

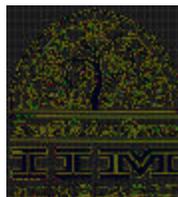


Contracting-out of Reproductive and Child Health (RCH)
Services through Mother NGO Scheme in India:
Experiences and Implications

Ramesh Bhat
Sunil Maheshwari
Somen Saha

W.P. No.2007-01-05
January 2007

The main objective of the working paper series of the IIMA is to help faculty members, Research Staff and Doctoral Students to speedily share their research findings with professional colleagues, and to test out their research findings at the pre-publication stage



INDIAN INSTITUTE OF MANAGEMENT
AHMEDABAD-380 015
INDIA

Contracting-out of Reproductive and Child Health (RCH) Services through Mother NGO Scheme in India: Experiences and Implications

Abstract

Partnership with NGOs in delivering and provision of Reproductive and Child Health (RCH) services through mother NGO (MNGO) in the un-served and under-served regions is one of the important initiatives in India. The scheme involves large number of contracts between government and the NGOs. As of April 2006, 215 MNGOs were working in 324 districts of the country. In addition to this there are about 3 to 4 Field NGOs attached with each MNGO in a district. This paper discusses this scheme with an objective to understand the make up of the partnership and the development of management capacity in the system.

MNGO scheme is a central sponsored scheme. This scheme faces management challenge to implement it in all states in India. Further, the case study of three states presented in this paper suggests that this challenge emanates several factors. Inter alia, these include delay and uncertainty of funding and contract renewal, lack of partnership orientation in the scheme, lack of trust among the key stakeholders, capacity constrain in the district and state health system, weak monitoring system, procedural delays and multiple points of authority and reporting relationships. It is also observed that the capacity of field NGOs to deliver in the programme is constrained due to non-availability of financial and human resources. The scheme demands a strong leadership at local levels and ownership from the state health system. This can be achieved through effective decentralisation, flexibility in decision-making and creating adequate accountability systems. Regional Resource Centres has to play an important role in coordination between state/district RCH society and the NGOs and strengthening their capacities. The central government instead of focusing on micro-management of the scheme at state level should focus on developing and strengthening the enabling environment and capacity of various stakeholders to implement the scheme. Also, they need to address various systemic issues including development of accountable and performance oriented system, ensuring financial autonomy and decentralisation, delegation of authority, building trust and accountability in the system, effective integration, continuity of the scheme and fostering true sense of partnership between the state and non-state sector.

We gratefully acknowledge the financial support from World Health Organisation, Geneva for this study. We are grateful to Dr. Dale Huntington, WHO for providing critical comments on the first draft of this study. The authors have gained from discussions with Dr. P C Das, Deputy Commissioner, NGO Division, MoHFW, Government of India. We also express our gratitude to coordinators of NGOs visited during the study and their field staffs for extended kind support in collection of data and sharing their experiences on the scheme.

Contracting-out of Reproductive and Child Health (RCH) through Mother NGO Scheme in India: Experiences and Implications

I. Introduction

In 1997, the Ministry of Health and Family Welfare, in accordance with the ICPD Cairo Conference and in concurrence to the Ninth Five Year Plan (1997 - 2002), initiated the RCH programme aimed to provide integrated health and family welfare services to meet the felt needs for health care for women and children. The concept was to provide the beneficiaries with need based, client centered, demand driven, high quality and integrated Reproductive and Child Health (RCH) services. The programme component included male involvement, adolescent component, RTI/STI issues, and gender in the context of reproductive rights in the RCH programme. In the same year, the Ministry introduced the Mother NGO (MNGO) scheme under the RCH programme in which selected NGOs were identified and designated as MNGOs. These NGOs were provided grants to strengthen RCH services in selected districts. These MNGOs in turn award grants to smaller NGOs called Field NGOs (FNGOs) to further strengthen the services at the grass-root levels and promote the goals/objectives of the RCH programme. MNGOs needed considerable capacity strengthening. For this purpose, the Government of India decided to establish Regional Resource Centers (RRCs) with financial assistance from the UNFPA to provide technical and programmatic support towards capacity building of MNGOs. MNGOs in this scheme were selected based on strong RCH programme and training experiences, understanding of gender issues and advocacy skills, strong networking ability and credibility in programme management and national status¹. The Mother NGO scheme is now part of National Rural Health Mission scheme implemented by Government of India.

II. Study objectives and scope

Mother NGO scheme is one of the largest initiatives in India to involve NGOs in delivering RCH services among the un-served and under-served areas. The scheme involves large number of contracts between government and the NGO sector. As of April 2006, 215 Mother NGOs are working in 324 districts of the country. Further, 3 to 4 Field NGOs are attached with each MNGO in a district. The objective of the study is to understand the make up of the partnership and the development of management capacity in the system to implement Mother NGO scheme. Specifically the study examines the following three issues:

- Studying the structure and process of building partnerships and contracting relationships in the national Mother NGO scheme of India;
- Understand the management capacity and competency in make-up of the Mother NGO scheme;
- Identify pathways towards developing state and district management capacity to implement this scheme.

The Mother NGO scheme is one of the components of the RCH/NRHM programme of the government of India. This scheme has been selected for analysis as the learning from

¹ CINI RRC Annual Report 2005

this study is expected to contribute to the larger programme implementation plan and understanding of contracting relationships in general. Moreover, the scheme, in spite of being a national scheme with involvement of a large number of NGOs throughout the country, is less researched and the dynamics of the partnership and the contracting relationships in the scheme is less understood. This has implication on programme implementation and taking mid-course correction from a management perspective. This study is not a comprehensive review or evaluation of the scheme. Our purpose has been more specifically focused on understanding the contracting relationships, management capacity, competencies and process of the scheme implementation. The study *per se* was not designed to evaluate the scheme. For example, the questions such as whether the scheme is effective in achieving its stated programme objectives and whether the scheme is adequately funded to achieve its stated objectives will need further studies.

The analysis and findings presented in this study are based on interactions and field visits to select organisations, meeting with government officials and stakeholders in three states viz., Gujarat, Haryana and Assam (see Exhibit 3 for list of Mother NGOs and the corresponding districts covered in these states). We also reviewed the web pages and newsletters of six Regional Resource Centres (RRCs) in India (see Exhibit 1 for list of RRCs). The web pages and newsletters reviewed are of Voluntary Health Association of India, Child in Need Institute, Population Foundation of India, Centre for Health Education, Training and Nutrition Awareness, Mamta Health Institute for Mother and Child and State Innovation in Family Planning Services Project Agency. A note on the study methodology, organisations visited by the research team and profiles of the NGOs is given in Exhibit 2.

III. Origin of the Scheme

In health sector, the rationale for contracting out services by state to non-state organisations is rooted in the belief that the state is over-extended, it can not reach to communities in effective and efficient way, and alongside a strong presumption that the practice of private sector management are likely to be more effective².

The National Health Policy of 1983 clearly spelled the role of non-state sector, particularly NGO sector, in India's provision of health care. During 1990s the involvement of NGOs in provision of health services in India gained momentum as the focus on participatory approaches through public-private partnerships and ideas emanating from these experiences formed key strategies of health sector programmes. The experiences, ideas and practices in this area also started shaping and influencing the strategies of various development partners. The new economic policy of government of India emphasised expanded role for the non-state sector in the provision of development services. The Cairo Population Conference 1994 also renewed the thrust on participation

² Bhat Ramesh (2000). Issues in health: public-private partnerships. *Economic and Political Weekly* 35 (53): 4706-4716.

Bennett S, McPake B, Mills A. The public/private mix debate in health care in Bennett S, McPake B, Mills A, (eds.) *Private health providers in developing countries: serving the public interest?* London, Zed Books, 1997

Jackson P, Price C. *Privatisation and regulation - a review of the issues*. Harlow, Longman, 1994

Ferlie E et al. *The new public management in action*. Oxford University Press, 1996

of NGOs in achieving the goal of reproductive and child health (RCH) programme. Over the years, the national policy documents have recognised the need for partnership with NGOs in achieving national targets in national health programmes. The 7th and 8th Five-year Plan envisaged larger role of NGOs in advocacy and promotion of health programme. During the 9th Five-year Plan, the roles of NGOs were widened to emerge as pioneers of reform movement. Further the National Health Policy 2003 and National Population Policy 2000 envisaged an increasing role for NGOs and civil societies in building up awareness and improving community participation and this became part of agenda of the tenth five-year plan advocating for NGOs to have a major role in promoting community participation. The plan also proposed to allow NGOs with adequate expertise and experience to participate in RCH service delivery.

The scope of NGO involvement in India has been largely limited to community mobilisation and discharging certain specified activities like running community health centres or community learning centres. This was seen more as an extension arm of the state – within a specified project framework. However, there has been concerns of continuity and long-term vision of these agencies in implementing the programmes. Over the years, apprehensions about effective use of funds and its management by NGOs prominently surfaced among the policy makers as one of the major concerns affecting the state-NGO collaborations. This also resulted in mistrust and unease in relationship. Instances of inappropriate utilisation of funds by NGOs, on one hand and allegations of vested interests within the government agencies in allocating and disbursing funds, on the other, have contributed to this often uneasy relationship³. Other important problems in dealing with NGOs were identified as follows:

- There are a large number of NGOs in the country. For example, the state of Gujarat has around 1500 registered NGOs⁴. While some NGOs have been trend-setter, capacities of many NGOs are not adequate to handle the concerns and challenges of the sector;
- Capacity building of such large number of NGOs is both a time consuming and involved task. Moreover regulating NGOs need a community focussed skills and understanding of the community dynamics;
- Coordinating with a large number of NGOs require huge resource and time for the health department.
- Financing large number of NGOs and timely monitoring required a huge workforce and capacity within the health department.

Recognizing that small field NGOs have limited technical and managerial capacity, MNGO Scheme provides support and institutional structure to facilitate that larger NGOs to serve as mother NGOs to mentor smaller and field level NGOs and provide support for their capacity building.

³ Nair P. India: Desk Study of Non-State Providers of Basic Services. International Development Department, School of Public Policy, University of Birmingham

⁴ The Mission Report (2003). Priorities for Mental Health Sector Development in Gujarat. Department of Health and Family Welfare, Government of Gujarat

MNGO Scheme in RCH II Programme

Based on the experience gained from first phase of RCH programme implementation and World Bank assessment of RCH I project⁵, several modifications were made in the MNGO scheme under RCH II. Key changes are as follows:

- In addition to community mobilisation, components of service delivery are added to the programme.
- The jurisdiction of MNGO area was also redefined. One MNGO would work only in the identified un-served and under served areas of one or a maximum of two districts.
- The concept of Service NGO, conceptualised in the original Mother NGO scheme plan document, was introduced in RCH II to directly provide integrated services in an area co-terminus to that of CHC/ block PHC with 100,000 populations. Service NGOs (SNGOs) are expected to provide a range of clinical services directly to the community.
- Greater emphasis is laid on specific output indicators for each of the programme component⁶. MNGOs prepare their project proposals after doing a community need assessment (CAN) study of the area allocated to them. Evaluations will be done after first and third year and NGOs have to report progress on specific indicators identified in the CNA study.
- From 105 Mother NGOs in 2003, the number of MNGOs has almost doubled during 2005. RCH II programme intend to scale up MNGO scheme to cover all districts of India. Because of the increased coverage and to facilitate technical support to implementing agencies six new RRCs were selected. This increased the number of RRCs to ten. List of RRCs along with the states allotted is given in Exhibit 1.
- Management of the programme was decentralised to the state level. State RCH society and state health department were actively involved in the selection of NGOs, disbursement of funds and monitoring of the activities. More RRCs were added for capacity strengthening of the NGOs and fostering effective partnership. Best practice centres were identified in states to compliment the RRC efforts.

Scheme objective and structure

The philosophy of the Mother NGO scheme is to nurture and build capacity of smaller NGOs with the following objectives.

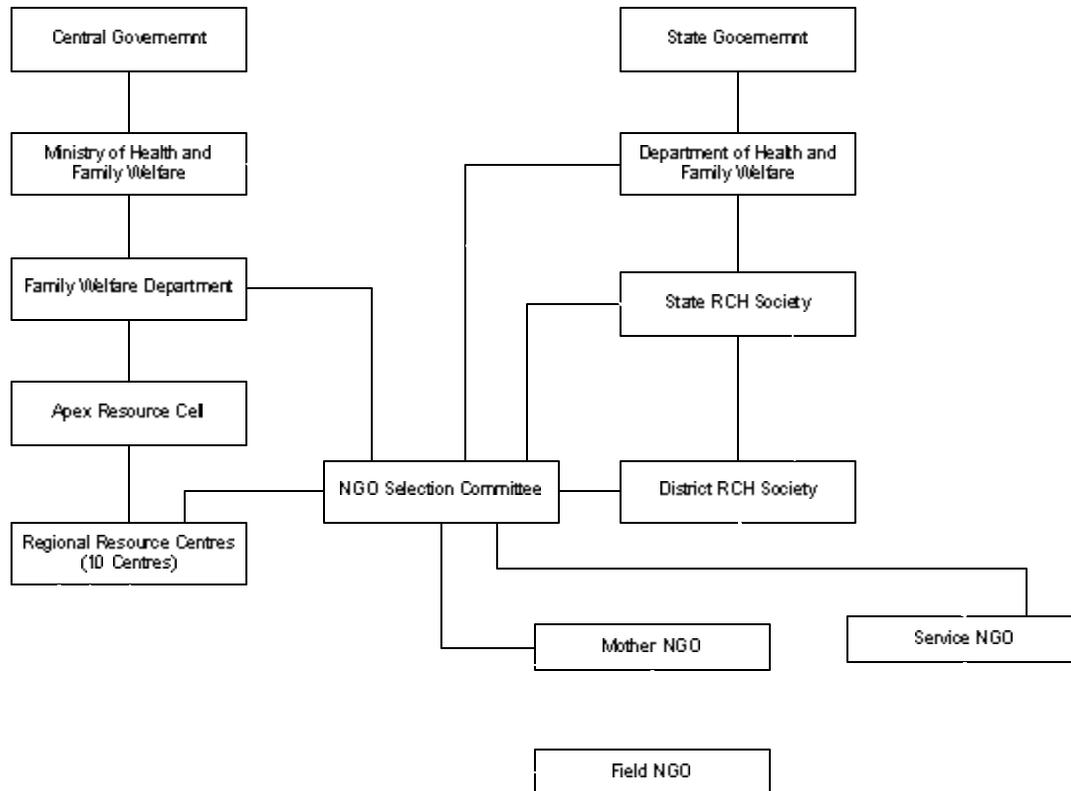
- address the gaps in information dissemination in RCH services in the project area
- build strong institutional capacity at the state, district/field level
- advocacy and awareness generation on RCH issues

⁵ New Concept Information System Pvt. Ltd. "Assessment of the RCH- MNGO Scheme". Referred in World Bank ICR for RCH I project. 2005

⁶ Sparch: Touching Lives. Quarterly Newsletter of Regional Resource Centre, Voluntary Health Association of Assam. April-June 2005. Vol. 1. Issue 1.

The basic structure of the scheme, the financial relationship between different stakeholders and relationship for technical support and performance monitoring is discussed in Figure 1.

Figure 1: Structure of Mother NGO Scheme Administration



It also maintains a database on demographic indicators, coverage and service delivery infrastructure and utilization data for the region.

State RCH Society: This society is an independent society within state health department for RCH programme implementation. The role of state RCH society is that of selection of MNGO, recommendations of MNGO projects for MoHFW approval, fund disbursement and monitoring and evaluation.

State NGO Selection Committee: This committee is chaired by the Secretary, Family Welfare and it is represented by MoHFW representative, Regional Director, State NGO coordinator, Director (Family Welfare) and RRC representative.

District RCH Society: This society is represented by District RCH/FW Officer and is responsible for selection and approval of FNGOs and recommendation of MNGO projects.

Regional Resource Centre (RRC): The objective of the RRC is to provide technical assistance and capacity building support for a range of programme management and technical intervention areas to the state NGO Committee, MNGOs / FNGOs and SNGOs. Regional Resource Centre (RRC) is expected to provide technical support in following areas:

- Capacity building of NGOs in working in partnership and develop networking of these institutions
- Support MNGOs to develop training and technical assistance plans based on participatory needs assessment.
- Share experience/skills in conducting surveys/FGD, monitoring and providing technical assistance for capacity building
- Sensitize the NGOs and stakeholders about RCH service delivery strategies
- Ability to streamline the MIS/reporting system
- Specific regional RCH issues addressed through training, technical assistance and nurturing of NGOs
- Identifying best practice centre and documentation of various experiences

The RRCs are expected to work as models for public-private partnership between government and non-government organisations. The key programme outcomes expected from RRCs are:

- A network of institutions across the country capable of providing high quality technical assistance to a range of NGOs working in partnership with the Government on RCH issues as per the goals of the NPP 2000.
- Closer linkage between State governments and MNGO at state and district levels.
- Increased access of NGOs to district level disaggregated data, training and communication material, and information on policies and programmes.
- Development of NGO resource directory for RCH issues at state level.
- State governments and GOI receive inputs for midcourse correction and policy modification.

Mother NGO (MNGO): MNGOs are registered under the Societies Registration Act with substantial presence and experience for at least three years in health and social sector in the state or district where they propose to work. The MNGO should also possess a minimum Rs 2 lakhs fixed assets through out the project period. The tasks of MNGOs in the scheme are:

- Facilitating capacity building of Field NGOs (FNGOs)
- Enhance FNGOs capacity for financial and administrative management
- Enhance FNGOs capacity for effective program monitoring and evaluation
- Documentation and dissemination of best practices

The MNGOs can work in maximum of 2 districts preferably in un-served and under-served areas as defined by the District RCH society. The Mother NGOs in turn, issue grants to smaller NGOs called Field NGOs (FNGO) in the districts.

Field NGO (FNGO): Field NGOs are smaller NGOs with field presence of at least two years in the geographical area for which it is seeking a grant. These NGOs implement small projects, for a population of two sub-centres (10-15 thousand population), in specific aspects of RCH service delivery. FNGO is supported by MNGO for meeting their skill requirement either directly or through linkages with district hospitals, private service providers etc.

Service NGO (SNGO): NGOs with an established institutional base and engaged in directly providing integrated services in an area co-terminus to that of a CHC/block PHC with 100,000 populations is called a SNGO. These NGOs are expected to provide a range of clinical services directly to the community. The services expected from these NGOs pertain to safe delivery, neo-natal care, and treatment of diarrhea and ARI, abortion and IUD services, RTI/STI etc. Such NGOs should have clinic/hospital, ambulance for the purpose.

Funding the Scheme

Under the MNGO scheme, the projects are sanctioned for a period of three years. Funds for the programme are transferred from the MoHFW to the State RCH Society. The State RCH Society disburses the money to the district RCH society for supporting the activities of NGOs. The national budget estimate for MNGO scheme during 2006-07 is Rs. 329.10 million that is 0.36 per cent of the budget earmarked for National Rural Health Mission in India⁷.

Funds are made available to NGO according to the proposed interventions. These include: community needs assessment (CNA) studies, conducting IEC activities, induction and in-service training for the staff, community orientation, development of mass media campaigns, various types of camps, MCH clinics, provisions purchase of FP supplies, essential drugs (according to specified list) to meet situations where government supplies are not available, purchase of clinical equipment, consumables required for the

⁷ Public Expenditure Management (2006-07). Ministry of Health and Family Welfare, Government of India

clinics/camps, setting up of depots hiring of space for clinic/meetings, monitoring visits-travel and DA, referral transport, documentation, relevant records, registers and formats, follow up on referral cases, administrative and contingency. The salary component of the budget is not expected to exceed 35 per cent of the total budget. Based on the number of FNGOs and nature of proposed interventions, MNGOs get an annual support of approximately Rs. 0.5 to 1.5 million per district. MNGOs are allowed to retain 20 per cent of the total project cost for administrative and establishment purpose including for capacity building activities. Besides, the MNGOs are allowed a non-recurring grant of Rs. 150,000 towards purchase of assets and Rs. 100,000 for meeting exigencies such as drugs, vaccines and contraceptives. Depending on the nature of intervention, Service NGO (SNGO) get an annual allotment of approximately Rs. 1.0 to 1.5 million per CHC/block CHC area. MNGO enters into MoU with FNGO and provides fund to support their activities.

IV. Service Delivery Areas

The NGOs in the Mother NGO scheme are expected to complement the service delivery by enhancing and sustaining the demand for RCH services at community level, collaborate, and strengthen the government system. Under RCH II programme, performance of the scheme is measured on a set of measurable output indicators. Before commencement of the activity, NGOs were expected to conduct a CNA study. An end line survey is conducted to assess the improvements in service delivery due to the intervention on the specific indicators laid down in the project proposal. The State RCH society conducts an external evaluation of the project at the end of first year and third year of the project Key RCH programme components and performance indicators for service delivery of the NGOs are:

Maternal and Child Health : NGOs are expected to cover a population of 25-30 thousand spread over 30-40 villages through basic package of MCH services in the area.

Strategic interventions	Performance Indicators
Access to quality ANC	% reduction in maternal death. % increase in women and men getting married after attaining the legal age of marriage % increase in the birth interval by all women in reproductive age group
Institutional deliveries	% of deliveries assisted by skilled personnel (including TBAs)
Essential neo-natal care	% of new born initiated breast feeding within ½ hours of birth
Access to quality child survival interventions	% of girls and boys in 12-23 months age group completely protected with immunizations.
Safe motherhood and child survival interventions	% of girls and boys in 0-6 yrs given rational management of diarrhoea % of girls and boys reduced by 50% from several grades of malnutrition

Family Planning: NGOs are expected to provide comprehensive Family Welfare counselling and contraceptive services and cover a population of 850 to 6000 eligible couples depending on the type of NGOs.

Strategic interventions	Performance Indicators
Demand generation through awareness, information, products	% of reduction in unmet demand for contraception by the end of the project period
Family welfare services for eligible couples and young adults including counselling	% increase of boys and girls postponing their marriage % increase of eligible couple postponing birth of first child % of eligible couples reporting current unmet need % increase of men using condoms % of villages having assured supplies of non-clinical spacing contraceptives % increase in couple protection rate, client continuation rates for OCPs and condoms % of facilities reporting regular IUD insertion, % of PHCs/CHCs reporting sterilization (male and female) cases every month, ratio of male and female sterilization, % reduction in women resorting to unsafe abortion, % of FP/RH camps held in the district as planned
Community based distribution of contraceptives	% of private practitioners providing contraceptive services %Number of workers trained in counselling skills

Adolescent Reproductive Health: The NGO will be expected to provide comprehensive Adolescent Reproductive Health (ARH) education for increasing the knowledge on RH issues (family planning, RTI/STI, personal hygiene, anaemia, teenage pregnancy and age at marriage), and services. Focus will be on both n-school and out-of-school, married and unmarried adolescent girls and boys. Intervention for the programme has to be gender sensitive and comprises of:

Strategic interventions	Performance Indicators
Creating supportive environment in the community	% of adolescent girls and boys gained knowledge on RH leading to improved behaviour/practice
Access of adolescent girls and boys to knowledge and counselling/ clinical services	% of improvement in utilization of RH services % reduction in teenage pregnancies % of adolescent girls and boys coming for voluntary counselling and treatment of RTI/STI %number of peer educators per 100 adolescents available to impart nutrition and health education and reproductive hygiene % of adolescent girls who adopt hygienic practices during menstruation/reproduction % of boys who observe penile hygiene % of adolescents who use condom during their last sexual act
Enhancing life skills opportunities for adolescent girls and boys.	% of girls and boys getting married after reaching 18 and 21 years respectively %Qualitative changes as depicted through process documentation, case studies etc

Prevention and Management of RTI: NGOs are expected to work towards reducing prevalence of RTI/STI through networking and linking with institutions having required expertise and experience. Strategic interventions for the component are:

Strategic interventions	Performance Indicators
Behaviour change communication and social mobilisation	% of male/female in 15 -49 yrs age group reporting RTIs/STIs on the basis of household survey
Promoting condom as a method of dual protection	% of male /female/couples/partners who complete treatment
Case management of symptomatic individuals	
Orientation of private practitioners	

In addition to the above, Service NGOs cover the following services:

- MTP services
- Dai Training
- Violence against women
- Male Involvement

Identification of Un-served and Under-served Areas

Identification of un-served and under served areas is done in consultation with the district health department through mapping of the district based on parameters socio-economically backward areas and having no access to healthcare services from the existing government health infrastructure, especially urban slums, tribal, hilly and desert areas including SC/ST habitations. In specific terms these areas are: where the post of MO, ANM and LHV have been vacant for more than 1 year; the PHC is not equipped with minimal infrastructure and performance on critical RCH indicators is poor.

V. Capacity Building Initiative in the Scheme

Under NRHM scheme, a major capacity strengthening initiative has been undertaken in the MNGO scheme designating RRCs to take a lead role in capacity strengthening.

Capacity Strengthening of MNGOs and FNGOs

RRCs undertake several capacity strengthening meetings and workshops for Mother NGOs and Field NGOs. Some of the key initiatives include:

- Training of trainers for new MNGOs
- Orientation workshop for newly selected MNGOs

- On spot support for CNA study and data monitoring
- Organising baseline survey data entry package training
- Advocacy with district, state and central government to ensure policy implementation,
- Networking with the state/district/MNGOs and strengthening linkages and advocate for access to health care services.
- Information sharing about policies, programs, and schemes by MOHFW and awareness program by NGOs through newsletters/bibliographies/website
- Documentation and dissemination of best practices on RCH
- Publishing newsletter to disseminate the progress and information in the project

RRCs have organised regional Government-NGO (GO-NGO) partnership workshops with an aim to improve network between the public and private sector, uniformity in messages, enhance trust, transparency and accountability. The workshops were attended by representatives from MNGOs, Chief District Health Officers, RCH officers, Regional Directors, Additional District Health Officers, District Health Officers and representatives from state health department. The key objectives of the workshop were:

- To discuss the importance of GO-NGO partnership in effective implementation of the RCH programme
- To share about the MNGO and role of various stakeholders in the programme
- To develop the GO-NGO partnership strategy and action plan for the effective implementation of RCH II programme.

Along with discussion of the key challenges in implementation of the programme from NGO and Government perspective, the workshop involves the participants to work on a workable action plan. An analysis of three GO-NGO partnership workshops during 2005, organised by RRC-Chetna, brings out the three major areas of challenges in the programme implementation. These are summarised below:

Challenges in working with Government

- Communication gaps between government and NGOs
- Too much of paper work involved in dealing with government
- Difficulties in implementation of work due to bureaucratic attitudes of officers
- Lack of coordination between NGO representatives and health functionaries
- Lack of statistics to substantiate the findings
- Inadequate funds to carry out the project activities
- Absence of mechanisms to share information on various issues by the state on a continuous basis
- Less clarity of roles and responsibilities
- Lack of coordination with local self-government bodies (panchayat and elected members)
- Non availability of transport services in remote field areas

- Lack of strategic planning and follow-up activities at government level
- Block and district health officials were involved in programme planning. They just act in implementing the programme in the field area

Challenges in working with NGO

- NGOs have multiple projects and can not concentrate on one aspect
- Communication gaps exist within the organization
- NGOs face frequent staff turnover which effect their performance
- Selection of dedicated FNGOs is a major challenge for the programme
- NGOs lack transparency and coordination with other NGOs
- NGOs lack skills in documentation

Challenges within and on the Field

- There are problems related to migration of project beneficiaries to other areas and vice versa.
- People lack awareness, explaining new trends and development takes time.
- Non-availability of referral services at the district level
- Lack of willingness among staffs to work in the remote areas
- Lack of transparency between GO and NGO
- At the district level, there is lack of clarity about the role of MNGO and the government

Special Initiatives

Special initiatives were taken by the RRCs to address specific needs of the state. For this purpose, RRCs organised state level theme based workshops on different aspects of RCH. Some of the key initiatives are discussed below.

RRC-MAMTA: Female feticide and infanticide is a major problem in Haryana with only 819 females per 1000 males (2001 census). Kurukshetra (771), Ambala (782), Sonapat (788), Kaithal (791), Rohtak (799) are the worst hit districts. In order to tackle this burning issue, RRC – Mamta organised several district level workshops on this issue. The workshops were attended by representatives from NGOs, district, state health system. Through the workshops, ideas were generated that can be applied at the community, district and state level for addressing the declining sex ratio of Haryana. Recommendations from the workshops were endorsed by the state government and presented to the planning commission.

RRC-VHAI: Rajasthan ranks second in the country in maternal mortality. With an intention to address this issue, RRC-VHAI has set up a Janani Suraksha Yojana Helpline in Rajasthan in collaboration with the State Health Mission, Rajasthan. The Janani Suraksha Yojana Helpline seeks to promote emergency referral ensuring safe delivery of women with obstetric emergencies at the health facility and thereby contribute to reduction of maternal mortality by tackling the three delays. This will be achieved by

establishing 28 JSY Helplines in the selected blocks of the 28 Districts of Rajasthan. It is an innovative project, which is in partnership with the Government and selected NGOs of Rajasthan most of whom are MNGOs and FNGOs.

Identification of Best Practices Centres

Recognising that no single RRC can have the full complement of technical resources to fulfil the diverse requirements of the MNGOs and SNGOs, Best Practice Centres (BPC) were identified with issue-based expertise (for example neo-natal care, FP, RTI/STI, MCH, adolescent health, in service training for management, documentation etc.). The criteria for selection of BPCs include demonstrated credibility in the chosen technical aspect, appropriate infrastructure and in-house expertise. The programme budget for RRCs includes a minimum support for engaging two BPCs per state. The support of the BPC is mainly to develop an institutional mechanism for drawing upon external expertise by the RRCs.

VI. Observations

Based on the review and description of roles of various stakeholders in MNGO scheme there are several areas that need understanding of issues having bearing on developing the structure and processes of such public-private partnership. Specifically some of points include:

- Understand the management capacity and competency in make-up of these partnerships
- Identifying pathways towards developing state, district and NGOs management capacity

From our discussion with key stakeholders and based on the review of the MNGO scheme, following key questions emerge as the determining factor towards success of scheme:

- Do the stakeholders involved in the scheme design and implementation have adequate capacity to ensure proper implementation of the scheme?
- Do financial management system in the scheme provides right incentive for desired performance?
- Have the scheme and its implementing agencies developed and acquired appropriate and adequate capacity to implement and monitor the contracts?
- Are there systems in place to manage and monitor the contract process?
- Are the NGOs involved in the scheme comfortable with the costs involved in managing relations with different stakeholders in the scheme?

We address these questions in the following sections.

Capacity of Stakeholders to Implement the Scheme

Implementation of the scheme involves competencies required at each level of scheme implementation. This relates to identification of organisation, request for proposal, evaluation and appraisal of organisations, disbursement of payments, induction training,

monitoring the scheme progress, adequate and timely reporting. Health department and NGOs involved in the scheme have to assume new competencies and skills to manage the scheme.

Facilitative roles in health sector calls for coordination skills, communication skills and stakeholder sensitivity⁸. Competencies here are adopted from UNIDO competency model⁹. The model has discussed about different attributes of individual competencies in delivery of services. Additionally we observed that community capacity and institutional capacity in the system are essential attributes for service delivery. Following this logic, three competency attributes are used to analyse the MNGO scheme in this paper:

- Individual Competency
- Community Capacity
- Institutional Capacity

Individual competencies

Each stakeholder involved in MNGO scheme need a wide range of competencies and skill mix in order to achieve the scheme objectives and coordinate with the different stakeholders involved in scheme implementation. Attributes of the individual competencies important for Mother NGO scheme implementation are discussed below:

Managerial Competencies: Competencies considered essential for staff with managerial or supervisory responsibility in any service or programme area relates to:

- Strategic orientation: relates to capacity of managers in leadership roles to be continuously able to develop appropriate programme strategies after discussing with various stakeholders and communities and policies for the programme and translate programme strategies into clear objectives and action plans.
- Continuous updating and being innovative: refers to the quality of programme managers to benchmark best practices and encourage adoption of new practices. Managers with creative role encourage risk taking and respond quickly in case of contingencies.
- Analytical skills: refers to quality to analyse and understand the programme dynamics identify problem factors and problem solving skills.
- Partnership orientation: refers to the skills of programme managers to understand partners view in implementation of the programme.

Technical/Functional Competencies are considered essential to perform any job in the organisation within a defined technical and financial area of work. Strong commitment to

⁸ Bhat, Ramesh and Maheshwari SK (2005). Human resource issues and its implications for health sector reforms. *Journal of Health Management*, 7, 1(2005), pp 1-39.

⁹ UNIDO Competencies. Strengthening Organizational Core Values and Managerial Capabilities. Accessible at www.unido.org/userfiles/timminsk/UNIDOCompetencyModel-Part1.pdf

the NRHM objectives is other important attribute in implementing this scheme effectively.

Community capacity¹⁰ is “the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well being of that community. It may operate through formal social processes and /or organized efforts by individuals, organizations, and social networks that exist among them and between them and the larger systems of which the community is a part.”¹¹ Different NGOs implementing the Mother NGO scheme acts as a community between themselves.

NGOs working in the system should have:

- Community connect: the degree to which NGOs feel connected and share common interest. NGOs working in the MNGO scheme should nurture feeling of integrated network of NGOs working towards achieving common goal. All NGOs are expected to share knowledge and sort out differences among themselves.
- Commitment: sense of feeling “all in the same boat”.
- Ability to solve problems: ability to solve a problem must be enduring, extending beyond just one NGO and should include alternate routes appropriate to solving the problems faced by the NGO community in the scheme
- Access to resources: in order to implement the scheme, NGOs require access to economic, human, physical and political resources, which may not be possible to a single organization. These resources enable the NGOs to link to systems in the larger context.

Institutional capacity¹² refers to the ability of the system to identify problems, develop and evaluate policy alternatives for dealing with them and operate the programme. Different attributes of institutional capacity are discussed below.

Institutional resources represent the attributes an organization possesses or controls and consist of:

- Governance (Board, Mission/Goal, Constituency, Leadership, Legal Status);
- Human Resources (Human Resources Development, Staff Roles, Work Organization, Diversity Issues, Supervisory Practices, Salary and Benefits);
- Management Practices (Organizational Structure, Information Systems, Administrative Procedures, Personnel, Planning, Program Development, Program Reporting); and

¹⁰ Bishop R and Bella L. 2004. Community Capacity Development. Accessible at www.cpha.ca/literacyandhealth/documents/Empowermentcapacityoct18.pdf.

¹¹ Chaskin, Robert J. 1996. *The Ford Foundation’s neighborhood and family initiative, moving toward implementation: An interim report*. Chicago: The Chapin Hall Center for Children at the University of Chicago.

¹² VanSant J. Framework for assessing the institutional capacity of PVOs and NGOs. Duke University. Accessible at www.ngomanager.org/vansantarticle.htm.

- Financial Resources (Accounting, Budgeting, Financial/Inventory controls, Financial Reporting)

Institutional performance measures an institution's program, services, or other impacts as a result of how effectively it employs its institutional and technical resources.

- External Relations (Constituency Relations, Inter-NGO Collaboration, Government Collaboration, Donor Collaboration, Public Relations, Local Resources, Media); and
- Applications of Technical Knowledge are key attributes of institutional performance. Institutional performance assesses both efficiency and effectiveness at a point in time.

Institutional Sustainability incorporates more forward-looking attributes such as organizational autonomy, leadership, and learning capacity that, in turn, help ensure sustainability and self-reliance in the future.

Rating the Competencies

The three capacity components of individual, community and institutional play an important role in implementation of MNGO scheme in India. The capacity and competencies of different stakeholders involved in the MNGO scheme is depicted in the matrix below. The matrix has been drawn based on our assessment and based on discussions with principal stakeholders of the scheme and issues and concerns raised at various GO-NGO partnership workshops organised at Gujarat and Haryana. The stakeholders of the scheme, discussed in this study, relates to Apex Resource Cell, Regional Resource Centre, State RCH Society, District RCH Society, Mother NGO and Field NGO.

Three researchers having significant experience and understanding of NGOs and India's Public Health system made an independent assessment of different competencies required in functioning of the MNGO scheme. Subsequently members shared their assessment on different component to other members. Through discussion consensus was arrived in reaching the final assessment of competencies. This method of assessment is in congruence with qualitative data analysis methods.

The matrix scales the different competency attribute in the programme on a scale of high involvement to low involvement. The matrix is further divided between Actual – what is currently observed and desired – what is the best expected from the system given the current constraints to make the programme more effective. Though utmost care has been taken to ensure proper representation of the facts, interpretation of the matrix has to be done with a caution considering interviewer and judgement bias.

Matrix: Capacity Assessment of the MNGO Scheme Implementation

Composite Attributes	Central (ARC)		RRC		State RCH Society		District RCH Society		MNGO		FNGO	
	Actual	Desired	Actual	Desired	Actual	Desired	Actual	Desired	Actual	Desired	Actual	Desired
Individual Capacity												
Managerial Competency												
· Strategic Orientation	M	H	M	H	L	H	L	M	L	H	L	M
· Creativity	L	H	L	H	L	M	L	M	M	M	M	H
· Analytical Skills	M	H	M	H	L	M	L	M	M	H	L	M
· Consultative Skills	M	H	M	M	L	M	L	M	M	H	M	H
· Partner Orientation	L	H	L	H	L	M	L	M	L	M	L	H
Functional Competency	M	H	M	H	M	M	L	M	L	H	L	M
· Availability of Skilled Personnel												
Community Capacity												
Sense of Community	L	M	L	H	L	M	L	M	L	H	L	H
Commitment	L	H	M	H	L	H	L	M	M	H	L	H
Ability to Solve Problem	L	M	M	M	L	H	L	M	L	H	L	M
Access to Resources	L	M	M	H	L	M	L	M	M	H	L	H
Institutional Capacity												
Institutional Resources												
Legal Structure and Governance	H	H	M	H	M	M	L	M	M	M	M	M
Human Resources	M	H	M	H	L	M	L	M	L	H	L	M
Management Systems and Practices	M	H	M	H	M	M	L	M	M	H	M	M
Financial Resources	M	M	M	H	M	M	L	M	L	H	L	M
Institutional Performance												
Networking and External Relations	M	H	M	H	L	H	L	M	M	H	L	H
Application of Technical Knowledge	M	H	M	H	L	M	L	M	M	M	M	M
Institutional Sustainability												
Organizational Autonomy	H	H	L	H	L	M	L	M	M	M	M	M
Leadership	L	H	L	H	L	M	L	M	L	H	L	H
Organizational Learning	M	H	M	H	L	M	L	M	M	M	M	H

Note: H- High Involvement, M – Medium Involvement, L – Low Involvement. Actual represents the current scenario. Desired indicates the expected scenario.

Assessment of capacities of different stakeholders

Based on the discussions with various stakeholders, the study team undertook a mapping of capacity in the MNGO scheme at different stakeholders' level. "Actual" shows the existing level of capacity in the system among various stakeholders. "Desired" reflects how the scheme in order to be more efficient should structure itself.

Apex Resource Cell: The Apex Resource Cell is the nodal agency in the MNGO scheme at the central level. The current capacity in the system shows that ARC is rated poorly on several community capacity as well as creativity and partner orientation. The major challenge for the ARC is an effective leadership. In spite of having good organisational autonomy, the role of ARC is limited due to lack of effective leadership. The study team proposes enhanced institutional and management competencies at the ARC level to carry out its desired activities.

Regional Resource Centre: As with ARC, the RRCs too have remained as hub for training and reporting. Much of the responsibilities of RRCs were taken away by the State RCH societies. The RRCs need to take up a major role in steering the scheme progress, have good strategic orientation, developing creative solution and demonstrate strong commitment to the cause. Leadership in RRC has to play important role in coordination between state and district RCH society and the NGOs.

State and District RCH Society: The state and district RCH societies would need more flexibility in decision-making and accountability in work. Currently their involvement is low on most of the capacity dimensions. Although not excellent, however medium capacity strengthening will be required on most of the dimensions to leverage effective programme output and provide support to the NGO initiatives. This relates to identification and selection of NGOs, monitoring and fund disbursement.

Mother NGO: Mother NGOs forms the backbone of the entire programme. However, they rate medium on several key capacity dimensions. Under the RCH II programme, capacity strengthening of the MNGOs has been stressed in through several initiatives. However, experiences from several workshops shows that the NGOs in the scheme lacks adequate mechanisms of ensuring transparency, role clarity, communication gaps, frequent staff turnover, orientation to scheme objectives, and documentation skills. A strong capacity strengthening is required specifically focusing on their strategic orientation, consultative skills, partner orientation, availability of skilled human resource, developing strong community connect, financial resources, networking and external resources and leadership. Mother NGOs with good leadership and financial base have demonstrated better results in the programme.

Field NGO: Field NGOs are the true implementers in the programme. However, their capacity to deliver is constrained due to unavailability of good financial and human resources. NGOs working in the field do lack the sense of being a part of the larger NGO community, commitment and sharing of resources between themselves. Given this constraints, it is expected that moderate improvement in several capacity dimensions will produce excellent results in programme implementation.

VII. Issues

Different issues emerge from a review of the capacity and competencies of actors in the mother NGO scheme. These are discussed below.

Financial management and funds flow: The financial budget for the scheme provide for dedicated line items for human resource for the ARC and RRC. MNGOs and FNGOs do not have any earmarked allocations for human resource in their budget. Uncertainty of funding and contract renewal is considered a major barrier to hire qualified personnel in the programme. For example, the period of 2004-05 was a transition period from RCH I to RCH II programme. There was no funding available for the programme implementation during this period. None of the MNGO visited do have a full time person responsible for implementation of the scheme. In most cases, it was an add-on to existing workload of the NGO personnel. While this can be beneficial for integration with other health activities, there were no special efforts made in the scheme to develop human resource capacity in the programme. NGOs implementing the scheme in general have been observed not having partnership orientation and working together. This contradicts the basic philosophy of implementing such schemes. There is a sense of competition among the NGOs to attract resources hampering the process of knowledge sharing and problem solving.

“During the beginning of phase II of the programme, we were given training on conducting Community Need Assessment (CNA) survey. However, while we were preparing for the survey, new RRC were assigned and they said that the approach has now changed to Baseline Survey (BLS). The problem is that many of our FNGO have already done CNA and now there is no additional fund for conducting BLS. We have to somehow manage with the funds from our own resource.” One MNGO representative from Haryana

This suggests that the implementing agencies have not invested time on developing a fair and good plan. The changes in approach pose difficulties in implementing the scheme and create confusion in implementation process.

Delay in Fund Release: With the transition from RCH I to RCH II, release of grants have become a contentious issue in the programme. Representatives of all the NGOs that were met in during the study mentioned that delays in receipt of funds for programme implementation. Although initial grant of Rs. 1 lakh is released to the MNGOs for identification of field NGOs, programme implementation grant is pending in most cases. Effectively the NGO activities under the RCH project have no significant progress since end of RCH I Phase. Decentralisation of the programme to the state level, while has created a sense of ownership of the programme by the state, have also delayed the fund release process. Moreover, several operational problems have also compounded the process of fund release from the state. Delay on the part of district health officials to clear the NGO proposal. It was observed that district officials wait for clearance of the entire proposals of the MNGO and FNGO in their district and then only the same is forwarded at the state level.

“After end of RCH phase I, the entire programme scheme has been redefined and we have to start from the scratch. We have to re-apply for the scheme as MNGO and have to surrender districts where we were implementing programmes earlier. There is no funding for programme implementation since last one year. Discontinuity of the project leads to gaps between old and new project resulting

hindrance in achieving the ultimate objective of programme.” MNGO representative from Assam

Credibility and trust: There is a lack of trust among the key stakeholders in the scheme. While NGOs feel that government officials lack time bound and efficient mechanism creating unnecessary delay and irregularity in sanction and release of funds; district officials feel that NGOs are over budgeting, do not submit reports on time, lack transparency, work with unqualified or semi-qualified staffs. In appraisal of NGO proposals district officials have articulate their capacity constrain in selection of right NGOs. The lack of trust and confidence in the stakeholders also creates delay in selection and release of funds to implementing agencies.

“NGOs come with their own perspective, not necessarily having community perspective. We do not have NGO coordinator position and evaluation guidelines of projects not clear.... Some NGOs do not pay staff that is on paper..... If NGOs do not have activities or network in the proposed districts, but submit a proposal – What can we do?” One health official in a GO-NGO partnership workshop in Haryana

There are differences in perspectives of agencies implementing the scheme. It is felt that various stakeholders have not been oriented to the scheme properly. In addition, it is also observed that various guidelines of implementing the scheme lack clarity. Inadequacies of proper systems, which ensure adherence to the processes, are major concerns. This sometimes creates mistrust and lack of faith in the system.

Integration Issues: Integration refers to both vertical and horizontal integration in the programme. While stress has been given on vertical integration in the programme that is between NGOs and government - horizontal integration has been largely left out. Horizontal integration refers to exchange of knowledge and resource between the NGO partners and learning from each other's activities. It is also felt that current initiatives for experience sharing and best practice consultation are quite inadequate in the scheme.

Nature of Contract: For implementation of the scheme district RCH society enters into contract with the MNGO, FNGO and SNGO. The contract for the scheme is done through a Memorandum of Understanding between the Chief Medical and Health Officer of the district and the NGO. The MoU broadly focuses on objectives of the scheme, commitment from the department towards technical and financial support for the scheme implementation, obligations from the MNGOs towards the project aims, reporting requirement and penalty clause. The MoU and contract looks more as an informally worded document and lacks specifications. These documents do not specify implications and risks and how these would be addressed in case of delay from the government in fulfilling funding commitment or in case there is failure to facilitate the service delivery provision.

In absence of these, it becomes difficult on the part of the parties to follow the contract process. The terms and conditions as laid out in the contract, put the government in a position of power vis -à-vis the NGOs and leave little room for the NGO partners to negotiate with the government on critical issues.

It is also silent on the key outcomes expected out of the project that are to be implemented by the NGOs leaving room for subjective decision making on the part of the government. Given the fact that NGOs are expected to 'partner' with the government for implementation of the programme, the NGOs strongly expressed the need for 'better' and 'fairer' contract that contained 'clearly defined' reporting relationships and objective grievance redressal mechanisms.

Management of Contract Process: Management of contract process and monitoring in the scheme needs much attention in the programme implementation. As an integral part of the scheme design, monitoring of the scheme have been responsibility of the Regional Resource Centres. However, in RCH II programme, many of the responsibilities were delegated to the district and state RCH society. This has resulted in procedural delays in the scheme implementation. This is reflected in, for example , selection of NGOs where District NGO Selection Committee played an important role.

NGOs complained that the selection processes of NGOs are often complicated and time consuming. At the district level, a selection committee for NGOs is headed by District Commissioner and Assistant District Commissioner. It was observed that due to work pressure, ADC and DC were hard pressed to spare time for the meetings. Moreover, non-availability of district NGO coordinator hampers the evaluation process of NGO proposal. All proposals from the districts are compiled and send to the state level agency. This resulted in procedural delay, as some NGOs were required to rework their proposals. Due to this, proposals from all NGOs from the districts are delayed. The state NGO selection committee has members from different offices of the government including representative from central ministry and different departments of state government. Availability of all members for the meeting is a problem in NGO selection process.

"District NGO selection committee is headed by the District Commissioner and Assistant District Commissioner. They were so busy that finding their time for meeting and appraisal is a great problem. If the appraisal authority were delegated to the District Health Officer, things can be speeded up." One civil surgeon in a GO-NGO partnership workshop in Haryana

Identification of un-served and under served areas was done by the District Health Official and the same is notified to the concerned Mother NGOs. However, the system is not based on GIS mapping, but often based on the perception of the district officials and availability of FNGO to work on this areas.

Multiple points of authority and reporting relationships have raised issues of effective coordination of the scheme implementation. Although the scheme is funded exclusively by the central ministry of health and family welfare, the onus of selection and monitoring of the scheme implementation rests with the state government. Regional resource centres were responsible for technical support and capacity strengthening in the scheme. There were instances where Mother NGOs have to send periodic reports to multiple agencies or bypass RRCs to get their work done from the state health department. This creates a dual reporting system that dilutes the scope of authority for RRCs in scheme implementation.

"We have good terms with the state officials and get our work done through the directorate. We do not need to talk to the State NGO Coordinator or the RRC people. They are new and inexperienced in the field. Getting works done through

them delays our process” Coordinator of a MNGO having presence in multiple states

Managing Networks and Relationship: Cost of administering the Mother NGO scheme does not restrict to the budget specified in the programme. There are costs related to managing relationship with district officials and networking with other NGO partners. While it was not possible to quantify the resources needed to manage relationships, it relates to the cost of time associated with liaising with the state government officials from district to state level. Similarly, district officials have to make visits for field appraisal to the NGOs. During routine government programmes, NGOs participate in the programme for community mobilisation.

NGOs claim that the scheme does not provide adequate resources to meet all the requirements and support all activities of the scheme. However, they have to remain in the scheme because of national character of the programme. There were instances of uncertainty in the scheme with the initiation of Phase II of the RCH programme. With RCH II project declared, there was a change in strategy in the Mother NGO scheme. NGO areas were relocated with each Mother NGO and each MNGO was allowed to work in maximum of two districts. To strengthen the programme further new RRCs were created leading to reallocation of work, programme strategies shifted from mere demand generation to adding component of service provision and CNA instrument modified to baseline survey. All this necessitated re-selection of NGOs, preparation of project proposal and conducting of baseline survey (BLS). Shifting of the project ownership from the centre to the state has created a delay in approval of proposals and release of funds. Because of this, no activities on RCH implementation were possible during the end of the project in Phase I.

“The scheme is not financial rewarding for us. However, we have to continue with the scheme as it is a national programme funded by the World Bank. It was the delay on the part of state government because of which funds are remaining unutilised, and not because the funds are not released for implementation... We are losing credibility in the community” Representative from an FNGO in Haryana

VIII. Experience in RCH II

MNGO scheme has been modified under RCH II programme to address the weakness identified under Phase I of RCH programme implementation. The modified programme is expected to make it more participative, responsive to community needs and address some of the management and implementation problems. However, discussion with various stakeholders involved in scheme implementation does not instil confidence on the capacity of the system to carry out the desired tasks. Some of the implementation problem in the scheme and suggested measures, based on observed evidences, are summarised below .

Centrality of Roles: The MNGO scheme in India involves tripartite relationship between Government of India, State Government and NGOs. In the network of relationship, state governments are losing the centrality of their roles. Over the period, state government have viewed the programme as a centre driven programme with not much role on their part and ownership. Although under RCH II, involvement of state government and delegation of power have taken place, the mindset of state officials have remained more

of a passive implementers. For success of programmes like MNGO scheme, it is essential to develop a sense of ownership among important stakeholders like the state government.

Monitoring the Activities: Although the design of MNGO scheme have laid down different stages of monitoring where MNGO monitors the FNGO, RRC monitors the MNGO and ARC monitors the RRC, it is observed that monitoring of the scheme should have involved more active role from the state and district health officials. Currently the state or district health officials do not have any dedicated person for monitoring the scheme. Many of the state have the crucial position of state NGO coordinator vacant.

Diminished Role of Regional Resource Centres: Although RRCs in the scheme were conceptualised to play the role of capacity strengthening and monitoring of the scheme implementation, their current roles are greatly reduced in the scheme. Much of the activities relating to appraisal and selection of NGOs, earlier done by RRCs are now delegated to district and state authorities. RRCs were seen to face situations with confronting instructions from State and Centre. This creates problem for them to balance the dynamics.

Incentive System: The current incentive system of different health programmes involving NGOs does not follow a uniform pattern. It was observed that NGOs are more interested to work for HIV/AIDS programme than RCH programme, given the financial packages involved. NGO representatives do not consider the MNGO scheme as financial attractive. This has implication on the availability of quality human resource to manage the scheme.

Procedural Delay in Selection and Disbursement of Funds: Selection of NGOs to implement the programme is severely hampered due to capacity constraints at the district and state health official level. Moreover, lack of accountability and a well-defined institutional structure for release of funds greatly hamper the fund disbursement process in the scheme. In order to make the system more responsive, a time bound process for selection and disbursement of funds have to be laid down along with well-defined responsibility.

VIII. Making the Partnership a Success – Some Insights

The Mother NGO scheme started by Government of India has the potential to be an effective platform of involving the network of NGOs to achieve health objectives set in the RCH programme in a unified and effective manner. However, effective implementation of the scheme calls for high level of cooperation and coordination between centre and state government. Although under RCH II, responsibilities were decentralised to the state level, state still consider the MNGO scheme as a centre scheme. This has implication on monitoring of the scheme at the state level. It is generally observed that schemes promoted by individual state government have greater accountability and chance of success. On the other hand, in the changed circumstance, Regional Resource Centres find their role greatly diminished and they have no role in selection and appraisal of NGOs. Other general areas to make the scheme a successful model of partnership are as follows:

Delegation of Authority

Current authority in the scheme leaves scope for ambiguity to scheme implementation. Many of the activities like advertisement for request for proposal and appraisal of NGOs carried out earlier by the RRCs and MNGOs were now performed by the state and district health officials. This is positive step towards decentralisation and delegation.

In its endeavour to streamline and simplify the procedure for providing assistance to the NGOs, the Department of Family Welfare has evolved a system in which all the small organisations working at the grass-root level are not required to go to the National Capital or State Capitals for getting the assistance. Under this scheme, small organisations at the village, panchayat and block levels are assisted through Mother NGOs. Chapter 8: Organised Sector and Voluntary Organisations, MOHFW

However, the Regional Resource Centres feel their role has greatly diminished in the changed circumstances. It was argued that due to the heavy workload of the district officials and complicated administrative process, the process of appraisal and selection gets delayed. Moreover, state government consider the MNGO scheme as a centre-sponsored scheme. Many big states do not have NGO Coordinator, a crucial position required for coordination of the scheme between government and the NGOs. Policy changes without clarifying the roles of various stakeholders under changed situation and without ensuring capacities at implementation levels may defeat the basic purpose and intentions.

Financial Autonomy and Decentralisation

Currently the scheme follows a complicated administrative process for release of the fund. District NGO selection committee receives the compiled proposal (including proposals of the FNGO) from the MNGO, conducts a field and desk appraisal, and sends the proposals to State NGO selection committee. State NGO selection committee waits for all proposals to be received from all districts and convenes a high-level state NGO selection committee meeting which is attended by representative from the Central government apart from different departments of the state government.

The budget for MNGO scheme is small as compared to the total health budget of the state. The states would be in better position to implement this scheme and the powers to develop and design the system of NGO evaluation and release of funds should be delegated to the states. A proper line of accountability can be followed in the programme along with financial autonomy. State and Centre should play the role of supportive supervision in scheme implementation.

Building Trust in the System and Accountability

True sense of partnership cannot be achieved without building trust in the system and proper accountability. Currently the system suffers from distrust among government and NGO sector. Trust and accountability in the system can be developed through democratic decision-making, equitable power distribution, and two-way communication and customer sensitiveness. Both parties have to be open to examination. However, trust and accountability in the system needs capacitated stakeholders.

Capacity of Stakeholders

Capacity of stakeholders in the system is essential to formulate effective partnership. Capacity building has been addressed through training which are more often in the form of in-house presentation of scheme details. Such training has limited impact on the participants. Capacity strengthening needs, in order to be effective, have to focus on: (1) structures, systems and roles, (2) staff and facilities, (3) skills, and (4) tools. Potter and Brough¹³ have discussed nine component elements of systemic capacity building and these are as follows:

- *Performance capacity*: These relate to availability of tools, money, equipment, consumables, etc. to do the job.
- *Personal capacity*: This includes adequacy of knowledge, skills and confidence of staff to perform job properly. Strengthening of skill mix includes focusing on technical, managerial, interpersonal, gender-sensitivity, or specific role-related skills. Identifying capacity-strengthening needs and providing experience in these areas are critical.
- *Workload capacity*: This focuses on ensuring adequacy of staff positions with broad enough skills and appropriate skill mix to cope with the workload and providing practicable job descriptions.
- *Supervisory capacity*: This includes specifying the reporting and monitoring systems, describing clear lines of accountability, ability of supervisors to monitor the staff under them and ensuring effective incentives and sanctions available.
- *Facility capacity*: This ensures the appropriateness of training and capacity strengthening effort, making it sure that there is right staff in sufficient number, size of facilities is adequate to handle the service load, and ensuring that staff houses and offices space are adequate to handle the job.
- *Support service capacity*: This makes sure that laboratories, training institutions, bio-medical engineering services, supply organizations, building services, administrative staff, laundries, research facilities, quality control services are adequate and in place.
- *Systems capacity*: Strengthening this means that flows of information, money and managerial decisions function happens in a timely and effective manner by reducing the lengthy delays for authorization, by proper filing and information systems in use, by ensuring good communication with the community. Developing partnerships and other contracting relationship also forms part of this.
- *Structural capacity*: Ensuring that there are decision-making forums where inter-sectoral discussion may occur and corporate decisions made, records kept and individuals called to account for non-performance.
- *Role capacity*: This applies to individuals, to teams and to structure such as committees and by giving them the authority and responsibility to make the decisions essential to effective performance, whether regarding schedules, money, staff appointments, etc?

¹³ Potter C and Brough R. 2004. Systemic capacity building: a hierarchy of needs. Health Policy and Planning, 19 (5): 336-345.

Effective Integration

Integration is required both vertical and horizontal. Vertical integration refers to integration between FNGO and MNGO, MNGO and RRC, RRC and ARC, MNGO and District Officials, RRC and State Officials and so on. Horizontal integration refers to integration between the FNGOs, MNGOs and RRCs. Currently the programme has focussed more on vertical integration. Horizontal integration is largely left out and there is a sense of competition among the NGOs to grab more resource and show results.

Continuity in the scheme

Last but not the least, continuity in the scheme is most important for success of the programme. After RCH Phase I, the programme came to a complete halt on ground with no support to NGOs implementing the programme to carry on their activities. With reallocation of work areas, all NGOs had to resubmit proposals and go through selection process. The scheme has to come out with some measure to ensure that some funds remains with the NGOs as working money and never gets dried up. This will be used by the NGOs to sustain their activities during the period when the programme is not running.

In summing up

Partnership and contracting has been much talked about in the context of involving non-state providers in achieving public health objectives, however the former has been basically into rhetoric and the later have been in practice. Some of the conceptual difference between partnership and contract is summarised below:

Partnership Attributes	Contract Attributes
Driven by context	Driven by set rules
Partly written goals	Everything is written down
Partnership is a dynamic process and evolves over time	Contractual relation is static
Concern for other party	Control and monitoring
Trust	Control

Lastly, although contracting is a form of partnership, true partnership is an involved affair with participation of all stakeholders in the process. While in contracting practices in the health sector, government expects a certain level of activities to be done by the private sector, in partnership the government gets involved with the private parties to tackle public health problems. Partnership dwells on a level playing field for both the parties. However, developing partnership in the programme is an involved task, which demands greater delegation of authority, financial autonomy, and faith in partners, accountability and capacity in the system. Current state of the MNGO scheme does not instil confidence on a fruitful partnership. The essential attributes of partnership in the health sector, particularly in the context of MNGO scheme will demand attention to many of the issues discussed in this paper.

Exhibit 1: Regional Resource Centres and Allotted States

Name	Outreach states/ Regions/ UT
Voluntary Health Association of India (VHAI)	Delhi, Himachal Pradesh, Rajasthan, Uttaranchal, Jammu and Kashmir
Child in Need Institute (CINI)	West Bengal, Jharkhand and Andaman Nicobar Islands
Family Planning Association of India (FPAI)	Maharashtra and Madhya Pradesh
Gandhigram Institute of Rural Health and Family Welfare	Karnataka, Tamil Nadu, Kerala and Lakshwadeep
Centre for Health Education, Training and Nutrition Awareness (CHETNA)	Gujarat, Union territories of Daman, Diu, Dadra and Nagar Haveli
Hindustan Latex Family Planning Promotion Trust (HLFPPT)	Andhra Pradesh
Mamta Health Institute for Mother and Child (MAMTA)	Punjab, Haryana and Chandigarh
Population Foundation of India (PFI)	Bihar and Chattisgarh
State Innovation in Family Planning Services Project Agency (SIFPSA)	Uttar Pradesh
Assam Voluntary Health Association	Assam, Tripura, Arunachal Pradesh, Nagaland, Manipur, Mizoram, Sikkim

The first four are the old RRCs.

Exhibit 2: A Note on Study Methodology**Selection of Organisation**

For purpose of the study, three Regional Resource Centres were identified as entry point for studying the Mother NGOs. We conducted the study through the newly created RRCs. The reason because all the new RRCs have started functioning since last 1 year only and many of them are grappling with problems to cope up to the increased role of RCH II programme. Learning about the difficulties and ways to deal with the problem at this stage will give good insight into further fine tuning the programme and addressing its immediate concerns.

The two RRCs selected for the study are:

1. CHETNA, Gujarat
2. Mamta Health Institute for Mother and Child; and
3. Voluntary Health Association of Assam

Mother NGOs visited:

1. SWACH, Haryana
2. Haryana Nav Yuvak Samiti, Haryana
3. Rural Women Upliftment Association of Assam

CHETNA

CHETNA has been identified as a RRC for Gujarat and Union Territory of Daman, Diu, Dadra and Nagar Haveli since October 2004 to reduce child mortality and improve maternal and women's health by promoting improved access to gender sensitive quality health services. A four-member team work for the RRC within the ambit of the parent organization. In order to bridge gap by ensuring uniformity in messages, improve networking, enhance trust, transparency and accountability, CHETNA RRC organised regional GO-NGO workshops in six regions of Gujarat State.

Mamta Health Institute for Mother and Child

MAMTA is a national level NGO, started in 1990, committed to integrated health and development issues in the context of poverty, gender and rights with 'life cycle approach'. The organization has evolved to expand its operations into newer areas including adolescent health, education, entrepreneurship development and empowerment of the young people with a thrust on community participation for better health outcomes. Mamta has been recognised as the Regional Resource Centre in Reproductive and Child Health by the Ministry of Health and Family Welfare, Government of India for the states of Punjab, Haryana and Chandigarh in 2005. However, in terms of activities and networking, Mamta has been relatively new in the states of Punjab and Haryana. The organisation has set up an office at Chandigarh with staff complement to coordinate the RRC activities. The primary responsibility of RRC is to provide technical assistance for capacity building of all stakeholders under the NGO scheme. It also envisages coordinating Best Practice Centre (BPC) as specialised institutions to provide technical resources in adolescent health, gender issues and exclusive breast-feeding. Three mother NGOs from Haryana, two from Punjab and one from Chandigarh are linked to the RRC. They in turn are linked to a number of Field NGOs per district. List of MNGO and

Voluntary Health Association of Assam

Voluntary Health Association of Assam was started in 1990 by promoting the preventive aspects of community health through capacitating voluntary organisations and creating a network of like-minded grass-root level organisations working towards a common mandate of bringing about positive change in vital aspects of the socio-economic fibre of life of communities. During RCH Phase I, VHAA worked as one of the MNGO in Assam with Child in Need Institute (CINI) playing the role of RRC. From Phase II, VHAA have taken up the role of RRC for north-eastern states. 11 Mother NGOs from seven north-eastern states were associated with the RRC.

Exhibit 3: NGOs working in the MNGO Scheme in Punjab, Haryana, Gujarat and North-Eastern States

Punjab & Haryana			Gujarat			North-eastern States		
MNGO	Districts	No. of FNGO	MNGO	Districts	No. of FNGO	MNGO	Districts	No. of FNGO
Society for Women and Children's Health (SWACH)	Yamunanagar	3	Gujarat Voluntary Health Association	Ahmedabad	3	Voluntary Health Association of Arunachal Pradesh	East Kameng	3
	Panchkula	3		Anand	3		West Kameng	4
SOSVA, Haryana	Sonepat	4	CHETNA	Mehsana	3	Rural Women Upliftment Association of Assam	Barpeta	4
	Gurgaon	3		Sabarkantha	4		Nalbari	4
Haryana Nav Yuvak Kala Sangam	Bhiwani	3	Spandan	Kutch	4	Deshbandhu Club	Cachar	3
Family Planning Association of India	Ferozepur	4	Inreca	Narmada	4		Hailakandhi	3
	Mukatsar	4	Jagrut Mahila Sangathan	Kheda	3	Landing Cherapur Homeopathic and Unani Association	Thoubal	4
SOSVA Punjab	Chandigarh	3	FPAI	Dahod	3		East Imphal	3
	Ropar	4		Gandhinagar	3	Chandel	3	
	Patiala	3	Sarvodaya Mahila Udyog	Jamnagar	4	Family Planning Association of India	Churachandpur	3
			Gramin Vikas Trust	Bharuch	4	Presbyterian Hospital	Aizwal	4
			Navjeevan Trust	Rajkot	4		Champai	3
			Rural Development Society	Panchmahal	4	Christian Hospital	Lawngtial	4
			DHRUVA -BAIF	Valsad	3		Lunglei	4
				Shroffs Foundation	Dangs	3	Nagaland Voluntary Health Association	Kohima
			Vadodara		3	Phek		4
			SWATI	Surrendranagar	3	Woodland Multipurpose Cooperative Society Ltd.	Mokokchung	4
						Voluntary Health Association of Sikkim	East Sikkim	4
							West Sikkim	3
						Voluntary Health Association of Tripura	South Tripura	3
							West Tripura	3