



Guidelines for NGO Involvement

Under National Health Mission in the Twelfth Five Year Plan





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FOREWORD

The contribution of India's Non Governmental Organizations (NGOs) to social sector programmes, most particularly in health, has been significant. They have developed creative approaches to enable accessible and high quality services, particularly for marginalized and vulnerable communities. Indian NGOs have been the crucible for several innovative models which have been scaled up with government support.

The challenges to achieving Universal Health Coverage cannot be met by the public health sector working alone. The National Health Mission (NHM) offers States a unique opportunity by committing up to five per cent of funds for supporting NGOs for a range of activities. Over the past few decades, the Government partnership with NGOs in the health arena has matured. However, we are yet to realize the full potential of this partnership. Fundamental to a robust Government - NGO partnership is a framework for transparent selection, adequate financial and technical support and the development of mutual accountability indicators.

It gives me great pleasure to introduce the Operational Guidelines for NGOs involvement under NHM which lays down the broad parameters of such a framework. States must leverage these funds and use this framework to build mutually beneficial partnerships with NGOs in order to traverse the path to achieving UHC for India's people.


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FOREWORD

India has a long tradition of involving Non Governmental Organizations (NGOs) in promoting public health. Since the Ninth Plan period, the MOHFW has supported NGOs in undertaking interventions that range from generating community demand, training of community health workers, and providing health services in underserved areas.

These partnerships with NGOs have proved to be mutually advantageous and constructive. NGO led innovations in India have informed large scale programmes both nationally and globally. In a pluralistic society such as ours, civil society complements government efforts through advocacy, action research, and social mobilisation. Even where large scale programmes for training or supportive supervision of ASHA, and paramedical workers are underway, evidence demonstrates that NGO led efforts, that are of high quality often positively influence government led efforts in adjacent areas through the mechanism of diffusion.

NGOs have thus become mainstream actors in health, and in appropriate recognition of this fact, the National Health Mission commits upto five percent of its funding to NGOs. Lessons from the National Rural Health Mission and from several urban health initiatives demonstrate that NGOs can and have played a significant role in enabling positive outcomes. However, NGO engagement in both NRHM and in the National Urban Health Mission, both of which are sub Missions of the NHM, must be scaled up. Harnessing the energy, knowledge and competency of NGOs can serve to strengthen the Mission's objectives.

Recognizing that State ownership of NGO led interventions are crucial for achieving the desired outcomes, the guidelines represent a major shift in the policy wherein the States now have the onus of selecting, planning and involving NGOs in implementation of its programmes.

The Operational Guidelines for NGOs provide a broad framework for states to strengthen their engagement with NGOs. States must now engage with the task of selecting NGOs with competency and credibility and enter into meaningful partnerships and collaborations so that the vision of Universal Health Coverage is realized.


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FOREWORD

NGOs in the health sector in India have played a vibrant role since the late eighties. While the contribution that is most often lauded is in the area of social mobilization and demand creation, they have played no less significant a role in direct service delivery, research, advocacy, and technical support to smaller grassroots organizations.

These Operational Guidelines for NGOs are based on substantial learning over the last few years, and are designed to provide a broad framework for states to engage with NGOs. The National Health Mission envisages an array of roles for NGOs, and has expanded the scope to cover such areas as formative research, serving as a learning laboratory for innovations in community led health interventions, monitoring, research and advocacy for public health issues such as rational drug use, tobacco control, etc. Under the NRHM, Community Monitoring was piloted in several districts across the country by NGOs and this lays the ground work for scaling up community led accountability systems.

NGOs have displayed their comparative advantage in areas such as community rapport, and in reaching the most vulnerable and marginalized both of whom form key constituents of the NRHM and NUHM. The diversity of situations in rural and urban areas, and providing services in remote, rural areas to enabling mapping of vulnerable marginalized populations in the slums of our urban areas, all call for nimble and competent organizations that can partner fruitfully with the government to further the agenda of Universal Health Care.

The revised NGO Guidelines is an attempt to collectively pursue the goals and objectives of NHM, with a major turnaround in the policy wherein the States have been given the onus of selecting and involving NGOs in implementation of its programmes. Selection of NGOs to partner with is a challenge, and yet remains the critical step for a strong NGO programme. The guidelines seek to facilitate and encourage setting up of mechanisms for selection that are transparent and accountable.

I hope that state make use of the operational guidelines to partner with NGOs in ways that are mutually rewarding.

Manoj Jhalani

Acknowledgements

The Operational Guidelines for NGOs in the National Health Mission, under the Twelfth Five Year Plan emerged from consultations organized by the National Health Systems Resource Center (NHSRC), with multiple stakeholders including representatives from the Government of India, State Government, Regional Resource Centres, and the Advisory group on Community Action.

A drafting committee comprising of Ms. Limatula Yaden, Director, NHM, Dr Rajani R. Ved, Advisor, National Health Systems Resource Centre (NHSRC), Dr. H. Sudarshan, Karuna Trust, Bangalore, Mr. Alok Mukhopadhyay, Voluntary Health Association of India, New Delhi and Dr. Smita Bajpai, Childhood Enhancement for Learning and Training, Ahmedabad, drafted the operational guidelines.

Special thanks for their valuable insights are due to the then Secretary, Health and Family Welfare, Mr. Keshav Desiraju, Ms. Anuradha Gupta, then Additional Secretary & Mission Director, NHM, Shri. Manoj Jhalani, Joint Secretary, Policy, MOHFW, Shri S.K. Nayak, Joint Secretary, PMSSY, Dr.T. Sundararaman, Executive Director, NHSRC, Ms. Abha Tewary, Consultant, (NHSRC) and Ms. Neha Kashyap, Consultant, NHM.



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I. Background

- I.1 In the Ninth Five Year Plan (1997-2002), the Department of Family Welfare introduced the Mother NGO scheme under the Reproductive and Child Health (RCH) Programme. Under the scheme, grants were sanctioned to NGOs called Mother NGOs (MNGOs) in allocated districts, who in turn issued grants to small NGOs called Field NGOs (FNGOs) in the districts. The broad objectives of the MNGO scheme were, addressing the gaps in information on RCH services in the project area, building institutional capacity at the State, district/field level, advocacy and awareness generation.
- I.2 The selection of organizations in the MNGO scheme was formalized through detailed guidelines issued by the GOI in 2003 which predate the design and launch of NRHM. Although several clarificatory amendments to the guidelines were issued, repeated evaluations of the scheme revealed that while the scheme had the potential to reach the vulnerable and marginalized, several limitations of the design elements, including limited decentralization, and transparency in the selection of NGOs, lack of clarity in the roles and responsibilities of the participating NGOs, complicated programmatic and financial guidelines, and delays in fund releases, had limited the effectiveness of the scheme. After the MNGO scheme was decentralized from 2008-09 onwards, the Ministry of Health and Family Welfare through its NGO Division
- has been providing grant-in-aid to 10 Regional Resource Centers, which are National Level NGOs working for capacity building of NGOs in the States.
- I.3 The National Rural Health Mission (NRHM) was launched in April 2005. The NRHM Framework for Implementation¹ encourages partnerships with Non-Governmental Organizations to improve the effectiveness of implementation and to make health services and facilities accountable to citizens. The Mission provides for collaboration with voluntary groups/organizations for advocacy, building capacity at all levels, monitoring and evaluation, delivery of health services and working together with community based organizations. The NRHM implementation framework provisions about 5% of the total NRHM outlay as the resource allocation to the voluntary sector². Such an allocation provided an opportunity to build NGO capacity and leverage community linkages to develop/strengthen people's organization for more active participation in enabling improved health outcomes especially for the poor and marginalized.
- I.4 NGOs have played a significant role in shaping the design of NRHM and in championing

¹ Reference: Framework of implementation NRHM

² As defined in Para 2.1



its implementation. They have consistently expressed eagerness to participate in strengthening public health systems, instead of becoming parallel to it. There is now sufficient experience across the country to show that NGOs can take on a variety of roles beyond awareness generation and community mobilization or undertaking service delivery in special situations. There are NGOs that can work to leverage and support the health department in terms of human resources, developments of skills and provision of technical assistance. Though some States have made considerable use of NGO capacity, this has neither been consistent and widespread enough, nor is it focused in the districts where it is needed the most.

1.5 It is important to revitalize the NGO Partnership in the 12th Five Year Plan keeping in mind the potential for broadening the scope of NGO involvement so as to accelerate the achievement of public health goals. The context of the scheme has also changed. The National Health Mission announced in 2012, which encompasses NRHM including RCH and the National Urban Health Mission as its two Sub-Missions, anticipates a much larger and wider set of roles for NGOs.

1.6 The rationale for NGO participation in NHM include:

- a. There is a need for the participation of all those sections that have a commitment to the principle of universal access to quality health care. The task is too big for the department alone and anyone who wants to meaningfully participate must be provided the space to do so.
- b. As part of national commitment to inclusive growth, we must make special efforts to reach out to poor and marginalized sections of the rural and urban population. Many NGOs have formed and structured themselves explicitly to address such a goal.

- c. Human resources and capacity within the department are limited particularly in the high priority districts and NGOs could bring in additional human resources, especially in the areas where community involvement is required. Given the low density with which skilled professional service providers are available, many tasks of the department remain undone merely because the system cannot spare professionals for tasks like community mobilization, training PRI members or Village Health Sanitation and Nutrition Committee (VHSNC) members, or training, supporting and supervising ASHAs or for BCC programmes in schools.
 - d. There is a need for innovation, fresh ideas and many different perspectives to inform the process of health planning and programme implementation. There are today a number of NGOs who have built up technical capacity and professional public health experience which the government acknowledges and seeks to tap for enhancing outcomes.
- 1.7 Past experience of NGO schemes at the State and National Level suggests that there is a need of flexibility to suit NGO competencies and State contexts alongwith clarity on the measurable outcomes that are expected to be delivered and adequate financial packages to enable achievement of these outcomes. There is also a need of well-designed monitoring and evaluation framework to assess the achievement and mentoring and technical support as per need to enhance NGO capacities to deliver the expected outcomes. In particular, with the continuing focus on community engagement in NHM, the need for NGO participation is much higher than it has been ever before. Therefore, there is a wider scope for NGO involvement and the consequently the need for revised guidelines for the NGO participation under NHM. These operational Guidelines are intended to provide a broad framework to the States to engage with NGOs and facilitate their participation in a seamless manner.



II. Broad Framework for NGO Involvement under NHM

Key Features of the Revised Guidelines

- 2.1 2.1 For the purpose of this document, the term NGO means “not for profit organizations registered as a Trust or a Society”. There are several players within the “for profit” sector ranging from individual private providers (Untrained and trained), private nursing homes and private teaching hospitals, as well as organizations established by corporate bodies (as part of Corporate Social Responsibility) that could play the roles set out in these guidelines. However, the mechanisms and guidelines for engaging such agencies are not covered in this document.
- 2.2 The scope of work for the NGOs is envisaged to move beyond reproductive and child health to a more comprehensive approach which would include community level interventions under NRHM, NUHM, Communicable Diseases, Non Communicable Diseases, and other emerging issues.
- 2.3 The Ministry of Health and Family Welfare (MOHFW), Government of India would provide policy guidance and technical support. Support to NGOs functioning at state and district level would be routed through the Programme Implementation Plan (PIP) of the state.
- 2.3 At the National level, an NGO Support Resource Centre (NSRC) housed within the existing National Health Systems Resource Centre would provide policy and technical inputs to GOI and state and technical assistance to the RRC/NSO at the state level. State and District Health Societies will be required to play a more active role. The NRHM guidelines to utilize up to 5% of the total NRHM funds as Grants-in-aid to NGOs would be maintained in the NHM Funds.
- 2.4 Effective NGO participation requires capacity building and on-site mentoring of NGOs; Experience sharing workshops and documentation of best practices in NGO-led interventions. In the earlier phase of the programme the Regional Resource Centers (RRCs) played this role. At present, Grant-in-aid is provided directly to these RRCs by GOI. The funding for these RRCs would also be through the State PIP route and not directly to the RRC as was the case hitherto. States which do not have RRCs, or which do not wish to continue with the existing RRCs, may set up or house NGO Support Organization (NSO) – one per State to provide technical assistance to the NGOs at the State/district level. In larger States (with more than 30 districts), the NSO could have a larger team to ensure high quality support. NSOs need to be instituted as per



state's priorities, and at the state's discretion. The NSO may be selected by the Grants in Aid Committee at the state level in order to enable State ownership and to ensure that planning and support for NGO interventions is synergized with state and district specific priorities.

2.5 The revised framework for the Implementation of NHM envisages that programme funds will be administered through the following five Flexipools envisaged in NHM.

- a. NRHM and RCH flexi pools funds.
- b. NUHM Flexipool
- c. Flexible pool for Communicable Diseases
- d. Flexible pool for Non Communicable Diseases, Injury and Trauma
- e. Infrastructure Maintenance.

2.5 NGO interventions under the four Flexipools would be routed through the state State Programme Implementation Plans (PIPs). The funds requirement for the RRC/NSO as well as the NGOs at the State level and district levels would be reflected in the under the four component flexipools of the NHM. For interventions under the Communicable diseases and certain Non-Communicable Diseases such as the National Blindness Control programme (NPCB), the respective programme divisions have formulated their own guidelines articulating the system of approval, selection, fund release and monitoring and evaluation etc. which would continue to apply. In the case of new emerging programmes like tobacco control, mental health, control of cancer, diabetes cardiovascular diseases and stroke, guidelines for NGO involvement may be developed by the concerned programme divisions.

2.6 The reporting of NGO interventions under the various flexipools would be to the respective divisions at the State level. These divisions at the State level would in turn report to the divisions at the Central level. The NGO division at the Ministry would maintain a centralized

database for the funds allocated and released through various divisions at the Center for NGO interventions to support policy inputs and avoid duplication of efforts and funding between different divisions.

2.7 NGOs with the required level of competence would be selected by the states to work at the State and District levels. For some activities, the entire district can be covered and for others the district can identify the blocks for NGO support and prioritize the engagement of NGOs in those blocks.

2.8 Selection of NSO and NGOs may follow the process outlined in Section IV. At the district level, the NGOs could be divided into two types based on function as follows:

- Field NGOs (FNGOs) – NGOs which would carry out the activities like training and capacity building, community monitoring, advocacy and community mobilization, planning, etc.
- Service NGOs (SNGOs) – NGOs which would focus on service delivery especially in un-served and underserved areas.

2.9 Clear cut output/performance indicators for NGOs will be identified and indicated in the MoU signed between the State/District health societies with the NGO laying down the tasks to be performed by the NGOs. The MoU should also include performance indicators on the financial parameters like submission of UCs, audited bank statements etc. For example, in case of service NGOs running a health facility; utilization rates, and increase in OPD attendance etc. could be measurable output indicators. In case of Field NGOs engaged for capacity building and training of PRIs, VHSNC members, the output indicators could include the number of batches taken up for training, the number of persons trained, the pre and post training level of knowledge of the trainees etc. These indicators must be specific and measurable to evaluate the task to be performed by the NGO. The agreement/ MoU with the NGO should elaborate upon

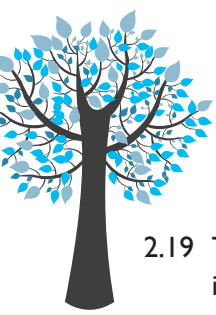


the resources extended by the districts, State and NSO.

- 2.10 Periodic reviews and external evaluations will be undertaken by the state to assess progress in accordance with the terms outlined in the MOUs. The state could seek support from the NGO Support Resource Center (NSRC) at the central level or academic and research bodies at state or national levels in undertaking reviews and evaluations.

Role of NGOs

- 2.11 2.11 Since health is a State subject and decentralization is a priority under NHM; The States may identify priority areas for partnerships with NGOs according to the State's priorities. Further, different NGOs have a range of capabilities and areas of expertise and thus the areas for NGO involvement also need to be broad based. NGOs could be effectively involved in training, service delivery, supportive supervision and monitoring advocacy, research and innovations in Maternal Health, Child Health – including Immunization and Newborn Care, Sexual and Reproductive Health, Adolescent health including School Health, Malnutrition including anemia, Communicable and Non Communicable diseases, Declining sex ratio and Inter-sectoral Convergence.
- 2.12 NGOs could be supported for capacity building, and support for community processes (the VHSNC, the ASHA programme, public participation in the RKS, public participation in district planning and in community monitoring). The element of community monitoring could be further expanded in areas such as improving data quality in HMIS and MCTS, measuring availability of drugs, and monitoring support to JSSK.
- 2.13 NGOs could be supported to work in special cases such as Left Wing Extremists affected districts, disaster prone areas etc.
- 2.14 NGOs could also be involved for supplementing capacities in some key areas where they have interest and a high priority, but where medical professionals are unable to give continued attention. Examples include the monitoring of PCPNDT implementation, assessing environmental health impact, monitoring of food and drug adulteration, and promotion of rational drug use – amongst the population and also professionals.
- 2.15 Community monitoring which emerged as a viable strategy in the Eleventh Plan needs to be built upon and scaled up. VHSNCs, PRI members and SHGs should develop the capacity to undertake community monitoring and social audits. This is one area where NGOs can play an important role in capacity building and support.
- 2.16 NGOs could also be supported to undertake Service delivery in un-served and underserved areas through managing health facilities such as Primary Health Center, First Referral Unit and Mobile Medical Units. Un-served and underserved areas are those that are remote, inaccessible/hard to reach such as tribal, hilly, and desert areas or areas that do not have access to existing government health infrastructure like peri-urban areas. The State and District Health Society have the flexibility to categorize areas as un-served or underserved for focused attention.
- 2.17 NGOs can be effectively engaged in addressing social determinants of health such as nutrition, water and sanitation and convergence with schemes for women empowerment and poverty alleviation.
- 2.18 Given the needs of the XIIth Plan and the move towards Universal Health Coverage, there are several areas, particularly in approaches to community health intervention, for which evidence needs to be build. NGOS would be supported to undertake innovations in order to test approaches and gather evidence.



2.19 The roles and theme areas for NGO involvement discussed above are illustrative and the States may further determine and define the role of NGOs as per their priorities. While reflecting the fund allocation for NGOs in the State PIP the role of the NGOs would also be defined by the State.

Duration of a Project assigned to an NGO

2.20 Duration of the project will be decided by the State based on the activity for which the NGO is selected. The duration will vary according to the intervention for which the NGO is funded and should be reflected in the state PIP. In case of Service NGOs the suggested average project duration may be fixed for three years.

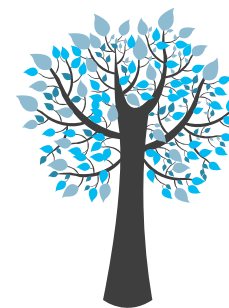
Monitoring, Evaluation and Reporting

2.21 A monitoring and evaluation system is essential for effective, participatory and periodic monitoring of NGOs based on local situation and priorities. A system of periodic reporting, review, and ongoing monitoring will be instituted for tracking NGO performance. This will enable the NGOs to make mid-course corrections, if required, based on the findings of the review. It will also ensure that the State's priorities and the goals of the project are being met. The monitoring and evaluation system proposed is as follows:

- The performance of the NGO would be monitored on the basis of agreed indicators, which would be clearly mentioned in the MoU signed between the NGO and the State government. These indicators should be relevant and specific to the work undertaken by the NGO and not be long-term impact indicators like reduction in IMR, MMR etc. that are affected by several other factors.
- Depending upon the level of functioning, the NGO will submit a detailed report of its activities in the prescribed format

(financial and physical) to the State Nodal Officer / Mission Director or the Chief Medical Officer (CMO) of the district through the designated NGO Coordinator (quarterly for narrative and monthly for financial) with a copy endorsed to the NSO/RRC. The NGO Coordinator/CMO would give their suggestions and guidance after examining the report.

- Quarterly Review meetings will be held at state / district level (as applicable) involving NGOs, State Nodal Person / Mission Director at State level, District Collector / CMO at district level, NGO Coordinator and the NSO/RRC. The District Collector will chair these review meetings. At the meeting, the NGO will report on progress as well as constraints faced in the field. These meetings will serve as a forum for discussing any problems faced by the NGOs in the project implementation, the inputs and support required from the government machinery etc.
- The State would commission external evaluations as and when required to review, study and improve the programme. The State NGO Coordinator would be empowered to conduct external evaluation of state and district level NGOs of upto 5% NGOs, selected on a random basis. These evaluations could also include the performance indicators agreed upon at the time of signing the MoU with the NGO. However, it should be ensured that the same NGOs are not subjected to repeated, multiple evaluations unless there is a specific reason for doing so. The Terms of Reference for Monitoring and evaluation (M&E) should be developed with NGO participation, as far as possible. NGOs should have the opportunity to provide feedback for M&E processes and reports.
- Monitoring of community based NGO activities should be undertaken by teams which have both the competence and experience in implementing community based interventions.



2.22 The suggested frequency of monitoring of performance of NGOs at various levels is as under:

Levels	Monitored by whom	Frequency
NSO	SHS, with technical inputs from the NGO Support Resource Centre	Annual
Field NGO	DHS, NSO/RRC	Bi-annual
SNGO	DHS, NSO/RRC	Bi-annual

System of Grievance Redressal

2.23 An effective grievance redressal system will be instituted at the state level so that NGOs can get a fair hearing in case on non- selection and or termination.



III. Structure of the NGO Scheme

The proposed structure is a three-tier system extending from the district to the national level. The structure, function and constituency at each tier are given in the following sections.

National Level:

- 3.1 The role of the GOI/ MOHFW would be one of policy guidance and financing of NGO activities in the State through the State PIP.
- 3.2 The NGO division will be a part of the National Programme Management Unit (NPMU) and would provide support to the states as and when required. The NGO division would be strengthened to maintain a centralized database of NGO Schemes under various programme divisions within the Ministry of Health and Family Welfare (MOHFW).
- 3.3 The NGO Support Resource Center would be set up within NHSRC to function as the technical arm of the NGO division. It would provide technical support to NGOs, Coordinate and forge country wide linkages to NGO assisted interventions, develop capacity of, mentor and monitor NGOs.
 - The NHSRC would be adequately staffed for performing the functions of NSRC. The concerned technical divisions in NHSRC

would be utilized for mentoring and training of NGOs and NSOs. The NSRC would also facilitate linkages of the NSOs/ RRCs and NGOs and other national state policies and programs. Capacity building of NSOs and NGOs for qualitative research and process documentation through collaboration with research organizations will be undertaken. In addition, the expertise of the NIHFV, as required for training and capacity building would also be employed.

- The NSRC will be responsible in identifying areas where innovations are needed and will provide technical support to NGOs in implementing, evaluating and documenting such innovations. Funding for such innovations could be routed through the NSOs or directly to implementing organizations in the field through state PIPs.
- 3.4 The Advisory Group for Community Action (AGCA) has been established for supporting the process of community based planning and monitoring through NGOs. The NSRC would work with the AGCA to ensure that the selection, capacity building and monitoring are in synergy.



State Level

3.5 The organizational structure proposed at the State level is as follows:

- State Grants in Aid Committee
- State Advisory Group
- State NGO Cell (SNGOC) / Coordinator
- NGO Support Organization (NSO/RRC).

States Grants in Aid Committee (SGIAC)

3.6 The State Grants in Aid Committee (SGIAC) would select the NSO and NGOs to work at the state and district levels, including for such activities such as training, evaluations and innovations.

3.7 The proposed constitution of committee is as follows:

- State Health Secretary
- Mission Director NRHM
- Director SIHFW
- Representatives of two State level NGOs nominated by the State Health Secretary
- State NGO Coordinator
- RRC/NSO Project Director (except when selection for RRC/NSO is under consideration of State GIAC).
- Regional Director of MoHFW.
- When the state is in the process of selection of the NSO/RRC the state GIAC will include a representative of the NSRC and the MOHFW.

State Advisory Group

3.8 The State Advisory Group (SAG) would be the body at the State level to guide, support and advise the programme and would be housed within the NSO. The SAG would be chaired by the State Health Secretary. The SAG would consist of the following official and non-official member:

1. State Health Secretary/Commissioner Health Services
2. Mission Director, NRHM
3. Lead NGOs/Institutions
4. Head of RRC/NSO
5. Representatives of 1-2 district NGOs (depending on the size of the State) nominated by the districts by rotation
6. Director, SIHFW
7. Director, SHSRC
8. State NGO Coordinator would act as the Convener for this group.

3.9 The roles and responsibilities of the SAG would include:

- Overall guidance to the NGO programs under NRHM in the State
- Review of performance of State and District level NGOs
- Review the work of the NSO/ RRC.
- Assist regular Monitoring and Evaluation of the NGO led programmes.
- Internal and external evaluation of the NGO led programmes after completion of one year
- Share views and experiences with all stakeholders in the State and National advisory group
- Adapt guidelines for NGO participation in the context of the States requirement.

State NGO Cell

3.10 The State NGO cell will be located within the State Programme Management Unit. The State NGO cell will be responsible for fund release to the NGOs and administration of the NGO led programmes in the State. It will monitor and evaluate the NGO programmes under NRHM in the State, and coordinate with the NGO division, NSRC at the Centre and with the NSO/ RRC of the State.



3.11 The proposed State NGO cell staffing is as follows:

- State NGO Coordinator-I
- Programme Assistant– 1-2
- Data Assistant - 1
- Finance Assistant – 1

3.12 A full time State NGO coordinator will head the State NGO Cell. The State NGO Coordinator may be placed on deputation from the State government or hired on contractual basis from the open market.

3.13 In States where the required quantum of support for NGOs is low, the State could in initial phase appoint a State NGO coordinator with 1—2 assistants to manage the program rather than establish a NGO cell and then gradually expand as the NGO program scales up.

3.14 The functions of State NGO Cell will be:

- Support the RRC/NSO and District Health Society (DHS) for the management of the NGO schemes.
- Work closely with the State Health Society and DHS, and communicating government policies to NGOs.
- Coordinate with the programme officers of various health programmes to facilitate interface between the NGOs and the State health department.
- Enable periodic field visits, developing terms of reference and participating in the evaluations, ensuring timely submission of reports by the NGOs, timely release of funds and maintaining the necessary records.
- Function as the coordination point between the NSO and the NGO and other technical resource institutes for meeting the technical needs of the NGOs under the scheme and sharing monitoring reports with the NSO.

- The State NGO Coordinator will be the Member Secretary of the State Grants in Aid Committee.
- Facilitate signing of MoU between NGOs and State Health Society
- The State Coordinator will undertake external evaluation of upto 5% of the NGOs working in the State under the scheme on a randomized sample basis.

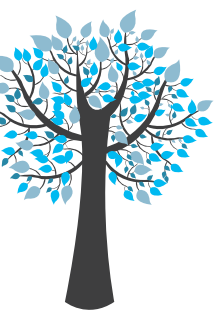
RRC/ NSO

3.15 3.15 The RRC/NSO would also be responsible for capacity building of the NGOs in the State. They would be responsible for maintaining a list of master trainers, adaptation of training modules to State requirements/ language, training of trainers in the State and / district level, and monitoring and evaluation.

3.16 The main role of the NSO is to provide technical support and assistance to the NGO Programme. The NSO will be collocated/work in close collaboration with the State Health Systems Resource Centers / ASHA Resource Centers.

3.17 Key functions of the NSO include:

- a. Support the state in field appraisal and selection of NGOs at district levels.
- b. Serve as the secretariat for the State Advisory Group
- c. Develop a data base of NGOs in the state that could participate in the programme
- d. Build capacity of district NGOs to manage interventions
- e. Develop training and communication material as needed.
- f. Build up systems for monitoring and periodic evaluation of NGO performance vis a vis the objectives set for the programme.
- g. Ensure that participating NGOs at state and district levels in other programmes (skill building, service, delivery, advocacy/social



mobilization, and certification/quality monitoring) have access to standardized protocols, guidelines, and standards and are closely linked to the respective public sector programs in the particular area of implementation.

- h. Serve as a center for conducting research and documentation of best practices.
- i. Could serve as a laboratory for demonstrating best practices and innovations and serve as learning and training center.
- j. Support advocacy efforts and liaison with other such agencies at state and district level.
- k. Organize review workshops, experience sharing workshops and thematic workshops at state and district levels, based on emerging needs.
- l. Support the state in development of PIPs.
- m. Participate in National level activities as appropriate

3.18 In addition to supporting the NGO Programme, the RRC/NSO, may be entrusted by the State government with providing technical assistance to other community based programmes under NRHM or with the State government as it has the capacity to manage. States will provide separate funding to RRC/NSOs for taking up additional works. This decision may be made by the State based on the capacity and quality of leadership available with the RRC/NSO.

3.19 The RRC/ NSO maybe selected with the understanding that it would serve the period of the NHM (in the 12th Plan) but be subject to annual appraisal. Its performance would be appraised annually based on its reports and based on feedback from the Mission Director of the State Health Society. Its continuation would be subject to its performance being found satisfactory on the annual appraisal. The criteria for annual appraisal would be provided to both the State and the NSO at the time of signing the MoU. All NSOs will undergo a midterm review commissioned by the NSRC.

3.20 The selection of the RRC/NSO would be done by the State GIAC. There are already existing RRCs/NSOs who could be included in the program after an appraisal of their effectiveness. New NSO would be selected in the states that currently do not have RRCs. The selection process includes the invitation by advertisement, desk review to short list using a scoring system and a field appraisal. Details on selection of NGOs can be seen in Section IV.

3.21 NSOs will have the following personnel:

1. NSO Coordinator - 1
2. Training Coordinator - 1 S
3. Community Processes and M&E Coordinator – 2
4. IT Assistant - 1
5. Finance and Administrative Assistant - 1

3.22 RRCs/NSOs with the necessary competence could be provided with implementation grants (i.e serve as an FNGO or SNGO) but this cannot exceed more than two projects whose intent primarily is to serve as demonstration of best practice.

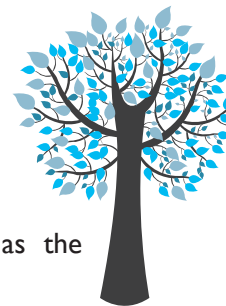
District Level

3.23 The organizational structure proposed at the District level is as follows:

- District NGO Committee
- District NGO Coordinator
- Field NGO
- Service NGO

District NGO Committee

3.24 The District NGO Committee would be constituted within the District Health Society and will be responsible for selection of NGOs in the district. The members of the committee would include:



- District Collector or his nominee
- CMO of the District
- One CHC in-charge
- District Social Welfare Officer (in charge of WCD)
- Representative of the NSO/RRC
- District Programme Manager
- District NGO Coordinator will be the Member Secretary
- State NGO Coordinator may be included as a special invitee
- Representatives of two reputed State NGOs nominated by the Mission Director (NRHM)

3.25 District level NGO selection will be undertaken for activities to be conducted at the district or block level. This could include ASHA training, VHSNC training, support supervision, IEC in a district specific issue, training and orientation of district staff on social determinants. Technical support for district level NGO selection and for the functions of district NGOs will be provided by the NSO.

3.26 The key functions of the District NGO Committee will be:

- Selection of district level NGOs.
- Facilitation of the signing of MoU between the NGO and the District Health Society.
- Conduct review meetings to assess performance of NGOs.
- Facilitate training programmes by NGOs and keep the State Health Society informed about the selection and release of funds to NGO.

District NGO Coordinator

3.27 3.27 A District NGO coordinator would be nominated by the DHS for the implementation of NGO programmes at the district/block level. One of the district level Medical Officer or the District Programme

Manager (DPM) may be designated as the District NGO Coordinator.

3.28 The key functions of the District NGO coordinator would be as follows:

- Implementation of NGO Program in the district.
- Selection of NGOs as a member of District NGO Committee.
- Coordination of activities of NGOs in the district.
- Facilitation of the advertisement for the selection of NGOs.
- Undertaking desk review of all the applications and inform all the applicants about the status of their applications.
- Ensuring timely fund disbursement to NGOs and collection of Utilization Certificates.
- Suggesting corrective action to NGOs on the basis of their activity reports.
- Monitoring of NGOs performance to enable needs based technical support and to make recommending the on continuation of grants
- Ensuring adequate supplies to NGOs
- Ensuring close collaboration between NGOs and all health related programmes
- Coordination with the RRC/NSO to ensure that training and technical support is provided commensurate with programme requirement
- Coordination of programmatic and financial reporting to State and Centre.

3.29 At the district level, the NGOs would be divided into two types based on function as follows:

- Field NGOs (FNGOs) – NGOs which would carry out any of the activities listed in –2.11 to 2.18.
- Service NGOs (SNGOs) – NGOs which would focus on service delivery especially in un-served and underserved areas—running PHC, FRU, MMU etc.



Field NGO (FNGO)

3.30 These NGOs will be selected to carry out interventions at the district and sub-district level. Activities like Community Monitoring, capacity building of PRIs, VHSNCs, etc. would be carried out by FNGOs. They can undertake work in the entire district or a part of it depending upon the capacity and requirement.

Service NGO (SNGO)

3.31 These are NGOs with proven capacity to deliver services in identified un-served and underserved areas based on requirements of the district.

3.32 The following are the guidelines specific to Service NGOs:

- Not more than 40% of the funds proposed by the State in their PIP for NGOs may be allocated for SNGOs.
- The scale of funding depends on the nature and scale of intervention proposed.

- Charitable institutions and also hospitals running on a not-for-profit basis may be included under Service NGOs.
- If the state selects an NGO to manage a PHC, then all Sub Centers under the PHC should also be allocated to that NGO
- For Service provision the plan should be to run government infrastructure through government functionaries in the long term. If a State wants to run a government facility through SNGO then NRHM will support this on a reducing balance basis.
- NGOs providing services through their own establishments, in areas where government services are not available, will be fully funded depending on the project cost.



IV. Financial Structure

- 4.1 Laying down robust, efficient, transparent and timely processes for selection, supervision and payment is the cornerstone of good NGO policy. Hitherto NGO schemes have been constrained by problems in the selection, supervision and prompt and dignified payment to NGOs. Poor governance issues that affect these processes lead over time to weakening the entire nongovernmental sector.
- 4.2 Upto5% of the total NHM funds should be earmarked for NGO involvement.
- 4.3 Funds required for the RRC/NSO and for NGOs at the State and district levels would be reflected under the respective flexipools of the Annual Programme Implementation Plans submitted by states for NHM.
- 4.4 The flow of funds will be from the NHM flexi pools to the State Health Society. The State Health Society will release funds to the district, which in turn will release funds to the District Health Society, which in turn will release it to the NGOs. For NGOs that are funded to State level activities, funds will flow from SHS to NGOs directly.
- 4.5 After the issue of sanction letter and signed MoU, the District Health Society will release grant to the NGOs. The State Health Society and the District Health Society will together ensure that fund releases to the NGOs are timely and adequate. The funding in a district may be enhanced by the State Health Society depending on the specific requirements of the District.
- 4.6 A bank guarantee may be asked of the NGOs for 10% of the amount of the first tranche of fund release. Fund disbursement would be done at the implementation level with a bank transfer i.e. State level or District level for NGOs engaged at the respective level.
- 4.7 Release of funds of subsequent installments would to be done only based on utilization of funds released earlier and ensuring appropriate physical progress.
- 4.8 In case of default, no further grants would be released to a NGO. The District Health Society will evaluate the performance and if there is a violation of any norms, will blacklist the NGO. The NGO can appeal to the State Health Society.
- 4.9 A 12 % institutional overhead for internal organizational strengthening would enable NGOs to stay motivated and interested in the programme and reduce pressures on even good NGOs to falsify accounts to cover some



legitimate institutional needs, especially the needs to develop its own internal capacity, pay its support staff and renew its own motivation levels.

4.10 The following are financial guidelines for Field NGOs and Service NGOs:

- The salary component shall not exceed 35% of the total budget, however.
- Charges such as rent for space, capacity building, TA and DA for the staff will not exceed 25%.
- Contingency of 10% of the total cost minus the salaries is permissible
- Funds will not be provided for construction of building and purchase of vehicles, however in extremely under-served areas, SNGOs could be funded for capital expenditures but that is a decision to be taken at state level.
- FNGO/SNGO may be permitted a one-time non –recurring grant to purchase of essential assets during the first six months of the project. The amount of the grant would be decided by the State or District Health Society with whom the MoU is signed.
- The following would be the permitted expenditure:
 - ◆ Clinical equipment required for the implementation of the proposed project
 - ◆ However, purchase of land or construction of building is not permitted.
- Once the MoU has been signed the District Health Society releases the grant to the NGO as under:
 - ◆ 1st release: 15% of the total grant
 - ◆ 2nd release: 40% of the total grant based on the UCs received
 - ◆ 3rd release: 40% of the total grant based on UCs submitted and favorable evaluation report.
 - ◆ 4th release*: 5% of the total grant – the final grant is released on receiving the completed UCs and audited Statement of accounts along with project completion report.
- The following would be the funding provided to the SNGO providing services through a government facility:
 - ◆ 1st year: 80%
 - ◆ 2nd year: 75%
 - ◆ 3rd year: 50%
- The remaining funds would be provided by the State Government.
- From the 4th year onwards, NRHM will provide only a token grant of 25% for operating government facilities through SNGOs.
- The NGO will claim reimbursement of the last installment after submission of the final report.



V. Selection of NGOs

5.1 In view of the broad vision of the NHM, there is a need for many different types of NGOs to be involved both at the State and the District Levels. The NGOs also bring in very different competencies to assist the government in fulfilling its commitments to the people. To enable this, that could there is a need to understand NGO competencies as categorized into four overlapping but distinct sets.

- NGOs with good grassroots organizations that have a strong commitment to the marginalized and dispossessed, but with little technical and professional health expertise. They also have competencies for advocacy and for training elected representatives, community level workers and functionaries – not necessarily in the health sector.
- NGOs with professional or managerial skills and with substantial expertise in managing hospitals and outreach health service delivery programmes.
- NGOs that have professional competencies in training health workers especially paramedical and nursing staff, but little service delivery experience, especially of larger projects.
- NGOs with public health expertise, which could serve as institutions of evaluation

research and policy development support, of advocacy and support to planning and programme implementation.

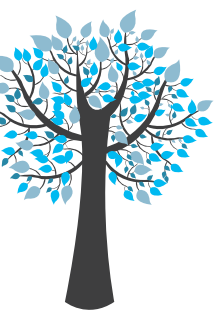
5.2 Presently there are very few organizations that combine all these functions and at scale. Therefore the objective of these guidelines would be to allow the states a flexibility to enter into a variety or partnership models with a diverse number of NGOs in order to achieve the objectives of the National Health Mission.

5.3 RRC/NSO and Field/ Service NGOs selection would be by the State GIAC and District GIAC respectively

5.4 Selection of NGOs would be based on the following criteria:

I. Registration:

- ◆ NGO should be registered under the Societies Registration Act/Indian Trust Act/ Indian Religious and Charitable Act/Companies Act or the State counterparts of such acts for more than three years.
- ◆ NGOs applying for projects in a State other than that of its registration should have experience of working in the state for atleast three years in the last 7 years. However in the case



of specialized activities such as those related to technical and support functions, organizations registered in other states would also be considered. Alternately, branches affiliated to a National federation/organization can be registered with the parent body.

- ◆ For Field NGOs, the NGO should preferably have office premises in the district/block where it wants to operate.
- ◆ An NGO blacklisted or placed under funding restriction by any Ministry or Department of the Government of India (GoI), State Government or CAPART would not be eligible for applying under the scheme. NGOs applying for projects under the NGO scheme should give an affidavit to this effect certifying that they have not been blacklisted by any Ministry or Department of the Government of India or a State Government.

2. Experience:

- ◆ At least 10 years experience for NGO support organization, 5 years for State level projects and 3 years for district level projects in health sector and/or in the concerned social sector (e.g. education, women's empowerment, training, community mobilization, health services, micro-planning, IEC, rural development etc.)
- ◆ Past experience in working with state/central governments preferably in health sector.
- ◆ Experience in working with NRHM would be desirable
- ◆ Field presence in the district for which the NGO is applying
- ◆ Experienced/Qualified personnel.

3. Financial:

- ◆ Annual turnover of at least 50 lakh for the NSO/RRC, Rs 25 lakh for State Level and Rs 10 lakh for district level projects.

- ◆ The NGO should be financially stable.
- ◆ Either have own infrastructure or access to rented infrastructure.
- ◆ NGOs should have appropriate infrastructure, strong community outreach networks, stable governance structures, transparent financial systems and flexible administrative norms.
- ◆ Assets amounting to Rs 20/10/2.5 lakh for NGOs applying for projects at the level of RRC or NSO/State/District level respectively in the name of the organization.

Procedures for Selection

State Level

- 5.5 State GIAC will select RRC/NSO/NGOS that will carry out projects that span the entire state (e.g. IEC, campaigns, state training functions, or cover interventions in more than one districts, and service delivery NGOs.
- 5.6 Depending on the identified need of the region, NGOs may also be engaged for work at the divisional level, or for a cluster of districts. This could be done in circumstances where district NGOs are difficult to find or for a specific purpose, for example – if gender empowerment training is to be imparted to specific groups like SHGs. NGOs that have done good work under the MNGO scheme may be given preference.
- 5.7 The same process for selection to be followed with NSO and state NGO Coordinator taking an active role.

District Level

- 5.8 The District NGO Committee will be responsible for selection of NGOS who will implement in either a few blocks or the entire district.

For NGO interventions that require annual



budgets or over Rs 10 lakhs, the State GIAC will be involved in the selection.

5.9 Process for selection should be transparent, well defined open and accountable. The selection process should be initiated through an open advertisement process. The proposal would be ranked on a set of scoring criteria, approved by the GIAC at each level. After the desk review and short list, field appraisal would be conducted for final selection. The list of the selected /empanelled NGOs would be available on MoHFW website. NGOs would be categorized based on schemes and geographical locations.

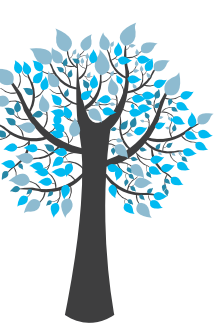
5.10 The selection process for NGO selection will be through the following steps:-

- Open advertisement in 2 leading newspapers – one in English and the other in the regional language.
- Names of the selected NGOs would also be displayed on the website of the State/ District Health Department.
- Field appraisal of the short listed organization would be done by a team constituted for the purpose, which could include members from the NSO, district

NGO coordinator, finance personnel and District Programme Manager.

- Based on the recommendations of this team, the district NGO selection committee will be finalized. The whole selection process should normally take 60 days.

5.11 The partnerships will be formalized through an MoU with the district, state or center as appropriate. The DHS would enter into a MoU with the NGO, which would detail the key roles and responsibilities of each. These MoUs would be subject to central review and be the basis of audit and programme monitoring. The period of appointment of the NGO would be based on the project duration which would vary depending on the nature of the project.



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Guidelines for NGO Involvement Under
National Health Mission in the Twelfth Five Year Plan



National Health Mission
Ministry of Health & Family Welfare
Government of India, Nirman Bhavan, New Delhi