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Sustainability of Private Voluntary Health Organisations in India: Some Methodological Issues

Barun Kanjilal and Suneeta Sharma

The paper discusses the key methodological steps to assess and improve the sustainability profile of private voluntary health organisations (PVHO) on the basis of a comprehensive conceptual framework. Sustainability is seen as a natural product of the transformation process—the transformation of the PVO–community relationship over time. Sustainability requires that the PVO move away from its original role of a provider, towards a role which is more facilitative, institution-based, strategically broader, and has a longer term horizon.

Introduction

The private voluntary health organisation (PVHO) sector in India is at a threshold. The 1970s model of the ideology-driven, individual-based, single-focused (comprehensive rural development) PVHO scenario is fast being replaced by an alternative paradigm of donor- dependent, organisation-based, service-oriented PVHOs. The structural change in the sector has gained momentum from the increasing attention and influx of funds from international donor agencies. The limited success of the public healthcare system to provide minimum healthcare to the poor and underserved has also helped trigger the entry of PVHOs into the public healthcare market.

A phenomenon gradually emerging out of this new paradigm of the donor–PVHO relationship is the *projectisation* of development. The PVHOs receive funds on the basis of a well-defined *project*. The projects are finite (with a beginning and an end), have clear goals and objectives to overcome specified problems, are based around defined sets of activities and have measurable outputs. Development, in this new

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paradigm, is largely packaged into bundles of activities, typically three and seldom more than five years in duration. The project framework, first introduced into official aid projects, is now the dominant planning framework for PVHOs.

Sustainability has assumed a new and indispensable dimension in this projectisation process. On the one hand, the PVHOs are required to package their inputs to deliver services through a professional time-bound mechanism; on the other hand, they cannot but see the futility of the process, if the services stop flowing (and thus the benefits of services) after a given period. The community may not be ready to share the expenses; workers may refuse to work without compensation; buildings, vehicles and other capital items would require recurring maintenance; and so on. The donors' funds, which come to help jump-start the development process, thus bring forth a potential opportunity to some and a threat to others, as far as extending the boundary of organisational role in social development goes.

The traditional concept of sustainability is based on the donors' perspective, which sees it as the ability of a health project or programme to deliver health services or sustain benefits after major technical, managerial and financial support have ceased (LaFond 1995: p. 28). The fact, however, remains that the life of projects beyond the time of the donors' involvement rarely reflects a self-sustained growth path for the recipients, especially in those situations where the donors' involvement did not go beyond a typical one-time financial contribution to the voluntary organisations. As mentioned elsewhere, development is not a one-time procedure like a vaccination with a lifetime effectiveness; therefore, simple infusions of outside resources rarely generate self-sustaining improvements in productivity and quality of life (Honadle and VanSant 1985: p. 2). In practice, therefore, many voluntary organisations seek to solve their sustainability dilemma by simply looking for another donor at the end of the project period (Harvery 1991).

The proper way to get out of the dilemma is to recognise that a strategy for sustainability, even by the donors' standards, does not necessarily imply a quick switchover to self-financing or a sudden transfer of activities to the resource-starved government. It is, rather, an opportunity to build internal capacity of the system so that, over time, it becomes less and less vulnerable to hostile external shocks. This strategy must be an integral part of the overall project design so that, from the very beginning, the project helps an organisation build three types of capacities (Kanjilal 1997):

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1. The capacity to secure sufficient resources locally;
2. the capacity to use resources effectively and efficiently to meet real health needs; and
3. the capacity to manipulate external favourable factors.

The major challenge is: How this can be done? The answer is not easily available in the literature since very little research has been done on the methodological aspects of sustainability efforts, especially in the context of PVHOs in developing countries like India. The present paper addresses this gap in knowledge. Specifically, it attempts to delineate the key methodological steps to assess and improve the sustainability profile of a PVHO on the basis of a comprehensive conceptual framework. The main objective of the paper, thus, is to provide researchers and practitioners in developing countries with a generic tool of assessment of sustainability and designing appropriate strategic directions to improve under a set of given constraints. Since the focus of the paper is on developing a theoretical ground for analysing sustainability of PVHOs, no attempt has been made to discuss the issues in the context of any particular set of PVHOs. A single case study, however, is added only to demonstrate the analytical power of the proposed methodology. The two following sections discuss the conceptual framework and methodological instruments for analysing major sustainability issues of the PVHO sector in India. The article then discusses the applicability of the proposed methodology through a case study on an Indian PVHO.

Sustainability of PVHO: A Conceptual Framework

The study attempts to define a conceptual framework for discussing sustainability issues and build the analytical blocks on the basis. The model is based on the premise that the benefits accrued from a project generates a transformation process—transformation of the PVO-community relationship over time. The benefits are less likely to be sustained if the project fails to initiate this process. Sustainability is thus considered a natural product of this transformation process.

The Indian experience shows that, in the beginning, a PVHO usually establishes its link with the community through direct provision of services to address the immediate needs of the people; it assumes the role of a *feeder* or a *provider*. Fixed and/or outreach clinics are set up; health

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workers start delivering services; and physical capital (building, vehicle, etc.) is built up to facilitate the provision of services. Almost the whole of the operating cost is covered by the project fund. The community, at this stage, is best described as an *absolute receiver of* benefits, that is, their needs are partially met without claiming any reciprocal responsibility.

Ideally, in the second stage, the PVO would engage in mobilisation of internal resources and manipulation of favourable but dormant factors of sustainability. It would not stop providing free (or heavily subsidised) services, but may scale it down. At the same time, the organisation would put its efforts more in the direction of mobilisation of resources, both internally and externally. It would involve the community in sharing the responsibilities, especially in filling up the gap of physical and human resources. For example, some of the clinical services (consultation, drugs, etc.) may now come with a price tag. Or, the community may be urged to contribute space, volunteers or other supports. Simultaneously, the organisation would look for additional external supports from donor agencies or the government. It would try to manipulate the potential funding sources to fill up the increasing resource gap. The community, at this stage, would partially respond to the PVO's deal; the response may manifest in dissatisfaction, negotiation or agreement to share the burden.

The third stage comes when the PVO is ready to act as a *facilitator* and the community is found to be totally concerned about the continuity of the project benefits. In other words, a healthcare system is built up and the PVO intensifies its rapport with the community through more comprehensive approaches, such as, generating need-based income-generating projects. Quality issues take a front seat since people start translating their need into demand, and respond with willingness to pay for care. The community, in such a scenario, may thus be denoted as a *responder*. The PVO, on the other hand, squeezes the extent of direct loan and subsidy to the community and invests on improving the quality aspects of services. For example, the staff associated with direct service delivery may receive higher level of training in the healthcare of women and children, more sophisticated equipment for preventive and curative care are purchased and so on. The major transition, however, is experienced in the internal management of the organisation, and the efficiency in allocation and utilisation of resources (human and non-human) receives greater attention. The PVO, with a broadened infrastructural base, more efficient management, and

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costs shared by the community, makes headway towards financial sustainability.

In the final stage, the PVO emerges as a successful organiser of the community so that the local community is prepared to provide time, resources and political support to sustain the programme benefits for the achievement of longer term outcomes even without any direct involvement of the PVO. In other words, the community assumes the role of an actual *participant* in the development process. The PVO, on the other hand, outlines a new and extended shape to its interface with the community. More emphasis is placed on addressing the people's need for *technical assistance* in their income-generating efforts and creating an appropriate atmosphere for applying modern technology of production.

The conceptual framework explained above may be denoted as a general optimum *pathway to sustainability of a PVO* when it starts as an absolute provider. It has three distinct characteristics: (*a*) sustainability of the benefits of a programme is modelled as a product of a dynamic interaction between the PVO and the community; in other words, the community's participation is an in-built ingredient in this model; (*b*) it is built on the proposition that, in developing countries, sustainability of benefits is closely linked, and sometimes synonymous to, the sustainability of the catalyst organisation (i.e., the PVO); and (*c*) financial sustainability cannot be meaningfully addressed unless the dynamic relation between the PVO and the community reaches a certain stage of development.

The reason why the actual transition of a PVO–community relation rarely follows the optimum pathway is simple: achieving optimality is not a self-propelling process. The progress needs a vision and consistent effort to break the barriers on the way, and an average Indian PVO hardly meets that need. Specifically, sustainability requires the PVO to attempt to move away from its original role of a provider, towards a role which is more facilitative, institution-based, strategically broader and longer term in the time horizon. The next section discusses how it can be done.

Instruments for Achieving Sustainability

The main argument of this section is that the transition of a PVO from one stage to the next, as explained above, becomes feasible only

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if it develops several social instruments. The instruments may be broadly categorised as;

1. Need-based projects,
2. organisational units at the community level,
3. service quality,
4. accumulated assets,
5. resource generator, and
6. resource manager.

Each of the above categories is discussed below.

Need-based Projects

For sustainability, it is absolutely necessary that the PVO gets involved in those services which are priority needs of the community. For example, PVOs working with sex workers must address the needs for STD control and treatment since this is the major health problem among them. A support service organisation (SSO) which provides technical assistance to PVOs must identify their real training needs and meet those needs. A deviation from the community's perceived needs, which is not so rare in the present Indian context, creates conflict and generates indifference among those for whom the services are meant. These benefits are hardly sustainable. The most rational way to address a community's real need and to ensure its effective solution is to avoid a top-down strategy, and involve the community from the inception (or planning) of the project, right through its implementation.

The Comprehensive Rural Health Project of JAMKHED provides an excellent example of need-based planning. *Mahila mandals* (women's groups) conduct a house-to-house survey each year to find out the health and economic status of the village. Based on these health surveys, they plan and carry out for the village, special programmes such as, organising eye camps, diagnostic camps for tuberculosis and other diseases, and immunisation camps. The *mahila mandals* also help in fixing user charges for medical services on the basis of ability to pay and in identifying the poor for exemptions (Arole and Arole 1994).

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Organisational Units at the Community Level

There is hardly any disagreement over the view that the community's participation in the development process, which is the most important ingredient for the sustained flow of a project's benefit, cannot be ensured without organising it in some way or another. The task becomes easier for a PVO when it commits itself to a certain ideology and keeps it as the guiding force for any kind of community service. A more common way is to set up small organisational units, such as youth clubs, *mahila mandals*, self-help groups, etc., and gradually empower them to take over a part of the PVO-initiated services. Alternatively, the PVO can utilise the existing local or governmental organisational resources (such as the Panchayati Raj Institutions or the existing public healthcare system) to share some of its activities. Failure to establish new or utilise existing organisational units often implies the failure of a PVO to penetrate the community and be acceptable to them.

Many NGOs have demonstrated their capacity to mobilise people into organised structures of voluntary groups to achieve common objectives. These groups take initiatives to become agents of change. For example, the Rangabelia *Mahila Samiti* maintains links with the community through hundreds of village groups and 28 zonal committees. The village group assesses the needs of the villages and sends village plans to the zonal committees. The organisational structure and its link with the community, established 20 years ago, have been sustained (Kanjilal et al.1997).

Service Quality

At the initial stage of development, the quantities get better scores in the assessment of project performance. Quality aspects, especially the provider's competence, accessibility, and acceptability—the three major quality attributes of a healthcare programme—are often neglected at this stage. A programme without sufficient quality assurance is bound to be self-defeating in the long run. For example, it is a common experience that a significant proportion of women who accept certain contraceptives through a birth control programme, discontinue their use due to health problems and method failure. Most of these drop-out cases could be avoided if sufficient attention is given to 'how' and not

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'how many', contraceptives are distributed. The fall out of this neglect of quality aspects is the plummeting rate of utilisation in the long run.

Accumulated Assets

The pathway to sustainability is a long-term process. It is expected that a PVO would accumulate physical and human assets during this process and create a strong infrastructural base. The physical assets may include building, modes of modern communication, transport, service equipment, etc. On the other hand, the human assets would consist of skilled manpower at service delivery points, trained management staff, good working conditions, etc. A PVO with strong asset base is less vulnerable to adverse external shocks and thus, is more prepared to switch over from one role to another.

Resource Generator

Sustainability requires a phased-down withdrawal of external support to its minimum. In other words, it is extremely important that the PVO identifies a range of alternatives, reliable local sources of fund (both governmental and private), and starts tapping these sources. Although it is hardly possible to achieve 100 per cent cost recovery through this process, especially for primary healthcare projects, the potential contribution of the local community should not be undermined. The success in resource generation substantially depends on the PVO's success in improving the community's economic well-being through income-generating projects and the people's willingness to pay. Together they define a process of resource generation and one cannot expect gliding up along the pathway to sustainability without consistent effort to keep the process alive.

Various innovative health financing schemes initiated in Co-operative for Assistance and Relief Everywhere (CARE) assisted seven states of India provide a successful example. Under their Integrated Nutrition and Health Programme, they initiated grain banks, drug fund, community health fund and a service fee on health days. The revenue is generated, managed and utilised by the *mahila mandals* (Sharma et al. 1998).

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Resource Manager

Resource generation is self-abortive if it is not associated with an effective and efficient resource management process. Inefficient management of resources ultimately takes its toll in terms of spiraling recurrent cost and increasing tension. Without an effective instrument of resource management, the PVO is likely to be caught in a low-level equilibrium trap. Cost reduction measures taken by different NGOs include expanding coverage without increasing the number of workers (worker–client ratio), staff reduction, use of part-time instead of full-time workers, sharing of office space with others, renting out unnecessary office space and bulk purchases. For example, in the Himalayan Institute Hospital Trust, the maternal and child health (MCH) budget under the State Innovations in Family Planning Services Agency (SIFPSA)-funded project was reduced by 50 per cent during 1995–97. As a result, they are now offering MCH services with an added reproductive tract infections (RTI) and sexually transmitted diseases (STD) component to the people at 50 per cent expenditure (Sharma 1998).

The argument presented above implies that in order to achieve sustainability, a PVO must develop the given instruments to their optimum level. The crucial question is: How can the managers of donor-supported health projects do this? Following Brinkerhoff (1992), one can suggest the following three kinds of perspectives for a programme manager: looking out, looking in and looking ahead.

Looking out means relating with the context or external environment surrounding the project. Project managers should identify the critical contextual factors, such as, prevailing socio-economic conditions, political factors, government policies, local institutional structure and all other relevant factors beyond the control of the PVO, and try to manipulate them in favour of the project. For example, the PVO may utilise the opportunity of favourable patronage of a local municipality and piggyback on it for future expansion of project activities.

Looking in means making the project function and maintaining its internal organisation. Typically, it includes all **operational factors,** such as, management of inputs, process, information, and their relation to the project output. The project managers should diagnose the ailments in the present input–output relationship and solve them

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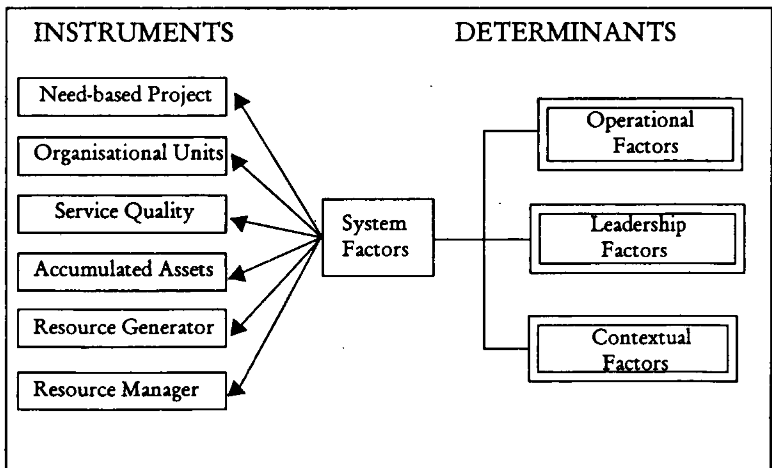
systematically. For example, a serious lapse in the quality of service could be solved through continuous training of health workers. Adequate and regular supply of drugs and contraceptives should be ensured to fill the input gap. The external and internal information systems should be strengthened to facilitate monitoring, evaluation and self-improvement. All these and other 'internal fix-it' activities are important to develop the instruments mentioned above.

Looking ahead involves working to achieve the project's long-term goals. This would mean developing leadership factors including vision, mission and commitment to the community. Simply speaking, the PVO leadership without clear vision and commitment is likely to get stuck in the primary stage of the pathway. A successful metamorphosis requires looking much ahead of its regular operational management.

The functional relationship between the instruments and the determinant factors (contextual, operational and leadership) is given in Figure 1. Combined with the conceptual framework, it gives a one-way relationship between the determinants and the instruments, and between the instruments and different stages of sustainability. Therefore, to assess sustainability, one needs to see the present status of the instruments and diagnose their deficiencies through a systematic assessment of the determinant factors.

Figure 1
Instruments for Sustainability



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The operational steps to apply the method are as follows:

1. Assess the current level of project performance in comparison to its projected goals.
2. Identify/diagnose the positive and negative aspects of: (*a*) contextual; (*b*) operational; and (*c*) leadership factors.
3. On the basis of the diagnosis, score each instrument on a 1–5 scale.
4. Take the average score of all instruments and locate the organisation in the pathway of sustainability. For example, if the average score is below three, the organisation is still located in the first or second stage (i.e., absolute provider).
5. Devise a strategy for improving sustainability on the basis of scores of the instruments. For example, if service quality scores are very low and others high, the strategy would require special emphasis on quality improvement.

A better way is to use a simple checklist or a questionnaire for each instrument. Typically, the checklist would include various aspects of the instruments and score each question on a 'yes/no' basis. Finally, the score for each instrument could be derived on the basis of a simple average of the scores (yes = 1; no = 0) for all questions under the instrument. A sample checklist is given in the Annexure.

Demonstration of the Methodology: A Case Study of an Indian PVHO

The PVHO under study is a voluntary organisation for the women of a sub-division in one of the eastern states of India. The area of operation of the organisation is spreaded over 200 villages with approximately 300,000 population. The head office of the organisation is located in a small town which is approximately 100 km away from the capital city of the state. The region is predominantly agricultural, with substantial commercial activities due to its close spatial link with a port and two important cities. The status of women is low, as reflected in a recent survey done by one local management institute. The most prevalent disease among the adult women of the region, according to the survey, was anaemia followed by gynaecological disorders such as, high risk and complicated pregnancies, menstrual irregularities, prolapse of the uterus, etc. The high prevalence of MCH problems is a

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manifestation of poor economic profile of the region, coupled with the low status of women.

The organisation emerged out of the need for a women's platform in the locality to bring about a positive change in their economic, social and health status. An organisation for the women and of the women can act as a catalyst in mobilising this huge potential force to fight for their causes and to proceed towards the goal of complete emancipation from social and economic bondage and deprivation.

The major focus of the organisation is on early childhood education and mothers' and children's health. The organisation took its major healthcare programme for mother and children in 1990 under the United States Agency for International Development (USAID)/Government of India (GOI) sponsored PVOH-II scheme. The project ended in 1995. The programme was implemented in 118 villages in a district of this eastern Indian state. The major objectives of this programme are to:

1. Improve the health and nutritional status of women and children;
2. promote the planned family concept and adoption of spacing methods;
3. increase trained personnel in health at the community level;
4. improve the status of community sanitation;
5. prevent diarrhoea deaths by initiating oral rehydration therapy (ORT); and
6. establish a good referral linkage with the existing government and other available health facilities.

Given the scenario of the public healthcare system, it was found obvious that the sustainability of the project benefits in these 118 villages would be hard to establish without the sustainability of the programme itself. In other words, the present level of activities of the PVO needed to be continued at least for a few years to expect some self-driven healthcare activities in the area. High level of health awareness produces limited results unless it is supported by a consistent flow of services. The present scenario did not indicate the readiness of the community or any other government or non-government organisation to keep the current level of services flowing.

The organisation seriously started thinking about sustainability only at the later stage of the programme. The programme co-ordinator took a serious initiative to explore the potentiality of sustaining the benefits

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on the basis of: (*a*) active community participation; (*b*) building up a corpus fund; (*c*) income-generating activities; and (*d*) scaling down the activities.

The result of this initiative was notable. For example, (*a*) regarding community participation, it attempted to form village level self help groups (SHG) in the villages. The groups would consist of one member from each family of the village. They would assess the community's healthcare needs and try to solve the problems. Fund would be raised through community subscription; the PVO would provide a 100 per cent matching grant (and 50 per cent of the cost of medicines) for each rupee mobilised this way. The initial response was encouraging. Within two months, 10 such SHGs were formed; approximately Rs. 10,000 was raised and put into bank accounts as total subscriptions; (*b*) a corpus fund of Rs. 800,000 was raised through donations from a variety of sources. It was planned that the interest of the fund be used to meet a part of the operating cost of the programme; (*c*) the organisation got involved in several income-generating activities. According to its estimates a sum of Rs. 200,000 was being earned as profit per year from these activities. However, no long-term plan and special drive in this respect was visible to ensure the sustainability of PVOH-II project benefits; and (*d*) the area of operation was reduced; the programme would continue in 30 core villages, while the rest of the area would receive some sort of support services (such as, health awareness).

A detailed exercise was done to first identify the status of institutional development. Primary data were collected through interview with the key officials, group discussions and a specially designed workshop, where all staff members of the organisation were involved in the diagnosis. The output of the exercise may be summarised by Table 1.

The evaluation of the PVO's performance, as given in Table 1, in developing sustainability instruments is basically subjective and, therefore, risks some bias. The average score is 3.1, which is slightly higher than overall average of 3.0. This implies that the organisation is located somewhere in the middle of the pathway to sustainability, and needs to concentrate on the development of some of the instruments, especially the quality of services, more vigorously.

Since the level of instrumental development depends on the three sustainability factors (contextual, operational and leadership), the next stage would be to identify the individual components in each of the factors responsible for slow development of the lower-ranked instruments. Once the link is identified, it becomes methodologically easier to

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Table 1
Project Performance in Developing Instruments for Sustainability: The Case of an Indian PVHO

Instruments	*Scoring*	*Positive factors*	*Negative factors*
Need-based project	4	Targeted poorer women and children for comprehensive development. Projects on education, income generation, and health are carried out with need assessment. Strong project on non-formal education.	The needs for curative services are not effectively addressed.
Quality of service	2	Committed group of village health promoters.	Insufficient training exposure to the health workers. Quality of clinical services requires improvement.
Community organisations	3	Focus on formation of *mahila mandals* and self help groups. Attempt to utilise these groups in generating internal resources. Good experience in working with the community.	No clear directions to the *mahila mandals* in planning resources. The units have a long way to go to act independently in health care activities.
Accumulated assets	4	Completed the main project building on own initiative. Physical assets worth Rs. 1.3 million accumulated under the project. A piece of land was added to total asset.	No systematic plan to recover the maintenance of fixed assets. Land assets still remaining untapped for generating resources for health care.
Resource manager	3	Dynamic project leadership. Good number of training workshops attended by the project leader and some other staff. Significant interest in sustainability.	Centralised decision-making process. Management decisions are mostly ad hoc and individual-based. Needs consciousness about cost effectiveness. Potential integration with other projects (e.g., non-formal education) remains largely untapped.

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Table 1 contd.

Instruments	*Scoring*	*Positive factors*	*Negative factors*
Resource generator	3	Substantial effort in income generating activities and linking it with self help health initiatives. User fee charged for ambulatory and curative care. Great potential in utilising land assets to subsidise health care activities. Established a corpus fund of Rs. 0.8 million.	Recovery of operating cost through user fee and other means is still a distant goal. Interest from corpus fund is insufficient for meeting salary bills. No specific direction towards utilising land assets for cross-subsidisation of health care.

Note: 1–5 scale; 1 = very poor, 5 = very strong.

develop a strategic plan for improving the sustainability profile which should address the major ailing problems in these three areas. For example, the operational factors responsible for the low status of service quality were: (*a*) excessive coverage; (*b*) absence of continued professional curative services; and (*c*) lack of sufficient supervision. The major contextual factors for the same problem was lack of awareness among the community, and the leadership factors were; (*a*) ad hocism in decision-making; and (*b*) non-delegation of authority.[1]

Conclusion

Only a strong conviction that sustainability is achievable can motivate the PVOs to initiate systematic planning from the very beginning towards this end. The potential to achieve programme sustainability includes both the will to achieve sustainability through setting and working toward sustainability objectives, and the capacity to identify and apply mechanisms for achieving them (Centre for Development and Population Activities [CEDPA], 1997).

It is well-established that the community's involvement at every stage—planning, initiating and implementing—is an essential ingredient to achieve the above objectives. The problem is: How can this be done? The present Indian scenario reflects that usually the PVOs initiate their activities as a provider, with little participation from the beneficiaries. Given the priorities of donor agencies and a weak base of community leadership, there is a risk that they remain stuck at that level for a long period of time and facilitate the erosion of sustainability

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of the programme and its benefits. The only solution under this constraint seems to remain in some systematic steps to be taken by the PVO itself, which would push it up through the role of a facilitator and a catalyst in delivering services. The methodology presented above is expected to help the Indian PVOs understand this process.

Sustainability Assessment Checklist

Indicators			*Yes*	*No*
Organisational Units at the Community Level	⇨	*Do you have viable group structures* (mahila mandal, *youth club) at the community level?*	—	—
Need-based Projects	⇨	*Are key decisions regarding project planning and implementation taken by the local staff?*	—	—
	⇨	*Does the community and local staff participate in project planning and implementation?*	—	—
	⇨	*Do you organise meetings with local people regarding project objectives/process/achievement?*	—	—
	⇨	*Does your programme prioritise the activities on the basis of local needs?*	—	—
Service Quality	⇨	*Does your programme regularly conduct a baseline needs assessment to determine client needs and preferences of service delivery?*	—	—
	⇨	*If yes, does the needs assessment address capacity and willingness to pay for services?*	—	—
	⇨	*Do trained supervisors conduct individual interviews with existing and potential clients?*	—	—
	⇨	*Does your programme use results of the need assessment survey in designing the strategy?*	—	—

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	➪ *Does your programme regularly survey services provided by competitors, their quality and cost?*	___	___
	➪ *Is there an increase in the number of beneficiaries each year?*	___	___
	➪ *Is there any increase in coverage (area/services) in the last two to three years?*	___	___
	➪ *Is a majority of the clients satisfied with your services?*	___	___
	➪ *Do you have trained manpower at each service delivery point?*	___	___
	➪ *Does your programme offer a wide range of services to the client?*	___	___
Accumulated Assets	➪ *Does your organisation have sufficient reserve fund to cover deficit over the next five years?*	___	___
	➪ *Does your organisation have trained managerial staff?*	___	___
	➪ *Does your organisation have dependable transport facilities?*	___	___
	➪ *Does your organisation have communication facilities?*	___	___
	➪ *Is the organisation's building in good condition?*	___	___
	➪ *Does your organisation have adequate (quantitatively and qualitatively) equipment for service delivery?*	___	___
Resource Generator	➪ *Does your organisation have more than one funding source?*	___	___
	➪ *Do you have financially viable community-based schemes?*	___	___
	➪ *Has there been a decreasing trend in external funding in the last five years?*	___	___

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	⇨ *Is the ratio of internal to external funding increasing?*	___	___
	⇨ *Is your programme able to recover recurrent cost through user fee, insurance and sale of drugs?*	___	___
Resource Manager	⇨ *Do you have a transparent system of financial accountability in your organisation?*	___	___
	⇨ *Does your organisation have a multi-year programme budget?*	___	___
	⇨ *Do you have a provision for operations and maintenance in your budget?*	___	___
	⇨ *Does your organisation regularly analyse the costs of providing each type of service offered?*	___	___
	⇨ *Have you used 'unit costs' as a basis for setting user fees in order to cover part of your cost per visit?*	___	___
	⇨ *Do you prepare a balance sheet, income statement and cashflow analysis on a quarterly/yearly basis?*	___	___
	⇨ *Does senior staff/top management review the financial reports?*	___	___
	⇨ *Do managers utilise information gathered from the MIS for decision-making?*	___	___
	⇨ *Is there community ownership in fund generation, management, and utilisation?*	___	___
	⇨ *Are local groups trained in record keeping?*	___	___

Note

1. Since the main objective of including the case study is to demonstrate how to use the conceptual framework of sustainability, we refrain from providing specific details on the development of the strategy. For details sec Kanjilal (1997).

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Barun Kanjilal is Associate Professor, Indian Institute of Health Management Research (IIHMR), 1 Prabhu Dayal Marg, Sanganer Airport, Jaipur 302 011, India. Fax: 91-141-582138. E-mail: iihmrjai@jp1.dot.net.in.

Suneeta Sharma is Assistant Professor, IIHMR, Jaipur, India.

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