions that are most important in contributing to population health status. The indicators for Component 1 are measurements of coverage for key health services and household behaviors that most affect these health conditions.
Index Scale	This refers to the single numerical measure for the attainment of each of the components of the SF. The index scales of the SF are all constructed to take values from 0 to 100. The way the indices are constructed is standard in order to give a clear, intuitive, and valid picture of the attainment of the component. An index value of 0 means that there is no attainment of that component, and a value of 100 means complete or ideal attainment of that component, even if the project does not set as a target this ideal level of attainment. In other words, "100" on the scale does not mean simply the level of attainment targeted by the project. As an example of the thinking in the construction of an index scale, for Component 4 (main local NGO organizational capacity and viability) there is a subcomponent of resource mobilization. A "100" level of attainment is 100 percent cost coverage, even if the project realizes this value is not attainable during the project period and only sets a target of, say, 60 percent cost coverage.

Glossary—*Continued*

Indicator	A clearly stated measure of attainment of a subcomponent (see explanation below in this Glossary) or part of a subcomponent. An indicator can be constructed in a categorical manner. For instance, an indicator for management capacity (a subcomponent of Component 3—local organizational capacity) might be "Management committee meeting at least monthly." Indicators can also be constructed in a quantitative manner. For instance, another formulation of this indicator could be "Percentage of months in the last year during which the management committee met."
Local System	The stakeholders that affect health outcomes, acting within the area (usually, but not always, the geographic area) of interest. These actors include at least the health facilities, critical governmental and civil society organizations, and communities and their members.
Objective	This provides information as to what and when a key outcome will be attained, and quantifies the amount of change expected. Traditional project objectives focus on health outcomes (Component 1) and often service delivery capacity (Component 2). The SF helps project staff plan to improve local capacity and viability to sustain these health outcomes. Measurement of these other capacities is included in the other components of the SF. It is suggested that measurements for all the subcomponents of the SF be included in the project's Results Framework or Logical Framework, each with their own objectives, in order to make sure the project's priorities align with the priorities of the local system.
Radar Diagram	Visual representation of the results of measuring attainment of each of the six components of the SF. Attainment is measured as an index score from 0 to 100. These scores are plotted on the six-sided radar diagram. Examples can be seen in Chapter 3.
Stakeholder	A person or organization that has direct or indirect interest in project-initiated activities because it can affect or be affected by them. Key stakeholders can include local system actors such as beneficiaries and community groups, public and private health care providers, and those working in local NGOs. Those that are outside the local system but influence it are also stakeholders. This category of stakeholder can include the national MOH or other government agencies, the donor, and other donor or technical agencies with activities in the local system. Not all stakeholders are equal. Different stakeholders ought to be treated differently by programmers, according to their interest and influence. A tool for local system and stakeholder analysis is included in Annex 2.
Subcomponent	Components comprise specific items or *subcomponents*. There are about 50 subcomponents in the SF. As an example of a subcomponent, Component 4 (local NGO organizational capacity) has 12 subcomponents. Some of these subcomponents are legal structure and governance, human resources and administration, management systems and practices, and financial management. Attainment of these subcomponents is measured with specific indicators, their values transformed to scores of 0 to 100 and combined to give subcomponent scores. Finally the subcomponent scores are averaged to give each of the six component index scores.

Glossary—*Continued*

Sustainability	Sustainability is a process that advances conditions that enable individuals, communities, and local organizations to improve their functionality, develop mutual relationships of support and accountability, and decrease dependency on insecure resources (institutional, technical, financial). Sustainability enables these local stakeholders play their respective roles effectively, thus maintaining gains in health and development beyond the project period. The individuals, communities, health services, and local organizations constitute a local system (see above) interacting with and embedded in a larger environment. The efforts and interactions of these actors in the local system are what lead to lasting health impact. Their efforts will be based on their own understanding of their community's health and development.
Sustainability Framework	A conceptual structure and set of tools to systematically plan for and evaluate progress toward sustainable improvements in health outcomes in a defined population.
Sustainability Scenario	The sustainability scenario is a clear consensus statement by stakeholders in the local system of how they believe that their vision (see below) of a healthy population will be attained and sustained. By stating this scenario clearly, the roadmap to attain this vision is made more clear and explicit. This, in turn, gives guidance as to how to plan for the roles and activities of the key actors, and finally of the subcomponents that should be monitored to track progress in each of the components of the SF. An example of a sustainability scenario that would correspond to the vision below might be "In order to attain our vision of improved child health in a sustainable manner, we will improve the supervisory and logistics systems in primary health facilities, strengthen local village health committees and mother's groups to deliver sustained behavior change among mothers for key household behaviors, and advocate for policy change to allow for community case management of sick children."
Tool	An instrument for measuring progress in one of the components of the SF. Annex 2 has suggested management tools for assessing, planning, monitoring, and structuring evaluations. Annex 3 has suggested tools for measuring progress on each of the components. Projects are also free to use or develop their own tools that measure the same components and subcomponents, as long as the information produced and scales constructed follow the principles outlined in Chapter 3.
Viability	The ability of an organization or community to secure resources (institutional, technical, and financial) for its role in advancing population health in a given local system.
Vision	This is a term taken from organizational strategic planning. In the case of the SF, the vision is a description of the idealized long-term health situation that the local system actors are striving to attain and sustain. This should be a consensus of the local system actors. An example of a vision might be "Children will not die of preventable causes. They will find quality care in well-managed health centers and be cared for by well-informed families."

ABBREVIATION LIST

ACT	Artemesenin Combination Therapy
ART	Anti-Retroviral Therapy
BF	Breastfeeding
CATCH	Core
CBIO	Community-Based Impact-Oriented
CBO	Community-Based Organization
CDR	Case Detection Rate
CHW	Community Health Worker
CORE	A Network of U.S.-based Private Voluntary Organizations Working in Health Programming
CRWRC	Christian Reformed World Relief Committee
CSHGP	Child Survival and Health Grants Program
CSSA	Child Survival Sustainability Assessment
CSTS	Child Survival Technical Support
CSTS+	Child Survival Technical Support Plus Project
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DOTS	Directly Observed Therapy, Short Course
DPT1	1st Immunization for Diphtheria, Pertussis, and Tetanus
DPT3	3rd Immunization for Diphtheria, Pertussis, and Tetanus
EBF	Exclusive Breastfeeding
EVI	Environmental Vulnerability Index
FAQs	Frequently Asked Questions
FGD	Focus Group Discussion
FP	Family Planning
GDI	Gender Development Index
HBC	Home-Based Care

HCP	Health Communication Partnership
HDI	Human Development Index
HiCAP	Health Institution Capacity Assessment Process
HR	Human Resources
HW	Health Worker
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Result
KPC	Knowledge, Practice, and Coverage
LAM	Lactation Amenorrhea Method
LiST	Lives Saved Tool
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MNH	Maternal and Neonatal Health
MOH	Ministry of Health
NBI	Unfulfilled Basic Needs (*Necesidades Basicas Insatisfechas*)
NCHS	National Center for Health Statistics
NGO	Nongovernmental Organization
NTP	National Tuberculosis Program
OCVAT	Organizational Capacity and Viability Assessment Tool
OI	Opportunistic Infections
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PC	Palliative Care
PHC	Primary Health Care
PLAN	A Private Voluntary Organization Working in Health & Development
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
POU	Point of Use

PVO	Private Voluntary Organization
RF	Results Framework
RHF	Recommended Home Fluids (for diarrhea treatment)
R-HFA	Rapid Health Facility Assessment
SAWSO	Salvation Army World Service Organization
SD	Sustainable Development
SF	Sustainability Framework
SHOUT	Sustained Health Outcomes
TB	Tuberculosis
TBA	Traditional Birth Attendant
TSR	Treatment Success Rate
TT	Tetanus Toxoid
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Family Planning Agency
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VDC	Village Development Committee
VHC	Village Health Committee
WHC	Ward Health Committee (a local government-mandated structure in Bangladesh)
WHO	World Health Organization

INTRODUCTION

This manual is designed to assist project managers, planners, and evaluators in their efforts to improve their approaches to planning for and assessing sustainability in health projects implemented in developing countries. It is intended as a practical guide for health project managers, especially those implementing community health projects in resource-constrained settings. It focuses on a specific framework, the Sustainability Framework (SF), developed through the U.S. Agency for International Development's (USAID) Child Survival and Health Grants Program (CSHGP).[1] This manual represents the collective learning of about 30 projects that have applied and helped refine it over a 7-year period, many of them CSHGP-funded projects. It has been used for project planning, monitoring, end-of-project evaluation, and post-project evaluation.[2] If you're wondering whether this manual fits your needs, Table 1 offers some guidance on deciding.

Table 1:
Is this Manual for Me?

This manual *is* for you if—	This manual *is not* for you if—
You are looking for practical suggestions and guidance to— • Integrate best practices in sustainability design from the initial planning stages of your project through key review stages. • Apply sustainability concepts to an ongoing or soon-to-end project. • Improve how you track progress toward sustainable health outcomes of the intended beneficiary population and how you present this progress to stakeholders.	• You want to explore sustainability at a conceptual level only. • Your interest is exclusively on institutional sustainability or financial viability. Although this manual covers those aspects, our focus is broader. We are interested in sustaining health outcomes through the totality of institutional sustainability, financial sustainability, behavioral sustainability, and other aspects of sustainability. • You are interested in research design rather than program design, management, and evaluation. We are also interested in research, and the SHOUT Group[3] would love to hear about your ideas. This manual probably won't meet all your needs, although its evaluation and measurement sections might still prove useful to you. • You are interested in the broader concept of sustainable development (SD). Although some of the concepts come from SD, the question we set to answer in this guide is whether health benefits are sustained, not whether programs are environmentally sustainable, as covered in SD.

[1] See the textbox on the next page.
[2] For a rapid review of recent experiences, see: Sarriot, E., Ricca, J., Ryan, L., & Basnet, J. (2008). Measuring sustainability as a programming tool for health sector investments—report from a pilot sustainability assessment in five Nepalese health districts. *International Journal of Health Planning and Management, 23,* 1-25. For an application outside of Child Survival, see: Jacobs, B., Price, N., & Sam, S. O. (2007). A sustainability assessment of a health equity fund initiative in Cambodia. *International Journal of Health Planning and Management, 22,* 183-203.
[3] The Sustained Health Outcomes (SHOUT) Group is a community of practice for health programmers interested in advancing practical learning about sustainability in community-oriented health and development programs. For more information on SHOUT, send an e-mail to SHOUT@childsurvival.com.

We present a specific method to plan for, manage, and measure progress toward sustainability that can help you to—

- Plan and manage your interventions by thinking systematically about the essential components that will support the long-term maintenance of health outcomes in the appropriate population.

- Develop an Evaluation Framework that you can fully integrate with your Results Framework or Logical Framework in order to assess the progress made by local stakeholders toward a sustainable process of health improvement.

Thinking and practice using the SF represents a comprehensive attempt to synthesize research and evidence on sustainability and apply it in practical terms to community-oriented programs. Those who have done so have found that it has helped projects and their partners to (1) understand better what constitutes sustainability and (2) better respect essential "pro-sustainability" principles[4] in project design and implementation, thus steering them toward achieving a more lasting impact in their work with some of the world's neediest communities.

The research, lessons, and experiences that have led us to this point began in 2000 through an effort to provide clearer guidance and rigor to the sustainability plans generated through the CSHGP; it has since expanded to applications in projects not sponsored by USAID and to programming in family planning, tuberculosis, HIV/AIDS, and other health areas.[5] The projects that have used the SF have been community-oriented, but they have been implemented at various scales—from subdistrict-level programs to programs operated in multiple municipalities in Bangladesh, and from multidistrict

USAID Child Survival and Health Grants Program

Since 1985, the USAID Child Survival and Health Grants Program (CSHGP) has promoted innovations for community-oriented programming and local capacity building, including at the community level. Projects deliver evidence-based and integrated maternal, newborn, and child health interventions along a continuum of care to vulnerable populations. These projects are grants to U.S.-based PVOs, which implement in partnership with the MOH (district and sometimes regional/national), local NGOs and CBOs, and communities in order to sustainably improve child survival and health outcomes. They are coordinated with USAID Missions and other global and national stakeholders.

Since its inception, CSHGP has reached over 222 million beneficiaries in poor and underserved communities in 62 countries through 428 grants to over 50 different PVOs. The grants from USAID range from $1.25 to $4 million over 4 to 5 years and require a 25 percent match by the PVO.

Projects have demonstrated consistent improvements in health outcomes in vulnerable populations (e.g. rates for vaccination, exclusive breastfeeding, etc.), usually at levels that surpass concurrent coverage increases achieved at the national level.

[4] It is important to understand that externally funded interventions in a resource-constrained environment naturally disrupt the system even while bringing valuable benefits. "Pro-sustainability" principles are those that decrease undesirable effects on the local system and increase the capacity of local stakeholders to cohesively plan and manage a better future. Chapter 2 discusses further what is meant by "pro-sustainability" planning in practice.

[5] Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf. Also see: Sarriot, E. (2002). *Sustaining child survival: Many roads to choose, but do we have a map?* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/csts_new.pdf.

programs in Cameroon to a national-level framework for sustainability planning in Nepal. Our experience to date leads us to believe that health programmers can fruitfully apply the ideas presented in this manual in an even greater variety of settings.

The SF suggests a series of six systematic and iterative steps to plan for sustainability and to measure progress toward sustainability. It also has a toolbox of standard management and measurement tools. Considering that project designers and implementers rarely find themselves in the conditions that would allow an "academic" step-by-step approach, this manual is also written for those who might be operating projects in less-than-ideal circumstances, referring to field reality and constraints as often as possible. Even if you have not been able to incorporate pro-sustainability thinking from the start, we think you will find this manual useful. You may find yourself in one of the following situations, which we have tried to account for in writing this manual:

- You are thinking of starting a project in a new district or intervention area. Your organization may not have worked in this setting yet, or at least not in the health sector, and you would like to take an explicit pro-sustainability approach from the start.

- You have been awarded a grant for a new project. Your proposal mentioned sustainability, but you are not sure how you will implement these ideas. If you are a grantee of the CSHGP, you are planning to have a Detailed Implementation Plan (DIP) workshop and carry out a series of baseline assessments. But you wonder how all this can fit with your sustainability concerns. Will you have to have a sustainability workshop after your DIP workshop? Would you then have to have a sustainability assessment in addition to all your other baseline assessments? You wonder whether you can integrate all these activities in a way that leaves you with a clear plan.

- Your project is approaching an evaluation phase, and you would like to review the approach to sustainability and better understand what progress was made at a system level.[6]

What you will find in this manual

Chapter 1: **What Is the Sustainability Framework?**	This chapter describes the structure of the Sustainability Framework. It briefly describes key assumptions and how the evidence base for the tool was developed.
Chapter 2: **Using the Sustainability Framework for Project Management—Planning, Designing, Implementing, and Evaluating.**	This chapter describes the suggested steps to follow in order to design a project, to plan it in detail, and to manage it using the Sustainability Framework. The reader is provided practical guidance and referred to tools found in Annex 2: Project Management Toolbox.
Chapter 3: **The Sustainability Framework and Measurement of Progress Toward Sustainability.**	This chapter describes how to use the Sustainability Framework to organize measures for monitoring and evaluation of progress toward sustainability of the local system and the project contribution to this. This chapter also describes how to analyze and present data. Suggested tools are found in Annex 3: Sustainability Framework Measurement Toolbox.

[6] What we mean by "system level" will be explained in this manual.

Afterword: **Stay Involved.**	If you are a new user of this method, we hope this will be a first step and that you will contribute your experience to the SHOUT Group.
Annex 1: **Tips from Practitioners—Answers to Frequently Asked Questions.**	This annex answers frequently asked questions and makes recommendations based on practice, linking pro-sustainability principles to strategies and action.
Annex 2: **Project Management Toolbox.**	This annex contains the tools described in Chapter 2 for use in managing a project using pro-sustainability principles.
Annex 3: **Sustainability Framework Measurement Toolbox.**	This annex contains the tools described in Chapter 3 for use in measuring progress along each of the six components of the Sustainability Framework.

CHAPTER 1: WHAT IS THE SUSTAINABILITY FRAMEWORK?

The Sustainability Framework (SF) is a way to organize thinking about sustainability as well as inform planning, management, and evaluation of activities in order to improve and maintain health outcomes at a population level. The SF is implemented by project staff and local stakeholders. Chapters 2 and 3 and the annexes suggest some tools specifically developed to help manage projects and evaluate progress toward sustainable outcomes. Although these tools are suggested, other tools can be used that gather equivalent information or accomplish equivalent management tasks.

1.1 THE EVIDENCE BASE FOR THE SUSTAINABILITY FRAMEWORK

The SF was developed based on a review of the evidence for what makes the gains in community health projects sustainable, starting with the work of Bossert, Shediac-Rizkallah, Bone, Katabarwa, Lafond, and others.[7] Research on sustainability is scarce overall, but continues to progress in identifying critical factors for sustainability for different interventions and contexts.[8] The evidence that exists, however, does not come from randomized controlled trials or meta-analyses. Little money and effort have been invested in post-project evaluations (even less so, prospectively planned ones), which constitute the most solid basis for evidence-building in the field of sustainability. Those post-project evaluations that have been done often have had vague terms of reference. Not only are post-project studies methodologically difficult (e.g., to design with controls), but they are also rarely able to base themselves on a consistent and prospective data trail. A recent study conducted with Concern Worldwide in Bangladesh represents a substantial effort to remedy this gap in the data,[9] and work conducted by Macro International Inc. with the U.S. Agency for International Development (USAID) in Nepal suggests how to better use the evidence base offered by the SF to develop research applications.[10] The vast majority of evidence on sustainability that exists now is of a weaker variety; that is, it is based on "expert opinion" among development practitioners, gleaned from their own practice experience. Ideas have also emerged from conceptual discussions as to the definition of what sustainability is or should be in health programs, both in developing and developed countries. Finally, it is clear that sustainability is a complex subject, subject to many factors, several of them context-specific. So sustainability is not easily amenable to testing through the acknowledged "gold standard" of evidence, the randomized controlled trial.

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[7] Sarriot, E. (2002). *Sustaining child survival: Many roads to choose, but do we have a map?* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/csts_new.pdf. Also see: Sarriot, E. G., Winch, P. J., Ryan, L. J., Bowie, J., Kouletio, M., Swedberg, E., LeBan, K., Edison, J., Welch, R., & Pacqué, M. C. (2004). A methodological approach and framework for sustainability assessment in NGO-implemented primary health care programs. *International Journal of Health Planning and Management, 19,* 23-41. Available at http://www.childsurvival.com/documents/CSTS/SustainabilityArticleIJHPM_2004_22.pdf.

[8] Amazigo, U., Okeibunor, J., Matovu, V., Zouré, H., Bump, J., & Seketeli, A. (2007). Performance of predictors: Evaluating sustainability in community-directed treatment projects of the African programme for onchocerciasis control. *Social Science & Medicine, 64,* 2070-2082. Available at http://www.who.int/apoc/publications/amazigo_2007.pdf. Also see: Israr, S. M., & Islam, A. (2006). Good governance and sustainability: A case study from Pakistan. *International Journal of Health Planning and Management, 21*(4), 313-325. Also see: Jacobs, B., Price, N., & Sam, S. O. (2007). A sustainability assessment of a health equity fund initiative in Cambodia. *International Journal of Health Planning and Management, 22,* 183-203.

[9] Sarriot, E., Jahan, S., Kouletio, M., Sardar, M., Ali, K. L., Saha, S., & Rasul, I. (2008). *The end of magical thinking: Sustainability evaluation three years after the end of the Saidpur and Parbatipur Urban Health Project. Final report.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/SP_Sustain_June08_f3.pdf.

[10] Sarriot, E., Ricca, J., Ryan, L., & Basnet, J. (2008). Measuring sustainability as a programming tool for health sector investments—report from a pilot sustainability assessment in five Nepalese health districts. *International Journal of Health Planning and Management, 23,* 1-25.

1.2 KEY ASSUMPTIONS OF THE SUSTAINABILITY FRAMEWORK

The SF first emerged as an effort to systematize approaches to sustainability planning and assessment, and to ensure that an evidence base for sustainability is built prospectively instead of retrospectively; for example, seeking to predict and monitor—from the outset—those factors we believe will influence sustainability, as opposed to reflecting on which factors influenced sustainability after the project has ended. This is a central philosophy of this manual. It is grounded in the two key assumptions outlined below.

Sustainability:

A working definition

Simply put, *sustainability* is the ability to sustain population health outcomes.

The Sustainability Framework conceives sustainability as a *process within a local system whose aim is to maintain improved health status*. This local system is composed of local stakeholders (individuals, communities, and local organizations) that operate within a larger environment.

A sustainable process enables these local stakeholders to express their potential through balanced improvements in several key components—service delivery, organizational capacity, and community capacity. The actors within the local system improve their functioning and develop mutual relationships of support and accountability.

Local stakeholders should decrease their dependency on insecure resources (financial, technical, and institutional) as they strive to fulfill their mutually agreed-upon roles in pursuit of their common vision of a healthy population, to be attained outside the bounds of any one project.

The *outcome* we measure is progress toward this mutually agreed-upon vision of population health. It is improvement in this outcome that shows that the sustainability process is working successfully.

Sustainability planning is most effective when approached from a "system perspective." Most systems are not just lacking that one thing that a project can add to make the whole local system work sustainably. Interdependent components of progress need to be considered together within a local system that is embedded in a larger environment. Progress needs to be comprehensive and balanced across these different components to result in sustainable positive health outcomes (see textbox—left). Many actors need to contribute to this progress, all interacting within a system. Consequently, piecemeal approaches that only focus on one factor are unlikely to address sustainability successfully. For instance, if the quality of health services is improved, but demand does not increase, then there will likely be little effect on health outcomes. Similarly, if the financial viability of an organization is improved, but its technical capacity to deliver services does not, the organization is unlikely to have improved ability to contribute to sustaining health outcomes. In the worst case, a project may even disrupt what is already working in the local system, causing unintended consequences that may actually worsen health outcomes afterwards.

Sustainability is a dynamic process. Sustainability is a set of processes and qualities that make a system of actors more resilient and encourages more stakeholders in the system to support the desired outcomes. The local system will not remain static while project staff members "tinker" with it. The local system whose improved functioning will determine the sustainability of health progress is dynamic, with actors coming and going, increasing and decreasing in strength; it is constantly exposed to new stresses and aids. The environment of the local system similarly is dynamic; it has new policies, actors, and even emerging problems and opportunities. The best a project can hope to do is to contribute to this dynamic process and catalyze positive change within this complex system, making it more resilient.

"Help! It's too complex! I can't take it anymore!"

Talk of "processes," "systems," and "synergies" among "local actors" sometimes has people shaking their head and wishing for a simpler, more straightforward approach.

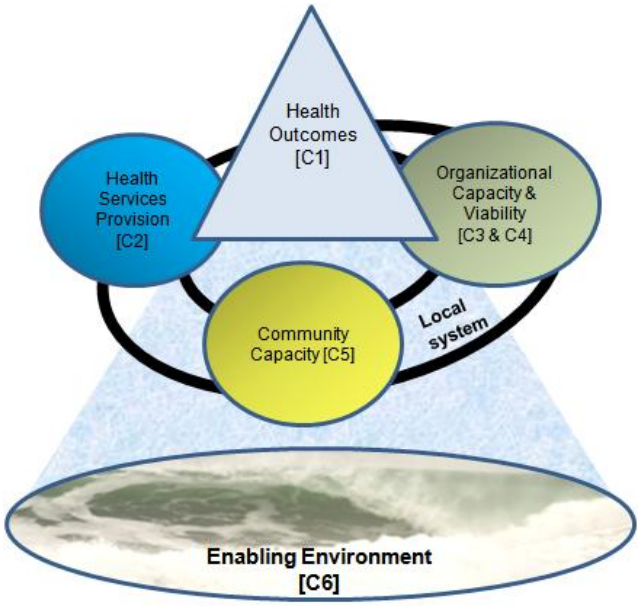
OK, before you give up, we would like to use an example from outside of health care to illustrate why the SF is constructed the way it is:

How many "actors" can you list who have a hand in sustaining pension and retirement systems in various countries of the world? Is the sustainability of retirement systems only a financial issue? Or is it also a political issue? What is the role of the executive branch of the government in ensuring their future? What about parliament? Does the capacity and influence of civil society organizations such as unions play a role? And is the capacity of retirement and pension funds organizations to manage themselves effectively and efficiently also important?

At first the sustainability of pension funds might seem like a simple matter of financial viability (i.e., the amount of money taken in equals the amount of money paid out). But by considering the various factors listed above, you start to realize the complexity of the issue of the sustainability of even such a seemingly simple institution. The retirement system fits within a larger and more complex system with multiple actors, along with processes both synergistic and competing. Can you see how retirement benefits will never reach a point when one can say that their benefits are completely sustainable? That their delivery of benefits to beneficiaries is a process relying on overlapping and interlocking financial, political, management, and accountability systems?

The SF offers ways to deal with the complexity of the real world, rather than dismiss it in favor of simplistic but unrealistic analysis.

Figure 1.1
A visual representation of the Sustainability Framework



1.3 THE STRUCTURE AND LOGIC OF THE SUSTAINABILITY FRAMEWORK

The SF takes the point of view of the local system, which the project attempts to change for the better. The chance of sustaining project-facilitated health improvements is greatest when local system actors have sufficient capacity and viability (i.e., are not reliant on insecure inputs) to carry out the key tasks needed to produce key health outcomes within an enabling environment.

Put in more detail, the SF focuses on improving and measuring progress on the following six components (shown visually in Figure 1.1 on the previous page):

- Component 1: Health outcomes
- Component 2: Health service provision
- Component 3: MOH[11] district capacity and viability[12]
- Component 4: Main local NGO[13] capacity and viability
- Component 5: Community capacity
- Component 6: Enabling environment.

The six components of the Sustainability Framework: A magic formula?

While the research and experience of program managers of community health programs show that these six components are critical to establishing sustainability, there is no perfect mix of strategies that can be universally applied to optimally improve these components. This mix will largely depend upon factors specific to the local context, such as cultural norms and socioeconomic/political variables. It is therefore important to define your strategies for each component within the context of the local system in which you are working, and to ensure that systems are in place for you to monitor critical developments in each of the components; major weaknesses in any one component can diminish the chance of sustaining health outcomes.

Component 1: Health outcomes

This component is meant to measure the outcome of the sustainability process. Ideally, it would measure the population health status. The measurement of health status itself (i.e., morbidity and mortality) would be burdensome and unrealistic.[14] To be the most credible while still giving the most useful information, this component tries to come as close as possible to health status measures. With that in mind, the usual data used for Component 1 are a summary of the population health outcomes (i.e., indicators of key household behaviors and service

[11] MOH stands for Ministry of Health.
[12] The presentation of Components 3 and 4 represent a slight change from the traditional presentations of the framework—see textbox on page 7.
[13] NGO stands for nongovernmental organization.
[14] There are some exceptions to this. See Measurement Toolbox Annex reference in Chapter 3 on measurement about the lives saved calculator, which provides an estimated measure of mortality (child mortality) from key behavioral and coverage indicators. There are also feasible community information systems—such as the World Relief's Care Group approach and the Community-Based Impact Oriented system—that allow tracking of morbidity and mortality data. Finally, projects that monitor child height and/or weight also capture an important health status measure—nutritional status.

coverage) that are known to be associated with a high impact on health. These are the very measures that many projects use to track their progress.[15]

In each of the technical areas in which the SF has been used, there is a short set of outcome indicators that are known to affect the health status of the population. They are key household behaviors and service coverage indicators—essentially, they are the "practice (P)" and "coverage (C)" indicators in the USAID Knowledge, Practice, and Coverage (KPC) surveys. The indicators under "knowledge (K)" are not health outcome measures and are used instead to inform measurement of community capacity in health (i.e., Component 5). For instance, a child health project would measure things like the prevalence of exclusive breastfeeding and coverage of key services, like antibiotics for treatment of pneumonia.

My MOH district partner wants to track malnutrition and children sleeping under bed nets, but my project doesn't have a nutrition component and we don't work on malaria. It's nice to involve stakeholders, but what health outcomes are we going to track now?

You are facing a very typical problem. You invited stakeholders to become partners, and you convinced them that you have a set of tools for tracking progress toward *their* vision of sustainable health for the community. Now they want to use it for their *own* purpose.

So we have to ask: Whom would you trust to help sustain the health outcomes? Would you rather provide training, equipment, coaching, tools, and support to a district manager who does not care, or to one who wants to maximize the capacity of his/her organization to do its job, even if 100 percent of his/her effort is not completely relevant to your project?

Whatever health outcomes you are accountable for to your donor will be better advanced and sustained if they are "piggybacked" onto general partner-owned efforts to improve community health. The added cost of including two or three more indicators in your surveys is marginal, assuming you are working on closely related issues. You should still be able to report progress on the full vision of sustainable health—and all related health outcomes—of your partners. You will also still be able to show your project's contribution (1) to sustainable capacity development and (2) to provide key inputs and processes for the improvements in the outcomes for which your project is directly accountable. Our advice? Track those additional outcomes and show your partner that you really take seriously the idea of thinking from the perspective of the people and organizations in the local system who will be responsible for sustaining health outcomes when the project ends.

[15] More details will be provided in Chapter 3, but let's consider a simple example: Reduced overall child mortality or reduced cause-specific child mortality from measles would be a health impact/status measure for a child health project. Although ideal in terms of reliability and validity, these measures are costly and time-consuming, so they are not recommended. Therefore we might consider "the next best thing": acquired immunity against the measles virus. It would be measured through immunological tests, so it would be very costly. It is also not recommended. Measles immunization coverage is a proxy measure for this immunological outcome (and ultimately the impact on mortality). It is a reliable and valid indicator that can easily be measured. It is best measured through a population survey. Finally, we would *not* want to rely on coverage statistics derived solely from data from health facilities, based on their output of measles vaccinations delivered. Although these data are very easily collected, those statistics are not reliable, as they routinely overestimate population coverage and so are only loosely correlated with population health status.

Component 2: Health Service Provision—Access and Quality

This component addresses how well the local health providers—both facility and community-based—deliver services and products to the beneficiary population. This service delivery contributes directly or indirectly to the health outcomes measured in Component 1.

Thinking has evolved over the years as to what constitutes a strong health system. The most recent thinking is encapsulated in the World Health Organization's (WHO's) conception of the six "building blocks" of a strong health system: service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership and governance.[16] Component 2 focused specifically on the building block of service provision and the readiness of health facilities and their outreach workers to provide services. Specifically, Component 2 focuses on the quality of and access to key health services. Access includes the idea of equity—that is, health services that have achieved high levels of access have also achieved high levels of equity. The quality of the services delivered includes subcomponents like the following:

- Availability of key inputs, like infrastructure, supplies, and medications
- Competence of health service providers both technically and in their relations with clients.

The other WHO building blocks are included elsewhere in the SF, as they are higher-level functions not directly associated with service provision. The building blocks of human resources and information relate to institutional capacity to support service provision, so they are included in Component 3, while financing and governance are part of the policy environment included in Component 6.

Component 2 does not address the population coverage of technical interventions such as immunization, as this is already measured in Component 1. But it does consider access to the services provided by health facilities and their outreach workers, like community health workers (CHWs) and traditional birth attendants (TBAs). The measures come from service provider and health facility assessments.

The local context should drive the decision about the exact information that should be included in the SF. For example, if government health services account for only 20 percent of service coverage in an area and private health providers account for the other 80 percent, then it would be essential to include measures of quality and access to private providers in Component 2. If we exclude them, there would be a disconnect between what one measured in Component 2 as the strength of health service provision and the true strength of health service provision as experienced by the population in the local system. This, then, would not have a strong relation with Component 1, as implied by the SF.

Component 3: Local MOH District Capacity and Viability
Component 4: Local NGO Partner Capacity and Viability

In thinking about which to include as the subject of the measurement for Components 3 and 4, you should think about who will supply the institutional support for health service delivery. This is the institution whose capacity and viability should be measured in Component 3. Then you should think

[16] As found at http://www.who.int/healthsystems/topics/en/index.html.

about who will supply the institutional support for (1) the activities in the community necessary to demand services and for (2) household behaviors related to relevant health outcomes. These behaviors include "services" such as breastfeeding supplied within the household as well as demand for services supplied by the health system—preventive services such as immunization, as well as care for illness. The organization supplying this support is the one whose capacity and viability should be measured in Component 4.

As discussed in the textbox below, the "default" types of organizations suggested for these two components are the district MOH for Component 3 and a key local NGO for Component 4. This may not conform to the local situation in your area, but it is often the case that such institutions are central to supporting facility- and community-based delivery of services.[17] Each project has to define a sustainability vision, scenario, and plan based on the local context. In the experience of the projects that have applied the SF to date, Component 3 is most appropriately applied to an MOH district health office and Component 4 to a local NGO partner. That makes this scenario the default for the SF. On the other hand, there may be variations in certain situations. For instance, if a district health office is committed to sustainably supporting household and community capacities for health, then its capacity should be used for Component 4 as well as Component 3.

"What? You changed Components 3 and 4 of the Sustainability Framework? How could you?"

Yes, those of you familiar with the Child Survival Sustainability Assessment (CSSA) knew a slightly different model. Component 3 referred to the organizational capacity of a local partner, and Component 4 referred to the organizational viability of the same partner. We haven't changed our mind; we still think that both capacity and viability need to be addressed, usually through different program strategies. This is why we distinguish them.

But practice led us to observe that many projects operate in partnership with both health districts and local NGO partners. Consequently, they need to address the capacity and viability of at least these two critical partners who should be "owners" of key processes if health gains are to be sustained. The second factor that encouraged this superficial change is that most organizational tools combine the capacity and viability components. Some users did not like having to present the capacity of a health district, followed by the NGO partner, then again the viability of a health district, and then again an NGO partner.

Finally, there were those projects that measured the capacity and viability of a local partner, but that partner was not able or committed to supporting both the community and service delivery levels. Thus, measuring the progress of this partner alone could give a false sense of how well supported the local system was in its totality.

Since many projects are in this situation, we offer a common denominator solution: Address MOH districts in Component 3 and local NGO implementing partners in Component 4. The important thing is that, in both cases, viability issues need to be addressed as an essential "subcomponent" and not be dismissed as secondary to capacity issues.

[17] For an example not related to child survival, see the recent publication: Jacobs, B., Price, N., & Sam, S. O. (2007). A sustainability assessment of a health equity fund initiative in Cambodia. *International Journal of Health Planning and Management, 22,* 183-203.

Chapter 2 explains the step-by-step process managers can follow with partner organizations to examine the roles and the capabilities required by each one individually or within networks of peer institutions (i.e., NGO networks). Chapter 3 presents measurement options. For each type of partner (MOH or NGO), the following two sets of subcomponents should be considered.

- **Organizational capacity** refers to a range of functions that are necessary to the life of a local organization, its administration, and its ability to perform its mission. These include leadership and governance, financial management, human resources, and organizational performance.

- **Organizational viability** includes financial viability, but also encompasses the more general idea of securing access to the inputs necessary to sustain the level of capacity and performance attained during the project. These inputs can be categorized in several ways, but a common breakdown is that they are institutional (also called "managerial"), technical, and financial. So on the technical side, we might ask not only if there are trained and competent staff members, but also if there is access to ongoing training for new staff after inevitable turnover. One key subcomponent under the rubric of viability, then, is the connectedness of the organization with other important actors within and outside the local system that may have resources (institutional, technical, and financial) that the actor will need after the project ends.

It is possible to build organizational and management capacity while undermining viability. By the same token, you can also develop viability in an institution, but fail to build the capacity to support services and deliver results. Since capacity and viability respond differently to interventions and each requires specific effort, it is better to consider them as individual entities. Of course, we recognize that they overlap, particularly when it comes to organizational assessment tools; this is why they are put together (see Chapter 3).

Experience has shown that the concept of organizational viability is also relevant to governmental structures, such as a health district. In Bangladesh this was the case for municipal health departments. At first it seemed counterintuitive to consider their viability, since as government-funded entities they do not depend on fundraising for support. But decentralized government structures can build management capacity to organize or deliver services and, yet, not receive the institutional, technical, and financial support they need to be viable in their role.

Component 5: Community Capacity

The SF recognizes community capacity as a fundamental contributor to sustaining health outcomes. Community members and, more specifically, household caretakers must not only demand key health services, they must also "supply" other activities, like breastfeeding, use of family planning (FP), or delivery of home-based care (HBC) for chronically ill family members. Without the ability to effectively exert these supply-and-demand functions, the service delivery capacity measured in Component 2 will have no ability by itself to produce improved health outcomes. The subcomponents of Component 5 include—

- The competency of mothers and household caretakers in the relevant field of health—for example, knowledge and attitudes about health behaviors, openness to change, ability to make important decisions regarding health.

- The collective organization and skills of community members with regard to the community action cycle—that is, assessment, planning, implementation, and reflection/evaluation.

- The viability of community competences—for example, connectedness to key organizations and access to finances and technical skills.

What's so important about community capacity?

Models to organize the concept of community capacity come from many sources. They were present in the Alma Ata Declaration for Primary Health Care;[18] they were front and center in the Ottawa Charter for Health Promotion;[19] and a few decades later, they appeared in the Community and Household Integrated Management of Childhood Illness model.[20] The initial research behind the SF confirmed how important community capacity was in the thinking of experienced project managers.[21]

Recently Henry Mosley[22] has adapted the ideas of Peter Senge[23] to the global health context. This model clearly articulates the idea that community members do not just "receive" or "demand" health services as beneficiaries, but rather are active agents of change and—to use the language of economists—producers of health. Particularly when it comes to community health, the women and mothers themselves should be seen as part of the health system, the "frontline workers." Just as there is a need for competent health service providers to deliver services such as immunization and case management of pneumonia, there is also a need for competent individuals, acting either alone or collectively through community organizations that can generate effective demand for those services. But the role of the community is even more expansive than to just demand formally delivered services. No one in the health services "delivers" breastfeeding to an infant, recommended home fluids (RHF) to a child with diarrhea, or use of the Lactation Amenorrhea Method to limit the fertility of a new mother. It is the woman who supplies these "services," either to herself or her child, right in the home itself.

Consistent with the SF model, the Senge/Mosley model entails the production of health within a local system, also including managers/providers, policymakers, and interest groups. It gives the household the following pivotal roles:

1. Households are the primary units for the production of health. Mothers are the primary *managers and implementers* of the household health production tasks and are the primary beneficiaries.
2. Households, like every social institution, have three basic *competencies* for the production of the desired outputs: *values and beliefs, practices, and tangible resources*.
3. Households produce health in the context of the local community and the wider society, which are a

[18] World Health Organization, & United Nations Children's Fund. (1978). Primary health care. Paper presented at the International Conference on Primary Health Care Alma-Ata, USSR, September 6-12, Geneva and New York.
[19] World Health Organization. (1992). The Ottawa charter for health promotion. *WHO Regional Publications, European Series, 44,* 1-7.
[20] Winch, P. J., LeBan, K., Casazza, L., Walker, L., & Pearcy, K. (2002). An implementation framework for household and community integrated management of childhood illness. *Health Policy Plan, 17,* 345-353.
[21] Sarriot, E. (2002). *Sustaining child survival: Many roads to choose, but do we have a map?* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/csts_new.pdf.
[22] Available at http://www.jhuccp.org/training/scope/starguide/begin.swf.
[23] Senge, P. (2006). *The fifth discipline: The art and practice of the learning organization*. New York: Random House.

are a nation's *health production system and the enabling (one hopes) environment.*

Health competency expresses itself through knowledge, beliefs, social norms, and the ability to act on these (e.g., the need to "dry up" diarrhea in children, the social acceptability of using FP methods, the authority of mothers to seek care when needed, etc.).

Above the level of households, community capacity affects the sustainability not only of the production of health (i.e., the supply and demand of services), but the capacity of the local system to respond to challenges and maintain progress. There is the capacity of the community to organize itself to not only demand services, but also deliver and oversee these services.[24]

Finally, there is social cohesion and social capital, which—although not directly linked to knowledge or the production of health per se—affect the resilience of the community, how it will support progress when change is needed, and how it will allow social support systems to thrive and community organizations to fulfill their roles. Another way to present this is that community capacity influences the "climate" in which changes and innovations are introduced and maintained at the local level.[25]

While some of these community characteristics continue to challenge researchers, Chapter 3 offers a way to break down some of these abstract competencies into more discrete and concrete capabilities through several tools for measuring community capacity. While our options for measuring community capacity are not optimal yet, we are determined to acknowledge this fundamental component, which will heavily contribute to the long-term success of community health efforts. We will continue to pay attention to efforts underway, such as the CORE Social and Behavioral Change Work Group's efforts to develop a measurement framework for community competency; the transformational development indicators being implemented at scale by World Vision; Save the Children's work on identifying key community competencies; Christian Reformed World Relief Committee's community capacity indicators; as well as the work of Susan Rifkin, Lisa Howard-Grabman, and others.

Component 6: Enabling Environment

There are essential social-ecological environment variables that can either support or weaken gains in health. If we are going to be accountable for progress toward sustainability, we should be clear about the context in which the local system operates. The stakeholders who need to be part of the functioning of the local system, the strategies for achieving effective service delivery and positive health outcomes, the social arrangements, the distribution of roles among partners, and consequently what capacity and viability needs to be built within partner institutions—these are only meaningful within a given environment.

Some environmental factors may be within the ability of a project or local system stakeholders to influence, whereas others will not be. For instance, a project might identify partners to advocate for policy change; on the other hand, vulnerability to drought, food insecurity, and other disasters will be difficult to mitigate. More specifically, if a project promotes community case management of pneumonia, a national policy that prohibits the use of antibiotics by anyone other than a licensed

[24] Rifkin, S. B., Muller, F., & Bichmann, W. (1988). Primary health care: On measuring participation. *Social Science and Medicine, 26*(9), 931-940. Also see: Sarriot, E. (2002). *Sustaining child survival: Many roads to choose, but do we have a map?* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/csts_new.pdf.
[25] Sen, A. (1999). *Development as freedom.* New York: Random House.

doctor is an "environmental factor" that will constrain the sustainability of any gain achieved locally. It would be still worse if there was not even a policy recognizing the legitimacy of community health agents in general.

Given the vastness of the social-ecological environment, you can feel overwhelmed by the task of addressing it at all. But the task does not have to be daunting. We propose, through the SF, to guide you through an "environmental scan" that includes six subcomponents. Before presenting them, you must remember that the detailed content of the subcomponents for your project will ultimately depend on the local context. But rather than start the discussion of the environment with partners on a blank page, we suggest that you start with the description of the content of the six subcomponents presented below (see Chapter 3 for a discussion of suggested measures for each of these subcomponents).

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.

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 is likely to be disruption of services, strains in social networks, and even physical displacement of people. Disruption of this sort makes gains in health tenuous at best. When the situation is at its worst, perhaps immediately post-conflict, project managers should be cautious in terms of what they promise with regards to sustainability.

Strength of civil society

Gains in specific local organizational capabilities of civil society organizations like NGOs, faith-based organizations, and community-based organizations can be supported, maintained, or hindered by the social environment in which they operate. The World Bank and others have developed summary national measures for this.[26]

Human development

Large swings in the economic and development landscape can cause 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 United Nations Development Programme (UNDP) computes a summary measure of human development—the Human Development Index (HDI)—for all countries on a periodic basis. UNDP country offices sometimes compute this score for subnational regions as well. Progress on the HDI supports greater expectations for what can be sustained. In the Americas, the Pan American Health Organization uses a similar summary measure known as Unfulfilled Basic Needs (*Necesidades Basicas Insatisfechas*).

[26] U.S. Agency for International Development. (2000). *The 1999 NGO sustainability index* (3rd ed.). Author.

Women's empowerment

The role of women is critical in population health gains, as women are the main caregivers to 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 change for health. This correlates with their level of education and literacy.

Natural environmental factors

Many areas are prone to natural disasters that have the ability to quickly wipe out gains in health and development. Some geographic regions are more prone than others to disruptive natural phenomena. The profile of vulnerabilities will vary from location to location. Some areas are prone to drought 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 disproportionately affected by natural disasters.

The ability of a project to influence these subcomponents directly or indirectly is greater for the first subcomponents listed than for the last. Some will consider the ecological environment part of "the world as it is" and not deserving to be part of a project's analytical model. But in some contexts, projects will find reporting on vulnerability and national preparedness important for drawing attention to threats to the sustainability of local efforts. This can be a tool for advocacy. There can also be ecological variables with more direct effects, such as whether mosquito breeding sites are controlled or not.

1.4 PUTTING IT ALL TOGETHER

As seen in Figure 1.1(page 3), the central logic of the SF model is that strengthening the capacity and viability of key partners in the local system (health service providers, key government organizations, NGOs, and communities) and strengthening their cohesion within a supportive environment increases the chance that the improvements in health outcomes supported by project-initiated activities will be sustained.

What relationships does this model convey? First of all, *what* we are trying to sustain are improved health outcomes after the project ends (e.g., exclusive breastfeeding, immunization, appropriate treatment for pneumonia, and modern contraceptive use). Although we have borrowed many key principles and lessons about processes from the field of Sustainable Development, the SF is more narrowly focused on sustaining human benefits (i.e., health outcomes).

How we try to sustain these improved outcomes is through strengthening the capacity and viability of key actors ("stakeholders") in the local system as well as ensuring that these actors operate within an enabling environment. The "environment" includes national policies, human development, even the risk of natural disasters. So some factors that determine the level of sustainability of health outcomes will unfortunately not be within the control of the project or local system stakeholders. On the other hand, there are actions that local system partners can take to influence the environment (e.g., advocate for needed policy change) or at least adapt to it (e.g., mitigate the effect of natural disasters). This implies that a project cannot fully guarantee the long-term sustainability of

its achievements. Are we saying that health planners have no responsibility for sustainability? Are we undermining accountability? We don't think so. Actually, by being grounded in reality and explicit about what we are trying to achieve, how, and with whom, the SF increases the accountability of all parties to sustain the gains achieved in the short term.[27]

The SF expands our vision beyond that of traditional health project planning. In traditional planning there is an exclusive emphasis on the health outcomes and the health services delivery improvements needed to achieve them. In the SF, these are only the first two components of analysis. The SF also requires that planners think about the underpinnings that will support these gains during the project period and beyond—not only service delivery (Component 2) and community capacity (Component 5), but also the capacity and viability of local organizations (Components 3 and 4) that support this supply/demand of services, and finally the environment in which this local system is situated (Component 6). The higher the level of attainment for each of the components, the greater the chance of sustaining the health gains made during the project period. What level of attainment is necessary in each component—what is sufficient—are empirical questions that have not yet been answered. What specific weaknesses need to be addressed in each component is context-specific (See "A magic formula?" in Section 1.3). In the end, sustainability planning and measurement is not dramatically different from traditional planning and measurement. It simply is more comprehensive and holistic. But one key difference is the point of view. In the SF, the planner is the local system with all its various stakeholders, and not simply the "project management team." The project management team ought not to be the central actor, but the facilitator of those actors that will continue to be engaged after the end of the project.

Using the SF alone will not ensure sustainable health outcomes any more than a Logical Framework or a Results Framework ensures an effective program. Planning and evaluation tools exist only to help us be clearer and more organized about how we design and carry out interventions. The situation is identical for the SF in terms of measuring the durability of health gains. The information produced by using the SF for measurement can be very informative and provide intelligent signals to improve decisionmaking, but the soundness of the project design is even more important for ensuring long-term results. The tools in Annex 2 give some guidance on pro-sustainability project design and management; but there will always be some context-specific issues that can potentially derail sustainable processes. We present one scenario in the textbox on the following page ("A cautionary tale") to illustrate some of the subtleties of pro-sustainability planning. We also try to answer other questions that have arisen from practice in Chapter 4, which is also posted on the Sustainability page at www.childsurvival.com. If you have other questions you think are important, we invite you to post your question (and any answer you might already have) at the Sustainability page or ask them of the practitioners' group, by joining the Sustained Health Outcomes (SHOUT) Group (List_SHOUT@childsurvival.com).

[27] For an innovative donor effort to be explicit about this shared accountability, see the Nepal paper referenced above.

A cautionary tale:

The role of institutional commitment in the success of your sustainability plan

An international project has measured performance in all six components of the SF. The local NGO partner is showing signs of better management and increased performance in delivering services to community members. The viability of this local partner is also increasing: It has diversified sources of funding as it is recognized for its good work, and it is developing strong relationships with government and international development partners. These are great results and everyone is quite optimistic about the future. Excellent sustainability progress according to the SF model! But when the project ends, to the shock of everyone, the local partner simply reorients all its activities to another sector. The promised sustainability does not occur.

What went wrong? In this case, the local partner had no long-term ownership of the goals pursued. Progress on sustainability metrics, sound as they were, hid the *basic design flaw* that this partner was committed to its institutional growth and only committed to supporting child health services as long as they aligned with this goal. No one had asked, at the stage of project design while the local system was being mapped out, whether the selected partner could effectively institutionalize its involvement in child health into its core mission and activities and—more importantly—if the partner wanted to do so.

What is the lesson here? *The lesson is that it is the soundness of the design and process of implementation of the project that ultimately determines the sustainability of the results.* What the SF tries to do is to provide signals about progress along various components, given that design. However, the SF is only a planning and measurement tool. Just as growth monitoring only helps children thrive if it is used to provide signals about proper nutritional behaviors, sustainability monitoring and evaluation cannot replace sound design; it can merely assist it.

However, ending on an optimistic note—There is one more thing that the application of the SF approach could do to help sustain child health benefits in our example: In developing its sustainability plan, the project must have brought together not only the local NGO partner, but also MOH representatives and other key stakeholders. If the process of joint visioning, planning, and monitoring was genuine, there is a chance that these partners can get back together—assisted or not—and talk in practical terms of the local NGO's role and what can be done to bring them back into the picture, or substitute for them given their lack of interest. Preferably, this would have been discussed repeatedly throughout the life of the project. In the end, institutions work together to the extent that their own interests are taken into account. The sustainability assessment process supports building this common ground. It takes trial and error for partnership arrangements to be solidified, but we can create processes that support progress.

CHAPTER 2: USING THE SUSTAINABILITY FRAMEWORK FOR PROJECT MANAGEMENT—PLANNING, DESIGNING, IMPLEMENTING, AND EVALUATING

The initial design (proposal) and detailed planning stages are the most critical for pro-sustainability thinking. This is the time when you will establish the tone of the project's relationship to its partners, identify the key activities and contributions that the project will make toward sustained health outcomes in the local system, and establish the indicators you will use to monitor and evaluate progress and results. The differences with pro-sustainability design are whom you bring to the table and what questions you ask; these differences indicate the intent to plan for the long term and not just for a 3- to 5-year project. What you *should try not do* is design the project *and then* consider sustainability implications. Because we do not live in an ideal world, this may happen anyway, so in Annex 1 we deal with the question of applying pro-sustainability principles after the initial stages of a project.

2.1 STEPS TO FOLLOW

Figure 2.1 shows the ideal sequence of the six steps for applying the principles of the SF for planning. In practice, the application of these six steps is not likely to be so neat and linear. For one, the initial project planning stages are structured differently for different donors, so the steps should be adjusted to be most feasible in the context in which you find yourself. Options will also vary depending on whether your organization is already present in the field or planning to start in a new area, as this will greatly influence the level of involvement of local stakeholders that it is possible to achieve. In many cases, a proposal for the project is submitted to the donor and must be approved before in-depth planning and work plan development can begin. In this case, you must consider issues like resource availability and time lag between submission and acceptance of your proposal in determining how extensive the planning should be at the various stages. But many of the tools proposed below should be applied as early as possible.

Once a proposal has been accepted and moves to the initial implementation phase, the detailed planning or project design steps begins in earnest.[28] The proposed tools and activities of this manual will help practitioners to develop their detailed plan and fully integrate pro-sustainability thinking within their Results Framework, rather than try to conduct two parallel processes (one for project planning and one for sustainability planning of the local system), an unworkable solution in the long run.

It should also be noted that there are humanitarian or sanitary emergency situations where immediate needs take precedence over thinking about sustainability. For instance, it would make little sense to spend several days in a workshop on visioning when a cholera epidemic has broken out. In that situation the pressing issue is the need to respond as quickly and effectively as possible with whatever capacity is available. On the other hand, as soon as the immediate outbreak is controlled and you and others are considering the prevention and management of future outbreaks, sustainability planning should once again be a key part of the agenda.

[28] In the USAID-supported programs in which this framework was originally developed, this stage centers on the Detailed Implementation Plan, which includes development of the Results Framework (or Logical Framework), a work plan, and a detailed narrative of the project's proposed activities.

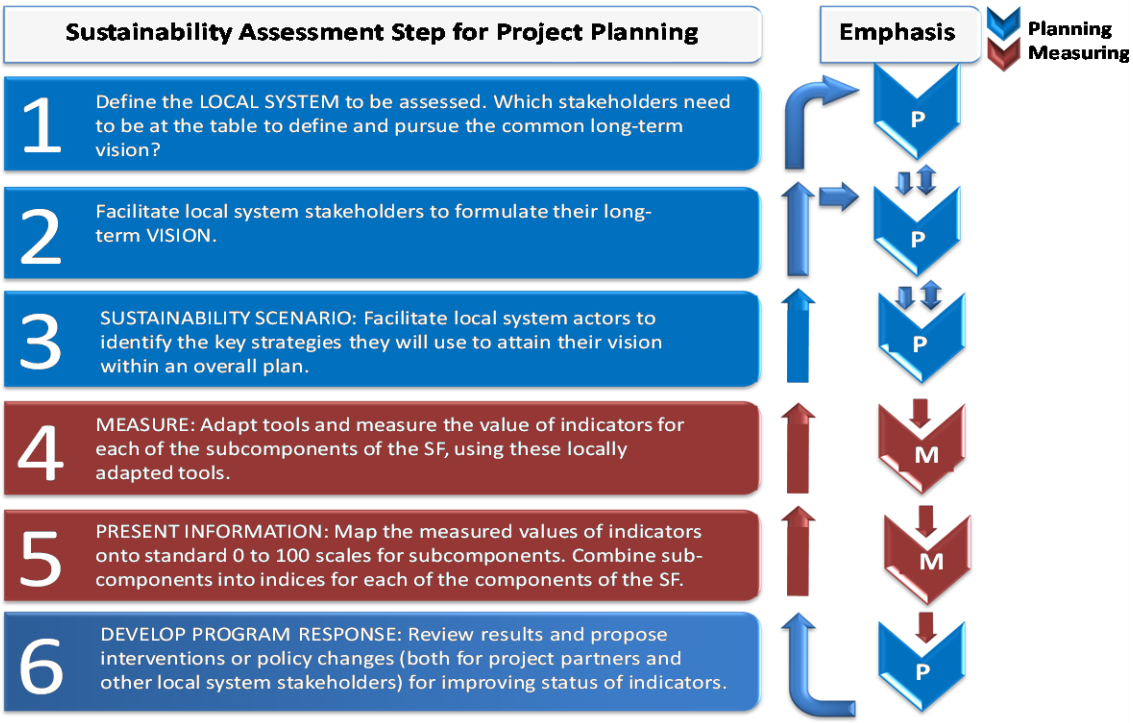
In theory, the implementation of the SF involves a clear and logical stepwise approach (Figure 2.1). In practice, however, some of those steps will be repeated, some will demand more time, and some will overlap with one another. The purpose of this chapter is (1) to provide managers with a good understanding of these steps and (2) to offer practical guidance for their implementation in the "real world."

An important reminder

An essential feature of the Sustainability Framework is its *nonnegotiable focus on building the cohesion and capacity of a local system*. This creates inherent tensions with *project-centered* planning. We believe that despite the difficulty, this tension should not be avoided, but should be addressed head-on. Accepting and facing this tension is critical to developing successful pro-sustainability strategies, since projects, by their very nature, tend to disrupt local systems (even while providing valuable inputs) and face structural problems in maintaining the gains they achieve. We try to provide clear guidance about addressing this tension in the following sections.

A first glance, Figure 2.1 shows that these six steps involve both planning and measurement. This chapter is designed to provide the tools and guidance for the essential planning and design stages of your project, which correspond largely to Steps 1 to 3 in the six-step planning process outlined. Once you have completed these steps, you will be well positioned to proceed with the measurement-related steps (Steps 4 and 5), which are described further in Chapter 3. This chapter then describes how to conduct a partner workshop to review and revise the first five steps as well as plan programmatic responses (Step 6).

Figure 2.1
The Six Steps to Apply the Sustainability Framework for Initial Project Planning and Measurement



My project has already been going on for 2 years. It's too late! None of this can help me now. What can I do?

Don't panic! Although we assume here that users are trying to plan for sustainability from the project design and planning stages, we know that project managers often find themselves worrying for the first time about the sustainability of their efforts later in the process. If you are in this situation, we recommend that you start with the Sustainability Planning Checklist (Annex 2.1) and identify gaps in the design and implementation of your project. We also encourage you to get acquainted with a previous publication that details practical experiences and suggestions from past projects in the same situation.[29]

At a minimum, you can use the SF to reconsider which components and subcomponents you might have neglected, and maybe carry out some field assessments to better understand their status. Even at this stage, it can be valuable to convene key local actors to discuss the future. Many projects have done this at the midterm or final evaluation stage. Also, sustainability success stories have been achieved because partners were encouraged to take ownership of the future, even at these later stages. Depending on context and possibilities, you can combine different tools already presented and adapt them to your conditions. In some cases, this can lead to a full redesign of your project activities (see "How can this chapter help you?" in next section).

Table 2.1 puts the six-step process in the context of the project cycle. It suggests which steps to focus on, whether you are early in planning (i.e., pre-proposal, with a presence on the ground and contacts with stakeholders) or are post-award of a grant (where you have not established partnerships as much as you would have liked to). The rest of the chapter is organized around the structured thinking in this table.

[29] Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects*. Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

Table 2.1
Suggested Timing for the Steps of Planning for the Sustainability Framework

SF assessment and planning steps	Pre-proposal or proposal stage	Post-award/ pre-baseline	Post-award/ work planning stage
Prepare—Review Sustainability Planning Checklist	✓	✓	
Step 1—Define and map local system and its stakeholders	✓	✓	
a. Define the local system	✓	✓	
b. Conduct a stakeholder analysis	✓	✓	
Step 2—Facilitate local system stakeholders to formulate their vision for health	✓	✓	
Step 3—Facilitate local system stakeholders to develop their sustainability scenario and its key strategies	✓	✓	
Steps 4 & 5—Measure: Carry out baseline assessments and present results		✓	
Stakeholder planning workshop **(Cover all sub-steps from here to bottom of table):** **Review and refine first five steps**—Lead a project work planning meeting with partners/stakeholders. Before moving to Step 6, review previous steps: • Revisit Sustainability Planning Checklist • Review stakeholder analysis and draft vision and sustainability scenario and consider if anyone else needs to be brought into the system • Review baseline survey results			✓
Step 6—Develop programmatic responses			✓
a. Conduct environmental scan activity with partners for measurement of Component 6 and begin thinking about environmental barriers that might be improved by stakeholders			✓
b. Present/future reality analysis			✓
c. Determine what your project can contribute by identifying priority activities	✓		✓
d. Develop your project Results Framework within a sustainability plan for the local system	✓		✓

Prepare: Use Sustainability Planning Checklist to Review Important Issues from the Onset

Tool	When
Sustainability Planning Checklist (Annex 2.1)	Proposal Before detailed project planning workshop Evaluations (midterm, final)

Start using the Sustainability Planning Checklist as soon as the broad concept of a project is laid out. It will focus managers on important considerations and provide a good overview of the steps in systematic pro-sustainability planning. Of course, you will not be able to answer all the questions on the checklist until the end of the planning process. The 45 questions in the tool are grouped into five categories, which closely follow the Sustainability Framework process.

The Sustainability Planning Checklist goes through the components of the SF to help you to systematically determine whether you have covered all the important aspects. Even later in the project cycle (detailed planning or even evaluation stage), as you bring new people onboard, you can use it to refresh everyone's memory and review initial choices by answering its questions to guide brainstorming and dialogue. It also can build consensus for thinking in a more holistic manner, especially for members of the team that are used to more traditional project thinking. The other subsections we will cover describe in more detail some of the other key steps in pro-sustainability project planning that are embodied in the checklist and supported by other tools in the annexes.

Step 1: Define and Map the Local System and its Stakeholders

Tool	When
Local system mapping and stakeholder analysis (Annex 2.2)	Onset (proposal) Repeat at Detailed Implementation Plan (DIP) stage to validate and expand partner and stakeholder mapping.

Step 1a: Define the local system

Sustainability planning must begin with understanding what the local system is. In fact, as the project interacts with stakeholders, it also can help better define this local system. Starting to draw a simple Venn diagram as a team is a simple way to start thinking about this local system. Within the circle of the Venn diagram belong all the actors in the local system. Outside the circle you can write in those key organizations that influence the actors in the local system.

There are always multiple organizational and individual stakeholders operating in one place; some that we can see (associations) and some that we cannot see (informal support structures). The villages of an African district, and the different authorities and agencies working in the district, can be presented as a geographically bound system. Generally, projects work with beneficiaries within defined geographic boundaries. This can be defined by health authorities (e.g., district, block), by local government (e.g., municipality, oblast, state), by the catchment area of a local civil society organization, or by an ethnically or culturally homogenous area.

In an increasingly globalized world, however, the stakeholders working within this local system may not actually all be in a geographically contiguous area. For instance, there may be an association of village expatriates in a European or North American city that sends remittances and maybe even has established a formal mechanism for financing development projects. Such an organization would be a geographically remote but significant stakeholder of the local system.

Previous publications show examples of how local systems can be presented and mapped out, such as through Venn diagrams.[30] But as just discussed, one must often think beyond a simple geographic area to capture all the relevant stakeholders.

There is one key question for determining the content of the local system: What are the key structures and persons who should work together for the long-term health of the communities?

Local System:

A network of people and institutions whose coordinated actions will bring about sustainable positive health outcomes in a population.

"Local system" refers to the local stakeholders and communities brought together to map out their vision and goals for sustained health improvement in the community. Local system also defines the level at which evaluation can take place in a meaningful way. Examples of stakeholders in the local system include villages, women's associations, local authorities, rural development associations, health district and health posts, local socially active NGOs, and private sector partners.

An important question for project planners and stakeholders to ask is, "How broad is the local system?" Consider answering this question in terms of three aspects: (1) it is the level of bodies/stakeholders that can be feasibly brought together; (2) it is the level at which assessment can be conducted (villages surveyed, facilities assessed, and institutions willing to examine their cooperation and functioning); and (3) it is the level at which decisions can be made in response to the sustainability assessment (for example, the national government is usually not involved, though its decisions might be very important for components of the SF, in particular Component 6).

A local system has boundaries: Some people and groups are included, groups that are too remote might have to be excluded, and some groups exclude themselves.

Finally, a local system can evolve: Groups once excluded can be included as they see the benefit of the project's efforts. Ultimately, a stronger and more cohesive local system can help sustain increasingly better health outcomes.

Source: Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

Defining the local system is a process of cultural discovery that itself induces change. Stakeholders may not always be motivated enough to work "as a system," and a project can be catalytic in

[30] Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

promoting more cohesion and coherence (see the frequently asked questions [FAQs] on this topic). It is not up to the project to decide that such and such a group should do this or that (see "A cautionary tale" in the previous chapter), but it is the role of the project to encourage stakeholders to consider consequences of not operating with cohesiveness and a common vision.

Mapping out this system will make it easy to identify those that should be a primary partner of the project, and those that are expected to lead and carry on after the project period. To ensure that the definition of the local system is sensible and coherent, it is best to work with a small group of local informants, thus smoothing out the potential biases of a single informant.

As success induces change during the project's lifecycle, local partners should be ready to revisit the definition of the local system and possibly add new stakeholders (see box on the previous page). But once again, it is not up to the project to "make up" the local system it wishes to have by picking and choosing partners. Of course the project will have to pick implementing partners, but the logic of the local system is broader and more enduring than that of mere programmatic allies to support a project. Ultimately the definition of the local system is intimately tied to the development of a vision (see the description of Step 2, starting on page 23).

To emphasize the importance of defining action in a coherent local system, let's consider an example of a project that applies only its own internal logic and that does not take seriously the idea of working within a coherent local system.

A project defines its "target population" as the under-five children in a collection of several poor villages that cross several political/health district boundaries. The project devotes all its resources to working with beneficiaries and with local village leaders. After the end of the project, with its intensive attention and resource deployment, local district-level leaders will quite logically revert to paying attention to their entire districts. Since the project area crossed the boundaries of several districts, there is no strong sense of ownership of project-initiated health gains, and the various district authorities are not likely to give the support needed to maintain the fragile project gains in local structures that were used to improve health status in the selected cluster of villages. The lesson is that a vision focused on a cluster of villages cannot and will not be sustained by a local system built around a different way of organizing itself.

Step 1b: Conduct a Stakeholder Analysis

Understanding who the stakeholders are in order to engage them fully is a central part of the definition of the local system. Local actors (stakeholders) can be involved in different ways based on their relevance to the local system and its vision. This is discussed further in the FAQs.

The initial stakeholder analysis should be broad and wide-ranging; however, this does not mean that all identified stakeholders will be equally important or involved. Managers must sort stakeholders by their appropriate level of engagement, focusing the majority of energy on those stakeholders that are the most influential and interested in the vision of improving health. There are many stakeholder analysis tools, some of them quite complex, especially in the business planning world, but all of these tools will take account of at least two dimensions for the involvement of "actors" or stakeholders:

- Those interested in the specific population, the health issue, outcome, or vision
- Those with the power to influence the outcome or vision, regardless of their current interest.

Annex 2.2 has an example of a simple but useful stakeholder analysis tool. It first leads users through a brainstorming exercise to identify all stakeholders in the local system (e.g., mothers and children, village development committees, the mayor, health facilities, private medical practitioners, etc.). One should also identify stakeholders that are important influences, but are outside the local system (e.g., national health authorities, UN agencies, and international NGOs with activities in the area). Each stakeholder is then mapped on a simple grid to guide the planning team in deciding how to approach and involve them.

Step 2: Define a Shared Vision for Sustainable Health of the Population

Tool	When
Leading a visioning activity and developing a "sustainability scenario" (Annex 2.3)	During preparation stages with early partners. Fully at detailed planning stage.

In practice, describing the local system and developing the local system vision are interrelated activities since inclusion of stakeholders in the local system depends on the vision to be pursued. By the same token, different configurations of the local system will affect how the vision is defined. The project management team should start by imagining the desired accomplishments on a timetable that extends well beyond the end of the project. If the project period is 5 years, then a reasonable timetable might be 10 or even 20 years.

What is a vision?

The "vision" is a description of the preferred future reality for the local 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.[31]

An example of a vision

"Children will not die of preventable causes. They will find quality care in well-managed health centers and will be cared for by well-informed families."

A vision should be challenging to achieve, but still be realistic in the sense that, even if not immediately achievable, it could be attainable with enough effort over the long term. Such a vision can be inspiring and rally stakeholders. For example, a vision of "universal health insurance and access to quality primary health care" would be difficult to achieve, but certainly imaginable. On the other hand, a vision of "free health care for everyone" lacks realism and, therefore, is much less likely to inspire and rally diverse stakeholders. The process of arriving at the consensus statement for the vision already begins the process of working together, which is central to optimal local system functioning.

[31] Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

It should be obvious that a local system vision is different from a project objective. An objective is constrained by what can be achieved within the time of the project. For instance, a project objective might be to "fully immunize 60 percent of children age 0 to 23 months by end of project." In an equivalent situation, a vision might be to "fully immunize all children in a timely manner."[32]

To plan effectively for sustainability, it is vitally important to include local stakeholders and potential beneficiaries in the development of the vision. Their involvement in the development of the vision is fundamental and nonnegotiable. There will always be feasibility issues, such as the availability of partners, doubts about the value of the exercise, and even skepticism about the commitment of the project to the idea of sustainability. So because of lack of availability or interest, you may have to initiate the visioning process with a smaller group of stakeholders, who will have a valid but only partial view of the ideal future they envision. Going forward with them can help to build credibility. Later, as more stakeholders come on board, the vision can be refined and become more of a consensus of all local stakeholders.

Why do we bother developing a "vision"?

Developing a vision with stakeholders serves the following essential purposes:

1. A vision statement is the start of a contextual planning process for the local system and for the project.

2. It is an opportunity to facilitate a genuine sense of ownership of the future among partners. There is an "Ah-ha!" moment when stakeholders realize the issue is not the success of the project, but their own success at working toward a vision they created.

3. Because the vision is a collective exercise, it is an opportunity to build consensus and begin the negotiation process among partners. This ability to negotiate and dialogue is itself a determinant of sustainability.

Source: Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

Although a vision statement is usually quite simple, it is best to build it with partners through a process that involves the following steps:

- Start by exploring long-term sustainability issues through initial contacts and consultations to get the perspective of a variety of stakeholders.

- Develop a draft idea of what the vision could realistically be (and what it might not be).

- Begin to pull these thoughts together by convening a "health sector meeting." At this meeting you might brainstorm about some of the ideas that have been forming and explore in depth some of the strengths and weaknesses of the local system as it exists presently and as it might potentially evolve over the medium and long term.

[32] Yourkavitch, J., Ryan, L., & Sarriot, E. (2004). *Lessons learned from applying the Child Survival Sustainability Assessment (CSSA) framework to seven maternal and child health projects.* Calverton, MD: Macro International Inc. Available at http://www.childsurvival.com/documents/CSTS/sustDoc/Sust_lessons_main.pdf.

- Carry out a formal activity with a broad range of stakeholders to develop a vision and sustainability scenario (see below). Ideally, this should be done before baseline assessments, but in no case should this be done later than a work planning meeting with stakeholders.[33] It is most useful to carry out a visioning exercise with partners before carrying out all baseline assessments; this way, you can make sure that these studies will provide the information you need in finalizing the agreed-upon vision. The work planning workshop can then review the findings and modify the vision, if need be.

- Later in the life of your project, you and your partners may decide to refine or adjust the vision even further. This may occur at an annual review, a midterm evaluation, or a final evaluation. Although this might sound frustrating to revisit the vision so many time, if these adjustments are a consequence of increased commitment and present/potential partners, you should consider this a positive part of the process. This adjustment of the vision may be based on—

    - Lessons learned during implementation, especially in light of ongoing partner development concerning pro-sustainability thinking

    - Insights of new stakeholders who have joined more fully in the process since its initiation

    - Opportunities caused by substantial changes in the environment.

Step 3: Facilitate Local System Stakeholders to Develop their Sustainability Scenario and its Key Strategies

Tool	When
Leading a visioning activity and developing a "sustainability scenario" (Annex 2.3)	During preparation stages with early partners. At detailed planning stage with all partners/stakeholders

The sustainability scenario is a short description of how *the local system can expect to achieve and maintain its vision in the long term. It broadly identifies the roles and responsibilities of stakeholders, the capabilities they need to have to fulfill these roles, the flows of inputs needed, and the attributes of an environment that would be properly supportive.*

The sustainability scenario is not an operational plan, but rather presents the big picture in terms of roles and essential components of capable and viable key partners in a local system producing an adequate level of health in the population. For example—

- **Health service providers:** What services will be most critical? What capacities will they need to possess/develop to be capable of delivering these services?

- **Local MOH/government:** Do they act as a regulator? Do they act as a manager of local health units?

[33] What USAID's Child Survival and Health Grants Program grantees know as a Detailed Implementation Plan workshop.

- **Key local NGO(s):** Will they mobilize communities, and for what purpose(s)? Will they deliver services? Will they work on issues of access, including developing community-based health insurance?

- **Communities:** Will they be organized, and for what purpose(s)? Will they create demand for facility-based services? If so, which services? Will they support healthy household behaviors, and how?

- **Key outside actors with influence in the local system (e.g., technical agencies, donors, policymakers):** What roles will they play to develop local capacities? Will this role be a short-term investment or a long-term commitment? What functions are necessary to improve and maintain health status—change in policy, technical support for implementation of activities, continued funding, and/or other resources?

An example of a sustainability scenario might be: "To attain our vision of improved child health in a sustainable manner, we will improve the supervisory and logistics systems in primary health facilities; strengthen local village health committees and mother's groups to deliver sustained behavior change among mothers for key household behaviors; and advocate for policy change to allow for community case management of sick children. We will seek to develop a strong relationship with UNICEF[34] for technical support." This statement gives the broad outlines of strategies that will be employed to strengthen local system partners. It refers to most of the categories of actors outlined in the bullet points above.

Steps 4 and 5: Perform Baseline Assessments and Present Data

Tool	When
Measurement tools (Annex 3) See also notes on basing an evaluation on the Sustainability Framework (Annex 2.6)	Baseline assessments Midterm and final evaluation Post-project evaluation

You should now carry out a set of assessments to determine baseline attainment of each of the six components of the SF. In practice, because of the pressured timelines under which projects are often developed, these assessments may take place during or even before the development of the vision/scenario. The specifics of data collection (Step 4) and presentation (Step 5) are provided in Chapter 3. Annex 3 has a set of suggested measurement tools for each of the components of the SF. These tools should be adapted for local use, preserving the subcomponents measured and the general indicators, but making sure there is locally relevant terminology and revision of the indicators where necessary. The information in Annex 2.6 is relevant as well. While Annex 2.6 focuses on final or post-project evaluation, the principles presented are also relevant as guidance for baseline assessments.

[34] UNICEF stands for the United Nations Children's Fund.

Stakeholders' Planning Workshop: Review and Refine First Five Steps; Step 6—Develop Programmatic Responses

Tool	When
Facilitating a detailed planning workshop with local stakeholders (Annex 2.4)	Detailed planning stage

Having a meeting with project partners and an even broader group of local system stakeholders is a good way to build consensus. It also is a good opportunity to review and refine the first five steps of the SF assessment process before moving on to the sixth step (developing programmatic responses). Involving partners as early as possible is always better, but even if you've fallen short of that ideal—now that you have data from your baseline surveys—it is a great time to use a sustainability assessment approach to guide your project's work planning workshop. Part of the challenge will be to distinguish between what your project can and cannot do. Although every project has its limitations, yours can use the workshop to build upon a clear sustainability vision and scenario. Annex 2.4 presents options used in the past to conduct a work planning workshop while integrating pro-sustainability thinking and the SF in the process. Such a work planning workshop represents an opportunity to—

- Revisit the sustainability planning checklist to make sure all important issues are being covered
- Review baseline survey results
- Review the stakeholder analysis and first draft vision for the local system; consider if additional stakeholders need to be brought into this system and if the vision needs to be refined.

The following activities are recommended to complete the process:

- Step 6a—Conduct environmental scan activity with stakeholders to look at barriers/facilitators to action outside the direct control of the local system. Consider whether any of the identified factors are amenable to improvement by local system stakeholders. Think about mitigating the effects of any others.
- Step 6b—Conduct a present/future reality analysis in order to develop or refine the sustainability scenario of the local system.
- Step 6c—Determine what your project can contribute to the vision/scenario by identifying priority activities.
- Step 6d—Develop your project Results Framework within a sustainability plan of the local system.

Step 6a: Conduct environmental scan activity with stakeholders.

Tool	When
Component 6 tool—environmental Scan (Annex 3)	Baseline assessments Midterm and final evaluation Post-project evaluation

Look at barriers/facilitators to action outside the direct control of the local system. Consider whether any of the identified factors are amenable to improvement by local system stakeholders. Think about mitigating the effects of any others. This sub-step is most easily done when all stakeholders are together, so it is included here. But since this is part of the measurement aspect for Component 6 of the SF, a fuller description is included in Chapter 3.

Step 6b: Conduct a Present/Future Reality Analysis and Refine the Sustainability "Facilitating a Detailed Planning Workshop with Local Stakeholders" Scenario for the Local System

Tool	When
Facilitating a detailed planning workshop with local stakeholders (Annex 2.4)	Detailed planning stage

The shared vision that partners create for the local system is a powerful motivator for sustainability planning. It serves as a firm "compass" for all stakeholders to guide their decisions about how to act when they are not sure which direction to take. The vision can also guide initial planning discussions and prioritize the key activities of the project. The vision represents the "sustainable system" (i.e., the future reality). The planning process should also include an assessment of how close you are to the vision (i.e., the present reality). This present/future reality analysis should be done with stakeholders.

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 SF provide a useful set of categories into which you can group ideas. You can guide the discussion by asking the following questions:

1. 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 tuberculosis (TB), increased breastfeeding rates, increased immunization rates, etc. These are the outcomes you will measure in Component 1.

2. 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).

3. 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

competencies that the supporters of health services (Component 3) ought to have and supporters of community capacity (Component 4) ought to have.

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. These are the risks and supports about which planners should be aware and try to influence if possible (Component 6).

A central challenge at this point will be to start identifying those parts of the vision/scenario that 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 worst, 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 its *current or potential assets*. That is, there may be strong religious organizations or mother's 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.

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. The final analysis of the "present reality" will serve as your baseline (preferably documented through presentation of the findings of the initial baseline sustainability assessments). The process of visioning and relating your baseline to that vision

positions you and partners to measure progress toward sustained health outcomes (e.g., the vision) over the life of the project, and then to have the systems in place for returning to the project area 5 to 10 years post-project to see if your original sustainability scenario was realistic.

Step 6c: Determine What Your Project Can Contribute By Identifying Priority Activities

Tool	When
Facilitating a detailed planning workshop with local stakeholders (Annex 2.4)	Detailed planning stage

This step is different in subtle but important ways from that of project planners having carried out a situation analysis and having to decide how the project should position itself and what it should tackle:

1. The focus on sustainability of health outcomes has brought stakeholders together and facilitated some early measure-of-system thinking among them.

2. A vision and sustainability scenario—even if they will evolve through time and experience—has been developed for the local system and its stakeholders. This encourages the discipline of thinking of the project as a contributor to the local system's history, rather than the center of its own world.

3. The baseline assessments provide a more comprehensive or holistic picture of the road ahead to achieve the vision and will encourage more strategic choices for the project within a framework that encourages greater accountability for all project partners and local system stakeholders.

4. The project can now effectively make decisions on activities within a larger framework of the local system, setting in motion "pro-sustainability thinking from the outset."

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.

At this point, as illustrated in Figure 2.2 below, some objectives will be identified as the responsibility of the project and others not. This should lead to critical thinking on the following two things, possibly through a session during the planning workshop:

- **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? The 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

Tool	When
Pro-sustainability Results Framework (Annex 2.5)	Detailed planning stage

Having defined the roles and responsibilities of both project partners and other stakeholders in the local system, the project team will be ready to develop a project Results Framework fully integrated in the newly developed local system's Sustainability Framework. The initial Results Framework was probably drafted at the proposal stage, but the early implementation stage (i.e., while formulating the Detailed Implementation Plan) 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 for a fuller explanation):

- The shared vision of the Local System is placed at the level above the project goal
- The project Results Framework is presented with Intermediate Results that correspond to each of the Components of the SF (see Annex 2.5 for an example)
- The project targets results that are achievable within a specific and tight timeframe, but the Sustainability Framework clearly presents how progress needs to go beyond those levels on some subcomponents. This is illustrated in Figures 2.2 a, b, and c

Figure 2.2a is an example for representation of the baseline situation the local system Sustainability Framework. In this simplified model we show only two subcomponents (each with one indicator) per component and all are at the poor or intermediate level. This is to keep the discussion simple, but there will be more indicators/subcomponents per component in a real Local System SF.

Figure 2.2a—Simplified representation of results of the baseline situation for the local system's Sustainability Framework

Level of Indicators (Component Index Score)	Sustainability Framework Components											
	1		2		3		4		5		6	
	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2
Optimal												
Intermediate												
Poor												

Figure 2.2b shows target setting for project partners in this project Results Framework that fits in the local system Sustainability Framework. Since this is the *project's* Results Framework only the progress targeted by project partners is shown. The green represents the progress that project partners are expected to make by the end of project. The planning staff has the realistic expectation that project partners may not be able to make progress on certain key indicators/subcomponents. This is not to say that these sub-components are unimportant for sustainability, but rather that they are outside of the project's mandate. For instance, under Component 2, indicator#2 is not targeted for progress. This indicator may be for infrastructure improvement in health facilities and may lie outside the mandate of a community-oriented project. But as we shall see below in Figure 2.2c, there may be other stakeholders whose commitments may be secured that can fill in these gaps in the project's Results Framework.

Figure 2.2b—Simplified representation of progress targeted by project partners toward sustainable health outcomes

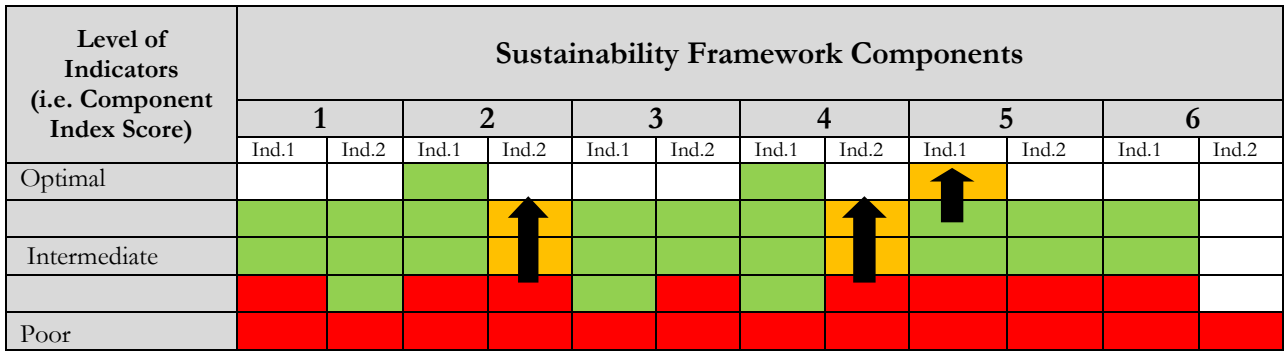
Level of Indicators (i.e. Component Index Score)	Sustainability Framework Components											
	1		2		3		4		5		6	
	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2	Ind.1	Ind.2
Optimal												
Intermediate												
Poor												

In practical terms, it is crucial that local system stakeholders feel as accountable to one another for achievements of their results as project staff feels 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 all stakeholders agree to report.

In Figure 2.2c, the targeted contributions of non-project stakeholders (in orange) are included in the final local system Sustainability Framework. For instance, Component 2 indictor #2 (which we imagined above to be infrastructure improvements outside the project's mandate) is now targeted,

perhaps, by the provincial MOH authorities or another development NGO. Similarly, Component 4, indicator 2 has been targeted for improvement by a non-project stakeholder. Indicator #1 for Component 5 has been targeted for further improvement by a non-project stakeholder. But even here in this expanded representation we see that indicator #2 under Component 6 is not targeted for improvement. Perhaps this indicator represents vulnerability to drought or some other factor that stakeholders feel they cannot realistically improve even over the medium term. Even though it is not targeted for improvement, it is still recognized as important for sustainability of results, and so it is kept in the SF to give a realistic sense of the state of key factors influencing sustainability. To do otherwise might make us feel better but it would be a denial of the true situation.

Figure 2.2c—Simplified representation of progress targeted by both project partners (green) and other stakeholders (orange) toward sustainable health outcomes



Observe how this sort of thinking can make subsequent sustainability evaluation much more focused and able to concretely answer important questions. You can now ask and assess whether the project's choice of targets (its Results Framework) is the most strategic possible, as you will have data on both health outcomes (Component 1) as well as on the subcomponents meant to achieve and maintain these outcomes (i.e., in Components 2-6). You may ask whether the project helped partners and other stakeholders define a common vision and sustainability scenario, embodied by the Sustainability Framework of the local system; and whether there is a sense of shared accountability to meet the objectives of Figure 2.2a. So you review the achievements of the project against its targets, you can consider not only its short-term effectiveness but also its possibility of longer term sustainability.

By using the suggested tools outlined in the next chapter (or others with similar characteristics of feasibility of use and validity of results obtained), progress on outcomes in each of the SF's six components can be documented on a periodic basis. These tools give a comprehensive picture of all the subcomponents in each of the six components. But in order to increase motivation and accountability among stakeholders, more frequent tracking of progress (i.e., monitoring) is necessary on the key subcomponents identified for priority action by local system partners. For instance, a full organizational capacity assessment of the key local NGO partner(s) should be done at baseline, possibly at midterm, and again at final evaluation of the project. The tool suggested in the next chapter for organization capacity assessment (i.e., the Organizational Capacity and Viability Assessment Tool) has 12 subcomponents that should all be measured at these key evaluation stages. Even though *all* of these subcomponents are measured at these evaluative stages, weaknesses targeted for priority action may have been identified in just two or three of these. It is indicators for this shorter list of targeted subcomponents that should be monitored more frequently, as reporting on progress is shared among mutually accountable stakeholders in the local system.

2.3 A WORD ON MONITORING AND EVALUATION

Tool	When
Notes on basing an evaluation on the Sustainability Framework (Annex 2.6)	Baseline assessments Midterm and final evaluation Post-project evaluation

If the project has been planned and the monitoring and evaluation (M&E) system set up with the SF in mind as outlined in the last subsection, then incorporating pro-sustainability thinking throughout implementation of the project should not be problematic. Annex 2.5 shows an example of a Results Framework set up to follow the SF. Within the corresponding Project Management Plan, activity monitoring and management should be done for the intermediate results that lead to capacity development as well as those that lead to the service coverage and outcomes. In doing so, one will be monitoring those important underpinning factors that support sustainable health outcomes. It is important that these intermediate results be monitored with all important partners involved to foster a sense of mutual accountability and transparency.

CHAPTER 3: THE SUSTAINABILITY FRAMEWORK AND MEASUREMENT OF PROGRESS

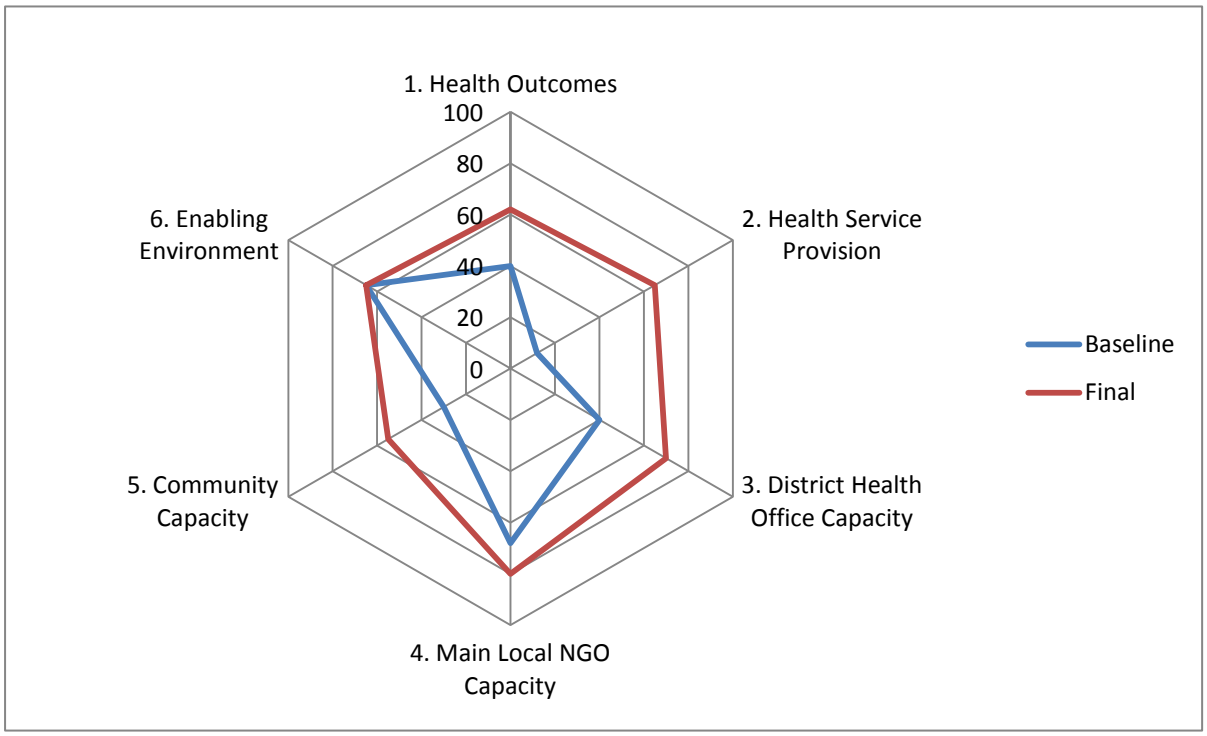
TOWARD SUSTAINABILITY

Previous chapters introduced the general structure of the SF and how to use pro-sustainability principles to design, plan, and manage a project using the thinking of the SF. This chapter deals with the specifics of measuring the level of attainment of the components of the SF, both at baseline and during subsequent evaluations. Of course, there is much more to evaluation than just the numeric estimation of progress on which this chapter focuses. These other, more comprehensive, aspects of sustainability evaluation are covered in Annex 2.6.

3.1 A REVIEW OF TYPES OF INDICATORS THAT ARE USEFUL FOR THE SUSTAINABILITY FRAMEWORK

Figure 3.1 shows an example of how the numerical data for measurement of each of the six components of the SF can be presented as a radar diagram. We present this now to give you an idea of where the discussion is headed, even though we have not yet explained how to arrive there. In this chapter we will show how to get to a summary diagram like this, with a general discussion of the data needed in general and for each of the components specifically. There will also be examples.

Figure 3.1
Sustainability Framework Summary Radar Diagram



Each component has a summary index score. Each component is made up in turn of subcomponents shown in the table in Annex 2 (Table A1.1).

Much has been written about what constitutes a good indicator. We will not repeat that here, as you can read about it elsewhere.[35] One should also keep in mind that no matter how good the numerical indicators summarized in the SF, this can only tell part of the story. This information must always be supplemented with a more in-depth narrative. The narrative of a sustainability evaluation might, for instance, describe *why* leadership is not democratic or *how* it evolved to its present state. It could talk about why access to service delivery is low and about difficulties experienced by the district in improving the situation. Such a narrative can help to track progress by analyzing the barriers overcome or still to be overcome for a key indicator or set of indicators. This information is also essential for formulating strategies for improvement. See Annex 2.6 for a more in-depth treatment of the suggested parameters of a pro-sustainability evaluation.

Some of the components of the SF include indicators for inherently qualitative data. As you can see in Figure 3.1, the SF measures progress toward sustainability using indices that are numeric scales. Data for health outcomes (Component 1) and health service provision (Component 2) are usually quantitative, so scaling this information to fit the SF's 0 to 100 scales is not difficult to imagine. But the SF's other components (i.e., organizational capacity/viability, community capacity) include complex and qualitative concepts, like leadership, networking, and sound management practices. So how do we get such information into numerical data we can present on the SF's 0 to 100 scales? The simplest way is to grade these concepts on rating scales for each of the subcomponents. In the other sections of this chapter we will consider the types of subcomponents that make up each of the components. There will also be a discussion of how the measurements of each of the subcomponents are combined into the component index score. In Annex 3, there is additional information on indicators and suggested tools as well as ways to *transform* the measured indicator values to make them all comparable so they can be combined into subcomponent index scores that range from 0 to 100. If you use the five suggested tools in Annex 3, then you will not have to concern yourself with transforming data to fit the 0 to 100 scales of the SF, as this is already done by the tools themselves.

An additional complicating factor is that the concepts measured in Components 3, 4, and 5 can seem exclusively process-oriented. For instance, for the management subcomponent of Component 4, one might be tempted only to measure something concrete and easily quantified, like the number of management meetings held. But such an indicator would not tell us how well the meeting was conducted, who participated, or ultimately whether organizational performance was affected by having the meeting. There are in-depth treatments of the different levels of indicators one can measure for capacity.[36] Here we will present some concrete examples that illustrate how we can measure if performance really has improved, which is what we would like to measure in Components 2 to 5. The following table gives an idea of a hierarchy of indicators one could follow for typical capacity or viability objectives. This is compared to the hierarchy of indicators that would

[35] For instance, the following is a good brief treatment of the types and levels of indicators needed; available at http://www.emro.who.int/GFATM/guide/system/indicators.html. The discussion is specifically for HIV/AIDS programs, but applies equally well to any health program.

[36] LaFond, A. K., Brown, L., & Macintyre, K. (2002). Mapping capacity in the health sector: A conceptual framework. *International Journal of Health Planning and Management, 17*(1), 3-22.

be used for exclusive breastfeeding, as an example of a health outcome from a traditional Results Framework. The indicators in the table under outcome/performance should be evaluated at least at baseline and end line. In the case of exclusive breastfeeding, the outcome will likely be measured through a population survey. In the case of the organizational capacity/viability indicators in Table 3.1—networking, financial management, and supervision—outcomes (performance) will likely be collected through an organizational capacity assessment tool (e.g., the Organizational Capacity and Viability Tool [OCVAT] discussed later in this chapter). The results of these assessments can be combined into indices and mapped onto the SF radar diagram described later in this chapter.

Table 3.1
Hierarchy of Indicators for Selected Subcomponents of the Sustainability Framework

Level of Indicator	Breastfeeding	Networking	Financial Management	Supervision
Outcome/ performance	Percentage of infants age 0 to 5 months who are exclusively breastfed (i.e., received only breast milk in last 24 hours)	Percentage of projects jointly conducted with key local organizations	Percentage of recurrent costs covered by cost recovery	Percentage of health workers performing tasks according to protocol covered in supervisory visits
Output	Number of mothers with minimum level of positive knowledge and attitudes about Exclusive Breastfeeding (EBF) (post-test from promotion sessions)	Number of agreements for joint action signed	Number of health facilities with specified level of funds in bank account	Number of health workers at local health facilities with performance improvement plans based on supervisory visit
Process	Number of breastfeeding promotion meetings held	Number of meetings with other organizations	Number of health facilities regularly collecting user fees	Number of supervisory visits conducted
Input	Number of trained breastfeeding promoters	Work plan includes meetings with other organizations	Number of health facilities with cost recovery plan	Number of mandated supervisory posts filled at district level

On the other hand, the indicators for outputs, processes, and inputs should go into the project monitoring plan (see Section 3.4 of this chapter), but do not belong in an evaluation framework like the SF radar diagram. This is as true for the indicators that correspond to key project activities for Components 3, 4, and 5 as it is for indicators corresponding to tracking progress on the more traditional Components 1 and 2. This is not to say that following process indicators is not important.

It is just that they are part of frequent project monitoring, and it is outcome measures that belong in evaluation frameworks like the radar diagram in the SF.

Some data that are typical of Components 3, 4, and 5 cannot be broken down into counts or percentages as in Table 3.1. An example is the indicator for "consultation and participatory decisionmaking." This indicator is part of the organizational leadership subcomponent of Component 4 (main local NGO organizational capacity and viability). The suggested tool (the OCVAT, see subsection on Component 4) has a scale that tells an evaluator what conditions should be present for the organization to be rated as a 0, 10, 30, 50, 70, 90, or 100 (see Figure 3.2). If a different tool is used, it would be common to rate this indicator on a 1 to 5 scale. This could then easily be converted to the 0 to 100 scale of the SF by assigning a 1 score a value of 10, a 2 score a value of 30, a 3 a value of 50, a 4 a value of 70, and a 5 a value of 90. The end result is that all the data for all subcomponents of the SF are eventually converted to numeric scores that can be combined into the component index scores that we graph on a radar diagram like Figure 3.1.

Figure 3.2
Example of a Rating Scale Used for Consultation and Participatory Decisionmaking (Part of the Organizational Leadership Subcomponent of Component 4)

Descriptions of scale scores						
Minimum—No Attainment	**1. Informal Activity Only**	**2. Start of Formal Activity**	**3. Some/fair Progress**	**4. Good Progress**	**5. Excellent Progress**	**Maximum—Complete Attainment**
0 points	**10 points**	**30 points**	**50 points**	**70 points**	**90 points**	**100 points**
Only the top leaders make all important decisions on their own and without consulting others. They are not open to new ideas.	There is an informal process of consultation by top leadership for important decisions with a few trusted colleagues, and/or some delegation of important decisionmaking occurs. But this consultation or delegation is not systematic and occurs at the whim of the top leader.	Leaders make decisions in consultation with one or two others, but delegation of important decisionmak-ing does not occur.	Although there is a formal process of consultation and/or a formal structure for delegation of important decisions, this process is only followed about half the time.	There is a formal process of consultation, but it is not always followed and/or there is a formal structure for delegation of important decisions. This process is followed about half the time.	There is a formal process of consultation, but it is not always followed and/or there is a formal structure for delegation of important decisions. This process has usually but not always been followed in the last year.	There is a formal and regular (at least quarterly) process in which leaders discuss decisions taken. If the rules for discussion and dissemination are not followed, there is some sort of corrective action taken.

3.2 SUBCOMPONENTS OF THE SUSTAINABILITY FRAMEWORK AND THEIR MEASUREMENT

I. Step 4: Measuring each Component of the Sustainability Framework

Component 1: Health Outcomes

As was said in Chapter 1, Component 1 should convey the sense of the population health outcomes (or, if we are talking about a single point in time, it may be more appropriate to talk about health status). A few principles are critical for constructing a sensible index that gives a valid picture of health outcomes/status:

- You should only pick the category of outcomes with which your project and local system partners are concerned. That is, if you are working on a child health project, then you would only be concerned with the nine subcomponents under "neonatal/child health."

- To give a true sense of the health status of the relevant population as much as feasibly possible, the indicators used to make the health outcomes index should cover *all* health outcomes relevant to the population of interest, not just the outcomes on which the project will intervene.

- The data should be population-based and cover the entire relevant population.

- The data should be as close as feasibly possible to outcomes known to make a difference in health status. In other words, indicators of knowledge and attitudes do not belong here, but rather coverage of key interventions and behaviors.

Below is a summary of the subcomponents of Component 1 for the various types of common community-oriented health programs. Each health area's subcomponents are explained in the sections below.

Subcomponents of Health Outcomes

Neonatal/child health
1.1NC Newborn conditions
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

Family planning
No subcomponents

Tuberculosis
No subcomponents

HIV/AIDS
1.1H Prevention of child HIV (prevention of mother-to-child transmission [PMTCT])
1.2H Prevention of HIV in adults/adolescents (e.g., ABC programs)
1.3H Adult treatment (antiretroviral therapy [ART] and opportunistic infection [OI])
1.4H Palliative care (e.g., HBC)
1.5H Care of orphans and vulnerable children (OVC)

Neonatal/child health (neonatal/child health index)

Table 3.1 outlines population health outcome indicators that are suggested for use in constructing an SF health outcome index for neonatal and child health. Indicators in the table are included either in the Core Assessment Tool for Child Health (CATCH) indicators[37] or in the *Lancet* series on child health (2003)[38] or the series on neonatal health (2005).[39] There is strong overlap between these two lists. It is advisable to use as many of these indicators as possible to construct the index in order to give the most valid and comprehensive picture of the health of under-five children in the local area. Once compiled, the indicators can be combined and converted to a 0 to 100 index. The method for doing this is covered in more detail in Annex 3.

An alternative method for summarizing Component 1 data is to present it as estimated mortality. At baseline, this would simply be the baseline under-five mortality rate (U5MR) estimated from secondary data. For midterm, final, and post-project evaluations, changes in U5MR would be estimated through the use of a tool called the Lives Saved Tool (LiST) covered in Annex 3. The LiST (also known as the Lives Saved Calculator) is available at www.childsurvival.com. This tool was developed by the Child Health Epidemiology Reference Group. It takes *changes in coverage* for the evidence-based interventions in the last column of Table 3.2 and converts these to an estimate of the overall impact on U5MR. We can then map this onto a 0 to 100 scale in a way that is described in Annex 3. Briefly, the idea is that U5MR of 200 or greater is scored as 0 and a U5MR of 20 or less is scored as 100. Intermediate values can be calculated on this linear scale.

[37] http://www.childsurvival.com/kpc2000/rapidcatch.pdf
[38] Jones, G., Steketee, R., Black, R., Bhutta, Z., & Morris, S. (2003). The Bellagio Child Survival Study Group: How many child deaths can we prevent this year? *Lancet, 362*(9,377), 65-71.
[39] Darmstadt, G., Bhutta, Z., Cousens, S., Adam, T., Walker, N., de Bernis, L., et al. (2005). Evidence-based, cost-effective interventions: How many newborn babies can we save? *Lancet, 365,* 977-988.

Table 3.1
Suggested Measures for Subcomponents of Neonatal/Child Health

Subcomponent	Indicators for constructing Neonatal/Child Health Outcome Index	Rapid Catch	*Lancet* Lives Saved
Newborn Health	Antenatal Care in last pregnancy	X	X
	Maternal Tetanus Toxoid × 2, last pregnancy	X	X
	Skilled birth attendants—nurse or doctor	X	X
	Clean home delivery by trained TBA		X
	Postnatal visit within the 3 days of birth	X	
Vaccine-Preventable Diseases	Measles immunization before 12 months	X	X
	Access to immunization services (DPT1)	X	
	Immunization health system performance (DPT3)	X	
	Pneumococcal vaccine coverage		X
	Hib vaccine coverage		X
Diarrhea	Hand washing by caretaker	X	X
	Point-of-use water treatment	X	X
	Sanitation—proper feces disposal by caretaker		X
	Zinc treatment for diarrhea		X
	Oral Rehydration Salts (ORS) or Recommended Home Fluids (RHF) use during last diarrhea episode	X	X
Pneumonia	Antibiotics for pneumonia, community or facility	X	X
Malaria	Insecticide-treated net (ITN) use last night by child under 5 years	X	X
	Intermittent presumptive treatment for malaria, at least one dose in last pregnancy		X
	Malaria treatment within 24 hours of onset of fever	X	X
HIV/AIDS*	PMTCT coverage (as in HIV/AIDS subsection below)		X
Child Spacing	Met need for FP (see FP subsection below)	X	
Breastfeeding	Exclusive breastfeeding, 0-5 months	X	X
	Continued breastfeeding, 6-11 months		X
Nutrition	Infant and young child feeding	X	X
	Underweight prevalence	X	X
	Vitamin A supplement in last 6 months	X	X

* Include only in areas where AIDS is a major cause of child death.

Maternal health

The number of evidence-based outcomes that should be summarized in order to get a picture of maternal health is not as large as for neonatal/child health. These outcomes have been summarized in the 2007 *Lancet* articles on maternal health. The table below has four to five of the most critical interventions that collectively could prevent the large majority of maternal deaths in most settings (the indicator for HIV should only be included where this is a significant contributor to maternal mortality). There is not as much of a one-to-one correspondence between the indicators and the subcomponents, as in child health. This is because the indicators are for interventions that have effects on multiple causes of maternal mortality. These should be tracked whether the project is working on the area or not, as this will give the truest picture of maternal health among the women

of reproductive age in the geographic area of the local system. Further details on measurement and analysis for this suggested data are given in Annex 3.

Table 3.2
Suggested Indicators for Measuring Subcomponents of Maternal Health Outcome Index

Subcomponent	Suggested Indicator*
Hemorrhage/anemia	Met need for modern FP (see FP section) Home birth by trained attendant, coverage Skilled birth attendance, coverage Met need for essential obstetric care
Hypertension/eclampsia	
Sepsis/infection	
Obstructed labor	
Abortion	
HIV/AIDS**	Anti-Retroviral Therapy (ART) coverage, female-specific, if available

* All indicators listed here are explained in: Bertrand, J., & Escudero, G. (2002). *Compendium of indicators for evaluating reproductive health programs* (Vol. I). (MEASURE Evaluation Manual Series No. 6/USAID Cooperative Agreement No. HRN-A-00-97-00018-00).
** Only in high HIV seroprevalence settings.

Family planning

Family planning has no subcomponents. There is only one indicator for measuring its outcome. Following the philosophy of deriving a number that is as close to the population health outcome as possible while being feasibly collected and analyzed, we can construct a single indicator that summarizes the state of the relevant population quite well. This is the met need for modern contraception among women of reproductive age. This measures the extent to which demand for contraception is being met by all methods of modern contraception. The formula for met need is simply *Met Need = 100 – Unmet Need,* which is a commonly used FP indicator. A description of how to calculate unmet need is on USAID's Flexible Fund website[40] as well as in Annex 3. This is a coverage rate and therefore varies from 0 to 100 percent.

Tuberculosis

Tuberculosis has no subcomponents, as it is a single health area itself. A fairly valid impression of the state of population health with respect to TB can be derived from just two outcome indicators that all national tuberculosis programs collect, so the data are readily available and updated annually. These two indicators are—

- Estimated case detection rate (CDR)
- Treatment success rate (TSR)

The CDR is usually only available on a national level and is therefore only completely accurate as an estimate at this scale. Many projects work at a sub-national level where this estimate may not be completely accurate; however, there will usually be no other data available that can give a more accurate estimate, and this value will give some idea of case detection in the project area. The measure for TB outcomes is calculated by multiplying these two indicators (i.e., CDR × TSR), giving an index value with the meaning of "percentage of TB cases in the population that were successfully treated." The range of values for both CDR and TSR is 0 to 100 percent. So this tuberculosis outcome index also takes values ranging from 0 to 100.

[40] Available at http://www.flexfund.org/.

HIV/AIDS

The term "HIV/AIDS programs" encompasses several disparate types of activities. That is, an HIV/AIDS program can do any or all of the following: prevent HIV infection, medically treat those with HIV/AIDS, deliver palliative care to those dying from AIDS, and/or care for those affected by an ill or deceased family member. These encompass different target populations with different sorts of outcomes. In fact, if we consider the effects of HIV/AIDS on society as a whole, the situation is even more complex and could include psychological, social, or economic outcomes as well. But if we restrict ourselves to health outcomes as Component 1 does, then the following five subcomponents cover most of the variety of health outcomes and target populations of HIV/AIDS programs:

- 1.1H Prevention of HIV in infants (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 orphans and vulnerable children (OVC)

Some of these types of programs are more problematic than others to derive a number that accurately summarizes the appropriate population health status/outcome. Table 3.3 gives the suggested indicator for each of these. All of the suggested indicators are coverage percentages that vary between 0 and 100. If one is working on a combined HIV/AIDS program that includes several or all of the types of programs in the table, one can make a composite index that averages the value of each of the relevant coverage indicators. Annex 3 (containing the measurement toolkit) includes a Component 1 index calculator that automatically does this, given data for each of the relevant indicators.

Table 3.3
Subcomponents and Indicators of HIV/AIDS Outcome Index

Type of HIV/AIDS Program	Indicators for Constructing HIV/AIDS Outcome Index
Prevention of HIV in infants (PMTCT)	Coverage with perinatal ARV
Prevention of HIV in adolescents/adults	Use of condom at last at-risk sex
Treatment of adults (ART)	Coverage with ART (denominator: adults with AIDS)
Palliative care/home-based care	Coverage with a basic package of services (determined by program)
Care of OVC	Coverage with a basic package of services (determined by program)

Before combining indicators into a single composite Component 1 HIV/AIDS index, one should consider whether the various HIV/AIDS programs to be included are similar enough that this makes sense. Will you be describing a single local system in such a combined SF? If not, you might consider constructing separate SFs for each of the separate HIV/AIDS programs. For instance, if there is a PMTCT program and an OVC program, the former program will entail working heavily in health centers and hospitals, while the latter program works in schools and with income-generating organizations. The service delivery modes and the organizations that need to be strengthened may

be so distinct between the PMTCT and the OVC programs that it may simply be better to keep them separate. That is, construct an SF for the OVC program with a Component 1 index that only includes outcomes for OVC, service delivery for OVC, organizational strengthening for OVC-relevant institutions, etc., and construct another SF for PMTCT, with coverage of PMTCT as the Component 1 outcome, service delivery specifically for PMTCT, organizational capacity for organizations supporting PMTCT services, etc.

An example of calculating a Component 1 index score

Table 3.3 shows an example of a calculation of a Component 1 index score. This example is for neonatal/child health programming only. The data used in the third column for the 18 indicator values are from national data for Ethiopia, mainly derived from the 2005 Demographic and Health Survey. In the case of a project, we would use the data collected from a population survey. We need the measured values of at least one indicator for each of the nine subcomponents of neonatal/child health. This example shows the data as they are displayed in the Component 1 index calculator, a tool described in Annex 3. After the indicator values are entered, the tool automatically transforms these values to those in the next column ("Transformed indicator value"). Indicators for which there are no data are ignored by the calculator. The transformed indicator values for all the indicators with data in a subcomponent are averaged to give each of the nine subcomponent scores. Finally, these subcomponent scores are averaged to give the overall value for the Component 1 index. In this case, the value of the Component 1 index score is 22, as you can see in the last row of the table.

Table 3.4
Example of a Calculation of Component 1 Index, for Neonatal/Child Health

Neonatal/ Child Health Subcom-ponent	Indicator	Indicator value	Transformed indicator value	Sub-com-ponent score
Newborn Health	Antenatal care in last pregnancy	22	5	13
	Maternal tetanus toxoid × 2, last pregnancy	57	32	
	Skilled birth attendance—nurse or doctor	10	1	
	Clean home delivery by trained TBA			
	Postnatal visit within the 3 days of birth			
Vaccine-Preventable Diseases	Measles immunization before 12 months	25	6	21
	Access to immunization services (DPT1)	63	39	
	Immunization health system performance (DPT3)	42	17	
	Pneumococcal vaccine coverage			
	Hib vaccine coverage			
Diarrhea	Hand washing by caretaker	7	0	5
	Point-of-use water treatment	16	2	
	Sanitation—proper feces disposal by caretaker	36	13	
	Zinc treatment for diarrhea			
	ORS/RHF use during last diarrhea episode	19	3	
Pneumonia	Antibiotics for pneumonia, community, or facility	27	7	7
Malaria	ITN use last night by child under 5 years	2	0	0
	Malaria intermittent presumptive treatment, one dose or more	3	0	
	Malaria treatment within 24 hours of onset of fever	3	0	
HIV/AIDS	PMTCT coverage	10	10	10
Child Spacing	Met need for FP	20	20	20
Breast-feeding	Exclusive breastfeeding, 0-5 months	73	53	75
	Continued breastfeeding, 6-11 months	99	97	
Nutrition	Infant and young child feeding	90	80	49
	Underweight prevalence	47	26	
	Vitamin A supplement in last 6 months	65	42	

Component 2: Health Service Provision—Access and Quality

Health service provision is critical for delivering many of the outcomes measured in Component 1. On the other hand, we should keep in mind that this is not the only delivery pathway, as community members also "deliver" themselves some crucial health behaviors, like breastfeeding, hand washing, and fertility awareness FP methods. The readiness of communities to deliver key services and demand others is measured in Component 5. In Component 2 we measure the readiness of the

health facilities and their outreach workers to deliver those key outcomes included in Component 1 for which they are responsible.

The data used to construct the Component 2 score focus on two key aspects of health service provision—access to and quality of health services. Clearly, both of these aspects are critical for health service delivery. It serves no purpose to have high-quality services that are inaccessible or to have highly accessible services of low quality. In either case, we would expect little improvement in health outcomes.

For the measurement of access, we use the simplest and most feasible measure: geographic access (i.e., the percentage of the population in the area that is within reasonable distance of the service in question). The standard WHO definition of "reasonable distance" is within 5 kilometers or 1 hour travel time by local means of transport. The easiest way to estimate this is simply to speak to an informed respondent, perhaps in the district health office. The suggested tool for measuring Component 2 is the Rapid Health Facility Assessment (R-HFA), described in Annex 3 and available at www.childsurvival.com. This tool has a simple mapping exercise for calculating the geographic access.

To get an accurate picture of the quality of the health facilities to deliver key services, we cannot measure just one or two indicators. Rather, we need to take a "systems approach." For instance, we might be concerned that those children with pneumonia receive proper treatment. Clearly, well-trained health care providers are essential for this task. They must be able to recognize those children in need of this potentially lifesaving treatment. However, trained providers are not enough. There must also be a reliable supply of the needed antibiotics. If there are no medications in the facility on a given day, a health provider might well recognize a case of pneumonia in need of treatment and yet be unable to provide the child with the treatment he or she needs. So we need to measure a "balanced scorecard" of indicators across a variety of subcomponents. These are shown below.

Subcomponents of Health Service Provision

Access
2.1 Geographic access/availability of services

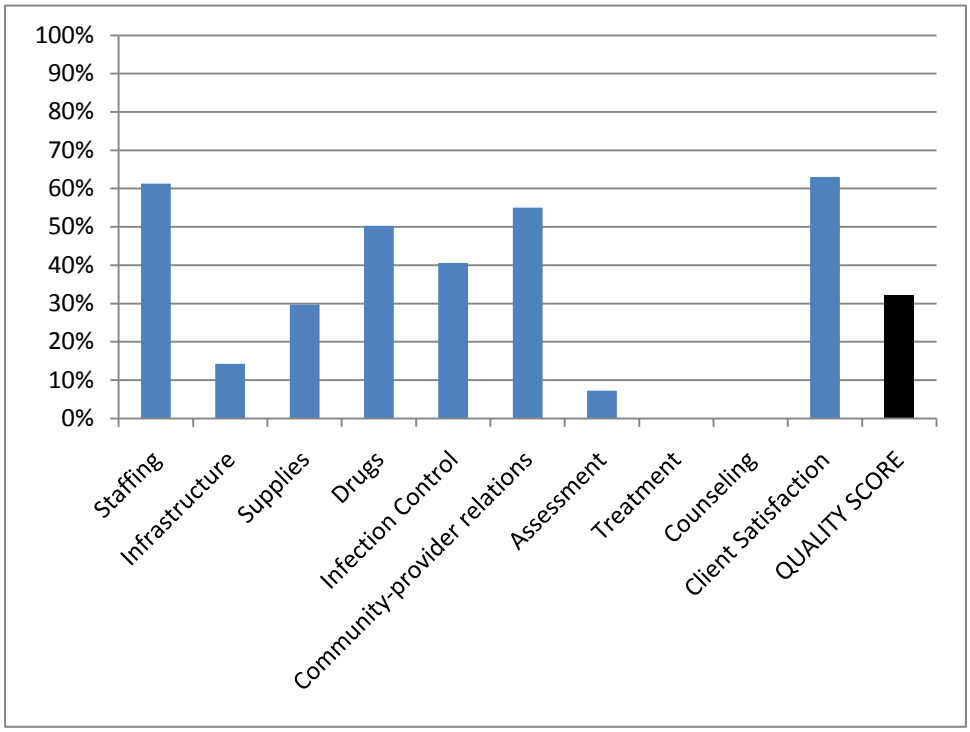
Quality
2.2 Staffing
2.3 Infrastructure
2.4 Supplies
2.5 Drugs
2.6 Infection control
2.7 Community-health facility relations
2.8 Health worker technical performance (assessment, treatment, counseling)
2.9 Client satisfaction

An example of calculating a Component 2 index score

To construct the Component 2 index, we multiply the geographic access score by the quality score. This gives a sense of the access to services, weighted by the quality of services received. The R-HFA

tool automatically does this for you. Below is an example of the data produced by the R-HFA. Each indicator (staffing, infrastructure, etc.) is constructed to describe the minimum level of quality that a primary care facility should have. For instance, there are five drugs that are checked. The fact that the chart shows a value of 50 percent means that, on average, 2.5 (50%) of these 5 drugs were present in the health facilities assessed. The other nine quality indicators are constructed in the same way. An overall quality index score is constructed as the average of the 10 quality indicators. In this case, the quality index score was 31 percent. If we find that, say, 70 percent of the population has access to these services, then the Component 2 index would be 72% × 31% = 22%.

Figure 3
Presentation of Subcomponents of Component 2 and Quality Score



Component 3: MOH/District Organizational Capacity and Viability

There are certain key basic capacities that a district health officer (DHO) or district health management team (DHMT) needs to have in order to support service delivery in its area. There are other areas of functioning that correspond to the ability to sustain this capacity—that is, the ability of the DHO. These are the subcomponents of Component 3, outlined in Figure 3.4. These are measured on a new DHO module of the R-HFA tool. The method for measurement and/or the exact indicator may need to be adjusted depending on the context, but it is unlikely that a DHO or a DHMT will not have these basic responsibilities. There will be some variation, especially contingent on how decentralized the health system is. Of course, even if they don't have these responsibilities, it could be argued that perhaps they should so that the health system in the local area will function optimally.

Some of the DHO competencies outlined here are best measured by speaking with personnel in the district health office itself (e.g., planning, budget management). The R-HFA included in Annex 3 has a DHO module that has questions for construction of the indicators from these subcomponents.

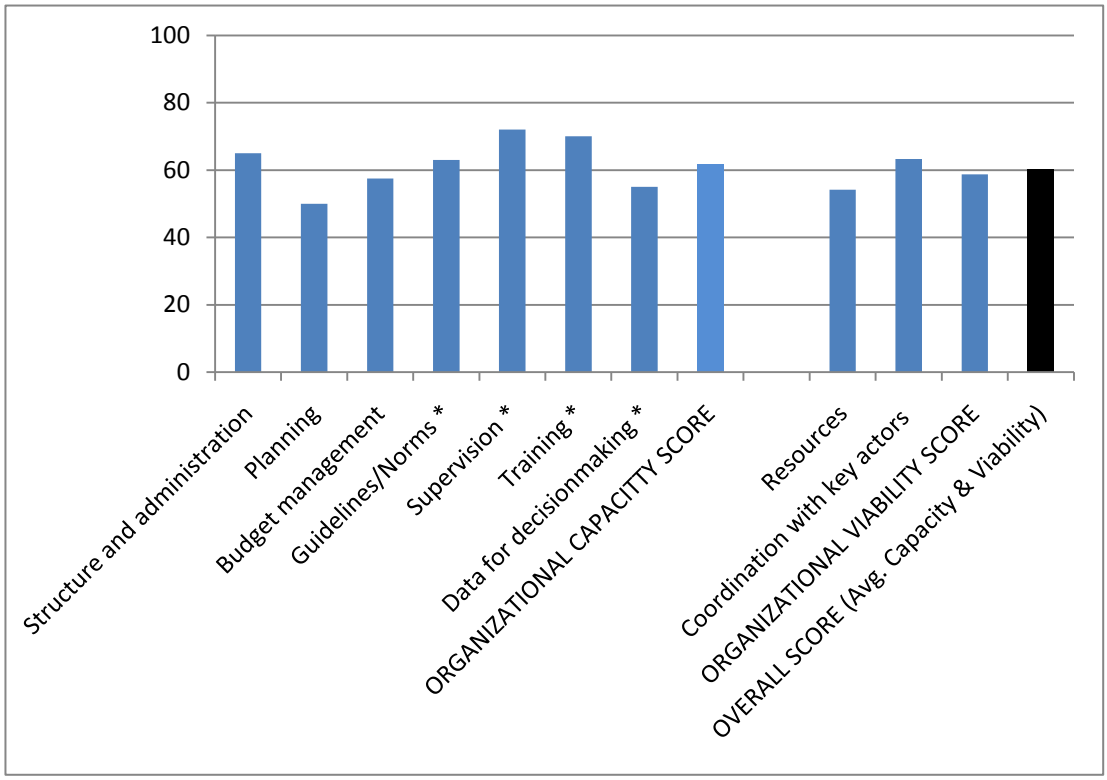
Other subcomponents are most feasibly and accurately measured through collection of information from the health facilities in the area (e.g., supervision and training). For those competencies measured at the health facilities themselves, the data are collected and analyzed through the traditional modules of a health facility assessment (see R-HFA description in Annex 3). This tool includes an automatic calculation of the Component 3 index score, combining the data for the subcomponents collected from individual facilities with the subcomponents collected from the DHO module. The subcomponents collected from facilities give the average percentage of attainment of the relevant minimum competencies in the facilities assessed. The competencies from the DHO module are more qualitative information. These are rated on 0 to 100 scales to be comparable with the quantitative indices from the subcomponent information collected at facilities.

Subcomponents of MOH/District Organizational Capacity and Viability

Capacity
3.1 Administration
3.2 Planning
3.3 Budget management
3.4 Guidelines/norms*
3.5 Training*
3.6 Supervision*
3.7 Data for decisionmaking*

Viability
3.8 Financial resources
3.9 Coordination with key actors (civil society, donors, technical agencies)
* From individual health facility data

Figure 3.4
DHO Capacity and Viability Index Score



The scores for each of the subcomponents are calculated. Then the capacity score is calculated as an average of the seven capacity subcomponents; similarly, the viability score is calculated as an average of the two viability subcomponents. The capacity and viability scores are then averaged for the overall Component 4 index score.

Component 4: Main Local NGO Organizational Capacity and Viability

Component 4 measures the organizational capacity and viability of the main supporter of community capacities. This is likely to be a local civil society partner or NGO. This organization will need to survive and thrive post-project in order for health gains to be sustainable. The subcomponents of capacity and viability listed in the table are typical ones covered in many organizational capacity assessment tools. For this capacity to increase the sustainability of health outcomes, this capacity must be directed at supporting the health outcomes, most likely through their effects on supporting community capacity. A fuller description of each of these subcomponents can be found in the Child Survival Technical Support (CSTS) technical reference material on capacity building on www.childsurvival.com. There is a suggested tool in Annex 3—the OCVAT. This tool has a similar philosophy as Components 2 and 3. That is, it does not focus on a single indicator or subcomponent, as this would not give a valid and accurate picture of organizational functioning; rather, it measures a variety of subcomponents covering organizational inputs, processes, and performance. By looking at all these subcomponents, a valid picture can be developed of the functioning of a key organization in the local system.

Subcomponents of NGO Organizational Capacity and Viability

Capacity
4.1 Governance and legal structure
4.2 Human resources and HR management
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

An example of calculating a Component 4 index score

Figure 3.5 shows an example of a calculation of an NGO capacity index score for Component 4. The sample data are generated by the OCVAT developed by the SHOUT Group for use with the SF. This tool generates data on 46 individual indicators. These indicators are given scores from 0 to 100. Indicator scores are averaged for each subcomponent (each of which is composed of 3 to 5 indicators). Then the nine subcomponent scores for capacity are averaged to give the overall capacity score (41 in this case). The three subcomponent scores for viability are averaged to give an overall viability score (36 in this case). Finally, the capacity and viability scores are averaged to give the Component 4 index score (39 in this case).

Table 3.5
Example of a Main local NGO Capacity Index Score

Subcomponent	Indicator	Indicator Score	Subcom-ponent Score	Overall Scores
Governance	Legal recognition	50	45	
	Governing committee or board	50		
	Constitution/bylaws	30		
	Mission and values	50		
Leadership	Leaders' accountability and transparency	20	37	
	Consultation and participatory decisionmaking	40		
	Leadership development	50		
HR & admin.	Staff/volunteer organization	20	23	
	Staff performance evaluation	10		
	Staff and volunteer development	40		
	Office and equipment	20		
Mngt.	Strategic planning	40	47	
	Activity development and planning	50		
	Project supervision	50		

Subcomponent	Indicator	Indicator Score	Subcom-ponent Score	Overall Scores
Financial mngt.	Financial accounts	30	55	Capacity Score 41
	Bank account	50		
	Recordkeeping	80		
	Budgets and cash flow planning	85		
	Financial reporting	30		
Tech. cap.	Beneficiary targeting	30	53	
	Technical area knowledge and skills	50		
	Training and updating knowledge	80		
	Behavior change communication	50		
M&E/learning	Data collection	30	34	
	Data analysis and information dissemination	30		
	Project evaluation	20		
	M&E data inform decisions	30		
	Quality improvement system	60		
Equity & empower.	Participation of women in organizational leadership	10	45	
	Gender in staffing	50		
	Gender in programming	60		
	Involvement and empowerment of beneficiaries	60		
Perform.	Client satisfaction	40	33	
	Staff satisfaction	30		
	Technical program performance	30		
Res. mob.	Resource mobilization planning	20	35	
	Proposal development capacity	30		
	Local resource mobilization	60		
	Cost recovery (only if applicable)	30		
Networking	Relations with other nongovernmental implementers	20	30	Viability Score 36
	Relations with government entities	20		
	Relations with technical agencies	30		
	Relations with potential donors	50		
Institutionalization	Institutionalization of key health area in mission	50	43	
	Institutionalization of technical-managerial structure	40		
	Seek adequate financial resources for health	40		
Component 4 Index Score (average of capacity and viability scores)				**39**

Component 5: Community Capacity

Measurement of this component is the most difficult of all of the six components of the SF. This is mainly because there are a variety of ways of conceiving what community capacity is. This subsection attempts to pull together several ways of conceiving this important component into an overall framework, but there are certainly other ways of looking at this topic. There is ongoing work on this topic that the CORE Group (http://www.coregroup.org/) will be trying to pull together over the next year, so expect the concepts here to be updated and refined as this work progresses.

The subcomponents of community capacity are outlined in the table below. These are based mainly on two tools that are comprehensive in their assessment of various competencies of communities, while also being feasible and participatory in their application. These two tools (see reference in Annex 3) are—

- How to Mobilize Communities for Health and Social Change, by the Health Communication Project.

- Malaria Competent Communities, developed by Constellation for AIDS Competence in conjunction with PLAN International.

There are others ways to look at community capacity, but many other tools share a large number of the subcomponents of these two tools. There are several advantages of these tools, besides their feasibility:

- They do not assume a particular community structure (e.g., village health committees), so they can be applied in many different contexts.

- They have subcomponents that cover both competencies (i.e., attitudes, knowledge, skills) as well as the strength of community organization (i.e., organization, participation, linkages, resource mobilization).

- They follow a community action cycle (assessment, planning, implementation, and evaluation).

These subcomponents characterize the collective capacity of the community and its relevant members to engage in key health behaviors—that is, to demand key health services like vaccination and illness treatment and to engage in key household behaviors like breastfeeding and hand washing.

Subcomponents of Community Capacity

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

Table 3.6
Comparison of Subcomponents of Community Capacity in Recommended Tools

SF Comparison of 5 Subcomponents	Health Communication Partnership	Malaria/AIDS Competent Communities
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

An example of calculating a Component 5 index score

Both the suggested tools rate each of the subcomponents on a 1 to 5 scale. To make this compatible with the 0 to 100 indices of the SF, we do a simple conversion of the scores. A score of 1 is given an index value of 10, 2 a value of 30, 3 a value of 50, 4 a value of 70, and 5 a value of 90. As an example, see Table 3.7. The scores for each of the seven subcomponents are shown. The conversion is done to give index scores for each subcomponent. Finally, these are averaged to give the Component 5 index score of 50 shown in the last row of the table.

Table 3.7
An Example of Conversion of Data From the Health Communication Partnership Tool to a Component 5 Index Score

Subcomponent	Scale	Index
Organization	3	50
Participation	4	70
Needs assessment	2	30
Consciousness	4	70
Programmatic involvement	3	70
Linkages	2	30
Financial management	2	30
Component 5 Index Score		**50**

Component 6: Enabling Environment

The subcomponents here consist of those areas that comprise the "environmental scan" that project staff members perform with local system participants across a variety of areas. The idea is to see if the environment is truly enabling or instead presents possible future risk. The six broad areas for this environmental scan are shown in the table. These cover areas that show how strong the outside support (or threats to that support) are. All of these six general areas have standard, internationally recognized summary indices that are collected by country on a periodic (usually annual) basis that

give a sense of their attainment. One can then score them on a 0 to 100 scale and average them, giving a final Component 6 index score.

Subcomponents of Enabling Environment

6.1 Health policy
6.2 Governance and stability
6.3 Strength of civil society
6.4 Human development
6.5 Empowerment of women
6.6 Natural environment

An example of calculating a Component 6 index score

There is a tool on the CSTS website (www.childsurvival.com) that is a simple Excel worksheet that helps to organize and analyze data on each of these six subcomponents of an enabling environment and to calculate an overall index score. The tool directs you to data sources for measures that are compiled for each index measuring each of the subcomponents. There are websites with periodically updated country tables showing their scores and ranks. Some of these data are already on 0 to 100 indices. Others are not. When the data are entered in the table, they are recalibrated to all be on 0 to 100 indices and are presented that way in the table. This gives the "national score." Then a group of informed respondents answers the questions posed in the next column of the tool: Is the situation significantly worse, significantly better, or about the same in the local area compared to the national situation? If the same, the Excel sheet will give the same score for the local system as the national score. If significantly better, it will add 20 points to the score; if significantly worse, the sheets will automatically subtract 20 points. The only score that is not calculated at the national level is the natural environment score, as this can vary significantly from place to place. So there is no conversion from national to local for this subcomponent, as this is simply given a local system score directly. This way of handling the data for the enabling environment will clearly only give a rough estimate, but this is fine, as our main goal in thinking about this component is to make sure that we have "scanned the environment" and made sure that we've thought about those things we can influence and are aware of those things that might help or hinder us even if we can't influence them. So this does not need to be a completely rigorous and time-consuming exercise.

Table 3.8
Enabling Environment Index Score Example

Subcomponent	National Scores	Is the situation significantly worse, significantly better, or about the same in local area compared to the national situation?	Explain why you think that the local system situation for a subcomponent is significantly better or worse than the national situation.	Local system scores
6.1 Health policy score	56	Same	Not applicable	56
6.2 Governance score	41	Same	Not applicable	41
6.3 Civil society strength score	48	Same	Not applicable	48
6.4 Human development score	50	Worse	The project area has a significantly lower level of socioeconomic development than national average.	30
6.5 Women's empowerment score	23	Better	The culture in the local area is less conservative socially than the country as a whole in terms of gender roles.	43
6.6 Natural environment score*				60
Component 6 Index Score				**46**

II. Step 4: Suggested Tools to Measure Attainment of Components/Subcomponents

The tools listed in the table for each component are simply suggestions. Other tools are available that can measure most or all of the subcomponents of the relevant component. Some of these alternative tools are summarized in Annex 3. The tools in Table 3.9 have the advantage that they have been adapted or specifically developed to measure all the subcomponents of the SF and to be easily mapped onto the index scales of the SF's six components. Annex 3 has descriptions of each of the tools and links to the tools themselves, which have in-depth descriptions and instructions. In all cases, these tools should be locally adapted. The project M&E group should work with local informants to agree to adapt the questions to conform to the reality in the area. The terminology should be made locally appropriate. For instance, if the local health area is not called a district, but rather a block, then this should be changed throughout.

Table 3.9
Suggested Tools to Measure Each Component

Component	Tool(s)
1. Health outcomes • Neo/child health • Maternal health • FP • TB • HIV/AIDS	• Neonatal/child health: Rapid CATCH (set of core KPC outcome indicators) • Maternal health: KPC—maternal-neonatal health module • FP: Modern contraceptive prevalence • TB: Case detection rate and treatment success rate • HIV/AIDS: Coverage for five key services, through community survey
2. Health service provision (quality and access)	Rapid Health Facility Assessment (R-HFA) for neonatal/child health, maternal health, and PMTCT part of HIV/AIDS Also available— District Rapid Health Facility Assessment (TB) Quick Investigation of Quality (FP)
3. District MOH organizational capacity and viability	DHO Module (Part of expanded R-HFA tool)
4. NGO organizational capacity and viability	SHOUT OCVAT
5. Community capacity	Health Communication Partnership Community Competence Tool http://www.hcpartnership.org/Publications/Field_Guides/Mobilize/htmlDocs/cac.htm PLAN Community Competency Tool (specifically for malaria, but easily adapted). Available on the CSTS website (www.childsurvival.com). Also available— KPC knowledge indicators to inform analysis of community knowledge subcomponent when using the above two tools CORE Social and Behavioral Change Work Group Tool (under construction) Malaria/AIDS competent communities

Component	Tool(s)
6. Enabling environment	When doing an environmental scan of the six subcomponents of the environment, the following standard indices/tools can be used. Their national-level values should be discussed with informed respondents, adjusted to local system reality, and averaged to arrive at the Component 6 index value. There is a Component 6 calculator on the CSTS website (www.childsurvival.com) that helps do this calculation: *6.1 Health policy and government commitment to health* • Neonatal/child health&maternal health: Countdown to 2015 Policy Index http://www.countdown2015mnch.org/reports • FP: FP Effort Index http://www.popline.org/docs/1062/098473.html • TB: Summary of DOTS political commitment indicators http://www.stoptb.org/wg/advocacy_communication/assets/documents/Compendium%20of%20Indicators%20for%20Monitoring%20and%20Evaluating%20NTP.pdf • HIV/AIDS: UNGASS country commitment indicators http://viewer.zmags.com/showmag.php?mid=ghsqd#/page0/ *6.2 Governance and Stability* World Bank Governance Index http://info.worldbank.org/governance/wgi/index.asp This index includes not only government functioning and participation, but also civil stability. The following five components of this index relate to this subcomponent. This includes all but the voice and accountability sub-index: • Political stability and absence of violence • Government effectiveness • Regulatory quality • Rule of law • Control of corruption *6.3 Strength of civil society* World Bank Governance Index—Voice and Accountability http://info.worldbank.org/governance/wgi/index.asp The voice and accountability index has information about representation and openness that are essential for a thriving civil society sector. There is also the Civicus Civil Society Index, but there is not a world ranking table as with other indices: www.civicus.org/csi *6.4 Human development* UNDP Human Development Index includes information about socioeconomic status, education, and general health status. It is updated every year: http://hdr.undp.org/en/statistics/ *6.5 Women's empowerment* UNDP's Gender Development Index (GDI)—part of the annual UNDP Human Development Report. By comparing a country's attainment in the GDI with its attainment in the HDI, one can get a sense of the level of gender equity:

Component	Tool(s)
	http://hdr.undp.org/en/statistics/indices/gdi_gem/ *6.6 Natural environmental factors* This is probably best analyzed by having informed respondents recall and analyze the occurrence and severity of severe environmental events (i.e., disasters) in the local area. National data can be examined as well at the United Nations Environment Programme's Environmental Vulnerability Index, especially the questions related to disasters): http://www.vulnerabilityindex.net/EVI_2005.htm

III. Step 5: Presenting the Data for Each Component as Indices

The data for each of the six components of the SF are summarized in index scores that can vary from 0 to 100. This puts each of the components on the same scale, so we can easily track progress over time and prioritize lagging components for improvement. The indices present progress summarizing outcomes/performance—that is, health outcomes, service delivery outcomes, and organizational and community competency outcomes. A traditional midterm or end-of-project evaluation will summarize progress on health outcomes (Component 1) and service delivery outcomes (Component 2). A project manager using the SF also will collect and summarize data on organizational support for service delivery (Component 3), community capacity (Component 5), organization support for community competencies (Component 4), and enabling environment (Component 6).

Each of these components is graphically represented on a radar diagram on a scale that ranges from 0 to 100. A zero indicates no attainment of the attribute and a value of 100 indicates complete attainment (see Figure 3.5a for an example of the data presented as a radar diagram and Figure 3.5b for the data in the form of a bar graph). These diagrams show the level of attainment of each of the six components of the SF. An overall look a the diagram gives an impression that there were clear gaps at baseline and that by the end of project period there was a fairly balanced picture across all six components. We can also take a closer look at each of the components. For instance, the level of health service provision increased dramatically (from an index score of 12 at baseline to 65 at final). On the other hand, the enabling environment index did not change at all from baseline to final (both scores are 60). This gives a quick visual summary of very complex data. In doing so, it helps project managers quickly analyze the situation; communicate it to stakeholders; and formulate priority questions/actions with them. For instance—

- Is there anything that could be done to improve the enabling environment?

- While the community capacity index improved, it still lags behind the other components. What are the subcomponents that are lagging and can they be improved?

The data summarized and presented on the SF radar diagram or bar graph are evaluation data. This is not to say that monitoring data is not important. It just belongs somewhere else in the pro-sustainability project. We deal with sustainability monitoring in the next section of the manual (Chapter 3.3). As an example of how monitoring for sustainability could be incorporated in a project management plan, one of the subcomponents of health service provision is the supply of drugs. This is measured on the R-HFA tool for Component 2 by actual performance (i.e., availability of the drug

when facilities are assessed). If this had been identified as a problem in need of intervention by the project, then project managers would want to monitor progress on the strategies employed to improve this. Perhaps these will be the number of health facility staff trained in use of MOH logistics system (activity); the number of staff passing a posttest from training (output); the number correctly filling out stock cards; and the number of orders to central stocks placed on time (intermediate performance measures). All these are important to track on a frequent (perhaps quarterly) basis, to give an idea if the performance indicator for that subcomponent is likely to reach the target value. In the well-constructed pro-sustainability project, each of these intermediate indicators will enter into the monitoring system and be tracked there (see Annex 2.5 for an example of a pro-sustainability Results Framework). Based on this, a pro-sustainability project monitoring plan can be constructed.

Figure 3.5a
Example Presentation of Summary Sustainability Framework Data in Radar Diagram

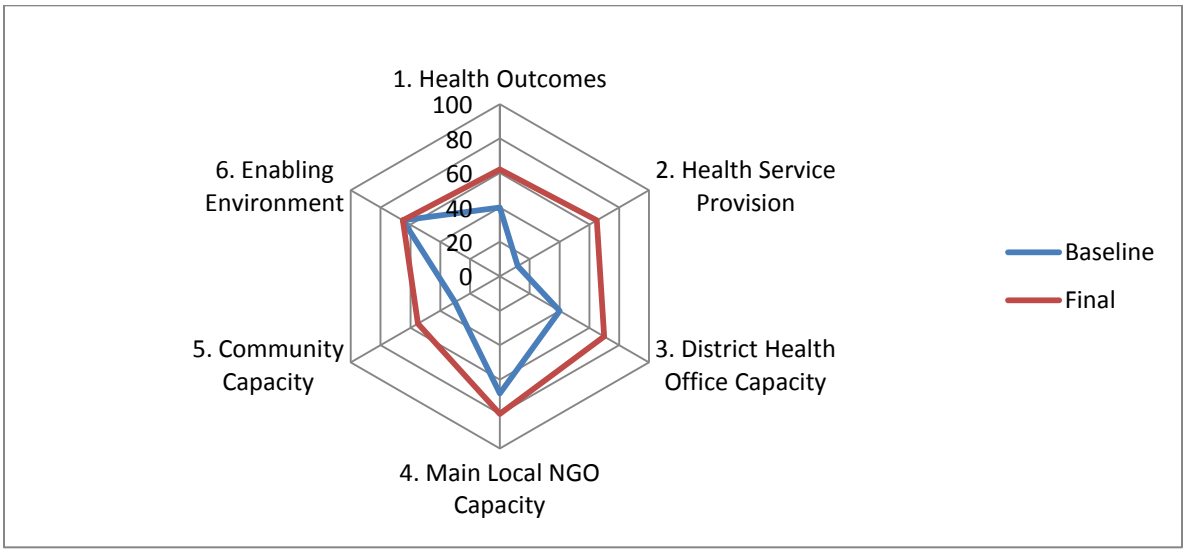
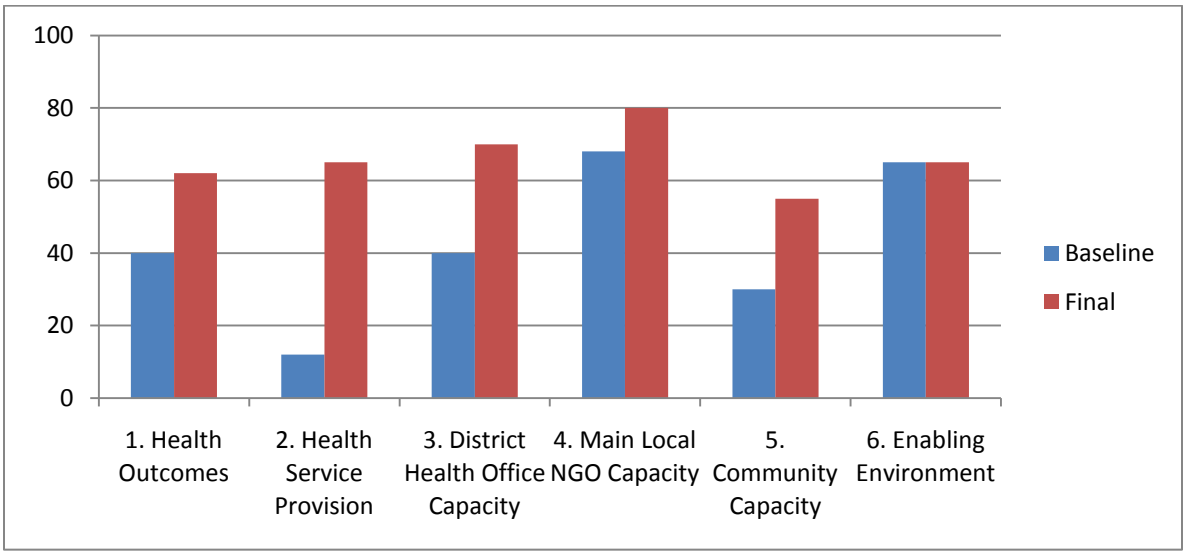


Figure 3.5b
An Alternative Way to Display Summary Sustainability Framework Data, as a Bar Graph



In summary, one gets from the raw data on attainment of indicators to the data in Figure 3.5 by following these steps:

Step 4: After adapting SF tools to the local context, measure attainment of the indicators for each of the subcomponents in each component by using the five suggested tools in Annex 3 (or other equivalent tools, if desired).

Step 5a: Transform measured indicator values into indicator scores, so that all indictors take on 0 to 100 values. This is done automatically in the suggested tools in Annex 3. If other tools are used, Annex 3 describes rules for transforming indicators into scores.

Step 5b: If there is more than one indicator for a subcomponent, average the indicator scores to calculate a subcomponent score.

Step 5c: Combine subcomponent scores into a component index score by averaging all the subcomponent scores.

Step 5d: Graph these component index scores on a radar diagram or bar graph. Note that Excel can make radar diagrams.

3.3 PROJECT SUSTAINABILITY MONITORING: SIGNALS FOR NEEDED SUSTAINABILITY ACTIONS

This chapter has mainly dealt with how to measure, analyze, and present data for *evaluation* of sustainability outcomes. These are data that are only collected on an occasional basis (no more than annually, and usually less frequently than that). Collecting such data more frequently would be an unnecessary and unsustainable burden on a project and, even more importantly, on local system stakeholders who, it is hoped, will continue to track these outcomes even after the project is finished. But to make sure that we are on track to reach these outcomes, we also need to *monitor activities and outputs* that will lead to these outcomes and do this on a much more frequent basis.

Even though we will do comprehensive evaluative measurements of all subcomponents of each of the six components to construct the radar diagrams, we do not need to track all these subcomponents in the monitoring system. We should only track indicators for the prioritized subcomponents on which partners/stakeholders have decided to work. For instance, Component 4 deals with organizational capacity of the key local NGO. The suggested evaluation tool (i.e., the OCVAT, described in this chapter and Annex 3) measures 12 subcomponents. The baseline assessment might identify, for instance, three of these subcomponents in need of improvement. So the project staff in consultation with this stakeholder should plan activities that they believe will help to accomplish the targeted outcomes for these three subcomponents. In turn, the monitoring system should then track progress on these activities and their outputs. Table 3.10 shows an example that would be relevant if resource mobilization had been targeted as one of the subcomponents in need of improvement. The OCVAT could be used in the evaluation stage when we care to measure outcomes or organizational performance (the top row of Table 3.10). For the project monitoring plan, we will want to include indicators like the examples shown in Table 3.10 for inputs, processes, and outputs that eventually lead to the targeted outcome for improved organizational performance in Resource Mobilization. These indicators should be agreed upon with the relevant stakeholder/partner and then tracked on a frequent basis, perhaps quarterly.

Table 3.10
Example of Indicators to be Tracked in Project Monitoring

Level of Indicator	Resource Mobilization
Outcome/ performance	There is a plan for local fundraising. Targets are set. Activities are regular. There is assessment of progress toward targets and action if targets are not made. **(TARGET = score of 90 on OCVAT)**
Output	Cash value of funds raised
Process	Number of fundraising events carried out
Input	Approved local fundraising plan with regular activities and monitoring plan.

In the rest of this section, we give several suggestions for how best to set up a monitoring system to track progress toward sustainability. These suggestions will allow you to have pro-sustainability thinking fit within traditional project tools like the Results Framework and Project Management Plan, but they also point to areas where there might be some divergence from traditional project thinking. You will have to implement and test these suggestions in your own practice.

1. Make a concrete monitoring plan which is regularly reviewed with partners/stakeholders.

With pro-sustainability management as with traditional project management, even the best-laid plans and strategies will hit obstacles, some expected and some not. One must always plan and use sufficient time to review, think critically, and revise plans with partners. Building a sense of mutual understanding and trust among partners/stakeholders is critical so that honest discussions of progress or lack of progress can occur. If you schedule these times appropriately, they will allow you to make changes and document how the local system is evolving in nature and in its thinking. You should use these review meetings to hold partners accountable to one another, even for those stakeholders not formally part of the project. Your project can serve as an example, reviewing strengths and weaknesses and fulfilling its responsibilities; then trading places and letting other partners follow the same process. This could be helped by a dynamic M&E team working with partners in anticipation of those review meetings. The SF then provides a structure to show how evaluation serves a long-term purpose, rather than being bogged down in finger-pointing and dodging responsibilities for shortcomings.

2. Use indicators in the project monitoring system as signals to make decisions to improve the chance of sustainability.

If you follow the recommendations of this manual, you will develop your project Results Framework or Logical Framework within the overall SF of the local system. Your M&E plan should provide signals—intermediate signposts—showing that local partners are engaging in the needed activities and making the needed progress toward the objectives and goals measured in the SF. As in the previous example, if there is an objective for resource mobilization for a key local organization, then this should be in the Results Framework. In turn, strategies may be developed for financial management, fundraising, and cost recovery. The activities and outputs associated with these strategies should be in the project monitoring plan. If a critical subcomponent is in the SF but outside the mandate of the project, then we encourage you to be as systematic in developing

monitoring signals for this subcomponent as you would be for any subcomponent in the project Results Framework. Then the activities and outputs leading to the desired outcome can be tracked as well, not only by your project staff but by the local partners/stakeholders who are the "owners" (i.e., those who are expected to carry on after the project ends—see FAQs "Involving Stakeholders" for a fuller description).

3. Document what role project partners are taking as well as what other stakeholders are contributing.

Partners understand fully that your project is accountable to a donor agency. You should be quite clear and transparent about what your project can and cannot do, especially if your partners have developed a very ambitious SF for their local system. While sustainability planning emphasizes the roles of all stakeholders, you also need to document honestly and clearly what you and specific project partners are contributing.

- Directly, in an inputs-activities-outputs approach, toward key indicators of the effectiveness of your project within its Results Framework.

- Indirectly, by facilitating the process of building a sustainable situation with all stakeholders. It is best if there is a person or organization with recognized authority that can hold all local system actors accountable. This need not be the MOH authorities. This may be a mayor or other political authority or other well-respected leader. Although "mutual accountability" does not demand that there be a single authoritative entity like this; in reality, having a specific and identifiable authority is often the most functional form for holding key non-project stakeholders accountable for reaching their promised targets.

4. Be flexible and allow changes, but if changes are made always document the discussions, lessons learned, and the content of proposed changes.

Project monitoring tends to be quite rigid. Indicators are agreed upon. Targets are set. Progress is monitored. There are rewards for compliance and possible sanctions for falling short. But when working within a local system, the project staff should be facilitators of action rather than implementers of those actions. This begins to model the actions that will need to occur after the project is gone, when local actors will need to carry out the actions without any project staff present; however, facilitation rather than "command and control" implies a loss of control by project staff. It also implies being more open and realistic about competing pressures that local system actors feel. If we want gains to be sustainable, then there should be more flexibility than in traditional project management. On the other hand, we do not want to lose the accountability implied by sticking with agreed-upon indicators and targets. We need to balance realism and idealism.

In the ideal situation, local system stakeholders show that they have the capacity to maintain progress in health outcomes through their passion for the goals. They progress from being contributors to being leaders. This shows that there is learning. Eventually they should feel empowered and competent enough to modify the subcomponents to be improved in the sustainability plan, or they may feel that an initial target was set unrealistically and want to change it. In the ideal, it is certainly better to let the SF evolve to reflect this, rather than stick rigidly to the initial design. In actual practice, you and your project have a mandate and a set of

deliverables to accomplish. You are accountable to a donor agency and you simply cannot reinvent the project every time a partner has an epiphany. You must also deal with the resources you have. Establishing and revising the SF and the M&E systems that go along with it takes time from project implementation, and there is only so much you can do. You will need to strike a balance between the ideal of flexibility and discussion on the one hand, and results-orientation nad practicality on the other.

Regardless of what changes you introduce to your framework and official project documents, it is essential that you document the lessons being learned and the changes being recommended. For your partners, it is probably less important to show changes in the numbers (for example indices) from baseline to final in your SF than to be able to tell the story of how the situation has evolved and what learning has happened. Document and provide the narrative for the story that unfolds toward realization of the vision and sustainability scenario. This does not require complex measurement efforts, but it can have tremendous value to share information and lessons, as well as being useful for the purpose of future evaluations.

To summarize, within the SF, monitoring is just as important as in a traditionally planned project. This keeps all actors accountable to one another. The following actions help partners to develop a balance between the flexibility needed in a learning environment and the accountability needed for results-based management:

- Develop an M&E plan for the project Results Framework that is in line with the local system SF. This provides meaningful signals in a timely fashion to make decisions.

- Plan sufficient time to review monitoring information, think critically about it, and revise plans with partners.

- Hold all partners accountable to one another: Use the SF to involve stakeholders in evaluation and monitoring; and to consider how the local system evolves toward sustaining health outcomes rather than merely documenting project success.

AFTERWORD: STAY INVOLVED

The Sustainability Framework is not the final word in terms of thinking about how to sustain health outcomes, but it does give project managers, district health management teams, and others a useful framework. With this manual, there is now a more organized set of tools for planning, managing activities, and measuring progress with an eye toward sustaining health outcomes in community-oriented health work. It allows for a comprehensive look at the many factors that can influence progress—organizational and managerial, service delivery performance, community capacity, and environmental/social factors. It also supplies a standard framework for organizing and analyzing data. It is hoped that this will begin to allow for comparisons and more systematic research into determinants of sustainability and strategies for achieving it. Such comparative work has been hampered until now because of multiplicity of definitions, outcomes, and measurement techniques. We hope that the Sustainability Framework will contribute toward moving research in the field forward.

We also hope that you will want to share your experiences—the strategies you have employed, any new or adapted measurement tools used, and the results obtained. Macro maintains a website and listserv for the SHOUT Group—a group of professionals interested in the topic of sustainability in community-oriented health programming. You can look through the resources maintained on the website—tools, this manual, definitions of terms used—at www.childsurvival.com. You can also join the SHOUT Group's listserv by sending a message to List_SHOUT@childsurvival.com.