

Journey of a  
**GOINGO**  
Collaborative Process

1998-2004



सत्यमेव जयते

Ministry of Health and Family Welfare  
Government of India

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GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
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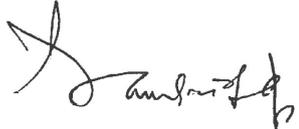
## **MESSAGE**

Under the mandate of the National Health Policy and National Population Policy, the Government of India is committed to improve the health care systems and services for all with particular focus on women and children living in areas under-served by the existing government health system. The National Rural Health Mission has provided a broad framework for achieving the national health objectives in partnership with various stakeholders. NGOs play a major role in supplementing the efforts of the government in this process.

As part of the Reproductive and Child Health Programme Phase II, the Mother NGO Scheme aims to strengthen the role of NGOs in service delivery for contributing towards the goals of reducing IMR, MMR and TFR. The MNGO scheme is a special effort in collaboration and partnership building, since it is a joint effort by the Government of India (GoI) and the state governments. The decentralized management provides an opportunity for the FNGOs and MNGOs to work closely with the health system at the district and block level. Appropriate capacity building mechanisms have been established for NGOs both at District and State level, ably facilitated by the NGO division and its technical wing ARC.

UNFPA's partnership in this process is valuable and has given some critical learning points in partnership building. This partnership has shown that facilitating a dialogue between government and the NGOs, and creating continuous opportunities for upgrading technical skills of the stakeholders are as important as funds provision.

The FNGOs, MNGOs and the RRCs are posed with the challenge and opportunity of sustaining the GO-NGO partnership in the years to come for reaching the Health and Family Welfare goals set by the governments at the national and state levels.

  
(PRASANNA HOTA)  
Secretary (H&FW)



सम्पर्क से पहले सोचो, एचआईवी/एड्स से बचो

**HIV/AIDS: Prevention is better than cure**

## Abbreviations

FNGO	:	Field NGO
Gol	:	Government of India
MoHFW	:	Ministry of Health and Family Welfare
MNGO	:	Mother NGO
NGO	:	Non Government Organisation
RCH	:	Reproductive and Child Health
RRC	:	Regional Resource Centre
SNGOC	:	State NGO Coordinator
UNFPA	:	United Nations Population Fund

# GO-NGO

## Background

The Government of India and several state governments have encouraged NGO involvement in various development sectors over the years. Well-established GO-NGO collaborative models can be seen in the fields of education, women and child development, HIV/AIDS, and natural resource management, among others. Over the last two decades NGOs have been encouraged to get involved as contractors, collaborators and as partners in primary health care, and more recently to become more active in the area of Reproductive and Child Health (RCH).

A collaborative effort is successful when the concerned stakeholders agree on a set of objectives, establish and respect systems and build capacities to meet common objectives. This becomes critical when the government seeks the collaboration of civil society in general and NGOs in particular. The achievement of objectives through GO-NGO collaborations depends largely on transparency, clarity of purpose and roles, and the ability of the collaborative arrangement to meet the needs of each other. The processes adopted in this journey are as important as the results achieved.

The following pages seek to explore the processes adopted in capacity building and strengthening the partnership between government and NGOs in population stabilization efforts through a reproductive and child health approach. By documenting the specific processes adopted in the Mother NGO (MNGO) scheme, initiated by the Department of Family Welfare (DFW) to improve RCH indicators, it is expected to highlight the steps in partnership building between stakeholders.

# 1

## MNGO Scheme: 1997–2000

The Department of Family Welfare introduced the MNGO scheme in the 9th Five-Year Plan (1997–2002), under the Reproductive and Child Health (RCH) Programme – Phase One. The underlying philosophy of the scheme is one of capacity building by forming partnerships between larger and smaller NGOs.

From the time of its inception in 1998–99 till March 2003, 105 MNGOs and over 800 field NGOs (FNGOs) have been participating in the scheme. The presentation of the scheme as it evolved is divided into two sections of the present documents from 1998 to 2000 and from 2001 to 2004, in order to highlight the learning and processes adopted for strengthening the partnership effort. By the end of 2005 the MNGO scheme is expected to cover all the districts.

The Indian government had implemented several schemes in the 7th and 8th Five-Year Plans in which NGOs were co-opted to generate demand for primary health care through awareness education and IEC (information, education and communication) with specific reference to family planning and maternal and child health. The approach under schemes like the Rolling Fund Scheme was limited, where the large intermediary NGOs identified the field NGOs, disbursed funds and submitted financial reports to the government. This approach did not visualize the capacity building needs of the NGOs who were co-opted merely to fulfil the government's need to meet family planning targets. Despite the involvement of a large number of NGOs, this remained

a contractual arrangement and community mobilization did not take on the form of an empowering tool.

Learning from this experience, the design of the MNGO scheme during the 9th Five-Year Plan emphasized capacity building of the implementing NGOs. This had positive results in terms of FNGOs gaining management and technical skills and leveraging resources with other donors and thus upgrading themselves enough to apply for MNGO status.

### 1.1. Implementation Strategy: 1998–2000

Under the MNGO scheme, government funding was routed to small NGOs through MNGOs. MNGOs were responsible for building the knowledge base as well as communication skills of FNGOs. This was in order to effectively support the efforts of the public health system by generating a demand for health care services through health awareness campaigns, education and community mobilization. The MNGOs directly sent their monitoring and financial reports to the NGO Division of the Government of India.

At the implementation level, it was expected that FNGOs would coordinate with AWWs (anganwadi workers), ANMs (auxiliary nurse midwives), panchayats, mahila swasthya sanghs, SHGs (self-help groups) and other local-level government functionaries.

The selection of MNGOs was a democratic and transparent process since only those responding voluntarily to an

advertisement of the government were appraised and included. During this period, the MNGO scheme guidelines provided the framework outlining the roles and responsibilities of the MNGOs and the FNGOs and the reporting mechanism. But it did not prescribe the processes to be adopted in implementation. This was empowering since it provided a large degree of flexibility in decision making for the MNGOs. For example, the guidelines laid down the criteria for the selection of FNGOs, the ceiling on the funds that could be disbursed per FNGO, and the reporting and monitoring requirements. Within this framework, the MNGO had enormous flexibility in terms of choosing FNGOs that responded to the advertisement, in terms of geographical area of work, programme content and the amount of funds to be distributed to each FNGO within the ceiling.

Similarly, the FNGOs had the flexibility to choose their own method of community mobilization and undertake IEC activities through camps, campaigns and advocacy and support to the Government system through service delivery. This flexibility in decision making encouraged NGOs to explore innovative methods of community mobilization by interfacing with grass-roots level government functionaries. It also helped FNGO capacity building.

## 1.2. Gaps and Missed Opportunities

Despite the inbuilt flexibility that could have resulted in a stronger collaboration between the government and the NGOs, some of the shortcomings in the structure and systems resulted in sub-optimal utilization of NGO potential. Some administrative requirements, though useful to control the use of government grants, could not facilitate the easy and timely flow of funds, thus creating gaps in implementation from time to time. A set of clear guidelines on financial norms, reporting formats and orientation to NGOs,

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could have avoided some of the confusion, and unnecessary delay in implementation.

Though capacity building was a focus, the mechanisms to achieve this at different levels were not established. For example, no formal structure was identified to facilitate capacity building of MNGOs or provide orientation for grass-roots level government functionaries on NGO work.

Similarly, the lack of specific mechanisms to facilitate the active participation of the state government also limited the process of partnership building between the government and NGOs. Apart from a request by the DFW for feedback on selected NGOs within two months and a representation in the final selection of FNGOs, there was no formal mechanism for the inclusion of state governments in the scheme. The NGOs were dealing directly with the NGO Division at the centre. The non-involvement of the state government meant the absence of a formal system that could have helped MNGOs and FNGOs to receive support at the field level in their respective states. While some NGOs shared reports and participated in the district health committee meetings, there was no formal mechanism for sharing support services or learning. This meant that there was no formal system available for measuring the outcome of NGO work on RCH-related issues in the community.

It was also further found that several MNGOs lacked the relevant institutional capacity to develop such linkages. Many were also inherently reluctant to work closely with the government. In some

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The lesson learnt clearly was that partnership development is a lengthy process, which requires appropriate support systems and mechanisms for interfacing and facilitating a basic functional working relationship.

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instances, government health functionaries viewed NGOs as competitors and had doubts about their accountability and capacity. It became apparent that a partnership process could stabilize only when there was trust and understanding of each other's involvement and a development of mechanisms that fostered such involvement.

A limiting factor in the development of partnerships between the MNGOs and the FNGOs was the MNGO selection process itself. Though the MNGO selection was rigorous, the lack of emphasis on experience in the area of health in the selection criteria led to the inclusion of MNGOs that had very little or no health experience. While some of the MNGOs had experience in working on health promotion and service delivery, most of them required technical and managerial training and support to meet the demands of the programme. Observations from annual evaluations and periodic field visits by GoI officials revealed that some of the FNGOs had more institutional capacity, including outreach clinics and technical ability, than the MNGOs that were expected to support them. Such MNGOs could only provide routine monitoring input. This imbalance created a certain amount of friction. It also meant that FNGOs received training of varied quality and that there was no mechanism to measure the outcome of this.

Another weakness identified was the MNGOs' perception of their role as a 'grantor' rather than as facilitators or mentors.

Partnership development requires frequent communication between partners. MNGO concerns, whether related to administrative or technical matters, had to be directly addressed by the government which had constraints in terms of manpower and technical resources. This, apart from putting a strain on the NGO Division, also resulted in delayed communication.

By the end of 2000 and early 2001, it was clear that certain strategic directions had to be provided to the MNGO scheme to ensure that partnership at different levels was nurtured and that the partners had the capacity to mutually support each other. The DFW began a series of consultative meetings with the NGOs and identified a 'think tank' group, called the Technical Advisory Group (TAG). The NGO consultations and TAG recommendations resulted in strengthening the NGO schemes and the establishment of technical support mechanisms that could guide, support, and facilitate capacity building efforts at both the government and NGO levels. The process of developing NGO guidelines thus began in earnest.

The lesson learnt clearly was that partnership development is a lengthy process, which requires appropriate support systems and mechanisms for interfacing and facilitating a basic functional working relationship.

# 2

## MNGO Scheme: 2001–2004

The MNGO scheme witnessed a very active period from early 2001 till 2003 in terms of introduction of policies and changes in programme content aimed at strengthening the GO-NGO partnership. The National Population Policy 2000, National Health Policy (NHP) 2002 and the 10th Five-Year Plan (2003-2008) documents, emphasized decentralization and RCH service delivery.

Apart from the policy framework, field insights from MNGO/FNGO evaluations and lessons from other NGO initiatives guided the process. For example, the Gol-UNFPA supported initiative titled, “Support To Gender Issues” (SGI; 1999–2003), focused on gaining greater understanding of gender issues in RCH and mainstreaming this through partnerships and transfer of knowledge between large and small NGOs. The key learning from the SGI project was that capacity building involved more than just making funds available. Selection of the technical support unit had to be done carefully to avoid friction with implementing NGOs. Creating frequent interaction opportunities between NGOs and the state/district government and among NGOs for sharing and learning, and establishing enabling mechanisms and organizational systems that clarify the roles and responsibilities of all stakeholders, are critical for strengthening partnership and capacity building.

The period between 2001 and 2003 was a period of transition for the MNGO scheme. The development of revised guidelines required that prior discussions were held on a number of procedural, administrative and programme content issues in a participatory

and consultative process by governments and NGOs. To this end, in 2003, all the 105 existing MNGOs went through an orientation on the revised guidelines, providing them an opportunity to comment and provide feedback on various aspects of implementation. Five regional-level advocacy workshops were organized to orient the state government health officials and to provide them with an opportunity to present their views, perspectives and suggestions.

### 2.1. MNGO Evaluation

While such intensive efforts were on, an external evaluation commissioned by the DFW in the first quarter of 2003, brought out the need for speeding up the finalization of the revised NGO guidelines and developing a process for wider communication and consultation with state government and district-level officials and with wider society.

The evaluation highlighted the efforts of FNGOs located in remote areas to promote RCH awareness and the innovative approaches adopted for community mobilization. It also pointed out weaknesses in terms of the absence of capacity building institutional mechanisms and support structures at the district level and the lack of involvement of state governments in the implementation of the scheme.

Accordingly, the revised guidelines were posted on the DFW, Gol website, providing an opportunity for society at large to understand and comment on the proposed processes. State-level GO-NGO partnership workshops were also organized for generating greater understanding between NGOs and state governments.

# 3

## Policy and Programme Initiatives

The policy and programme initiatives taken during the period 2001–2003 were aimed at increasing the ownership of the RCH efforts at the state and district levels by decentralizing the management of the NGO scheme, establishing institutional mechanisms for the GO-NGO interface and capacity building of the stakeholders. Policy decisions were also made to rationalize the jurisdiction of MNGOs in order to make their work more intensive and to include more NGOs. The UNFPA played a catalytic role in moving these processes forward by providing resources, technical reviews and participating in the TAG discussions.

### 3.1. Technical Advisory Group and Capacity Building Processes

One weakness repeatedly identified in the MNGO scheme was the absence of a mechanism for enhancing the government's understanding of NGOs and their work, as well as bringing NGO perspectives into government policy-making processes. The formation of the Technical Advisory Group (TAG) addressed these issues to some extent.

The TAG came into existence in May 2001, bringing in a mix of policy, advocacy and technical expertise drawn from DFW, state governments, CAPART, Planning Commission, national-level NGOs, academic institutions, individual experts, UNFPA and advocacy groups. The TAG was primarily expected to provide guidance on how capacity building of NGOs could be undertaken to improve the RCH programme and how partnerships with NGOs could be strengthened through the MNGO Scheme.

During the same period, two national-level MNGO consultations in Kolkata and Kodaikanal, organized by the NGO Division, GOI, highlighted the need to establish support organizations to fulfil a wide range of technical and managerial needs of NGOs. Based on the MNGO demand in June 2001, the TAG developed profiles of the Regional Resource Centres (RRC). The RRCs became a reality in January 2002 with support from the UNFPA. Four RRCs were identified to provide support to all the existing MNGOs on a pilot basis.

The TAG recommended the identification of Best Practice Centres (BPC) to complement the efforts of the RRCs. It also recommended the setting up of an Apex Resource Cell (ARC) at the national-level that could effectively coordinate the interventions of RRCs, strengthen RRC liaison with state governments and assist the NGO Division with technical inputs related to the NGO scheme.

Further, it recommended that the GoI develop a national-level NGO strategy and NGO guidelines. Towards this, it suggested that stand-alone NGO projects that had no capacity for scaling up or replication could be closed, and that specific projects addressing cross-cutting issues such as gender, may be streamlined according to the requirements of RCH II. Many innovative schemes have been implemented as stand-alone ones and have not lent themselves either to replication or to being up-scaled to regional or state levels.

Similarly, it recommended the winding up of small NGO projects that began during the 7th and 8th Five-Year Plans such as the Rolling Fund Scheme, Special Methods and Sterilization Schemes, Model Scheme for Promotion of Small Family Norms, and Population Control, Private Voluntary Organizations on Health, I and II. The NGOs, however, felt that pilot schemes should be supported for some more time since understanding gender issues and specifically, gender issues in the RCH context, is complex.

Till September 2003, the TAG met every quarter and gave critical inputs to the government for streamlining the NGO scheme, in line with the proposed goals of RCH II. The TAG guided the sub-group working on the revision of NGO guidelines by critiquing the various drafts to build coherence in the NGO scheme and to avoid duplication. By December 2003, the NGO guidelines were finalized and were widely disseminated amongst MNGOs and states through state-level GO-NGO partnership workshops, MNGO consultation-cum-trainings, and the Gol website. Feedback from NGOs and government officials was considered for further simplification and modification in the guidelines.

The major advantage of the TAG was to bring collective inputs to policy-making processes.

### **3.2. Strategies for Strengthening Partnership**

The revised NGO Scheme guidelines have identified strategies that would promote and strengthen collaboration and partnership between stakeholders. The overall approach shifted from a project mode to a programme mode (from a one-

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year cycle to 3 to 5 year cycle), thus creating an opportunity for a longer period of collaboration and involvement of NGOs and the government. The rationalization of NGO jurisdiction (reducing coverage from five or more districts to one or two only) is expected to facilitate intensive NGO involvement and bring in more NGO participation in population stabilization through RCH services. The pool of MNGOs will expand from the current 105 to nearly 300. In addition, a new category of Service NGOs, each of which will provide services for a population of 100,000 people is under selection. Under the revised mode, NGOs are expected to provide RCH service delivery, supported by appropriate awareness education.

Administrative strategies, such as the establishment of a smooth fund flow mechanism for programme implementation, are expected to improve trust between NGOs and the government and reduce uncertainties regarding receipt of funds.

Another strategy to build trust and enhance mutual understanding between the NGO and the district-level health functionaries is the identification of unserved and underserved<sup>1</sup> areas with poor RCH indicators. It was felt that there could be greater joint involvement of the MNGO and the district health functionaries in these areas.

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<sup>1</sup> Unserved or underserved areas are those socio-economic backward areas which do not have access to health care services from existing government health infrastructure, especially urban slums, tribal, hilly, desert areas including SC/ST habitations. In specific terms, these areas are those in which the post of MO, ANM & LHV have been vacant for more than one year; the PHC is not equipped with minimal infrastructure; performance on critical RCH indicators are poor. (NGO guidelines –Gol).

Decentralizing programme management and implementation is expected to enhance ownership at state and district levels since the State RCH Society has been identified as the structure that would manage the entire process and provide policy support.

The NGOs, both MNGOs and FNGOs, will complement the government system in service provision in the areas of maternal and child health, RTI/STIs (sexually transmitted infections), family planning, immunization and adolescent sexual and reproductive health. The FNGOs will implement service delivery interventions in collaboration with the panchayati raj institutions, sub-centre, PHC (Primary Health Centre) and district health system as the case may be.

Another step initiated to strengthen partnership building is the sharing of responsibilities between the GoI and the state government by decentralizing programme management and implementation at the state and district levels. This measure is expected to enhance ownership at state and district levels since the State RCH Society has been identified as the structure that would manage the entire process and provide policy support. The district NGO committee (formed by district RCH society) has been made responsible for managing and monitoring project implementation at the field level. The role of the GoI is related to the provision of policy guidelines, technical support for capacity building and fund release to state governments.

Partnerships can thrive only when systems are available to establish the accountability of both NGOs and the government. While NGO accountability is established through performance and outcome indicators, accountability of the government system

is established through the involvement of state and district health functionaries in the programme management at different stages of implementation.

A mechanism for supporting the DFW at the state level has been instituted with the appointment of State NGO Coordinators (SNGOC). The SNGOCs are responsible for monitoring implementation, facilitating timely submission of NGO reports to state governments and facilitating NGO dialogue with the district health system. Initially 11 coordinators were identified and placed, while others were being identified in other states.

### 3.3. Institutional Mechanisms for Capacity Building

The Apex Resource Cell (ARC), Regional Resource Centres (RRCs) and the Best Practice Centres (BPCs), the three institutional mechanisms suggested by the TAG, are expected not only to support one another's efforts in NGO capacity building, but also provide overall technical support to state governments to manage the NGO programme.

The ARC is responsible for the provision of technical inputs to GoI on all policy matters relating to the implementation of the NGO scheme, facilitation of overall coordination among the RRCs and liaison with state governments for facilitating the RRC-state government interface.

Though all the four RRCs have been identified for their national-level stature, experience and expertise, it is expected that as RRCs they will gain recognition over a period of time within states where they support the NGOs.

The RRCs are expected to act as a catalysts. This embraces a variety of tasks including strengthening managerial and technical competencies of the MNGOs, facilitating NGO understanding of gender

in RCH, updating skills and knowledge, providing a platform on which to interact and facilitate interface with state and district health functionaries, documenting and disseminating best practices, collecting and disseminating RCH policies, laws, and programmes from the respective states where they work, undertaking advocacy, networking with state governments and maintaining the database on technical and human resources related to RCH.

Best Practice Centres (BPCs) are expected to complement the NGO capacity building efforts of RRCs by, meeting the technical capacity building requirements of FNGOs in specific aspects of RCH service delivery.

The RRC scheme, which was piloted with four RRCs in 2002, has been found to be a useful mechanism for NGO capacity enhancement. Based on the recommendations of an RRC assessment conducted in 2002, the RRC pool has been expanded from 4 to 10. The RRC jurisdiction has also been rationalized in order to facilitate in-depth support to MNGOs and FNGOs from two states and one or two Union territories. While state NGO coordinators and district RCH societies are responsible for routine monitoring of NGO programmes, RRCs are ultimately responsible for ensuring the effectiveness of NGO capacity building efforts.

A well-coordinated effort between the state NGO coordinators and the RRC is critical for sustaining the partnership between the state and district health system and the NGOs. However, clarity on the role of SNGOC is still evolving. As a part of the state team, the SNGOC is expected to undertake several activities such as appraising NGOs and coordination between state government and RRC.

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The UNFPA has played a key role in the establishment and expansion of RRCs, the setting up of and strengthening the ARC and supporting state NGO coordinators.

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Available mechanisms to strengthen cooperation and coordination between SNGOCs and RRCs include participation by both in Gol and state government review meetings, participation of SNGOCs in workshops and trainings organized by the RRC, and exchange of monitoring and field visit reports. However, these mechanisms have to be formalized in coordination with state governments for optimal use and in order to avoid duplication. Since RRCs are represented in state NGO committees that are responsible for MNGO selection and are also in charge of MNGO appraisal, there is already a mechanism for RRCs to develop good linkages with state governments.

### **ARC–RRC Partnership for Effective Capacity Building**

The UNFPA has played a key role in the establishment and expansion of RRCs, the setting up of and strengthening the ARC and supporting state NGO coordinators. In continuation of their CP5 programme for support to NGO initiatives by Gol, the UNFPA has expanded its allocation under the CP6 programme. Apart from funds, the UNFPA plays a catalytic role in capacity building initiatives at the national and state levels by providing diverse inputs such as consultants, critiquing documents, developing training manuals, identifying personnel, conducting workshops, assessments, review of materials, and participating in training and other events.

The ARC–RRC relationship again is crucial for sustaining the Gol–NGO partnership

The ARC has facilitated the RRC capacity building through development of standardised training manual, training of RRC staff in strategic planning, developing systems for baseline data collection and data processing.

as envisaged in the programme. The RRCs bring in an operational perspective of NGO capacity building requirements while the ARC brings in a policy perspective. The synergy between the two is critical for achieving capacity building objectives. In addition to clearly defined roles, an institutional mechanism requires an enabling environment to function to its full potential.

The ARC has the dual responsibility of meeting the technical needs of RRCs as well as the NGO Division, GoI. While the ARC has been active in providing inputs for the NGO policy to GOI and technical supervision to RRCs, it is to further develop close linkages with state governments.

The ARC has facilitated the RRC capacity building through development of standardised training manual, training of RRC staff in strategic planning, developing systems for baseline data collection and data processing. The data collection and data processing formats are field tested and refined with support from National Informatics Centre, Government of India. The ARC also provides technical support to RRCs for strengthening relationship with the state governments by conducting thematic workshops on critical RCH issues as per the requirement of the state.

**Challenges:** Sustaining initiatives such as the RRCs requires a strategic approach. To ensure the continuation of the mechanism the RRCs should take ownership of their initiatives. Further, state governments

should appreciate the need for sustaining initiatives.

The SNGOCs have to build both vertical and lateral relationships — with state governments as well as RRCs. Strengthening the linkage between RRCs and the SNGOCs will be critical for effective implementation. State governments have been directed to identify staff for managing SCOVA (Standing Committee of Voluntary Agencies), which will coordinate all RCH-related work including NGO schemes. It will be critical for the state government to explore the probability of including the position of state NGO coordinators in the SCOVA composition when they are in the process of selecting the team.

### 3.4. Capacity Building Process

The design of NGO capacity building efforts in the scheme adopts a cascading model, where the RRCs familiarize themselves with a set of MNGO training modules with the support of the ARC, and facilitate MNGO capacity building through periodic trainings.

In turn, MNGOs train the FNGOs, which are responsible for RCH service delivery and community mobilization in the field. The design of the scheme places a lot of expectation on the FNGOs, who will actually deliver the services in the field at the grassroots level. At present, the actual technical input by the RRCs is geared towards the MNGOs. Some MNGOs feel that though they are accountable for FNGO performance, the mixed capacity of the MNGOs could affect the results in the field. It could also put a lot of pressure on the RRC's capacity building efforts.

There is at present no mechanism for the RRCs to reach the FNGOs. Yet, to avoid capacity building from becoming an end in itself, it is necessary that the RRCs find a way of working with MNGOs

and FNGOs on certain critical issues (e.g development indicators, development of base line information and analysis, gender and RCH, project proposal writing, setting up of community participated monitoring systems, understanding reporting systems and formats, documentation of experiences etc).

The RRCs are expected to facilitate the state government's understanding of partnering with NGOs and develop credibility within states through technical inputs. While the role of a RRC in MNGO capacity building is clearly articulated, the RRCs are in the process of exploring methods to develop a sustained working relationship with the state governments.

### 3.5.1: Perspective Building among Stakeholders: NGOs

The strategy of creating consultative fora has been very effective in developing a broader perspective among NGOs on decentralized programme management and creating better understanding among state governments on NGO involvement in RCH service delivery.

While a number of MNGOs do not seem to have any reservations about entering into service delivery, many expressed concerns about this approach. The concerns expressed were the following:

- Do FNGOs have the capacity to clearly understand service needs and deliver them?
- Will the local government cooperate appropriately?
- How realistic is it to expect FNGOs, with minimal staff and infrastructure, to fulfil the unmet RCH needs in under-served areas, where the government system has failed to reach despite a vast resource pool and infrastructure?
- What are the services that could effectively be taken up by the FNGOs?

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Apart from enhancing NGO understanding of the revised guidelines, the consultative processes have provided NGOs with a platform to make valuable suggestions related to simplification or modifications of some of the procedural guidelines.

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- How prepared are the state and district health systems to support and guide this process?
- What systems and support services will be available for MNGOs to facilitate the FNGO service delivery?

Another concern raised by the MNGOs related to the proposed process that seems to address the RCH issues in a vertical manner whereas, in reality, issues like water-borne diseases, lack of adequate sanitation, etc. contribute to poor RCH indicators.

NGOs also had reservations about decentralized programme management at the state level due to the possibility of closer scrutiny of their work. The MNGO consultative meetings, MNGO training-cum-orientation and participation of MNGOs in the GoI-NGO partnership development workshops have cleared some of their apprehensions regarding involvement in RCH service delivery and decentralized programme management.

Apart from enhancing NGO understanding of the revised guidelines, the consultative processes have provided NGOs with a platform to make valuable suggestions related to simplification or modifications of some of the procedural guidelines. As a strategy, frequent interaction among stakeholders has been useful in enhancing the RRC's understanding of NGOs and their perspectives on RCH issues, field realities and their role in FNGO capacity enhancement.

The ownership of the process by the state government is reflected in the taking over of responsibilities for conducting GO-NGO workshops, supported by the RRC and the State NGO Coordinator.

### 3.5.2: Perspective Building among Stakeholders: Government

The GoI-NGO workshops have been a useful mechanism for opening the door for dialogue between GoI and state governments as well as RRC interaction with state governments. The state family welfare departments have demonstrated their ownership of the scheme by organizing the GO-NGO workshops including conceptualization and development of workshop content of the day-long event by the Project Director or Joint Director, RCH, from the respective state, supported by RRC for resources. Where available, the state NGO coordinators played an active role in coordinating with state governments for logistical and other arrangements. In the absence of a coordinator, the RRCs took on full responsibility.

The ownership of the process by the state government is reflected in the taking over of responsibilities for conducting GO-NGO workshops, supported by the RRC and the State NGO Coordinator. These workshops have helped state governments to address some of their apprehensions about the credibility, accountability and effectiveness of NGOs who are willing to explore the possibility of working with them for improving specific RCH indicators in certain geographical areas. So far, 12 such workshops have been completed. The focus in these workshops is on identifying workable strategies for promoting GO-NGO partnerships to contribute towards improving RCH indicators. Critical questions taken up for

discussion include the following:

- Can NGO involvement foster interdepartmental convergence?
- How and to what extent can Panchayati Raj Institutions (and zilla parishads get involved in the implementation of the scheme?
- What are the modalities available that are workable in the block and district context to avoid conflict between the NGOs and the PHC, ANM and other health staff?
- What systems could NGOs have to establish their credibility?
- What measures should be taken in places where no suitable NGOs are available?

These consultative processes have contributed to further simplification of procedures, removal of administrative bottlenecks, identification of areas of collaboration between districts and MNGOs for RCH service delivery and clarification of the roles and responsibilities of various stakeholders. The follow-up and feed back mechanism within GoI/ARC and RRC needs strengthening to maintain the momentum. One aspect that needs attention in this process is the establishment of a mechanism for community feedback as well as a participatory community-monitoring process, since the community is the primary client of the programme.

### 3.6. Partnerships and Capacity Building: Some Observations

Building a partnership is a long process. The lessons from the first two years of the MNGO scheme implementation clearly indicated that partnerships are not developed overnight, especially between a grantor and grantee. Over the past five years, as the MNGO scheme evolved, partnership development was expected

at different levels - between the ARC and RRCs, technical and academic institutions with the RRCs, FNGOs with the community and PRI, MNGOs with district officials, etc.

An enabling policy framework and processes in place have contributed to developing a congenial working relationship between some of these institutions. It has also contributed to the development of a common understanding of RCH issues and the strategy needed to address these (e.g., GO-NGO partnership workshops). But in some contexts, the enabling mechanisms seem to have been used sub-optimally, resulting in missed opportunities to learn and make a difference. There is a need to explore the possibility of strategically using these opportunities (e.g., in the annual planning process) so that could help the RRCs realize their full potential.

A partnership can grow and develop only in an atmosphere of trust and mutual respect and when the partners make space for each other. The NGO scheme is evolving slowly as a model that responds to the needs of the stakeholders through an enabling policy framework, establishing systems and institutional mechanisms and by adopting the values of a partnership.

Steps that could change the perception of there being only 'a one-way communication with the government' and enhance the potential for sustained partnerships with the NGOs are: improving logistics support; establishing communication and feedback mechanisms; sensitizing government staff at different levels on the changing RCH scenario and the role of NGOs in this context.

The scheme is conceptually sound and

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The NGO scheme is evolving slowly as a model that responds to the needs of the stakeholders through an enabling policy framework, establishing systems and institutional mechanisms and by adopting the values of a partnership.

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seems to have moved towards addressing the issue of service access to people in remote areas. A number of national, state and regional-level structures (NGO Division, ARC, RRC, SNGOC, state and district RCH societies, state NGO committee) have been established to fulfil this objective.

One question that has been raised is: how effectively can NGOs contribute to the improvement of service delivery in the field? Is there too much focus on management, establishment of institutional mechanisms and coordination of the work of these institutions, while FNGOs have to fend for themselves except for the support of the MNGO?

The Gol is examining these concerns. Measures are already being taken to reduce administrative bottlenecks, simplify guidelines, develop a clear communication strategy to avoid delay in communicating decisions to the field, responding to questions and fully integrating the scheme with the state RCH II processes and the framework of the National Rural Health Mission (NRHM).

### **2004–2005: NRHM, RCH II and implications on GO-NGO partnership:**

The year 2004–2005 witnessed a very active period in terms of Gol articulating specific measures for improving the quality and access to health services in areas that are poorly served by health system

through the National Rural Health Mission\* (NRHM).

A critical component of NRHM is the Reproductive and Child Health Care (RCH), RCH –II, which focuses exclusively on improving the poor RCH indicators. The NRHM also visualizes a strong partnership with the NGOs and their critical contribution in this process.

The MNGO scheme, despite coming into operation one full year ahead, is in consonance with the principles and values of the NRHM. The institutional mechanisms such as the State and District RCH Societies will eventually be merged under the proposed state and district NRHM structures. This will facilitate the MNGO scheme getting integrated into the larger health system reforms.

By focusing on districts and below, the NRHM proposes to improve the health systems and services. This is likely to benefit the work of FNGOs and the MNGOs, located in areas un-served or under-served by the government system, through closer support and facilitation from the district and block health system.

A paper is being developed on potential involvement and contribution of NGOs in NRHM. However, the challenge remains for the FNGOs, MNGOs, RRCs to understand the changes in the systems and the processes and reorient themselves to the expectations of the district and the state health systems in terms of implementation processes, monitoring evaluation and sharing results.

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\* The NRHM aims to provide an overarching umbrella to the existing programmes of Health and Family Welfare including RCH-II, Malaria, Blindness, iodine deficiency, Filariasis, KalaAzar, T.B, leprosy and integrated disease surveillance. It further emphasizes convergence with other sectors such as water, sanitation and hygiene, nutrition, which are determinants of health status in any community. The Mission also seeks to build greater ownership at the community through involvement of Panchayati Raj Institutions, NGOs and other stakeholders at national, state and sub-district levels to achieve the goals of National Population Policy 2000 and National Health Policy 2002.

