

PD-ABP-001

**SUSTAINING THE BENEFITS OF CHILD SURVIVAL  
COLLABORATION: COMMUNITIES,  
GOVERNMENTS, PVOs, CSSP, AND  
USAID/BHR/PVC**

**LESSONS LEARNED - 1991-1994**

**Review conducted by:**  
PVO Child Survival Support Program  
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School of Hygiene and Public Health  
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**SUSTAINING THE BENEFITS OF CHILD SURVIVAL COLLABORATION  
COMMUNITIES, GOVERNMENTS, PVOs<sup>1</sup>, CSSP<sup>2</sup>, AND USAID/BHR/PVC<sup>3</sup>  
LESSONS LEARNED - 1991-1994<sup>4</sup>  
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**PURPOSE OF THIS DOCUMENT**

This document provides feedback on sustainability-related issues involving Private Voluntary Organization's in work with communities, governments, and other partners to decrease under-five mortality and improve child health. This sharing of factors identified in final evaluations<sup>6</sup> as contributors to or barriers to sustainability is directed at those involved in planning and implementing USAID PVO projects with the expectation that dialogue on these issues will contribute to strengthening ongoing and future PVO projects. In the ideal setting, these issues will be discussed at the field level with representatives of communities, health facilities, health districts, and PVO partners to identify opportunities for increasing effectiveness and sustainability. How best to use this paper to strengthen child health and survival programs? Three possibilities are presented below:

- Self assessment tool for ongoing projects at each level
- Briefing document for individuals planning or evaluating child survival projects
- As a case study document for small group use at PVO meetings

**BACKGROUND**

Of children born in the developing world, 10-25% die before their fifth birthdays. An estimated half these deaths are preventable by low cost community-based strategies of disease promotion, prevention, and case management. As part of the Congressional-approved commitment to the children of the world, USAID through its Bureau of Human Resources provides grants to Private Voluntary Organizations (PVOs) to strengthen the capacity of communities, local NGOs, private providers, and governments in the planning, implementation, and evaluation of interventions to reduce under-five mortality and improve health status. Since 1985, 218 projects have been initiated in 35 countries.

As the child survival program developed, it became apparent that in serving disadvantaged people, difficult choices had to be made in allocating resources to meeting current needs versus investing in the development required to sustain future health benefits beyond the period of project funding. The institution of the baseline and final knowledge-practice-coverage surveys, an important innovation and essential step for planning and management, has focused programmatic attention on issues of coverage. In 1991, USAID added a sustainability component to the evaluation of all projects in the seventh (CS VII) and subsequent cycles. Since that time, sustainability has become an increasing prominent part of project proposals, detailed implementation plans, and annual reports.

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<sup>1</sup>PVO - Private Voluntary Organization

<sup>2</sup>CSSP - Child Survival Support program at Johns Hopkins School of Hygiene and Public Health

<sup>3</sup>USAID/BHR/PVC United States Agency of International Development's Bureau of Human Resources, Office of Private Voluntary Cooperation

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<sup>6</sup> Africa - Cameroon-CARE; Malawi-Hope; Malawi-IEF; Mali-PLAN; Mali-WVRD; Senegal-WVRD;

Asia - Bangladesh-WRC; India-WVRD;

Latin America - Bolivia-PCI; Dominican Republic-WVRD; Guatemala-Hope; Guatemala-PCI; Haiti-Plan, Haiti-WVRD; Honduras-CARE;

Honduras-WRC; Nicaragua-ADRA; Nicaragua-PCI;

Pacific - Indonesia-ADRA; Indonesia (Maluku)-PCI; Indonesia(RIAU)-PCI; Solomon Islands-FSP;

Since 1991, the sustainability evaluations have been reviewed and tabulated (1991-Stansfield, 1992-Kalter, 1993-Brennan, and 1994-Powers). Although there have been changes in the evaluation sustainability guidelines over the 5 years limiting full comparisons, there has been a definite expansion in individual project attention to developing structures that will continue to provide needed services.

At the request of the CSSP, under contract with USAID, this lessons learned paper was prepared to provide feedback to PVOs and their collaborating partners on factors identified as contributing to or obstructing project sustainability. This is not a quantitative summary, but the authors' assessment of sustainability-related issues reported in final evaluation reports that merit sharing among those concerned with child survival. The success of this report, if any, is attributable to the many "jewels", both successes and failures, imbedded in the individual evaluation reports. It is important to remember that we frequently learn more from our failures than our successes.

## SUSTAINABILITY

The concept of sustainability arose during the late 1980s as those involved in providing child survival technical assistance (recipients and providers) began to address the issue of phasing out of projects and decreased availability of resources. Projects designed to meet specific quantitative targets of coverage, quality, decreased morbidity and mortality, and improved health status were suddenly confronted with issues of post-project viability. A number of papers (see bibliography) have addressed the issue of sustainability. Bossert, in a retrospective study of AID health projects for sustainability, identified two groups of factors that determined the probability of sustainability: 1) contextual (political, economic, socio-cultural, and environmental), and 2) project (perceived project effectiveness, integrated component of ongoing structure, development of funding mechanisms, strong training components, and mutually respectful negotiating process) (Bossert 1990).

Most of the work on sustainability has focused at the national level and has been understood as the continuation of benefits after the termination of technical assistance. While this concept resonates with project funders, it is unrealistic for many of the poorest countries. To achieve the goals agreed to at the World Summit on the Child, the poorest countries will need significant external support well into the 21st century. A realistic approach to sustainability requires a developmentally-sound redefinition. This paper proposes such a redefinition: **child survival sustainability is the maintenance of individual, community, NGO, health system, private sector, government partnership capacity to continue the essential promotive, preventive, and case management services necessary to achieve locally established targets with the minimal amount of external inputs.** This definition differs from traditional sustainability definitions in three ways: 1) the focus on capacity of public-private-government partnerships; 2) the achievement of targets set by those involved; and 3) the recognition that many countries will require external inputs well into the future.

Many of the evaluation reports have grasped the underlying message of strengthening capacity to plan, train, implement, monitor, evaluate. Others have been trapped by reporting requirements for numbers in seeing sustainability as number of VHWs trained/active, numbers of VHCs organized/functioning, number persons trained, coverage levels achieved, or income generation projects initiated. While these are important, they do not predict sustainability. Assessing sustainability requires monitoring of capacity to plan, implement, and evaluate in the community, at health facilities, and at the district and national levels; and a realistic assessment of needs for external resources. In many projects, countries have the commitment and resources to achieve sustainability in the traditional sense; in others, especially in sub-Saharan Africa, continuing external assistance will be required. This is not a carte blanche approval for unlimited external assistance, but a recognition that achievement of a minimum package of essential services will, for many countries, require continuing external resources. Such assistance should not be unconditional, but should evolve from mutually respectful negotiations on a realistic assessment of needs, a solid plan developed with community inputs, and a creditable mobilization of resources both in terms of national budgets and cost recovery. Underlying this definition is a global sense of equity and justice which commits the world to a basic minimum of benefits to its children and its future.

## **METHODS**

1. Evaluation guidelines for 1991-1995 were reviewed.
2. Sustainability summaries for 1991-1994 were reviewed
3. Sustainability sections of 22 - 1994 evaluations were reviewed in detail
4. A level specific matrix was developed (community, PVO/NGO, health structure, private sector government) as a framework for looking at sustainability issues.
5. Factors identified in final evaluation reports as contributing to or barriers to sustainability with then allocated to sections in the matrix (page 4).

## **MATRIX**

As mentioned above, PVO child survival interface at multiple levels in the health care system including:

### **Community**

- Family
- Community Health Agents (VHWs, TBAs)
- Community Health Groups (VHCs)
- Community Political Groups

### **Health Area (Government/NGO)**

- Health Staff
- Health Facility
- Health Committee with or without community representation

### **Partners in Development**

- NGOs
- PVOs
- Bilaterals
- Multilaterals

### **District**

- District Health Authorities
- District Political Structure-Local Governments
- District Health Committee

### **Private Sector**

- Mission
- Private
- Commercial
  - Media
  - Manufacturing

### **Government**

- Ministry of Health
- Other Ministries (Education/Works)
- Partner (Donor) plus/minus Coordination

Some PVOs work primarily at the community level; others work at the interface between the health system and the communities; and still others interact at district, provincial or national levels. Most PVO projects, in fact, interact with multiple levels. While projects use different names for village based workers (promotores, animatrices, brigadistas), a generic title of volunteer health worker (VHW) is used below recognizing that duties differ from health promotion alone to health promotion and treatment.

## **FACTORS IDENTIFIED IN EVALUATIONS AS CONTRIBUTORS OR BARRIERS TO SUSTAINABILITY**

### **Community**

#### **Contributes to Sustainability**

- Orientation of traditional and religious leaders prior to initiating activities
- From the beginning, VHCs were involved on planning and implementation through an open dialogue and joint planning
- Community informed of baseline survey results and asked to identify priorities
- Community involved in a participative analysis of the baseline survey
- Every single activity is discussed with the responsible committee
- Choose CHWs and TBAs already identified by government
- Participation of supervisor in selection of CHW
- Careful recruitment and training critical to sustainability
- Training of CHWs at local level
- Training locally and in the afternoons
- Participatory training methods
- Community provided food during training
- CHW collaborate in the search for problems for the benefit of the community
- CHWs work effectively without payment
- CHW participation in proposal, dip, and evaluation
- CHWs felt empowered to identify and solve problems
- Financial incentives for CHWs failed; motivated by job satisfaction and community status
- CHWs can work effectively with non-material incentives, such as the prestige and knowledge acquired and the sense of importance which the work has for the community
- ORT units and pharmacies located in house of VHW
- VHW groups for specific purpose, e.g., reproductive health
- Communities have confidence in VHWs
- Formation of mother's groups
- Organized and trained ladies savings societies and provided them loan funds
- Income generating activities offer alternatives to break the cycle of poverty
- Training in health during community bank meetings (decisions on use of money)
- Development of human resources at community level is effective because they are able visualize their problems and simultaneously seek solutions
- Increased basic health knowledge of family members
- Community ownership of the program
- Community felt control of the project, self confidence
- Inputs non-monetary (time, land, materials)
- Constructed birthing huts to increase safety of delivery
- Supervise community workers
- Fees are charged for services and cover most costs
- Cost recovery system (Bamako Initiative) through sale of medicines and fee-for-service replenish drugs and support transport for MOH staff; committee sets fees and determine fund use
- In the stronger communities, committees run drug revolving fund, supervise workers, and provide money for collection of vaccines
- Development of community water supplies
- Degree to which the communities have succeeded must be attributed to the commitment of leaders and the ability of project staff to build relationships and engender confidence
- Development activities are perceived by communities to meet felt needs
- Poorest families given priority to engage in financially empowering activities
- Use of community volunteers as trainers
- Developed capacity to network with NGOs
- Human capital is now available in the communities to continue what we started
- Trained TBAs received higher fees
- Increased self-reliance through support to community sanitation (sense of control over the environment)

### **Barriers to Sustainability**

- No evidence community participated in design
- Lack of community inputs into project design
- Lack of participation of ladino males - unanticipated cultural barrier
- Male health committees less committed and less effected
- Lack of credibility of VHC leadership
- Lack of motivation of VHC members
- Isolated VHWs (better if several in village)
- High drop-out rate for VHWs
- Community education carried out by PVO staff rather than CHWs
- Education carried out without written plan
- Lack of support from Health Center
- Lack of sustained input to VHCs has undermined their sense of purpose
- Leaders recognized they have been helped by the project, encouragement to take control of the project's accomplishments, but are frustrated at not having the financial means
- Non-sustainable system of training and support for VHWs and VHCs
- Lack of supplies and backup for CHWs

### **Health Center**

#### **Contributes to Sustainability**

- Monthly meeting of CHWs at Health Center
- Train midwives as TBA trainers
- Training of TBA peer supervisors
- Training of health staff in participatory methods and technical content
- Training and support of health staff (more efficient than developing parallel structure)
- Strengthened support/supervision of VHWs
- Using local transport
- Use locally available materials in training
- Improved relationship with communities
- Taught local staff to collect and use data
- Develop capacity to analyze and use data
- Decentralized decision making including use of funds

#### **Barriers to Sustainability**

- Lack of funds for recurrent costs for training, support, maintenance
- 20% of mothers reported that they didn't receive services because they couldn't pay
- Too much time for reporting - takes time away from service and supervision
- Supervisory teams do not understand their role
- Training in supervision failed
- Failure to maintain costs at a level the MOH can take over
- Community structure perceived as effective
- Transport

### **PVO**

#### **Contributes to Sustainability**

- Competence and cultural sensitivity of project staff
- Worked closely with MOH in training activities
- Mission and activities consonant with the MOH
- Must be careful not to disable communities through misplaced generosity or understanding of what they are capable of doing themselves
- Innovative in new priority areas, e.g., family planning, HIV, kitchen gardens
- Cooperation among health projects is great benefit, NGO forum
- PVO staff formed local NGO
- Good linkages with private sector
- Complimentarity of other PVO projects - water and sanitation
- Donor coordination under leadership of Ministry of Health

### **Barriers to Sustainability**

- Direct PVO training and supervision of VHWs (rather than training health staff as trainers)
- Functioning independently as a health provider
- Failure to decentralize decision making to the field level
- High percentage of budget used to pay salaries
- Payment to volunteers
- Payments at rate government can't sustain
- Withdrawal of technical and financial support to EPI led to a collapse in coverage
- Inconsistent policy - one agency charged for seeds, another gave them free
- Lack of expertise in income generation/cost recovery
- Donor competition
- Lack of donor cooperation

### **District**

#### **Contributes to Sustainability**

- Project proposal reviewed and approved by District Development Committee
- District participation in surveys
- Presentation, discussion, and feedback of coverage survey results
- Participation in design, added interventions, approved project
- Assisted MOH in increasing/expanding coverage/quality
- Provide MOH staff training in participatory learning
- Joint training activities including management and finance
- Sharing responsibilities and control
- Close coordination with MOH
- Written and signed agreement with MOH
- PVO serves as technical resource, e.g., survey during drought
- Investment in maintaining good working relationships with MOH

#### **Barriers to Sustainability**

- Absence of sustainability plan
- Absence of written sustainability agreement
- Lack of agreement on continuing support to CHWs
- Poverty of people and the chronic financial crisis in the government makes sustainability unrealistic in the short run
- Image that vaccination services are sustainable without help from international organizations is not reasonable
- Poor management
- Improper allocation of resources
- Lack of resources for training/supervision of VHWs

### **Private**

#### **Contributes to Sustainability**

- Press - crossword puzzles on health
- Radio - advocacy, quiz shows
- Manufacturers - prizes for quiz show
- Health committees established in churches
- Developed capacity of tea estates to upgrade coverage and quality of services
- Agreement with estate to support community program
- Technical training and resource to private sector.
- Management willing to support additional costs

#### **Barriers to Sustainability**

- Lack of dialogue/coordination
- Lack of support to private sector by MOH
- Lack of being asked, consulted, invited

## **Government**

### **Contributes to Sustainability**

- Active leadership and coordination of donors
- Development with Ministry of Education plan, materials, support for inclusion of health in curriculum (child to child, and child to mother)
- Training of teachers to include health in curriculum
- Teachers provided with and trained in use of interactive materials
- Teachers attitude changed in terms of perception of the importance of health
- Teachers are educating the community through the school children
- New knowledge in health matters(school teachers) allowed them to help community
- School program brought community together around environment, personal and food hygiene.
- School children are loved and respected by adults, they are excellent educators

### **Barriers to Sustainability**

- Lack of vision - commitment to PHC
- Lack of resources - 90% of budget goes to salaries
- Lack of funds for recurrent costs
- Poverty of the families and the lack of government ability to sustain minimum project activities
- It is less certain that the MOH will be able to provide the resources to sustain benefits
- Non-functional government
- Underfunding of Urban Primary Health Care
- Devaluation
- Drought
- Embargo related shortages
- Resources are insufficient to carry on CS activities- a reflection of the realities of the economy
- Relatively simple and inexpensive project cannot be self sufficient in this tribal area
- Lack of donor coordination

## **USAID**

### **Contributes to Sustainability**

- Mission interest and flexibility
- Technical support
- Development and training in survey methodology

### **Barriers to Sustainability**

- Short length of project
- Resources allocated to surveys and evaluation
- Reporting requirements take time away from working with community
- Expense of evaluations

## **DISCUSSION**

Superficial examination of the above lists provides a heterogeneous and apparently contradictory picture. Beneath the surface, however, certain patterns emerge. Capacity for sustainability varies significantly among projects. Numerous factors determine this capacity including political stability, country and local area economic status, education, and climate. Although many of the projects included in this report occurred prior to the increased focus on sustainability, projects have learned through their experience and are focusing more intently on factors encouraging sustainability. PVOs working in child survival need to see themselves as builders of capacity in the home, community, health area and district. Extension into other sectors including education, agriculture, and water have contributed to the potential for sustainability. PVOs have a key role as innovators and risk takers, testing and assessing. Successful innovations are being incorporated into the government program both within and beyond the project area. The above list of items is in no way meant to be prescriptive for future PVO projects. It is, however, hoped that identified items will provide implementing teams benchmark to assess their own progress toward sustainability and areas where program strengthening should be considered.

## CONCLUSIONS

1. No single definition of sustainability is applicable to all PVO projects. The following definition is proposed: **sustainability is the maintenance of individual, community, NGO, health system, private sector, and government partnership capacity to continue essential promotive, preventive, and case management services necessary to achieve locally established targets with the minimal amount of external inputs.**
2. Project areas vary in the degree to which sustainability can be achieved without outside resources. Certain areas such as urban slums, rural Haiti, or drought prone areas of Africa will require continued external assistance to maintain child survival gains.
3. PVO efforts have strengthened child survival capacity of families, communities, health facilities, districts, and countries. Effectiveness in moving toward sustainability is related, in part, to the development of working partnerships based on mutual trust and respect.
4. Potential of sustainability is also related to projects ability to tap into and strengthen existing individuals and institutions at each level.
5. Development of skills (technical, training of trainers, participatory learning techniques) among those who will continue to be in the loop at the time of project phase out is an effective method of technical assistance.
6. PVOs have been effective in closing the gap between communities and health facilities.
7. PVO innovation and risk taking in an environment of mutual trust and respect have been effective empowers at the community, health facility, and district levels.
8. From an overall perspective, there have been successes and failures. We learn from both.
9. Reading between the lines, one cannot miss the underlying human effort that has been generated by the PVO projects (concern, commitment, sacrifice, and hard work) by community members, health workers, teachers, and project staffs.
10. The bottom line is empowerment; progress in this direction is a long term investment in sustainable health.
11. How best to use this paper to strengthen child health and survival programs? Three possibilities are presented below:
  - Self assessment tool for ongoing projects at each level
  - Briefing document for individuals planning or evaluating child survival projects
  - As a case study document for small group use at PVO meetings

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