Lessons Learned from Applying the Child Survival Sustainability Assessment (CSSA) Framework to Seven Maternal and Child Health Projects

Guidelines for implementation of the CSSA based on the experience of CARE and IRC, Sierra Leone; PCI, Indonesia; WV, India; Project Hope, Nicaragua; ADRA, Madagascar; and CWI, Bangladesh

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Acronyms

ADRA	Adventist Development and Relief Agency International
BC	Behavior Change
CARE	Cooperative for Assistance and Relief Everywhere
CATCH	Core Assessment Tool for Child Health
CBO	Community-based Organization
CEDPA	Centre for Development and Population Activities
C-IMCI	Community-based Integrated Management of Childhood Illness
CORE	Child Survival Collaborations and Resources
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSHP	Child Survival and Health Project
CSSA	Child Survival Sustainability Assessment
CSTS+	Child Survival Technical Support Plus
CWI	Concern Worldwide Incorporated
DIP	Detailed Implementation Plan
DHMT	District Health Management Team
HFA	Health Facility Assessment
IMCI	Integrated Management of Childhood Illness
IRC	International Rescue Committee
KPC	Knowledge, Practices, and Coverage (survey)
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Nongovernmental Organization
PCI	Project Concern International
PHC	Primary Health Care
PHU	Peripheral Health Care Unit
PVO	Private Voluntary Organization
SHOUT Group	Sustainable Health Outcomes Group
TA	Technical Assistance
USAID	United States Agency for International Development
WHC	Ward Health Committee
WVI	World Vision International

Glossary

Shared by all projects	Dimensions	The CSSA Framework has three complementary dimensions of evaluation.	- Dimension 1: health outcomes and health services characteristics; - Dimension 2: local organizational capacity and viability; and - Dimension 3: community capacity and social ecological context
	Components	Major subdivisions within each dimension of the framework.	Organizational capacity and organizational viability are the two components of the second dimension of the framework.
Context- and local system-specific	Local system	Refers to local stakeholders and communities within a specific environment brought together to map out their vision and goals for sustained health in the community; this local system also defines the level at which evaluation can take place in a meaningful way.	Villages, women associations, local authorities, rural development associations, health district and health posts, local socially active NGOs, and private sector partners brought around the table.
	Vision	Represents what the local system partners are able to imagine as an ideal long-term sustainable health situation for their community	"Children will not die of preventable causes or in greater number than other countries of the region; they will find care in well-run health centers and be well advised and cared for by educated mothers."
	Elements	Specific items of evaluation within components. For example, financial management capacity is an element of organizational capacity. Elements can have sub-elements. Elements and sub-elements translate into general objectives (see below).	An element within the Dimension 2: financial management capacity of health committee leadership. Two sub-elements within this element: i—capacity of health committees to plan annual expenditures ii—capacity to account for funds disbursement.
	General Objective	A broadly stated objective for the local system.	Having health committees with strong management capacity.
	Indicator	A measure providing information on progress toward an objective.	Satisfactory financial audit passed according to project standards.
	Indicator status scales	Predefined stages of progress of an indicator toward a status most favorable to sustainability on the considered issue.	See Annex 9.
	Index	Provides a single measurement resulting from a combination of several key indicators	See Annex 9.
Project-specific	Project Objective	A specific objective defined as a target by the project. A project objective is a specific and measurable contribution of the project to a general objective of the local system.	Two years from now, 20 health committees will demonstrate the ability to plan expenditures and monitor disbursements through an annual financial audit conducted by the project.

INTRODUCTION

The Child Survival Technical Support (CSTS+) project and the Child Survival Collaborations and Resources Group (CORE) have been working to define, assess, and measure *sustainability as a process* since 1999, efforts which culminated in the development of the Child Survival Sustainability Assessment (CSSA).[1,2]

This report presents the lessons learned through the efforts of private voluntary organizations (PVOs) and CSTS+ to integrate the sustainability framework at different stages of project life, particularly at the detailed implementation plan (DIP) development stage.

HISTORY

CSTS+ and CORE are neither the first nor the last to tackle the issue of sustainability in primary health care. Another elaborate and recent effort with some conceptual similarities to the CSSA was tested and developed by The Centre for Development and Population Activities (CEDPA), focusing on the sustainability of reproductive health services in India.[3] For a background and history of previous efforts to address the concept of sustainability in primary health care (PHC) and its measurement, the reader should refer to previous publications of CORE and CSTS+.[4] Some of the guideposts on this cooperative effort in the PVO community can be highlighted as follows[5]:

- March 2000: Sustainability Dialogue Meeting (CSTS+ and CORE) and publication of CORE's sustainability review of child survival projects in Bangladesh and Bolivia from 1985 to 1997.[6]

- 2000–2001: Sustainability Initiative Study with CORE members and active Child Survival (CS) projects

[1] Sarriot, E. 2002. The Child Survival Sustainability Assessment (CSSA): For a shared sustainability evaluation methodology in Child Survival interventions. *Child Survival Technical Support*. Calverton, MD: ORC Macro. (http://www.childsurvival.com/documents/CSTS/sustainability.cfm)

[2] Sarriot, E., P. Winch, L. Ryan, J. Bowie, M. Kouletio, E. Swedberg, et al. 2004. A methodological approach and framework for sustainability assessment in NGO-implemented primary health care programs. *The International Journal of Health Planning and Management, 19*(1), 23–44. http://www.childsurvival.com/documents/CSTS/SustainabilityArticleIJHPM_2004_12.pdf

[3] Kahn, A., and L. Hare. 2003. Sustaining the benefits: A field guide for sustaining reproductive and child health services. The CEDPA training manual series.

[4] Sarriot E., P. Winch, L. Ryan, J. Edison, J. Bowie, E. Swedberg, et al. 2004. Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organizations. *The International Journal of Health Planning and Management,* 19(1), 3–22.

[5] Documentation and reports on most of these events can be found at http://www.childsurvival.com/documents/CSTS/Sustainability.cfm

[6] Seims LK. A sustainability review of BHR/PVC-funded child survival projects in Bangladesh and Bolivia from 1985 to 1997: What's left after all these years? 4-28-2000. The Child Survival Collaborations and Resources (CORE) Group.

- 2001: Presentation and testing of sustainability framework concept to PVOs in the United States and in the field (CORE Meetings; International Health Program Conference of Plan International, Senegal; Save the Children U.S. and partners, Egypt; CSTS+ and Save the Children Sustainability workshop in Bamako, Mali)

- September 2002: Publication of the CSSA and background documents

- January–March 2003: Dialogue meetings and brown bag sessions at CSTS+ and United States Agency for International Development (USAID) on improving and measuring the PVO Contributions to Sustainable Child Health

- CSTS+ provides technical assistance (TA) to Concern Worldwide Incorporated (CWI) to apply the CSSA for its Bangladesh project's midterm evaluation

- Summer 2003: CSTS+ releases a call for concept papers to PVOs funded by the Child Survival and Health Grants Program (CSHGP), preparing their DIP, or having recently completed it. Fourteen papers are received and five are selected.

- December 2003: CSTS+ and PVO partners hold a workshop on Child Survival and Health project (CSHP) design: Applications of the Sustainability Assessment Framework

- January 2004: Publication of a two-paper series on the Sustainability Initiative and the CSSA in *The International Journal of Health Planning and Management*

- January–March 2004: CSTS+ staff and consultants provide TA to six PVO projects in five countries, to integrate sustainability in their DIP. This report is primarily concerned with this effort.

- September 2004: CSTS+, CORE members, and outside partners such as the London School of Hygiene and Tropical Medicine initiate the Sustainable Health Outcomes Group (SHOUT Group)[7] to accelerate learning, exchange of experiences, and methodological advancements with sustainability design in health programs.

WHAT THE READER WILL FIND

This report demonstrates that the CSSA can be a useful tool to support project planning for sustainability at different stages in the project life cycle. Through the seven case studies presented, some clear benefits emerge, including a sense of joint ownership by project partners; a systematic analysis of contextual elements that impact sustainable health; and the production of summary index measures, which provide information that can be used to compare progress across time and place. Challenges remain in terms of validating index measures and definitions of progress; fully incorporating the CSSA into an existing project design; and applying the CSSA in a project planning phase when funding is not insured.

The recommendations formulated in Part III emphasize that projects should start early to involve partners in designing for sustainability. This begins with defining the local system and

[7] Sustainable Health Outcomes Group—detail to come in www.childsurvival.com in October 2004.

identifying a common vision of sustainable health. Implementers must be flexible and persistent in advancing monitoring and evaluation design. To avoid duplication of information systems, application of the CSSA should be translated in clear "intermediate result" definition for projects applying the USAID-recommended Managing for Results methodology. Particular attention should be paid to displaying information that is meaningful to the audience.

This document is organized into four main sections—

- **PART I: The Sustainability Framework: From a concept to an assessment methodology.** This section is for the newcomer to CSTS+ and CORE's efforts; it provides an overview of the proposed CSSA content and process, covered in more detail in the literature already referenced.
- **PART II: Review and lessons learned from the implementation of the CSSA with seven CSHPs.** This section provides a thorough and comparative discussion of the most recent efforts to apply the CSSA at different stages of a CSHP life.
- **PART III: Practical recommendations for applying the CSSA.** This section provides practical guidance to project managers, PVO backstops, project developers, and evaluators wishing to use the CSSA to design, reorient, or evaluate a CSHP.
- **Annexes**

PART I: THE SUSTAINABILITY FRAMEWORK: FROM A CONCEPT TO AN ASSESSMENT METHODOLOGY

Sustainability is a complex concept and a term with many definitions, but it inspires one general vision in the community of child survival and generally primary health program practitioners: improved maternal and child health outcomes that will continue after project inputs cease decrease or shift.

A definition of sustainability heavy in local processes *

Sustainability in primary health care projects is a contribution to the development of conditions enabling individuals, communities, and local organizations to express their potential, improve local functionality, develop mutual relationships of support and accountability, decrease dependency on insecure resources (financial, human, technical, informational), in order for local stakeholders to negotiate their respective roles in the pursuit of health, wellness and development, beyond a project intervention.

The individuals, communities and local organizations constitute a local system with their environment, and it is ultimately their coordinated social interactions and efforts, based on the understanding of their own health and development that will lead to lasting health impact.

* Sarriot, E. 2002. Sustaining child survival: Many roads to choose, but do we have a map? Background document for the Child Survival Sustainability Assessment (CSSA). Child Survival Technical Support. Calverton, MD: ORC Macro. (http://www.childsurvival.com/documents/CSTS/sustainability.cfm)

The PVO and larger child survival communities generally agree that it is important to define, assess, and measure sustainability, but progress has been slow and only recently revived through joint efforts. The CSSA offers both a framework—a system to organize a range of variables influencing health and its sustainability in a local community—and a process that projects can use with local stakeholders to define the contextually -relevant elements and indicators of their sustainability plan.

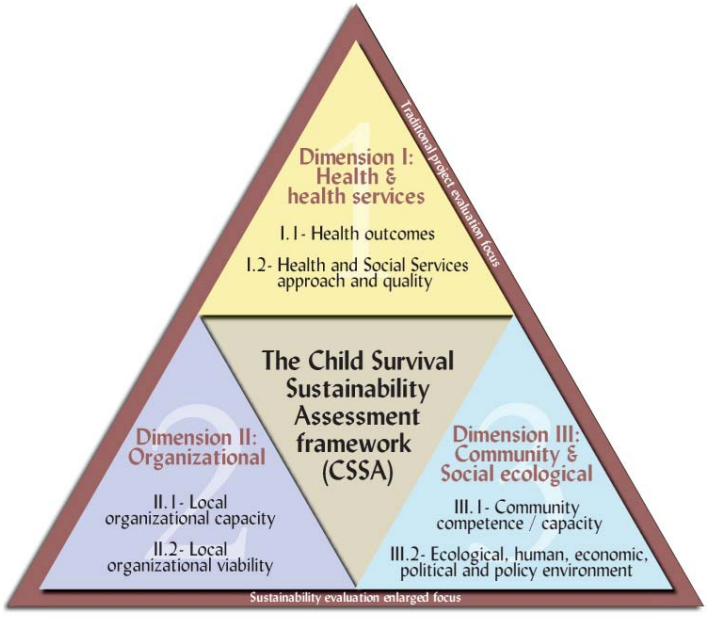
CSSA: THE FRAMEWORK

The CSSA is based on experiences of the PVO community and is grounded in research on sustainable development from several sectors, including health and business. It presents sustainability as progress resulting from interrelated processes and outcomes across three main dimensions of evaluation, each one composed of two distinct components. The CSSA framework is a graphic representation of inter-related components affecting the potential for sustaining positive health gains that should be addressed in a community-based health program: health outcomes and health services characteristics; local organizational capacity and viability; and community capacity and the social ecological context (Figure 1). For most practitioners involved in implementing programs, these components are not new. However, the framework, and the process that CSTS+ and partners have used to apply it, are unique in that they help

planners explore the interrelationships between dimensions for the purpose of strengthening and improving the local conditions.

> ***What does our definition of sustainability mean in practical terms?***
> -It means that projects do not control the future, especially not after they have packed and moved away.
> -It means that local stakeholders will have the responsibility of supporting the continuation of progress, even with many unpredictable events interfering with their plans.
> -It means that a project should try from the beginning to bring these local stakeholders together, and support processes and results that will leave them in a better position to respond to ongoing and unpredictable challenges to health in the future.

Figure 1: The Child Survival Sustainability Assessment Framework (CSSA)



Dimension I, Health and Health Services, consists of two components including elements reflecting progress in the health situation and the characteristics of health and social services of the local system.

- The **first component,** Health Outcomes, represents the population's health, which is generally addressed through health indicators (e.g., child growth) or proxies such as immunization coverage, healthy household behaviors (e.g., exclusive breastfeeding, weaning practices, sleeping under bed nets), and improved knowledge (e.g., management of the sick child, risk of HIV transmission).

- The **second component,** Health and Social Services, consists of elements in the health and social services approach, such as quality, cost, accessibility, equity, appropriateness, and coverage, whether through public or private, or community- or facility-based service delivery.

This dimension connects sustainability with the health progress local practitioners want to achieve. It does not represent only *what* stakeholders want to sustain (health outcomes), but it is also part of the conditions needed for sustainability. Capacity building efforts (see Dimension II) should be judged in parallel to progress achieved in the health of poor communities. Any disconnect between these dimensions (health achievements and capacity developed) goes against the principles of sustainability.

Dimension II addresses the organizational capacity and viability that need to develop at the local level.

- The **third component,** Organizational Capacity, refers to a range of functions that are necessary to the life of a local organization, to its administration, and its ability to perform its mission.[8]

- The **fourth component,** Organizational Viability, relates not only to financial viability, but to other essential types of support and relationships—connectedness—that an organization depends on to fulfill its mission. This is not so much self-reliance, an optimistic and ambiguous concept at best, but a rational profile of organizational dependency, or interdependency, in a given institutional environment.

Organizational capacity and viability are overlapping concepts, and are sometimes considered one and the same. We distinguish between them because differences in programmatic efforts will enhance one or the other. For example, significant effort can be invested to improve the *capacity* of a local nongovernmental organization (NGO) to manage itself and perform activities, while actually increasing its dependency on a single international source of funding, thus, potentially putting the NGO's *viability* in question. To increase the viability of the organization, efforts of another kind will be necessary to improve its financial autonomy and integration within a societal network to access knowledge and human resources. [9]

The nature of the organization concerned with this dimension, whether Ministry of Health (MOH) structures at the facility or district levels, local NGOs, or community-based organizations (CBOs), will vary depending on how the local system has been defined.

Dimension III addresses the conditions in the community and the social ecological system in which the project evolves.

- The **fifth component,** Community Competence/Capacity, refers to overlapping elements that affect the community, such as cultural acceptance of positive changes, social cohesion,

[8] Lafond, A., L. Brown, and K. Mcintyre. 2002. Mapping capacity in the health sector: A conceptual framework. *The International Journal of Health Planning and Management 17*(1), 3–22.
[9] Cottrell, L. 1983. The competent community. In R. Warren and L. Lyons (eds.), *New perspectives in the American community*. Florence, KY: Dorsey.

and collective efficacy. It's helpful to consider community capacity as a range of functions of community life (e.g., leadership, communication skills, conflict management, sense of community, internal participation) that contribute to the competence of the community. Community competence is defined as the ability of the community to collaborate on need and problem identification, to achieve consensus on goals and priorities, and to agree on ways and means to implement the required activities.[10]

- The **sixth and last component,** Ecological, Human, Economic, Political, and Policy Environment, includes a number of elements within the environment of the local system: national and regional policies, the economic and political environment, the environmental/ecological conditions, and the human development situation. These elements are frequently outside of a project's scope of intervention, but represent important factors of development, which NGOs cannot ignore.

These last two components are strongly related: policy and local political climates will influence the ability of the community to express its capacity. Reciprocally more capable and cohesive communities will bear greater influence on larger social, political, and environmental progress. The community competence/capacity component is essential to NGO work, and central to their experience with sustained health benefits. The social ecological component is essential for recognizing the importance of the environment in enabling the maintenance of progress.[11]

The CSSA does not offer directives or ready-made indicators to measure project sustainability, but it supports the systematic development of a monitoring system we might refer to as a dashboard or scorecard toward sustainable health, tailored to the realities of each situation. As a tool, the CSSA is not a rigid assessment with specific indicators, related survey questions, and a protocol for administration. It is, instead, a conceptual framework designed to guide a program's thinking about how it might best be designed, implemented, monitored, and evaluated in order to address the issues that most influence sustained health outcomes in a given cultural context. **Measured progress along the three dimensions describes an increased prospect of durable health gains, while lack of progress in any of the dimensions predicts a decreasing prospect for sustainable health.**

CSSA: THE PROCESS

CSTS+ recommends applying the CSSA through a six-stage participatory process, which has been adapted from a model successfully applied in other settings with communities around the world.[12]

Sustainable program design—6 steps to guide the process

1. Define the system to be assessed, its vision and its goals.
2. Identify the relevant elements/general objectives for the local system.

[10] Stokols, D. 1996. Translating social ecological theory into guidelines for community health promotion. *The American Journal of Health Promotion 10*, 282–298.

[11] Najam, A. 2000. *Community level sustainability assessment—Dasudi, India: A case study based on the work of the IUCN/IDRC project on 'Assessing Progress Towards Sustainability'.* Cambridge, UK: IUCN (The World Conservation Union).

[12] The CSHGP is administered by the Global Bureau of USAID.

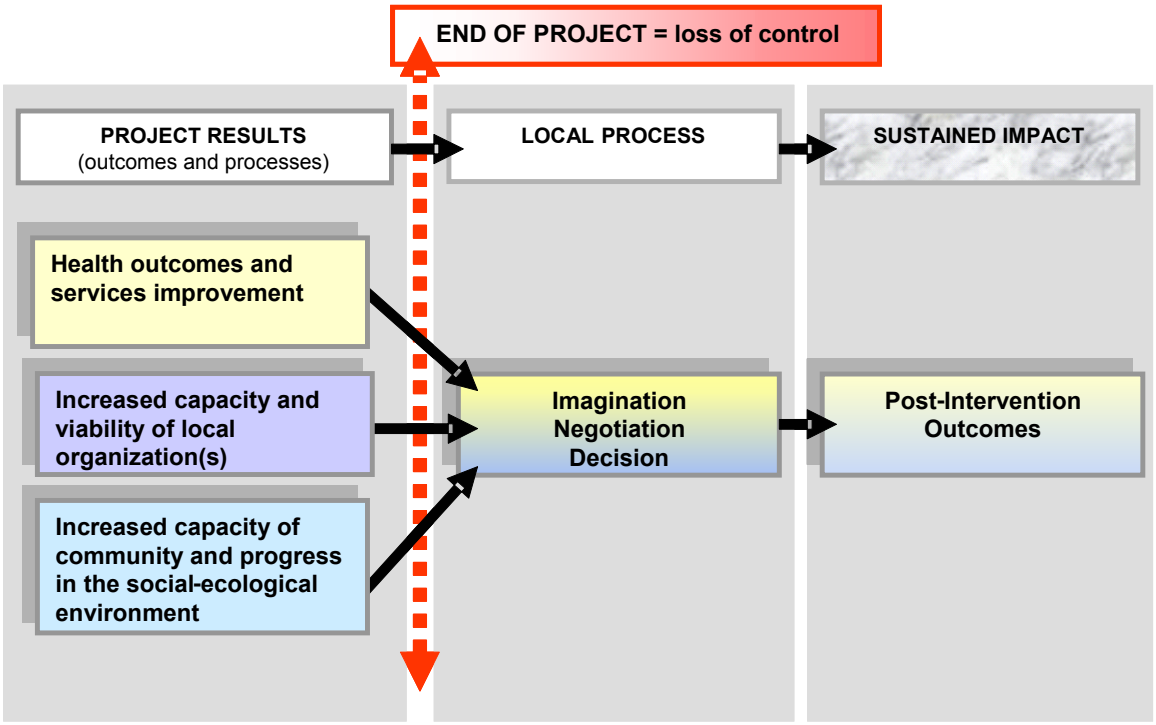
3. Choose indicators and identify scales you will use to judge the progress they measure.
4. Measure the status on the individual indicators you've selected.
5. Map indicators along the scales you've created to define progress and, as needed, combine the indicators into indices.
6. Review results and propose programmatic intervention (including specific project objectives) or policies for improving the status of the indicators.

More details on this process can be found in the references cited previously, and in the second and third parts of this report. It is essential to emphasize a few simple concepts illustrated in Figure 2:

- A sustainability plan for health is first and foremost the plan of local constituents (e.g., communities, health providers, political leaders, activists, associations), which constitute a local system. The more these constituents are able to work together (and PVO projects play a key role in this) the more this local system is functional and able to achieve and maintain progress.

- A project has a beginning and an end. Addressing sustainability means aiming for something that will (or won't) materialize at a point beyond the project's control. What sustainability planning will mean for the project is an informed effort to improve the local system's ability to sustain defined health gains.

Figure 2: Improving a Local System's Ability to Sustain Health Gains



The next section of this document reports the experiences of seven PVOs who used the CSSA for child survival program design.

PART II: REVIEW AND LESSONS LEARNED FROM THE IMPLEMENTATION OF THE CSSA WITH SEVEN CHILD SURVIVAL AND HEALTH PROJECTS

BACKGROUND

In FY 04, CSTS+ offered technical assistance to assist PVOs in the CSHGP[13] with applying the sustainability framework in the early years of their child survival projects. PVOs submitted 13 applications for TA. Through a competitive process involving representatives from the CSHGP and CORE, CSTS+ chose six PVOs in five countries. TA consisted of two or three phone calls for planning purposes, a series of e-mails, including a set of Q&A to establish the parameters of the activity, a facilitator visiting PVO project sites and working through the steps of the CSSA, and follow-up phone calls or e-mail contacts between the facilitators and PVOs as needed. Table 1 gives an overview of the TA recipients. The table is followed by a brief narrative providing context to the six PVO projects. In addition to the PVOs listed in the table, this document also highlights the experiences of CWI Bangladesh, who used the framework for program evaluation and planning.

A note about the CSHGP project cycle

The CSHGP cycle begins with the release of the RFA in late August. Project proposals are due at the end of November and applicants are notified of funding decisions in early May. Projects are then set to begin October 1 of the following year. A draft DIP is due April 30, and the final DIP is submitted at the end of June, after technical review, feedback, and revision. Applicants submit proposals in one of the following categories: entry/new partner (for applicants who have never received USAID development funding; standard (main category); cost-extension (applicants with a current grant that ends in the coming FY); expanded impact (scale-up proven interventions); and TB (prevention and control).

Table 1: Overview of TA Recipients

PVO	Country	Project Phase (new or follow-on project)	Facilitator
CARE	Sierra Leone	DIP preparation (new)	Nancy O'Rourke, CSTS+ Consultant
International Rescue Committee (IRC)	Sierra Leone	DIP preparation (new)	Nancy O'Rourke
Project Concern International (PCI)	Indonesia	DIP preparation (new)	Michel Pacqué, CSTS+ Senior Child Survival Specialist
World Vision International (WVI)	India	DIP preparation (follow-on)	Eric Sarriot, CSTS+ Capacity Building Specialist
Project Hope	Nicaragua	In Year 2 (new)	Leo Ryan, CSTS+ Project Director
Adventist Development and Relief Agency (ADRA)	Madagascar	DIP preparation (follow-on)	Karl Blanchet, CSTS+ Consultant

[13] The CSHGP is administered by the Global Bureau of USAID.

APPROACHES: PROCESS, OUTPUTS, NEXT STEPS, AND PROGRAMMATIC CHANGES

The purpose of this section is to describe the approaches used and general outputs of the TA provided by CSTS+ in 2003–2004. Following a summary of the six country experiences,[14] a brief synopsis compares and contrasts their approaches.

Planning processes

The common course of action when organizations plan and design projects is to hold a series of participatory meetings, conduct field assessments, host a workshop to bring all data and partners together to finalize work plans, and (for CSHGP grantees) commence DIP writing. How did the CSSA enhance this design process?

As in most DIP-design processes, PVOs applying the CSSA brought project partners together in a workshop, which contributed toward building local ownership of the project. However, practitioners using the CSSA found that it differs from their previous methods in the following three ways:

- It supports a strategic approach toward creating a *long-term vision* and *long-term goals*, rather than a vision and goals for the life of the project only (3–5 years). This has implications for planning and implementing projects, as well as for measuring progress (see final item).

- It builds ownership with local partners by sharing responsibilities and roles to achieve improved maternal and child health *beyond the project itself.*

- Measuring progress through the CSSA offers the opportunity to create *composite measures* (e.g., indices) suitable for sharing with policymakers and the general public, while providing the same detailed data (indicators) associated with results frameworks and logframes.

The CSSA offers a more strategic formulation of project plans to address sustainability because it focuses efforts on examining and assessing data to identify elements critical to sustained health outcomes, creating indicators to measure progress toward achieving sustained health outcomes, and eventually creating indices that map progress toward sustainability in three dimensions. The explicit use of team exercises to envision the future (see Part III) bolsters a sense of shared responsibility for long-term health gains. Previous methods of working with project data and partners often indirectly address this step, and do not necessarily see beyond the end of a project. That approach may lead to increased partner participation in the short-term, but does not necessarily inspire a sense of responsibility for the long-term.

To a great extent, the CSTS+ assistance provided an educational practicum, where PVOs learned as much about the CSSA itself as about how to apply it to their individual projects. Learning and conceptual acceptance had to occur before the CSSA could be applied. Each PVO that received TA had adopted the CSSA as the project's approach to sustainability, and each

[14] Information taken from consultant and PVO reports, as well as e-mail and phone communication.

PVO progressed through the assessment steps and identified the tasks required to complete the assessment.

Table 2 compares and contrasts contexts and approaches among the PVOs whose experiences are profiled in this guide. A table displaying some participants' feedback on the process is included in Annex 1. This section continues with an overview of approaches, providing further detail to the data in Table 2. Figure 3 describes the generic sequence of process steps that characterized recent PVO work with the CSSA. Individual charts are included for those PVOs with a significant difference in steps taken or in their sequence.

Figure 3: General Process Sequence

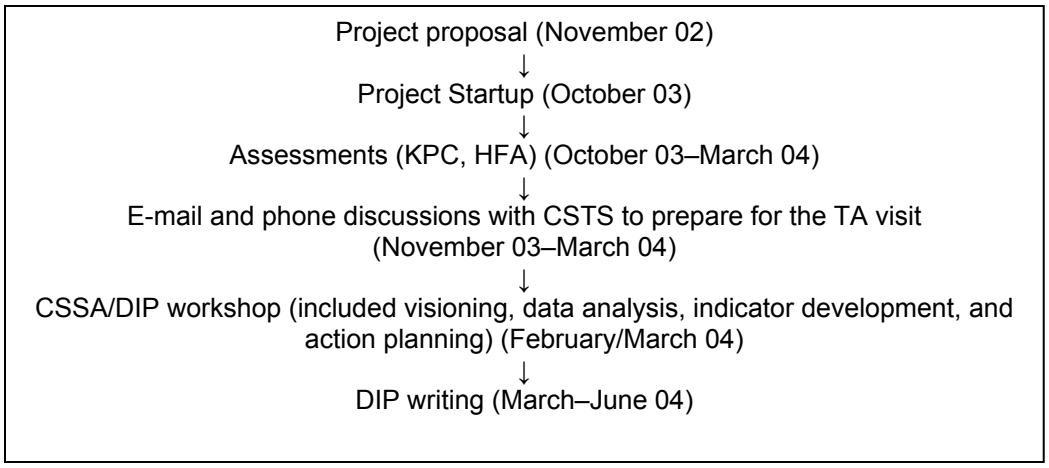


Table 2: Summary—Contexts, Approaches, and Outputs at Time of CSSA TA

	CARE	IRC	PCI	WVI	ADRA	HOPE	CWI
Country	Sierra Leone	Sierra Leone	Indonesia	India	Madagascar	Nicaragua	Bangladesh
Project Phase	DIP	DIP	DIP	DIP	DIP	Year 2	Midterm
Years In Area	0	2	4	6	5	>5	4
Implementing Partners (Type)	MOH, community (TBAs, village health committees, CBAs, traditional healers)	MOH, community (TBAs, village health committees, CBAs, traditional healers)	MOH, NGO, community (village heads, religious leaders, health cadres, TBAs, village midwives, CBOs)	ICDS, NGOs, MOH, and community	MOH, NGOs, community (health agents, TBAs, other groups)	MOH, NGOs, community (health committees, volunteers, reps from coffee plantations)	MOH, community (Ward Health Committees)
Prior experience with implementing partners	NGO and community partners are new	Yes	NGO is a new partner	Yes	Yes	NGO and community partners are new	Yes
TA impact on Project Design	Yes(added indicators)	Yes (added indicators)	Yes (Reframed indicators under CSSA components	Yes (added indicators)	Yes (monitoring plan and methodology)	Yes (monitoring plan)	Yes (monitoring and new project design)
Assessments Completed at Time of Sustainability TA							
Org Cap assessment (partners)	ND*	ND	ND	Yes	ND	ND	Yes
HFA	Yes	Yes	Yes	Yes	Yes	Yes	Yes
KPC	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Community Capacity assessment	ND	ND	ND	Yes	Yes	Yes	Yes
Activities Carried out During the TA							
Visioning exercise	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Created indicators	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Built indices	Not completed	Not completed	Not completed	Yes **	Yes **	Yes **	Yes **
Identified threats	Yes	Yes	ND	ND	Yes	ND	Yes

*ND = not done at time of TA
**began mapping status

CARE and International Rescue Committee

Process: Cooperative for Assistance and Relief Everywhere (CARE) and the International Rescue Committee (IRC) are presented together because they are implementing projects in adjacent districts and are working together to ensure sustainability through their projects by using the CSSA. Nancy O'Rourke, CSTS+ consultant, provided TA to both groups, resulting in a joint working group meeting. The project teams also collaborated in a joint visioning exercise preceding the workshop. With respect to the six steps of the participatory process (see Part I), the team completed steps 1, 2, and 3. The status on some elements still had to be measured and mapped and combining indicators to build indices remained as a next step.

Outputs: The TA was designed in the form of a working group meeting. Major activities included the following:

- ✓ Reporting on the visioning exercise and refining the vision
- ✓ Clarifying the goals
- ✓ Identifying key elements for each dimension, and partner roles and responsibilities
- ✓ Identifying threats
- ✓ Developing indicators for sustainability, by district
- ✓ Sharing and refining indicators
- ✓ Defining next steps.

The teams defined the following *next steps:*

IRC	CARE
Meeting with stakeholders to discuss a plan of action	Continuation of health sessions
Meeting with DHMT to plan and finalize the DIP	Stakeholder planning workshop
Meeting with peripheral health care units (PHUs) and communities to plan and finalize the DIP	DIP
Prioritize sustainability indicators	Assessments: quality of care, partner capacity
Obtain sustainability baseline data	Develop BC strategy
Pilot activities	Develop a monitoring and evaluation (M&E) plan
Establish a computer-based system/HIS	Integrated Management of Childhood Illness (IMCI) training for PHU staff
Conduct cross-visits with CARE every 4 months	Collaboration with PHUs
	Participate in routine village development committee, PHU, and CARE meetings
	Ongoing collaboration with DHMT and IRC

Q&A: What is the difference between a vision and goals?
It may be helpful to start with a common vision, something more general than goals. This can be a good way to start negotiations and dialogue. If the discussion becomes too vague, it may help to refocus on specific goals. A vision can emerge from that discussion.

It is particularly important to have broad goals in the three dimensions because they provide direction and suggest desired interaction among stakeholders over the long-term. Local dynamics, the history of partners' relationships, and the organization's experience with participatory planning exercises should guide the approach.

Programmatic change: The key programmatic change for CARE and IRC was the addition of indicators for monitoring elements previously unidentified, including those not directly addressed by the projects (e.g., issues related to education). As a result of the working group meeting, the team realized the importance of monitoring and reporting as many elements affecting sustainability as possible, even if they may not be directly affected by the project.

Project Concern International

Process: Project Concern International's (PCI's) CHOICE project is implemented in 30 villages of the Pandeglang District in Indonesia. Michel Pacqué, CSTS+ Senior Child Survival Specialist, joined PCI's team and partners at the DIP workshop to introduce the CSSA and facilitate formative work to integrate the CSSA with PCI's project. The workshop included several commitment and rapport-building exercises. With respect to the six steps of the participatory process (see Part I), the team completed Steps 1–4.

The team successfully fit existing project indicators into the CSSA framework, and did not create any new indicators (see Annex 3). Remaining steps included partner capacity and community assessments, choosing performance criteria for indicators (status scales), measuring and mapping status of some elements, and combining indicators to build indices next steps.

Outputs:
- ✓ Stakeholders oriented to the CSSA
- ✓ Vision created and goals selected
- ✓ Project design fit into the strategic framework (indicators grouped by component)
- ✓ Next steps defined

Q&A: How is a project vision different from a vision for sustainable health?
A project vision may be "60% of children immunized," whereas a vision for sustainable health is "all children immunized." Often visioning exercises are helpful, but other times it is very hard for partners to create a common vision, because there isn't enough trust or positive experience. So, the vision has to be modest, and then as progress is made, the context changes, and partners can start to see a truer vision of their future.

Next steps:
- Collect information needed from community
- Focus group discussions/further survey
- Data inventory and analysis
- Prioritize activities
- Plan for implementation
- Plan for M&E
- Technical team meeting
- Conduct program orientation at district and subdistrict levels
- Distribute meeting summaries

Programmatic change: PCI's team found that their process of relating the project design (from proposal) to the sustainability framework required more retrofitting than creating new approaches or indicators. The existing design, which employs the C-IMCI strategy, provided a solid foundation for incorporating the CSSA. The team was able to fit existing indicators into each component, and thereby recast the monitoring plan in the sustainability framework.

World Vision International

Process: Eric Sarriot, CSTS+ Capacity Building Specialist, traveled to Lucknow, in Uttar Pradesh state (UP) of northern India, to assist WVI with incorporating the CSSA into the *Pragati* project design. As an "expanded impact" project, Pragati builds on WVI's successful experience from the Ballia Rural Integrated Child Survival (BRICS) project, introducing a focused set of interventions in three widely-separated districts of UP. WVI oriented project partners to the CSSA and conducted visioning exercises in each of the three districts prior to holding a joint workshop. Based on these discussions, the team decided to divide the first dimension (health services) into two dimensions: health status and health services. This was done "to account for the fact that health status can change without change in health services during or after the project."[15] During the sustainability workshop, a vision was adopted, and the elements of the four dimensions were identified and prioritized. Participants at the workshop decided to consult more thoroughly with the communities before adopting the project-wide sustainability framework. WVI and partners also decided to link the project's results framework and the sustainability framework, and are continuing to work toward accomplishing this.

Outputs:
- ✓ Project-wide vision
- ✓ Elements identified and prioritized
- ✓ Project-wide sustainability framework

[15] WVI draft DIP, April 2004.

WVI team's and partners' vision
"All children survive their first five years and all mothers survive their pregnancy, delivery and post-partum period. Health services and information are of good quality, are timely, and reach all children. Community groups, families, and service providers work together to bring services and the beneficiaries closer to each other. Mothers are empowered to act on the information to care for their children. Communities know and exercise their rights to quality health services."

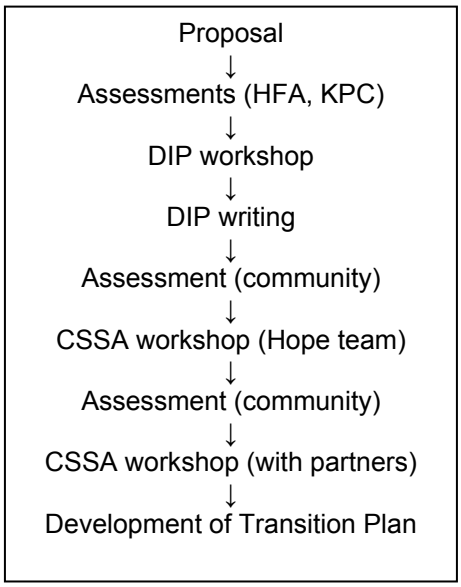
Next steps:
- New round of consultation with communities in 3 districts
- Assessments: health worker performance, NGO partner capacity, and community competence (this last using WVI's methodology and transformational development indicators. For more information, please see Annex 4.)
- Follow up meetings in each district to discuss linkages between the Pragati results framework and sustainability framework

Programmatic change: The project team added four indicators, which link the sustainability framework to the project results framework. These were adapted from the Transformational Development Indicators developed by WVI, and now being introduced in all of their Area Development Programs. As a result of the sustainability workshop, the team also agreed to conduct further studies to assess the performance of certain categories of health workers, the capacity of the NGO partners, and the competence of communities. The team will formulate and implement sustainability action plans and confirm sustainability indicators and data sources.

Project Hope

Process: Leo Ryan, CSTS+ Project Director, traveled to Nicaragua to assist Project Hope (in Year 2 of project) with a transition plan to reframe the project for sustainability, using the CSSA. Project Hope is implementing a CS project in the eight municipalities of Jinotega Department. Using the CSSA as a guide, the project team and partners engaged in a visioning process, classified key project activities along the dimensions of the framework, analyzed data to determine the present state in relation to the vision, and strategically planned to improve the present state through building community and partner capacity. Because Project Hope implemented the CSSA in Year 2, some differences in approach, as compared with those of other PVOs, can be seen in Figure 4.

Figure 4: Project Hope's Process Sequence



Outputs:

- ✓ Created vision/actual state matrix
- ✓ Created dashboard for current status
- ✓ Identified areas in which to focus efforts and develop specific strategies to facilitate the gradual transition of implementation responsibilities (transition plan)
- ✓ Identified steps to secure partner support of the transition plan

Next steps:

- ➢ Orient partners who could not attend the workshop
- ➢ Clarify roles and responsibilities described in DIP with partners in relation to the transition plan
- ➢ Meet with partners to discuss role of Project Hope as a facilitating/capacity building organization, rather than an implementer

Process note:
The experience of Project Hope produced recommendations for other PVOs that may consider implementing the CSSA part-way through a project. These recommendations, as well as those from CWI that also implemented the CSSA part-way through, are incorporated in Part III of this document. More information about CWI's experience follows in this section.

Programmatic change: The CSSA (occurring during Year 2 of project implementation) refocused efforts on the basis of its results, namely in the development of an action plan to increase community and local partner capacity. The project team modified its monitoring plan to include indicators measuring the range of sustainability issues that came to light through use of the framework.

Adventist Development and Relief Agency International

Process: Adventist Development and Relief Agency International (ADRA) is working in two coastal districts of Madagascar. Karl Blanchet, CSTS+ consultant, traveled there to assist ADRA with implementing the CSSA as part of DIP development. Preceding the DIP workshop, Mr. Blanchet facilitated a CSSA workshop to orient ADRA staff. This was followed by a community assessment to fill information gaps. Next came the CSSA/DIP workshop, and the project team and partners conducted a visioning exercise (incorporating elements of the organization's oft used approach of *Appreciative Inquiry*), defined indicators, and created sample indices. An approach to monitoring sustainability using star, or radar, diagrams was presented at the workshop. More on this method is described in Annex 2.

For the visioning exercise, ADRA's team dreamed by dimension, listing several dreams for each dimension instead of stating one overall vision. The team then selected proxy indicators for each dream and used star diagrams to measure current status. Contrasts between this and another approach are discussed in the analysis section at the end of this Part II.

Outputs:
- ✓ Defined local system
- ✓ Discovered data gaps, collected and analyzed additional data
- ✓ Defined dreams for each dimension
- ✓ Built star diagrams for each dimension to measure sustainability
- ✓ Developed draft business plan

Next steps:
- ➢ Consult with partners for feedback on draft business plan
- ➢ Finalize and submit DIP
- ➢ Refine proxy indicators for the dreams of each dimension

Programmatic change: Through the CSSA, the project team identified data gaps, collected additional information, and then designed a monitoring plan and adopted a methodology to measure progress toward sustainability across the three dimensions. The project team also reframed the project design by identifying indicators to measure the three dimensions of the sustainability framework.

Concern Worldwide International

Process: Leo Ryan, CSTS+ Project Director, worked with CWI to apply the CSSA at the midterm point of its CS project in Bangladesh. The information presented here comes from the report on that process.

From 17–23 February 2003, a multidisciplinary team applied the CSTS sustainability framework to review the program. Through this review, the staff identified strengths and opportunities in its approach within the three sustainability dimensions of community, institution, and health goals. The review also served as an on-the-job training in capacity building planning and measurement. Finally, the review allowed staff to develop a shared understanding of a transition plan towards greater Municipality independence of the program.[16]

Process note:
For a reality check in the field, the team simply asked the Ward Health Committees "How are things going with your committee?" and found that WHCs were able to discuss their capacity in detail. Specific indicators and progress benchmarks were developed on the basis of these discussions, and used to guide monitoring of WHC capacity in the last 2 years of the project.

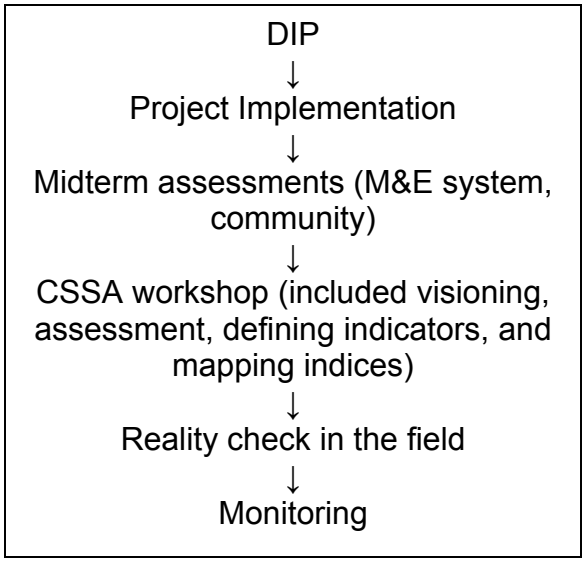
The team conducted a 6-day workshop, which included visioning; assessing and defining the three dimensions; consulting with local partners and conducting field research; and analyzing (triangulating) data from different sources. To characterize the present state in terms of the three dimensions, the team answered the following questions:

- What do we know about the current situation?
- How do we know this?
- What questions do we need answered to better determine the current situation?

CWI's process, which begins with the DIP, is outlined in Figure 5.

[16] Datta, D. and R. Helali, *et al.* 2003. *Sustainability Review of a Model for Municipal Health in Bangladesh.* Concern Worldwide.

Figure 5: CWI Process Sequences



Outputs:

- ✓ Defined community capacity elements, created a scale to measure capacity growth and scored ward health committees (WHCs)
- ✓ Consolidated prioritized organizational capacity areas, as defined by two municipalities
- ✓ Refined indicators
- ✓ Conducted reality check in field
- ✓ Created sustainability dashboard and analyzed performance to date
- ✓ Identified key challenges and developed strategies to address them

Next steps:

- ➢ Build in alternative leadership at the WHC level
- ➢ Strengthen municipality coordination capacity and improve accountability across all levels
- ➢ Facilitation skill development of CSP personnel
- ➢ Broaden civil society participation in WHCs
- ➢ Strengthen the financial management capacity of WHCs
- ➢ Improve the viability of the Municipality Health Department
- ➢ Continue and scale-up CWI's leadership in urban health

Programmatic change: CWI used the results of the CSSA to strengthen its monitoring plan, reprioritize objectives, and inform its successful proposal for follow-on funding. In that follow-on project, Saidpur and Parbatipur will serve as learning centers for other municipalities that will seek to replicate the successes from those areas, and the sustainability framework will be used from the outset to guide design and monitoring.

COMPARISON OF APPROACHES

This section compares and contrasts approaches. It is important to consider each approach within its context when evaluating what is appropriate for replication. Table 2 (presented

earlier) provides an overview of each context. Elements that affect the application of the CSSA include the following:

- Length of time the PVO has been working in the area
- Type of implementing partners
- If the partners are working with the PVO for the first time
- The time in project lifecycle that the CSSA implementation is taking place
- Types of assessments conducted
- Cultural considerations
- Other aspects of context that are assessed by Dimension 3 of the CSSA (e.g., community capacity, macroeconomic environment, political climate).

Visioning

Care and IRC conducted a visioning exercise that preceded the CSSA/DIP working group meeting. The facilitator believes that a project team (with partners) working through a visioning process preceding the TA visit significantly helps to prepare for the sustainability workshop, by providing a solid base from which to launch discussions and activities, while inspiring a sense of responsibility. WVI also conducted a visioning exercise that preceded the workshop. The facilitator also noted that this made for a smoother and more straightforward introduction to the CSSA framework.

Differences in approaches to visioning included separate times for developing an overall vision and for identifying goals for each dimension (CARE, IRC, PCI) and accomplishing both tasks in one visioning exercise, with refinement later (WVI, Hope, ADRA, CWI). There doesn't seem to be an issue related to quality with either approach. It seems that time available for each activity will dictate whether or not these activities can be done together. It is reasonable to assume that as familiarity with the CSSA increases, goal statements may become more specific.

Data Collection

All PVOs that applied the CSSA at the DIP stage had conducted health facility assessments (HFAs) and knowledge, practice, and coverage (KPC) surveys. Some had not yet completed organizational capacity assessments, but had plans to do so in the coming months. Some conducted community assessments as part of the KPC preceding the workshop, others did these during the workshop days, and still others decided to obtain more information from the community after they completed the workshop and identified information gaps.

Those **PVOs that began the process with more information, and that had oriented their partners to the data collected, accomplished the most in terms of the steps of the CSSA**. With data filling in the tool, it appears less conceptual and becomes more practical. Some PVOs got to the step of defining indicators and began to combine and map them to create a dashboard, while others did not reach those steps, particularly indicator mapping. Two main differences are noted between the PVOs that progressed as far as indicator mapping and those that did not. PVOs who advanced to that step had 1) worked for more than 3 years in the project area and 2) conducted community assessments preceding the workshop. Thus, it seems that more familiarity with and more information about an area facilitates a more rapid sustainability assessment.

Defining and mapping indicators were also cited as conceptually harder to grasp for workshop teams. In part, this impression may have been affected by time constraints; if more time was spent orienting teams to the first several steps of the process, then less time was available for the latter steps, which left participants feeling uncertain and unclear about these latter steps.

Workshops

Most teams combined CSSA and DIP workshops because of time constraints. This caused some participants to feel rushed through the CSSA process, and some facilitators decided to eliminate the later steps of the process (scoring indicators and building indices) to ensure that enough time was spent ensuring participants' understanding of the CSSA and its overall process, and that responsibility for achieving project goals was shared equitably among the stakeholders. In addition, element identification, as a distinct step of the CSSA, was not undertaken by all groups. Some groups identified elements de facto through the dreaming or visioning process. **Other groups identified elements through a distinct process, and this seemed to help focus their work plans on sustainability by addressing elements specifically within the context of each component of the framework.**

Timing of the CSSA

When asked, those **PVOs that received the TA preceding the DIP writing believed that the CSSA process helped them develop the DIP because it framed discussions within a system, and that systematic process led to concrete outcomes and plans for next steps**. It also encouraged them to consider the wider context of sustainability, including elements that projects may not affect, but that affect project outcomes. However, when facilitated into discussion at the CSTS+ mini-university,[17] **these same PVOs stated that it would be more useful to introduce the CSSA during proposal preparation**. The proposal preparation phase has its own inherent constraints. It is important to bear in mind the combined elements of 1) the effort required to introduce and work with the CSSA; 2) the expectations that may be created in partners due to the nature of CSSA-related discussions; and 3) the uncertainty of funding. There must be a certain amount of information available to do the CSSA, and sometimes an adequate amount of information is not available until assessments are undertaken after the grant is received, in preparation for DIP writing.

One facilitator felt that implementing the CSSA in Year 2 was advantageous because a team is in a better position to develop a dashboard after one or more years of project implementation. However, Project Hope's experience indicates that the translation involved in shifting project approaches and reframing activities to purposefully address the dimensions of sustainability presents its own challenges. This is because of the nature of reframing project accomplishments and future plans in the context of sustainability, orienting the project team (including partners) to what may seem like a new course, and refocusing monitoring systems to capture data that supports the expanded vision of sustainability. CWI's experience with applying the CSSA at the project midterm point worked well to create a strategy for a successful follow-on proposal. The team used the assessment results to reprioritize project objectives, strengthen the current monitoring plan, and design the new program.

[17] CSTS+ mini-university, JHSPH, June 7-11, 2004

Reframing the Project After the CSSA

An issue related to the timing of the CSSA (described above) is the possible need to reframe project approaches and activities to purposefully address components of the sustainability framework. In PCI's experience, with a project design employing C-IMCI, very little practical reframing was necessary; in effect, the indicators stayed the same. In this case, using the CSSA may have strengthened the sense of shared responsibility among project stakeholders and helped to create a balanced sustainability strategy, but it did not require the adoption of new project approaches, activities, or indicators. Annex 3 contains PCI's results framework integrated with the sustainability framework. Other project teams added indicators to measure aspects of sustainability after applying the CSSA. This may indicate that those teams did not feel that reframing was necessary to balance their approaches, nor to measure sustainability satisfactorily. One PVO representative said, "If we were to rewrite the objectives and indicators, I think we felt that we'd, in many ways, be starting from scratch. Our objectives also focused on the key areas/levels of project focus, which made it unnecessary to really change them."

Self-efficacy and timing were also factors influencing how much/to what extent the CSSA could be carried out. One PVO representative said, "The reality is that we are still only beginning with the sustainability framework and don't have enough confidence with our sustainability indicators to have our entire program be built around them." Another PVO reported that the team was severely overextended and "the CSSA process was just one of a series of intensive exercises underway at the same time." That respondent advocates for finding a way to streamline the process. Part III of this document (Practical Recommendations) begins this discussion.

PART III: PRACTICAL RECOMMENDATIONS FOR APPLYING THE CSSA

This section synthesizes the PVO experiences reported in Part II into practical recommendations for applying the CSSA. The field experience to date suggests that the CSSA can add value to a project at the planning, design, monitoring, and reporting stages of a project's lifecycle.

Before presenting our recommendations in a step-by-step approach, we need to revisit the purpose of using the framework and discuss its introduction to a project team before it is shared with other stakeholders.

WHY USE THE FRAMEWORK?

The CSSA provides a unifying framework to guide project planners and other stakeholders to discuss a prospective project in a comprehensive manner. It encourages all key players to identify their roles in the eventual implementation of the project and its M&E, and ensures an approach that will take into account the complex interrelationships among the three dimensions of sustainability. Using the framework helps an organization guide dialogue with partners; increase the likelihood of sustainable health outcomes; integrate learning throughout the design-implementation-evaluation process; and evaluate outcomes. The benefits of framework can be summarized in the following ways:

- Think and plan logically and with comprehensive focus (management)
- Guide dialogue with partners (mobilize and empower)
- Predict sustainable health outcomes (research)[18]
- Learn (design-implementation-evaluation process)
- Evaluate (accountability and knowledge development).

Remember that the CSSA process is:
- Locally-driven and participatory
- Action-oriented
- Focused on creating conditions for sustained child health gains

INTRODUCING THE CSSA TO A PROJECT TEAM

Before the CSSA framework can be applied, it is important to introduce it in context. It is important to help people understand that the CSSA framework is not an assessment tool in the sense that a survey or focus group guide might be. Instead, it is a framework for guiding our

[18] The question of predictability of long-term outcomes remains a complex and uncertain one, and best addressed through more research. See the discussion of complexity in E. Sarriot, P. Winch, L. Ryan, J. Bowie, M. Kouletio, E. Swedberg, et al. 2004. A methodological approach and framework for sustainability assessment in NGO-implemented primary health care programs. *The International Journal of Health Planning and Management 19*(1), 23–41.

thinking and planning about the types of assessments to carry out, and which strategies, tools, and approaches to apply.

Though the CSSA framework is based on research and field experience, it is important to introduce it into the context of a specific project in concrete and simple terms. It has been useful to present the three dimensions and six components as something that most people intuitively understand, and as a helpful visual for thinking about how the pieces of their project might fit together (see information in Annex 4 for resources and links to presentations that can be used or adapted). As people work with the framework, exploring the issues for planning, inclusion, measurement, and reporting that it presents, they learn more about the complex layers beneath the apparently simple design. When introducing the framework, it is important to convey the following points:

- The concepts behind the elements and dimensions are familiar to most implementers, although they may not realize it. It is useful to provide some illustrative examples of what kinds of activities might be included in each dimension, and ask participants to give their own examples to become more comfortable with the framework.

- The interrelationships among dimensions are important when thinking about sustainability. For example, strong health outcomes are good, but only temporary if they are not complemented by community systems and local organizations capable of supporting these outcomes in the long term. Likewise, it is not very useful to have strong organizations that have been trained in ineffective approaches toward quality assurance, or communities that are mobilized around the wrong health behaviors.

APPLYING THE SUSTAINABILITY DESIGN PROCESS

The CSSA framework has been applied by projects at different stages of their work. Some have used the framework to inform the project design process after an initial proposal has been approved and detailed planning has begun. Others have used it to review the direction of their programs and the potential sustainability of their activities in the early implementation phases or midpoints of their projects. Some have argued that the framework is best applied from the initial stages of conceptual planning, to inform a proposal that might be submitted for funding. Experience to date suggests that it can be useful at any of these phases, but must be tailored to the phase of the project at which it is applied.

Program terminology

- This guide defines the **program planning stage** as the time when an organization and key stakeholders are conceptualizing a project, including identifying local partners, rapidly assessing needs, and outlining a general approach. This is often done when writing a proposal to secure funding to implement a project.

- This is distinct from **program design,** which takes place when funding is in hand and many data are available to inform prioritization and workplans.

In this section, each step of the CSSA is presented with a description and examples. A few text boxes highlight key points. While some steps may be more difficult to complete at the program planning stage, they are relevant and can be completed to varying degrees, regardless of the project stage.

> **Program planning phase example**
> In a 3-day workshop, PVOs and partners may accomplish the following: review and discuss the CSSA, identify and collect missing information, develop a vision for the project, and identify indicators and activities to be included in the proposal. A sample agenda, created from real experiences, is included in Annex 7.

The six steps of the CSSA are:

1. Define the system to be assessed, its vision and its goals.
2. Identify the relevant elements/general objectives for the local system.
3. Choose indicators and identify scales you will use to judge the progress they measure.
4. Measure the status on the individual indicators you've selected.
5. Map indicators along the scales[19] you've created to define progress and, as needed, combine the indicators into indices.
6. Review results and propose programmatic intervention (including specific project objectives) or policies for improving the status of the indicators.

Define the system to be assessed, its vision and its goals

What is the local system?

"Local system" refers to the local stakeholders and communities brought together to map out their vision and goals for sustained health in the community; this local system also defines the level at which evaluation can take place in a meaningful way. Examples 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 it in terms of three levels: 1) it is the level of bodies/stakeholders that can be brought together; 2) it is the level at which assessment can be conducted (villages surveyed, facilities assessed, institutions willing to examine their cooperation and functioning,

[19] Indicator status scales have also been called performance criteria for the indicator. This language seems to induce confusion with the *performance* of projects. A status scale is a way to answer the question: If indicator X is at 20% versus 40%; and if indicator Y is at 1.6 points versus 2.2 points, ***what does it mean?*** See Part III for more discussion on this.

environment that can be assessed); 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 many components of the CSSA, in particular component 6).

A local system has boundaries: people and groups that are included; groups that are too remote might have to be excluded; and groups that exclude themselves. And a local system can evolve: groups once excluded can be included as they see the benefit of the project's efforts. A stronger local system might create a more sustainable health situation.

PCI and partners define their local system*

"The session started by inviting all participants to identify all potential stakeholders in the CHOICE Program. All individuals/organizations present were first asked to write their organization's name on a colored card and attach this card on a page of flipchart paper. Flipchart pages were prepared in advance and had a circle drawn with in the middle a picture of a healthy mother and her child to indicate the objective of the CHOICE Program. Cards put inside the circle indicated direct involvement in, or commitment to the program and the health of the mother and child, while cards attached outside the circle indicated indirect involvement with the program. After they attached their 'organization cards' participants were asked to identify other players and write in these names on the flipchart. At the end of the activity, it became clear that most individuals/organizations had attached their names inside the circle. Participants thus committed themselves or their organization to the project and learned that a program for improving health status of mothers and children was a multi-sectoral mission and should be the responsibility of various parties."

**See Annex 6 for PCI's graphic representation of the CHOICE project's local system.*

After defining the local system, a team must identify the vision and goals of this system.

Visioning sustained health outcomes

An assumption of the CSSA methodology is that project plans should be based on a vision of sustained health outcomes. The framework can guide discussion with local partners and other key stakeholders about what, ideally, would be happening in each of the three dimensions if the target community were optimally healthy.

Visioning can be done through focus groups or interviews with community members and local partners or through a workshop or event that brings all key stakeholders together, and should reflect "dreams for a healthy community." Using the dimensions and elements of the framework, a planner might use or adapt the following to gain input for a vision:

- If everything were ideal/perfect and if your project were completely successful, how would you describe a healthy community?

- A broad vision can be broken down into broad goals specific to each component of the CSSA. Inversely, defining these smaller level dreams (goals) for each component can help a group build its larger vision:

  - What would the norm be for the health of mothers and children where you live?
  - How would you describe the situation regarding health services (if "dreams for a healthy community" are reached)?
  - How would you describe the situation regarding the capacity of local organizations to support/deliver health services?
  - How would these local organizations be able to continue functioning?
  - How would you describe the community's capacity to manage its own health services?
  - What factors in the sociopolitical environment would support sustained health outcomes in the community?

A vision can be the first common creation of practitioners in the newly-defined local system. If the local system functions well (if partners have already worked together and trust each other), it will be able to dream big ideas. If the local system does not operate like a functional system, visioning will be challenging at best and more humble dreams might be the best place to start.

Whether the vision is ambitious or modest, it can serve the following essential purposes:

- A vision statement is the start of a contextual planning process.

- 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.

- Because the vision is a collective exercise it is an opportunity to build consensus and begin the negotiation process among partners, which is a determinant of sustainability.

- A vision also provides a direction (of the local system and of the project) for planning efforts.

> **Timing of visioning exercises**
> Visioning is most useful when done during initial planning, even before data is collected, and should reflect the dreams of key partners for an ideal situation. However, Concern Bangladesh did visioning in Year 3, and HOPE Nicaragua in Year 2 to check on whether their existing programs were anchored in a shared vision, and whether the vision they created suggested changes in focus to their projects.

An example of a visioning process conducted by CARE and IRC is included in Annex 5. These teams adopted one overall vision for their projects, but also appointed one goal for each dimension, which is distinctly linked to the overarching project vision.

Identify the relevant elements/general objectives[20] for the local system

When visioning is conducted in the context of the CSSA framework, it yields a broad perspective of the issues in the organization, health facilities, and community that need to be addressed to achieve sustained health outcomes. Before developing strategies and objectives, it is important to step back from the vision and assess existing data and information gaps that describe the local situation. It is helpful to compare the vision (or ideal state) with the present reality, using data, experiences, and perceptions. The first step in this process is for the local practitioners to inventory the elements of each component. The selected elements are those for which indicators will be identified (see next step), and which will then be assessed.

Most teams used the sustainability framework along with the vision to guide element identification. Under each component heading, teams listed elements that affect the attainment of the vision within that component. CARE and IRC used this approach; IRC's element identification is included in Annex 8.

To complete this step, it is useful to ask: What pieces of the puzzle are missing to get to our goal or vision? Facilitators and project staff also have a role to play in suggesting issues that are often neglected.

Choose indicators and identify scales you will use to judge the progress they measure

Choosing indicators

At this point in the process, project teams and partners need to choose indicators. Indicators measure what the project and partners are trying to achieve (objectives), or the situation they are hoping to reach. For example,[21] if an objective is "full immunization of children by first birthday," a corresponding indicator would be "% children age 11-23 months who are fully immunized by first birthday."

There is now a rich store of experience in the CS community with choosing and measuring health outcome or proxy indicators using the KPC tool. Other measures (e.g., capacity, quality of care, community and social change) are proving to be more challenging. This report cannot provide an in-depth discussion about finding indicators for all the relevant elements. References to guides for creating indicators are included in Annex 4. Links to M&E tools that can be used with different components of the CSSA can be found on the CSTS+ Web site sustainability page.

[20] Throughout the CSSA process, we distinguish between general objectives of the local system, and specific objectives taken on by the project. General objectives can be broadly stated, describing an ideal to be reached (e.g., all children will be well nourished; all children will be immunized; all women will deliver in safe conditions). Presumably, the local system needs to advance toward these general objectives to reach its vision. Project objectives, however, need to be specific, time-bound, reachable, and measurable (e.g., the percentage of underweight children (<5) will decrease from 19% to less than 7%; full immunization coverage will be more than 85% within 3 years). Projects want to have specific objectives that serve the general objectives of the local system.

[21] World Vision International. *Visions Developed in Balia, Lalitpur, and Moradabad*. World Vision/India: 2004.

A program planner might use some of the following questions to guide this grounding process:

- For each major element of the vision, how would we describe the present situation?
- What information, experience, or data do we base this description on?
- For which elements do we need more data to better understand the present situation, and how might we get those data?

Q&A: How do we decide which indicators are key for monitoring?
There are no rules for how to choose key indicators to build composite measures. However, there are several guiding principles to keep in mind when creating or selecting indicators to be monitored —

- All indicators should comply with the following principles:
  - Valid (an accurate measure of a behavior, practice, or task)
  - Reliable (consistently measurable, in the same way, by different observers)
  - Measurable (quantifiable using available tools and methods)
  - Programmatically important (to be linked to a public health impact or to achieving the objectives that are needed in order to have a public health impact)
  - Easy to interpret (it is clear what they mean in terms of individual behavior or practice).
- Use system thinking and refer back to the team's vision. Does the measure contribute to an understanding of the system?
- Does the indicator attest to the validity of the system?
- Can you trust the measurement?
- Does the measurement inform someone's decision?

*CSTS. 2004. Technical reference materials: Monitoring and evaluation. www.childsurvival.com.

Defining and selecting valid indicators often requires professional or technical inputs. Helping to measure what matters, and measuring as well as possible, is a notable contribution of projects to local progress.

Building indicator status scales

Building indicator status scales can be done as the indicators are selected, which is the preferred order of steps, or after the data have been collected. In practice, PVOs and partners may not get to this step until data have been collected, and they are ready to conduct exercises to map out the situation with the measurements they have recorded.

Table 3 depicts the Rapid CATCH Status Scale that was introduced by CSTS+ in 2002, which is one way to communicate progress.[22] In this scale, ranges of indicator performance correspond to different levels of health status in the population, and suggest a shifting focus for projects. Using the status scale to describe progress promotes discussion about whether an increase in coverage represents a greater or a lesser shift in the health situation for the population.

Table 3: Rapid CATCH Status Scale

Indicator status	Indicator Benchmarks	Focus of Project
Strong	Underweight: 5% and below Other CATCH: 90% and above	**Phased Out**—PVO involvement probably not needed.
Promising	Underweight: 6%–15% Other CATCH: 75%–89%	**Consolidating**—the PVO should be working on consolidation, strengthening to complete a phase out strategy.
Intermediate	Underweight: 16%–30 % Other CATCH: 55%–74 %	**Building Capacity**—interventions at this level need to be justified by a high level of capacity building, in parallel to an improvement of the health indicators.
Emerging	Underweight: 31%–45% Other CATCH: 35%–54%	**Achieve results**—focus efforts on the intervention to strengthen health outcomes. Ensure early partners buy–in; start building capacity.
Poor	Underweight: 46%–100% Other CATCH: 0%–34%	**Emergency intervention**—extremely high need for public health intervention because of associated high morbidity and mortality.

For quantitative indicators, the status scales represent a simplification and reduction of data for the purpose of quickly getting a clearer picture of the situation. The status scales will also be needed to create meaningful indices (see below). They allow comparability between progress (or lack thereof) in different components of the framework (and different areas of intervention), though these are measured in different ways.

In the area of NGO capacity development, for example, a number of tools have been developed that measure overall organizational growth in specific capacity areas along a continuum that ranges from nascent to strong capacity[23]. In the area of community capacity, WVI's Transformational Development model offers a scale for measuring community competencies in 13 key areas[24]. Other tools can be found on the CSTS+ website, or referenced in documents found there.

[22] CSTS, *Child Survival and Health Grants Program Review*. Macro International: 2002. http://www.childsurvival.com/documents/csts.cfm

[23] USAID Center for Development Information and Evaluation. Measuring institutional capacity. *Recent practices in monitoring and evaluation TIPS 2000,* 15 (PN-ACG-612).;
Management Sciences for Health. 1998. Management and Organizational Sustainability Tool (MOST). Management Sciences for Health, ed., *A user's guide.*

[24] http://www.childsurvival.com/documents/CSTS/sustappendix.cfm#CIII.1

By collectively defining what progress is and what the data mean, status scales provide a common lens through which to show an integrated picture of the situation (and, at a later point, the progress that has been made). This is further discussed in the section on mapping below.

Measure the status on the individual indicators you've selected

The next step is to collect data. Some measures are already part of assessments conducted at the outset of a project (e.g., HFA and KPC), but others may need to be collected either directly (using different methods and assessment tools) or indirectly (using data collected and reported by other groups or sectors).

Data used at the project planning stage may not come from recent or rigorous assessments, but result from participant agreement after a thorough analysis of all available data, including observational and anecdotal information. That process leads to a shared understanding of the present state. The picture that emerges provides a best estimation of the current status and points to where projects might direct and prioritize efforts. This is not an ideal approach in terms of measurement, but it can be helpful nonetheless. At the program design phase, more data are available and contribute substantially to the creation of a sustainability dashboard (indices described in the next section of this text).

Map indicators along the scales you've created to define progress and, as needed, combine the indicators into indices

Mapping indicators and calculating indices

Indicators provide raw data. These data require both a context and an analytical grid to give us meaningful information. Let's consider the following examples:

- Our KPC survey reveals measles immunization coverage rates of 25 percent. This raw information is immediately meaningful: Something is wrong! This is bad! There will be measles outbreaks in the coming season. Children are going to die of measles and complications.

- We have measured quality of care in district health facilities, which earned scores from 44 to 66 (out of a maximum of 100 points). What does it mean? Are facilities at 66 doing 50 percent better than those at a score of 44? How bad is 44? How good is 66? Building status scales and mapping our results on these scales gives meaning to raw data.

Our first step is to look at the indicators we have collected and present them in a way that helps us derive meaningful information from the measures.

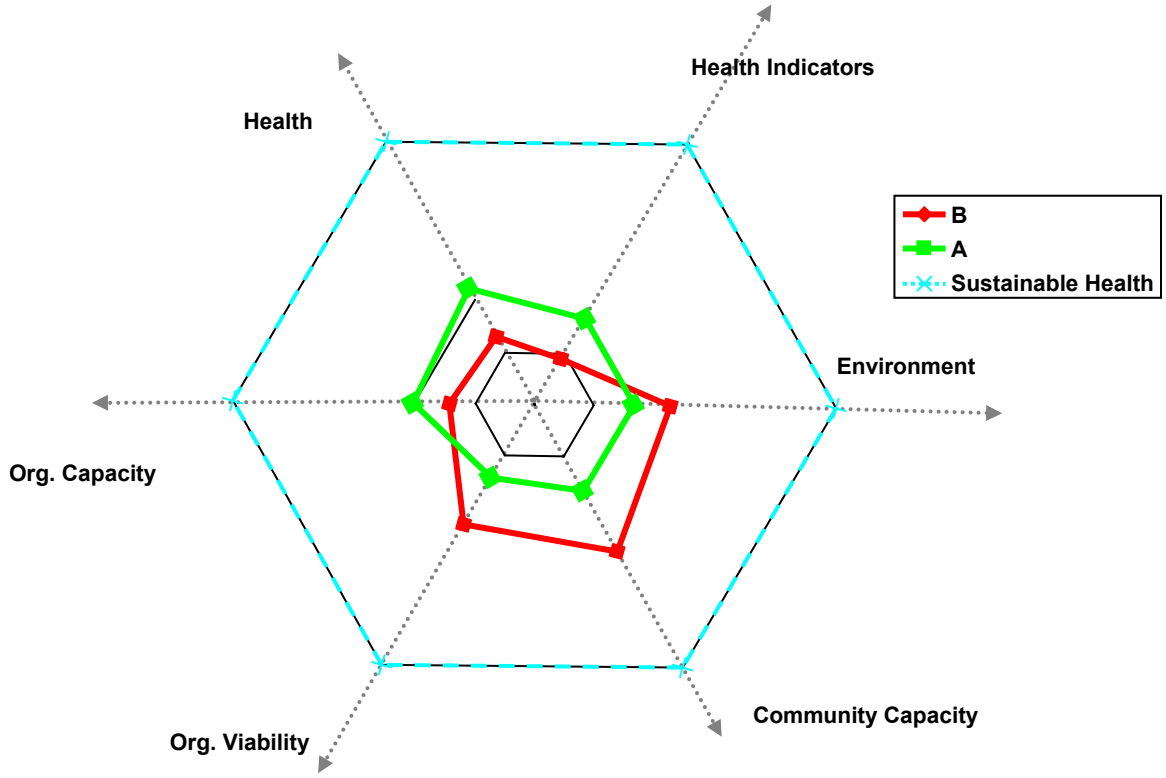
The next step is to determine how to understand the situation if we have 24 health indicators (component 1), a dozen indicators for component 2 (health services), another 20 or so for component 3 and 4, etc. Where should efforts be directed? Where are the critical gaps?

To answer these questions, indicators can be combined into indices to further explain the situation underlying each component of the framework. This process offers a simpler presentation of the situation, but it is important to remember that an index is based on real and

specific data, which provide much more information than an index alone can. Having said that, indices are useful for mapping what the sustainability assessment reveals, allowing rapid comparisons between different geographic areas using the same assessment, and graphically representing change over time in each of the framework's components; but, they are not the real data.

A useful rule to remember is that indices help us ask questions, but not answer them. The closest we get to the truth is through the actual indicators we have measured. Indicators provide the data that will need to be considered and analyzed. At the same time, combining the indicators into indices to map the situation on a sustainability dashboard (see Figure 6) provides an appreciation of the situation at a glance.

Figure 6: Mapping Two Situations (A and B) on a 6-Component Sustainability "Dashboard"



For example, if most targeted health indicators have improved except one (e.g., skilled attendance at birth) over the project life, it can be tempting to focus a lot of attention to this apparently neglected indicator. However, by mapping what the situation is in each component of the sustainability framework (i.e., by building indices), it can be revealed that a crucial component such as organizational capacity or service quality is critically lagging. This may lead to some questions: Is the lack of increase in skilled attendance at birth particularly sensitive to local capacity and quality of services (as opposed to PVO project implementation)? If nothing is done to build local management capacity and service delivery quality, what will happen to all our health indicators over time, even if we manage to increase skilled attendance at birth?

Project Hope Nicaragua Example

Participants divided into three working groups (one per dimension of the framework; partner representatives distributed across the three groups). Each group was tasked with reviewing all available data related to its assigned dimension, and on the basis of that data to choose the number between 1 and 5 that best represented the present state in relation to each sub-element of the dimension within which they were working. Each group was requested to back up its numeric scores with an evidence-based justification.

Each group presented its final analysis and justification, provided feedback to the others, and refined the collective dashboard that had been created through this activity. Participants then prioritized the areas that they felt would have the greatest impact, and were most feasible to address in the next 3 years (time remaining in project), in order to best contribute to sustained health outcomes. Each participant was asked individually to identify his/her first and second priority subelement in the sustainability framework, on the basis of the analyses conducted to that point in the workshop by the group. The dashboards that resulted from this process are included in Annex 10.

One other process for creating a dashboard was piloted with ADRA in Madagascar, and is briefly described below. More information about the method and the resulting diagrams are presented in Annex 2.

ADRA Madagascar Example

The issue was to define the level of detail required for the gauging of sustainability. How many indicators did we need? It depends on the audience to whom the report is destined (see Figure 7). We agreed that 20 indicators would be enough for our current needs. It was important to find the right balance between collecting sufficient information and having the capacity to regularly monitor these indicators.

It was also crucial to be able to represent the progress towards sustainability. Mr. Blanchet proposed to apply a radar or star diagram. Each indicator was represented by one arm and its value was ranked from the centre of the start to the end of the axis. The system was not sustainable if any of the values was less than one and was plotted inside the unit circle. The reference system was represented by this unit circle.

The objective of the afternoon workshop was to build three star diagrams, one for each dimension. Each group would build a star diagram for one dimension.

The first phase consisted in determining one or two proxy indicators describing each dream (goal). Then, the group defined a value or criteria under which the system was perceived as unsustainable. This value was plotted on the reference circle. Third, participants evaluated the present situation.

Building indices requires a number of steps followed rigorously and methodically. Although each of these steps is fairly simple and straightforward, the number of steps, their repetition, and the unavoidable arithmetic involved make the entire process unappetizing to many. To avoid the unpleasantness of a long methodological discussion revolving around indices in this report, it has been included in Annex 9. The next section presents some of the ways that data can be presented.

Step approach to build indices (see Annex 9 for details)

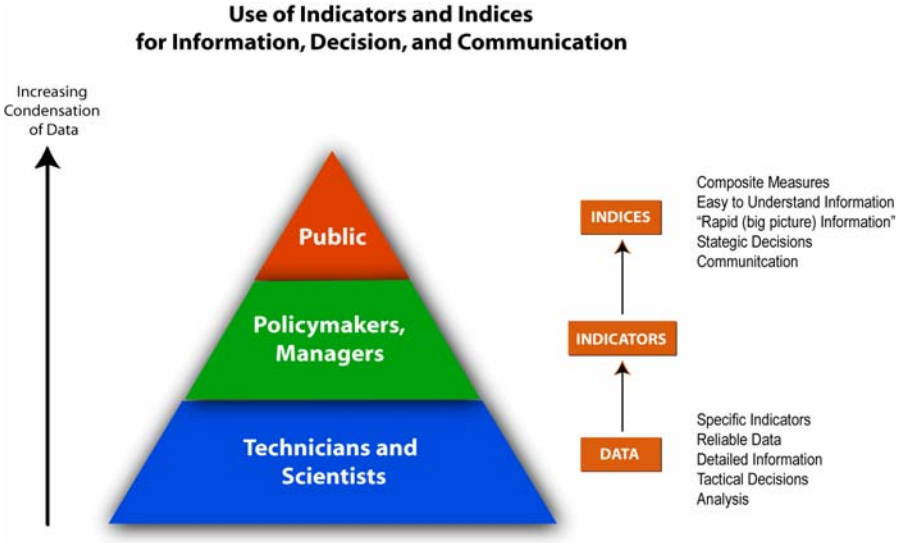
1. Select indicators to be included in the index
2. Transform indicators into computable scores
   - Define status scales for each indicator
   - Compute score for each indicator
3. Compile indicator scores
   - Define computation rule
   - Compute scores according to rule
4. Further aggregation (for example aggregate two component indices into a dimension index)
5. Map and report

Reporting

Consider Figure 7. The graphic[25] depicts the differences between composite measures (public-level information) and specific measures (project-level information). It also illustrates which project information is appropriate to share with different audiences. Composite measures are more useful (and probably more interesting) to those who are removed from project implementation; whereas, more and specific information is needed by project managers. Each project team will need to determine what level of information and how much is appropriate to share with various stakeholders, considering their degrees of participation in the project and their potential for influencing elements of sustainable health in the project area.

[25] Adapted from Karl Blanchet, *Trip Report (to ADRA Madagascar)*. March, 2004

Figure 7: Information Decision-Communication



The following simple rules about communication should be remembered:

1. Know your audience: To whom are you writing/talking/presenting? Consider the information needs of the audience and provide the information that is relevant (e.g., the head of the Expanded Program of Immunization (EPI) at the MOH might not be interested in what an index measure represents, but would want to see the immunization coverage indicators and the vaccine stockout data, so start with the information that is meaningful).

2. Know your data: If you cannot explain clearly how an index measure was created and what it means, then do not confuse the audience with it. Always be ready to present the actual indicators that were used and how they were used. Once you have explained the conditions of the index measure, you will need to refer to specific indicators to actually analyze what is happening.

3. Know what decisions need to be made: Information is meant to aid decision making. If you want to emphasize the need to focus more effort on components of the sustainability framework that have been neglected, presenting a sustainability dashboard built on indices may be a way to draw attention to the gaps. Using a dashboard is also helpful if you are trying to stimulate learning between districts (that have used the same measures).

Review results and propose programmatic intervention (including specific project objectives) or policies for improving the status of your indicators

At this point, the program design team has defined the project system and created a vision and sense of shared responsibility among stakeholders; identified elements affecting each component of sustainability; created objectives and indicators; collected data and satisfied information gaps; measured and mapped indicators; and combined indicators to build indices. It is now time to review priorities and identify and describe activities the project will undertake to move from the actual state toward the vision (i.e., create the project work plan). This is where specific project objectives are defined to support the general objectives of the local system, and is the heart of the DIP (for CSHGP grantees). There are a variety of cross-cutting strategies that teams can use to complete the design at this point, including behavior change communication, C-IMCI, quality assurance, and capacity-building. This guide does not attempt to catalogue or prescribe approaches for this part of the design phase; a diversity of approaches contributes to creative variability and the uniqueness of each project.

Remember, what sustainability planning is and is not:

Sustainability planning means—

- Being thorough in working with local stakeholders and encouraging a local system perspective
- Being systematic in helping local stakeholders examine the elements they can identify, which will determine whether they progress toward a vision or not
- Committing to assessing or estimating the situation of the local system in all the components of the sustainability framework, to the greatest extent possible
- Committing the project's resources to work within the sustainability plan for health developed with the local stakeholders
- Mobilizing the local stakeholders to play their part and to work together toward common goals, which can grow with trust and first successes

Sustainability planning does not mean—

- Creating false expectations that everything will be achieved within a 3 to 5 year timeframe
- Committing the project resources to an unrealistic plan to change all the identified indicators
- Committing the project resources to measure and assess everything in the communities of interventions
- Creating yet another participatory process, which does not translate into changing the way business is done, and which fails to optimize the local stakeholders' capabilities and potential

USING THE CSSA IN DIFFERENT SITUATIONS

We have considered the use of the CSSA with projects operating in an ideal situation: when the CSSA introduced to stakeholders for the first time at a point when funding for the project is certain, and in-depth assessments can be conducted as part of project planning and design. Often, project development must be split into a planning phase (where stakeholders are mobilized, project goals and objectives are chosen, but funding is not certain and in-depth assessments cannot be conducted) for the purposes of applying for funding to implement the project, and a design phase (project and stakeholders regroup, affirm or change previously selected goals and objectives, and conduct in-depth assessments after funding is awarded) when the project officially starts. Other contexts in which it is possible to conduct the CSSA are considered in this section, with a few adaptations to the process noted.

Implementing the CSSA at the design phase (for the first time): Retrofitting and Reframing

For PVOs using the CSSA for the first time at the DIP phase, the order of events follows the same steps presented earlier in this section, with the key addition of retrofitting the initial project design into the sustainability framework. A significant difference between beginning work with the CSSA in the planning phase and beginning it in the design phase is that there is a larger amount of quality information (from recent assessments) available to the team in the design phase. This information is an essential contribution to the process of integrating the CSSA, but there may still be information gaps that will require research before the team feels that they are able to adequately address the elements related to each component.

Some of the PVOs profiled in this guide conducted a visioning exercise before fully introducing the CSSA. This activity laid the groundwork for further discussions, assessment, and ultimately, an addition to the project structure to incorporate the framework. They then moved through the six steps of the assessment process, which are listed in Parts II and III. The assessment process assumes a degree of familiarity with specific data related to each dimension; if there is a need to review data (like those collected from recent assessments), this must be built into the process.

To retrofit a preliminary project design into the sustainability framework, you might consider adapting the steps of the CSSA as follows:

1. Introduce the CSSA to team and stakeholders.

2. Describe the local system.

3. Identify elements/objectives (can refer to project plan or proposal, create new lists, or both).

4. Choose indicators and identify scales you will use to judge the progress they measure.

5. Measure the status on the individual indicators you've selected.

6. Map indicators along the scales you've created to define progress and, as needed, combine the indicators into indices.

7. Review results and propose programmatic intervention (including specific project objectives) or policies for improving the status of your indicators.

8. Compare the results of steps 2–7 above to the planned results- or logical-framework. One should find that the CSSA results include all of the information from the project planning phase, while highlighting gaps where more information in terms of sustainability is needed. When the framework is filled in with data, the team should feel that they have created a comprehensive picture of the potential for sustaining maternal and child health gains.

9. Decide how to proceed. Ideally, the team should rewrite the results- or logical-framework to represent the dimensions or components of the sustainability framework.

At a minimum, the CSSA will either validate the existing project design or suggest a shift in focus, because it provides a different way to view the project by inviting practitioners to ask, "are we doing what we said we would do?" Again, projects do not have to address every issue prompted by the framework, but the team needs to be aware of all factors that could affect the sustainability of health outcomes. In the future, projects may attract additional resources to address elements affecting sustainability that may be outside of the project scope. Regardless of which incorporation style is chosen, it is reasonable to expect that a fair amount of reframing of the project will need to take place, to account for additional elements that are not usually monitored in CS projects, and to ensure that sustainability is systematically addressed, using the best tool that we have currently: the CSSA.

CSSA as a monitoring tool:
- Tracks progress toward sustainable health outcomes
- Informs coordinated management decisions across all aspects of the project
- Identifies specific components and objectives that need stakeholders' attention and coordinated action

Using the CSSA for project monitoring and reporting

A great benefit to using the sustainability framework from the beginning of a project is that it provides a useful methodology for regularly monitoring progress. *A team would not have to go through each step of the CSSA every time it wants to check progress.* Although the vision, local system, and elements do not have to be revised at each monitoring point, it may be helpful to review and consider updating them at certain times, as needed (e.g., midterm). When annually monitoring the progress of a project, consider the following steps:

1. Review available data (per monitoring plan) and map key indicators
2. Identify information gaps and collect missing data
3. Calculate and combine key indicators
4. Update maps/dashboards based on results
5. Make program adjustments as necessary

Figure 8 shows how progress can be mapped from baseline to midterm. The solid circle indicates the baseline status measure in each dimension. The open circle indicates the midterm status measure. This particular example shows a project that made excellent progress in Dimension 1, but has not advanced in Dimensions 2 and 3. This information is extremely useful for project managers. It prompts the questions: "Where are the fracture points?" and "Who needs to do what about it?" Detailed monitoring data (indicators) show what objectives are not being met, and guide managers' decisions about where to intensify efforts, modify approach, or collect more or different information.

Figure 8: Progress on Sustainability

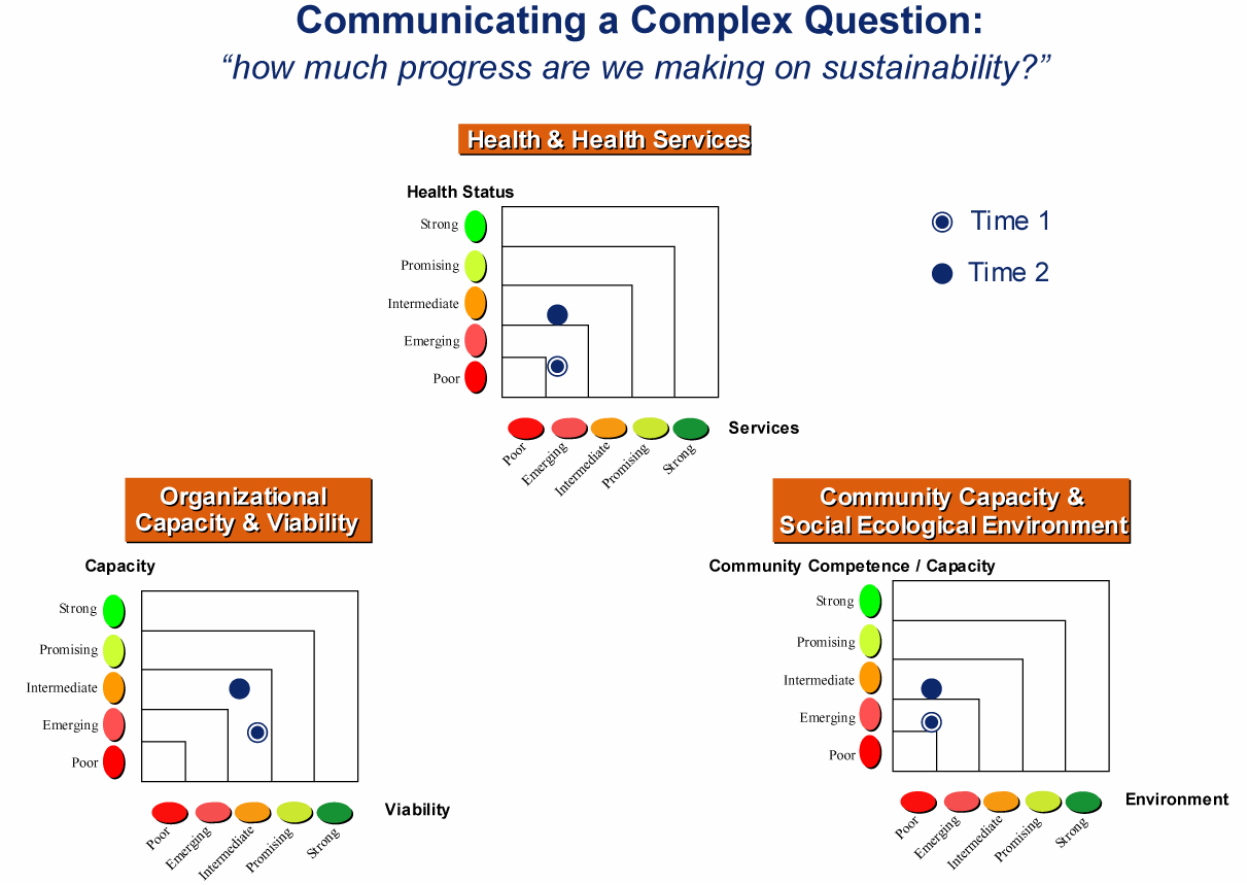
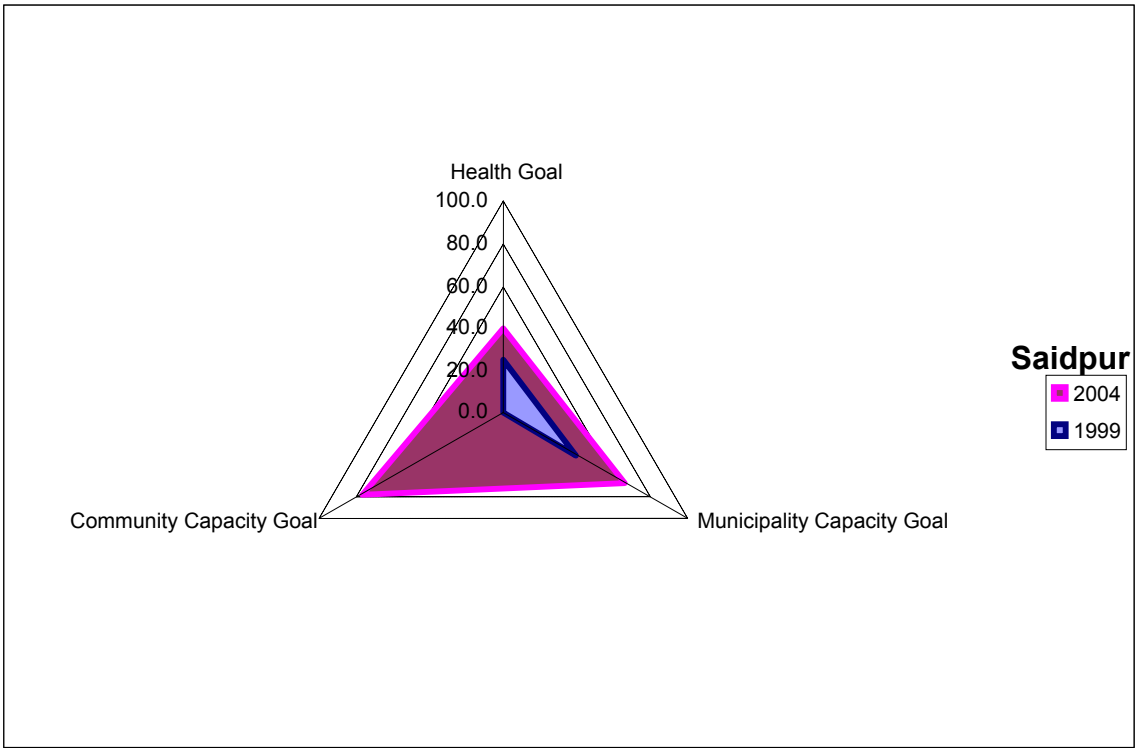


Figure 9 is adapted from CWI's presentation of final assessment results to project stakeholders, and represents another way to show progress. At a glance, one can see the progress made by dimension over time.

Figure 9: CWI's Final Sustainability Dashboard (Saidpur)



Reviewing and refreshing the sustainability framework with partners at the program design phase

In the case of the CSHGP, a PVO and partners will prepare the DIP after the grant is funded. This is an intensive 9-month or more period, full of assessments, meetings, and writing. A PVO usually brings partners together for a review of the assessment data and proposal sometime around month 5, after assessments have been conducted. This gathering has been called a DIP workshop. When using the CSSA, the idea is the same, but a pre-assessment meeting is recommended to be followed later in the process by the DIP workshop. The agendas for both meetings should be specially designed to build upon any previous work done with the sustainability framework, keeping in mind that a year or more may have passed since staff and partners have worked with it (if they were introduced to it during proposal preparation).

Workshop formats can vary greatly depending on the partners and the work that needs to be done. Ideally, integrating the CSSA in the project planning phase limits the amount of work needed to finalize the design of the project. Instead of suggesting different workshop formats to try to address the variety of possible scenarios, this guide gives a general recommendation that can be adapted (see Annex 7).

The emphasis of the pre-assessment meeting is on 1) reviewing and validating and 2) updating as necessary. It is important for participants to understand the work that was done during the planning phase and not spend too much time recreating that work; there will be plenty of time

and opportunity for creative work in the latter stages of the assessment and in designing the work plan.

Consider the following steps for the pre-assessment meeting:

1. Refresh/reintroduce the CSSA to the team and stakeholders
2. Update the local system and ensure adequate representation at the meeting and subsequent workshop (if possible)
3. Revisit and validate the vision(s)
4. Review and update elements/objectives
5. Review and refine indicators (if needed)
6. Choose and adapt assessment tools to collect data needed for each indicator.

This does not imply that any previously discussed aspect of the framework is static and should not change or adapt to contextual or capacity changes throughout the life of the project. Rather, this process ensures a thoughtful and comprehensive approach from the beginning, and provides a solid foundation from which to continually assess and measure project results, including sustainability outcomes.

After the pre-assessment meeting and assessments have been conducted, the team starts preparing for the DIP workshop. A project team should consider repeating steps 1 through 5 listed above, to varying degrees and as needed during the DIP workshop, perhaps led by other stakeholders who have been part of the ongoing process. At this point, the team will also have to identify information gaps and collect outstanding data. The next step is to combine indicators and build indices of sustainable health. This was done in the preliminary planning phase, using available data and expertise. This time, there is fresh assessment data to calculate and plot on the dashboard.

Keep in mind:

- Look at the big picture, but always go back to the details
  [go back and forth between the indices (aggregate data) and the specific measures (detailed information)]

- Evolve the model but keep a clear narrative (document decisions made, when, and why)

- Use information (even imperfect data) to
  - Analyze & question
  - Decide & act
  - Communicate & advocate
  - ...together!

WHAT'S NEXT?

> Think about the issue of sustainability as a journey, in which it's important to track the steps we take and activities we pursue.

As a community, we are steadily progressing, learning more about sustainability with every application of the CSSA and continuously seeking feedback toward creating simpler and streamlined processes for assessing, measuring, analyzing, and sharing results. Possible next steps in this journey include the following:

- A formal curriculum with prepared presentations that introduce the CSSA and reveal what it can do
- Rapid assessment guides for components to be used in the planning phase
- Recommendations for using the CSSA to frame operations and long-term research questions

Finally, we hope you will contribute your experience and insights to the SHOUT group,[26] as we continue learning together.

[26] Sustainable Health Outcomes Group—detail to come in www.childsurvival.com in October 2004.

Annex 1. Participant Feedback

Annex 1. Participant Feedback

PVO; country	At end of process, some in group understood:	At end of process, some in group did not understand:	Recommendations/other notes
CARE and IRC; Sierra Leone	- Process and definition of CSSA. - Indicator development.	- Dimension 3 (see last note next column). - Indicator development. - Defining elements. - Difference between organizational capacity and viability.	- Spend more time educating about CSSA so all concepts are clear. A slow, more thorough approach is best, rather than attempting to initiate people to entire framework and process at once. - Take sustainability training to all levels (e.g., communities, health facilities, DHMTs). - Need to understand CSSA before visioning exercise. - Take a slow approach to ensure understanding; do not rush process in order to move quickly to development of indices. - Development of indices (with followup CSSA training) is more appropriate 1 year into the project. - Overall country capacity (context) needs to be considered when designing process (e.g., postconflict situation presents a certain capacity level in communities and government).
PCI; Indonesia	- Six participatory stages; they are practiced in daily routines.	- Materials presented were too abstract for most participants.	- Need further guidance on implementation management and concrete procedures for using the six stages.
WVI; India	- It is possible to awaken government counterparts' enthusiasm if projects like ours decide to look beyond their own lifespan. - It is possible to do so in heavily hierarchical structures like India. - That attention had to be paid to issues usually ignored (though everyone agreed they affected long-term progress).	- The last dimension (that of sociopolitical environment) needs to be explained in greater detail. There is no doubt that participants understood the importance of these issues for sustainability, but what was not clear were the reasons why a CS project should consider these in its framework and how these could be addressed. - Not all understood that the future needs to be invented and that roles of local partners can be reinvented.	- Disbelief in what is possible (during visioning) is a constraint to sustainability planning. - Each step of the CSSA may have to be revisited to ensure participation of key players. - Regular reality checks are helpful; after a conclusion is reached regarding elements of a component, ask, "Why is X important for sustainability?" The answer serves to validate the decision. - CSSA should assess strengths to build upon, as well as weaknesses. - Plan for regional (Southeast Asia, for example) workshops for disseminating lessons, etc. -Monitoring and evaluation is always difficult. Adding issues to a project's concerns makes it even more difficult.

PVO; country	At end of process, some in group understood:	At end of process, some in group did not understand:	Recommendations/other notes
Project HOPE; Nicaragua	- People understood more about the strengths and needs of the communities they are working in, and what the visions of their local partners, including the communities, are for long-term health in the community. - While a "CSSA process" per se was not introduced, participants felt the graphic of the framework was a simple tool they could use to describe what their project was doing, and it gave them a clearer understanding of where their focus needed to be in the future.	- At the end, some people may have been wondering how to finalize the indicators they had used in each dimension and how to track some of that information. - Some in the group expressed an interest in replicating the process, but felt they didn't really know how we got from where we started to where we ended. (Although they liked the process a lot and felt it helped move them forward.)	For projects using the CSSA post-DIP submission: Previsit (project team) 1. Orient the group to the Sustainability Framework dimensions in a very simple sense. Something they could work with ahead of time before the visit. 2. Ask the group to identify its project goals, activities, and roles and responsibilities of local partners, and how they relate to each dimension. Prework or onsite, depending on level of readiness of the participating group: 3. Ask the group to work with local partners to identify vision/present state for the local system. It would be important to include all local partners in these discussions. This could be done through focus groups, key informant interviews, or another participatory technique. Onsite (workshop): 4. 1-2 days: orient the project team to the framework and the big picture of how everything will eventually fit together. 5. 2-3 days: field work with local partners and communities to identify key elements of a vision, and their perceptions of the present state of the issues (if not done ahead of time). 6. 2 days: Analyze field work, pulling out key elements of vision and present state. Identify data sources for all elements of present state (even if they're just opinion). Partners workshop (2-3 days): 7. Ask a member of the project team to introduce the Sustainability Framework to the larger team of partners. 8. Introduce idea of dashboard and illustrate how it might work. 9. Partners and project team create dashboard to reflect the present state in each dimension. 10. Big dashboard is analyzed to discuss where priorities should be placed. 11. Next steps are developed to move from one number to the next. Ideally, participants would identify benchmarks and indicators for each number/level. 12. Partners and project team jointly identify next steps for putting their plans into action. 13. Overall, create a step-by-step guide, in Spanish, for applying the framework.

PVO; country	At end of process, some in group understood:	At end of process, some in group did not understand:	Recommendations/other notes
ADRA; Madagascar	-Tools and concepts overall (however, we need some more robust measurements to check the validity of perceptions).		-Choice of venue and participants' comfort is important to ensure the quality of work done. -Drawing exercise was a good way of introducing the notion of dreams, especially if people are not used to phrasing dreams.
CWI; Bangladesh			-Start with the future in mind.

Annex 2. ADRA's Radar Diagrams

Annex 2. ADRA's Radar Diagrams

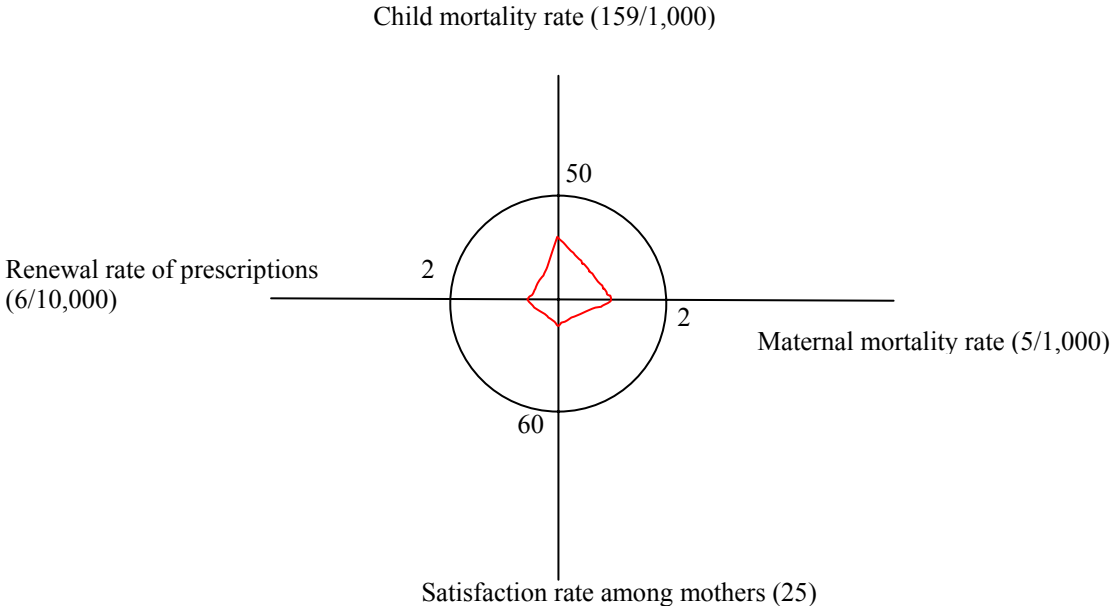
ADRA Madagascar followed the structure of the Sustainability Framework with its three dimensions, but adapted the concept of the status scales offering an alternative approach.

One of the project's concerns was to have less indicators to track. For each of the three dimensions, it selected a smaller set of indicators to assess progress and created a "radar" measuring progress in each dimension.

The next step was to define, with stakeholders' involvement, what should be the status level of each indicator that would correspond to a sustainable health situation. (This is similar to building the indicators' status scales, but only identifying the threshold to the highest band of the scale.)

The available data on the indicators were then reviewed and mapped on each radar, to create a display of progress needing to be made. This is an effective way to present indicators within each dimension (the same could be done within component), but it obviously requires limiting the number of indicators. Figures 1, 2, and 3 present the radar display for each dimension, along with discussion points.

Figure 1: Radar display of ADRA Madagascar Dimension 1 (health and health services) sustainability indicators

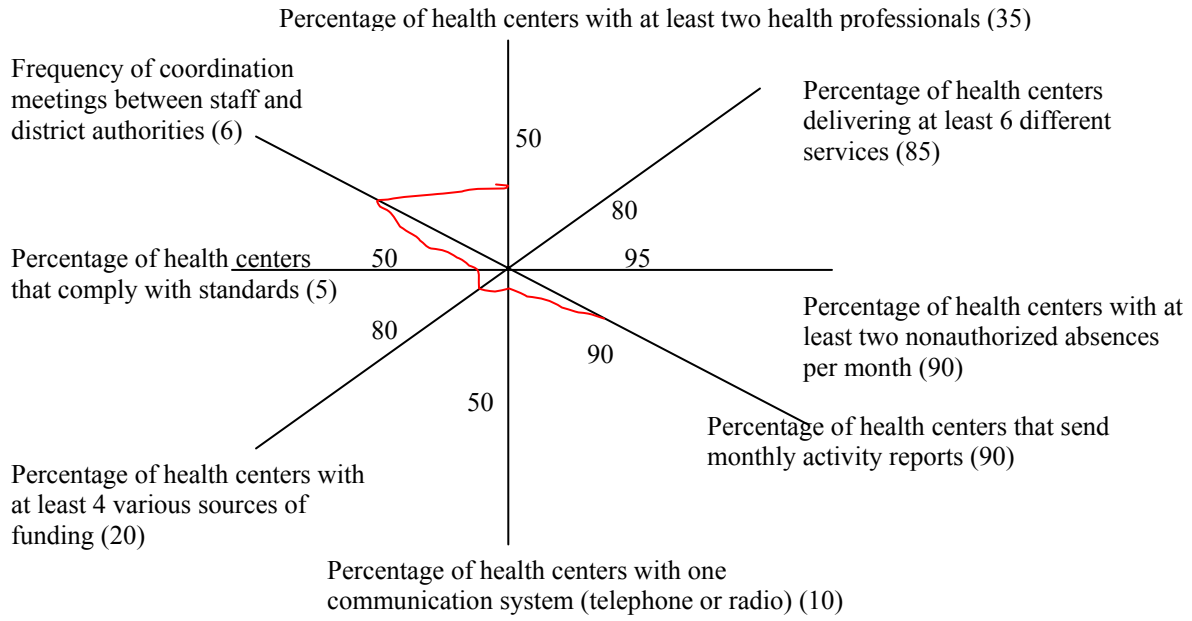


The first observation is that obvious progress is needed in both quality of services and health impact.

The second is that it probably will be difficult for the project to monitor such high-end results as child and maternal mortality. As indicators need to be revisited along the way, the project might think of ways to make use of the health information that is available through small population-based surveys, traditionally more in line with PVO practice.

Only two indicators inform on the characteristics of the health services. These appear sufficient to show how critical the situation is. For more in-depth assessment, it is likely that the project will need more indicators, which would be difficult to map on the same graph after a certain point. This is one of the rationales for creating indices that can be then expanded into their constituent indicators. In other words, Figure 2 could be designed at different levels.

Figure 2: Radar display of ADRA Madagascar Dimension 2 (local organization capacity and viability) sustainability indicators



The list of selected indicators and the diagram that they map (Figure 2) not only clearly show serious concerns about the capacity of the centers, but also about their viability.

Figure 3: Radar display of ADRA Madagascar Dimension 3 (community capacity and social ecological environment) sustainability indicators

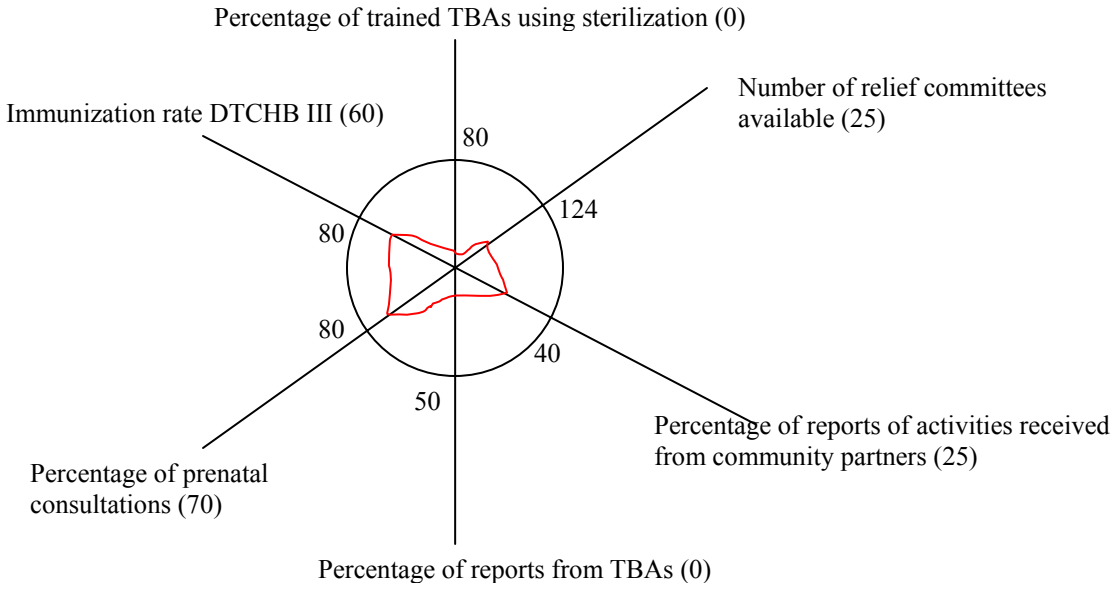


Figure 3 points clearly to the need to strengthen community interventions, in particular the work with TBAs and community organizations.

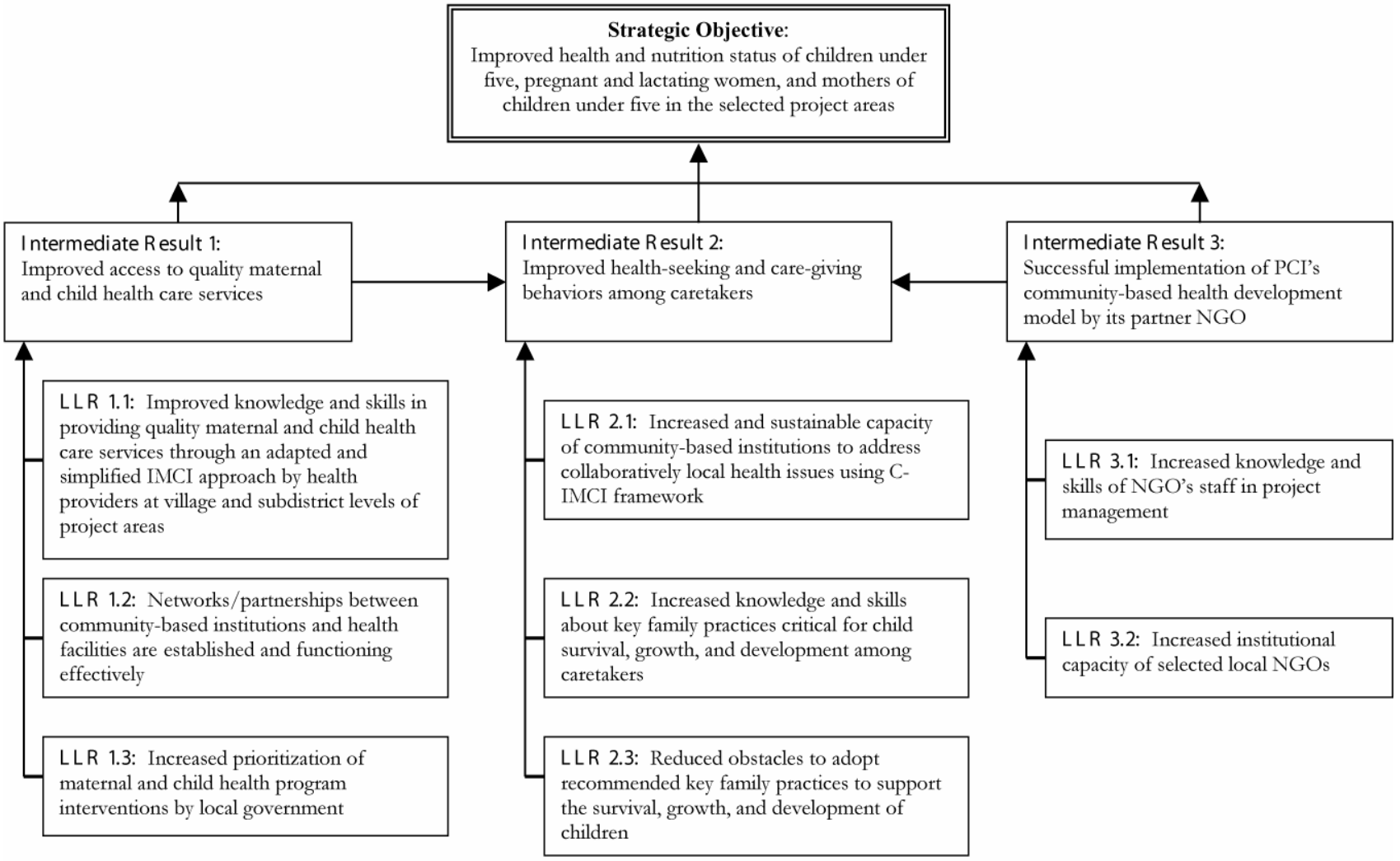
ADRA chose to include immunization and ANC as indicators of community capacity, as these are end results of a health competent community. This choice is legitimate but also open to debate, since immunization coverage is one of the more reliable proxy measures for health status, and use of ANC is also a proxy measure for better maternal health and is strongly dependent on the quality of services. Additionally, if these indicators lag, other community capacity indicators might be more useful in this dimension to orient project and partners toward remedial activities (e.g., cultural norms, social patterns, community organization)

This, however, represents an innovative and useful way to display the information.

Annex 3. PCI's Results Framework

Annex 3. PCI's Results Framework[1]

CHOICE Project Results Framework



[1]Project Concern International, *CHOICE DIP Workshop Report*. 2004

Dimension 1	Element 1 (population health status: Nutrition, KPC) 1. Percentage of underweight (weight/age < –2 SD) children aged 0-23 months, in the 30 villages 2. Percentage of mothers with chronic energy deficiency (MUAC of <22.5 cm) 3. Percentage of stunted (height/age < –2 SD) children aged 0-23 months, in the 30 villages; percentage of mothers who wash their hands before food preparation, before infant/child feeding, after defecation, and after attending to a child who has defecated 4. Percentage of children aged 0-5 months who were fed breast milk only in the 24 hours preceding the survey 5. Median duration of exclusive breast feeding increased from 1.0 month to … months 6. Percentage of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment 7. Percentage of sick children aged 0-23 months who received increased fluids and continued feeding during the illness in the 2 weeks preceding the survey 8. Percentage of children aged 0-23 months, in the 30 villages, with diarrhea in the 2 weeks preceding the survey and who received oral rehydration salts and/or recommended home fluids 9. Percentage of children aged 0-23 months who were breastfed within the first hour after birth	Element 2 (health and social services approach and quality): 1. Percentage of health workers in the project areas who received at least one supervisory visit that included observation of case management in the 6 or 12 months preceding the survey 2. Percentage of health workers who perform assessment, treatment, and counseling correctly in the management of a sick child 3. Percentage of midwives who have been trained on safe and clean delivery and care of premature/low birth weight neonates and lactation management 4. Percentage of health providers (midwives and paramedics) in the project areas who have been trained in the management of child illness 5. Percentage of mothers with children aged 0-23 months and who received at least two tetanus toxoid injections before the birth of their youngest children 6. Percentage of children aged 0-23 months whose delivery was attended by skilled health personnel 7. Percentage of children aged 12- 23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday 8. Percentage of children aged 12- 23 months who received a measles vaccine. Percentage of children aged 0-23 months who were weighed in the 4 months preceding the survey 9. Percentage of posyandu attended by one health provider at least once/month
Dimension 2	Element 1 (organizational capacity in key local partners): 1. Percentage of assigned villages in which partner NGOs have implemented activities according to PCI's community-based health/nutrition development model 2. All NGO/CHOICE project staff have been trained/oriented in community mobilization, program management, technical skills, and other skills needed for program sustainability 3. NGO partners already have their own specialist for health, nutrition, and training included in their own organizational structure	Element 2 (organizational viability): 1. Number of proposals developed by partner NGOs to expand their health/nutrition beyond CHOICE's project areas and/or beyond the health/nutrition issues to be proposed to other funding agencies 2. Number of proposals accepted for funding by other funding agencies to continue support communities in the CHOICE project areas or beyond the areas

	4. All training at community level organized, managed, and facilitated by NGO partner without supervision from PCI technical persons	3. Collaboration/partnership between partner NGO and district authority continued beyond the CHOICE project period
Dimension 3	Element 1 (community competence/capacity): 1. Percentage of villages that conducted community-health provider regular meetings (at least two times/year) as a mechanism for improving the quality of maternal and child health services 2. Percentage of posyandu attended by one health provider at least once/month 3. Percentage of registered TBAs who have been trained. Ratio of active cadre/posyandu 4. Number of cadre's forum established in the project areas as a place for sharing experience and updating skills and knowledge on neonatal care, lactation management, and appropriate home care of sick child 5. Percentage of parents/caregivers having children aged 0-59 months, in the project areas, who actively participate in parent/caregiver education activities 8. Number of parents/caregivers education sessions facilitated by trained cadres and conducted regularly in the 30 villages 9. Number of villages with high percentage of child's malnutrition (≥30%) applied positive deviance (PD) approach for improving the nutrition status of malnourished children 10. Percentage of underweight children aged 6-59 months who participated in CBNERP/PD sessions to rehabilitate (achieve normal weight) and sustain their normal status at least 3 months after recuperation, healthy growth, and development 11. Percentage villages that conducted community-health provider regular meetings (at least two times/year) as a mechanism for improving the quality of maternal and child health services. 12. Percentage of registered TBAs who have been trained. Ratio of active cadre/posyandu. 13. Number of cadre's forum established in the project areas as a place for sharing experience and updating skills and knowledge on neonatal care, lactation management, and appropriate home care of sick child 14. Percentage of fathers/men of children aged 0-59 months who are actively involved in parent education/posyandu activities	Element 2 (social ecological environment): 1. Number of village midwives/village birth huts run by midwives available in the project areas 2. Number of villages inside or outside subdistrict project areas that adopted integrated posyandu and NERP/PD models to promote child survival, healthy growth, and development 3. Percentage of households in the 30 villages with safe drinking water from piped or covered well (available all year long) 4. Percentage of households in the 30 villages with access to a flush toilet

Annex 4. Resources and Links to Presentations

Annex 4. Resources and Links to Presentations

- The Sustainability Initiative Page (http://www.childsurvival.com/documents/CSTS/Sustainability.cfm), which contains many links, resources, and references.

- Technical Reference Materials (http://www.childsurvival.com/documents/trms/update_trms.cfm), which have information on monitoring and evaluation and related indicator work

- The World Conservation Union (http://www.iucn.org)

- International Development Research Centre (http://www.idrc.ca)

- Other references (from text):

Kahn, A. A., and L. Hare. 2003. *Sustaining the benefits: A field guide for sustaining reproductive and child health services*. Washington, DC: The Centre for Development and Population Activities (CEDPA). (http://www.cedpa.org/publications/sustainingthebenefits/sustainingthebenefits.pdf)

Najam, A. 2000. *Community level sustainability assessment—Dasudi, India: A case study based on the work of the IUCN/IDRC Project on 'Assessing Progress Towards Sustainability'*. Cambridge, UK: The World Conservation Union (IUCN).

Sarriot, E. 2002. *The Child Survival Sustainability Assessment*. Calverton, MD: CSTS and the CORE Group.

Sarriot, E. 2002. *Sustaining child survival: Many roads to choose, but do we have a map?* Calverton, MD: CSTS and the CORE Group.

Sarriot, E. G., P. J. Winch, L. J. Ryan, J. Edison, J. Bowie, E. Swedberg, et al. 2004. Qualitative research to make practical sense of sustainability in primary health care projects implemented by non-governmental organizations. *International Journal of Health Planning and Management, 19,* 3–22.

Sarriot, E. G., P. J. Winch, L. J. Ryan, J. Bowie, M. Kouletio, E. Swedberg, et al. 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.

World Vision's Transformational Development Indicators publications can be obtained by contacting—
Development Resources Team
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220 I Street NE, Suite 270
Washington DC, 20002-4373

Tel: 202-547-3743
Fax: 202-547-4834
E-mail: resource_team@wvi.org

Annex 5. CARE's and IRC's Visioning Process

Annex 5. CARE's and IRC's Visioning Process

The visioning process that CARE, IRC, and partners undertook prior to the DIP workshop consisted of a daylong meeting in which participants answered the following questions and discussed the following points:[2]

1. Who will own the future health of the communities and continue to promote it?
2. In addition to the first group listed, who will influence the future health of the communities (e.g., central government structure may not be directly involved in the work that needs to take place, but may be influencing policies and resources)?
3. What dream/vision do you have for a healthy community or your community describing roles, responsibilities, and relationships?

The group then identified roles and responsibilities and defined relationships in their vision.

4. In this vision/dream, describe the situation of health for the children and mothers of the community as well as services that will be available to them.
5. In this vision/dream, describe the capacity of essential partner institutions and organizations identified in Question 1.
6. In this vision/dream, describe the way communities will operate internally and externally with other stakeholders and with their environment.
7. What possible threats exist in striving to achieve this vision?

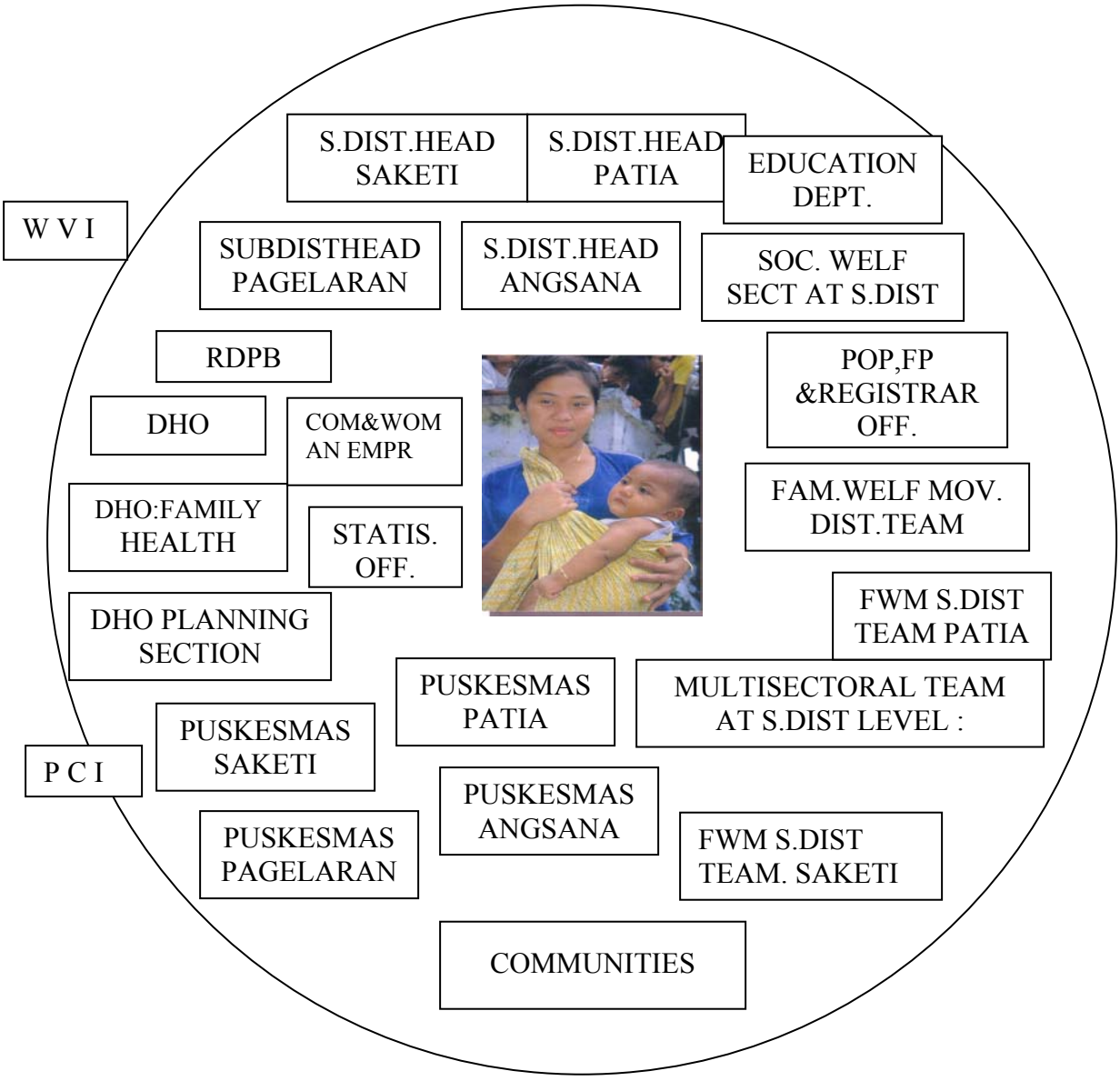
It is felt that the Sustainability Working Group Meeting, designed to introduce and integrate the CSSA into project planning, went smoothly because of this advance preparation and identification of goals.

[2] CARE International in Sierra Leone, Ministry of Health and Sanitation, *Our Vision for Health.* CARE Sierra Leone: March, 2004.

Annex 6. PCI's Local System

Annex 6. PCI's Local System[3]

The session was started by the identification of the roles played by each stakeholder within the CHOICE project. All individuals/organizations involved in the CHOICE project were asked to attach their name card on a piece of flipchart already prepared. A circle had been drawn on the flipchart. In the middle of the circle, a picture depicting a healthy mother and her child was attached to indicate the objective to be reached by the CHOICE project. Cards put inside the circle indicated direct involvement with the project, while cards attached outside the circle indicated indirect involvement with the project. At the end of the activity, it was clear that most individuals/organizations (except WVI) attached their names inside the circle. Participants learned that a program for improving the health status of mothers and children was a multisectoral mission and should be the responsibility of various parties.



[3] Project Concern International, *CHOICE DIP Workshop Report.* 2004

Annex 7. Sample Agenda for Introducing the CSSA at Program Planning Stage

Annex 7. Sample Agenda for Introducing the CSSA at Program Planning Stage

(With partners; the team may want to take ½ or 1 day to review the CSSA framework with staff before this workshop)

DAY 1

Time	Group size	Activity	Resources
8–8:30	Large group	Greeting and introductions; ground rules	
8:30–9:15	Large	CSSA—introduction to the framework	Presentations can be downloaded from http://www.childsurvival.com/documents/CSTS/sustainability.cfm
9:15–11:30	Large and small	Define the local system	Includes visioning exercises (includes break); see visioning examples in this text (CARE, IRC; PCI for local system)
11:30–1	Small groups	Game/activity to identify location-specific elements of each dimension; turn elements into objectives	Answer this question: "What must be considered when working to improve X (e.g., maternal and child health status)?"
1–2	Large	Lunch	
2–3:30	Large	Refine vision; review objectives	Ask, "Is this realistic? Is this the best that can be achieved by the partners? When do we want to revisit this?"
3:30–5	Large and small	Begin discussion of current status; turning objectives into indicators, choosing key indicators and identify information gaps	
Evening	Facilitators	Make plan to fill information gaps	Develop field questionnaire/focus group discussion guide

DAY 2

Time	Group size	Activity	Resources
8–8:15	Large	Greeting; overview of day	
8:15–10	Large	Energizer; review of CSSA and critical review of work of previous day	
10–12:30	Small, then large	Field work to acquire missing information	
12:30–1:30	Large	Lunch	
1:30–3:30	Small, then large	Plug in missing info, review all data; report to large group with brief discussion	
3:30–3:45	Large	Break	
3:45–5	Large	"Sustainability dashboard"—introduction	Presentations can be downloaded from http://www.childsurvival.com/documents/CSTS/sustainability.cfm

DAY 3

Time	Group size	Activity	Resources
8–8:15	Large	Greeting	
8:15–9:30	Large	Energizer/ review of previous day, giving particular attention to dashboards	
9:30–9:45	Large	Formulas for computing index scores	Presentations can be downloaded from http://www.childsurvival.com/documents/CSTS/sustainability.cfm
9:45–10:45	Small (mix up group member-ship)	Combine key indicators and build index	
10:45–11	Large	Break	
11–1	Large	Build indices and discuss	
1–2	Large	Lunch	
2–3:30	Small (mix up group member-ship)	Identify appropriate project activities	
3:30–5	Large	Present and discuss project activities	(includes break)

Annex 8. IRC's Element Identification

Annex 8. IRC's Element Identification[4]

Dimension—Component	Element—Issue	Stakeholder Involvement
Dimension 1—Component 2	***Competence of service providers (technical performance, interpersonal skills, and safety of procedures)***	
	▪ Provide competent service ▪ Participate in monitoring of their competence	CHWs
	▪ Provide competent service ▪ Participate in monitoring of their competence ▪ Monitor and improve CHW performance	PHU staff
	▪ Monitor and improve PHU staff performance ▪ Monitor and improve PHU monitoring of CHW performance	DHMT
	▪ Provide logistical support ▪ Provide technical support	INGOs
	Provision of affordable and accessible health care delivery of services	
	▪ Participate in ensuring geographical accessibility	VDCs
	▪ Facilitate and provide outreach services	CHWs
	▪ Make sure set prices are adhered to ▪ Ensure clinic and outreach services are provided	PHU staff
	▪ Provide logistical and training support so services can be provided ▪ Supervise, monitor, and evaluate accessibility of services	DHMT
	▪ Provide logistical support ▪ Provide technical support	INGOs
	▪ Secure necessary resources	MOHS Freetown
	Awareness and utilization of services	*VDCs, CHWs, PHU staff, DHMT*
	Effectiveness and response to epidemiological situation	PHU staff, DHMT, INGOs
	▪ Participate in surveillance ▪ Provide response in outreach areas	CHWs
Dimension 2—Component 3	▪ Management and governance	DHMT, INGOs, local government
	▪ Human resources management	DHMT, INGOs, community
	▪ Technical capacity	DHMT, INGOs, PHU staff

[4] Nancy O'Rourke, *Sustainability and Child Survival in Sierra Leone (draft)*. Trip report: 2004

Dimension—Component	Element—Issue	Stakeholder Involvement
	▪ Organizational learning	DHMT, INGOs
Dimension 2—Component 4	▪ Cost recovery mechanisms and Bamako initiatives	DHMT, PHU staff, VDCs
	▪ Independent identification of donors and submission of grant proposals	DHMT, VDCs
	▪ Local partners connectedness	CBOs, VDCs, DHMT
	▪ Independent access to human resources, technical assistance, skills, and knowledge	DHMT, VDCs, INGOs
Dimension 3—Component 5	▪ Agree and collaborate on ways and means to implement activities	VDCs, DHMT, CBOs, INGOs, PHU staff
	▪ Extent of community participation in and ownership of health promotion activities	VDCs, DHMT, PHU staff
	▪ Understanding community history	CHWs, DHMT, individuals, PHU staff
	▪ Extent of community organizing and ability to manage conflicts	VDCs, DHMT, CBOs, community leaders
Dimension 3—Component 6	▪ Health policies of central government	MOH
	▪ Political stability	Local and central government, traditional leaders, individuals (politicians)
	▪ Water and sanitation indicators	MOHS, CBOs, MOW, INGOs
	▪ Women's literacy	Central and local administrators

Annex 9. Illustrated Guidelines for Building a Component Index Measure

Annex 9. Illustrated Guidelines for Building a Component Index Measure

It can be useful to obtain a general measure about sustainable health in an area. To obtain this general measure, a project team could consider combining several key indicators as an index. We cannot explain how to build indices without addressing first what the purpose is, and what caveats exist with their creation and use.

What is a component index measure?

Let's think about common usages of an index. Many people follow the daily fluctuations of the Dow Jones to assess how the U.S. stock market is doing. In a computation of the Dow's points, a wide number of measures (indicators) are pulled together to provide one number used to represent a greater concept: the stock market. Not all possible indicators are used to create this number. The Dow Jones uses one set of stock values, and the NASDAQ uses another set of stocks. It is complicated to look at all of the individual stocks that are bought and sold at the stock exchange, so "smart people" select (some think scientifically, some claim a little arbitrarily) a known group of stocks; next they design a standard way of computing the stock values (dollars) to create the Dow Jones Index, which is measured not in dollars but in points. Because the same set of stocks is used every day and computed together through the same algorithm, regardless of the Dow Jones limitations (e.g., how well does it really represent the stock market?), most people derive valuable information from comparing the index from one day to the next or one year to the next.

We are faced with a similar challenge when we want to assess progress on the health status of children, or quality of care in a district, and the capacity of NGOs or communities. There are hundreds of indicators we can use to assess all of these, and to measure overall progress, we would like something—unlikely to be perfect, but hopefully showing some validity—with which we can work.

In steps 2 and 3 of the CSSA process, we selected indicators that will inform us of progress in each of the components of the framework. As the "smart people" (we may know nothing about the stock market, but maybe one or two things about child health indicators, quality of care, and even community capacity), we have thus selected from the range of possible indicators defined sets to represent the components in which we measure progress.

Having done this, we need to have a standard process/algorithm to compute these indicator values together if we want to create a summary point value (index) for this component. Before examining how we can do this, let us consider what such indices can be used for.

What are component indices useful for?

Since indices aggregate and summarize the information from different indicators, they effectively reduce the data available. So what is their advantage? It can be summed up around two points: comparing and communicating.

Comparing

Component, or summary indices allow us to compare a single measure across time and across areas, if a project is working in more than one area. This tells us at a glance how the project and partners are progressing toward creating a sustainable environment for improved health.

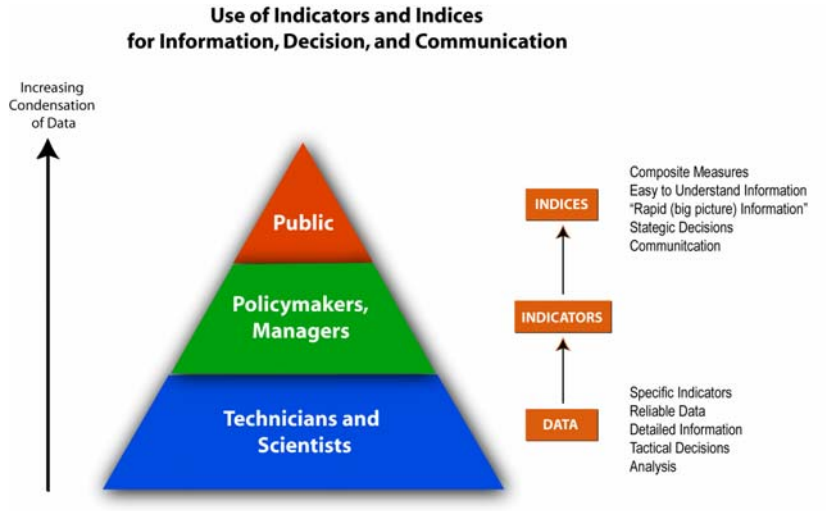
This can be shown in a simple example—while we've improved the health status of children notably over the years, local organizational capacity and linkages might still be lagging behind. Too often these issues are known to be important but are not given proper focus. Using M&E data to produce a simple map (e.g., sustainability dashboard) showing how far we've come and how much further we want to go can help us and our partners appropriately shift the level of effort to focus on areas (like organizational capacity) that are lagging behind others (like the health status of children).

By examining differences between neighboring districts or areas, we can draw attention to substantial and critical differences. By mapping an index measure on a graph, we bring to light issues that could otherwise be neglected, like organizational capacity.

Communicating

Consider Figure 1.[5] It illustrates which project information is appropriately shared with different audiences. It is obvious that composite measures are more useful (and probably more interesting) to those who are removed from project implementation, whereas more and specific information is needed by project managers. Each project team will need to determine what level of information and how much is appropriate to share with various stakeholders, considering their degrees of participation in the project and their potential for influencing elements of sustainable health in the project area.

Figure 4: Level of Data Reduction/Condensation and Target Audience



[5] Karl Blanchet, with ADRA Madagascar, 2004.

Four steps to building a component index

This section describes in detail four steps for building a component index. Each step is illustrated through four types of indicators. Box A provides an overview of the steps the reader will follow.

Text Box A—Overview of the four steps

1. Select indicators
   In this section, we present four types of measures, which are very different in nature, format, and quality: KPC indicators; organizational self-assessment scores; indicators of availability and quality of CHW care; and indicators of quality and coordination of care in facilities based on an "expert panel."
2. Transform indicators into computable scores
   In this section, we first define how progress is measured on these four types of indicators by placing each of them on a standard status scale (from "poor" or 0, to "strong" or 100). Then we transform each indicator value into a score (0 to 100) through a simple computation.
3. Compile scores into index values
   In this section, we explain how scores are aggregated according to a predetermined rule to create an index.
4. Report
   Finally, we show how the computed indices can be presented with different types of figures.

We need to start this section with a caveat, or disclaimer:

- We explained previously how, regardless of its limitations, the Dow Jones is thought to be useful because standardization in the way values are computed provides comparability from day to day. We need to recognize that for measuring sustainable health, we are far from having something as reliable as the Dow Jones.
- No one can claim at this point to have a definitive word on which indicators should be included in each component. Additionally, there are many remaining unknowns about how even commonly used indicators actually measure progress. For example, considering the ordinal scales frequently used to describe growth in organizational capacity, we really do not know very well whether the "distance" between "nascent" and "emerging" is in any way comparable to the distance between "emerging" and "expanding" organizations.[6] We can describe, in general terms, the effect of progressing or regressing from one level to the next on organizational performance, but we are challenged to scientifically measure and validate it.

It is important to realize that we are not trying to build Dow Jones measures at this point, but rather locally reliable summary measures to inform analysis, decision, and communication. The steps for building an index are to be followed systematically to make local comparisons between subareas and over time. It is understood that in each context the selection of indicators—and at times the definition of how progress occurs (i.e., indicator status scales)—will vary, until science and consensus lead us toward more homogeneity. Once a calculation method has been chosen locally, it will be important to use it consistently in all areas and for all periods one wishes to compare. To this end, it is critical that measures and related decisions are carefully documented at each measurement point. For instance, if those involved in measurement in year 1 are not available to participate in year 2, it would be important to have everything carefully documented from year 1, so that the same measures used then can be used again in year 2. This ensures the ability to compare results across time. *No comparison should be attempted between sites and projects that do not use the same measures.*

[6] Christian Reformed World Relief Committee. *Partnering to build and measure organizational capacity: Lessons from NGOs around the world*. Grand Rapids, MI: 1997.

1. Select indicators

Obviously, as previously discussed, the selection of the appropriate, relevant, and meaningful indicators is the first step in building an index measure. Great care should be given to this selection (more information is given in Part III).

Let's use three examples, adapted from actual project data.

For its final evaluation in two municipalities (originally Saidpur and Parbatipur, renamed here District A and B to compile this example), CWI collected the following Rapid CATCH indicators,(Table 1):

Table 1: District A and District B Rapid CATCH indicators

Rapid CATCH 2004	District A	District B
At least one dose of TT last pregnancy	89%	88%
Exclusive BF	65%	86%
Child spacing 3+ years	62%	71%
Vaccination	71%	83%
Weight age < –2 SD	73%	72%
Diarrhea treated with ORT	79%	68%
Child vitamin A	76%	81%

CWI also used a participatory tool to assess the capacity of municipalities' health departments, whereby capacity in different areas received a score from 0 to 6.

Table 2: Organizational assessment scores of District A and District B

Capacity scores	District A	District B
Leadership	3.0	5.0
Coordination	3.0	4.0
Participation	4.0	5.0
Resource mobilization	4.0	5.0
Human resource development	4.0	4.0
M&E	3.0	5.0
OVERALL	3.5	4.7

To illustrate another level of complexity, we will use a second example, inspired by another project. In this case, measures of availability and quality of care at the community level, as well as quality of care (including linkages with CHWs) at the facility level are thought to be the key indicators representing component 2 of the sustainability assessment: health services.

On the basis of supervision visit observations, supervisors from the project and the health district score from 0 to 10 the performance of CHW, using five observed behaviors.

The scores were analyzed as follows:

Table 3: CHW performance scores for District A and District B

CHW score	Level of performance	Decision
10	Meets all standards with excellence	Recognition of performance
8–9.5	Meets most standards appropriately	Discuss areas of improvements
5–7.5	Meets standards only partially	Identify need for retraining/coaching; reinforce supervision
0–4.5	Does not meet standards	Retrain or replace

While each score for each CHW can be used to track the progress of individuals, particularly by identifying the areas needing improvement, project-level monitoring requires a first level of aggregation of these measures. The project and partners have decided that two indicators will be used for the sustainability assessment, and provide information about the availability and quality of care through CHWs at the community level.

Table 4: Availability and quality of CHW care in District A and District B

Indicators	District A	District B
Percent of CHWs performing appropriately	25%	70%
Percent of villages with trained and active CHWs	75%	60%

In the absence of a rigorous assessment at the facility level, district managers and supervisors, facility nurses, and at least one community representative per facility were gathered as part of the sustainability assessment and scored each facility on quality of services and coordination with CHWs and district referral level.

Two elements (Quality of services in facilities, and Coordination of facilities with district and with CHWs) were rated by consensus through a very simple scale:

□ **N**ot so good □ Needs **I**mprovement □ **M**oderate □ **G**ood □ **V**ery Good

Table 5: District A and B staff assessment of quality and coordination of care in facilities

Indicators	District A	District B
Perceived quality of services in facilities	**G**	**I**
Perceived coordination of facilities with district and with CHWs	**I**	**N**

In this example, we now have measures of vastly different natures (and quality!), which we want to use to map the progress that needs to done to reach some state where more sustainable health outcomes are expected. We want to compare District A and District B, and this is why the same indicators have been used. But we also want to map this situation on one summary picture—perhaps to communicate better where we are, perhaps to better understand where the critical gaps are, or simply to get a "big picture" of what this abundance of data is telling us.

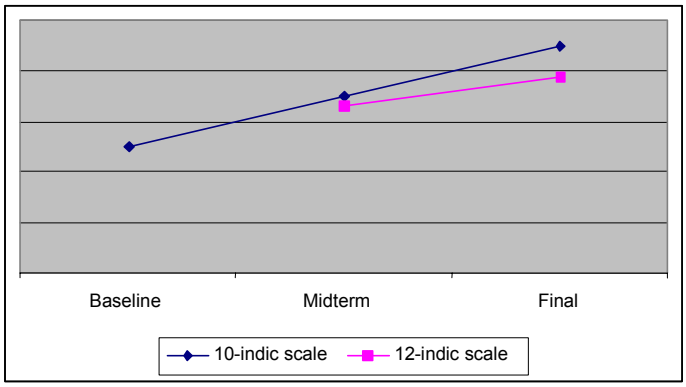
Question and Answer: Dealing with Change

Question: We had 10 indicators to measure quality and appropriateness of care 3 years ago (baseline), but now (midterm) we have included 2 more. How can we make comparisons between baseline, midterm, and then final evaluations when we get there? How many indicators do we need to create for our index?

Answer: You cannot compare an index based on 10 indicators, with 1 based on a different set of indicators. You may be quite right that quality and appropriateness of care are better assessed with the two additional indicators you have identified, and so you should use them (it would be stupid to ignore better information that will inform your management). Here is what you can do—

a) Compare how your 10-indicator-based index measured at baseline has evolved by midterm
b) Explain why two more indicators are necessary and present the corrected value at midterm
c) For the final evaluation, report change on the 12-indicator-based index measure between midterm and final. You can even report on the 10-indicator index for the three periods of time. (Figure 2)
d) Accept the idea that neither measure is perfect, but over time, stick to the measure that makes the most sense and drop the old one.

Figure 2: Reporting an Index Over Time and Dealing with Change



Question: We want to report on progress on our health indicators and the other components of the Sustainability Framework through indices in order to rapidly compare different project subareas. We have a problem for the selection of the indicators that will be used for the Component 1 (health outcomes) index.

Our project intervenes in malaria, diarrhea, ARI, and nutrition, but it does not intervene in immunization, which we think is better handled by other partners. We've been very successful at bringing the MOH around the table as a full partner, but now the district medical officer insists that we need to include the indicator for complete immunization that we collected through the KPC into this health index. Our project staff are concerned that this will not represent what the project is trying to do.

Should we include immunization or not to calculate this index?

Answer: So, you are a victim of your success! The DHO is motivated and wants to monitor health outcomes thoroughly (hopefully to do something about it), and this does not match your project's objectives. Your local partners are more likely to keep up the work and sustain their vision of health for their community than to devote themselves to your project's objectives after you're gone. Your success is in that they are dedicated to monitor progress in across the board.

The answer to this question comes in the form of other questions: Which way should you calculate this index to more validly represent how the local system of actors is making progress on mother and child health goals? Would progress toward sustainable child health measured by an index that ignores immunization coverage be more or less valid than by including it?

Obviously, your DHO is quite right in wanting to include this indicator in your index.

What you are pointing to however is the fact that you are dealing with two accountability questions and possibly two audiences. On one hand, you want to account to and with local partners on progress toward sustainable health. On the other, you want to show your sponsors that you are effective and reaching your targets. The fact that your local partners are looking more broadly than your project's objectives is a reason for rejoicing and perhaps partly caused by your own efforts to prioritize sustainable child health. So, continue supporting this. But also show independently the results of your project-specific efforts on indicators for which you are accountable.
Better to give two answers that meet the needs of your two audiences, than to give one that satisfies neither.

2. Transform indicators into computable scores

Since we want to compute different measures together to create an index, we need all of these measures to be based on the same scale. And since we want to map progress on different components on the same graph, we need the scales for each component to be equivalent.

In order to do this, we will need to transform all of our measures into a score on a standard scale from 0 to 100, where 0 is the worst situation and 100 the best, and where 50 is exactly halfway between the two. (Obviously, this is different from even measures of quantitative indicators. Would we agree that 50% of children underweight represent half the progress we need to make to reach a fully satisfactory level? Probably not.) We are going to need to follow two simple steps to obtain scores for each indicator:

1. Construct status scales to tell us what measures of each indicator mean.
2. Compute a score for each indicator on the basis of its status scale.

This is illustrated with numerous examples below.

Define indicator status scales

To compile different indicators together to create an index, we need a scoring system that is uniform, describing a more desirable state from the poorest level possible (which we will score at 0) to the best possible level (which we will score at 100) (Table 6).

Table 6: Rapid CATCH Status Scale

Indicator status	Range of score values for each band	Indicator benchmarks	Suggested focus of project
Strong	81–100	To be defined for each indicator	**Phased out**—PVO involvement probably not needed
Promising	61–80		**Consolidating**—the PVO should be working on consolidation, strengthening to complete a phaseout strategy
Intermediate	41–60		**Building capacity**—interventions at this level need to be justified by a high level of capacity building, in parallel to an improvement of the health indicators
Emerging	21–40		**Achieve results**—focus efforts on the intervention to strengthen health outcomes. Ensure early partners buy in; start building capacity.
Poor	0–20		**Emergency intervention**—extremely high need for public health intervention because of associated high morbidity and mortality

We provide below different examples of status scales for the indicators proposed in Tables 1, 3, and 4.

➢ *Example 1: Linear correlation between indicator and index score*

In the example below (Figure 3), there is a direct one-to-one correlation between an indicator expressed in percent and a score that can be used to create an index. This is the simplest situation (X% → X "points").

➢ *Example 2: Nonlinear correlation between indicator and index score*

The illustration below (Figure 4) has been used by CSTS+ since the 2002 Program Review to describe progress on the Rapid CATCH indicators (except for anthropometry). This choice was based on the following logic:

- The scale is controlled at the higher end, arguing that a situation is strong when indicators are above 90 percent coverage.
- It keeps the critical level of the scale below a coverage rate of 35 percent. This means that an "emerging" health status on a given indicator is identified when roughly more than a third of the population is "covered."
- Between the two cutoff points of 35 and 90 percent, it presents progress in the situation regularly in a linear fashion. A situation is judged "promising" when more than three-quarters of the population are covered.

Figure 3: Linear between indicator and index score

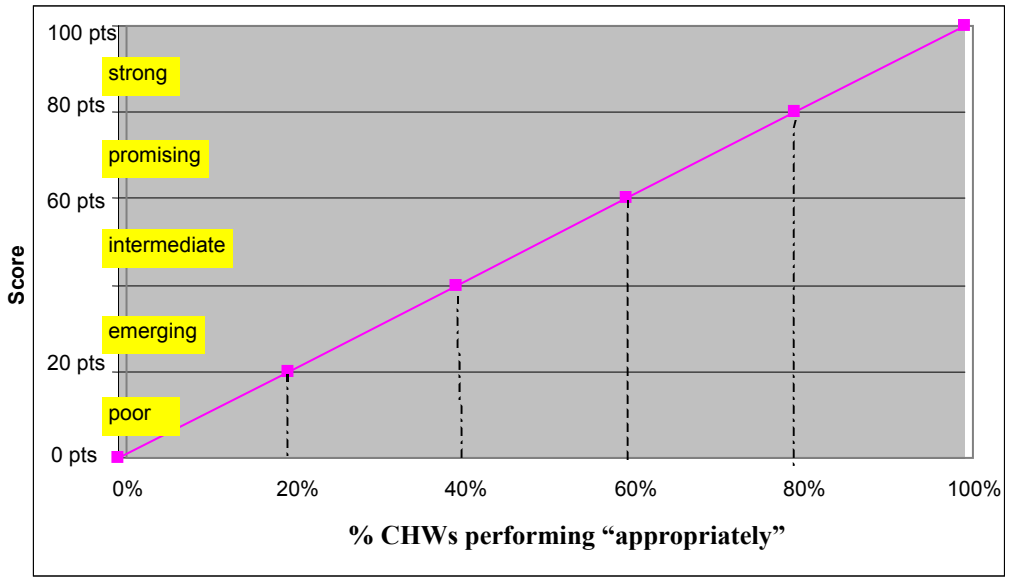
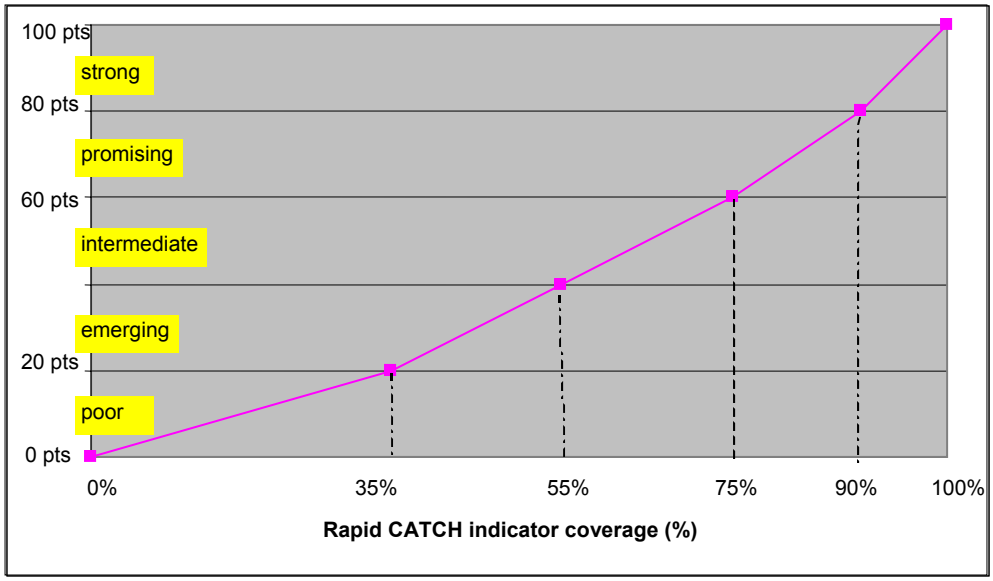
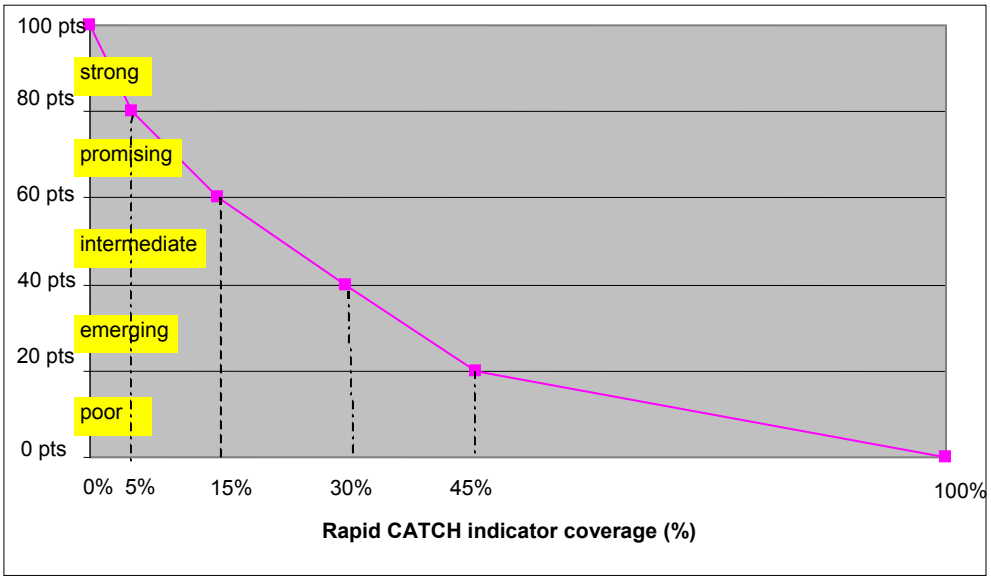


Figure 4: Proposed status scale for non-anthropometric Rapid CATCH indicators



➢ *Example 3: Inverse and nonlinear correlation between indicator and index score (Figure 5)*
The illustration below has been used by CSTS+ since the 2002 Program Review to describe progress on the weight-for-age Rapid CATCH indicator. This status scale is obviously heavily skewed, considering the importance of this indicator, and rapidly describes as intermediate or worse smaller percentages of underweight children (as compared to a linear scale).

Figure 5: Proposed status scale for weight-for-age indicator



➢ *Example 4: CWI's capacity scores*

Although CWI already had scores for describing the capacity of municipalities, these needed also to be standardized in a similar fashion. This is represented in Table 7. (This table offers the same type of information as Figures 3 through 5, which are useful for visualizing how we control the scale.)

Table 7: Status scale of organizational capacity scores

Indicator status	Capacity score 6-pt scale	Index score range for each band
Strong	4.5–6	81–100
Promising	3–4.4	61–80
Intermediate	1.5–2.9	41–60
Emerging	0.5–1.4	21–40
Poor	0–0.4	0–20

➢ *Example 5: Qualitative data*

For our last and most simple example, the rudimentary scale used to assess quality of care described previously can easily be converted as well. In this case, the midrange score for each band can be allocated to each level.

Table 8: Status scale for staff assessment of quality and coordination of care in facilities

Indicator status	Quality of care assessed by consensus	Index score
Strong	**V**ery good	90
Promising	**G**ood	70
Intermediate	**M**oderate	50
Emerging	Needs **I**mprovement	30
Poor	**N**ot so good	10

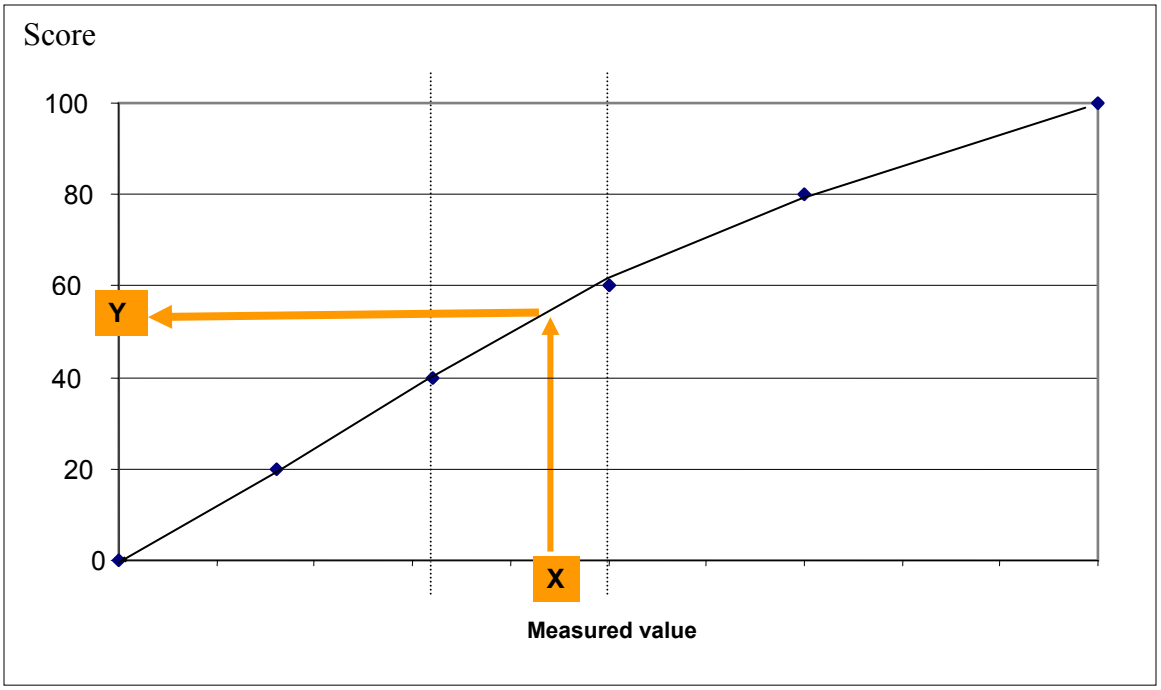
Having created a correspondence between measured indicator values and scores, or points that can be used to create an index, the computation itself is relatively simple.

Compute

For examples 1 and 5, the computation is a direct one. In example 1, a 15 percent coverage level yields a score of 15. In example 5, each status has a numeric value attached to it (e.g., moderate quality yields 50 points).

For any of the other examples, a simple computation allows us to transform X (measured value of the indicator) into Y (score) (Figure 6).

Figure 6: From indicator value to score



Because the status scale is based on five bands (0–20, 20–40, 40–60, 60–80, and 80–100), the computation uses the base of each band to find the value of Y. A slight change in the formula is required if there is an inverse correlation between the indicators and the scores (e.g., example 3—weight-for-age).

The formula is as follows:

Calculating a score from an indicator value:

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

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

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

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

Good news for the math-phobic!

If the formulas, graphs, and algorithms leave you cold, but you still need a compute a score for a measured indicator in order to build an index, you can simply go to:
http://www.childsurvival.com/documents/sustain/2districts/Computing_Scores.xls
Download the spreadsheet or use it online.

It will only ask you to provide the minimum and maximum value of the indicator you are using for each band of the status scale, and will then give you a graphic to show how you've defined your status scale.

All you will have to do then is enter an indicator value and read what score it yields.

3. Compile scores into index values

Having translated each indicator measure into a standard score within all components, we can simply define how the scores will be aggregated (define the rule) and perform a simple calculation to obtain an index value.

Define the rule

We can use the average, median, weighted average, or even the minimum score among the variables being aggregated. By default, averages are a natural choice; although, an average is more sensitive to one extremely low or high score than the median score, which is sometimes preferred for this reason. Whatever you use, be clear about your choice, explain it, and be consistent.

Compute the index value

The computation itself can be done using pencil and paper or a spreadsheet.

Again, the steps for transforming a range of indicator data into a component index are:
1. Transform each percent value into a score from 0 to 100 using the appropriate scale—use http://www.childsurvival.com/documents/sustain/2districts/Computing_Scores.xls if you don't want to remember the formula.
2. Average the scores to obtain a component-level index.

4. Report

The last step is to display and report the information. The next section (Examples) illustrates the different ways of displaying the information, starting with an example using the indicators used in this appendix.

Examples

Table 9 presents the data from Tables 1, 2, 4, and 5 on the left with scores computed according to the status scales definition for each indicator (see legend) on the right. The detail of information available in the table is contrasted with the display of summary indices for the four domains examined (health, municipality capacity, CHWs, and facilities) in Figure 7.

Table 9: Computing scores from indicator measures

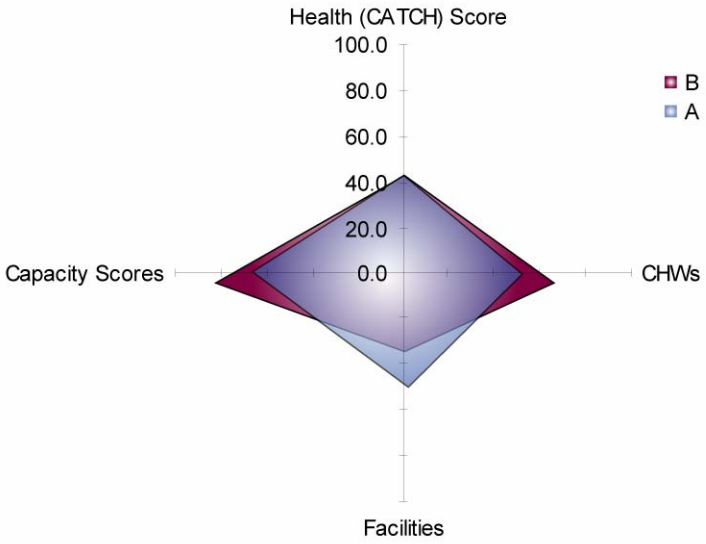
DATA		INDICATORS	SCORES	
District A	**District B**	**Rapid CATCH indicators**	**District A**	**District B**
89%	88%	At least one dose of TT last pregnancy*	51.0	50.4
65%	86%	Exclusive BF*	37.2	49.3
62%	71%	Child spacing 3+ years*	35.5	40.7
71%	83%	Vaccination *	40.7	47.6
27%	28%	Weight age < –2 SD **	42.7	44.0
79%	68%	Diarrhea treated with ORT*	45.3	39.0
76%	81%	Child vitamin A*	43.6	46.4
		OVERALL	**42.3**	**45.3**
A	**B**	**Capacity scores**	**A**	**B**
3.0	5.0	Leadership+	60	87
3.0	4.0	Coordination+	60	73
4.0	5.0	Participation+	73	87
4.0	5.0	Resource mobilization+	73	87
4.0	4.0	Human resource development+	73	73
3.0	5.0	M&E+	60	87
3.5	**4.7**	**OVERALL+**	**67**	**83**
A	**B**	**CHWs**	**A**	**B**
25%	70%	Percent of CHWs performing appropriately++	25	70
75%	60%	Percent of villages with trained and active CHWs++	75	60
		OVERALL	**50**	**65**
A	**B**	**Facilities**	**A**	**B**
G	I	Perceived quality of services in facilities+*	70	30
I	I	Perceived coordination of facilities with district and with CHWs+*	30	30
		OVERALL	**50**	**30**

Legend: Calculating scores from indicator value
* See Figure 4 ** See Figure 5 + See Table 7 ++ See Figure 3 +* See Table 8

While Table 9 provides a lot of data, Figure 7 makes a few points clear:

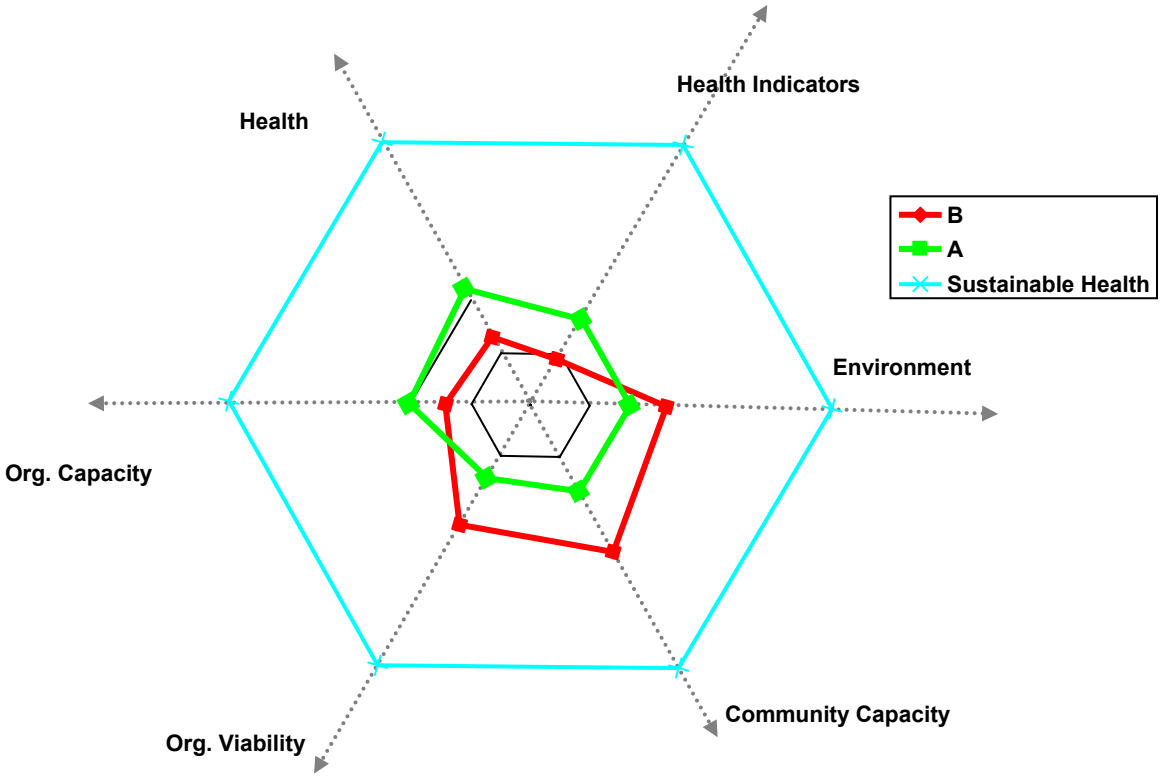
- District A and District B are comparable in terms of the health situation measured by the selected indicators (small differences in a couple of indicators can be found in Table 9, however).
- The capacity of municipalities as the availability and quality of CHW care are better in District B than in District A. These two issues might be related, and the natural question is, What explains this difference?
- Quality and coordination of care in facilities is notably better in District A (but we need to go back to Table 9 to see that it is quality that is much better and that coordination needs improvement in all cases).

Figure 7: Graphic Representation of District A and District B Situation



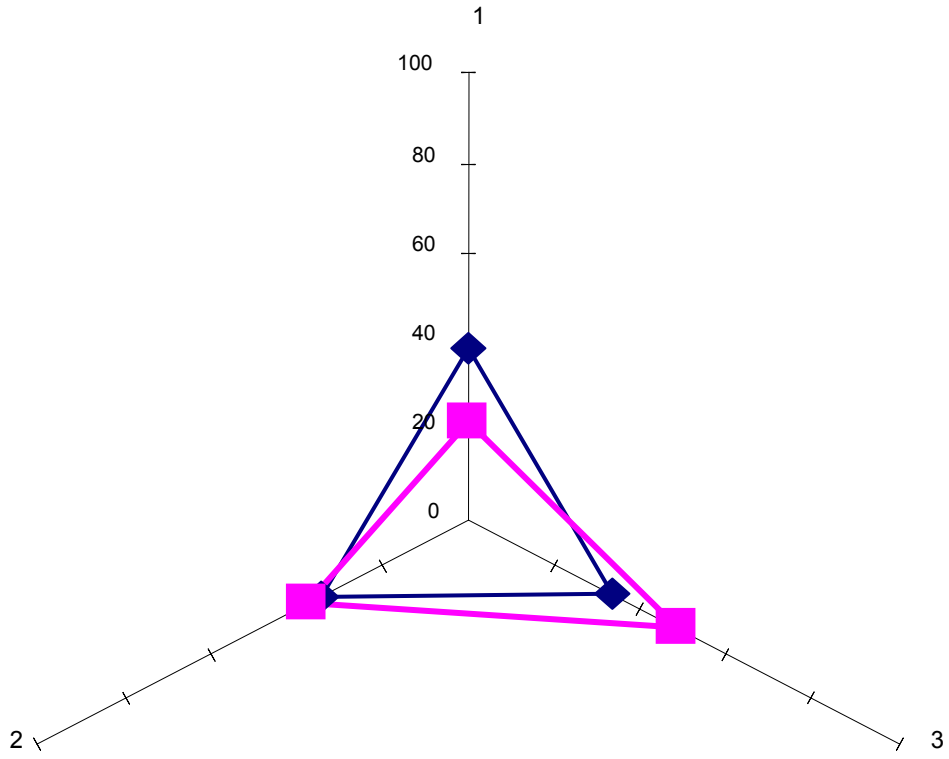
Similarly, using indicators measured in all components of the CSSA Framework, indices can be mapped as displayed on Figure 8. Again, one should refer to the "hard" data in Table 9 in order to interpret specific details represented by this figure.

Figure 8: Mapping the Situation in Six Components of the Sustainability Framework



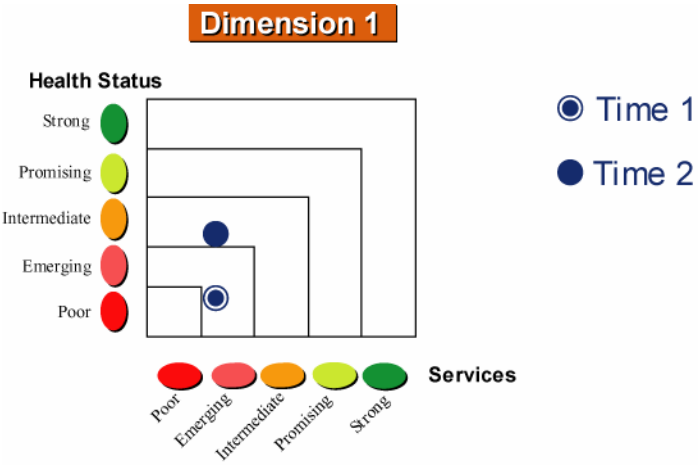
It is also possible to further aggregate each pair of components to create a dimension index. (It is even possible to create a single-value "sustainable health index.") The challenge is not in the arithmetic of the process but in remaining clear about how the information is reduced and what index measures actually represent (see discussion in Part III of this document). Figure 9 maps the situation toward sustainable health on the basis of three dimension indices.

Figure 9: Mapping the Situation in Three Dimensions of the Sustainability Framework



It is also possible to present the situation of the six components with a different display. Two components of the same dimension can be represented on the same graph (Figure 10). One component is on the x-axis, and the second is on the y-axis. The intersection of the vertical line (x value for component 1) and the horizontal line (y value for component 2) plots the situation of the dimension.

Figure 10: Hypothetical Dashboard for Dimension 1



However you choose to present your data, remember the three simple rules presented in Part III of this report:

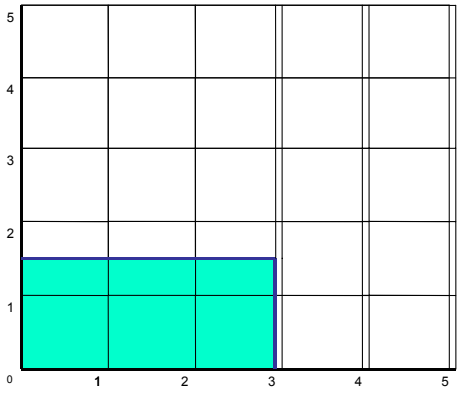
1. **Know your audience:** Consider the information needs of the audience and provide the information that is relevant.
2. **Know your data:** If you cannot explain clearly how an index measure was created and what it means, then do not confuse the audience with it.
3. **Know what decisions hang in the balance:** Choose what to look at (detailed indicator versus big picture index) depending on the type of question asked and the nature of the decision to be made.

Annex 10. Sustainability Dashboard—Present State of PROCOSAN in Three Dimensions

Annex 10. Sustainability Dashboard—Present State of PROCOSAN in Three Dimensions

Dimensión I

Calidad y Alcance de los Servicios de Salud Pública



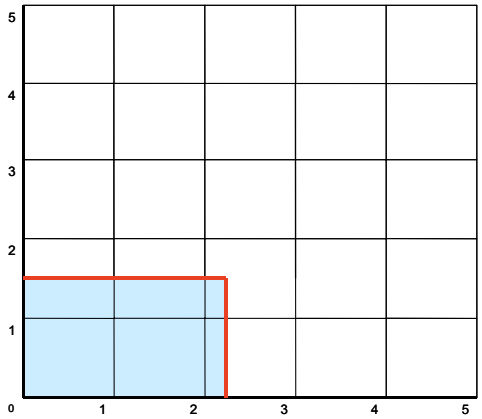
Estado de Salud de la Población beneficiaria

Dimensión II

Actores:

1. MINSA
2. ONG
3. Sector Privado
4. Alcaldía

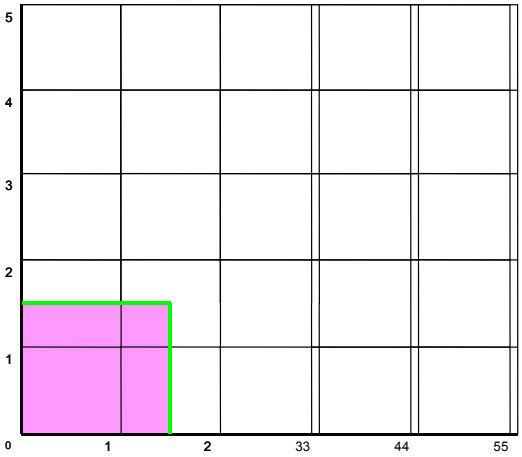
Viabilidad de la Organización



Capacidad Organizacional

Dimensión III

Ambiente Político, Económico y Social



Capacidad Comunitaria