CHAPTER VII
ANALYSIS OF ISSUES-
DISCUSSION
The present chapter analyses the factors of sustainability of the NGOs as discussed in the case studies in previous chapter. This analysis is based on the discussion of the capacity of NGO effectiveness followed by qualitative assessment of NGOs based on the observations on the social instruments of sustainability, as was discussed in the methodology. This is followed by a note on the NGO capacity in the form of its strengths, weaknesses and related management strategy needed to focus on sustainability.

7.1 SEVA MANDIR
7.1.1 Capacity of NGO Effectiveness

Health services of Seva Mandir started in 1984 in ten villages of Kherwada block. From the very beginning the thrust was on the curative and promotive services. It was felt that to make health a reality, people must be aware of the common causes of ill health and how to prevent it from illness. It was felt that people needed some curative services for treatment of minor ailments because of the remoteness of the villages from the nearest centre of cure. Therefore health education along with basic curative services began.

The health intervention are based on 12 point health programme, which was elaborated under PVOH-II project to cover 20 points in all which are included in the following list:

- Ladle with handle
- Kitchen garden
- Smokeless furnace
- Soak pits
- Sanitary latrines
- Pregnant women inoculated with 1,2 and 3 doses
- Family planning
- Water filter with double layered cloth
- Dustbins
- Compost pits
- Children inoculated with 1,2 and 3 doses
- Children provided with booster
- Houses with windows and Houses with separate cattle shade
- Covering faces with soil and washing hands

Four pillars of health i.e., nutrition, increased income, family welfare and planning and cleanliness support this programme. Envisaging the health interventions to promote healthy living and at the same time providing treatment for minor ailments at the doorstep, require well-trained and equipped VHWs. These para-medical workers were thus imparted comprehensive training and refreshers to help them understand the
entire gamut of health care interventions related to MCH and family welfare, sanitation and hygiene and referral services.

Also considering the fact that the area of operation is remote, where in some cases even basic medicines are not available. Therefore it was decided by the NGO to provide the health workers with medicine kit. The VHWs who are literate were given a health kit consisting of 21 items including paracetamol, stemctil, interquinol, baralgan, dispirin etc. Government sponsored items like IFA, ORS, condoms etc scissors, soap, pen, records, health education book – the ‘Arogya Darshika’, Choti-choti bimariyon ke gharelu ilaaz, Flip books for health education. The idea is that people must have excess to at least some common drugs, which sometimes also help save time in case of emergencies.

The home remedy workers are healers who have practising ISM for generations, sometimes they are illiterate. However, acknowledging their vast experience and knowledge and easy acceptance by the community, they also have been provided with a kit, which has about 20 traditional herbal combinations, the usual government supplied drugs and the health education material.

TBA or Dai is a major resource as far as women and children related health issues are concerned. Seva Mandir has strengthened Dai’s skill and has provided her with a kit that greatly helps her in conducting aseptic deliveries, tackling anaemia in women among other things. There is yet another person who has been strengthening considering her contact with the mots vulnerable group – the small children, she is the Balwadi Sanchalika. Medicines for common ailments like cold, cough, stomach-ache, diarrhoea, skin disease, fever, tooth ailments ate given by the Sanchalika. The Sanchalika’s are illiterate, therefore the bottles and caps are very colourful and corresponding to the colour of bottle, the cap, the prescription of medicine for a specific disease, a guide book has been given to them including a kit with bio-chemic medicines.

The health unit has tried to approach the curative aspects from all angles, so that the community stands gain in all respects. All community has a choice in the type of medicines they wish to have. The para-medical workers provide the first source of
treatment and also send for referrals. The referral in case of normal conditions generally is – sub-centre to PHC to district hospital. In case of emergencies referral is directly to the specialists.

An interesting fact noticed during the interaction about the community perception of availability of services from different sources and their preference for the same. It seems that people had evolved their own referral services: however, they did acknowledge the timely help that health team provides and also their credibility in the government hospitals. The two rural health centres are really a big asset to the people, not only in terms of the treatment given but also the calm and soothing disposition of the doctors and staff of RHCs. These RHCs provide the basic treatment, efforts are on to upgrade the facilities on the service by increasing the bed capacity. The RHCs have also become the local centre for the health education and cure in the areas they cater to. To support and strengthen the health component, the health team has made available to the community some very simple indigenous and low cost technologies. The focus of this aspect is to provide solutions with the existing village resources. This in addition to promoting healthy living, also provide a sense of income for the NGO. Some of the technologies introduced include construction of sanitary latrines, digging compost pits, making smokeless furnace, soap and developing kitchen gardens.

The PVOH-II project portrays the real emphasis of Seva Mandir’s health intervention i.e., health education. The thrust is to make healthy living a habit and for that, different tools and techniques are used. The health educators, LHAs the para-medical workers all are well versed to spread these messages. Sometimes specifically demonstrations are offered, sometimes they happen on the job.

Intensive health campaigns are also organised. The thrust is again on promoting the 12 point health programmes and integrated development inclusive of all sectoral interventions. It is usually in four phases of six months each. Women’s health awareness camps are organised twice a year. Also door to door contact wherein about 5 VHWs get together and they take five-village cluster at a time for 5 days. There are meetings, role-plays, movie shows etc along with meeting community individually. Everywhere the ideas is to make people aware and well versed in all aspects of health
education and then constantly reinforce the same so that a habit can be promoted. From time to time the messages are reinforced through folk media.

Girwa, Badgaon, Jhadol and Khedwara block of Udaipur district are fairly large and characterised by undulating topography and remoteness of many villages. The community is mostly tribal and settlement is scattered or disbursed. Agriculture is the mainstay of the people, supported by labour works. The literacy level is low and so is the per capita income. The supposed better status of women among tribal seems top have diluted due to intermixing of castes as well as importation of non-tribal cultures. Today the scenario is more or less similar to the general status of women in India. It is against this background that Seva Mandir’s health intervention need to be understood.

Broadly, the health programme of the NGO can be categorised into three phases 1994 -1986 was essentially on eof learning, assimilation and percolation of future strategies. The health unit had by now understood that, for health interventions to be successful, people’s capabilities and motivation needs to be built, so that they understand on problem, prioritise their needs and arrive at solutions. This approach stressed an intensive health education, establishment of network of VHWs and improved domestic and environmental hygiene. At the end of this phase, following are the outcomes as noticed:

- 85 VHWs are trained
- Health campaigns are carried out to develop model health villages
- Health programme diversification started
- Village health committees are formed
- 959 patients benefited from the referral facilities

During the second phase from 1986-1989 earlier aims and objectives gained and new ideas emerged, the concept of rural health centres and TBA programme was mooted, and low cost technologies were introduced. The TBA programmes were launched with the view to focus on MCH and family welfare activities, reducing IMR and MMR and create yet another resource base in the village for a self-reliant health unit. Also during this period the intersectoral approach was envisaged to make health interventions more holistic with the following outcomes:

- 35% increase in the number of VHWs from 1986-1989
- TBA added to network of VHWs
• 235 mass media events held by health unit in 1989

Immediately following this was the third phase from 1989-till date. This period was also the one, when PVOH-II project was launched. During this period following are the changes noticed at Seva Mandir:

• Coverage of villages increased to 200 with the addition of 48 villages
• TBA programme grew in strength with the provision of ANC, INC, PNC birth spacing, supplementary feeding for pregnant and lactating mothers
• RHCs were created to strengthen the promotive, curative and preventive aspects
• School health programmes was started to inculcate the habit of healthy living from childhood and provide timely guidance to protect children against diseases
• The post of LHAs was created to supervise the work of TBAs

This phase saw the following achievements:

• Expansion in the work of village health workers
• TBAs assisted births increased school health programme started, AIDS awareness programme started
• Inter-sectoral linkages strengthened
• Efforts began to integrate income generation activities with health
• RHCs have become focal point of health education and health care
• Organising treatment of TB patients

As of today, the health education component remains the most important tool with 60% of minor ailments are cured in the village itself. The TBA programme has grown up remarkably (Annex-V: on KPC and Final Evaluation Report).

7.1.2 Strategies on Sustainability

The very fact that Seva Mandir has never thought of setting up a parallel health structure to that of the government and their understanding both are complimentary which has paved the way for good relationship between the two. This relation manifests itself at all levels from the NGO programme execution to that of implementation at the village level. The CMHO, Udaipur, Dr.K.L.Kummat was quite supportive of NGOs health intervention. He acknowledged the good work of Seva Mandir for which it has become easier to identify the target group for immunisation.
Even at the block level the medical officer of PHC at Badgaon block felt that the combination of government system and the presence of Seva Mandir with the community made everyday working easier and also during epidemics 'we realise how much we need each other'. One ANM from Jhadol block accepted the fact that it is becoming easier in the presence of TBA who helped her in identifying villages where focus is required to work for immunisation coverage. TBAs and ANM work together for immunisation, TBA motivates and identifies mothers and children and ANM administers the vaccine. Also the health educators participate in the PHC meetings. There is also a proposition that the LHAs will also attend zone level PHC meetings.

In the two RHCs at Khojwada in Kherwada block and the other at Saru at Girwa block, Medical insurance schemes are in operation. Rs.18 per year are charged from the patients. All treatments are given free. In both the centres this scheme is operational, however the hospital staff feels that this amount is too small to sustain activities for a long time. Efforts are on to explore the viability, affordability and possibility of increasing the amount for insurance cover.

Community organisation building, mobilisation of the community linking health programme with income generation activities, community financing mechanism such as user fees, health insurance, revolving fund through self-help group formulation and cost sharing are some of the steps organised by the NGO to achieve sustainability. Networking linkages for sharing the best practices and the achievements with Government and the other NGOs is very useful in advocating sustainability of NGO programmes in health.

7.1.3 Contextual Factors
The major contextual factors affecting the sustainability of the PVOH-II project is discussed according to their impact on NGO management strategy.

7.1.3.1 Favourable factors
7.1.3.1.1 Community Need
The organisation is increasingly realised the need for some structured means to encourage and motivate the villagers, especially the women community to train and involve them and the members of the village groups. The NGO has been successful to
a large extent in raising awareness among the women community in the project area. It established the Lok sanskriti vikas ikai—the cultural unit and a small training centre at Kaya, a village in the tribal area. This is very much used for the exchange of IEC activities for health and social mobilisation messages in the project area through cultural practices.

Seva Mandir’s involvement with community development had identified with local need in the form of its change in focus from literacy programmes to a wider concern for the well-being and development of tribes, led it in 1984 to decide to work in the areas of health care.

Initially, Seva Mandir decided to invite villagers, if they wish to avail health care facility at the village level, to nominate one of their family members for training as a village health worker. In later part these health workers serve the community as Home Remedy Workers (HRWs), to administer indigenous herbs and plants for the treatment of minor ailments and TBAs to provide aseptic delivery and family planning services including supplementary nutrition.

Seva Mandir believes, that the encouragement of the revival of traditional cures is worthwhile, since they are safe and inexpensive, and also because they can be made available locally. They also encourage the maintenance of biodiversity. The NGO has promoted a network of model health villages to provide examples for the remainder. The real struggle is reflected in working with local community for realising people’s health in people’s hand in meeting effective demand for health care.

7.1.3.1.2 Community Response

The NGO effort in mobilising community response received remarkable support in the form of popular participation in health and community development programmes. Community awareness is created through a series of meetings with mahila mandals (Records on mahila mandal meetings). As a result of which health network of model health villages are created with the involvement of women groups and village health team to serve as the link between the community and the rural referral hospital of the organisation in project villages. The organisation also receives substantial response
from different social action groups in terms of donation to their corpus fund (NGO profile and annual report year 97-98).

7.1.3.1.3 Other supporting projects
The major strength of the organisation lies on its focus and approach to integrated action on health and social development. From a modest beginning more than two decades ago- not only in terms of size but also in terms of its understanding of how to be relevant for the poor- Seva Mandir has reached a stage where it can claim to have activated the potential grassroots development work at various levels, that is at the level of the poor, the government system and the voluntary sector.

With adult education as the entry point, Seva Mandir has to date expanded its activities to include wasteland and watershed management, water resource management, women’s development, health and sanitation, social forestry and to mention only a few.

7.1.3.2 Unfavourable factors
7.1.3.2.1 Cessation of PVOH-II grant
The MOHFW and USAID support almost 75% of the total project outlay. This cost takes care of total non-recurring and recurring cost of the project. This was a sizeable support, which once stopped, could pose substantial threat to sustainability.

7.1.3.2.2 Poor paying capacity of the Community
Resource mobilisation through increased user fee or any other direct mechanism is difficult due to two basic reasons; the target population is extremely poor, and a sudden increase in existing or application of new charges would generate some sort of resistance among the community.

7.1.3.2.3 Decrease in focus on MCH due to flow of other Projects
Seva Mandir is always overburdened with a variety of social development projects due to its good name and credibility for its commitment to social need. There is a danger for excessive attention of health team towards the provision of curative health care for effective cost-recovery, which can divert the prime focus of MCH care at the end of the project period. Health care at the community level is taken care by a cadre of village health workers, but strategic direction and supportive supervision are the
7.1.4 Operational Factors

7.1.4.1 Favourable Operational factors

- The VHWs are found to be the real strength of the project. They are the link between target population in the community and the health services of the NGO. With low salary they are serving the organisation for the benefit of local community in the respective villages.

- Over the project period, there has been a significant achievement in skill building and expertise among the managerial team in creating a critical mass of skilled human resources. In general both members from a family is provided the opportunity to work in the organisation at the field level to ensure effective monitoring, regularity of services, recognition in the village community and contributing to family income of the couple.

- Two hospital buildings of the NGO serve as referral centres, Rural Resource centre and a centre for training for health education resources with having outdoor and in-door facility for the clinical care. The building and other assets in the hospital determine the NGO’s confidence and commitment to continue its activities.

- Training modules and instruments constitute an integral part of the input strength of the project. Village health committee, linking with government health programmes, Referral health centres, government -collaboration are some of the effective operational strategies favourable in the direction of sustainability.

7.1.4.2 Major unfavourable aspects associated with the operational factors

- The programme focused only on preventive and promotive aspects of MCH care and motivation for family planning services. Demand for continuity of good quality of care has been raising as a consequence of the increased awareness, but SM is not sufficiently ready to deal with the rising demand to continue its
activities in the absence of regular availability of lady doctor in the hospital, as seen in the case of project period.

- The major potentials of resource generation were remaining largely untapped. The *Mahila Mandals, Basic Health Workers, Home Remedy Workers and Village Health Committees* were yet to receive a definite direction and guidance for owning the project. Different village based project units of the organisation could be used in linking health care with income generation activities, economic benefit programmes of the government and the NGO etc. while approaching community development activities. All these projects are conceptually and theoretically integrated at top-management level but hardly integrated programmatically at the field level. There is a long way to go to achieve measurable results in this direction.

- Integration of health care activities required to be addressed within the opportunity of existing framework of community welfare activities of the NGO. Various community projects diverted the organisational attention to focus in an integrated manner resulting in missing the synergistic effect and deviating from ensuring higher cost-effectiveness for the MCH activities.

- The strategy on project management training was ad hoc, and to some extent, biased. While the top managerial staff (Project Co-ordinator, Secretary, MOs) having similar capacity of responsibility attended almost all the project related training programmes, exposure to other NGO experiences. But the supervisory staff and village based health workers received hardly any external training and exposure input.

7.1.5 Leadership Factors

7.1.5.1 Major favourable aspects with respect to the leadership factors

- Interest to sustain the most essential and primary ingredient for sustainability. The interaction with Programme Co-ordinator and Medical officers of the NGO, reflected the willingness of the organisation to sustain the health care benefits to the project area community.

- Programme Co-ordinator involved in the management other community development projects of the NGO such as; Social forestry, care and welfare of the women and children, women empowerment, community advocacy, non-formal
education, networking and co-ordination of social action involving community participation. Organisation's President is the guiding force for promoting sustainability.

7.1.5.2 *Major unfavorable factors are*

- Seva Mandir is a big organisation working in the grassroots set up. But planning and formulation of key policy decisions are taken unilaterally at the top-management level. Lack of decentralised planning in decision making, disparities among headquarter and field staff facilities affect the implementation process in most cases. Personnel management policies favouring contractual offering and uncertainty in the involvement at the period specific field based project put the functionaries in difficult situation. High turnover of professional staff due to the existing working situation affects the quality of project management and so thus limiting the opportunity for sustainability.

- There is evidential support for the lack of long-term vision and planning about resource mobilisation and utilisation of community support for sustaining the benefits of the project activities. Unilateral directions are always provided with a top-down control mechanism. Though the leadership quality is dynamic, it needs encouraging coherence, participatory planning and decentralised decision making for effective management strategies.

- The organisation needs to have more effective participation of women in the leadership at all levels of functionaries instead of projecting women members as frontline health workers at the grassroots level.

- Networking and co-ordination of activities are limited to the exchange of experience sharing with government and other NGOs in the state and participation in national and internal conferences and seminars, and state level consortium on social forum for advocating gender equality in development etc. But it has hardly made any effort to link institutions of Panchayats at the village, block or at the district levels. This suffered an adequate value addition to the component of decentralised planning, and linking co-ordination of organisational decisions involving health care decentralisation. Sustainability of health care benefits is the equal responsibility and concern of all the actors of development in the context of
health care decentralisation. This fact was highly neglected by the NGO management during its project period.

These favourable and unfavourable factors taken together create a sustainability profile of the NGO. These also help to identify the status of the social instruments discussed in the 'design of the present research' under conceptual framework on 'Instruments of Sustainability'. The following table shows a relative scoring of each of the relevant instruments with respect to the responsible factors discussed above.
SEVA MANDIR

Qualitative Assessment of Sustainability

[On the basis of positive and negative Factors observed on a Five point scale]

*(1-5 scale: 1=very poor, 5=very strong)*

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Scoring</th>
<th>Positive Factors</th>
<th>Negative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need-based Project</td>
<td>4</td>
<td>Targeted poorer women and children for comprehensive tribal development projects on adult education, school health education, environment al protection, social forestry, alternative systems of health care with suitability of community need assessment</td>
<td>Need for curative, preventive and promotive services to provide holistic health care is not effectively addressed. This is evident in the absence of preparation for an integrated nutrition and health package</td>
</tr>
<tr>
<td>Quality of service</td>
<td>3</td>
<td>Preventive, promotive and curative intervention with committed group of village level health workers involving traditional healers, RMPs and ISM practitioners are well integrated</td>
<td>Insufficient training and exposure to the health workers, specialised training on quality of care needs improvement</td>
</tr>
<tr>
<td>Community Organizations</td>
<td>3</td>
<td>Focus on formation of <em>Mahila Mandal</em> and self-help groups, home remedy workers and network of health villages. Attempt to utilise these groups in generating internal resources. Good experience in working with the community</td>
<td>Not clear direction to the <em>Mahila Mandal</em>, grassroots workers in planning resources. The health units have long way to go to act independently in health care activities. No co-ordination established with panchayat system through these community organisations</td>
</tr>
<tr>
<td>Accumulated Assets</td>
<td>4</td>
<td>Completed the main project hospital building by own initiative. The hospital land was added to total asset of the organisation, well equipped training centres</td>
<td>Some systematic plan to recover the maintenance of assets. This asset still remains untapped for generating resources for health care in the absence of professional staff</td>
</tr>
<tr>
<td>Resource Manager</td>
<td>3</td>
<td>Dynamic project leadership. Clarity of organisational vision and mission strategy. Good number of exposure to training workshops and sharing events. Significant interest in sustainability</td>
<td>Centralised decision-making process. Management decisions are mostly ad hoc and individual-based. Needs consciousness about cost effectiveness. Potential linkages with other projects is up-to some extent tapped</td>
</tr>
<tr>
<td>Resource Generator</td>
<td>4</td>
<td>Substantial effort in income generating activities and linking it with self-help initiatives. User fee charged for ambulatory and curative care. Great potential in utilising land assets to subsidise health care activities</td>
<td>Recovery of operating cost through user fee and other means is still a distant goal. Interest from corpus fund is insufficient for meeting staff salary. Some specific direction towards utilising land assets for cross-subsidisation of health care. NGO introduces new projects for sustainability</td>
</tr>
</tbody>
</table>
The above analysis of the qualitative assessment of sustainability on the basis of positive and negative factors observed on a Five-point scale reveals the following. The average score is 4.25, which is sufficiently higher than overall average of 3.0. This implies that the organisation is located somewhat above the middle of pathway to sustainability and needs to concentrate its strategies on the development of some of the instruments vigorously.

### 7.1.6 Strategisation

The above assessment can be strategised by the following SWOT matrix, which can be used to devise the optimum management strategy. The present report contains only the most relevant components of the matrix.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical infrastructure (Hospital building, land assets, vehicle etc.)</td>
<td>• Drive to mobilise internal resources needs more emphasis</td>
</tr>
<tr>
<td>• Dynamic project management team and NGO leadership</td>
<td>• Operational management decision is mostly centralised and ad hoc</td>
</tr>
<tr>
<td>• Experience in working with community (especially women groups) for social action and holistic development of the tribes</td>
<td>• Too much emphasis on preventive and promotive aspect but lack emphasis on linking health care benefits with other community programmes of the government and of the NGO</td>
</tr>
<tr>
<td>• Dedicated group of Village level health workers and health services promoters</td>
<td>• Technical training is very much a need for grassroots health workers with emphasis on curative health care for emergency and at risk cases</td>
</tr>
<tr>
<td>• Strong interest in sustaining health care benefits</td>
<td></td>
</tr>
<tr>
<td>• Established two hospitals in remote and populated villages</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Huge unmet need for MCH care</td>
<td>• Disadvantaged social condition and poor compensation threatening low retention of village level health workers and professional staff</td>
</tr>
<tr>
<td>• Leadership role in networking with other NGOs in the region and co-ordination with Panchayat raj institutions (PRIs)</td>
<td>• No possibility of extension of PVOH-II grants</td>
</tr>
<tr>
<td>• Strong ongoing projects on variety of community projects in social development</td>
<td>• Compensation of private health care providers</td>
</tr>
<tr>
<td>• Potential recognition in the state</td>
<td>• Community’s poor paying capacity on health care</td>
</tr>
<tr>
<td>• Significant progress in knowledge and awareness among women creating potential demand for services</td>
<td>• Overloaded with external funding projects for social development dilutes purpose of attention for MCH care for the poor and needy</td>
</tr>
<tr>
<td>• Interest of donor agencies in ‘health and family welfare sector reform’, HIV/AIDS awareness projects, women empowerment for reproductive health care in the state</td>
<td>• No linkages established with PRIs and other NGOs to avail external co-operation for organisational co-ordination</td>
</tr>
<tr>
<td>• Accumulated knowledge and skills gained from the technical assistance under PVOH-II project</td>
<td>• Scaling up of activities makes the NGO initiatives provide better management in a more challenging manner</td>
</tr>
<tr>
<td>• Good community response to SM drive towards sustainability</td>
<td></td>
</tr>
<tr>
<td>• Overloaded with external funding projects for social development dilutes purpose of attention for MCH care for the poor and needy</td>
<td></td>
</tr>
</tbody>
</table>

The analysis shows about the fact that there is sufficient strength in the organisation to achieve sustainability. The optimum strategy should be one, which extracts maximum opportunities on the basis of the strengths and minimises the threats. In this situation, the optimum strategy should be focusing in the direction of extracting opportunities.
on the basis of these strengths and minimising the threats to continue the NGO health programmes.

7.2 **BHORUKA CHARITABLE TRUST (BCT)**

Under the PVOH-II project in the name of 'Comprehensive Rural Health Development' project BCT covers 40 villages having the target population of 50,000. Female Health Volunteers (FHV), Mobile Medical Units (MMU), Health Posts, Hospital building for curative, referral and emergency clinical services, institutional networking are some of the key strategies adopted by the NGO to provide community health activities during the project life. BCT is a corporate NGO backed by Bhoruka Group of companies, a sister concern of Transport Corporation of India (TCI). Provision of curative health care facilities is the key objective of the health team of BCT. Financial backing in the form of charity is the key source of corpus for the organisation. However, project implementation strategies incorporate community participation as the key to achieve programmatic achievement in the present project.

7.2.1 **Strategies on Sustainability**

Involvement of women community in the process of organisation of *Mahila Mandal* s for health education awareness, income generation, and women empowerment to develop leadership quality among them is the key community mobilisation strategies adopted by the society. This sort of awareness generation integrated with income generation and women empowerment related mass mobilisation is considered to be a designed approach of the organisation to achieve sustainability.

Quality health care at the doorstep of the community is a surer test for increasing the demand at the grassroots set up is adequately met by the NGO during the life of the project. For sustaining benefits of project activities and health services delivery the organisational strategic focus was limited to the delivery of project specific health care services through the organisation's well-constructed Rural Hospital, Mobile Medical Unit and Rural Health posts. The cost recovery mechanism would be introduced through the introduction of user fee, community financing and community contribution mechanisms.

The government health infrastructure is situated at far distance from the project area. This is the reason for which, after the project period the linking with of the existing
government system is not the priority of the NGO, but looking for more projects to continue the ongoing activities under a different name is the classical understanding of looking into the issue of sustainability. The community dependency on NGO system is no way different from that of depending on the government system other than the delivery of quality care at the doorstep. This is probably the spirit of voluntary action, which can be sustainable for creating community involvement in health development.

Accordingly, it was decided that all health related activities under the existing PVOH-II project would continue through the MMUs visit to project villages and at the referral health posts with the introduction of user fee accepted to the local community. Apparently this seems to be a prudent step because with a delayed approach to sustainability drive the NGO should be very cautious about the constraints before defining its future strategies.

During the life of the project implementation, BCT never considered sustainability as an issue that would affect the programmatic benefits to the local community. Probably, therefore the organisational strategic focus was limited to the delivery of project specific health care services through the organisation's well-constructed Rural Hospital and Referral Health posts.

All the agenda of community participation, women empowerment, capacity building of Mahila Mandals remained limited to project specific strategies for the effective management of project to deliver quality health care. But not leading to the strengthening or operationalisation of linkages with existing government system in the project area. Co-ordination with government system is limited to the frontline workers for completing the targets of immunisation coverage, distribution of family planning aids, IFA tablets etc.

Another strategy for sustainability adopted by BCT is to train the RMPs in the area of operation. Even training of TBAs is designed into the project operations for the expansion of outreach coverage and benefiting the targeted population within the project period. After which the role of NGO is completely unaware of the area situation unless and until it gets another project these activities can never been
addressed or even been discussed. This is explaining the lack of vision of the NGO leader in fulfilling its social commitment instead of concentrating on its business commitment to the donor. This is opposed to the NGO effectiveness in achieving health care sustainability.

BCT is providing free and charity health care services out of the support it receives from its parent organisation- Transport Corporation of India (TCI) (NGO evaluation report). This is reflected in the community's identification that, 'The Seth- the owner of TCI, would help us in our difficult time even after the closure of project life'. Further no one in the community is aware that the project will be ended by the year 1997. Therefore, the provision of continuity of health care services at the free of cost would continue even after this period. Such a perception of community is a matter of concern, which clarifies further that charity driven social action is hardly having any possibility for sustainability. Unless the NGO modifies its strategy to address these issues it is premature to discuss its potential position on the road to sustain the benefits of health care to the local population.

Within the three-tier system of PVOH-II project, there have been some attempts to create continuity in services although there are various concern areas too, both of which are discussed under the heading of following instruments of assessing sustainability.

7.2.2 Contextual Factors

The major contextual factors affecting the sustainability of the PVOH-II project is discussed according to their impact on NGO management strategies.

7.2.2.1 The favourable factors are

7.2.2.1.1 Community Need

The NGO has been successful to a large extent in raising awareness among the women community in the project area (CNA report on Project). However, effective awareness also generates effective demand for health care. The health status of women and children of the poorer section is still remarkably low and miserable and the fact remains valid that community care in public health delivery system is still far from being able to address the raising demand on its own.
7.2.2.1.2 Community Response

The NGO effort in mobilising community response received remarkable support in the form of its involvement in awareness creation through a series of meetings with *mahila mandals* (NGO records on *mahila mandals*). As a result of which health posts were created by the women groups to function as a referral link between the community and the rural hospital of the organisation. The organisation also receives substantial response from different community groups in terms of association of local community development activities.

7.2.2.1.3 Other supporting projects

The major strength of the organisation lies on its focus and approach on social welfare activities through the rural development. Community development projects relating to the improvement of social-economic situation, primary education, extension of non-formal education to girl children, management of natural resources, soil and water conservation, and water supply encourages the project team to exchange respective experiences and co-ordinate implementation problems for effective implementation in the project villages. A tremendous scope for inter-sectoral action through the convergence of inter-project co-operation is very much evident.

7.2.2.2 Major unfavourable factors

7.2.2.2.1 Cessation of PVOH-II grant

The MOHFW and USAID support almost 75% of the total project outlay. This cost takes care of total non-recurring and recurring cost of the project. This was a sizeable support, which once stopped, could pose substantial threat to sustainability.

7.2.2.2.2 Poor paying capacity of the Community

Resource mobilisation through increased user fee or any other direct mechanism is difficult due to three basic reasons; the target population is extremely poor, and a sudden increase in existing or application of new charges would generate some sort of resistance among the community, and the community perception for the acceptance of availing free services by the charitable trust. These facts make it more difficult to ensure sustainability.
7.2.2.2.3 Irregularities of Female health Volunteers

FHV's remain absence at the time of agricultural cultivation in which period the activity gets affected in the respective villages. In case of unmarried members the possibility of drop out is maximum due to their marriage or for having alternate opportunity. Even the threat of the closure of project support brings more uncertainty to the life security for these FHV's, discourages them to concentrate their activities in the usual spirit.

7.2.2.2.4 Referral Centre

A specific area of concern has been the high turnover of doctors and the absence of a lady doctor. Since for the last consecutive years, a number of doctors have left the organisation despite of the provision for a higher salary than the PVOH-II project offers.

7.2.2.2.5 Mobile Unit

The management of BCT is very much interested in supporting the ongoing MMUs provided it gets adequate assistance in the form of regular financial support from the TCI group, increase in cost of health delivery services and exploring avenue for further funding through new projects. This understanding and approach may be a possible threat to the sustainability.

7.2.2.2.6 Health Posts

Lack of male involvement in the PVOH-II activities at the grassroots level ignored the male members' possibility of consideration for support to the continuity of 'Health Posts' in the respective villages. Even though the women community expressed the relevance of continuity of these health posts, but due to lack of decision making power, their voice have hardly any say in the continuity of these 'Health Posts'. Management strategy at the BCT is very much concerned about this issue.

7.2.3 Operational Factors

7.2.3.1 Favourable Operational Factors

- The FHV's are found to be the real strength of the project. They are the link between target population in the community and the health services of the NGO.
With low salary they are serving the organisation for the benefit of local community in the respective villages.

- Over the project period, there has been a significant achievement in skill building and expertise among the managerial team in creating a critical mass of skilled human resources. In general female members from a village is provided the opportunity to work in the organisation at the field level to ensure effective monitoring, regularity of health services concerning women and children, recognition in the village community and contributing to family income.

- The hospital building of the NGO serves as a referral centre, Rural resource centre and a centre for health education resources with having out-door and in-door facility for the clinical care. The building and other assets in the hospital determine the NGO’s confidence to continue its activities.

- The decision for continuing the health services was a necessary step to maintain the availability of quality health care to the village community after the closure of project period, is a strategy in support of approaching sustainability.

7.2.3.2 Major unfavourable aspects associated with the operational factors

- The programme focused mostly on promotive and curative care. The demand for continuity of good quality of care has been raising as a consequence of increased awareness, but BCT is not sufficiently ready to deal with the rising demand to continue its activities as it was providing during the project period.

- The major potentials of resource generation were remaining largely untapped. The Mahila Mandal, and FHVs was yet to receive a definite direction and guidance for owning the project. Different village based project units of the organisation could be used in linking health care with income generation activities, economic benefit programmes of the government etc. There is a long way to go to achieve perceptible results in this direction.

- Integration of health care activities required to be addressed with the existing facilities of rural development activities of the NGO. Management strategy for focusing on the requirement of multi-sectoral projects diverted the organisational attention in supporting an integrated manner of programme implementation,
which resulted in the missing link of the synergistic effect for continuity of health services.

- The strategy on training was ad hoc, and to some extent, biased. While the top managerial staff (Project Director, Co-ordinator, MOs) attended almost all the project related training programmes, and exposure to other NGO experiences. But the supervisory staff and FHVs received hardly any training and exposure input.

- The role of Traditional Birth Attendants (TBA) is extremely important to sustain the activities and its impact. It was surprising to see that this potential instrument of self-sufficiency was never explored effectively e.g. in the form of sharing of responsibilities and organisation and training of new TBAs etc. Also the training of RMPs within the project life could not created much impact other than referring a few cases of emergency for curative care.

### Leadership Factors

#### 7.2.4.1 Major favourable aspects with respect to the leadership factors

- Interest to sustain the most essential and primary ingredient for sustainability. The interaction with Project Director, Project Co-ordinator and Medical officer of the NGO, reflected the willingness of the organisation to sustain the health care with the introduction of necessary community financing mechanism.

- Project Director manages other community development projects of the NGO such as; water sanitation, primary education, water supply and environment protection, rural development activities and networking and co-ordination with other NGOs in the state. Organisation's secretary is the guiding motivation for promoting sustainability.

#### 7.2.4.2 Major unfavourable factors are

- There is evidential support for the lack of long-term vision and planning about resource mobilisation and utilisation of community support for sustaining the benefits of the project activities. Unilateral decisions are always taken with a top-down control mechanism. Though the leadership quality is dynamic, it needs encouraging coherence, participatory planning and decentralised decision making for effective management strategies.
• The organisation needs to have more effective participation of women in the leadership at all levels of functionaries instead of utilising them at the grassroots level health activities.

• Networking and co-ordination of activities are limited to the exchange of experience sharing and participation in national and internal conferences and seminars and state level consortium on social action forum for promoting corporate social responsibility in community development. But it has hardly made any effort to link institutions of Panchayats at the village, block or at the district levels. This suffered an adequate value addition to the component of decentralised planning and decision making involving health care decentralisation. Sustainability of health care benefits is supposed to be the outcome of equal responsibility in the form of people's participation and contribution of all the actors of social development. This fact was highly neglected by the NGO management during its project period.

These favourable and unfavourable factors taken together create a sustainability profile of the organisation. These also help to identify the status of the social instruments as was discussed in 'research design' under 'conceptual framework' on 'Instruments of Sustainability'. The following table shows a relative scoring of each of the relevant instruments with respect to the responsible factors discussed above.
Qualitative Assessment of Sustainability

[On the basis of positive and negative Factors observed on a Five point scale]
(1-5 scale: 1=very poor, 5=very strong)

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Scoring</th>
<th>Positive Factors</th>
<th>Negative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need-based Project</td>
<td>3</td>
<td>Targeted poorer women and children for comprehensive rural health development project on primary education, school health education, curative health care with suitability of community need assessment</td>
<td>Need for curative, preventive and promotive services to provide holistic health care is not effectively addresses through establishing linkage with other projects</td>
</tr>
<tr>
<td>Quality of service</td>
<td>2</td>
<td>Medico dominated, curative intervention with committed group of village level health workers</td>
<td>Insufficient training and exposure to the health workers, specialised training on quality of care needs improvement</td>
</tr>
<tr>
<td>Community Organizations</td>
<td>3</td>
<td>Focus on formation of Mahila Mandal and self-help groups. Attempt to utilise these groups in generating internal resources. Good experience in working with the community</td>
<td>Not clear direction to the Mahila Mandal in planning resources. The units have long way to go to act independently in health care activities. No co-ordination established with panchayat system through these community organisations</td>
</tr>
<tr>
<td>Accumulated Assets</td>
<td>3</td>
<td>Completed the main project hospital building by own initiative. The hospital land was added to total asset</td>
<td>No systematic plan to recover the maintenance of assets. This asset still remains untapped for generating resources for health care</td>
</tr>
<tr>
<td>Resource Manager</td>
<td>3</td>
<td>Dynamic project leadership. Clarity of organisational mission. Good number of exposure to training workshops and sharing events. Significant interest in sustainability</td>
<td>Centralised decision-making process. Management decisions are mostly ad hoc and individual-based. Needs consciousness about cost effectiveness. Potential linkages with other projects is largely untapped</td>
</tr>
<tr>
<td>Resource Generator</td>
<td>1</td>
<td>Substantial effort in income generating activities and linking it with self-help initiatives. User fee charged for ambulatory and curative care. Great potential in utilising land assets to subsidise health care activities</td>
<td>Recovery of operating cost through user fee and other means is still a distant goal. Interest from corpus fund is insufficient for meeting staff salary. No specific direction towards utilising land assets for cross-subsidisation of health care</td>
</tr>
</tbody>
</table>

The above analysis of the qualitative assessment of sustainability on the basis of positive and negative factors observed on a Five- point scale reveals the following. The average score observed is 2.0, which is less than overall average of 3.0. This may be attributed to the fact that some of the major instruments are still not developed. This implies that the organisation is located somewhat in the lower level of pathway
to sustainability and needs to concentrate on the development of some of the instruments vigorously.

### 7.2.5 Strategisation

The above assessment can be strategised by the following SWOT matrix, which can be used to devise the optimum management strategy. The present report contains only the most relevant components of the matrix.

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical infrastructure (Hospital building, land assets, vehicle etc.)</strong></td>
<td><strong>Drive to mobilise internal resources needs more emphasis</strong></td>
</tr>
<tr>
<td><strong>Dynamic project leadership</strong></td>
<td><strong>Operational management decision is mostly centralised and ad hoc, and top-down</strong></td>
</tr>
<tr>
<td><strong>Experience in working with community (especially women groups) for social action</strong></td>
<td><strong>Too much emphasis on curative aspect but lack emphasis on linking benefits from other community programmes of the government and of the NGO</strong></td>
</tr>
<tr>
<td><strong>Dedicated group of female health volunteers</strong></td>
<td><strong>Technical training is very much a need for grassroots health workers</strong></td>
</tr>
<tr>
<td><strong>Strong interest in sustaining benefits</strong></td>
<td><strong>Absence of Women leadership in organisation</strong></td>
</tr>
<tr>
<td><strong>Established fully equipped hospital in outreach populated village</strong></td>
<td><strong>Too much of community dependency on charity driven project management strategy</strong></td>
</tr>
<tr>
<td><strong>Requisite emphasis on curative health intervention through provision of quality health care services</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Huge unmet need for MCH care</strong></td>
<td><strong>Social condition and poor compensation threatening low retention of village level health workers and high turnover of professional staff</strong></td>
</tr>
<tr>
<td><strong>Leadership role in networking with other NGOs in the region, women organisations and co-ordination with Panchayat raj institutions (PRIs)</strong></td>
<td><strong>No possibility of extension of PVOH-II grants</strong></td>
</tr>
<tr>
<td><strong>Strong ongoing project activities on community development</strong></td>
<td><strong>Compensation of private health care providers</strong></td>
</tr>
<tr>
<td><strong>Potential recognition in the corporate social responsibility forum in the state</strong></td>
<td><strong>Community’s poor paying capacity on health care</strong></td>
</tr>
<tr>
<td><strong>Significant progress in knowledge and awareness among women creating potential demand for services</strong></td>
<td><strong>No anticipated external fund for this purpose</strong></td>
</tr>
<tr>
<td><strong>Interest of donor agencies support and capacity in receiving more projects in health &amp; family welfare sector</strong></td>
<td><strong>No linkages established with PRIs and other NGOs to avail external co-operation for organisational co-ordination</strong></td>
</tr>
<tr>
<td><strong>Accumulated knowledge and skills gained from the technical assistance under PVOH-II project</strong></td>
<td><strong>Poor community response to BCT drive towards sustainability</strong></td>
</tr>
<tr>
<td><strong>Corporate backing makes the NGO initiatives provide better management of health care</strong></td>
<td><strong>No possible cooperation for continuity of health posts</strong></td>
</tr>
</tbody>
</table>

The optimum strategy should be one, which extracts maximum opportunities on the basis of the strengths and minimises the threats. The strategy for BCT is understood to be based on its drive towards sustainability, a part of which was discussed before this analysis. The analysis found that the effort for sustainability comes out of genuine interest of the top management in the form of reactive and competitive instead of a
clear cut strategic planning and designing from the day one of the project implementation.

7.3 BAL RASHMI SOCIETY

BRS is having a team of well-trained, experienced and devoted workers who function at the grassroots level for child development, rehabilitation, education and health care activities. The NGO is one of the 32 projects funded under PVOH-I scheme in January, 1987 which ended in September 1990. The findings of the PVOH-I experiences showed that this NGO had implemented the project successfully in the rural outreach areas of Bassi tehsil in Jaipur district.

Visit to the rural health centre located in a remote village in Lalgarh, which was established under PVOH-I revealed the following observations:

- The local health care is addressed through this health centre with the attendance of 50-60% patients per day
- The local community apprised the services rendered by the society as per the need and emergence of the area situation.
- In fact the organisation has been able to retain all the staff meeting within the expenses from the resources mobilised from various sources including local donations and to some extent through volunteered services

Under the present project the NGO has covered a total of 149 villages covering a population of 91609 (as per 1981 census) where in SC/ST population was reported to be 50%. Project villages of Jamwa Ramgarh tehsil of Jaipur district which is 28 kms away from Jaipur district and about 30 kms from the nearest PHC Banpurkalan, one of the government health care units functioning in the area. The entire area is not conveniently approachable considering the location and the scatteredness of the villages. One has to cover a distance about 50-60 kms to reach the farthest village of the project area. Keeping in view the distance, scattered locations of villages in Jamwa Ramgarh tehsil and other problems relating to the implementation of the project, it was decided with the consent of the Chief Medical Officer to cover only 107 villages from Jamwa Ramgarh tehsil and 42 villages from Bassi tehsil near
Khedi. This was the origin of government-NGO co-operation since the beginning of PVOH-II project of the society.

7.3.1 Capacity of NGO Effectiveness

In the year 1983, BRS stepped into the field of health for the needy rural community. In the beginning 14 villages were taken up on the strong demand of local people where medical and health care facilities were not available. The programme was carried out in collaboration with GOI under PVOH-I scheme covering a population of 40,000 in 83 villages of Bassi tehsil in Jaipur district. One MCH hospital and five sub-centres were built up at Lalgarh and in the adjoining area. People had low mortality and means of communication and transport were very limited. Lalgarh hospital, is the rural research centre, which is equipped with 15 beds with modern diagnostic facilities like x-ray, Pathological laboratory and qualified doctors and paramedical staff.

Under the PVOH-II project, a massive health programme was undertaken by the society in the name of 'Gramin Swasthya Sewa' in April 1992. The programme through two sub-centres, two mobile units and one nutrition centre for malnourished children covers 91,000 population. Working in the mids of filth and squalor of slums and in rural areas among people belonging to neglected sections of the community, BRS is confronted with problem of ill health, malnutrition and death at every step. The programme has four major aspects such as

- Health education, preventive and curative measures
- Hospital and health sub-centres and training of VLHWs(Village Level Health Workers)

The society provides package of MCH and family welfare services, immunisation to pregnant mothers and children, nutritional support to malnourished children of less than 6 years of age, preventive and curative health services at the centre and at the doorsteps of the people. In order to ensure sustainability the awareness camps, meetings, films shows and puppet shows are organised in the project area to educate people about personal health and hygiene, home and environment sanitation, immunisation, safe drinking water, prevention and cure of common diseases. Mahila
Vikas Mandals have also been an effective medium for organising such health programmes.

**Mobile Services**

In remote villages of Jamwa Ramgarh and Bassi Tehsils where communication is difficult and people are unable to get medical facilities; Bal Rashmi regularly sends two mobile vans with doctors and pra-medical staff to cover six to eight villages every day on a weekly basis. NGO’s mobile units cover 86 villages and provide treatment at the doorsteps to pregnant women, children, TB patients, eye care-patients etc. (project report).

**Maternal and Child Health Services**

Registration of pregnancy cases through VHWs and mutil-purpose (Females), prenatal care, immunization of pregnant women, iron and folic acid prophylactics against nutritional anaemia in mothers and children, post-natal care of women and child through trained MPW (F) and Dais, obstetric services by doctors at the health centre and, if necessary, at the doorstep, growth monitoring and immunisation of children etc. are provided. Nutritional aid is provided to poor families in the form of bulgur and oil on a regular basis. Training of Rural Health workers and Rural Sanitary workers is also organised.

**Family Planning**

Poor rural people, especially SCs and STs and other backward communities in the project area have large families, which is one of the main reasons for their poverty (BRS). Bal Rashmi through its field staff, doctors and extension education team motivates and mobilises eligible couples to adopt temporary family planning methods, for birth spacing between children and also permanent measures when necessary. Condoms, oral pills etc. are supplied to the eligible couple on a regular basis. The society workers accompany and assist the motivated women for sterilisation to urban hospitals in mobile vans.

The medical and health department of Government of Rajasthan has been extremely helpful in collaborating with the NGO in family planning and health related activities by ensuring regular supply of medicines, condoms and other family planning aids and providing sterilisation services to women motivated by the organisation.
**Eye Care** - In addition to the regular health programme the organisation is also conducting eye camps in the project villages at periodic intervals. To provide an example regarding the total number of patients served under 40 eye camps in which 15364 persons were treated for eye ailments and 1226 for cataract, glaucoma etc. (Annual Report-BRS).

**Health Education programme** – Keeping in view of the organisations capacity in the field of family welfare the society has undertaken a population education programme in Bassi and Jamwa Ramgarh *tehsil* of Jaipur district. The activities covered under this programme are to educate adolescent girls about physiology, menstruation, pregnancy, reproductive health, contraceptive choice etc to educate pregnant women about pre-natal and post-natal care, STD/HIV reproductive morbidity, abortion and contraceptive choice for spacing and permanent birth control.

### 7.3.2 Strategies on Sustainability

Organisation of *Mahila Mandals* for income generation, women empowerment and to develop leadership quality among them is the key community mobilisation strategies adopted by the society. This sort of awareness generation integrated with income generation and women empowerment strategy is considered to be a permanent resource for the organisation to promote sustainability.

Another strategy for sustainability adopted by BRS is to cut the size of the area of operation. Accordingly, it was decided that all health related activities under the existing PVOH-II project would continue only in the two villages where the NGO is having a very good set-up of health infrastructure. Whereas the remaining of the project area would receive some sort of support services such as; health awareness, co-ordination with government functionaries after the closure of the external support to the project. Apparently this seems to be a prudent step because with a delayed approach to sustainability drive the NGO should be very cautious about the constraints before defining its future strategies.

During the life of the project implementation, BRS never considered sustainability as an issue that would affect the programmatic benefits to the local community.
Probably, therefore the organisational strategic focus was limited to the delivery of project specific health care services through the organisation’s well-constructed Rural Hospitals and Rural Health Centres. These hospitals are situated within the proximity, next to the government sub-centre. BRS has not initiated any co-ordination measure to link with the functioning of government sub-centres instead of concentrated on the delivery of health services. This is the reason after the tenure of project period functioning of the existing system is not the priority of the NGO but looking for more projects to continue the ongoing activities under a different project with a new name. The community dependency on NGO system is no way different from that of depending on the government system other than the delivery of quality care at the doorstep. This is not the spirit of voluntary action, which can be sustainable for creating community involvement in health development.

All the agenda of community participation, women empowerment, capacity building of Mahila Mandal remained limited to project specific strategies for the effective management of project to deliver quality health care. But not leading to the strengthening or operationalisation of existing government system in the project area. Co-ordination with government system is limited to the frontline workers for completing the targets of immunisation coverage, distribution of family planning aids, IFA tablets etc. Even training of TBAs is designed into the project operations for the expansion of outreach coverage and benefiting the targeted population within the project period. After which the role of NGO is completely unaware of the area situation unless and until it gets another project these activities can never been addressed or even been discussed. This is explaining the lack of vision of the NGO leader in fulfilling its social commitment instead of concentrating on its business commitment to the donor. This is opposed to the NGO effectiveness in achieving health care sustainability.

7.3.3 Contextual Factors

The major contextual factors affecting the sustainability of the PVOH-II project is discussed according to their impact on NGO management.

7.3.3.1 The favourable factors are
7.3.3.1.1 Community Need

The NGO has been successful to a large extent in raising awareness among the women community in the project area. However, effective awareness also generates effective demand for health care. The health status of women and children of the poorer section is still remarkably low and the fact remains valid that community care in public health delivery system is still far from being able to address the raising demand on its own.

7.3.3.1.2 Community Response

The NGO effort in mobilising community response received remarkable support from the area. Community awareness is created through a series of meetings with mahila mandals (Records on mahila mandal meetings). As a result of which health posts were created by the women groups to function as a link between the community and the Rural hospital of the organisation. The organisation also receives substantial response from different community groups in terms of donation to their corpus fund.

7.3.3.1.3 Other supporting projects

The major strength of the organisation lies on its focus and approach on child welfare activities through its Children’s Homes (NGO profile-BRS). The village health workers and mahila mandals function as a great support for spreading messages of health awareness among children and the community.

7.3.3.2 Major unfavourable factors

7.3.3.2.1 Cessation of PVOH-II grant

The MOHFW and USAID support almost 75% of the total project outlay. This cost takes care of total non-recurring and recurring cost of the project. This was a sizeable support, which once stopped, could pose substantial threat to sustainability.

7.3.3.2.2 Poor paying capacity of the Community

Resource mobilisation through increased user fee or any other direct mechanism is difficult due to two basic reasons; the target population is extremely poor, and a sudden increase in existing or application of new charges would generate some sort of resistance among the community.
7.3.3.2.3 Irregularities of Village level health workers

VLHWs remain absence at the time of agricultural cultivation in which period the activity gets affected in the respective villages. In case of unmarried members the possibility of drop out is maximum due to their marriage or for having alternate opportunity (Evaluation report).

7.3.4 Operational Factors

• The VLHWs are found to be the real strength of the project. They are the link between target population in the community and the health services of the NGO. With low salary they are serving the organisation for the benefit of local community in the respective villages.

• Over the project period, there has been a significant achievement in skill building and expertise among the managerial team in creating a critical mass of skilled human resources. In general both members from a family is provided the opportunity to work in the organisation at the field level to ensure effective monitoring, regularity of services, recognition in the village community and contributing to family income of the couple.

• Two hospital buildings of the NGO serves as a referral centre, Rural research centre and a centre for health education resource with having out-door and in-door facility for the clinical care. The building and other assets in the hospital determine the NGO's confidence to continue its activities.

• The decision for scaling down of activities was a necessary step to maintain the quality of programme in continuing the hospital-based activities after the closure of project period.

Major unfavourable aspects associated with the operational factors

• The programme focused only on promotive and curative care. The demand for continuity of good quality of care has been raising as a consequence of increased
awareness, but BRS is not sufficiently ready to deal with the rising demand to continue its activities as in the case of project period.

- The major potentials of resource generation were remaining largely untapped. The Mahila Mandals was yet to receive a definite direction and guidance for owning the project. Different village based units of the organisation could be used in linking health care with income generation activities, economic benefit programmes of the government etc. There is a long way to go to achieve perceptible results in this direction.

- Integration of health care activities required to be addressed with the existing child welfare activities of the NGO. The two different projects diverted the organisational attention in an integrated manner resulting in missing the synergistic effect and deviating from ensuring higher cost-effectiveness.

- The strategy on training was ad hoc, and to some extent, biased. While the top managerial staff (Project Co-ordinator, Secretary, MOs) attended almost all the project related training programmes, exposure to other NGO experiences. But the supervisory staff and VLHWs received hardly any training and exposure input.

- The role of Traditional Birth Attendants (TBA) is extremely important to sustain the activities and its impact. It was surprising to see that this potential instrument of self-sufficiency was never explored effectively e.g. in the form of sharing of responsibilities and organisation and training of new TBAs etc.

7.3.5 Leadership Factors

7.3.5.1 Favourable factors

- Interest to sustain the most essential and primary ingredient for sustainability. The interaction with Programme Co-ordinator and Medical officer of the NGO, reflected the willingness of the organisation to sustain the health care benefits to the project area community.

- Programme Co-ordinator manages other community development projects of the NGO such as; Rehabilitation, care and welfare of the children, women empowerment, community advocacy, networking and co-ordination of social action involving community action. Organisation’s secretary is the guiding force for promoting sustainability.
7.3.5.2 Unfavorable factors

- There is evidential support for the lack of long-term vision and planning about resource mobilisation and utilisation of community support for sustaining the benefits of the project activities. Unilateral decisions are always taken with a top-down control mechanism. Though the leadership quality is dynamic, it needs encouraging coherence, participatory planning and decentralised decision making for effective management strategies.

- The organisation needs to have more effective participation of women in the leadership at all levels of functionaries.

- Networking and co-ordination of activities are limited to the exchange of experience sharing and participation in national and internal conferences and seminars and state level consortium on social action forum for advocating gender equality in development etc. But it has hardly made any effort to link institutions of Panchayats at the village, block or at the district levels. This suffered an adequate value addition to the component of decentralised planning and decision making involving health care decentralisation. Sustainability of health care benefits is the equal responsibility and concern of all the actors of development in the process of democratic decentralisation. This fact was highly neglected by the NGO management during its project period.

These favourable and unfavourable factors taken together create a sustainability profile of the NGO. These also help to identify the status of the social instruments discussed in ‘research design’ under ‘conceptual framework’ on ‘Instruments of Sustainability’. The following table shows a relative scoring of each of the relevant instruments with respect to the responsible factors discussed above.
# BAL RASHMI SOCIETY

## Qualitative Assessment of Sustainability

[On the basis of positive and negative Factors observed on a Five point scale]

*(1-5 scale: 1=very poor, 5=very strong)*

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Scoring</th>
<th>Positive Factors</th>
<th>Negative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need-based Project</td>
<td>4</td>
<td>Targeted poorer women and children for comprehensive child development projects on school health education, curative health care with suitability of community need assessment</td>
<td>Need for curative, preventive and promotive services to provide holistic health care is not effectively addresses</td>
</tr>
<tr>
<td>Quality of service</td>
<td>2</td>
<td>Medico dominated, curative intervention with committed group of village level health workers</td>
<td>Insufficient training and exposure to the health workers, specialised training on quality of care needs improvement</td>
</tr>
<tr>
<td>Community Organizations</td>
<td>3</td>
<td>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</td>
<td>Not clear direction to the Mahila Mandals in planning resources. The units have long way to go to act independently in health care activities. No co-ordination established with panchayat system through these community organisations</td>
</tr>
<tr>
<td>Accumulated Assets</td>
<td>4</td>
<td>Completed the main project hospital building by own initiative. The hospital land was added to total asset</td>
<td>No systematic plan to recover the maintenance of assets. This asset still remains untapped for generating resources for health care</td>
</tr>
<tr>
<td>Resource Manager</td>
<td>3</td>
<td>Dynamic project leadership. Clarity of organisational mission. Good number of exposure to training workshops and sharing events. Significant interest in sustainability</td>
<td>Centralised decision-making process. Management decisions are mostly ad hoc and individual-based. Needs consciousness about cost effectiveness. Potential linkages with other projects is largely untapped</td>
</tr>
<tr>
<td>Resource Generator</td>
<td>3</td>
<td>Substantial effort in income generating activities and linking it with self-help initiatives. User fee charged for ambulatory and curative care. Great potential in utilising land assets to subsidise health care activities</td>
<td>Recovery of operating cost through user fee and other means is still a distant goal. Interest from corpus fund is insufficient for meeting staff salary. No specific direction towards utilising land assets for cross-subsidisation of health care</td>
</tr>
</tbody>
</table>

The above analysis of the qualitative assessment of sustainability on the basis of positive and negative factors observed on a Five-point scale reveals the following.

The average score observed is 3.1, which is slightly higher than overall average of 3.0. This implies that the organisation is located somewhat in the middle of pathway to sustainability and needs to concentrate on the development of some of the instruments vigorously.
7.3.6 Strategisation

The above assessment can be strategized by the following SWOT matrix, which can be used to devise the optimum management strategy. The present report contains only the most relevant components of the matrix.

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical infrastructure (Hospital building, land assets, vehicle etc.)</td>
<td>• Drive to mobilise internal resources needs more emphasis</td>
</tr>
<tr>
<td>• Dynamic project leadership</td>
<td>• Operational management decision is mostly centralised and ad hoc</td>
</tr>
<tr>
<td>• Experience in working with community (especially women groups) for social action</td>
<td>• Too much emphasis on curative aspect but lack emphasis on linking benefits from other community programmes of the government and of the NGO</td>
</tr>
<tr>
<td>• Dedicated group of Village level health workers</td>
<td>• Technical training is very much a need for grassroots health workers</td>
</tr>
<tr>
<td>• Strong interest in sustaining benefits</td>
<td></td>
</tr>
<tr>
<td>• Established two hospitals in outreach populated villages</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Opportunities</strong></th>
<th><strong>Threats</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Huge unmet need for MCH care</td>
<td>• Social condition and poor compensation threatening low retention of village level health workers</td>
</tr>
<tr>
<td>• Leadership role in networking with other NGOs in the region and co-ordination with Panchayat raj institutions (PRIs)</td>
<td>• No possibility of extension of PVOH-II grants</td>
</tr>
<tr>
<td>• Strong ongoing project on child welfare</td>
<td>• Compensation of private health care providers</td>
</tr>
<tr>
<td>• Potential recognition in the state</td>
<td>• Community’s poor paying capacity on health care</td>
</tr>
<tr>
<td>• Significant progress in knowledge and awareness among women creating potential demand for services</td>
<td>• No anticipated external fund for this purpose</td>
</tr>
<tr>
<td>• Interest of donor agencies in ‘health and family welfare sector reform in the state</td>
<td>• No linkages established with PRIs and other NGOs to avail external co-operation for organisational coordination</td>
</tr>
<tr>
<td>• Accumulated knowledge and skills gained from the technical assistance under PVOH-II project</td>
<td></td>
</tr>
<tr>
<td>• Good community response to BRS drive towards sustainability</td>
<td></td>
</tr>
<tr>
<td>• Scaling down of activities makes the NGO initiatives provide better management more feasible</td>
<td></td>
</tr>
</tbody>
</table>

The optimum strategy should be one, which extracts maximum opportunities on the basis of the strengths and minimises the threats. The strategy for Bal Rashmi Society is understood to be based on its drive towards sustainability a part of which was discussed before this analysis. The analysis found that the effort for sustainability comes out of genuine interest of the top management in the form of reactive and competitive instead of a clear cut strategic planning and designing from the day one of the project implementation.

7.4 DISCUSSION ON SUSTAINABILITY

The overall project management strategy of the NGOs should have extended to avail the maximum of Government co-operation to attain and sustain the basic continuity of
health care benefits to the local community by effective linkages with the institutions of village-panchayts, creating awareness about various government and non-government schemes aiming at the economic benefits of the local community, linking health activities to the formulation of women self-help groups through initiating micro-credit for the rural poor. These benefits make the local community more responsive and responsible to concern the sustainability of the health care benefits to them, which was introduced through the project for a limited period.

But the NGO initiative, in general is limited to the delivery of health care with the involvement of its village based health team, even the staff salary is a big question before the management after the completion of the project period. Big infrastructure in the village was not the priority but the operationalisation of health services is the need for the local community. This was the proposition of sustainability by the donor. Role of NGOs seems to be limited to function as a service delivery contractor instead of emerging out as an agent of social change to empower community to have the ownership in their health and development activity.

The analysis also identified several factors, which impede sustainability. They are discussed as follows:

- weak strategic planning which often only focused on a specific project supported by the organisation rather than linking the overall NGO support,
- management systems which were stronger at the field project level than for the NGO itself,
- information collected was not used for planning and monitoring,
- no formal social marketing function and even resource mobilisation opportunities was present in the project management system i.e. linking the beneficiaries to the ongoing economic benefit programmes in the project area is very much absent,
- NGO leadership at the field level are either changed frequently or transferred in most cases affects the project team to mingle with new style of leadership,
- few of the NGOs had a business orientation,
- many NGOs relied on village based volunteers to both lead and manage the day-to-day operations of the organisation,
• program costs were rarely compared with the anticipated surplus of a planned income generating activity (IGA); therefore it was not possible to determine, in advance, whether the IGA would be able to subsidise the intended program,
• fees for services typically covered the operating costs of a NGO, but were not enough to cover routine maintenance and capital improvements
• NGOs rarely calculated inflation into the price of the family planning commodities or drugs they sold,
• none of the NGOs had any reserves, nor were they generating any surplus which could be used to develop reserves necessary to support such organisations in an unstable economy,
• local resource mobilisation efforts were not successful at generating significant income,
• absence of appropriate government co-ordination at the field level, absence of linkage with the existing government system and the lack of involvement of PRIs in the local level are key weaknesses observed in the strategies common to all these NGO project management.

In view of these general findings, the following measures are necessary for sustaining programmatic effectiveness:
• Develop the NGOs' strategic planning capabilities including linking planned activities with their associated costs provide training on how to use information, especially financial and linking the marketing information, for planning and monitoring to develop the resource mobilisation capabilities of the NGOs including collecting and analysing resources mobilisation data and developing strategic plans adapt and expand project management and financial systems to serve the entire organisation.
• Identify approaches to lower program costs and deliver the services more efficiently provide leadership training for all levels of the organisation determine which revenue generating activities are appropriate for each NGO, including fees, local and international fundraising, government or community contributions, investments, and income generating activities.
• Provide technical assistance which is tailored to the specific revenue generating activities of each NGO including: developing fundraising approaches, pricing of
services, and conducting feasibility studies link the information collected in this study with more complete service and management information to form a more comprehensive picture of NGO sustainability withdraw financial support slowly over the life of the donor supported project.

- Linking with local community organisations and institutions of panchayat system to avail maximum co-operation from the PRIs and ensure the involvement of local community in their benefits of health development activities. Handing over the responsibility of the functioning and management of local health problems to the local institutions through effective capacity building is the key to enhance sustainability.

This discussion leads to the lessons learned and strategic implications of the present study in understanding the key issues of sustainability, as emerged from three case-studies under the PVOH-II project in brief and their programmatic and policy implications for the major stakeholders and partners in health and social sector development. This is followed in the next chapter.