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The Complexity of Non-profit Administration in Global Development: A Case-Study on Neonatal Mortality

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The Complexity of Non-profit Administration in Global Development: A Case-Study on
Neonatal Mortality

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Abstract

In 2015, 5.9 million children died with 44% of those deaths occurring in the most vulnerable period of life: the neonatal period (first 28 days of life). Because this is such a pervasive problem, in order to meet the United Nation's third Sustainable Development Goal of reducing the global neonatal mortality rate down from 27 to 12 deaths per 1,000 live births, there needs to be more evidence-based, effective interventions. Thrive Networks addresses newborn mortality by improving facility-based care in low-resource settings via intensive training and lifesaving medical equipment built to operate in these conditions. Despite all of the evidence Thrive has depicting the success of their programs, they have decided to close down the Health Program due to a litany of moving parts ultimately forcing their hand to refocus and re-strategize their resources away from providing newborn interventions. Since this circumstance does not occur in a vacuum, it is important to understand why nonprofits like Thrive struggle to sustain their programs when they have potential to address the world's direst problems. A systematic review of academic literature attempts to find qualitative and quantitative measurements to understand nonprofit program closure and continuation. Thrive operates as a case-study in how these measurements can make sense of the closure of its Health Program.

Relevant Acronyms

WHO – World Health Organization

BoL – Breath of Life

MDG – Millennium Development Goals

SDG – Sustainable Development Goals

OECD – Organization for Economic Development and Cooperation

NMR – Neonatal Mortality Rate

U5MR – Under-5 Mortality Rate

DALY – Disability-Adjusted Life Years

EMW – East Meets West

USAID – United States Agency for International Development

MTTS – Medical Technology

IN – International Training

OUT – On Unit Training

TOT – Trainer of Trainers

ToC – Theory of Change

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I. Introduction

Public health and the nonprofit realms are a saturated domain, where the seemingly surplus of funds is only stymied by the sheer litany of organizations attempting to outpace the competition. Organizations rely on cutthroat tactics among austere industry leaders all attempting to change the world for the better. In tandem, funding organizations are desperately attempting to provide the funds create dizzying sense of bureaucracy that reigns triumphant over benevolence. That being said, when dealing with the betterment of entire nations and presiding over massive populaces, accountability is intrinsically crucial. As a result, the nonprofit dominion over global health is treated like any other capitalistic market.

These interpretations of the public health nonprofit world were echoed during my fieldwork at Thrive Networks. Thrive is an international nonprofit that provides evidence-based programs and technologies for underserved populations in both Asia and Africa. They provide interventions categorized into three programs: Health, Water/Sanitation, and Education. Thrive Water's programs help communities obtain clean water, improve sanitation and practice better hygiene behaviors. Thrive Health's newborn programs improve healthcare in developing countries to enhance the care of newborns. Thrive Education's programs improves the educational outcomes for impoverished, at-risk students through scholarships and intensive tutoring.

This paper detail the results of my fieldwork experience as the Health Intern at Thrive. I begin by providing some background on neonatal health outcomes and the United Nations' (UN) Millennium Development Goals initiative (MDGs). That is followed by a brief telling of Thrive's history, how their newborn programs address neonatal mortality, and the role I played in the organization. This leads into a discussion about the fragility of nonprofit funding as a

result of Thrive Networks closing their Health Program halfway into my tenure as an intern. Followed by a systematic review of understanding nonprofit sustainability. I conclude by discussing the policy implications on this work.

Questions of how to properly spend money in order to fish nations out of developing world statuses are ambiguously answered detracting from any actual altruistic benefit. Long story short? Because of the difficulty in ascertaining the most advantageous means of alleviating poverty and mortality, scores of short lived organizations prop up with new strategies only to end up among the gratuitous casualties that litter the battleground that is the not-for-profit global development sector (The Nonprofit Science Fund). My time at Thrive Networks has been a crash course in learning how promising interventions can be curtailed by inaccessibility of money. As a result of diminishing access to funds the same program I spent over three months appropriating is ramping down its efforts and escalating its withdrawal from providing vital newborn health programs that had a dirge of evidence of success in reducing newborn and maternal mortality while simultaneously bolstering overall healthcare systems.

While this dynamic shifting of prioritizing programs and shedding of weight is not a rare occurrence, I had the opportunity of experiencing the tectonic shifts whilst simultaneously in both the foreground and the background (Nonprofit Science Fund). As a product of my tenure with the organization, my role was fixed and included an end date. That was not the case for several of my colleagues. This imbues my fieldwork with a sense of urgency and peculiarity. The largest change I was to experience could have been situated on either side of the scales of fortune. On one side the importance of the work I produced thus far for future endeavors is reduced in opacity. And on the other, refocusing the abundant evidence and materials Thrive has built is an exciting and honorable task. Thus my story is full of subplots and timelines

unbeknownst prior to employment. The story of how Thrive has changed the world is contemporaneous with the fragility that nonprofits operate under. If an organization as magnanimous and promising as Thrive can experience the demise of such a large and beneficial program in such a fashion, it truly cannot be the only one. It feels important to look at the quietus of similar organizations under similar circumstances in order to strategize the most efficient means of providing assistance to developing countries.

II. Background

There is a litany of words one can use to illustrate the period of time following birth. No matter which specific term you end up using, every human alive has progressed through it independent of the complications they may have experienced. While that is true, it is impossible to deny that the resources and knowledge of the most effective ways to protect newborn babies pre- and post-birth can be as perforated as it is important. The first twenty-eight days of everyone's life (the neonatal period) are more vulnerable and consequential than all the days that follow (WHO). The proliferation of possible complications in those first days should remain a testament to the importance that period plays, yet the gap in the rate of neonatal mortality between countries is both disconcerting and omnipresent.

In 2015, over 5.9 million children died, with 2.6 million occurring solely in the neonatal period (WHO, 2016). In other words, five newborns twenty-eight days or younger die every minute. What makes that reality even more frightening is by accepting this as an overall average, because it illustrates the vast differences between the countries with the resources to address complications and those that cannot. According to the World Bank, in 2015 the neonatal mortality rate (NMR) for high-income countries was four per 1,000 live births. The NMR for

low-income countries is almost seven times higher at 27 deaths per 1,000 live births. The silver-lining is that in just 25 years the NMR for high-income and low-income countries have dropped respectively from 8 and 49 back in 1990 (The World Bank Group, 2016). The ambiguity of numbers can be deceiving, because the NMR, despite a fervent increase in global development funding has dropped much quicker in the developed world leaving the developing in the dust.

The problem of neonatal mortality is multifaceted; moreover, one could argue that the avoidable statistics underestimate the true incidence. NMR estimates might fail to account for stillbirths and the sheer amount of unreported deaths in rural areas throughout the developing world (Every Woman Every Child). NMR also fails to capture the full extent of the risk factors associated with the neonatal experience. The morbidity that results from newborns suffering complications can often persist for the rest of their lives, and is difficult to fully quantify let alone articulate this effect.

Morbidity is an invisible ubiquitous problem that permeates into all facets of a country's future as it continually drains already weakened medical systems. The best way to measure morbidity is via a measurement called the disability-adjusted life year (DALY). The WHO describes the computation of one DALY as "one lost year of 'health' life... [and] can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability" (WHO, 2004). In 2014 neonatal infections ranked as the tenth leading cause of DALYs worldwide. This paints an interesting picture because when grouped by income, neonatal infections rank sixth for low-income countries in the overall burden of disease yet does not even make the top ten for both middle- and high-income countries.

In order to paint a more accurate picture of how NMR affects a country, one must delve into both the quantitative and qualitative factors contributing to the vast chasm between developed and developing countries. Not all signs of mortality are a product of the assumption that strong economies equal strong health care systems. This can be seen in different ailments including chronic diseases like diabetes and heart complications. Despite this, the circumstance of newborn mortality often follows traditional patterns of growth in developing countries. Through scores of research, the measurements of both neonatal and maternal mortality rates are accurate indicators of a country's overall health care system. Despite difficulty in ascertaining a measurement that depicts the strength of an overall health care system as a result of disagreements on what constitutes a successful system, data points towards a correlation between them. As a result, by increasing efforts in reducing the NMR and MMR you are simultaneously bettering overall healthcare systems. The computation of reducing the NMR is a straightforward connection, but the parallel of addressing neonatal morbidity is opaque and is nearly impossible to gauge.

Aid member states of the Organization for Economic Development and Cooperation provided over \$131.6 billion to the least-developed countries in development assistance in 2015 (OECD). This staggering amount of money allocated to alleviating the world's most pressing problems should be reassuring. The unfortunate reality is that the money diverted into a smattering of different organizations is misappropriated and a vast proportion is wasted on nonprofit organizations who either cannot wrangle consistent funding, or foundations and grantees do not have reliable, measurable criteria to ascertain what organizations provide sustainable interventions. The cumulative experience working for a global development

organization was a perfect case study on the messy, complicated process of obtaining funds to continue interventions on neonatal mortality in low-resource countries.

A. From MDGs to SDGs: more than the difference of one word

The literature emphasizes that estimates of NMR are difficult to calculate and, if anything, investigating true mortality rates is unknown due to a number of deaths that go unreported or are incorrectly classified (Measure Evaluation). The available statistics paint a grim picture.

Despite the worrisome statistics, the NMR has improved over the last several decades, mostly thanks to the establishment of the Millennium Development Goals (WHO). Under the ambitions of the MDGs were a beautiful example of the world attempting to unite and tackle all of the most insidious problems that make up the gap between being a nation considered developed or undeveloped. Under the collaboration and agreement of over 190 United Nations member states, participating countries agreed to undertake eight time-bound goals in the hopes of mitigating some of the most insidious problems separating developed and developing countries. The goals included:

1. To eradicate extreme hunger and poverty
2. To achieve universal primary education
3. To promote gender equality and empower women
4. To reduce child mortality
5. To improve maternal health
6. To combat HIV/AIDS, malaria and other diseases
7. To ensure environmental sustainability

8. To develop a global partnership for development

Despite being forward thinking; in reality these goals were much more nuanced than in print. Nations and foundations alike made huge strides to meet the MDGs, and despite impressive gains, the targets remain largely unmet (WHO). The MDGs had a very interesting effect on NMR. Because measuring child mortality can be an arduous process, money was readily available, but little was specifically allocated to newborn interventions. The MDGs accelerated addressing child mortality, but because neonatal mortality was not differentiated from the overall children under-five mortality, NMR simultaneously reduced in numbers but increased in percentage of child deaths. This momentum did not proportionately address newborn mortality neonatal period. MDG target 4.A called for a reduction in the under-five mortality rate (U5MR) by two-thirds by 2015. By the end of 2015, the rate had dropped by more than 50%, from 12.7 to 6.3 million deaths per year. While short of the two-thirds goal, 50% is an undoubtedly an impressive improvement. Most of this improvement was seen in children outside of the neonatal period as there was no attention drawn towards addressing the NMR specifically (WHO). Indeed, in conjunction with an overall decrease in U5MR, researchers observed a simultaneous increase in the percentage of newborn mortality from 37% in 1990 to 44% in 2013 (WHO). This result illustrates the vulnerability of the neonatal period is and the need to provide specifically tailored interventions that explicitly target this demographic.

In order to continue development and hasten progress, the UN established a nonliteral sequel they called the Sustainable Development Goals (SDGs). The aim of the SDGs was to pick up where the MDGs left off, with alterations that are more comprehensive in scope and focus on sustainability. Regardless of the similarities, the SDGs breathed new vigor into the global community. As the name insinuates, the focus is on change rooted in sustainability. This time

around the SDGs were a product of international negotiations that included middle- and low-income countries, where the MDGs were mostly determined by OECD nations. Because of its universal approach, the SDGs included facets dedicated to covering economic growth, job creation and reducing both inequality and poverty. The third goal of the SDGs is to “ensure healthy lives and promote wellbeing for all at all ages.” With a revamped orientation on reducing the NRM, funding mushroomed.

III. Stepping stones: present day Thrive

Thrive Networks’, formerly known as East Meets West (EMW), origin story begins almost thirty years ago when East Meets evolved from one single Vietnamese woman fleeing the Vietnam War to the United States and began to offer a bridge between the two countries for those who were interested in bringing about world peace. Five years later in 1993 EMW received a grant from the United States Agency for International Development (USAID) to build a shelter for 136 impoverished children from Central Vietnam. The project was called Village of Hope and provided displaced and disadvantaged children a safe haven where they could obtain a full education, job training, and other skills helping facilitate their re-assimilation back into Vietnamese society. The Village of Hope is a prominent precursor for Thrive’s current Education programs, as well as the beginning of all that Thrive has come to accomplish. Thrive has a strong, holistic approach to addressing international development and has operated in three different sectors: Water/Sanitation, Education and Health.

As is the story with many nonprofit organizations, Thrive Network underwent a rebranding after it merged with several other organizations. The aim was to build off of resources resulting from merging with five separate organizations which together would constituting

something bigger than the sum of their parts. As a story of stories, the partnering with six other organizations helps paint a picture of the type of organization Thrive wanted to be with the Health Program becoming a larger and more comprehensive component (see Table A for the history of Thrive Network's mergers).

Together with Thrive's major programs, these organizations make up the combination of Thrive's evidence-based programs that operate in nine low-income countries. Together, the total beneficiaries to date reaches almost 3.4 million, with an estimated 890,000 this year. Thrive's health program, formerly known as Breath of Life (BoL) aims to improve facility-based care in low-resource settings through evidence-based interventions built upon the pillars of innovation, research, and capacity development. Through academic research on newborn health, it is apparent that one of the best measurements of a country's healthcare system is simultaneously its least funded and prioritized sector: newborn health (Every Woman Every Child). The reason newborn health remains continuously invisible in plain sight is for a many reasons. One involves the ambiguity of terminology. In academia the words used to describe children over a certain age are regularly used interchangeably, including: infant, newborn, neonatal, baby, and others. While it is agreed upon that child mortality measures the rate of death among under five year olds, where that stage begins and an infants' ends is contentious. As a result, neonatal health can often be overlooked and overshadowed despite being inherently critical to the development of a nation (as can be seen with the product of the MDGs).

Thrive develops the capacity of hospitals in low-resource settings through a sleuth of innovative medical devices and research. In a partnership with a private Vietnamese manufacturing company called Medical Technology Transfer Services (MTTS), Thrive reduces neonatal mortality and morbidity via medical devices built to operate in the low-resource settings

of Asia and Africa. In combination with the range of medical devices, Thrive provides clinical education on newborn care. They address NMR by training doctors and nurses to effectively operate provided durable medical equipment, supporting equipment maintenance, providing nurse mentoring and ensuring the effectiveness of their interventions via research, monitoring and evaluation. Since 2003, Thrive's Newborn Health Program has treated 450,000 newborns from 350 hospitals in 14 different countries.

The problem of utilizing life-saving medical devices is not access but usability. The WHO estimates that upwards of 80% of medical devices in developing countries were either funded or donated to their hospitals (WHO). Despite the well-intentioned gifting of these devices, it can be argued that these donations end up doing more harm than good. The WHO approximates that between 10 and 30% of these devices are ever used (WHO). The reasons are tenfold. Often the devices are too power-hungry and compromise fragile hospital power systems. Inherently important supplies to run or monitor the devices are often missing. When one of the devices breaks down, recipients rarely have access to the right supplies and training to fix them. When it comes to life saving equipment like neonatal warmers and phototherapy machines, donated devices can literally mean the difference between life or death. This incidence is exactly what MTTS sought to fix by developing machines that are built to work in the conditions they operate in.

IV. Overall project plan, including learning objectives

Despite the tumultuous evolution of Thrive's health programs my role included several consistent goals in concert with a few that dithered as time progressed. The first was simplistic in nature and was to become informed on the topic of mother and newborn mortality. This

encapsulated several objectives which branched into multiple activities. The first objective involved learning about the history of treating neonatal mortality in the larger global context. The activities that branched from there concentrated on how the MDGs affected NMR rates in the low-resource countries that Thrive has interventions in, followed by how the MDGs have evolved into the SDGs and what that means for addressing NMR. Despite similar goals, the difference in terminology has had a huge impact on how the world responds to addressing NMR. It was also important to look at the different interventions established to get a better understanding of what made Thrive unique. This was to then be compiled into a database that allowed future internal use in drafting grants and program proposals.

The second goal was to format and edit the training materials Thrive Networks uses to educate hospitals that were utilizing MTTS' machines. The trainings were an accumulation of modules that broke down not only specifics of the individual machines but dove into the intricacies that caused diseases specific to newborns mortality and morbidity. The trainings were organized into four programs. The package that contained modules to address neonatal jaundice acted as the master used to concoct the following three trainings. Each module included three tiers: the IN, TOT, and OUT packages (see Table E). The audience for each package differed, so the information provided had to be adapted to fit their necessary knowledgebase. It started on the macro-end with the IN (international training) package, and got more detailed with the TOT (trainer of trainers), which was a less technical remodel of the OUT (on unit training) package. The IN was coordinated to provide executives and directors of the hospitals a higher level overview of the machines provided and the way they addressed the health concern of interest. The TOT package facilitated ownership over the intervention as they were then responsible to disseminate the information to the employees who were to actually

use the machines in a clinical setting. The OUT packages were very similar to the TOT, but provided further context on the inner-workings of the machines, and what information was needed to operate and maintain them. The action of having staff facilitate the trainings is an integral aspect of global development, where through being accountable for understanding the interventions allows for program sustainability.

There were three training packages that needed reformatting and editing. The first addressed infection prevention. The second involved interventions for hypothermia and hyperthermia. The third was for respiratory complications. All three required standardizations of their packages so that both individuals running and those receiving the trainings could do so in as simple and straightforward of a manner as possible. This required working off of the already completed neonatal jaundice package and making sure they matched in flow and consistency. Within the packages were the presentations in the form modules and submodules with accompanying supplemental information and videos, pre- and post-tests to ascertain preliminary understanding followed by measuring knowledge acquisition of diseases and the interventions used, certifications showing completion of modules, detailed information on activities to encourage participatory learning, and forms to receive feedback on the trainings. This entailed a lot of work in PowerPoint altering verbiage, word flow, modification of images and examples, and overall formatting of the presentation. Each and every package has their own idiosyncratic issues that involved research and attention to detail because these trainings were to be seen by thousands of health workers in numerous hospitals all around the world. The overall goal was to make sure anyone can take one of these packages, follow instructions and attain the skills to instruct employees on every aspect of each intervention and the machines involved.

The third goal revolved around solidifying funding opportunities for future use. This included researching applicable grant and other occasions of obtaining funding. Using a program Thrive used to record past, present and future funders, employees would be able to see what grants to focus on currently versus what to save for future endeavors. Funder information ranging from foundations to private donors were recorded with relevant notes depicting the correlation of grants to Thrive's funding needs, and modes of networking within that organization. This was to be an important objective to ensure the Thrive's health program continually had the resources to persist their interventions. With the organization's decision to close down their health interventions, this became nonessential and forgotten.

There were numerous other objectives that came and went as the interventions evolved. For example, formatting and editing pertained not only to training materials but documents used for program reporting and intervention evaluations for current and future granters and private donors. Because one of Thrive's role in global development, ownership of program implementation was omnipresent. This is one of the organization's core values which resulted in data and information being shared by non-native English speakers. This required frequent adaptation of documents to ensure ease in understanding and consumption of relevant materials.

V. Conceptualizing nonprofit sustainability

The reasons behind Thrive's closure of their Health Program is multifaceted and difficult to understand. Historically Thrive has had little difficulty in finding sources of money for their water and sanitation projects, but the health program is another story. Because Thrive's work is global development, program ownership and capacity is one of their main focuses. This is mildly

oxymoronic because upon circumspection, Thrive's health program has done its job when they render themselves useless. This does not make much sense in any business model but is a core feature of development work. Is the structure of nonprofits in the development sectors facilitating organizational collapse? The health program uses funds mainly to manage trainings and purchase medical the devices for their interventions. If you calculate the percentage of funds that are allocated to program implementation and overhead fees, upon initial implementation of a program the dispersal makes sense: a majority of the funds go to providing the program. But once the hospital is self-sufficient and able to manage itself, the amount of money spent on program preservation goes way down without the cost of purchasing devices and the lack of offered training. Even if the amount spent on overhead does not change, the overall percentage skyrockets as a result. In order to maintain accountability, the majority of grants describe the amount allowed to go to factors like overhead. The majority of the money is not allowed to be funneled into things like employee salaries and office fees. No matter how much money Thrive is able to obtain, they have to properly appropriate funds forcing their hand in either growing in order to decrease overhead percentage, or decreasing vital services within overhead. Diving into the process of ascertaining why the closure of most their health programs resembles an arduous scavenger hunt dredging up more questions than answers. The smattering of clues was disconcerting, because initially it was so difficult to accept that scalable and sustainable programs like the neonatal interventions Thrive provides were ultimately unable to maintain due to funding complications. The preponderance of disappointment was only overshadowed by the overwhelming feeling that this cannot occur in a vacuum. Thrive's struggle must echo that of multitudinous likeminded nonprofits, and how this orchestra of whispers did not reverberate through the nonprofit and global development community was baffling. Ultimately several

questions loomed in the foreground. Thrive’s case study attempts to answer the following questions:

- What are the qualitative reasons nonprofits struggle to find funding?
- Are there quantitative measures that illustrate patterns of nonprofit closure and/or continuance?
- What can nonprofits do differently to proactively sustain their programs and futures?

As often is the case with searching for answers to the world’s most pressing problems, questions can perpetuate further questions rather solidify answers.

A. Questioning for quantitative answers: a holy grail, or a grail full of holes?

The initial conducting of research can be a dichotomous experience. Wading through relevant academic materials tends to either be littered by a preponderance of data, or one of great scarcity. The sheer quantity of terminology escalates the difficulty by the ambiguity of sought information. A perfect example of this is exactly what seems to demarcate successful nonprofits from those that are not: sustainability. Upon conducting systemic research, sustainability reigns as the differentiating factor. The problem of exactly how to measure something as vague as sustainability is intrinsically important when using it to delineate success from failure. The best example of a sustainable program can be described as one where “development meets the needs of the present without compromising the ability of future nations to meet their own needs” (Shediac-Rizkallah and Bone, 1998). But context is important. The terminology used often interchangeably to describe sustainability according to Shediac-Rizkallah and Bone is shown in Table B.

Project sustainability, developmental sustainability, organizational institutionalization, organizational standardization, and health promotion capacity all generally used to describe the process of a nonprofit's success and continuation. Despite the interchangeable use, they are not synonymous. Shediac-Rizkallah and Bone argue that there are three frameworks of organizational sustainability that allow you to conceptualize and measure the sustainability in the context of development. Using these frameworks, you can begin to understand how you can measure a development program's sustainability.

1. Maintaining health benefits achieved through the initial program.

This perspective provides insight into the different methods of tracking health-related behaviors and facilitates the continuation of controlling diseases that programs target. According to Shediac-Rizkallah and Bone, "both practitioners and researchers agree that many programs are prematurely terminated, resulting in recidivism in negative health outcomes." This can be seen through the complexity of attempting to control either or both infectious and chronic disease. This revolves around the assumption that preventative interventions to sustain behavioral-changes requires a slow ardent process that is achieved by focusing on education and social change. Often to preserve change the education and social interventions need to be fixed for following generations to be exposed to them, thus sustaining the targeted behavior change. This can be seen in an enumeration of examples like measles and tuberculosis. In 1990, a mass measles immunization campaign took place in Natal/KwaZulu, South Africa. A drastic reduction in measles admissions to the national Clairwood Hospital took place for twelve months following the campaign. But as a result of failing to maintain vaccination coverage levels measles admission rates rose to above pre-campaign levels less than two years later. This

example illustrates how poor project sustainability can expedite program failure and even exacerbate epidemics (Karim, 1993). The importance of assessing the potential re-emergence of targeted health programs instills responsibility in project sustainability.

Another recent example involves the “return of tuberculosis [which] has been attributed by some to sharp reduction in funding, leading to the breakdown of the infrastructure to maintain effective long-term control” (Shediac-Rizkallah and Bone, 1998).

2. *Continuation of the program activities within an organizational structure.*

This perspective offers a conceptual approach to how new programs become incorporated into the nonprofit allowing for organizational standardization. Robert M. Goodman analyzed a quantitative measurement of a programs institutionalization within an organization. The measurement is called the level of institutionalization (LoIn) and attempts to depict how integral the program is to the organization. The use of LoIn has the possibility to demonstrate how sustainable an intervention is within an organization and the community it targets. With this perspective, nonprofits can obtain quantitative evidence that can translate into guaranteed funding.

3. *Building the capacity of the recipient community.*

This perspective encourages accountability through community ownership. The promotion of ownership builds off the idea that participation together with ownership generates increased competence and capacity. By these means, programs that adapt to cultural norms and motivates community ownership greatly increases program sustainability.

Shediac-Rizkallah and Bone argue that the most important aspects that influence a program’s sustainability is the strength and fidelity of their initial program, how that program fits

into the organizational structure, and the capacity of the community in which you are implementing your program. Despite a few mentions of possible quantitative measures there does not seem to be much new information here which leads one to conclude there is too much complexity in program implementation to agree upon specific data to measure it.

B. Too many reinventions of the wheel

There has always been an interest in program sustainability, but oddly enough this has not evolved into any set of operational definitions or research paradigms. Instead of formulating universal definitions, variables and methods of data collection for analysis of program sustainability, nonprofits are “frequently reinventing the wheel in this area of research because researchers from diverse areas of specialized content do not know what sustainability research has been done” (Scherer and Dearing, 2011). One problem is that much of the data acquired to argue for a program’s continuation relies on self-reported data conducted via detailed questionnaires. This opens results up to biases nearly impossible to control for. It also rejects the ability to perform any comparative analysis for lack of methods to measure. A well-designed research paradigm is imperative to evaluate program sustainability, especially when funders are choosing between multiple equivalent programs that ultimately influence the health of the public. This begs the question, “how can we responsibly claim to assess effectiveness if we have no data on which interventions are most likely to be sustained in practice?”

Measuring a program’s sustainability requires data to measure. This argument feels simultaneously counterintuitive and circular. It bears an awful similarity to the chicken-and-the

egg scenario. Because of this, it seems this will only work upon initial adoption of a program and not retroactively.

C. A contemporary take on a traditional practice

David Hunter argues that the best way for organizations to prove their sustainability is to develop a theory of change (ToC). A ToC can be described as an illustrative product that states exactly how and why you want change in a chosen environment or situation. ToC in the context of building the capacity of a nonprofit to “deliver program reliability and sustainability” requires an output and an outcome. The output is something tangible, a blueprint that connects its programs into something valuable to the targeted demographic. The outcome is the how the organization will change as a product of the roadmap coming to its fruition. Hunter provides four indicators of a successful ToC. They are as follows:

1) *A nonprofit’s ToC must be meaningful.*

It must be drafted with an attempt to attain something valuable – that everyone can agree upon it being a good thing.

2) *A nonprofit’s ToC must be plausible.*

It is required to follow the traditional ‘if-then’ path – i.e. if x then y.

3) *A nonprofit’s ToC must be doable.*

It has to be realistic. *Your organization’s program can’t write a check that your target population can’t cash.*

4) *A nonprofit’s ToC must be testable.*

5) It needs a hypotheses and must be able to gather measurable data to support its claim.

It is through providing foundations with a concise, opulent ToC that they will prove their capacity for sustainability. The optimum way to facilitate the production of the ToCs is to develop workshops that instruct on the explicit means of drafting and editing a ToC to ensure organizations have the ability to convince funders through quantifiable data. The limitation derives from the ambiguity of choosing what data best represents their argument for their sustainability.

D. Constructing a measurement of measurements

If the argument for increasing program sustainability is providing standardized data to measure program success, the successive question is what can organizations do to better the likelihood of implementing programs that are successful? This question is difficult to answer because the variables that influence program success depends on innumerable factors impossible to standardize. Despite this, Joseph Dural and Emily DuPre in their review attempted to answer two questions correlated to understanding program success: how are program outcomes influenced by the impact of implementation, and what are factors that affect the implementation process? They write that “developing effective interventions is only the first step toward improving the health and well-being of populations. Transferring effective programs into real world settings and maintaining them there is a complicated, long-term process that requires dealing effectively with the successive, complex phases of program diffusion.” This process requires four phases for optimum program diffusion: dissemination (how well informed a community is about the value and existence of a program), adoption (whether or not a group/community decides to try said new program), implementation (whether the program was conducted well), and sustainability (is the program maintained over time). The best means of

understanding the relationship between the implementation process and program success revolves around measuring an organization's attention to these four phases. This implementation can be understood via eight aspects:

- 1) Fidelity: the extent that an innovation relates to the intended program
- 2) Dosage: the amount the original program was delivered
- 3) Quality: how well the main elements of the program are conducted
- 4) Participant responsiveness: how well the interest of participants is stimulated
- 5) Program differentiation: the uniqueness of a program's theory and practice compared to other programs
- 6) Monitoring of comparison conditions: measuring your program congruent to a control
- 7) Program reach: the level of involvement from the program participants
- 8) Program modification: how the program has adapted/changed since its origin during initial implementation

Durlack and DuPre sought to determine how implementation affected outcomes by answering two research questions. The first focuses on their primary assumption, does implementation actually influence program outcomes? In this instance they sought to analyze implementation in two different ways, firstly if the implementation was achieved in a continuous fashion (variable percentage which assesses the accurate level of dosage/fidelity) and dividing the groups into either high or low levels of implementation. To do so, they addressed five different meta-analyses that had a surprising amount of data to support their hypothesis. They found that the program which actually monitored implementation had an effect three times larger than the programs that did not report any monitoring. Via a regression analysis, implementation ranked as the second most important variable that ultimately influenced a program's outcome. If

a control was used to provide a comparative analysis on the probability that implementation would influence program success, programs were twelve times more likely to be effective. These studies yielded that “achieving good implementation not only increases the changes of program success in statistical terms, but also can lead to much stronger benefits for participants.”

Once the consensus that implementation does actually influence outcomes, they moved onto their second research question: what are the factors that affect implementation? This question is important because it looks to answer the degree in which found variables can affect outcomes and measure the capacity of sustaining effective interventions. This capacity is what fills the gap between research and practice. The variables that Durlack and DuPre found fell into seven categories and are shown in Table C.

They conclude that the magnitude of success for programs are two to three times higher for programs that carefully implemented and effectively resolve the problems that arise as a result of the variables from Table D. Obtaining data on these variables allows for organizations to accurately document the relationship between implementation and program success. Even though each and every variable has an important role to play in illustrating this relationship, several tend to have a greater sphere of influence. For example, the debate between adaptation and fidelity is vital and deserves extended discussion due to limitations in understanding it. It is difficult because “some interventions are more conducive to fidelity because they are highly structured and have accompanying detailed manuals or lesson plans, but many interventions do not have these features... the fidelity-adaptation debate is framed inappropriately in either-or terms, and suffers from imprecision in the measure of important constructs.” An often missed opportunity to understand a program’s implementation and comprehend its success is a lack of comparative analysis within an organization’s intervention. Frequently organizations shy from

comparison to controls because of the assumption they must be an intervention that represents zero treatment. Instead, as a practice of a program's adaptability, "compare the program already developed with the modified program you are suggesting to see how effective each one is in your setting." This allows you to see how well your program succeeded as a product of that adaptation and see the difference in implementation and success between the two implemented programs.

Durlack and DuPre acknowledge the limitations that the research analyzed here at best represents only one-third of the outcome research on prevention and promotion programs, and that their interpretations may differ from other researchers. That being said, there is strong empirical support that the outcomes of programs are heavily influenced by implementation practices, and they argue there are several areas of importance for the future research agenda. Some of them include:

1. Developing a consensus on the operational definitions and terminology for studying implementation that are theory-driven and involve both quantitative and qualitative features.
2. Data on the implementation must be collective throughout the process because it is not a static event but rather one that unfolds over time highlighting the importance of collecting data over time.
3. No program should be evaluated until a sufficient amount of time has been deployed for the implementation. How much time this requires varies with the complexities of the intervention. Some programs overestimate the level of implementation due to early data collection, and simultaneously some interventions can improve with each following year.
4. The monitoring of the implementation should occur with each major innovation component. Because many interventions have multiple innovative aspects to them,

organizations should be able to describe and understand the value of the different moving parts.

5. As with the analysis of the different innovations, data should be gathered on how interventions were perceived and utilized by different subgroups of participants.
6. An examination on implementation thresholds. Because more is not always better, it is possible that higher levels of implementation do not necessarily lead to better outcomes, especially once core components have already been delivered.
7. Researchers should be required to provide data on their implementation in order to assess its relationship with different program outcomes. Journals can require this for publication which would greatly motivate the research community to collect said data.

VI. Conclusion

Thrive Networks has had a long history of addressing neonatal mortality with interventions that show clear evidence of their effectiveness. Their programs focus on developing ownership and local capacity to address newborn health problems, which may simultaneously be their strength and the crux of their pitfall. Despite this, Thrive has decided to close their health program to focus on initial implementations instead of providing further newborn health programs. This is the result of many moving parts that are hard to quantify and understand.

A. Why do organizations fail?

Nonprofit organizations act like living breathing organisms. They are unique in their attempt to change the world, and in order to do so they must procure funding so that their

programs can see the light of another day. In order to receive the funds, they have to prove their worth, but problems arise as how to do that is more nuanced than it might seem upon initial circumspection. It is not enough to simply have a successful program, but organizations must find means to evaluate the level of implementation and argue for their sustainability. To make matters more difficult, there do not seem to be any consistent agreements upon what and how organizations should do this. As a result, programs continuously develop new means of evaluation without assuredness of their individual approaches. One would assume after the score of decades of nonprofit administration a set of standardized procedures would exist to facilitate evaluative measures, but the nonprofit community has not come to a concise consensus on how to do so.

The difficulty also stems from the administrative processes that dictate the development and management of nonprofits. Because these organizations operate under the necessity to be not-for-profit, the ways funds are managed involves a high level of organization which determines how much should be allotted to program implementation and overhead costs. The answer is not to diminish regulate the allocation of funds because this forces nonprofits to be accountable for their interventions. But there needs to be more evaluative measures to understand the leniency of how those funds are use within the organization. An example of this revolves around the amount of money used for salaries. On average nonprofits have much lower earnings, which sways more qualified employees to the for-profit sector, leaving nonprofits with less pull in harness more innovative staff. As with Thrive, the nature of global development work is derived from the focus on local accountability and ownership of provided interventions resulting in an altered budget misrepresenting the appropriation of funds for programs versus overhead.

This coupled with the fact that the essential aspect of development work is literally making your presence unnecessary and putting yourself out of a job.

B. Future implications and Thrive's legacy

From a bird's-eye-view, the nonprofit sector is overpopulated by organizations fighting for funding and a majority of them closing their doors. The superfluous amount of money that is appropriated to organizations with short lived interventions has enormous potential to further fund organizations with successful interventions. The need to argue for their sustainability provides an immense benefit to both funders and organizations alike by bolstering their ability to depict their ability to have long-sustain interventions that can bridge the gap between the third world and the first. Without these evaluative measures who knows if Thrive may have been able to influence funders on the importance of their programs. But in order to meet the SDG of reducing the NMR to 12 deaths per 1,000 live births, there needs to be more organizations like them.

The silver-lining is that Thrive's efforts are not simply dissolving into the mélange of nonprofit casualties but their packages have the ability to continue influencing and reducing the NMR in developing countries. By providing their packages for free online as well as included with purchases made from MTTS, hospitals can still implement their programs. This glass-half-full scenario still holds immense possibility, but Thrive will no longer help fund hospitals in the obtainment of these life-saving machines which undoubtedly will reduce the overall procurement.

Looking ahead there are numerous ways in which the realms of nonprofits and research communities can begin to influence program implementation. If funders and grantees begin to document and require agreed upon measures of evaluation and sustainability organizations will be coerced to obtain and measure institutionalization outcomes. The same can be said for journals publishing research on program interventions. The act of measuring program sustainability is incredibly complex due to the ambiguity of terminology and variables used for assessment which begs the question: why have we not yet developed standardized means of measuring program sustainability? This can only be done by practicing what the SDGs have done for the global community: by celebrating partnerships and coalitions that allow for cooperation and agreement upon what needs to be measured and how. Only then will the proper funds find the proper organizations to address the world's direst problems and cater equality to all those that are born, even in the neonatal period.

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Appendices

Table A. History of Thrive Network's mergers and partnerships

Organization	Description
Blue Planet Network	In 2013 TN added Blue Planet Network into their Water Program portfolio. Blue Planet Network facilitated a community of over 100 organizations to provide safe drinking water and improved sanitation in 27 different countries. They built and operated an online and mobile services platform that allowed member organizations to plan, manage, monitor and analyze their impact, allowing them to resolve problems early, minimizing inefficiencies and optimizing program benefits.
Reach Global	In 2014 Reach Global merged. Reach Global trained thousands of local community organizations throughout India via a network of social entrepreneurs on how to deliver behavioral change for millions of women and girls to facilitate solidarity

	and find solutions to their everyday problems. Their education programs have reach over 1.4 million women and girls in India's poorest states.
Coach for College	In 2014 Coach for College joined Thrive Network's growing portfolio. Coach for College is a service learning program that utilizes student-athletes from the United States and Vietnam to teach life skills and academics to disadvantaged Vietnamese children. Together over 700 American student-athletes and Vietnamese university students have taught more than 3,200 Vietnamese youth.
Hands to Hearts International	In 2014 Hand to Hearts International partnered with TN. Hands to Hearts International trains caregivers in early childhood development of vulnerable children across the world. They have developed scalable, replicable and cost-effective evidence-based trainings to a wide range of caregivers.
Embrace Global	In July of 2015 Embrace Global joined TN Health Program. In 2008 students from Stanford University designed and developed a low-tech, low-cost device that treats newborn hypothermia. It now operates as one of TN's life-saving medical devices.
Medical Technology Transfer Services (MTTS)	TN and MTTS formed a public-private partnership together in 2010.

Table B. Devices manufactured by MTTS and implemented in Thrive Network's Health Program.

Device	Use	Innovation
CPAP v3	CPAP (continuous positive airway pressure) therapy is an intervention that helps preterm and low-birth weight newborns who breathe spontaneously but inadequately. A successful alternative to invasive therapies like intubation and mechanical ventilation. Designed to protect airways that have been compromised by keeping the airways open enabling efficient capillary	<ul style="list-style-type: none"> • 100% reusable and cleanable with zero disposable parts. • Easily installed and maintained. • Gas mixing, humidification, PEEP chamber and air compressor all included in one unit.

	exchange for both oxygen and carbon dioxide in order to prevent collapse and obstruction of the upper airways, reducing episodes of apnea.	
Firefly Phototherapy	Highly effective, state-of-the-art phototherapy device used to treat neonatal jaundice. It features an intuitive design that is compact, has double-sided lighting, user-friendly controls and a removable bassinet. Designed to facilitate mother-child bonding and breastfeeding.	<ul style="list-style-type: none"> • Clinical evaluations show the design successfully reduces total treatment time by 40% (compared to a single-sided device) which allows for earlier discharge, lowering the incidence of infections and morbidity, as well as frees up resources to treat more infants. • Compact design allows for easy portability, fits in an infant cart or mother's bed for increased mother-child bonding • Design to be easily cleaned, sealed to keep out dust/liquids/bugs, and tight seams prevent build-up of dust • No moving parts or internal fans • Medical-grade power supply
Colibri phototherapy	The Colibri phototherapy device is compact, low-cost, and high-performance. Designed to be used simultaneously with any radiant warmer or incubator available in order to deliver effective PT treatment while simultaneously supporting developmental care.	<ul style="list-style-type: none"> • Long-lasting LED lights for an increased surface area, maximum exposure to LED lights, and high-spectral irradiance • Compact design with an intuitive control panel • Flexible mounting options which help with dosage of light ensuring prompt results. • The two canopies designed to not interfere with separate radiant warmers.
Lightmeter	A device that allows for the accurate measurement of the intensity of the blue light spectrum that is used to treat neonatal jaundice. This ensures that PT units are both working properly and determines when	<ul style="list-style-type: none"> • Developed to be used with the Firefly and Colibri PT units, but can be used with any PT machine that uses LED, fluorescent or compact bulbs. • Simple, compact handheld unit. • Two-sided measurement allows

	bulbs need replacement.	for the easy measurement of double sided PT devices (like the Firefly).
Hand sanitizer	Designed to address health-care associated infection (HCAI) the Optima hand sanitizer kit provides everything you need to create enhanced germ killing yet skin-friendly dispensing bottles to put on key hospital locations.	<ul style="list-style-type: none"> • Has all of the necessary ingredients and tools to create your own hand sanitizer that is low-cost and highly efficient.
Warmer	After birth newborns are thrust into cooler a cooler environment which limits metabolic capacity resulting from premature or low-birthweight. Allows for the safe control of patient temperature creating an ergonomic setting where care-givers are able to work efficiently.	<ul style="list-style-type: none"> • Designed to focus on enhanced functionality and performance. • Automatic control of patient temperature with a smart problem detector, safety fallback modes, and a LCD display that clearly shows set temperature, treatment time, total usage time, the power level of the heater, easy-to-open sidewalls, and temperature alarms.
Embrace (developed by students from Stanford University, not MTTS)	Low-cost device developed by students from Stanford University designed to effectively treat newborns suffering from hypothermia. Incredibly low-cost and low-power, it fills a key gap in care by allowing for the safe transport of newborns between health care facilities.	<ul style="list-style-type: none"> • Highly low-cost and low-power • Good quality of care for resource-limited settings

Table C. The different trainings offered in Thrive Network’s training modules.

Training Type	Targeted Audience
IN (international training)	Trainings created for head doctors and directors of the hospitals who were going to implement the BoL program in their

	hospital.
TOT (training of trainers)	Trainings created for doctors and staff who were in charge of disseminating the procedural information on the interventions to be used in hospitals.
OUT (on unit training)	Trainings performed by those who attended the TOT sessions. This is the most comprehensive training because it goes into all of the minutiae of what the interventions address, how they address it, how the machines work, and everything needed to know to run the interventions successfully.

Table D. Terms used to describe sustainability.

Term	Definition
Sustainability	The capacity to maintain service coverage at a level that will provide continuing control of a health program.
Project sustainability	The capacity of a project to continue to deliver its intended benefits over a long period of time.
Developmental sustainability	The ability to deliver an appropriate level of benefits for an extended period of time after major financial, managerial and technical assistance from an external donor is terminated.
Organizational institutionalization	The long-term visibility and integration of a new program within an organization.
Organizational standardization	The process by which new practices become standard business in a local agency.
Health promotion capacity	The extent to which a community has local access of the knowledge, skills and

	resources needed conduct effective health promotion programs.
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Table E. Factors which affect the implementation process.

1. Community level factors	
Politics	They can either hurt or help. This closely resembles leadership where it can either inspire or hinder compassion in the entire organization. If the trainers/implementers are committed to the intervention, it is much more likely to be effective than if not.
Funding	A huge causal factor but insufficient as it does not necessarily provide enough time and/or money to accurately implement.
Social policy	has a huge influence on whether new procedures and practices support the administrative and financial infrastructure of your program?
2. Provider characteristics	
Perceived need for innovation	Degree to which planned innovation is relevant to local needs.
Perceived benefits of innovation	Degree to which planned innovation will achieve the desired benefits at the community level
Self-efficacy	The ability to do what is expected from you.
Skill proficiency	Organization's possession of the relevant skills for implementation.
3. Characteristics of the innovation	
Compatibility	The level in which the intervention matches the mission, priorities and values of the organization.
Adaptability	How well a program can be modified or reinvented to fir the community's needs, values and cultural norms.
4. Factors that influence the organizational capacity	
Positive work climate	The measuring of employee's views on the organization's morale, trust and methods of resolving disagreements.

Organizational norms of change	An organization's openness to change, risk-taking and overall willingness to try novel approaches.
Integration of new programming	The level of incorporation of an innovation into their existing/predetermined organization practices.
Share vision	The degree in which members are united via a shared mission, consensus, and commitment to the overall value and purpose of planned innovation.
5. Specific practices and processes	
Shared decision-making	The level of openness in collaborating with local input, community participation and local ownership.
Coordination with other agencies	The ability to collaborate with local agencies to formulate partnerships and network to bring about different perspectives, skills and resources.
Communication	The components which encourage open communication.
Formulation of tasks	The procedures used to heighten strategic planning with concise roles and responsibilities relating to task accomplishments.
6. Staffing considerations	
Leadership	Important establishing consensus, setting priorities and the management of the overall implementation.
Program champion	A respected and trusted staff/administrator who is able to rally and maintain support, as well as negotiate solutions to problems that arise.
Managerial/supervisory/administrative support	The support providers receive from management and supervisors.
7. Prevention support system	
Training	Insuring the providers' proficiency and skills in conducting the intervention (providers' sense of self-efficacy).
Technical assistance	The resources provided to implementers after implementation has begun.

MPH Program Competency Inventory

USF MPH Competencies	Notes
1. Assess, monitor, and review the health status of populations and their related determinants of health and illness.	Practiced often when assessing academic materials about neonatal mortality worldwide and in developing countries.
2. Demonstrate the ability to utilize the proper statistical and epidemiologic tools to assess community needs and program outcomes.	
3. Identify and prioritize the key dimensions of a public health problem by critically assessing public health literature utilizing both quantitative and qualitative sources.	Utilized public health research in order to conduct a systematic review of literature pertaining to nonprofit program sustainability in both via qualitative and quantitative means.
4. Specify approaches for assessing, preventing, and controlling environmental hazards that pose risks to human health and safety.	
5. Apply theoretical constructs of social change, health behavior and social justice in planning community interventions.	
6. Articulate the relationship between health care delivery and financing, public health systems, and public policy.	Research on the complexities of public health administration and funding touched upon the relationships between healthcare systems in developing countries and the financing involved in funding interventions.
7. Apply evidence-based principles to the process of program planning, development, budgeting, management, and evaluation in public health organizations and initiatives.	
8. Demonstrate leadership abilities as collaborators and coordinators of evidence based public health projects.	
9. Identify and apply ethical, moral, and legal principles in all aspects of public health practice.	
10. Develop public health programs and strategies responsive to the diverse cultural values and traditions of the communities being served.	

11. Effectively communicate public health messages to a variety of audiences from professionals to the general public.	
12. Advance the mission and core values of the University of San Francisco.	

Student Evaluation of Field Experience

Student	
Student's Name: Paul Glantz	Campus ID #
Student's Phone: (415) 342-6514	Student's Email: pdglantz@usfca.edu
Preceptor	
Preceptor's Name: Danica Kumara	Preceptor's Title: Senior Program Manager, Health
Preceptor's Phone: (510) 763-7045	Preceptor's Email:
Organization: Thrive Networks	
Student's Start Date: 5/2/2016	Student's End Date: Hours/week: 8/11/2016,

Please use the following key to respond to the statements listed below.

SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree N/A = Not					
My Field Experience...					
Contributed to the development of my specific career interests	SA	A	D	SD	N/A
Provided me with the opportunity to carry out my field learning objective	SA	A	D	SD	N/A
Provided the opportunity to use skills obtained in MPH classes	SA	A	D	SD	N/A
Required skills I did not have Please list:	SA	A	D	SD	N/A
Required skills I have but did not gain in the MPH program Please list:	SA	A	D	SD	N/A
Added new information and/or skills to my graduate education Please list:	SA	A	D	SD	N/A
Challenged me to work at my highest level	SA	A	D	SD	N/A
Served as a valuable learning experience in public health practice	SA	A	D	SD	N/A
I would recommend this agency to others for future field experiences.	Yes			NO	
My preceptor...					
Was valuable in enabling me to achieve my field learning objectives	SA	A	D	SD	N/A
Was accessible to me	SA	A	D	SD	N/A
Initiated communication relevant to my special assignment that he/she considered of interest to me	SA	A	D	SD	N/A
Initiated communication with me relevant to general functions of the	SA	A	D	SD	N/A

2. Would you recommend this preceptor for future field experiences? Please explain.

Yes No Unsure

3. Please provide additional comments explaining any of your responses.

My time at Thrive Networks was great. The organization has wonderful programs and there is constantly work to be done. The problem in my experience was time since the organization decided to close the program I was currently working for. Luckily I still had work to do and I had a great experience utilizing this circumstance to my benefit.

4. Summary Report: All students are required to prepare a written summary of the field work to be submitted with this evaluation form.

The field work was a great experience. I was able to practice academic research, search from grants and other funding opportunities, format and edit training materials, edit relevant documents and more. Being able to have a direct effect on materials that are used by staff in developing countries to save lives is a wonderful experience. Despite the obstacles that I encountered as a result of Thrive closing down their Health Program, it was a very fulfilling experience and one I would recommend to any future MPH student at the University of San Francisco.

Student's Signature: _____



Date: 8/16/2016