



# Guidelines for Department of Family Welfare Supported NGO Schemes



सत्यमेव जयते

NGO Division  
Department of Family Welfare  
Ministry of Health and Family Welfare  
Government of India



## Acknowledgements

We are grateful and express our deep appreciation and sincere thanks to all those who have provided diverse inputs and support in the design, development and publication of these guidelines.

UNFPA deserves a very special mention for providing generous technical and financial support in preparation of these guidelines. We deeply appreciate the role of Technical Advisory Group for their critical views and suggestions that made it possible to bring these guidelines into the present shape. Department of Expenditure, other Departments of Government of India and State Government officials provided critical appraisal and valuable inputs from time to time and we are also grateful to all those who have contributed in preparation of these guidelines. We also express our sincere thanks to the Consultants, Departmental staff and other individuals who were associated and part of this effort of preparing these guidelines.



J.V.R. PRASADA RAO  
Secretary  
Tel.: 3018432  
Fax : 3018887  
email : secyfw@nb.nic.in

भारत सरकार  
परिवार कल्याण विभाग  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011

GOVERNMENT OF INDIA  
DEPARTMENT OF FAMILY WELFARE  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

Dated the 24<sup>th</sup> March, 2003

## Message

To supplement the efforts of Government in Health Care delivery, involvement of Non-Governmental Organisations (NGOs) plays a major role. NGOs have a distinct advantage in delivery of health care as they have a better knowledge of socio-cultural-economic status of the general population and therefore, have a wider reach among the marginalized and disadvantaged people. Ministry of Health & Family Welfare have many schemes to involve NGOs in various national programmes to tackle the problems of tuberculosis, blindness, cancer, HIV/AIDS and leprosy etc. NGOs have also been involved in the Government's effort of population stabilization by involving them in reproductive and child health programme. The Department of Family Welfare runs a unique scheme of Mother NGO (MNGO) to manage and fund the smaller NGOs known as field NGOs. Realising the need for enhancing service delivery to the masses, this scheme is being decentralised to the States and a new scheme known as Service NGO (SNGO) Scheme is being introduced. The new guidelines of Department of Family Welfare incorporate details of these schemes.

With the revision of the Guidelines of NGO Schemes of the Department of Family Welfare, we envisage larger participation of NGOs in the RCH Programme and these Guidelines provide all the necessary details for NGOs to involve themselves in the efforts of the Government of population stabilization.

(J.V.R. Prasada Rao)



No. Z.28019/33/2000-S.II  
Government of India  
Ministry of Health & Family Welfare  
Department of Family Welfare  
Nirman Bhavan, New Delhi.

Dated the 1<sup>st</sup> July, 2003

ORDER

Subject: Guidelines for NGO Schemes supported by Department of Family Welfare

In pursuance of efforts towards population stabilization and Reproductive & Child Health, aiming at sustainable development and inculcating a meaningful partnership with Non-Governmental Organizations (NGOs) as one of the strategic themes, envisaged in the National Population Policy – 2000, the Government of India after broad-based consultation with all stakeholders has evolved the revised guidelines. These are exhaustive and more focussed in approach to attain the laid down objectives of programmes.

2. These guidelines are in supersession of previous orders/directions on the subject.
3. This issues in consultation with Ministry of Finance (Department of Expenditure) I.D.No. 18/6/PF.II/97 dated 19.2.2003.
4. These guidelines are applicable with immediate effect.

Sd/-  
(R.B. Chawla)  
Under Secretary to Govt. of India

To  
All concerned



## TABLE OF CONTENTS

Acknowledgement	3
Message	5
Order	7
Abbreviations	10
Introduction	11
<b>PART ONE: Mother NGO (MNGO) Scheme</b>	
1.1 Introduction	12
1.2 Role of MNGOs and FNGOs	13
1.3 Institutional Framework	14
1.4 Guidelines for MNGOs (Procedural & Process)	17
1.5 Guidelines for FNGOs (Procedural & Process)	20
<b>PART TWO: Service NGO (SNGO) Scheme</b>	
2.1 Introduction	24
2.2 Institutional Framework	25
2.3 Procedural Guidelines	27
2.4 Process Guidelines	28
<b>PART THREE: Service Delivery Guidelines</b>	
3.1 Introduction	32
3.2 Detailed Guidelines of RCH Components	33
3.2.1 Maternal and Child Health	33
3.2.2 Family Planning	35
3.2.3 Adolescent Reproductive Health	38
3.2.4 Prevention and Management of RTI	41
3.2.5 MTP Services	43
3.2.6 Dai Training	45
3.2.7 Violence Against Women	48
3.2.8 Male Involvement	50
3.3 Financial Guidelines specific to Service Delivery	52
<b>PART FOUR: Formats and Checklists</b>	
MNGOs, SNGOs AND FNGOs: A Synopsis	61



## ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARC	Apex Resource Cell
ARH	Adolescent Reproductive Health
BCC	Behaviour Change Communication
CNA	Community Needs Assessment
CBO	Community Based Organisation
DoFW	Department of Family Welfare
DWCRA	Development of Women and Children in Rural Areas
FNGO	Field NGO
FP	Family Planning
GIAC	Grants-in-Aids Committee
GoI	Government of India
HIV/AIDS	Human Immuno Virus/ Acquired Immune Deficiency Syndrome
ICDS	Integrated Child Development Services
IEC	Information, Education, Communication
IFA	Iron Folic Acid
IPC	Inter Personal Communication
IUD	Intra-Uterine Device
LHV	Lady Health Visitor
MCH	Maternal Child Health
MIS	Management Information System
MNGO	Mother NGO
MO	Medical Officer
MTP	Medical Termination of Pregnancy
MoU	Memorandum of Understanding
MoHFW	Ministry of Health & Family Welfare
MTP	Medical Termination of Pregnancy
NGO	Non-Government Organisation
NPP	National Population Policy
NYK	Nehru Yuva Kendra
PHC	Primary Health Centre
PNDT	Pre-Natal Diagnostic Techniques
PPC	Past Partum Centre
PRIIs	Panchayati Raj Institutions
RCH	Reproductive Child Health
RRC	Regional Resource Centre
RTI	Reproductive Tract Infections
SNGO	Service NGO
STI	Sexually Transmitted Infections
TBA	Trained Birth Attendant
TFR	Total Fertility Rate
VHC	Village Health Committee



## INTRODUCTION

Population stabilisation is important for sustainable development. This requires that family planning and reproductive health care is accessible to all. It also means increasing outreach of primary and secondary education, extending basic amenities including sanitation, safe drinking water and housing, providing transport and communication. To make these meaningful, it is critical that women are empowered, have equal opportunities and can assert their rights in all spheres – health and reproductive health, nutrition, education, employment, etc.

The National Population Policy (NPP) 2000 emphasises the commitment of the Government of India (GoI) to voluntary and informed choice in family planning and reproductive health care services.

The NPP 2000 provides strategies for addressing the reproductive and child health needs of the people and achieve net replacement levels (TFR = 2.1) by the year 2010.

The purpose is to increase access and coverage of a comprehensive package of reproductive and child health services, including family planning. To achieve this purpose, the government, the corporate sector and the voluntary and non-government sector are expected to work together in partnership.

The NPP 2000 lists partnership with NGOs as one of the strategic themes. The Action Plan mentions the objectives of the collaboration. The work of NGOs is essentially supplementary and complementary in nature to that of the government. NGOs have a comparative advantage of flexibility in procedures, and a rapport with the local population. The GoI therefore proposes to involve NGOs in using strategies for expanding access to health services.

The Department of Family Welfare (DoFW), GoI, envisages collaboration with NGOs through state governments. The Mother NGO (MNGO) Scheme and the Service NGO (SNGO) Scheme are expected to facilitate this process. This NGO Guidebook presents the Guidelines of these two DoFW funded schemes. These are presented in Part One and Part Two of this Guidebook, respectively. Both the schemes focus on partnerships between the government and NGOs for improving RCH service delivery. Indicative service delivery guidelines for the different RCH components are outlined in Part Three of this Guidebook. Part Four presents some illustrative Formats and Checklists that can be used under the two schemes.



## PART ONE

# GUIDELINES FOR MOTHER NGO (MNGO) SCHEME

### 1.1 Introduction

The Department of Family Welfare in the Ninth Five Year Plan (1997-2002) introduced the Mother NGO scheme under the Reproductive and Child Health Programme. Under this scheme, the DoFW identified and sanctioned grants to selected NGOs called Mother NGOs in allocated district/s. These MNGOs, in turn, issued grants to smaller NGOs, called Field NGOs (FNGOs), in the allocated district/s. The grants were to be used for promoting the goals/objectives as outlined in the Reproductive and Child Health (RCH) Programme of GoI.

The underlying philosophy of the Mother NGO scheme has been one of nurturing and capacity building. Broadly the objectives of the programme are:

- Addressing the gaps in information or RCH services in the project area
- Building strong institutional capacity at the state, district/ field level
- Advocacy and awareness generation.

At the time of preparing these Guidelines, 105 MNGOs were participating in 439 districts, through approximately 800 Field NGOs. In keeping with the philosophy of capacity building, four NGOs had been identified as Regional Resource Centres (RRCs) to provide technical support to the MNGOs.

The lessons learnt over the past three years have indicated that modifications need to be made in the existing guidelines of the scheme. These are in terms of decentralisation, simplification of fund disbursal process, rationalisation of jurisdiction,

and interface with local government bodies. Additionally, it was found that involving the NGOs in service delivery and addressing gender issues cross cutting the RCH service areas would be required to make the programme more effective. The Guidelines of the MNGO Scheme were accordingly revised to make the programme more effective and user friendly.

#### ***Guidelines***

In addition to capacity building and nurturing small NGOs, the scheme focuses on addressing the unmet RCH needs. This is possible by involving NGOs in delivery of RCH services, in areas which are **under served or un-served\*** by the government infrastructure. Accordingly, NGOs are expected to move from exclusive awareness generation to actual delivery of RCH services. This will be done by utilising and strengthening the existing government infrastructure and human resources and not creating a parallel structure.

\* **Un-served and under served areas** are those socio-economic backward areas, which do not have access to health care services from the existing government health infrastructure, especially urban slums, tribal, hilly and desert areas including SC/ ST habitations.

In specific terms these areas are: where the post of MO, ANM & LHV have been vacant for more than 1 year; the PHC is not equipped with minimal infrastructure; performance on critical RCH indicators is poor.

Additionally, interventions are expected to address gender issues. Proposed interventions must seek to enhance male involvement and partnership in improving the reproductive health status of women and children. The interventions must also include adolescent population. Community needs to be adequately mobilised to generate demand for RCH services.



Greater emphasis on service delivery means that the service providers are able to measure outcomes concretely. Therefore the revised guidelines focus on development of clear outputs and measurable indicators at the project proposal stage by the MNGO. The role of MNGO becomes one of an active facilitator and manager of the project and not only a fund distributor.

A decentralised approach is adopted in the management and implementation of the MNGO Scheme. This means, starting from identification of NGOs, recommending NGO proposals for GoI approval, the State RCH Society takes responsibility for implementing the scheme. The MNGOs are members of the District RCH Society.

The role of Government of India is one of policy guidance, approvals, funding and technical support.

In order to optimise results, the NGO is expected to complement and supplement the government health infrastructure and not substitute it. The NGOs' efforts are more effective by developing linkages with local governments, related government departments, and establishing networks with technical and resource institutions.

Rationalisation of jurisdiction is done with a view to enable the NGOs to provide in-depth service in the project areas and optimise resources. The project duration of three years is extendable to five years, which facilitates long term planning and stable implementation.

## 1.2 Role of MNGOs and FNGOs

FNGOs under the MNGO Scheme are involved in service delivery, in addition to advocacy and awareness generation.

The key service delivery areas under the MNGO Scheme are:

- Maternal and Child Health
- Family Planning
- Adolescent Reproductive Health
- Prevention and Management of RTI

Indicative service delivery guidelines for the above mentioned RCH components are presented in Part Three of this Guidebook.

- Some MNGOs have expertise in various aspects of development but limited expertise in the health sector. In order to provide hands on experience in implementing RCH service delivery interventions to MNGOs, the scheme provides funds to MNGOs for implementation of demonstrative service delivery projects in the allotted areas. The scope and scale of the project is comparable to that of the FNGO project

To facilitate implementation of service delivery projects by FNGOs, the MNGOs must have a dedicated team of staff including Project Director with project management experience (preferably with regard to health/RCH), and qualified trainers.

- The MNGO cannot simultaneously apply as a Service NGO(SNGO) since these are two distinct functions

The role of the MNGO include the following functions:

- Identification of un-served and under served areas
- Release of advertisement, identification and selection of FNGOs



- Motivate NGOs, CBOs, SHGs and other local level bodies in case of non-availability of suitable FNGOs
- Development of baseline data through Community Needs Assessment (CNA) and end line project data
- Impart project orientation to FNGOs
- Development of proposal with output and process indicators for approval
- Provision of IEC materials to FNGO
- Capacity building of FNGOs
- Technical support to FNGO for induction and in-service training of project staff
- Ensure that qualified staff is appointed by FNGO according to the job requirement and support their search for the same through development of TOR, information on resources
- Wherever possible, inclusion of programmes/groups such as Mahila Samakhya, NYK, Swa - Shakti in the FNGO orientation and frequent interaction
- Liaise, network and coordinate with state and district health services and Panchayati Raj Institutions, linkages with other NGOs and technical institutions
- Monitor performance of FNGOs and progress of the project through supportive supervision
- Exchange and share learning and experiences with other MNGOs in the state and region
- Work closely with RRCs and State NGO Coordinator
- Document best practices
- Submit quarterly financial and project progress reports to State RCH Society and District RCH Society
- Submit statement of expenditure & utilisation certificates as per MoU

The role of FNGOs include the following functions:

- Conduct Community Needs Assessment
- Develop proposal based on baseline data
- Provision of RCH services as proposed
- Interaction for convergence with ICDS, rural development and anganwadi initiatives
- RCH orientation to PRI members, members of Mahila Samakhya, NYK, Swa Shakti , Mahila Swasthya and others
- Share information on the type of services that can be availed from the government health infrastructure
- Create conducive working environment for the ANM
- Facilitate the monthly RCH camps conducted by the PHC through mobilisation of community
- Timely submission of quarterly progress reports, utilisation certificates etc. as per agreement to the MNGO
- Documentation and maintenance of records and registers.

### 1.3 Institutional Framework

The revised guidelines of the MNGO Scheme are



expected to add value to the scheme as it exists and to improve accountability at all levels. These guidelines are applicable within the Institutional framework as laid out below.

### **Gol**

Government of India provides support through policy guidelines, approvals and release of funds to State RCH Society. Grants-in-Aid Committee, (GIAC) approves the MNGO project recommended by the NGO Selection Committee. The NGO Selection Committee is constituted at the state level for the purpose of MNGO selection and is chaired by the Joint Secretary, Department of Family Welfare, GoI. Its function is to recommend MNGO proposals for approval by the GIAC, which is chaired by the Secretary, Family Welfare, and has representation of Financial Advisor and Planning Commission.

### **Regional Resource Centres (RRCs)**

Technical support for NGO capacity enhancement, documentation of best practices, induction and in-service training, liaison with the state government, updating data base on RCH issues and development of MIS is provided by Regional Resource Centres and other technical institutions as found necessary. This is expected to complement the technical support decisions made by the State RCH Society.

### **Apex Resource Cell (ARC)**

Located within the NGO division, the ARC will coordinate the activities of all the RRCs, manage budgets, and facilitate RRC coordination and interaction with state governments.

### **Regional Director (RD)**

- Receive all applications from MNGO applicants and conduct pre-scrutiny/desk review of all applications, based on checklist

- Provide the collated information on the NGO applications to the State RCH Society and convene the meeting of the State NGO Committee till the State NGO Coordinator is identified and placed
- Participate in the review of applications as a member of the State NGO Committee
- Participate in the final selection of MNGO as a member of the NGO Selection Committee
- Undertake field visits if required and submit tour reports to State Secretary (FW) & copy to NGO Division, GoI.

### **NGO Selection Committee**

The selection of MNGOs will be carried out by the NGO Selection Committee, chaired by the Joint Secretary, FW, GoI. This Committee will be constituted at the level of each state for the purpose of selection of MNGOs. The other members include the State Health & Family Welfare Secretary, Regional Director, RRC Representative, Project Director RCH Society/ director (FW) as Member Secretary and 1-2 co-opted members.

The selection of MNGO will be based on desk review reports and field appraisals of the eligible NGOs conducted by the RRCs. After selection of the MNGO, the NGO Selection Committee will place the recommendation to the GIAC for approval.

### **State RCH Society**

The State RCH Society constitutes a technical NGO Committee, called the State NGO Committee and ensures the placement of State NGO Coordinator. From selection of MNGOs, recommendation of projects for GoI approval, fund disbursement, capacity building, training, monitoring to evaluation, is the responsibility of the State RCH Society.



### **State NGO Committee**

The State NGO Coordinator convenes the meeting of the State NGO Committee, chaired by the Secretary (FW) or his nominee. Till the time the State NGO Coordinator is identified and gets placed, the Regional Director convenes the NGO committee meetings. The presence of GoI representative, RD and State NGO Coordinator is mandatory. The RRC and Director (FW) are also members of the Committee.

The primary responsibilities of the State NGO Committee are:

- Examine findings of the desk review and identify eligible NGOs
- Get field appraisal of eligible NGOs done by the RRCs
- Coordinate training of selected MNGOs
- Release of grant –in –aid as per MoU
- Monitoring of MNGOs
- Organize meetings to review the MNGO performance from time to time and ensure timely release of funds
- Commission MNGO evaluation through external evaluating agency
- Send utilization certificates to GOI
- Act as arbitrator in case of dispute

For review of NGO applications:

- On receiving the pre-scrutiny/desk review reports from the RD's office, the State NGO Committee convenes a meeting for review of NGO applications and prepares agenda

- Invite Secretary (FW) and other members of the committee to attend the meeting
- Prepare minutes and decision taken. Communicate the same to GoI and respective NGOs.

### **State NGO Coordinator**

- The full time NGO coordinator is responsible for management of the DoFW supported NGO schemes, including the MNGO Scheme
- The roles and responsibilities of the NGO coordinator are liaising, coordinating and supporting the MNGOs
- Towards this, the coordinator works closely with the State RCH Society, communicates government RCH and health policies to MNGOs, undertakes periodic field visits, develops terms of reference and participates in the evaluations, ensures timely submission of reports by the MNGOs, timely release of funds and maintains necessary records
- The State NGO Coordinator functions as a coordination point between the MNGOs and the RRCs and other technical resource institutes for meeting the technical needs of the NGOs under the MNGO Scheme
- The State NGO coordinator is a part of the State RCH Society, and reports to Secretary (Family Welfare).

### **District RCH Society**

The District RCH Society constitutes a technical committee called District NGO Committee for selection and approval of FNGOs and recommendation of MNGO projects.

The District RCH/FW officer convenes the District NGO Committee. Other members include, State NGO Coordinator, RRC representative, MO, PHC,



ANMs of the concerned project area and an NGO (who is not a grantee) nominated by the district collector.

- Functions:
  - Select and approve FNGO projects
  - Approve and recommend the MNGO project proposal based on FNGO projects
  - Facilitate the signing of MoU between the MNGO and the District RCH Society
  - Send the signed MoU to State RCH Society for release of funds and inform GoI
  - Undertake review meeting to assess performance of FNGOs and MNGO.

### ***Appraisal and Evaluating Agencies***

The Regional Resource Centres conduct the field appraisals prior to MNGO selection. There is a panel of identified and trained evaluating agencies at the regional and state levels that conduct the subsequent mid term and final evaluations. The state can request any of these agencies to evaluate the MNGO project. The agencies also obtain feedback from the State RCH Society and the District RCH Society who are responsible for periodic monitoring of the MNGO projects.

### ***Inter-Departmental Linkages***

NGOs under the MNGO scheme are expected to network with PRIs, women's groups including self-help groups, youth networks, teachers, parents and other members in the community.

## **1.4 Guidelines for MNGOs**

The following two sections – 1.4 & 1.5 - provide detailed guidelines for MNGOs and FNGOs in terms of Procedural and Process Guidelines. Procedural Guidelines spell out the criteria that applicant NGOs must fulfill in order to apply for funding. Process Guidelines spell out the processes involved in selection, sanction and monitoring of projects.

### ***1.4.1 Procedural Guidelines for Submission of Application***

NGOs applying for MNGO status must fulfill the following eligibility criteria. The criteria have been grouped into four sections. These are criteria for Registration, Experience, Assets and Jurisdiction.

#### ***Registration***

- NGO should be registered under the Indian Societies Registration Act/ Indian Trust Act/ Indian Religious and Charitable Act /Company Act or their state counterparts for more than three years
- NGOs applying for MNGO status in a State other than that of its registration, should have State specific chapters registered. Alternatively, branches affiliated to a national level federation/ organisation can be registered with the parent body.

#### ***Experience***

- Proven experience of working for three years in Health & Family Welfare, and the social sector (e.g.. education, women's empowerment, rural development)
- Implemented preferably a field project in Health or Reproductive and Child Health (RCH)
- Scale of operation during the previous three years should be comparable to the funding sought
- Field presence for at least two years in the district for which the NGO is seeking MNGO status
- Experience in capacity building, organising training in health/RCH, gender and other social sectors is preferred
- An NGO blacklisted or placed under funding restriction by any Ministry or Department of



the Government of India (GoI), State Government or CAPART is not eligible for applying under the scheme.

#### **Assets**

- Minimum fixed assets of Rs 2 lakhs in the name of the NGO, in the form of land and/ or building. This should be reflected in the latest audited balance sheet of the NGO and should be retained during the length of the project
- Office premises in the district where it wants to operate.

#### **Jurisdiction**

- Each MNGO is allotted only two districts to work
- Only one MNGO can work in a district
- Preference is given to NGOs, which seek to cover un-served and underserved areas in the district. The NGO identifies these areas in consultation with the District RCH Officer.

NGOs who wish to apply for the MNGO status must fulfill the eligibility criteria as mentioned above. A transparent and participatory process of selection is followed for identifying suitable NGOs for implementing projects under the scheme.

#### **1.4.2 Process Guidelines for Selection, Funds Release and Monitoring**

Below are the guidelines for a stepwise selection of MNGOs.

##### **Selection Process of MNGOs**

- Advertisement is given in two leading state level daily newspapers for the un-allotted/ surrendered districts (under the MNGO Scheme)
  - Completed applications (See Part 4 for Format and Checklist) are received at the office of the Regional Director (RD) Health Services
- The office of the RD conducts desk review based on checklist (See Part 4 for Checklist)
  - GoI is informed of the status of applications received till the cut off date by the office of the RD. This is copied to the state government
  - A meeting of the State NGO Committee is convened normally within one month. The findings of the desk review are discussed here. The Committee identifies NGOs that have fulfilled the eligibility criteria
  - The State NGO Committee informs rejected applicants. This is copied to GoI & State Government
  - A field appraisal of all eligible applicant NGOs is conducted by the RRCs within a defined time frame (See Part 4 for Format)
  - A meeting of the NGO Selection Committee is convened under the Chairpersonship of JS (FW), GoI, for selection of the MNGO based on desk review reports and field appraisal reports of all eligible NGOs
  - The NGO Selection Committee recommends the proposal to the GIAC for approval of MNGO. Decision of GIAC is informed to State RCH Society
  - Selected MNGOs go through induction training within 4-6 weeks of selection by the RRCs. The focus of the orientation is on the relevant aspects including management (technical and financial) of the MNGO scheme. (See Part 4 for Checklist)
  - Following the induction training, the MNGOs use their skills for identifying suitable FNGOs in the unserved and underserved areas (See Part 4 for Checklist). The MNGO is expected to use the initial grant of Rs 1 lakh during this



preparatory phase. The MNGO identifies FNGOs in consultation with the District RCH Society (See FNGO selection process)

- Within four weeks of completing the selection of FNGOs, the MNGO is expected to develop a consolidated project proposal based on the collected data and the indicators from the FNGO proposals
- The MNGO's consolidated proposal is then placed for consideration of District NGO Committee, which communicates the recommendation to the State RCH Society. The State RCH Society recommends the MNGO project proposal to GOI for the final approval of GIAC and release of grants to the State RCH Society
- The selected MNGO signs a Memorandum of Understanding (MOU) with the District RCH Society
- Copy of the signed MOU is sent to the State RCH Society for release of funds. A copy is sent to GoI and RRCs for information.

#### ***Duration of Grant***

The MNGO is sanctioned a project for a period of three years. Retention of the MNGO status is based on the evaluation, which is to be conducted at the end of Year One and Year Three.

#### ***Fund Flow***

The flow of funds is from the GoI to the State RCH Society. The State RCH Society is responsible for release of funds to the MNGOs.

#### **GoI to State RCH Society**

- GoI releases the 1<sup>st</sup> installment to the State RCH Society for each district allocated under the MNGO scheme. This is done in the first quarter of the financial year

- Release of the 2<sup>nd</sup> installment is based on request from State RCH Society.

#### **State RCH Society to MNGO**

- State RCH Society releases a grant of Rs.1 lakh for the preparatory phase to the MNGO. This is primarily for conducting Community Needs Assessment /baseline survey, identification of FNGOs, orientation of FNGOs, getting FNGO proposal and preparing a consolidated proposal with indicators for submission. If found required, some parts of the fund may be used for nurturing/preparing SHGs/youth groups who could eventually become FNGOs
- MNGOs get an annual allotment of approximately Rs. 5 –15 lakhs per district. The budget is based on the number of FNGOs (to whom the grants will be given by the MNGOs) and the nature of the proposed interventions
- MNGOs are allowed to retain 20 % of the total project cost (i.e. Rs. 5 – 15 lakhs). This is in the range of Rs. 1 – 3 lakhs for administrative cost, which includes capacity building cost
- A non-recurring grant of a maximum of Rs 1.5 lakhs is permitted for purchase of assets during the first 6 months of the project. This expenditure is allowed as a one-time expenditure in the life of the project for clinical equipment and training materials as required by the project. Office equipment can include office furniture such as, table, chairs, storage, cabinets, computer, printer
- An emergency-rolling fund of Rs 1 lakh can be made available to the MNGO to meet exigencies such as non-receipt of drugs, vaccines and contraceptives. This is however subject to a no objection certificate from the District RCH Officer



- On receipt of the sanction letter and signed MoU from the District RCH Society, the State RCH Society releases grants to the MNGO in the following stages:
  - 1<sup>st</sup> release - for a period of 18 months
  - 2<sup>nd</sup> release- next 16 months and based on favourable evaluation report by the empanelled evaluating agency and utilisation certificate (UC) for the first 12 months or the end of the financial year, whichever is earlier
  - 3<sup>rd</sup> release\*\*- the final grant of 2 months is released on receiving all completed UC and audited statement of accounts along with project completion report
- The MNGO monitors the work of FNGOs on a monthly basis, and also undertakes field visits and review meetings as per appropriate checklist
- It is mandatory for the State RCH Society to have half yearly review meetings in which the District RCH Society is also represented. The MNGOs makes a presentation to the State RCH Society on their performance (project & financial), during the period based on the activity plan for the year
- The State NGO Coordinator shares the half yearly reports of the MNGOs with the RRCs, to identify areas requiring technical inputs.

\*\*The MNGO claims reimbursement of the last installment after submission of the final reports.

- In order to facilitate project continuation, the release of funds will not be totally stopped on account of non submission of UCs by one or two FNGOs with valid reasons (e.g: natural calamities). In such cases, the fund will be released proportionately for those FNGOs who have submitted the UCs, and the MNGO is required to submit the UCs for the complete project before the end of the financial year

In case of default, no further grant will be released. The State RCH Society evaluates the performance and if there is violation of any norms, blacklists the NGO.

### ***Monitoring***

A system of periodic reporting and ongoing monitoring is in place for assessing the NGO's performance.

- The MNGO submits reports (financial and performance) every quarter to the State NGO Coordinator and District RCH Society

### ***Performance Indicators***

Retention of MNGO grant and the funds release is based on performance of the NGO.

- The MNGO clearly identifies output and measurable indicators at the project proposal stage. The MNGO also encourages the FNGO to identify these when the FNGO submits its proposals to the MNGO. These are to be identified in consultation with the corresponding tier of Family Welfare Administration and related sectors of Social Development
- The MNGO supports the FNGO to conduct a baseline survey before the commencement of any activity in the project area. An end line survey is also to be conducted to assess the improvements in service delivery in a given area of intervention
- The MNGO must be able to demonstrate qualitative and quantitative improvement in meeting the RCH needs of the community in the project area
- The MNGO assesses progress of FNGO against a cluster of service delivery indicators selected



by the FNGOs. The progress of the MNGO is in turn assessed based on the indicators spelt out by it in its consolidated proposal.

#### **Evaluation**

- The MNGO performance is evaluated at the end of year one and year three by an external evaluating agency
- The State RCH Society commissions the evaluation.

#### **Reporting**

- The MNGO submits six monthly reports to the State RCH Society with copies to the District RCH Society
- The State RCH Society shares the 6 monthly reports with Regional Resource Centres and the GoI
- The utilisation certificates for the funds are submitted by the states to GoI
- At the end of the project, the MNGO submits a project completion report to the State RCH Society.

## **1.5 Guidelines for FNGOs**

### ***1.5.1 Procedural Guidelines for submission of Application***

NGOs applying for FNGO grant must fulfill the following eligibility criteria. The criteria have been grouped into four sections. These are criteria for Registration, Experience, Assets and Jurisdiction.

#### ***Registration***

- NGO should be registered under the Indian Societies Registration Act/ Indian Trust Act/ Indian Religious and Charitable Act /Company Act or their State counterparts for a minimum of two years.

#### ***Experience***

- Proven experience of working for two years in Health and Family Welfare and in social sector (e.g.. education, women's empowerment, rural development)
- Preferably implemented a field project in Health and Reproductive and Child Health (RCH)
- Scale of operation during the previous two years should be comparable to the funding sought
- Field presence for at least two years in the geographical area for which it is seeking a grant
- Experience in capacity building, organising training in gender and other social sectors is preferred
- An NGO blacklisted or placed under funding restriction by any Ministry or Department of the Government of India (GoI), respective State Government or CAPART is not eligible for applying under the scheme.

#### ***Assets***

- Minimum fixed assets of Rs 1 lakh in the name of the NGO, in the form of land and/ or building. This should be reflected in the latest audited balance sheet of the NGO and should be retained by it during the length of the project
- The NGO has office premises in the district/ block where it wants to operate.

#### ***Jurisdiction***

- Jurisdiction of FNGOs is linked to the service area of the health sub center
- Field NGOs are expected to provide RCH service delivery in the un-served and under served areas.



### **1.5.2 Process Guidelines for Selection, Funds Release and Monitoring**

#### ***Selection of FNGOs***

NGOs who wish to apply for the FNGO grant must fulfill the eligibility criteria as mentioned above. A transparent and participatory process of selection is followed for identifying suitable NGOs for implementing projects under the Scheme.

- MNGO undertakes field visits to identify underserved and un-served areas in the district, in consultation with the District RCH officer
- MNGO calls for applications from NGOs through open advertisement based on eligibility criteria
- MNGO screens applications. Based on scrutiny of documents and field visit the MNGO identifies suitable FNGOs
- MNGO provides orientation to selected FNGOs on baseline and/or Community Needs Assessment (CNA). MNGO orients FNGOs on how to develop a project proposal
- MNGOs provide input and guidance to FNGOs in carrying out the baseline and/or CNA in the identified geographical areas. (See Part 4 for Checklist)
- FNGOs submit to MNGO project proposals thus developed
- District RCH/FW Officer convenes the meeting of the District NGO Committee for approval of FNGO project proposals.

#### ***Duration of Grant***

The FNGOs work for a period of three years. The project is evaluated annually by the MNGO.

#### ***Funds Flow***

Funds flow from MNGOs to FNGOs. MNGO disburses grants in the following stages:

- 1<sup>st</sup> release - for a period of 18 months
- 2<sup>nd</sup> release - next 12 months and based on favourable report by the MNGO and utilisation certificate (UC) for the first 12 months or the end of the financial year whichever is earlier
- 3<sup>rd</sup> release - for a period of 4 months and based on the Utilisation Certificate (UC) of the next 12 months and supported by report from MNGO
- 4<sup>th</sup> release\*\* - The final grant of 2 months is released on receiving completed UC and audited statement of accounts along with project completion report.

\*\*The FNGO claims reimbursement of the last installment after submission of the final reports.

#### ***Monitoring***

- FNGOs submit quarterly reports (financial and performance) to the MNGO with copies to the District RCH Society
- MNGO conducts monthly monitoring visits to the FNGOs.

#### ***Performance Indicators***

Retention of grant and funds release is based on performance of the NGO.

- The FNGO identifies output level indicators when submitting its proposals to the MNGO. These are identified in consultation with the corresponding tier of Family Welfare Administration and related sectors of Social Development



- A baseline survey is conducted by the FNGO before the start of any activity in the project area. An end line survey is also conducted to assess the improvements in service delivery in the area of intervention
- The FNGO is able to demonstrate qualitative and quantitative improvement in meeting the RCH needs of the community in the project area
- The MNGO assesses progress of FNGO against a cluster of service delivery indicators selected by the FNGOs.





## PART TWO

# GUIDELINES FOR SERVICE NGO (SNGO) SCHEME

### 2.1 Introduction

NGOs with an established institutional base and delivery infrastructure are encouraged to complement the public health system in achieving the goals of the RCH programme. Any NGO that is engaged in directly providing integrated services in an area co-terminus to that of a CHC/block PHC with 1,00,000 population (approximately 100 villages or more) is called a Service NGO.

Service NGOs are expected to provide a range of clinical services directly to the community. For example, services for safe deliveries, neo-natal care, treatment of diarrhoea and ARI, abortion and IUD services, RTI/STI etc. These services must reach out to male and female population in all age groups. In order to provide these services effectively, the applicant NGO must have appropriate staff, infrastructure such as clinic/hospital, ambulance, etc.

Non-clinical services could include documentation and surveillance of data, health data management, training of dais, village health committees, SHG leaders and micro credit groups, PRIs among others. The purpose of training, for example, dai training or training of VHCs, will clearly be to improve the access and quality of clinical services. In order to impart these skills, the NGO must have the appropriate infrastructure base and a training center/institute recognised by the government. A non-recurring, one time grant can be provided to SNGOs for strengthening their existing infrastructure base, in case there is a requirement. Applicants for the SNGO scheme must have staff with demonstrated experience and skills, and credible referral linkages and network for providing outreach services.

This NGO Scheme, called the Service NGO Scheme, is expected to promote the achievement of the RCH objectives in the areas which are un-served or under served\*\* by the public health services and infrastructure and complement the MNGO Scheme. SNGOs differ from MNGOs in terms of their scope and coverage of work. SNGOs can provide a range of clinical and non-clinical services, directly to the community while the MNGOs provide through the FNGOs. While FNGOs can take up a particular service delivery area, SNGOs are expected to provide an integrated package of RCH services. The SNGO may be provided with a non-recurring one-time grant for infrastructure improvements as required whereas FNGOs are not eligible for this.

\*\* Un-served and under served areas are those socio-economic backward areas, which do not have access to health care services from the existing government health infrastructure, especially urban slums, tribal, hilly and desert areas including SC/ ST habitations. In specific terms these areas are: where one of the posts of MO, ANM & LHV have been vacant for more than 1 year; the PHC is not equipped with minimal infrastructure; performance on critical RCH indicators is poor.

The SNGOs provide the following comprehensive range of clinical and non-clinical services in the following RCH areas:

The SNGOs implement large-scale projects in the key RCH service areas covered under the MNGO Scheme viz. Family Planning (such as setting up of IUD clinics), Adolescent Reproductive Health, Maternal and Child Health, and RTI. Additionally, SNGOs can take up other areas such as MTP services, and Dai Training. SNGO proposals for service delivery in emerging RCH areas such as Gender based Violence, and Male Participation will



be encouraged. Gender and community mobilisation processes are expected to be cross cutting in all aspects of service delivery. Community needs to be adequately mobilised to generate demand for RCH services.

The above is an illustrative list only. Indicative guidelines for these RCH service delivery areas are presented in Part Three of this Guidebook. The SNGO can propose interventions in other service areas. The SNGO must provide a clear justification for this and it must be a felt need in the community.

Greater emphasis on service delivery means that the service providers are able to measure outcomes concretely. Therefore the guidelines focus on development of clear outputs and measurable indicators at the project proposal stage by the SNGO.

This will be done by utilising and strengthening the existing government infrastructure and human resources and not creating a parallel structure.

## 2.2 Institutional Framework

A decentralised and participatory approach is adopted in the management and implementation of the SNGO Scheme. The SNGO guidelines are provided to ensure accountability at all levels. These guidelines are applicable within the Institutional framework as laid out below.

### Gol

Government of India provides support through policy guidelines, approvals and release of funds to State RCH Society. Grants-in-Aid Committee (GIAC) approves the MNGO project recommended by the NGO Selection Committee. The NGO Selection Committee is constituted at the state level for the purpose of SNGO selection and is chaired by the Joint Secretary, Department of Family Welfare, GOI. Its function is to recommend SNGO proposals for approval by the GIAC, which is chaired

by the Secretary, Family Welfare, GOI, and has representation of Financial Advisor and Planning Commission.

### Regional Director (RD)

- Receive all applications along with letter of interest and concept paper from NGO applicants and conduct pre-scrutiny of all applications, based on checklist
- Provide the collated information on the NGO applications to the State RCH Society and convene the meeting of the State NGO Committee till the NGO coordinator is identified and placed
- Participate in the review of applications as a member of the State RCH Society
- Participate in the final selection of SNGO as a member of the NGO Selection Committee
- Undertake field visits if required and submit tour reports to State Secretary (FW) & copy to NGO Division, GOI.

### Regional Resource Centres (RRCs)

Technical support for NGO capacity enhancement, documentation of best practices, induction and in-service training, liaison with the state government, updating data base on RCH issues and development of MIS is provided by Regional Resource Centres and other technical institutions as found necessary. This is expected to complement the technical support decisions made by the State RCH Society.

### Apex Resource Cell (ARC)

Located within the NGO division, the ARC will coordinate the activities of all the RRCs, manage budgets, and facilitate RRC coordination and interaction with state governments.



### **NGO Selection Committee**

The selection of SNGOs will be carried out by the NGO Selection Committee, chaired by the Joint Secretary, FW, GoI. This Committee will be constituted at the level of each state for the purpose of selection of SNGOs. The other members include the State Health & Family Welfare Secretary, Regional Director, RRC Representative, Project Director RCH Society/ director (FW) as Member Secretary and 1-2 co-opted members.

The selection of the SNGO will be based on desk review reports and field appraisals of the eligible NGOs conducted by the RRCs. After selection of the SNGO, the NGO Selection Committee will place the recommendation to the GIAC for approval.

### **State RCH Society**

The State RCH Society constitutes a technical NGO Committee, called the State NGO Committee and ensures the placement of State NGO Coordinator. From identification of SNGOs, placing SNGO proposals for final approval by GoI, fund disbursement, capacity building, training, monitoring to evaluation, is the responsibility of the State RCH Society.

### **State RCH Committee**

The State NGO Coordinator convenes the meeting of the State NGO committee, chaired by the Secretary (FW) or his nominee. Till the time the NGO coordinator is identified and gets placed, the Regional Director convenes the State NGO committee meeting. The presence of GoI representative, RD and State NGO Coordinator is mandatory. The RRC and Director (FW) are also members of the Committee.

For review of applications:

- On receiving the pre-scrutiny/desk review reports from the RD's office, the State NGO Committee convenes a meeting for review of

NGO applications and prepares agenda

- Invite Secretary (FW) and other members of the committee
- Prepare minutes and decision taken. Communicate the same to GoI and respective NGOs

The primary responsibilities of the State NGO Committee are:

- Examine findings of the desk review and identify eligible NGOs
- Get field appraisal of eligible NGOs done by the RRCs
- Coordinate training of selected SNGOs
- Release of grant-in-aid as per MoU
- Monitoring of SNGOs
- Organize meetings to review the SNGO performance from time to time and ensure timely release of funds
- Commission SNGO evaluation through external evaluating agency
- Send utilisation certificates to GOI
- Act as arbitrator in case of dispute.

### **State NGO Coordinator**

- The full time State NGO Coordinator is responsible for management of the DoFW supported NGO schemes, including the SNGO Scheme
- The roles and responsibilities of the State NGO Coordinator are liaising, coordinating and supporting the SNGOs



- Towards this, the State NGO Coordinator works closely with the State RCH Society, communicates government RCH and health policies to SNGOs, undertakes periodic field visits, develops terms of reference and participates in the evaluations, ensures timely submission of reports by the SNGOs, timely release of funds and maintains necessary records
- The State NGO Coordinator functions as a coordination point between the SNGOs and the RRCs and other technical resource institutes for meeting the technical needs of the NGOs under the SNGO scheme
- The State NGO Coordinator is a part of the State RCH Society, and reports to Secretary (Family Welfare).

### District RCH Society

- The District RCH Society constitutes a technical committee called the District NGO Committee, for recommending SNGO project to State RCH Society. The District RCH/FW officer convenes the meeting of the District NGO Committee to be chaired by the District RCH Officer. Other members include, State NGO Coordinator, RRC representative, MO, PHC, ANMs of the concerned project area and an NGO (who is not grantee) nominated by the district collector
- Functions:
  - Reviews SNGO projects and recommends to state RCH Society
  - Facilitate the signing of MoU between the SNGO and the District RCH Society
  - Send the signed MoU to State RCH Society for release of funds and inform GoI.

### Appraisal and Evaluating Agencies

The Regional Resource Centres conduct the field appraisals prior to SNGO selection. There is a panel

of identified and trained evaluating agencies at the regional and state levels that conduct the subsequent mid term and final evaluations. The state can request any of these agencies to evaluate the SNGO project. The agencies also obtain feedback from the State RCH Society and the District RCH Society on the SNGO projects.

### Inter-Departmental Linkages

Service NGOs are expected to liaise with, as well as complement and supplement the government work at the district and block levels. Service NGOs liaise with PRIs at appropriate levels, for sharing information, orienting the elected members in RCH and planning for activities in sectors requiring extension of services.

Service NGOs are expected to work with diverse networks at the local level. These could include self-help groups, DWCRA groups, Mahila Swasthya Sanghas, programmes like Mahila Samakhya- Swa Shakti and youth groups such as Nehru Yuvak Kendras.

## 2.3 Procedural Guidelines for Submission of Application

### Eligibility Criteria

NGOs applying under the SNGO Scheme must fulfill the following eligibility criteria. The criteria have been grouped into four sections. These are criteria for Registration, Experience, Assets and Jurisdiction.

### Registration

- The NGO should be registered under the Indian Societies Registration Act/ Indian Trust Act/ Indian Religious and Charitable Act/Company Act or their state counterparts for more than five years



- NGOs applying for SNGO in the state other than that of its registration, should have state specific chapters registered. Alternatively, branches affiliated to a national level federation/ organisation can be registered with the parent body.

#### ***Experience***

- Proven experience (in the last three years) in implementing field projects in Health and Reproductive and Child Health (RCH) and social sector (education, women's empowerment, rural development, etc.). Proven expertise in provisioning of services, and training is required
- Scale of operation during the previous three years is comparable to the funding sought
- SNGO has the necessary human resource base with RCH and social sector qualification and experience. The NGO has qualified professionals such as medical doctors, paramedics, counsellors and accountants
- An NGO blacklisted or placed under funding restriction by any Ministry or Department of the Government of India (GoI) or CAPART is not eligible for applying under the scheme.

#### ***Assets***

- Minimum fixed assets of Rs 5 lakhs in the name of the NGO, in the form of land and/ or building. This should be reflected in the latest audited balance sheet of the organisation and should be retained by the NGO during the life of the project
- Office premises, service delivery center/s, training institute in the district where it wants to operate.

#### ***Jurisdiction***

- Minimal area serviced by the SNGO is equivalent to the service area of the CHC/block

PHC as appropriate. For SNGOs providing clinical services, the minimum geographical area is co-terminus to that of PHC and those providing referral services, will cover an area co-terminus to that of CHC

- The maximum geographical area covered by a SNGO providing training is not more than one district
- The SNGO can implement the programme in convergence with the intermediary organisations. (SHG, PRI, NYK, DWC, MSS, Mahila Samakhya). However, the NGO cannot sub contract to other NGOs or bodies in the project area.

## **2.4 Process Guidelines for Selection, Funds Release and Monitoring**

#### ***Selection of SNGO***

- Advertisement is given in two leading State level daily newspapers by the State RCH Society, inviting a letter of interest/concept note on the desired area of intervention
- Completed applications including letter of interest/concept paper (See Part 4 for Format and Checklist) are received at the office of the Regional Director (RD), Health Services. The concept paper is not a project proposal. It is to show the intent and the contents should reflect why such a project is required
- The office of the RD conducts desk review with the State NGO Coordinator based on checklist. (See Part 4 for Checklist)
- GoI is informed of the status of applications received till the cut off date by the office of the RD. This is copied to the state government



- A meeting of the State NGO Committee is convened normally within one month. The findings of the desk review are discussed here. The Committee identifies NGOs that have fulfilled the eligibility criteria
- The State NGO Committee informs rejected applicants, with copy to GoI and state government
- A field appraisal of all eligible applicant NGOs is conducted by RRCs within a defined time frame (See Part 4 for Format)
- A meeting of the NGO Selection Committee is convened under the Chairpersonship of JS (FW), GoI, for selection of the MNGO based on desk review reports and field appraisal reports of all eligible NGOs
- The NGO Selection Committee recommends the proposal to the GIAC for approval of MNGO. Decision of GIAC is informed to State RCH Society
- The SNGO prepares the detailed project proposal and submits within 6 weeks to the District NGO Committee/ District RCH Society for consideration
- District RCH Society communicates the recommendation to the State RCH Society. The State RCH Society places the final recommendation to GoI for the approval of GIAC and release of grants to the State RCH society
- The SNGO signs a Memorandum of Understanding (MoU) with the District RCH Society
- Copy of the signed MoU is sent to the State RCH Society for release of funds. A copy is sent to GoI and RRCs for information.

### ***Induction training***

- Through RRCs, GoI organises induction training within 6-8 weeks of sanction of NGO project
- The orientation focuses on the relevance of the scheme, expectations, finance and accounting information, programme implementation processes and reporting.

### ***Project Duration***

- Each SNGO proposal covers initially a three-year term. Based on the evaluation, the grant may be cancelled if the performance is found to be sub optimal. If favourable, the project duration is extended for another two years.

### ***Funding Pattern***

- The scale of funding depends on the nature of intervention proposed. The SNGOs can get an annual allotment of approximately Rs. 10 –15 lakhs per CHC/block CHC area towards recurring and non-recurring expenses. In order to determine the range of funding that can be proposed, a set of illustrative financial guidelines relating to the service delivery areas has been presented in Part Three of this Guidebook
- In order to make judicious use of existing primary health infrastructure, in the urban and rural areas, the service NGO networks where ever and to the extent possible with such infrastructure. This has direct implication on costing of services.

### ***Release of Funds***

The flow of funds is from the GoI to the State RCH Society. The State RCH Society is responsible for release of funds to the SNGOs.

#### **GoI to State RCH Society**

- GoI releases 1<sup>st</sup> installment to the State RCH Society under the SNGO scheme. This is done in the first quarter of the financial year



- Release of the 2<sup>nd</sup> installment is based on request from State RCH Society.

#### ***State RCH Society to SNGO***

- On getting approval from the State RCH Society based on the field appraisal, the SNGO prepares a project proposal. The State RCH Society releases a grant of Rs.1 lakh for conducting base line survey and development of detailed project proposal
- The SNGOs get an annual allotment of approximately Rs.10 –15 lakhs per CHC/block CHC area towards recurring and non-recurring expenses
- The SNGOs are allowed 20 % of the total project cost for administrative cost, which includes capacity building cost
- A non-recurring grant of a maximum of Rs 1.5 lakhs is permitted for purchase of assets during the first 6 months of the project. (List provided below). This expenditure is allowed as a one-time expenditure in the life of the project.
  - Purchase of land or building is not permitted.
  - Clinical equipment required for the implementation of the proposed project.
  - Office equipment: Office furniture such as, table, chairs storage cabinets, computer, printer
- SNGO may be provided with a one time non recurring grant for infrastructure improvements (civil works) as required. This will be roughly equivalent to one third of the grant amount. (PPC guidelines to define the exact % of grant allowance for infrastructure development may be looked at)
- An emergency rolling fund of Rs 1 lakh can be made available to the SNGO to meet exigencies such as non-receipt of drugs, vaccines and contraceptives. This is however be subject to a no objection certificate from the District RCH Officer
- On receipt of the sanction letter and signed MoU from the District RCH Committee, the State RCH Society releases grants to the SNGO as under:
  - 1<sup>st</sup> release - for a period of 18 months
  - 2<sup>nd</sup> release- next 16 months and based on favourable evaluation report by the empanelled evaluating agency and Utilisation certificate (UC) for the first 12 months or the end of the Financial Year, whichever is earlier
  - 3<sup>rd</sup> release\*\*- the final grant of 2 months is released on receiving all completed UC and audited statement of accounts along with project completion report.

\*\* The NGO claims reimbursement of the last installment after submission of the final reports.

#### ***Monitoring***

A system of periodic reporting and ongoing monitoring is in place for assessing the NGO's performance.

- The SNGO submits reports (financial and performance) every quarter to the State NGO Coordinator and District RCH Society
- The State NGO Coordinator undertakes half yearly field monitoring visits to SNGOs
- It is mandatory for the State RCH Society to have half yearly review meetings in which the District RCH Society is also represented. The SNGOs make a presentation to the State RCH Society on their performance (project & financial), during the period based on the activity plan for the year



- The State NGO Coordinator shares the half yearly reports of the SNGOs with the RRCs, to identify areas requiring technical inputs.
- The SNGO must be able to demonstrate qualitative and quantitative improvement in meeting the RCH needs of the community in the project area.

### **Performance Indicators**

Retention of grant and the funds release is based on performance of the NGO.

- The SNGO clearly identifies output and measurable indicators at the project proposal stage. These are to be identified in consultation with the corresponding tier of Family Welfare Administration and related sectors of Social Development
- The SNGO conducts a baseline survey before the commencement of any activity in the project area. An end line survey is also to be conducted to assess the improvements in service delivery and results in a given area of intervention
- Project proposal clearly indicates the TORs of the project and specific benchmarks against which the progress of the project can be evaluated. The progress of Service NGO is measured against a cluster of indicators selected and included in their project proposal

### **Evaluation**

- The SNGO performance is evaluated at the end of year one and year three by an external evaluating agency.
- State RCH Society commissions the evaluation.

### **Reporting**

- The SNGO submits six monthly reports to the State RCH Society with a copy to the District RCH Society
- The State RCH Society shares the 6 monthly reports with Regional Resource Centres and the GoI
- The Utilisation Certificates for the funds are submitted by the states to GoI
- At the end of the project, the SNGO submits a project completion report to the State RCH Society.



## PART THREE

### SERVICE DELIVERY GUIDELINES

#### 3.1: Introduction to Service Delivery

The achievement of the goals of the National Population Policy 2000 is possible only by increasing access and quality of RCH services. A great deal of effort has gone in raising awareness at the community level regarding small family, care during pregnancy, infant care, prevention and management of childhood diseases, prevention of unwanted pregnancy, among other RCH issues. However, this has not been matched by increasing the availability of FP products, information and services, and quality RCH care by the existing government health infrastructure, especially in remote and far-flung areas.

The MNGO scheme as implemented in the last three years has indicated that a number of FNGOs have been providing para-clinical and non-clinical RCH services. Their capacity can be enhanced to be included in the pool of service providers. Therefore the revised guidelines place emphasis on service delivery by the FNGOs.

Additionally, there are a number of NGOs who are not part of the scheme, but with capacity and resource to provide RCH services. These NGOs can be considered for support under the Service NGO Scheme.

The gap in services could be reduced if the capacity of the NGOs is combined with that of the government and complements the existing services.

FNGOs, MNGOs and SNGOs function in two kinds of scenarios.

- (a) Where the government infrastructure is present and functional with staff, supplies and service capacity. In such areas, the NGOs complement the service delivery by enhancing and sustaining the demand for RCH services at community level and by collaborating with the government system.
- (b) Where the government infrastructure is not in place, or available but with poor service quality. In such areas, the NGOs complement the service delivery by strengthening the government system, providing services and sustaining the demand for RCH services at community level, as the need may be.

In both scenarios, the service providing NGOs can draw upon central government schemes (e.g: National Maternity Benefit Scheme, fund for referral transport for emergency obstetrics care from PRI) and state government schemes for funds, technical support, training, IEC materials etc.

Service delivery areas for interventions under the MNGO Scheme are as follows:

- Maternal and Child Health
- Family Planning Services
- Adolescent Reproductive Health
- Prevention and Management of RTI

In addition to the above, the service delivery areas for interventions under the SNGO Scheme are as follows:



- MTP Services
- Dai Training
- Violence Against Women
- Male Involvement

Detailed guidelines for project development has been provided for each of the above-mentioned RCH components in this section of the NGO Guidebook. The concluding part of this section presents some financial guidelines specific to service delivery. The NGOs must refer to these broad financial guidelines when planning their intervention and budget.

### **3.2: Detailed Guidelines for RCH Components**

#### ***3.2.1 : Maternal and Child Health***

##### ***a) RCH Context***

Both the RCH programme and the National Population Policy (2000) place importance on achieving the policy goals of reducing maternal, infant and child mortality and morbidity. Several programmes have been introduced to reduce the Maternal Mortality Rate (MMR). It is estimated that India accounts for nearly 20% of maternal deaths worldwide. The maternal mortality ratio is defined as the number of maternal deaths (during pregnancy, child birth, and the puerperal period) per 100,000 live births. This situation is due to poor reach of health care delivery network in rural areas.

Infant Mortality Rate (IMR) refers to the possibility of an infant surviving up to the age of one year. The Infant Mortality Rate declined in India from 101 per thousand live births during 1978 to 72 in 1998. However, this reduction is not the same in all states. In UP, MP, Orissa, Rajasthan, Bihar and some other parts of the country, the IMR continues to range between 80-103 per thousand live births. The Child

Mortality Rate (CMR) (deaths of children 1-4 years age group per thousand children) has also shown similar uneven decline. Mortality risks are higher among infants born to women under age of 20 and where birth intervals are less than 24 months. Studies show that infant mortality rates are higher in rural areas than in urban areas. IMR declines sharply with increasing education and awareness of the mother.

Gender inequalities hamper access to health services. Even when services are available, the utilisation of services can be inadequate. This is due to ignorance or prevalent socio-cultural practices reinforced by the low status of women. Early marriage, childbearing and early motherhood increase the risk of maternal morbidity and mortality, and infant mortality.

Maternal and child health is also severely affected by repeated pregnancies. Child mortality rates are higher among girls than among boys. Neglect of the girl child's health is often due to socio-cultural reasons such as son-preference.

Maternal and child health programmes should address such gender biases and inequalities.

##### ***b) Coverage***

A population of 25-30,000 spread over 30-40 villages and preferably co-terminus with area of a PHC could be covered by the NGO. The NGO will be expected to provide a basic package of MCH services in the area. It will also establish linkage with referral services, especially with basic and comprehensive emergency obstetric care facilities, either in public or in private sector. Adolescent mothers will also be included.

##### ***c) Measurable Output***

The NGO should be able to demonstrate a measurable/describable change in maternal and



child (0-6 yrs) health status in the community. Following illustrative indicator/s can be considered at the output level:

- % reduction in maternal death
- % increase in women and men getting married after attaining the legal age of marriage
- % increase in the birth interval by all women in reproductive age group
- % of deliveries assisted by skilled personnel (including TBAs)
- % of new born initiated breast feeding within ½ hours of birth
- % of girls and boys in 12-23 months age group completely protected with immunisations
- % of girls and boys in 0-6 yrs given rational management of diarrhoea
- % of girls and boys reduced by 50% from several grades of malnutrition.

#### *d) Strategic Interventions*

In order to achieve the outputs, the NGO must identify key strategic intervention areas. A gender perspective must be duly incorporated in its project design and in identifying strategic interventions and activities. NGOs can consider the following strategic interventions:

- Access to quality Ante Natal Care services
- Institutional deliveries through skilled attendant at delivery
- Essential neo-natal care
- Access to quality child survival interventions

- Community action for safe motherhood and child survival
- Any other.

If necessary, the NGO must conduct a baseline to assess current MCH needs. This could be done for both preventive and promotive MCH services. If a supportive environment already exists in the community, the NGO should strengthen the same from a MCH perspective. In case the supportive environment is lacking, the NGO should invest in strengthening the same.

The NGO proposing to provide access to MCH services must have the capacity and infrastructure to do so. The NGO must avoid duplication. It must play a complementary role in strengthening the existing health care delivery system for addressing gaps in service delivery. Wherever the existing health care delivery system lacks the capacity, the NGO can identify appropriate referrals, and prepare budgets accordingly.

#### *e) Activities*

In each strategic intervention area, the NGO can undertake several different types of activities. The NGO is expected to establish verifiable indicators for each of the strategic intervention areas.

Given is an **illustrative** list of activities in the strategic intervention areas:

##### **Strategic Intervention 1: Access to quality ANC**

- Increasing knowledge on danger signs during pregnancy and delivery, early prediction of complications, weight monitoring, completion of immunisation, appropriate nutrition and nutrition supplements
- Development of a birthing plan and ensuring availability of skilled birth attendant



- Any other

**Strategic Intervention 2: Institutional deliveries**

- Appoint qualified nurses to conduct normal deliveries with back up transport for referral in the event of complications
- Mobilise community support for transport for referrals in case of complications
- Any other

of maternal and infant deaths and getting these issues discussed in Panchayat meetings

- Train the functionaries of community based agencies such as PRI, SHGs, ICDS, Health, etc. in developing an emergency transport plan, and in developing accounting and reporting systems for operating the same. Focus should be on encouraging the community to use the transport for reaching the EOC services
- Developing a Community Nutrition fund for severely malnourished children and pregnant women
- Any other.

**Strategic Intervention 3: Essential neo-natal care**

- Communication and education on components of essential neo-natal care
- Provision of essential neo-natal care in home deliveries
- Any other

Based on the facilities of undertaking activities, existing health care infrastructure (both in public and private sector), and ICDS, a work plan and budget needs to be prepared.

**Strategic Intervention 4: Access to quality child survival interventions**

- Establishing depot holders for ORS and co-trimoxazole tablets
- Scheduling immunisation services once a month in each village. (Hepatitis B vaccination can also be included in the package)
- Counselling of parents for improved care seeking behaviour
- Nutrition rehabilitation centres for grade III & grade IV children (As day care centres)
- Any other

### **3.2.2 Family Planning Services**

#### *a) RCH Context*

Family planning is an important RCH component. The National Family Health Survey II (NFHS) data shows 98% awareness regarding general family planning (male and female sterilisation). However, knowledge regarding spacing methods is inadequate and limited. Moreover, the increased awareness has not been matched by increased access to family planning products and services. The NFHS II estimates unmet needs for contraception at around 30%. It indicates that the unmet demand for both limiting and spacing continues to remain high in many states. In rural areas, dependable sources of contraceptive supplies (oral pills, condoms) and follow up care for acceptors are not easily available. Alternative service delivery systems such as commercial, social marketing, and community based distribution system are yet to take roots in rural areas.

**Strategic Intervention 5: Safe motherhood and child survival**

- Advocacy with PRIs and other stakeholders on improved care-seeking behaviour, social audit



An understanding of gender issues in the family planning services is important for effective service provision. Lack of information/services, prevailing myths and misconceptions regarding contraception and care during pregnancy, and poor quality of available family planning services result in unwanted and repeated pregnancies and unsafe abortions.

Male participation in acceptance of temporary or permanent methods is negligible. According to NFHS II data, 34.2% acceptors of family planning methods were for female sterilisations and 1.9% for male sterilisations. There are socio cultural beliefs that influence the choice of methods – for example that men are at the risk of losing their virility if they undergo vasectomy resulting in resistance to use of condoms. The project interventions should place emphasis on bringing attitudinal change among men about temporary and permanent methods of family planning as is in the case of women.

Women contra-indicated for sterilisation, often have few other contraceptive options. For example, sterilised women often cannot insist on condom use by their husbands. They are therefore exposed to the risk of sexually transmitted infections (STI). Health concerns, limited options, and husband's opposition are important reasons for non-use. Poor reproductive health and high pregnancy loss lead to limited use of temporary methods. Non-availability of a wide range of reversible methods to suit varying needs can lead to reliance on abortion as a method for spacing births. A significant proportion of unmet need can be met through provision of quality contraceptive services. However, the lack of inter-spousal communication leads to non-use of contraception.

The National Population Policy 2000 recognises the rights of men and women to be informed and have access to safe, effective,

affordable and acceptable methods of family planning of their choice. The number of unintended pregnancies can be reduced through adoption of appropriate family planning methods.

This will reduce the number of times a woman is exposed to the risk of child bearing under adverse circumstances. It is important to ensure that family planning products and services are available and accessible to both men and women. This also includes those in the reproductive age group including adolescent boys and girls. Special attention is to be given in areas which are un-served or under served by the existing government health infrastructure.

*b) Coverage*

Approximately 800-850 eligible couples are expected to live in a sub-centre area and 6000 eligible couples at the PHC level (the number will vary incase of tribal/desert area). The NGO should provide comprehensive Family Planning counselling and contraceptive services and establish linkages with other relevant RCH services. Focus should also be on unmarried young adults.

*c) Measurable Output*

The NGO should be able to define outputs that can be measured. The following indicators may be considered:

- % of reduction in unmet demand for contraception by the end of the project period
- % of couples in the reproductive age group who know about FP methods and source of availability
- % increase in boys and girls postponing their marriage
- % increase in eligible couple postponing birth of first child



- % of eligible couples reporting current unmet need
- % increase of men using condoms
- % of villages having assured supplies of non-clinical spacing contraceptives
- % increase in couple protection rate, client continuation rates for OCPs and condoms
- % of facilities reporting regular IUD insertion,
- % of PHCs/CHCs reporting sterilisation (male and female) cases every month, ratio of male and female sterilisation
- % reduction in women resorting to unsafe abortion
- % of FP/RH camps held in the district as planned
- % of private practitioners providing contraceptive services
- Number of workers trained in counselling skills.

#### *d) Strategic Interventions*

In order to achieve the output/s, the NGO must identify key strategic intervention areas. The NGO must have clarity on what gender issues need to be addressed. It must plan how to address them through selection of appropriate strategies and activities. The following are 3 suggested strategic intervention areas in which the NGO could undertake activities.

- Demand generation in the community for services through awareness, information, products
- FP services for eligible couples and young adults including counselling, natural, temporary and permanent methods, and referral

- Community based distribution of contraceptives
- Any other.

If it has not already undertaken, the NGO must conduct a baseline study in order to assess the needs of eligible couples and young adults in terms of knowledge, attitudes, practices and access to FP services. If a supportive environment already exists in the community, the NGO should strengthen the same. The NGO may like to undertake advocacy interventions for informing people about contraceptive choices. The NGO proposing to provide access to FP services must have the capacity and infrastructure to do so.

#### *e) Activities*

In each strategic intervention area, the NGO can undertake several different types of activities. Given below is an illustrative list only:

##### **Strategic Intervention 1: Demand generation**

- Orientation programmes for various stakeholders such as eligible couples, young male and female, teachers, community leaders, PRI members, women's groups, ICDS, NYKs on composite FP products and services
- Designing communication plan/activities for men/women/adolescent girls and boys for addressing biases/barriers relating to FP
- Health education/training for women's groups
- Mobilising eligible couples, individual men and women, to participate in FP and RCH camps
- Training of providers (of NGO) for all methods on IPC skills and for providing gender sensitive services
- Any other.



### Strategic Intervention 2: Clinic based FP programmes

- Establishing clinic days for offering contraceptive services
- Providing an expanded range of quality contraceptives
- Clinical and gender training of service providers (of NGO) for all methods
- Training of lady health supervisors/ANMs (of the NGO) in IUD insertions and in use of guidelines from a gender and quality of care perspective
- Any other.

### Strategic Intervention 3: Community based distribution of contraceptives

- Establishment of depot holders in each village for easy availability of FP services
- Training of depot holders/volunteers in non-clinical spacing contraceptives, gender and counselling skills
- Initiatives to promote linkages of women's groups with the health system
- Any other.

Based on the above, a work plan and a budget plan will be prepared.

#### 3.2.3: Adolescent Reproductive Health

##### a) RCH Context

The RCH Programme draws on a life-cycle approach. Adolescent Reproductive Health (ARH) is an important RCH component. In India, nearly 40% of the population comprises of adolescent and young

adults. They are in the reproductive age group. Despite being such a significant group, their special needs have not been addressed.

Sexual and reproductive decision making by adolescents is affected by factors relating to age and gender. Young boys and girls have poor understanding of pubertal changes and have very little access to counselling and services. Service providers often tend to be judgmental while catering to the needs of adolescents. There are few existing programmes providing information on sexual health and sexuality to adolescent girls and boys.

Adolescent girls have little choice on whom and when to marry. They are usually not in a position to negotiate contraceptive use. Almost 75 % of marriages in rural India among adolescent girls is below the age of 16. The first child is born even before the girl is 18 years of age. Infants born to teenage mothers are at higher risk of low birth weight, pre maturity and still born. Incidence of obstetric complications is also high among the adolescent mothers. Poor personal hygiene, myths and misconceptions about sexual and reproductive health lead to complications in pregnancies and maternal mortality. Often young girls do not get information on physiological implications of menstruation. Instead they are subject to taboos during menstruation such as, isolation, not permitted to cook/or mingle in the family.

The magnitude of adolescent sexual activity is significant. It is higher in boys than girls. Most adolescents seek information from friends and peers on sexual and reproductive issues. These tend to be misleading or inaccurate. Girls are not encouraged to know about their bodies and about reproduction till they are married.



However, gender norms expect boys to be sexually experienced well before marriage. This results in risky sexual behaviour on the part of many young men. Young people are at a greater risk of contracting sexually transmitted diseases including HIV/AIDS. This is due to early onset of sexual activity, reluctance /ignorance to use preventive methods and frequent partner change.

For unmarried adolescent girls, access to contraception and to MTP is very difficult. This is largely due to social pressures and biases of service providers. This puts unmarried adolescents at risk of unsafe abortions. Girls are not expected to be informed about contraception before marriage. There is pressure to bear the first child immediately after marriage. As a result there is near absence of contraception in the 15-19 age group. This also means that adolescent girls run greater risks related to STIs. Early pregnancy carries with it higher risks of maternal mortality.

In the past, both health and family welfare programmes have neglected the adolescent groups. Some interventions focused on married adolescents. It is important to understand age and gender specific reproductive health needs of adolescents. Increase in opportunities for awareness and access to affordable RH products and services will have positive impact on the lives of adolescents and their health status.

#### *b) Coverage*

Approximately 750-800 adolescent boys and girls in the age group (10-19 years) are expected to live in a sub-centre area (the number will vary incase of tribal/desert area). The NGO will be expected to provide comprehensive Adolescent Reproductive Health (ARH) education for increasing the knowledge on RH issues (family planning, RTI/STI, personal hygiene, anaemia, teenage pregnancy and age at marriage), and services. Focus will be on both in-school and out-of-school, married and unmarried

adolescent girls and boys. Interventions could cover mixed or exclusive group.

#### *c) Measurable Output*

The NGO should be able to define measurable outputs. It is expected that the NGO should be able to measure progress in terms of:

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

#### *d) Strategic Interventions*

In order to achieve the output/s, the NGO must identify key strategic intervention areas. There are differences in the needs and concerns of adolescent girls and boys. The strategies for working with girls would vary from that of working with boys.



Working with mixed groups of girls and boys must be attempted. Invariably, all adolescent interventions must have support of parents and guardians. The NGO must have clarity on what gender issues need to be addressed. It must plan how to address them through selection of appropriate strategies and activities.

The following are three suggested strategic intervention areas in which the NGO could undertake activities:

- Supportive environment in the community for addressing ARH
- Access of adolescent girls and boys to knowledge and counselling/clinical services related to ARH
- Enhancing life skills opportunity for adolescent girls and boys (personality development skills such as self-awareness, self-confidence, self-esteem, problem solving, negotiation skills, ability to analyze)
- Any other.

The NGO must conduct a baseline study in order to assess the needs of adolescent girls and boys in terms of knowledge, attitudes, practices and utilisation of services. If a supportive environment already exists in the community, the NGO should strengthen the same from the ARH perspective.

The NGO proposing to provide access to ARH services must have the capacity and infrastructure to do so. ARH is a relatively new aspect. It is therefore important that the NGO networks and links with institutions which have the required experience, both from public and private sources.

#### e) Activities

In each strategic intervention area, the NGO can

undertake several different types of activities. Given below is an illustrative list.

#### Strategic Intervention 1: Supportive environment

- Orientation programmes for various stakeholders such as parents, teachers, parent-teachers association, community leaders, PRI members, women's groups, ICDS, NYKs etc. on adolescent health issues
- Capacity building of teachers to take up the role of guide/counsellor and communicate messages related to adolescent health
- Mobilising community for identifying appropriate social space for imparting information and counselling
- Mobilising and enhancing the knowledge and skills of adolescent girls and boys to participate in this process
- Any other.

#### Strategic Intervention 2 & 3: Access to services & life skills development

- Orient service providers, including private practitioners (formal and informal) on ARH and selected health issues
- Co-curricular activities with ARH and selected health messages
- Capacity building of a number of students (boys and girls) in each school or in each village as peer educators for adolescent health
- Conducting family life education camps and life skills and leadership development training for adolescent girls and boys
- Provision of counselling services for adolescent girls and boys on ARH and sexuality issues.



- Training selected teachers, peer educators, and health workers as counsellors
- Checklist based RTI/STI during health camps
- Diagnosing anaemic girls and providing IFA tablets
- Linking adolescent clinic with monthly RCH camps conducted by PHC
- Any other

Based on the above, a work plan and a budget plan will be prepared.

### **3.2.4 Prevention and Management of Reproductive Tract Infections (RTI)**

#### *a) RCH Context*

Reproductive Tract Infections (RTI) including Sexually Transmitted Infections (STI) are being recognised as a major problem. This has been brought into the reproductive health agenda. Many RTIs are sexually transmitted. The emergence of HIV and identification of STIs as a facilitating factor for transmission of HIV/AIDS has led to efforts of designing appropriate programmes to address unmet needs for RTIs/STIs.

Young people are at a greater risk of contracting sexually transmitted diseases including HIV/AIDS, due to early onset of sexual activity, reluctance /ignorance to use preventive methods and frequency of partner change.

The common causes of RTI among women include infections due to inadequate medical procedures such as unsafe abortions, unclean deliveries, and other diagnostics and therapeutic procedures, infections associated with inadequate personal, sexual and menstrual hygiene practices and sexually transmitted infections. Men also

experience RTI in the form of urethritis and genital infections.

Though both men and women get infected, the prevalence and the consequences are much more severe for women.

Women hesitate to discuss the issue of RTI since it is related to sexual activity. Untreated RTI/STI create complications resulting from spread of infection to other part of reproductive tract or other organs of the body. Major complications include, infertility, ectopic pregnancy, and cervical cancer resulting in mortality or psychological problems for women. Some infection may cause fetal wastage, pre-term delivery, low birth weight babies or infecting the newborn during the delivery.

Treatment of women for STD and RTIs without the cooperation of men is an area of concern in the management of RTIs and STDs. Self-reporting of gynaecological problems is low. This is because it is associated with a sense of embarrassment and shame. This affects chances of being diagnosed and treated. Extra marital sexual behaviour of male partners contributes to the problem. Lack of negotiating ability of women in the practice of unsafe sex by partners also contributes to the problem. Treatment options available to the women are limited by a number of factors. These include a symptomatic nature of these diseases in women, their access to services, non-availability of female doctors, cultural resistance to internal examinations, and lack of availability of non-stigmatising treatment in public sector. Patients find it easier to use the services offered by unqualified quacks though the quality of service is poor. There is need to increase the availability of quality services to people to meet their unmet needs for the management of RTI.

#### *b) Coverage*

A population of 25-30,000 spread over 30-40



villages and preferably coterminous with the area of a PHC can be covered by the NGO. Since these services are yet to be introduced in many CHCs, such services can be expanded to include the entire block. The NGO will be expected to establish linkage with referral services for treatment failure or reoccurrence cases. It should also adopt linkages of RTI/STI with the other service components of RCH.

#### c) Measurable Output

The NGO should be able to demonstrate measurable change in terms of reducing prevalence of RTIs/STIs (i.e. self reported prevalence). Examples of specific output indicators could be:

- % of male/female in 15-49 yrs age group reporting RTIs/STIs on the basis of household survey
- % of male /female/couples/partners who complete treatment.

#### d. Strategic Interventions

The NGO must be able to duly incorporate a gender perspective in its project design and in identifying strategic interventions and activities. The NGO must have clarity on what gender issues need to be addressed. It must plan how to address them through selection of appropriate strategies and activities.

To achieve this output, following strategic interventions can be considered:

- Behaviour change communication (BCC) and social mobilisation
- Promoting condom as a method of dual protection
- Case Management of symptomatic individuals
- Orientation of the private practitioners
- Any other.

If it has not already undertaken, the NGO must conduct a baseline study in order to get the estimates on current patterns of treatment sought. If a supportive environment already exists in the community, the NGO should strengthen the same from the HIV/AIDS prevention perspective. In case the supportive environment is lacking, the NGO should invest in strengthening the same.

The NGO proposing to provide access to RTI/STI services must have the capacity and infrastructure to do so. It is important that the NGO networks and links with institutions having the required expertise and experience, both from public and private sources. Most medicines used for the RTIs/STIs cannot be prescribed by anyone other than a qualified allopathic doctor. Services of a medical doctor should be hired. Partnerships with private sector should be fully explored.

#### e) Activities

In each strategic intervention area, the NGO can undertake several different types of activities. Activities should be chosen keeping in mind the ground realities as mentioned above. Given is an illustrative list of activities in the strategic intervention areas:

#### Strategic Intervention 1: Behaviour change communication and social mobilisation

- Planning local area level communication strategy for BCC, with a focus on community members, especially women to protect themselves from RTI/STI and HIV infection
- Implementation of the communication plan for emphasising preventive behaviour
- Orientation programmes (for both private and public sector providers) for sensitisation to gender issues and issues of partner management, compliance, condom use and counselling for avoiding risky behaviour



- Outreach programmes for community based groups, PRIs, TBAs and adolescents
- Any other

**Strategic Intervention 2: Promoting dual protection**

- Depot holder providing quality condoms for dual protection in all villages having more than 500 populations
- Provision of quality condom supplies on a regular basis
- Communication activities by depot holder for prevention of STIs in the village
- Any other

**Strategic Intervention 3: Case Management of Symptomatic individuals**

- Setting up mobile clinics, attached with small lab setup, for the purpose of enhancing sensitivity of syndromic approach for the vaginal discharge patients. Simple lab tests e.g., RPR, Grams staining, Ph test, KOH test and wet mount can be offered through these clinics. Such clinics need to be designed in such a manner that the same village is visited again after seven days for the follow up
- Provision of lab equipments and reagents, drugs and medicines
- Any other

**Strategic Intervention 4: Orientation of private practitioners**

- Organise orientation programmes for raising awareness on causation, transmission and prevention of RTIs/STIs including HIV/AIDS, early diagnosis and immediate treatment of RTIs
- Related issues including partner management,

compliance, condom use and counselling for avoiding risky behaviour

- Any other

Based on the facilities of undertaking activities, existing health care infrastructure (both in public and private sector), a work plan and budget needs to be prepared.

### **3.2.5 MTP Services**

#### *a) RCH context*

In India, unwanted pregnancies are common. Abortion is one of the major causes of maternal mortality and morbidity. It is estimated that about 9% of maternal deaths in 1998 were due to unsafe abortions. The prevalence rate of abortion in India is unknown. However, the most widely cited figures suggest that around 7 million abortions take place annually. As per GoI service statistics, about 1 million abortions are performed annually under the Medical Termination of Pregnancy (MTP) Act. Around 6 million abortions are performed by practitioners, many of whom are unqualified and untrained. They induce pregnancy termination at uncertified places and use dubious methods. The health impact of unsafe abortions is a major public health concern. Post-abortion care and management of post-abortion complications is an essential service at the PHC, CHC, and district hospital levels.

Induced abortion is carried out to terminate unwanted pregnancies. There can be many reasons for seeking abortion services. These include non-use of spacing method, lack of information, fear of side effects, limited accessibility of quality services, and contraceptive failure. Male domination can restrict a woman's control over her body and fertility. Abortion can also be due to non-consensual sex within or outside marriage; sexual violence, including sexual abuse and rape of adolescent girls.



In a society like India, son preference is very common. This induces women to go for abortion of female foetus even though it is illegal in India. Second trimester abortions are usually high due to sex selective abortions. Easy availability of prenatal diagnostic techniques has resulted in increased use of sex determination tests even among the rural poor. Many private clinics offer both sex determination and sex selective abortion services. The education and counselling should focus on men as well as women regarding social implications of sex selective abortions, equal opportunity for girls children for survival and growth, safe sex and promotion of use of condoms/pills and other temporary methods.

Unmarried women who get pregnant find it difficult to seek MTP services. This is due to fear of social discrimination. Abortion services are also costly for many women, especially rural women. Women therefore often seek unsafe practices through quacks or through consumption of harmful indigenous substances. Abortion complications sometimes are quite severe. This can lead to infertility and RTI. Service providers may be biased and male partners may not be supportive. All these factors affect women's access to safe and legal abortion services.

#### *b) Purpose of Support*

The NGO should not promote abortion as a method of family planning. It should aim to reduce unwanted pregnancy. This can be through expanded and improved family planning services. Support will be provided to NGOs to:

- (i) Prevent, manage and treat the complications of spontaneous or unsafely-induced abortions; and
- (ii) Provide safe and legal abortion services, post-abortion counselling and family planning. Access to quality family planning information and services will be an essential part of post-abortion services.

#### *c) Coverage*

The NGO is expected to provide clinic-based FP and MTP services to a population located in a block covering approximately 200 villages. Women in reproductive age groups, including partners, will be the main clients for the services. The comprehensive services will include couple counselling, provision of FP products and services, safe and legal abortion and MTP services, post-abortion counselling, and temporary and permanent methods of contraception. Emphasis will be on providing quality and affordable services. The facilities can provide services for termination of pregnancy up to eight weeks of gestation by the MVA method. These services should be set up as per the guidelines of GoI. A copy of these guidelines can be obtained from the district health office.

#### *d) Measurable output*

The NGO should be able to define measurable outputs in terms of:

- % of abortion related complications reported at the facilities in the area
- % of repeat abortions
- % of abortions as per age distribution (including adolescent girls)
- % of MTP clients who have received post abortion contraceptive counselling and FP services
- % of girls and boys getting married after attaining the legal age of marriage.

#### *e) Strategic interventions*

To achieve the output/s, the NGO must identify key strategic intervention areas. The following are 3 suggested areas in which the NGO could undertake activities:



- Inform the community about safe and legal abortion services
- Increase access to safe and legal clinic facilities and improved quality care
- Follow up services.

The NGO proposing to provide access to safe and legal abortion services must have the capacity and infrastructure to do so.

#### *f) Activities*

In each strategic intervention area, the NGO can undertake several different types of activities. Given below is an illustrative list.

##### **Strategic Intervention 1: Demand generation for quality services:**

- Community orientation for eligible couples, SHG members, PRI, anganwadi, teachers, ANM, NGOs including FNGO/MNGOs, adolescent boys and girls IEC on complications of unsafe abortions and availability of safe and legal services
- IEC on MTP and PNNDT (Pre-natal Diagnostic Techniques Act)
- Develop network with related service providers such as pharmacies, chemist shops, private practitioners, *dais*, sub centres, ANM, PHCs, depot holders in the villages, other NGOs involved
- Any other.

##### **Strategic Intervention 2: Increase access to safe and legal clinic facilities and improved quality care.**

- Hiring of qualified staff as per guidelines
- Identification of proper premises for the clinic as per MTP Act and related guidelines

- Orientation and training of the staff on social dimensions of FP and MTP issues, legal implications, gender biases, government policies, quality service, developing a client centred approach, and counselling skills
- Equipment and supplies
- MIS
- Any other

##### **Strategic Intervention 3: Follow up services:**

- Availability of effective counselling services
- Post-abortion FP services
- Establish a follow up net work within the community
- Maintenance of records and documentation
- Any other.

Based on the above, a workplan and a budget plan will be prepared.

#### **3.2.6 Training of Traditional Birth Attendants (TBA)/ Dai**

##### *a) RCH context*

One of the main goals of National Population Policy 2000 is to reduce maternal mortality and morbidity. Unsafe deliveries and practices are often conducted at home by relatives and untrained Traditional Birth Attendants (TBA) or commonly known as 'Dai'. This can lead to high maternal mortality and morbidity. About 74% deliveries in the country take place outside formal health institution. Data on safe deliveries (institutional deliveries and deliveries conducted by trained personnel) is available from the rapid household surveys for 496 districts. This data shows that only 123 districts have more than



70% safe deliveries; 240 between 30-70% while in 142 districts safe delivery rates are less than 30%.

All deliveries should be conducted by trained health functionaries. However, presently the health care system is not in a position to provide services of a trained health functionary at the time of delivery. It is therefore important to ensure that the Dais are trained. The Dais or the traditional birth attendants (TBAs) have been conducting deliveries using traditional methods, handed down to them over generations. Most of them are illiterate, poor and do not have adequate skills in conducting safe deliveries or in identifying high-risk cases among pregnant women during the ante-natal period. Lack of proper skills and absence of aseptic techniques in their work lead to high morbidity and mortality. The services of the Dai need to be better utilised in the rural areas. This can be ensured by providing them with the necessary training and promotion of aseptic delivery practice.

#### b) Coverage

Pregnant women in a sub district area, covering approximately 100–120 villages will be served by the trained dais. The NGO will be expected to provide the basic training to dais, provide certification, monitor their performance, release the payment and do follow up work. The training will be comprehensive to enable the Dai to provide support to pregnant mothers from early registration stage till safe delivery. This will include nutrition counselling, antenatal check up, identification of high risk cases, identification of danger signals during delivery and make appropriate referrals.

The number of dais to be trained will be calculated based on the institutional delivery capacity available (30 beds/50 beds hospital) in the project area and the need in the community. At least one trained Dai plus a backup should be available in each village in the project area. It is important that dais are given hands on training to acquire skills.

This means that the NGO has adequate infrastructure to train the dais as per the GoI curriculum and for hands on training. The SNGO must have trained personnel with experience to provide the training. The SNGO should be clear on the certification and competency criteria for TBA/dais (after how many deliveries conducted independently, the certificate will be given to them).

The SNGO will develop appropriate mechanism to ensure that the dai will be able to link with the referral net work and her cases will be accepted on priority basis by these institutions. Monitoring mechanisms will be established to ensure that the Dai actually applies her skill in the project area. The training should enable the dais to provide support for safe delivery at home. They should also support those who wish to have institutional delivery.

#### c) Measurable output

The NGO should be able to demonstrate the usefulness of Dai training in measurable terms. This should reflect in terms of:

- Changes in the practices related to care during pregnancy
- Increase in the number of deliveries by trained persons in the project area

To achieve the output, at the end of the training the Dai should be able to:

- Understand the profile of the women who can safely deliver at home and those who require hospital care
- Monitor and manage first stage of labour
- Conduct normal delivery of baby and placenta, including newborn care using the right techniques



- Understand the importance of aseptic techniques during delivery
- Understand the five principles (clean hands, clean surface, clean blade, clean cord tie, and clean cord stump) and clean perineum
- Recognise the complications during the second and third stages of labour and link up with appropriate referral
- Know why to refer, when to refer, where to refer and how to refer
- Advice women on dangers of unsafe abortions, availability of MTP and help in their referral as required.

#### *d) Strategic Interventions*

In order to achieve the output the following strategic interventions may be considered.

- Demand generation in the community through awareness, information and service of dais
- Providing quality care. Ensure mechanisms are in place for continued use of services of Dai in the project area
- Any other.

#### *e) Activities*

It is important that the NGO has the capacity and infrastructure to provide Dai training and follow up. Since most of the Dais are illiterate or neo literate, the NGOs should be able to understand their requirements. They should have sufficient knowledge about the project area including existing pregnancy care and delivery practices. The NGO must conduct a baseline. The activities may include:

##### **Strategic intervention 1: Demand generation**

- Development of a data base for the availability

of safe institutional facilities and the number of trained and potential dais in the project area

- Development of criteria for the selection of trainees
- Community orientation for utilising the services of the trained Dais for simple cases
- Any other.

##### **Strategic intervention 2: Providing quality care and ensuring sustainability**

- Orientation of trainers
- Ensure availability of Disposable Delivery Kit (DDK) and weighing machines
- Linkages with private hospitals and the government infrastructure for referrals
- Linkage with other NGOs (FNGOs/MNGOs) engaged in MCH interventions in the project area for providing Dai support
- Development of simple and user friendly IEC and training materials
- Development of checklist for enabling the Dai to collect her fee
- Provision of certificate along with some form of identity to each trained Dai (a photo identify card or a distinctive badge).

Based on the above a work plan and a budget plan will be prepared.

##### **Reference: Contents of Dai Training**

The Dai training guidelines of Government of India are given for reference.

- Definitions of Asepsis and Sepsis, Sterilisation



Techniques and how to sterilise scissors or blade if necessary

- Discussion on physical signs of pregnancy, antenatal care, importance of early registration in the PHC, rest, IFA tablets, and TT immunisation
- Identification of Danger Signals during pregnancy, labour and postnatal period:
  - During pregnancy – bleeding, swelling of face and hands, severe headache, breathlessness at rest, twin pregnancy and anaemia
  - Labour – Mechanism of normal labour, labour pain of more than 12 hours without progress in primi-paras
  - Postnatal – severe bleeding, fever with chill and rigour and foul odour from genital tract
- Care of mother and newborn after delivery
- In addition, the ethical and legal issues involved in the practice of sex selective foeticide and infanticides must form a part of the curriculum
- Dais will be oriented on availability of funds for referral transport with the Panchayats and how to access the fund when needed. This should be done in areas where referral transport scheme is in operation.

### 3.2.7 Violence against Women

#### a) RCH Context

Violence against women and girls is a human rights and a public health issue. In the Indian context, violence begins even before a girl child is born (e.g.; sex selective abortions) or soon after birth (female infanticide). It continues to affect women throughout their lives. Women face nutritional, educational and recreational deprivation. They also face dowry related violence, rape, physical and mental abuse and many other forms of violence. Ninety

percent of domestic abuse, with or without visible violence, requires medical, psychological, and public health treatment. There are many causes for violence against women. These can be socio-cultural (son-preference and gender biases), economic deprivation, lack of control over resources, health related (infertility), non-recognition of women's labour and male superiority.

Women rarely come forward to register a case of violence. They hesitate to even discuss the issue openly due to lack of adequate support mechanisms both within the household and outside. In the rural areas, health workers are often the only point of contact with public services.

Health care providers can play an important role by (a) enhancing the awareness of the family and community members and (b) identifying victims of violence and linking them with medico-legal or medico-social support services.

Violence against women has a direct negative impact on several important RH issues. These are safe motherhood, family planning, and the prevention of sexually transmitted diseases and HIV/AIDS.

#### b) Purpose of Support

NGOs will be supported for:

- Increasing levels of awareness among the community and health care providers on violence against women and its RH consequences
- Providing services for prevention and management of health and RH consequences of violence against women.

#### c) Coverage

The NGO will be expected to identify and focus on a set of population starting from a block level. The NGO should adopt a comprehensive approach to



the issue of violence against women in the context of RH. The NGO should establish linkages with other relevant RCH services.

#### *d) Measurable Output*

The NGO should be able to define measurable outputs in terms of:

- % of reported cases of gender based violence by victim/witnesses/others
- % of women victims of violence accessing/provided timely health services/referral support
- % of women and young girls accessing counselling services
- qualitative changes as depicted through process documentation, case studies, etc.

#### *e) Strategic Interventions*

To achieve the outputs, the NGO must identify key strategic intervention areas. The following are 3 suggested areas in which the NGO could undertake activities:

- Supportive environment in the community for addressing violence against women
- Identifying institutional and community based mechanisms to address violence against women
- Access to services (information, counselling referrals) for managing RH consequences of violence
- Any other.

If necessary, the NGO must conduct a baseline study. This is to assess the prevalence of violence, its causes, and existing mechanisms for prevention and management of violence. If a supportive environment is already existing in the community, the NGO

should strengthen the same from a gender perspective. The supportive role of men and young boys in preventing and managing the RH consequences of violence must be emphasised.

The NGO should have the capacity and infrastructure and avoid any duplication with the existing health care delivery system. It must play a complementary role and sensitise/strengthen the existing health care delivery system for addressing the RH consequences of gender-based violence. Wherever the existing health care delivery system is found to be weak, the NGO can identify appropriate referrals and prepare budgets accordingly.

#### *f) Activities*

In each strategic intervention area, the NGO can undertake several different types of activities. Given below is an illustrative list.

##### **Strategic Intervention 1& 2: Supportive environment & community based mechanisms**

- Sensitisation programmes for various stakeholders such as adults, couples, young adults, teachers, community leaders, PRI members, village health committees, women's groups/SHGs, ICDS, NYKs on gender based violence and RH consequences
- Community mobilisation for identifying appropriate social spaces. This is to provide information and services for addressing the issue
- Male mobilisation activities for addressing the issue (*sammelans*)
- Set up CBOs/women's groups as community surveillance/vigilance groups on gender based violence
- Legal literacy camps
- Institutionalise innovative community initiated



responses to violence, such as, Nari Adalat, Nari panch

- Any other.

#### **Strategic Intervention 3: Service support**

- Checklists for screening women victims of violence developed and used by service providers
- Training of health care providers on identification and management of RH consequences of violence against women
- Establish counselling centres with community outreach facilities and referral linkages
- Selection of partner NGOs, counsellors, location and development of counselling protocols
- Establish information and surveillance systems for addressing the issue
- Any other.

Based on the above, a work plan and a budget plan will be prepared.

#### **3.2.8 Male Involvement**

##### **a) RCH context**

Male involvement refers to the various ways in which men participate in improving the health and reproductive health status of women and girls. Men also have their own health needs and concerns.

They are often misinformed about sexual and reproductive health issues. Family Welfare clinics are generally viewed as female places. Logistic constraints, such as lack of male staff or convenient hours, also make it difficult for men to access services. Male involvement in RCH programmes aims at promoting joint decision-making on issues of sexual and reproductive health.

Evidence also suggests that promoting safe/responsible sexual behaviour among men has positive results. Women and men can as a result make informed reproductive choices. The National Population Policy 2000 (NPP 2000) too brings men to the forefront in population and reproductive health programmes.

##### **b) Purpose of Support**

NGOs will be supported to increase male participation for improving the reproductive health status of women and men. This means that men support women in their access to reproductive health services. It also means that men assume responsibility for their sexual and reproductive behaviour. Men will offer their support for safe, voluntary and satisfying sexual relationships, participate in family planning, provide support to their partners during pregnancy, assist women during both normal and difficult deliveries, and participate meaningfully in children's well being. Male participation enhances cooperation and respect between sexes based on shared roles and responsibilities.

##### **c) Coverage**

NGOs will be expected to identify and focus on a set of population starting from a block level. Male involvement will be defined in relation to family and household members – men as partners, fathers, and brothers as well as community /religious leaders, managers and service-provider, and as clients. Focus will also be on young boys for their future roles as partners and fathers. Eligible couples will also be covered.

##### **d) Measurable Outputs**

The NGO must define measurable outputs in terms of:

- % of eligible couples covered by contraception, especially by temporary and permanent male contraceptive methods



- % of couples utilising other RH services
- % of males attending group communication activities conducted in villages
- % of men aware of causation, transmission and prevention of RTIs/STIs
- % of men aware of different components of ANC, etc.
- Qualitative changes as depicted through process documentation, case studies, etc.

#### e) Strategic Interventions

To achieve the outputs, NGOs must identify key strategic intervention areas. The following are 3 suggested areas in which NGOs can undertake activities:

- Build a supportive environment among men and community leaders through information, advocacy and behaviour change communication (BCC)
- Provide community outreach services with a focus on men and couples
- Improve access to sexual and reproductive health services for women and men
- Any other

#### f) Activities

In each of the strategic areas, the NGO can undertake one or more activities. These could be at the individual, collective or service provider level. The following is an illustrative list.

#### Strategic intervention 1: Supportive environment

- IEC/BCC for men using folk media, radio, TV, posters and innovative techniques such as puppetry to communicate on male responsibility

for their own and their partners sexual and reproductive health

- Involvement of experienced people as community advocates for addressing myths and misconceptions and changing discriminative norms around gender issues
- Sensitisation programmes on male involvement issues among religious/panchayat leaders and adult women
- Use of existing male spaces, for example, markets, taxi stands, sport arenas, youth clubs etc for creating a supportive environment
- Any other

#### Strategic intervention 2: Community outreach services

- Male group activities for participatory community diagnosis of health service needs, concerns of women, and obstacles to men's involvement in RCH
- Mass media activities that highlight health information /communication
- Sexuality and gender education for school boys and other youth
- Outreach health melas and other innovative ways of involving men
- Motivate/ train male community health volunteers to work with male clients and couples
- Form male groups to develop and implement transportation plans for emergency obstetric services
- Involve men as partners in women's visits to ANC/PNC and encourage their presence at the place of child delivery



- Work on gender-based violence prevention with focus on men
- Work with organised groups of men at work place, trade unions, farmer/dairy co operatives, migrant workers for RH services/referrals and promotion of male methods of contraception
- Any other.

#### **Strategic intervention 3: Access to Sexual and Reproductive Health services**

- Adapting clinic timings to meet men's needs
- Using couple approach in counselling for safe sex, partner treatment for RTIs/STDs, HIV/AIDS, and infertility
- Provide space/ time for couple counselling or having separate timings for men
- Community-based distribution of contraceptives aimed at men
- Training of male community-based distribution workers
- Training of private and public health paramedics in counselling and contraceptive methods
- Set up telephone hotlines to provide confidential counselling
- Screening, clinical diagnosis and treatment
- Integration of HIV prevention with FP during counselling and educational activities
- Counselling services for adolescent boys
- Any other.

NGOs providing services for addressing the sexual and reproductive health needs of men must have the capacity and infrastructure to do so. It must avoid duplication with the existing health care delivery system. It must add preventive and promotive services for men without restricting ongoing services for women. It must ensure integrated services for men within existing services instead of establishing independent services. The NGO must ensure that the programme does not contribute to reinforcing gender inequalities.

Based on the above, a work plan and a budget plan will be prepared.

### **3.3 Financial Guidelines specific to Service Delivery**

NGOs will refer to the following financial guidelines specific for service delivery.

#### ***Funds availability***

Funds will be made available to NGO according to the proposed interventions for: Base line studies, conducting Community Needs Assessment, staff salaries and honorarium, conducting IEC activities, induction and in-service training for the staff, community orientation, development of mass media campaigns, various types of camps, MCH clinics, provisions purchase of FP supplies, essential drugs (according to list) to meet situations where government supplies are not available, purchase of clinical equipment, consumables required for the clinics/camps, setting up of depots hiring of space for clinic/meetings, monitoring visits- travel and DA, referral transport, documentation, relevant records, registers and formats, follow up on referral cases, administrative and contingency.

#### ***Limitations***

- The salary component of the budget will not exceed 35% of the total budget



- Contingency of 10% of the total cost less the salaries is permissible
- Charges such as rented space, TA and DA for the staff will be according to existing government norms. A list will be provided as annexure for other items such as dai fee, where existing government norms will be adhered to. Any deviation will be approved after scrutiny by the RCH society
- Funds will not be available for construction of building and purchase of vehicles.

#### *Budget modification*

The NGO will incur expenditure as per the approved budget. Flexibility will be available to make adjustments among the budget heads up to 10% without prior approval. Additional changes between the budget heads will be permissible with prior approval by the State RCH Society.

### **1. Indicative rates for Medical and Para Medical Government staff**

Sl. No.	Category of Staff	Maximum permissible
1.	(i) Doctor (full time) – MO level (ii) Doctor – per visit (as per GoI schemes)	Rs.10000/- Gynae- Rs. 800/-Anaesthetist – Rs. 1000/-
2.	ANM – full time	Rs. 5000/- per month (Varies from State to State)
3.	Staff Nurse (graduate)	Rs.7500/- per month
4.	Dai	Rs 25/- per delivery (As applicable under scheme for EAG States)
5.	Community Health Workers – full time	Rs. 1000/- per month

### **2. Training cost per training**

S.No.	Details	Cost (in rupees)
1.	T.A.	Rs.50/-
2.	DA	Rs.50 per day
3.	Material and Admn.expenses	Rs.50 per candidate
4.	Honorarium for resource persons	Rs.300 per day

### **3. I.E.C.**

Rs.5000 per sub-centre (for handouts, street plays, wall painting etc.)

Stationery and Register: Rs.2500/-



## PART FOUR

### FORMATS AND CHECKLISTS

Following are some indicative Formats and Checklists that can be used under the MNGO Scheme and the SNGO Scheme. The checklists highlight some key criteria. These can be further adapted to local needs and based on the nature and scale of interventions by different categories of NGOs viz. FNGO, MNGO and SNGO.

#### 4.1 Project Proposal Format

##### A. *Organisational Profile*

- Name of the Organisation : .....
- Address : .....
- Street, Distt., State : .....
- Pin Code : .....
- Ph. & Fax no. (with STD code) : .....
- E-mail : .....
- Name & designation of Chief Functionary : .....
- Name of other Office bearers,  
with contact numbers & address : .....
- Registration details : .....
- Act under which registered : .....
- Date of registration : .....
- FCRA no. (if available) : .....
- Banking details (Account no.,  
name & address of bank) : .....
- PAN No. : .....
- Fixed assets (land & building) as per  
Audited balance sheet : .....
- Number of full & part time staff : .....
- Details of Technical Staff : .....



### B. Project Profile

Brief resume of work done in Health including RCH, and Social Sector/s by NGO in the last 5 years/3years/2years (as applicable for SNGO/MNGO/FNGO respectively), as below:

Year	Source of funds	Amount of funds (Rs)	Name of project	Objectives & key strategies	Geographical area & beneficiary

- Project proposal will specify proposed coverage area based on a situational analysis of the proposed district/ block, with respect to information on key RCH indicators, quality & equity issues viz. gender and socio- economic profile
- Based on the above, the organisation will specify its competencies and strengths to address these issues.

available with the organisation along with their designation, qualification and experience.

*Below is an illustrative Checklist for preparation of proposal by MNGO, based on the approved FNGO proposals, by the district level committee.*

### C. Attachments to be Furnished

(To submit 2 copies of the proposal and enclosures.)

- Registration Certificate
- Bye laws and Memorandum of Association
- Annual report for each of the previous last 5 years/3 years/2 years (as applicable for SNGO/ MNGO/ FNGO respectively)
- Audited statement of Accounts for the last 5 years/3years/ 2years (as applicable for SNGO/ MNGO/ FNGO respectively)
- Latest list of Executive members along with contact address and year of election
- Details of Health & Family Welfare infrastructure, medical and non-medical personnel

- Situational analysis clearly indicating the RCH status in the district
- Goals and Objectives
- Proposed intervention strategies and activities
- Quantitative and qualitative, verifiable indicators
- Monitoring and evaluation plan
- Documentation
- Reporting mechanism
- Organisation structure
- Financial management structure
- Action plan year wise and activity and fund flow chart for the first year
- Attach proposals from FNGOs.



## 4.2 Format for field appraisal for NGOs

Field Appraisal Reports will scrutinise the Organisational Profile, Project Profile and Attachments. For ease of reference these are mentioned below as well. Any information not available or unsatisfactory will be highlighted in the field appraisal.

### A. Organisational Profile

- Name of the Organisation :
- Address :
- Street, Distt, State :
- Pin Code :
- Ph. & Fax no. (with STD code) :
- E-mail :
- Name & designation of Chief Functionary :
- Name of other Office bearers, with contact numbers & address :
- Registration details :
  - Act under which registered :
  - Date of registration :
- FCRA No. (if available) :
- Banking details :
  - (Account no., name & address of bank) :
- PAN No. :
- Fixed assets (land & building) as per Audited balance sheet :
- Number of full & part time staff :
- Details of Technical Staff :
- Does the NGO have experience of working with CBOs? Provide details if any :
- Details of NGOs presence & networking in the district for which grant is sought :



- Has NGO been evaluated by any independent agency? If yes, attach report :
- Has a Government Department/ Ministry ever blacklisted or imposed funding restrictions on the NGO?  
(Please provide details, if yes)
- Brief resume of work done in Health including RCH, and Social Sector/s by NGO in the last 5 years/ 3years/2years (as applicable for SNGO/MNGO/ FNGO respectively), as below

Year	Source of funds	Amount of funds (Rs)	Name of project	Objectives & key strategies	Geographical area & beneficiary

- Please indicate specific experiences in RCH related issues, clearly indicating areas of specialisation if any
- Situational analysis of the proposed district/ block, with respect to information on key RCH indicators, quality & equity issues viz. gender and socio- economic profile.
- Annual report for each of the previous last 5 years/ 3years/2 years (as applicable for SNGO/ MNGO/ FNGO respectively)
- Audited statement of Accounts for the last 5 years/3years/ 2years (as applicable for SNGO/ MNGO/ FNGO respectively)
- Latest list of Executive members along with contact address and year of election
- Details of Health & Family Welfare infrastructure, medical and non-medical personnel available with the organisation along with their designation, qualification and experience.

#### **B. Attachments to be Furnished**

(To submit 2 copies of the proposal and enclosures.)

- Registration Certificate
- Bye laws and Memorandum of Association



### **C. Broadly the Field Appraisal Report should Focus on the Items Listed below in the Checklist**

#### **C.1. Management**

- Statement of goals and objectives of the organisation and whether the proposed project fits into that framework
- Extent of involvement of members of the board/Governing Body in guiding/review of the work carried out by the organisation.

#### **C.2. Organisation Staffing**

- Organisation organogram – assessing structure of the organisation
- Clearly defined roles and responsibilities of staff at different levels
- Length of service of core staff proposed in the organisation– examining staff turnover
- Examining the reporting structure and the teamwork that exists
- Assessing the staff morale, motivation and involvement.

#### **C.3. Experience of the Organisation in Project Management**

- Management of RCH / health project
- Management of social sector/community development project.

#### **C.4. Financial Management System**

- Details of number of staff, their qualifications and years of experience in the Accounts department of the NGO
- Accounting system being followed:
  - Are the primary books of accounts, voucher, cashbook and ledger being maintained?

- Examining the voucher – contents and process, including preparation, authorisation and acknowledgement of receipt
- Maintenance of cashbook and how frequently it is balanced
- Posting into the ledger and correlation of entries in the other books
- Process of preparation of receipts and payments account and annual balance sheet
- Examining the single largest project handled and the adequacy of the systems and other infrastructure to determine the capacity of the organisation to handle the proposed project – assessment of fund handling capacity
- Process of bank reconciliation and its periodicity
- Any internal audit system and notes of the auditors if any.

#### **C.5 Inventory Systems**

- Are their stock maintenance systems providing physical inventory?
- Are there periodic monitoring to track inventory and plan for purchase?
- Is there any inventory of capital assets and what form is it maintained in?
- What are the purchase policies and procedures available within the organisation?
- Are the inventory records updated and maintained?

#### **C.6 Project Planning & Monitoring Systems (especially for SNGO/ MNGO)**

- How is planning done for each project in terms of human resources, financial resources and other resources within the organisation?



- What experience does the NGO have in conducting Community Needs Assessment, Baseline and Endline Survey?
- Is there any mechanism by which they are able to identify strengths and weaknesses and measure the same through indicators?
- Is the process of planning a participatory one?

#### *C.7 Information Systems (especially for SNGO/ MNGO)*

- What is the system that is being adopted to monitor the projects?
- How effective has been the system in identifying bottlenecks, achievement of objectives and in planning and reporting?
- Is the system adequate to meet the requirements of the MNGO programme?
- What are the improvement areas?
- Credibility of the Organisation based on community feedback?

#### *C.8 Assessment of Liaisoning & Networking (especially for SNGO/ MNGO)*

Capacity of the organisation to forge relationships with:

- Central Government
- State government
- Other NGOs/ donors
- Private sector/public sector
- Community

A FNGO is assessed on its capacity to mobilise the

community and to liaise and network with local level health system and community groups.

#### *C.9 Overall Assessment*

- Evaluation of the organisation's potential
- NGO's presence in the community
- Areas requiring capacity building
- Primary areas requiring attention
- Level of transparency of information in the organisation
- If blacklisted by any Government body or Donor?

### **4.3 Criteria for Rejection during Pre-scrutiny at the RD Office**

- Insufficient fixed assets
- Insufficient registration details
- Late applications
- Any other

### **4.4 Identification of un-served & underserved Areas**

Checklist for identifying un-served and under served areas

- Collect secondary data from District Health Department
- Have discussions with CMO, District RCH officer, ANM & other Health Administration officials
- Prepare a map of the district, clearly identifying the un-served and underserved areas



- Listing of NGOs functioning in the area.

#### **4.5 Checklist for conducting Community Needs Assessment by FNGO, supported by MNGO**

- MNGO will guide the Community Needs Assessment process
- A group consisting of the following will conduct Community Needs Assessment:

**Mandatory:** FNGO, PRI representative, Teacher, Anganwadi Worker / ANM.

**Desirable:** Members from DWCRA groups, other SHGs, MSS, Mahila Samakhya.

#### **4.6 Induction Training for MNGOs will Focus on**

- Relevance of the MNGO scheme, expectations
- Conducting CNA / Baseline Survey
- Management of RCH Service Delivery Project with measurable indicators
- Project proposal development

- Project implementation and management, including Financial Management
- Reporting and Documentation
- Supportive supervision
- Monitoring
- Evaluation.

#### **4.7 Orientation of FNGOs by the MNGO will Focus on**

- Identification of RCH issues in the community
- Relevance of involvement of FNGOs in RCH service delivery
- Conducting Community Needs Assessment
- Project proposal development
- Project implementation and management processes, including financial management
- Reporting and Documentation.



## MNGOs, SNGOs and FNGOs: A Synopsis

The following are some points of similarity between the FNGOs/MNGOs and SNGOs:

1. Irrespective of the size of operation, MNGOs, FNGOs and the SNGOs will work in under served and un-served areas
2. FNGOs, MNGOs and SNGOs must address gender issues and enhance male involvement in improving reproductive health status of women, adolescents and children
3. The initial project period is for three years and extendable to five years based on evaluation of

performance for all categories

4. Proposals from MNGOs, FNGOs and SNGOs must be based on baseline survey /CNA
5. Technical support and facilitation for capacity building will be provided by the Regional Resource Centers to all the categories

The similarities end here. The difference between the FNGO and SNGO is not only of size and coverage but one of depth and integrated package of services to be provided.

### Difference between MNGO, FNGO and SNGO

MNGO	FNGO	SNGO
<p><b>1. Role:</b> MNGOs nurture, manage and coordinate the FNGO implementation of RCH projects.</p> <p><b>2. Coverage:</b> MNGOs do not implement projects except as demonstration project.</p> <p><b>3. Scope of work:</b> MNGOs move from being mere fund distributors to active facilitator and manager of projects implemented by the FNGOs.</p> <p><b>4. Mechanism of implementation:</b> MNGOs facilitate FNGO linkages with district level health infrastructure and functionaries.</p> <p><b>5. Fund for infrastructure development related to specific service:</b> Not eligible</p>	<p>FNGOs implement small projects in specific aspects of RCH service delivery supported by MNGOs.</p> <p>Implements project covering a population of two sub centers (10-15 000 population)</p> <p>Small NGOs implementing RCH projects on <b>specific issue/ aspects of an issue.</b> (MCH, FP, RTI/STI, Adolescent Reproductive Health) supported by MNGOs.</p> <p>FNGO is supported by MNGO for meeting their skill requirement either directly or through linkages with district hospitals, private service providers etc.</p> <p>Not eligible</p>	<p>SNGOs implement RCH service delivery directly in the community in an integrated way.</p> <p>Implements project covering CHC/ block area.</p> <p>SNGOs provide RCH service delivery in an <b>integrated</b> manner. (FP, MCH, RTI/STI, Adolescent Reproductive Health, male involvement, Dai training, MTP services, gender based violence etc.).</p> <p>SNGOs must have appropriate infrastructure (clinic, equipment, ambulance), adequately skilled staff, and appropriate network for referral services.</p> <p>SNGOs who require support for improving infrastructure related to the proposed services could be assisted based on appraisal.</p>

