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PVO Child Survival Grants Program

Sustainability Findings of 12 Expanded PVO Child Survival Projects

Review conducted by
PVO Child Survival Support Program
Department of International Health
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This report analyzes the findings of 12 Child Survival project evaluations with regard to the potential for sustainability of the project activities and the gains made in child survival indicators. These projects were selected for review because they had begun in approximately 1987 and had received a second Child Survival grant to continue and expand activities. It has certainly been recognized by the granting organization, USAID, and the cooperating private voluntary organizations that implement child survival programs that three years is not enough to build sustainable health activities and behavior changes at the community level. This report differs from previous analyses in that each of these projects have been operational for at least 6 years with two cycles of Child Survival funding. The question addressed by this report is whether a six (to eight) year investment in community mobilization for health is enough to find partners ready and able to assume the responsibility for project activities, or communities sufficiently motivated to demand and receive services to promote the health and well-being of their children.

The project evaluations, completed in late 1994, which were reviewed were

	<u>Population Served</u>	<u>Expenditures</u>
ADRA-Indonesia	867,268	\$524,917
ARHC-Bolivia	39,000	\$1,346,000
IEF-Malawi	151,000	\$1,095,000
MIHV-Kenya	40,000	\$1,098,500
PCI-Guatemala	45,000	\$570,000
PCI-Bolivia	22,785	\$1,093,400
PCI-Indonesia/Riau	327,488	\$1,809,350
PLAN-Mali	123,000	\$830,000
WRC-Bangladesh	210,882	\$456,583
WV-Bangladesh	186,542	\$1,047,000
WV-Mali	118,800	\$450,000
WV-Haiti	85,000	\$625,000

This report follows the questions to assess sustainability which form the majority of the final evaluation guidelines provided by USAID for Child Survival projects (issued in July 1994). As these guidelines have evolved over the years, particularly in terms of questions regarding sustainability and cost recovery, comparisons will be made when possible with previous reports on sustainability, gleaned from reviews of project evaluations in 1992 and 1993.

PUSH and PULL Factors

Before beginning, it might be valuable to explain two major thrusts in child survival program execution which play into the discussion below. Most child survival projects are some combination of PUSH and PULL factors to encourage health seeking behavior by community.

members. The PUSH strategy involves training local persons (community health workers, volunteers such as the kaders in Indonesia, traditional birth attendants, or mothers themselves directly) in child survival messages which will motivate or PUSH them to seek preventive care (such as immunizations, growth monitoring, vitamin A distribution), or to treat health problems proactively (such as oral rehydration in the home). Other techniques used to encourage health seeking behavior include social marketing and other information, education and communications outreach techniques. These broader, population-based motivational tools can also encourage the audience to at least ask their neighbors if they have in fact, heeded the advice given. PUSH factors can be multiplied at the community level by encouraging new behavioral norms through directly delivering health messages one-to-one, or via a media approach to the individual, or through peer pressure created to adopt new behaviors fomented by either of the PUSH techniques. The PUSH strategy increases community demand for services, typically both preventive and curative.

The PULL strategy involves strengthening existing or new health services so that community members who seek out preventive services or curative treatments will receive adequate care and counselling. In the child survival projects reviewed, the PULL strategy is typically in evidence through training of MOH staff to provide better preventive and curative services, and through support to private and public health care delivery points (in a stationary or mobile setting).

A combination of these two strategies was in evidence in all of the projects reviewed, although the weight of the emphasis on PUSH or PULL varied in each project. This issue is important to sustainability given that once the external aid and enhancement is completed, and the community and the local health services are left to operate on their own, the community must be able to show an effective demand for services, or the resources will be rerouted to another area, or a different priority. If the community continues the demand, but the service providers cannot maintain the quality of the service, either demand will die out, or people will identify other providers who will more adequately meet their needs - even if it means traveling some distance. Sustainability is more likely when both PUSH and PULL mechanisms are enhanced at the local level.

EVALUATION REVIEW FINDINGS

Community Participation

Child survival activities, particularly immunization services and nutrition demonstrations, were frequently mentioned as valuable by the community members interviewed as in previous years' evaluations. Those projects which distributed items, for example immunizations or the IEF Malawi project which distributed Vitamin A capsules, were highly valued by their communities. It seems that when a concrete or consumable child survival intervention is provided to the community this is typically mentioned by community members as a significant contribution of the project. In projects, such as the MIHV project in Kenya and the ARHC Bolivia project, which were attached to a clinical services provider, curative

services at the health center were also mentioned as the important contribution to the health of the community

A number of evaluations suggested that those interviewed saw the training of local health workers as an effective intervention, in and of itself. Community volunteer training was mentioned as an asset by the community members themselves in 75% (9/12) of the evaluation reports, which is similar to the findings in the past reviews. These persons can serve as resources for the community beyond the existence of project activities, even if they do not continue to conduct training sessions or do house-to-house visits. This is important information since this PUSH factor was a major component of the implementation strategy of all of the projects reviewed. If the value of these trained community members is recognized, they may continue their activities even without a great deal of external supervision or remuneration (whether in-kind or financial). However, it has been demonstrated that there is a need for continuing education and refresher training for these health workers as their retention of knowledge suffers over time. *Successful linkages of community volunteers to technically trained personnel, either in the Ministry of Health or in a private organization or clinic is critical to the sustainability of community health workers with appropriate technical information to impart to their community members*

Interestingly, in only one of the eight projects which had income generating activities, community members interviewed suggested that the income generating activities were a great contribution to the community. In past years, IGAs have sometimes been mentioned by community members as contributing to the community, but the success of these activities has been limited at best. Perhaps this lack of recognition of the value of IGAs to the community is due to the fact that most of these projects set up IGAs for the health workers themselves, as opposed to the community at large. There was no ability to draw a conclusion regarding the impact of starting these activities on either the sustainability of the health gains, nor on the sustainability of the IGAs themselves. (The income generating activities will be discussed later.)

PVO activities which strengthened communities' own abilities to solve health problems

All twelve projects reviewed used a strategy involving local collaboration, at the community and even household level, to deliver training on key child survival messages and techniques. All projects promoted community participation and community mobilization and education, typically through beginning their training of health workers as a training of trainers (mentioned in 10 out of 12 reports), so that the health workers could impart their knowledge to the community in an appropriate, participative manner. This type of training should leave behind health workers to serve as resources as well as more knowledgeable mothers and fathers to promote and protect their children's health. This use of training of trainers in 83% of projects compares favorably to use of TOTs in previous years' evaluations with only 9 out of 24 (38%) projects mentioned use of TOTs in 1993.

Nine out of the twelve (75%) projects created new community structures, either health committees, or supervisory committees to oversee the work of the community health worker and/or to identify health problems and potential solutions. It would be interesting to note whether projects which created these structures with the communities served are more effective at sustaining child survival activities or not. Projects that did not create any new community structures, e.g., ARHC-Bolivia, relied instead on existing community governing structures only, (the peasant's union or sindicato in the case of the ARHC and PCI Bolivia projects), arguing that while these organizations looked after a number of issues beyond health, they had a life of their own and had been borne out of a prior community need, rather than in response to an external suggestion. They are certainly likely to continue their other responsibilities, whether they continue to oversee health activities and improvements after ARHC discontinues its activities remains to be seen. Previous reviewers of child survival project evaluations have suggested that those projects with long-standing community structures were more successful in achieving their objectives and were more capable of taking on project responsibilities, such as some supervision of health workers.

Community Participation in Design, Implementation and Evaluation of CS activities

In only one of the 12 projects, was there any real indication of communities participating in the original design of the project. Typically, community organizations such as health committees were set up as an early step in the implementation of the project, and had limited impact on the design of how the project was to be executed. When project reviews mentioned this early role of the Health Committee, it was often to identify where to place the maternity hut or health post. This finding was a bit disappointing, given the fact that these projects were all follow-on projects which continued work with some of the same communities with whom the project had previously worked. It was surprising that only in the case of the project in Indonesia was there mention made of community involvement in the design phase of the project.

However, all twelve projects identified significant community participation in the implementation of the project. Specific examples of community participation included communities choosing health workers, community members serving as health workers, community health workers training other community members, and, community groups acting as focus groups to test educational materials design. This does compare favorably with previous years' reviews with 83% of projects reporting community participation in the design and implementation of child survival activities in the 1993 review. While in 1993, 66% of projects reported health committees participating in the project, this year 100% reported work with local committees.

All projects, due to the requirements of the evaluation guidelines, reported that community members were active in the evaluation of the project activities -- community members had to be interviewed by the evaluation team. Two of the twelve projects had community members or leaders on the evaluation team. In addition, in terms of on-going evaluation of the project

in a monitoring sense, 83% or ten of the twelve projects mentioned providing feedback to the community itself or the health committee as a method of either evaluating progress over time, or to revamp implementation plans based on needs. *Still this was an area that some evaluators felt needed more attention in program efforts to encourage a greater sense of community ownership and an understanding of the value of preventive health behaviors*

This is one area of child survival sustainability planning which has shown encouraging results over the years of analyzing the evaluations. In previous reports, there were fewer examples of community involvement in the design, implementation and evaluation of CS activities. In 1993, 83% of projects reviewed had mechanisms to allow community input in design and implementation, compared with 100% this past year. While last year only 33% of the projects had committees which part of on-going implementation planning, this year that figure was 83%. Again, it must be noted that the evaluations reviewed this year were all for projects with a minimum of six years of work with the communities, and thus, one could expect that greater responsibility would be taken on by community members and specifically, health committees.

Health Committee Functioning

Some type of local health committees were utilized in all twelve projects reviewed. As stated above, 3 projects utilized existing structures only. Nine other projects created at least one layer of community organization to promote child survival activities and/or supervise health workers. Many projects reported that the majority of health committees functioned, 75% said that monthly meetings were the norm. This compares favorably with the 1993 figure for monthly meetings of health committees (53%). Still there were projects which had trouble keeping committees functioning and most reported some unevenness in committee functioning and commitment. This was particularly true in the 5 projects with appointed health committees, rather than the 7 with elected committees. Although not a certainty, the election of the health committee can either boost the esteem of the committee, or the value given the committee by the community that elected it, and thus, elected committees may take their role more seriously. Those projects that did not create new local committees (ARHC-Bolivia, ADRA-Indonesia, and PCI-Bolivia) reported more consistent meeting frequency, due to the fact that the committees had a larger and longer-standing role in community development issues.

As discussed above, these committees do get involved in the implementation of the child survival activities, often receiving training, overseeing health post activities, and to some extent, providing support and supervision to the community health workers. A good example of functioning health committees was provided by the ADRA-Indonesia project. These previously existing committees were involved in identifying health and development needs, delegating responsibilities to community members including the kaders, managing and collecting fees, and directly interacted with MOH personnel. On the other side of the

spectrum, problems were noted in one evaluation (IEF-Malawi), when the newly created health committee was underutilized and thus, disgruntled. Health service agents hired by the project directly interacted with the village health workers, bypassing the Village Health Committees altogether. *Thus a real function should exist for the health committee otherwise, the committee will soon cease to exist or meet infrequently with limited concern and ownership of the child survival activities*

The WVRD-Haiti project reported that health committees were elected by the community members and evaluated all development activities before they were undertaken. These very involved committees coordinated the work of 8 health auxiliaries who provided curative services, the volunteer health agents and groups of key mothers. The committees in the project area often oversaw the activities of the health rally post. Another unique committee role was taken on by the health committees in the PCI-Bolivia project area -- parents who did not bring their children to the vaccination campaign outreach site were fined¹. The project evaluation also noted that the health committee in the peri-urban Potosi project served as the administrative oversight for a day care center set up to aid working mothers.

While all project areas had some kind of health committee, these committees varied in their involvement in the implementation and monitoring of project activities. The validity of the committee structure in promoting the sustainability of the child survival activities and the health protective behavior changes cannot be determined based upon the information gleaned from the reports. While we may be assuming that committees will take on responsibilities to monitor health worker activities at the community level after the project ends, only seven of the 12 projects offered management and supervision training, and often this training did not extend to the health committees -- only to counterpart institutions such as the MOH. This was despite the fact that 60% of the projects reviewed suggested that the village health committees, or other local structures would take on the oversight responsibility for the health workers after the PVO completed the phase-over. In 40% of projects, the health workers would report to an employee of the ministry of health or a clinic staff member.

Community Contributions

All twelve projects mentioned some type of community contribution to encourage child survival activities after the project ended. Typically, the labor contribution of community health workers and committee members was mentioned (12 out of 12) and sites, construction materials or facilities contribution for health post, oral rehydration unit, or training setting (8 out of 12). These contributions may indeed enhance project sustainability - at least in terms of having community resources (human and physical) which have the potential to improve health behaviors and enhance delivery. In projects where the CS PVO or another organization assisted with the provision of potable water sources (e.g., ADRA-Indonesia), communities were asked to contribute materials such as sand and labor to complete the water system. Only 3 of the 12 projects reported community inputs of cash (not including those who saw fees for services as a community cash input). These figures are similar to the trend over time seen in reviewing past evaluation summaries, with PVOs asking communities to contribute more to

the start up of CS projects (In 1993, 78% of projects stated that community members donated time to project activities) No project evaluations suggested that communities were too poor to donate at least time and labor to the project, although donations of money and materials were mentioned as difficult in a number of project settings

Another mentioned community contribution was food for nutrition demonstrations (ADRA-Indonesia, WRC-Bangladesh, and WVRD-Bangladesh) A number of evaluations discussed income generating activities as enhancing a community's ability to contribute to the projects costs In the WVRD-Haiti project, community members contributed land or a site for income generating activities In the opinion of the project staff there, the local poverty was the most pressing problem and had a clear link to the health conditions of the population Thus, community members donated sites to undertake community and family based income generating projects which might encourage the re-emergence of a cash economy for the families

The projects in Mali and Malawi which were reviewed mentioned minimal community contribution in cash or in-kind to the project activities In the case of the IEF project in Malawi, evaluators noted that previously implemented government policies which "forced self-help," made villagers hesitant to contribute energy and resources to a community health project, although they were willing to pay for services at the point of delivery

Counterpart institutions and their impact on sustainability

As described above, all projects reviewed focussed some attention on the PULL side of the delivery equation, that is, improving the services of either the government or possible private providers of health care Typically, projects attempted to anchor the project activities to both the government and some other private institutions in an effort to encourage a local synergy which might sustain child survival efforts These linkages with the ministry of health typically were solidified in the field with local district health officials, although central authorities were aware of the partnership in the field The collaboration with public sector counterparts extended in these projects from the design through the evaluation, in part, because as follow-on projects, all of the programs had already built a working relationship with local MOH staff Fifty percent of the evaluation teams included MOH officials

Compared to previous years's findings, it seems that *CS project working for at least six years are strongly linked to the government services (100% were linked to at least the MOH s services) AND some other local non-governmental entity (11 out of 12 or 92%)* This compares favorably with the 1993 findings where 71% of projects had links to both the public sector and a local non-governmental agency In some cases (e g , ADRA Indonesia) the project was linked to a number of governmental ministries (Health, Family Planning, Education, Women's Affairs and the Army!) and local NGOs

In addition, this year, 33% of projects also had some link to a private, for-profit partner,

either a clinic, a radio station or a company with some interest in the health of the local population. University linkages were mentioned by 25% of the projects. These findings regarding other institutional links are similar to previous findings, suggesting that neither universities nor private sector companies are likely to provide a significant contribution to on-going child survival activities, unless there are very unusual circumstances.

In terms of local institutions which might help sustain project efforts, there seemed to be two new trends emerging: one was to work with a long-standing organization with roots in the community, even if their focus was not on health (e.g., the peasants' unions in the two Bolivia projects, the church in the ARHC-Bolivia and WVRD-Haiti projects), the other was to create a local non-governmental organization, utilizing some of the project's national staff and to train this institution to continue the efforts (under development by two PCI projects in Guatemala and Indonesia). *When creating a local PVO to continue efforts, time needed to be invested to train staff in management, finance and accounting and fund-raising. These required additional time and resources* and both projects were still working with these nascent ngos to develop them at the time of the final evaluation.

The projects in Mali seemed to have the fewest potential collaborators with no other significant partners beside the ministry of health, and associations of health workers themselves. One interesting collaborator with an interest in the project's sustainability was a private sector sugar producer in Malawi who served on the Advisory Committee for the IEF project. In the MIHV project, a clinic-based outreach project, a local foundation had endowed the project with some of the initial capital for the clinic, now the head of the foundation was working with the project to identify potential cost-recovery options, and to serve on the advisory board for the running of the clinic.

It was heartening to note that no projects undertook to build a new health care delivery system or to take on a completely untouched population, but rather to work with existing systems and counterparts to try to improve the capacity and demand of services to communities. *Working with whatever system exists locally is better than imposing any external structure which would be difficult to sustain.* While this might seem an obvious conclusion, the PCI Guatemala report provides a corollary: that stepping into an area with little or no government service may address the concerns of the most needy, but mitigates the obligation for the government to ever address the needs of that population. If some other organization has stepped in to provide even a modicum of services, the area might no longer have a legitimate complaint for better government provided services.

Skill building and collaboration with counterparts

The skill building training with the counterparts, both private and public sector, which were described by the projects were collaborative technical training (12 out of 12 projects), training in training techniques (10 out of 12 projects), training in management skills and techniques (7 out of 12 projects), and turning over management of volunteer health workers to either MOH staff (4 projects) or counterpart institution staff (one project).

Another area mentioned in terms of collaboration was in the area of improving or utilizing management information systems. A number of projects ended up influencing local data collection and handling training of ministry of health staff in the use of the PVO-designed health information system. Other NGOs were often trained in the data collection techniques of CS PVOs as well. A good example of this exchange of systems was in evidence in the ARHC Bolivia project where other community development organizations came to training events which ARHC organized to train the counterparts in the use of the CBIO approach. Another creative HIS example was in evidence in the PCI project in Guatemala, where bracelets were given to infants and colored beads for each immunization given were added to the bracelet until the child was fully protected. This innovation and the health information system developed for the project were then shared with the local MOH counterparts.

Little mention was made of training in systems which support child survival projects, such as cold chain management or family planning logistics. This would suggest that either other organizations are working with the counterparts to improve these systems, or that these systems are already adequate.

Compared to previous years' summary of the sustainability findings, it seems that PVOs are recognizing the need to train MOH staff in management techniques (58% this year compared with 21% last year) and training of trainers (83% this year compared with 38% last year). *These managerial and technical skills are important to the sustainability of child survival activities and to the strength of public services in general.*

Counterparts' ability to assume costs and control of the project activities

No project reviewed suggested a seamless transfer of authority to their counterparts had already occurred, nor that their counterparts were able to provide the human, financial and material resources necessary to continue the project alone. Most projects were entering a third phase during which responsibilities would be turned over to counterpart organizations. Some evidence of counterpart readiness to assume financial and managerial responsibilities was apparent in five of the evaluations reviewed. While MIHV would continue to work with their clinic in a peri-urban area on the outskirts of Nairobi, much of the responsibility for the project was being turned over to the local staff of the clinic and to the Board of Management -- i.e., MOH employees, privately funded clinic employees, University of Nairobi interested professionals and a private foundation's leadership.

In the IEF project in Malawi, some responsibilities had been turned over to the government already, such as transfer of health workers to government supervision. Funding to continue the supervisory activities of the IEF-trained health agents was likely to be forthcoming in the MOH (through grants from the World Bank and USAID). Motorcycles and bicycles were already being transferred to the MOH staff. Similarly, the PCI Bolivia and ADRA Indonesia projects had begun to transfer some responsibilities and costs to the MOH.

More common was the case of the PCI and ARHC projects in Bolivia. In both instances, it seemed that the Ministry of Health was unable to assume the costs of the project, with shortages of staff, equipment, vehicles and fuel. In a sparsely populated setting, there are greater costs for each intervention, and the government, while committed to community health care, simply cannot pay for the needed inputs. With decentralization on the national agenda, some hope was offered that centralized resources might be transferred closer to the rural people, but this is not assured. Therefore, both of these projects assumed that the PVO itself and other local organizations would have to continue the effort for some time into the future. Supervisory responsibilities were however turned over to the regional ministry of health staff and the local Peasant's Union.

On the other end of the spectrum were the two projects in Bangladesh (WRC in Khulna and WVRD in Dhaka), where the projects had taken on little of the responsibility for providing services. Instead, these projects focussed almost entirely on the PUSH factors in the community, encouraging mobilization through health volunteers, training of trainers, TBA training to recognize high risk cases, and mobilizing mother's committees. WVRD in part concentrated on a PULL factor, improving the quality of care provided to slum-dwellers in Dhaka, but primarily worked through community groups to increase the demand for preventive and curative services. In both cases, existing MOHFW (Ministry of Health and Family Welfare) services and/or clinics were directly linked with the communities themselves and thus the PVOs needed only to extract themselves from the equation. In the WVRD-Bangladesh project, at least one large segment of their target population could be served by the clinic with whom the project had worked all along. This transfer was to take place in 1995. Even so, both PVOs were going to maintain a presence in the project area through a transition phase.

No project had already transferred all activities and responsibilities to counterpart organizations. In four of the twelve projects, turnover of project activities and costs was difficult to foresee in the near future (World Vision-Haiti, World Vision-Mali, Andean Rural Health Care-Bolivia, and PCI Guatemala). In the first three instances, the main counterpart was the Ministry of Health and it was not currently feasible for the government to take on the costs and management of the child survival activities. In the case of PCI Guatemala, the local NGO which PCI was helping to establish needed additional training and assistance before it could assume complete control.

When compared to previous years' evaluations, it is curious to note that seemingly less of these projects, which were operational for at least six years, felt certain that their counterparts were ready to assume the costs and responsibilities to continue project activities. Last year, six out of twenty-four projects (25%) reviewed felt that their counterparts could assume financial responsibility for the project. Here, only 33% (four out of twelve) felt confident that these activities were ready for transfer, and this after six years of experience. One might have expected that a much higher percentage of projects would be ready for turnover after a six year investment. *It seems that as we learn about sustainability and all the pieces that need to be in place to ensure sustainability project managers and counterparts are less*

confident about the turning these activities over In addition, one project review noted that communities and local MOH authorities are not anxious for the turnover, even if cost recovery schemes are working well and recurrent costs have been reduced because there will be a net loss of external resources to the area -- not just health resources, but jobs, vehicle repairs, per diems to workers, etc

Efficiency Enhancement

All twelve projects described attempts to improve efficiency of project implementation, primarily by cutting costs. Those most frequently mentioned were (1) training of trainers which would have a ripple effect with the least cost, (2) use of community volunteers and community donated materials and sites, (3) utilizing national staff rather than expatriates, (4) moving management offices (closer) to the field, (5) coordinating training activities with other PVOs working in Child Survival in the country, and (6) transferring activities to the MOH mid-stream, and (7) seeking contributions from the private sector (e.g., prizes for the radio health contest in Rau, Indonesia)

These cost-savings techniques were very similar to those noted in previous years' evaluations. What was interesting in these six (plus) year projects was that only one project suggested health worker drop-out was a serious and costly problem. This was a problem mentioned in previous evaluation findings. *This suggests that perhaps, the continued investment of working with communities and their voluntary health workers increases the value of the health workers in the minds of the community members and the health workers themselves and thus, they continue their activities.* It may also suggest that over time, projects are better able to identify the best profile for a community health worker (whether single or married, young or more mature, etc) for a given area and encourage communities to choose women who are most likely to stay "on the job."

One interesting note on efficiency -- while midterm evaluators suggested that the ARHC community-based, impact-oriented approach which utilizes home visits was too expensive and should be scaled back somewhat, the project management felt it was central to their success and to achieving equity in the delivery of services, and thus did not abandon the house-to-house approach.

Cost Recovery Mechanisms

Ten of the twelve projects had somewhat successful attempts at cost recovery, although a number of these schemes had begun relatively recently and their ability to continue was not yet assured. The most common approach was to set up revolving drug funds (local pharmacies) with basic drugs or other program relevant materials (immunization and growth monitoring cards) for sale with a small mark-up which was to cover costs of the program (used in 7 out of 10 projects). In addition to this, projects which had some curative and clinical services attached to the project (ARHC-Bolivia, MIHV-Kenya, PCI-Guatemala, WVRD-Bangladesh) collected fees for curative services to subsidize the preventive services.

Some of these clinics established a sliding scale for fees so as not to discourage any one from seeking care due to their lack of means. A few project reviews mentioned payment of fees to TBAs and midwives after the delivery as a custom which was reinforced by the project - particularly valid now that the TBAs had received training (e.g., ADRA Indonesia). One project, PLAN-Mali, attempted to recover fees for community health workers' efforts, but the charge of approximately \$1.00 was considered excessive and had to be dropped altogether, community members were not used to paying for preventive services and were particularly disgruntled at the amount of the fee.

This high percentage of projects successfully implementing some type of cost recovery is surprising when compared with the trend witnessed in past final evaluation reviews. It had seemed that cost recovery attempts were decreasing in popularity among PVO CS projects (50% of projects in 1992 and only 33% of projects in 1993). This reviewer believes the difference this year is related to the length of time in the community for these 12 projects, and that many of these projects had some curative services for sale to subsidize the costs of the preventive services. Perhaps working with the communities longer allows creative possibilities for recovering costs of the project through sales of items/services OTHER than the preventive services which form the core of child survival activities. Most of the projects reviewed this year had other services, and these were the services for which fees were typically collected -- not the child survival interventions.

Control of fees recovered typically rested with the individual who recovered the fees, or the health committee. CHWs were responsible for resupplying their drug boxes from the government or other low-cost supplier. In the case of fees collected at clinical services, the clinic management team, or Board of Managers was responsible for setting and utilizing fees collected. In the MIHV project which was quite successful at raising funds, many persons from the area served wanted to be a part of the Board of Management, in part to have a say in the control of the fees generated. (It seemed that many believed that the clinic was in fact posting a profit.) In two projects, it seemed that the PVO itself was responsible for allocation of the fees collected, in five projects, the committees maintained control over the funds collected from fees for services or drug sales.

In reviewing the costs recovered by those projects (four out of twelve) which attempted to quantify this item, it is surprising how much revenue can be raised. The PCI Guatemala project which collected fees for medicine and contraceptive sales, clinical, lab and pharmacy services recovered \$56,430 in one year alone. Clearly the local population is willing to pay for services and items upon which they place a value. Also impressive was the reported recovery of 68% of operating costs at the MIHV-Kenya project clinic. (One creative idea they had was to give a discount on curative services to those that received the free preventive services.) On the other hand, the ARHC sites were able to recover only 5% of their recurrent costs and are projecting an ability to move up to 10% over the next few years of efficiency enhancements and revenue generating attempts.

The critical issue when looking at the effectiveness of cost recovery attempts is whether the

project tries to charge for services which were previously provided free of charge to community members. *Where communities were used to paying for medicines or clinical care child survival projects which started revolving drug funds or fee for service clinical care merely brought an already valued commodity closer to the people (e.g., PCI-Guatemala project)* Less successful were attempts to collect fees for preventive care (PCI-Bolivia project) or even curative care that had previously been provided free of charge by government services. In all cases where fees for services were charged, inevitably, some persons who could not afford the services were given needed medicines or services free, preserving equity in service delivery.

Income Generating Activities

Eight of the twelve projects (67%) attempted income generating activities targeted toward community members at large (3 out of 8 had this as a focus), or toward community health workers (6 out of eight targeted health workers) to serve as an incentive for these workers. Similar to the situation in the section on cost recovery, compared to previous years' evaluations, it seems that while the previous trend suggested fewer projects are attempting this type of activity, these projects which have been inside the communities for longer periods of time are attempting to aid the community in this way. Still, the success of these schemes was far from assured, even in these projects which had been working with these communities for six or more years. Perhaps this is due to the fact, explained in the PCI-Guatemala evaluation, that *income generating activities targeted toward health workers can peter out when begun by the PVO and then allowed to run independently without significant technical assistance, and eventually any gains due to these activities are not necessarily transferred to health activities*. In fact, were these small enterprises extremely successful, they might serve as a disincentive for the volunteer health worker to continue her work as a health agent, due to her more lucrative occupation as a goat-rearer or bodega manager. Where the activities were somewhat successful for the community health workers, they involved the sale of health related items, such as mosquito nets, condoms, etc (MIHV-Kenya).

There seemed to be a trend toward a combination of cost-recovery and income generating activities where two projects attempted to set up loan funds for community members to begin income generating activities with the interest recovered channeled back into the project's health activities. This compares well with the 1993 report which suggested that none of the projects with IGAs saw income increases channeled back into the project. Successful examples in 1994 included the WRC project in Khulna, Bangladesh, the loan repayment rate seemed to be going quite well with the interest collected at 16% returning to the project coffers. In the World Vision project in Mali, 100,000 CFA were given to the village health committees to finance small income generating projects of the animatrices. The profits from these projects were to be divided according to this schedule: 40% to motivate the animatrice, 10% to increase the revolving fund for other micro projects, 50% to cover other CS activities, such as a per diem for the MOH supervisors, products for nutrition demonstrations, etc. The success of this type of one-time capital gift to sustain numerous rounds of income generating

projects has not been demonstrated as yet. Similarly, the WVRD-Haiti project provided loans and initial funds to start-up drugstores, and home-based income generating activities. So far, the net profits of activities started by the project's capital outlay totalled \$30,000. More importantly, the capital and the activities helped regenerate a cash based economy in an extremely cash poor area.

In terms of what PVOs have learned with regard to income generating activities, it is clear to this reviewer that where specific technical assistance is not available to the new entrepreneurs, the success of the IGAs is not assured. What has happened is that the influx of any source of capital for loans or as an outright grant of seed money can help those persons who are naturally gifted entrepreneurs. However, to offer loans or grants to health workers so that they can begin an additional activity on top of their responsibilities for community motivation for health, is a potential burden. What these evaluations suggest is that the better investment is in providing the health worker with the means to begin a health related income generating activity such as the sale of mosquito nets, which reinforces her role as a health worker and may gain her some income to offset her opportunity costs of volunteering. An excellent discussion of income generating activities and cost-recovery schemes is detailed in the MIHV-Kenya evaluation which learned valuable lessons about what works and what doesn't work on the road to cost recovery and income generation in their clinic based outreach program.

Sustainability Prognosis

Of the twelve projects reviewed, based on their own descriptions of activities, it seems that no projects have completed phase-over to local counterparts. However, eight projects seem to have the transfer in progress. Of the twelve projects, 6 would be turned over primarily to the Ministry of Health, 3 to local NGOs, one to the management of a private clinic, and two to a combination of NGOs and the MOH. In four evaluations, PVO withdrawal from the area with any hope of project sustainability was unlikely in the foreseeable future (WV-Haiti, WV-Mali, ARHC-Bolivia and PCI-Guatemala). These four projects, all of which showed excellent examples of community development work and community participation, suggest the range of difficulties in turning over activities. In the case of Haiti, while WVRD has done a laudable job of motivating communities to work together to demand health services (a successful PUSH strategy) the PULL of the available public services needs continued support. The extreme poverty of the community and the poor public services in Haiti argue that to leave the project area at this point would be irresponsible. The local people will continue to need the improved quality of services provided with WVRD's support until the political and economic climate in Haiti improves.

The situation in the project area for the WV Mali and ARHC projects argue for continued gradual attempts to transfer responsibility to the local government and non-governmental counterparts, but that in the short term, sustainability without outside resources is unlikely. The PCI-Guatemala project faces a different issue - now that the project has helped a local NGO to be formed, the young organization needs additional training before being handed the

costs and responsibilities associated with the CS activities. PCI needs to focus efforts on institutional development and training of trainers to gradually reduce its role and help the created NGO to sustain itself, financially, administratively and program-wise.

Seven of the twelve projects detailed outside funding sources which had been found during the project, many of which would continue to fund some activities of the project. Two projects mentioned additional resources from USAID local missions to continue activities, and six projects received follow-on funding from the central USAID Child Survival funds. No project reported that they would be ceasing all project activities, compared with 21% of projects which reported leaving the project area in the 1993 report. One should not surmise that projects are becoming less successful or sustainable though based on that comparison, rather, projects this year were cautiously planning to turn over activities to local counterparts in the next year or two with limited financial commitments *because of their demonstrated effectiveness and the concern about preserving services and behaviors*. As suggested earlier, it seems that as PVOs learn about what it takes to build a sustainable project, managers and counterparts are less confident about turning over these activities until every thing is in place.

In examining the evaluations of these projects which have been working longer with USAID child survival funding, the maturity of the organizations and their knowledge of the complicated nature of sustaining programs are apparent. While the child survival revolution is based upon some relatively simple interventions, developing the capacity of local organs to carry on these interventions without external support and motivation is quite complicated. While these 12 projects are well on the way to developing counterparts knowledgeable about the child survival techniques AND capable of delivering these services, the careful planning before phaseover is necessary to maintain the PUSH and PULL factors at work.

SUSTAINABILITY LESSONS LEARNED

What these 12 evaluations suggest is that sustainability at the community level, with the community changing their behaviors to protect the health of their children can be achieved with a significant investment of time at the community level. Leaving trained health workers and mothers in each community can create the new community norms to protect children's health, particularly in areas like nutrition and oral rehydration where minimal external service delivery is needed for success. Government and private resources have also been dedicated to promoting child survival messages through the media which should support and encourage health protective behaviors. Thus, these projects have successfully raised the PUSH for protective health services in a manner which is likely to be maintained.

The second part of the sustainability equation is the creation or enhancement of appropriate health services to couple with the individual's health seeking behavior to protect the health of the child. These twelve evaluations suggest that the projects have invested the time, training and resources necessary to develop health services which will PULL individuals in for preventive care. The difficulties in maintaining the PULL of health services once the external

aid and props retreat are many limited national budgets for health services in general, limited emphasis within health services on preventive rather than curative care, competing recurrent health crises (cholera or AIDS, for example), frequent transfer of government health personnel, lack of focus on needs of already marginalized groups (urban poor, widely dispersed rural groups, indigenous peoples, etc), lack of supervision and management techniques among public sector workers, and limited budgets for refresher training of workers

These problems can be ameliorated by CS projects only in part - through training of MOH staff in technical and managerial issues, and by leaving a strong vocal community demand for services among the needy populations. However, what was mentioned very little in these evaluations, and an oft-neglected area of PVO work in the child survival projects is national level advocacy, or at least advocacy training to local people to correct some of the above-mentioned problems

KEY FINDINGS AND RECOMMENDATIONS

Community Participation

NGOs should emphasize management and supervision training at the community level if local community organizations will have any role in the supervision and motivation of community health workers after the close of the project

Community health workers need to be linked to a technical resource to continue to receive and retain appropriate health information. Even after working for six years with these communities, it was not often obvious to whom health workers would go for up-to-date technical training

Child survival PVOs should continue to diversify their connections at the community level, identifying community and private sector groups with an interest in the health of community members and engage these groups in training. These groups can include school teachers, local employers, church groups, etc

USAID should compare the impact and sustainability of projects which rely upon existing community structures versus those that create community structures to determine the efficiency and effectiveness of created health committees. Previous evaluation reviews also noted this distinction in community structures which supported child survival project activities. A study of this kind would require re-entering some communities which previously were part of a PVO child survival project, some of which had pre-existing community committees for health and/or development and some which the PVO had to help create. Do these created committees continue to exist after the project closes?

Furthermore, a real function needs to exist for the health committee, otherwise the committee will cease to exist or meet infrequently with limited concern and ownership of child survival activities. Job descriptions or committee objectives could be part of design work at the community level so that committee members know what their role is in the success of the

project. Once roles and responsibilities are clear, MOH and PVO staff should meet with committee members to check their perceptions and concerns about program performance.

While six years of experience led to projects which all had significant community participation and contribution to the implementation of the project, there needs to be greater attention to community participation in the design and evaluation of project activities. This should not be limited to two exercises - one at the beginning and one at the end - but rather should include monitoring activities throughout the life of the project. While these projects, by and large, incorporated this feature, reviewers thought more could be done in this area.

Counterpart Participation

Six years of experience has led to projects with strong links to government services and to some other pre-existing local organizations. These linkages strengthened the projects' visibility, access to resources, and enhanced sustainability potential. These links through training also encouraged better performance by the local MOH and counterpart staff.

Working with whatever system exists locally is better than imposing any external structure which would be difficult to sustain. Strengthening the local MOH presence should continue as a major emphasis in PVO programs.

Training of trainers in management skills should be offered inside CS PVOs and alongside their counterparts so that staff become more efficiently utilized and public sector workers develop some basic skills in management which they can employ to improve the quality of services delivered.

Successful linkages of community volunteers to technically trained personnel, either in the Ministry of Health or in a private organization or clinic is critical to the sustainability of community health workers with appropriate technical information to impart to their community members.

Projects which attempt to create a local NGO to continue project activities after the withdrawal of the international PVO partner should develop realistic plans for the well-rounded institutional development of their partner organization. Training areas for the counterpart must include management, accounting and finance, and fund-raising. This focus on institutional development must be central to the project design from the beginning, with an appropriate training plan and timeline with benchmark for achievements which are followed by the turnover of specific activities.

Child survival PVOs with experience in evaluating and improving the quality of service delivery should share their models with other PVOs in-country so that sustainability of the PULL of government services can be enhanced.

USAID should require the participation of a collaborating counterpart agency official to whom the project will eventually be turned over (e.g., MOH official and/or local NGO representative) on the evaluation team. NGOs should budget for this accordingly.

Efficiency, Cost Recovery and Income Generation

Health worker drop-out, a costly problem, seems to diminish after a number of years of PVO work with a community. This suggests that PVOs need to sustain the investment in community health workers for some time to increase the value of the workers in the minds of the community members, and thus, to sustain their activities.

PVO projects should not attempt to collect fees for services which have consistently been provided free in the past unless they can offer a higher quality of care. Preventive child survival services are hard to sell to community members, however, PVOs should pass the costs of clinical and curative care on to the community members. This can be a successful attempt to recover some costs of preventive care, particularly when the desired care was previously paid for, but at a greater distance from the community.

USAID should continue to encourage PVOs to attempt cost recovery techniques at the local level, as resources can be raised, even in very cash-poor communities. However, expecting cost recovery schemes to cover all recurrent costs of project activities is probably unrealistic in the types of communities targeted by PVO projects.

PVOs should train community members, or counterparts in basic financial management skills to ensure that resources collected can be channeled into project activities. PVO staff should not be instrumental to the planning, budgeting and expenditure of cost recovery resources raised for any significant period of time -- communities have to oversee these funds themselves.

PVOs should only assist in the creation of income generating activities when appropriate long-term technical assistance to these enterprises will be available.

One successful model might be the sale of health related items (bed nets for example) which would reinforce her role as a health provider and gain her some income to offset the opportunity costs of volunteering. However, providing health workers with other activities to gain income (e.g., giving them a goat or teaching them to sew) might actually take them away from their activities as a health worker.

PVOs can assist community income generating schemes, if the technical assistance resources are available, but no one should assume that income raised will be somehow channeled into health activities.

Future Sustainability Analyses

To further understand the potential sustainability of PVO projects, USAID should sponsor operations research projects by PVOs to look at issues such as the use of pre-existing vs created health committees, the continuation rates of health workers once PVO resources are withdrawn, the continuation of field training by counterpart organizations who received trainings of trainers, and, retention of knowledge and practices after PVO activities end

PVOs should continue to analyze questions regarding the sustainability of their activities as part of the final evaluation exercise, but more measurement along the way of turning over responsibilities to counterparts should be measured. A series of continuums could be created for activities such as training, staff supervision, financial control, etc., and PVOs could measure their progress in turning over each activity to their counterparts over time.

Continued attention should be placed on cost recovery mechanisms and PVOs should at least be able to quantify what recurrent costs will be after their activity ceases. This should be part of project design, rather than something which PVOs try to estimate at the end of the project.