The Role of Non-Governmental Organizations in the Delivery of Health Services in Developing Countries

Robert M. Hecht

Vito L. Tanzi
Foreword

The World Bank’s *World Development Report 1993: Investing in Health*, the sixteenth in the World Development Report series, examined the interplay between human health, health policy, and economic development. Underlying the conclusions of *Investing in Health* is a series of economic, epidemiological, demographic and institutional analyses. Many of these analyses present original data and interpretations; and most of them are lengthy and somewhat technical. In order to make these analyses available to the policy and scholarly community, I have asked the authors to publish them in a series of background papers; this is one paper in that series. Titles of the other background papers appear on the following page. Views and conclusions expressed in the background papers are those of the authors and do not necessarily reflect those of the World Bank group.

*World Development Report 1993* concluded that a greater diversity of providers of health services would enrich opportunities of choice among consumers and implementation options for governments. It concluded that this diversity of provision could complement substantial governmental policy leadership and financial responsibility. Important among the potential private sector providers are the non-governmental organizations (NGOs). In this background paper, Robert Hecht and Vito Tanzi summarize the experience to date with NGOs in the health sector and draw some conclusions for enhancing their role in the future.

Dean T. Jamison  
Staff Director  
World Development Report 1993

April 27, 1994
Background Papers


1. Bobadilla, Jose-Luis, Peter Cowley, Philip Musgrove and Helen Saxenian, “The Essential Package of Health Services in Developing Countries”.
2. Cochrane, Susan H. and Thomas W. Merrick, “Family Planning and Health”.
4. Hecht, Robert M. and Vito L. Tanzi, “The Role of NGOs in the Delivery of Health Services in Developing Countries”.
8. Jamison, Dean T., “Disease Control Priorities in Developing Countries: An Overview of Cost-Effectiveness Assessments”.
10. Lau, Lawrence, Abdo Yazbeck, Kenneth Hill, Dean Jamison and Jee-Peng Tan, “Sources of Child Health Gains since the 1960s: An International Comparison”.
11. Michaud, Catherine and Christopher Murray, “Aid Flows to the Health Sector in Developing Countries”.
13. Murray, Christopher, Ramesh Govindaraj and Gnanaraj Chellaraj, “Global Domestic Expenditures in Health”.
14. Murray, Christopher, Jay Kreuser and William Whang, “Cost-Effectiveness Model for Allocating Health Sector Resources”.
15. Pritchett, Lant and Lawrence H. Summers, “Wealthier is Healthier”.
16. Yazbeck, Abdo, Jee-Peng Tan and Vito L. Tanzi, “Public Spending on Health in the 1980s: The Impact of Adjustment Lending Programs”.
The Role of NGOs in the Delivery of Health Services in Developing Countries

In some developing countries in Africa, Asia, and Latin America, up to one-third of health care services are provided by non-profit organizations. Their influence has grown as a result of increases in their numbers and in aid flows. Total aid flows to the health sector in 1990 were $4.8 billion, including $4 billion in Official Development Assistance and $0.8 billion or 17 percent provided by non-governmental organizations (NGOs). NGOs are being utilized more and more by governments and inter-governmental institutions in an effort to mitigate their fiscal burden while seeking ways to improve access and quality of health care. Globally there are thousands of NGOs operating at the international, national, and local levels; and there are at least a couple thousand active in the health sector.

This paper examines the significance of NGOs in the health area; the roles they play in delivery and financing health services; their strengths and weaknesses; and public policies to improve NGO performance in the health sector. NGOs contribute importantly to health services in developing countries. Many NGOs are experienced and efficient at providing services for which the government cannot satisfy. Governments should regulate NGO activities but in a manner which does not create obstacles or restrain NGO performance. Governments should seek opportunities to form "constructive partnerships" with NGOs to deliver essential clinical services.

Prior to World War II, Church missions were virtually the only groups that assisted in providing health care to rural areas in developing countries. In the aftermath of World War II, a wave of secular NGOs arose which viewed health as an integral part of
their activities. Today, NGOs play a significant global role in health as a result of government retrenchment in health spending and heightened interest in primary health care services which stems from the 1978 Alma Ata declaration.

An investigation into the roles and comparative advantages of NGOs requires a working definition. NGOs are non-profit, non-public, voluntary organizations, outside direct state control.\(^1\) However, the heterogeneity of NGOs makes a simple definition arduous. NGOs can be grouped into three categories: internationally based NGOs, religious organizations, and indigenous NGOs (see matrix below). There are however, many cases where it is difficult to determine where the line should be drawn. For example, the district designed hospitals in Tanzania are managed by the church, but are heavily subsidized and controlled by the state sector (Green, 1987).

<table>
<thead>
<tr>
<th></th>
<th>Religious</th>
<th>Secular</th>
</tr>
</thead>
<tbody>
<tr>
<td>International</td>
<td>Urban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td></td>
</tr>
<tr>
<td>National/Local</td>
<td>Urban</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td></td>
</tr>
</tbody>
</table>

There is tremendous variation in size, activities, and political importance of NGOs. In the health sector, NGOs operate in two main categories; service delivery and

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\(^1\) The World Bank defines NGOs as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment or undertake community development." This definition excludes private, for profit medical attention.
advocacy. NGOs operate hospitals and clinics; they have also played a key role in experimenting with low cost forms of primary health care i.e Bangladesh Rural Advancement Committee (BRAC); and they have campaigned on a variety of health issues from breast feeding to Oral Rehydration Therapy (ORT) to AIDS prevention. The World Health Organization’s National AIDS Control Program (NACP) has adopted a guideline that 15 percent of NACP funds should be channelled through NGOs. The advocacy role that NGOs play has been particularly important in promoting women’s health issues. Advocacy by NGOs and bilateral agencies brought about the 1987 Safe Motherhood Initiative launched at a conference in Nairobi, Kenya.

Many NGOs often have their own health infrastructures, including networks of clinics and hospitals. Others work in cooperation with the ministry of health on planning and training. In aggregate NGOs have been active in a myriad of health services including: Provision of curative & preventive services; Family Planning; Experimenting in health delivery systems; Assistance to national governments; and Health/Nutrition Education.

How effective can NGOs be in development activities? An answer to this question is derived through an understanding of NGOs’ intrinsic strengths and weaknesses as vehicles in development work.

**NGO Comparative advantages**

- The capacity to reach poor communities and remote areas with little infrastructure and minimal resources; and where government services are usually extremely
limited and ineffective: Operating on a small scale allows NGOs to be innovative, for example (AMREF’s Flying Doctor Service in East Africa). NGOs’ small scale and flexibility may also allow them to deliver services where government cannot, or for political reasons will not (Ethiopia during the 1984 famine), and to respond quickly to emergency demands (Somalia 1992). NGOs may also choose to provide services to groups in conflict with government (Medecins sans Frontiere in Northern Iraq).

The capacity to promote local participation "community empowerment": Being community based gives NGOs the advantage of being aware of the actual needs of the community. One of NGOs most significant strengths is their ability to involve the intended beneficiaries of a particular project. This is important since local populations have a better understanding of their own needs, but also of the strengths and limitations of their own environment i.e. local system, human resources. Further, program sustainability depends upon the people who continue to live in the affected region. AMREF, for example, has trained male and female traditional health practitioners living in remote villages to dispense drugs and some types of contraceptives. Since the project began, the share of women of reproductive age using modern contraception in six pilot sites has risen from less than 10 percent to over 25 percent.

Capacity to operate on low costs: NGOs tend to use appropriate technology in combination with low staff budgets which allows them to operate efficiently. They are also

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2 The African Medical & Research Foundation was established in 1957 to improve the health of the people of East Africa. "Flying Doctors" is an effort to deliver health services to remote areas in 9 countries. AMREF with an annual budget of $16 million is the largest health NGO in Africa.
able to mobilize volunteers and community resources. However, it should be noted that there is limited quantitative evidence of NGO efficiency in health service delivery.

- Capacity to innovate and adapt: NGOs have the advantage of being able to identify needs and build upon existing resources. Many of the elements of primary health care reflect the prior experiences of NGOs. This resourcefulness has allowed NGOs to pioneer new technologies, such as oral rehydration therapy (Cumper 1986).

**NGO Limitations**

- Limited replicability: many NGO sponsored activities are too small and localized to have important regional or national impacts.

- Poor information systems: lack of documentation of their activities. Oftentimes, NGOs do not evaluate their programs and thus their efficiency is questioned. There are exceptions, such as the Aga Khan Foundation which requires an evaluation of every project.

- Limited self-sustainability: many NGO sponsored activities are not designed to sustain themselves without outside aid. One of the biggest problems is their time scale. Since many NGOs have a weak financial base, long term planning is difficult for both a government trying to involve NGOs in a project or for the NGOs themselves.

- Limited technical capacity: many local projects are started with limited feasibility analysis and weak data bases and often rely excessively on intuition and impressions.
Lack of broad programming context: NGO projects are often implemented individually and not as part of a broader regional program. NGOs are usually isolated from each other and from the government.

Assessing Performance

In many low income countries, especially in Africa, private out of pocket payments account for more than half of the mere $3-25 per person spent each year for health care. Most of this is spent on fees to traditional healers, and to non-governmental organizations. NGOs particularly those related to religious institutions, contribute importantly to the provision of health services in many low income countries. In Tanzania and Haiti, NGOs operate nearly half of the hospitals, and in Cameroon and Uganda manage 40 percent of health facilities in the country. In Ghana and Nigeria, about a third of all hospital beds are located in mission hospitals (see Table 1).
<table>
<thead>
<tr>
<th>Country</th>
<th>Health Services provided by NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>NGOs account for 28 percent of health expenditures and operated 23 percent of all facilities in the three largest cities.</td>
</tr>
<tr>
<td>Burundi</td>
<td>Church missions operate 30 percent of primary health care facilities.</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Church missions provide 40 percent of health facilities.</td>
</tr>
<tr>
<td>Ghana</td>
<td>NGOs provide 35 percent of outpatient care and 30 percent of hospital beds.</td>
</tr>
<tr>
<td>Haiti</td>
<td>Over 200 private health organizations operate almost 50 percent of the country’s health facilities.</td>
</tr>
<tr>
<td>India</td>
<td>Private and Voluntary Hospitals account for 56 percent of India’s hospitals.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>NGOs provide 12 percent of hospitals and 10 percent of hospitals beds.</td>
</tr>
<tr>
<td>Kenya</td>
<td>NGOs deliver up to 35 percent of health care services.</td>
</tr>
<tr>
<td>Malawi</td>
<td>Private Health Association of Malawi is responsible for 40 percent of all health services.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>NGOs provide 31 percent of hospital beds.</td>
</tr>
<tr>
<td>Swaziland</td>
<td>NGOs provide 30 percent of health services.</td>
</tr>
<tr>
<td>Tanzania</td>
<td>NGOs operate 45 percent of all the hospitals.</td>
</tr>
<tr>
<td>Uganda</td>
<td>NGOs provide 40 percent of services. NGOs own 41 percent of tertiary and secondary hospitals and 39 percent of hospitals beds and 22 percent of primary hospitals and 16 percent of outpatient clinics.</td>
</tr>
<tr>
<td>Zambia</td>
<td>Church missions operate 35 percent of health care services.</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Church missions account for 35 percent of hospital beds.</td>
</tr>
</tbody>
</table>
Table 2 shows the percentage of total health expenditures by source of funding in a sample of countries. Even though NGOs account for less than 5 percent of health expenditures in most of these countries; this percentage may underestimate their importance in certain regions, diseases, or cohorts (see Table 2). These figures downplay the importance of NGOs in rural areas, areas the government often neglects.

### Table 2 Percentage Share of Total Expenditures by Source of Funding

<table>
<thead>
<tr>
<th>Country</th>
<th>Government</th>
<th>Total</th>
<th>Missions/NGOs</th>
<th>Modern/Traditional</th>
<th>Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana (1979)</td>
<td>35</td>
<td>30</td>
<td>5</td>
<td>25</td>
<td>35</td>
</tr>
<tr>
<td>Burundi (1986)</td>
<td>59</td>
<td>21</td>
<td>N/A</td>
<td>N/A</td>
<td>20</td>
</tr>
<tr>
<td>Ethiopia (1986)</td>
<td>24</td>
<td>71</td>
<td>2</td>
<td>69</td>
<td>5</td>
</tr>
<tr>
<td>Kenya (1984)</td>
<td>52</td>
<td>46</td>
<td>2</td>
<td>44</td>
<td>2</td>
</tr>
<tr>
<td>Lesotho (1986)</td>
<td>39</td>
<td>59</td>
<td>8</td>
<td>51</td>
<td>2</td>
</tr>
<tr>
<td>Madagascar (1985)</td>
<td>37</td>
<td>53</td>
<td>2</td>
<td>51</td>
<td>10</td>
</tr>
<tr>
<td>Mali (1989)</td>
<td>40</td>
<td>46</td>
<td>3</td>
<td>43</td>
<td>14</td>
</tr>
<tr>
<td>Rwanda (1982)</td>
<td>43</td>
<td>45</td>
<td>24</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Senegal (1989)</td>
<td>32</td>
<td>50</td>
<td>N/A</td>
<td>N/A</td>
<td>18</td>
</tr>
<tr>
<td>Somalia (1982)</td>
<td>26</td>
<td>51</td>
<td>N/A</td>
<td>N/A</td>
<td>23</td>
</tr>
<tr>
<td>Sudan (1985)</td>
<td>25</td>
<td>75</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Swaziland (1984)</td>
<td>30</td>
<td>61</td>
<td>3</td>
<td>58</td>
<td>9</td>
</tr>
<tr>
<td>Uganda (1982)</td>
<td>16</td>
<td>81</td>
<td>1</td>
<td>80</td>
<td>3</td>
</tr>
<tr>
<td>Zaire (1987)</td>
<td>5</td>
<td>90</td>
<td>N/A</td>
<td>N/A</td>
<td>5</td>
</tr>
<tr>
<td>Zimbabwe (1986)</td>
<td>53</td>
<td>35</td>
<td>1</td>
<td>34</td>
<td>12</td>
</tr>
</tbody>
</table>

How well does the NGO sector perform in providing health care? Literature on this subject is extremely limited and data quantifying NGO's comparative advantages are sparse.

NGO performance can be measured in a number of ways: the ability to provide services to isolated populations, ability to respond more quickly to demand, ability to provide the same services the government provides cheaper, and the ability to have access to drugs. Assessing performance for social programs is much broader than the economic concept of efficiency.  

It is widely assumed that NGOs working in health are somehow more efficient than the government sector. Countries should examine whether or not NGOs positive reputation has come about in response to shortcomings of state interventions rather than from a systematic review of concrete documented accomplishments. The evidence to prove or disprove this assumption is scarce and contradictory. For example, a United States Agency for International Development (USAID) study by Judith Tendler analyzing 75 evaluations of projects by NGOs found that the claim that NGOs are more effective in reaching the poor and involving them in innovative development assistance was without foundation (Tendler, 1982).

However, a 1986 USAID (PVOs Reach Out) study came to the conclusion that NGOs are effective in delivering health services. This USAID evaluation of 13 Primary

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3 Social development is more difficult to evaluate than building infrastructure, where performance is measurable in money terms. Social programs are implemented in a setting which is quantitatively different and goals are intangible. The variables in an open community setting are many and largely uncontrollable.
Health Care projects found that NGOs were able to provide health services such as ORT, immunization, and blindness prevention in some of the Third Worlds poorest, most neglected and most remote rural areas. The report states that NGOs were able to test and demonstrate imaginative, cost-effective PHC strategies, largely because of the hard work of their devoted staff members and their ability to work closely with individuals and communities in small, focused interventions. The report also found that NGOs had a significant impact at the community level but not at the national level.

While it is difficult to compare performance of NGO and government health facilities, a recent study of hospital costs in three government and two NGO hospitals in Uganda showed that spending per inpatient in 1989/90 by the government hospitals was approximately double that of NGOs (World Bank, 1992). Moreover, Ugandan estimates of relative productivity between government and NGO staff found that physicians in NGO hospitals would handle about 5 times as many patients as would government doctors. Nurses in the NGO hospital handle twice as many patients and medical assistants 18 times as many (see Table 3).

<table>
<thead>
<tr>
<th>Professional</th>
<th>Inpatients per year per professional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
</tr>
<tr>
<td>Doctor</td>
<td>471</td>
</tr>
<tr>
<td>Nurse</td>
<td>160</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>342</td>
</tr>
</tbody>
</table>

Source: National Health Manpower Study.
A good measure of an NGOs success is seeing poor populations using the services of NGOs that charge fees in preference to those of a nearby free government institution. In Tanzania, for example the public facilities are providing "free care", but there continues to be a large number of consumers that frequent the nongovernmental sector despite the fact that they are fee-charging facilities (UNICEF, 1992). NGO facilities are heavily used: the UNICEF study found the mean bed occupancy rate to be 86 percent. In addition, The National Health Personnel Study in Uganda (1991) shows that Bed Occupancy Rates are much higher in the NGO facility compared to the government facility (see Table 4).

<table>
<thead>
<tr>
<th></th>
<th>Secondary</th>
<th>Tertiary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
<td>NGO</td>
</tr>
<tr>
<td><strong>Average Length of Stay</strong></td>
<td>9.2</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Bed Occupancy Rate (%)</strong></td>
<td>48.6</td>
<td>91.4</td>
</tr>
<tr>
<td><strong>Reporting Units</strong></td>
<td>7.0</td>
<td>10.0</td>
</tr>
</tbody>
</table>


The UNICEF study found that NGO facilities collect on average 50 percent of their annual budgets (excluding donations) from user fees. These amounts enable a higher level of quality to be maintained in NGO services than is usually possible in government facilities.

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4 A UNICEF study, Charging for Services in Non-Governmental Health Facilities In Tanzania, compares NGO and Government facilities. The study sampled a mix of 42 NGO/Government facilities. The survey also interviewed 1,681 heads of household on 18 out of the 22 administrative regions. When asked where they seek treatment 40% chose the NGO facility as opposed to 30% who choose the government facility.
facilities. Revenues are generally used to pay for recurrent costs including drugs. About 52 percent of the consumers sought health care from NGOs where they had to pay, and over 80 percent of these consumers were poor (UNICEF, 1992). Moreover, in the free government facilities consumers were paying up to $20 (1988 US $) to facilitate delivery of services (UNICEF, 1992):

An intensive study of cost recovery experiences in Senegal, Mali, Cote d'Ivoire and Ghana has shown that cost recovery is much more successful in NGO facilities than government (Vogel, 1988). NGOs serving similar populations as the government facility often charge small amounts for their drugs in contrast to governments which subsidize drug prices. The missions have several advantages in procuring drugs; their country operations are more effectively managed, and they mobilize foreign currency in the form of charity. NGOs often have drugs and supplies in comparison to government hospitals which are plagued with shortages (Mburu, 1989). One constraint on government health services is the lack of foreign exchange which is needed for supplies and drugs. Donations of funds, drugs and other supplies were received directly from abroad reducing the foreign exchange requirement. For many people in sub-saharan Africa, pharmaceuticals are essential for establishing credibility. A survey conducted by the Harvard Institute for International Development (HIID, 1986) found that even though fees in mission hospitals were 2 to 5 times as high as those in government facilities, 90 percent of households indicated that they would accept higher fees if that charge would assume the regular availability of drugs (HIID, 1986).
While there are some evaluations of NGO performance relative to the public sector, the dearth of good data collection by NGOs has severely limited the evaluation process. The 1986 USAID report found that NGO performance could be heightened further by improved design and management. For example, through better documentation of activities. According to a 1985 USAID study, monitoring and information systems used by most NGOs were rudimentary and needed upgrading. This makes the assessment of the impact of projects very difficult. The USAID study indicated that many projects were not collecting or analyzing baseline data. This makes replication difficult as the impact of programs is ambiguous.

NGOs need to monitor the health related costs of each project and determine the number of beneficiaries in order to reveal per capita costs. This would allow the NGO to develop cost-effectiveness estimates for interventions using different approaches.

**NGOs in Practice**

In developing countries various groups have become involved in health. Churches have created development organizations such as the Lutheran World Relief and the Catholic Relief Service. Groups of individuals have organized and formed groups such as Save the Children Fund.

Save the Children Fund, for example, is an international NGO working in 37 countries. Their health programs’ focus mainly in four areas: child survival programs, maternal health, water and sanitation, and AIDS education. Save the Children involves the
local community by training volunteers to conduct a comprehensive household census. As a result of the census, health programs begin with information on most children and women of childbearing age. The information has been used in constructing a community based Health Information System, which is used to plan and follow up health interventions. The computerized Health Information System is currently monitoring five country programs, and is central to Save the Children’s approach to primary health care because it provides reliable data to measure progress toward the objectives of each health project.

The impact of a tetanus immunization program in Mali demonstrates the effectiveness of a Health Information System. After three years, Save the Children’s primary health care program in Mali has had a measurable impact on child survival. Save the Children began a child survival program in conjunction with the Malian government in January 1988. The program enrolled 24,000 residents in the Kolondieba District (Sikasso Region) into the Health Information System. After the families were enrolled, children and mothers were immunized; and mothers were trained in oral rehydration therapy. Health volunteers record all births and deaths occurring in Kolondieba and regularly update the Health Information System. As a result, program results can be measured against immunization coverage rates and services, pregnancies, and births and deaths. Save the Children can also pinpoint specific health problems and design appropriate interventions.

During 1988, only women who were pregnant during team visits were immunized (in accordance with government policy). In 1989, the Malian government in accordance with WHO recommendations changed its immunization policy, and as a result 76 percent of women of childbearing age were immunized. The results have been significant. In 1988, 28
per 1,000 infants died between ages of 4 to 15 days (when deaths from tetanus generally occur). In 1989, only 5.6 per 1000 died within the target age, an 80 percent reduction in the neonatal death rate.\textsuperscript{5}

The Health Information System enables Save the Children to monitor children's health status and to target children who are not receiving needed services. It also allows Save the Children to analyze the impact and consequences of its work in each community so "lessons learned" are incorporated into the planning and implementation of new projects.

\textit{NGOs in India}

NGOs in India have been active in the health field since India's independence in the 1950s. For example, the Comprehensive Rural Health Project (CRHP) in Jamkhed was launched in the Maharashtra State in 1971. The project covers a population of 250,000 (Abed & Chowdhury, 1989). The CRHP project has been able to reduce the birth rate to 25 per 1000 and the death rate to 8 per thousand population (Murthy, 1990). The project works through a three tier system of health care delivery:

\begin{itemize}
  \item \textit{Village Health Worker:} The village health worker is assigned to serve a village in which to provide primary health care. Mostly illiterate, these female workers treat villagers for minor ailments and receive a small salary. Their responsibilities include preventive care, nutrition education, and family planning.
\end{itemize}

\textsuperscript{5} Save the Children Fund, 1992.
Mobile Health Teams: This is the second tier of the Jamkhed project. The team is made up of a nurse, paramedic, social worker and doctor who visit their assigned villages either weekly or biweekly. The team provides support to the village health workers and takes care of cases which are beyond her capacity.

Health Center: The third tier consists of a center and 4 sub-centers. The main center in Jamkhed has a 30 bed hospital. The hospital takes care of emergencies or cases referred by the village health workers or mobile teams.

When the project started the infant mortality rate (IMR) was 180 per 1000 live births but by 1986, the IMR had been reduced to 28/1000 (Murthy, 1990). At the same time, the IMR in a control area was 80, while the IMR for India as a whole is approximately 100 (Walsh and Dayal, 1987). However, the project also included agriculture extension and the supply of safe drinking water which may have contributed to the improved health indicators.

NGOs in Bangladesh

One of the most famous NGOs is the Bangladesh Rural Advancement Committee (BRAC) established in 1972. Unlike Jamkhed, BRAC started out as a rural development program. One of BRACs main strengths is being able to identify problems facing the poor. BRAC has a staff of over 3,000 on its payroll, making it one of the largest NGOs in the world. In 1980, BRAC started a nationwide Oral Rehydration Solution (ORS) program for diarrhea. Groups of trained health workers visited each household in rural areas and taught mothers about the home preparation method of a simple oral rehydration solution with home ingredients. Moreover, BRAC staff have instructed approximately 13 million
mothers in ORS preparation (Chowdhury, 1991). An evaluation has shown that over 90 percent of mothers are capable of making a safe and effective ORS (Chowdhury, 1991). The ORS program has been enlarged to include an immunization and Vitamin A component. Through this selective primary care program, BRAC is covering about 33 percent of the country. Further, they are experimenting with a new comprehensive program in six districts covering a population of 1.2 million. The program has eight components: ORT, Family Planning, immunization, Vitamin A distribution, nutrition education, training Trained Birth Attendants (TBAs), basic curative services, and water and sanitation. At the request of the government, BRAC is now assisting in social mobilization and training of staff for EPI and Vitamin A capsule distribution. BRAC is currently training lower and mid government field officers in management of health programs. BRAC is also engaged in training government health care staff, in the field of management of maternal and child health and family planning (Abed, Chowdhury, 1989).

**Government Policy**

The relationships between NGOs and governments are at times characterized by mistrust and at times by collaboration. The NGO often finds itself in one of two positions: it accepts the government's health agenda and aids in carrying it out; or it takes the position that the government cannot do anything right and pursues its own agenda. Tensions usually arise out of differences: in ideology, in development priorities, and in development
approaches. Paradoxically, replicability and sustainability of NGO projects depend partly on the NGOs ability to work in collaboration with the government.

The relationship between national governments and NGOs varies from country to country and from region to region. In India, NGOs are considered "partners" in the task of eradicating poverty. While NGOs derive much support and encouragement from the government in India and Bangladesh, they have historically operated in opposition to governments in Latin America (Drabek 1987). NGOs developed in Latin America during the 1950s, a period full of authoritarian regimes, where their basic attitude was one of denunciation and resistance. The democratization of many Latin American governments during the 1980s bolstered the creation of new NGOs.

Governments that have banned NGOs or heavily restricted their entry and operations have seen access and quality of essential services deteriorate. When Mozambique decided after independence in 1975 to ban NGO health activities in the country, in favor of government run facilities, a wide range of health services in the rural areas suddenly disappeared. Wherever such bans or barriers to NGO activity exist, they should be removed.

Government NGO relations hinge on several factors, including the stability of the government, the type of political system, and the type and location of particular NGO projects. The best situation is to have a strong government with NGOs located in undisputed areas, as opposed to NGOs located by a contested border with a weak government.

Government/NGO contact occurs during the registration of NGOs, monitoring and through government provision of subsidies:
Legal Registration: Registration is the first place where the government begins to monitor NGOs. It is at this stage, before NGOs have started any health activity, that a government selects which NGOs will provide health services, spells out their accountability to the government, and sets controls on their geographic area of activity.

In reality, registration in many countries is extremely lax and after the fact. In Sudan in 1984, 90 NGOs poured into the country without approval. Many governments have formed coordinating groups to facilitate the registration process. In Zimbabwe a Primary Health Care Forum for inter-NGO and NGO government collaboration has been established. In Swaziland, a coordinating Assembly of NGOs in primary health care has been formed with the participation of the Ministry of Health. Building alliances of this nature builds trust and eliminates the need for legal restriction.

Governmental inefficiency can often be a significant constraint on NGO activities. Many African country governments are poorly equipped to deal with registration applications and administrative tasks required to facilitate NGO activity. In some countries the very existence of organizations outside the state control may be perceived as a challenge to governmental authority. Governments should legalize and simplify registration.

Monitoring: Regular contact with the ministry of health is crucial in order to avoid duplication of activity. Many governments impose time consuming demands such as financial accounting and planning of activities on NGOs. The reality is that most national governments do not have the time or the resources to undertake monitoring activities.

Government Subsidies: Many governments provide subsidies to NGOs i.e. Pakistan and India. This may come in the form of an annual grant or paying for a particular
service i.e. salaries or drugs. Indirect subsides come in the way of waiving tariffs on imports for pharmaceutical and medical supplies. In Rwanda religious NGOs are reimbursed by the government for 86 percent of staff salaries. The governments of Zambia/Zimbabwe also cover a substantial part of NGO expenditures on health services. Governments frequently provide NGOs not only with direct subsidies but also "hidden subsidies" in the form of relief from import duties, taxes and other financial obligations (Green, 1987).

Governments are forming constructive partnerships with NGOs to deliver essential clinical services. One approach being followed in Africa and in some states of India is to nominate appropriately located NGO hospitals as district (first-level referral) hospitals, and thus to incorporate NGO health centers into the network of public facilities. The NGOs are expected to provide a range of public health and clinical services, and to perform a series of district wide functions such as health planning, supervision of lower-level clinics and community activities and maintenance of emergency transport. In return the government pays some of the NGOs' costs through subsidies (per case, per diem, block grants) for essential clinical services.

There are a number of examples of this kind of government-NGO collaboration. In Lesotho, nine of the country's eighteen "Health Service Areas" (districts) are headed by a church mission hospital that carries out comprehensive health planning and management for its entire area. In Zimbabwe, government funds for rural health improvement are being used to expand mission ("designated district") hospitals and to purchase ambulances for NGOs. Ministries of health pay for the salaries of nursing staff in mission hospitals in Zaire and for most of the recurrent costs of NGO facilities in Botswana.
Government donations of free vaccines and contraceptives to NGO health providers has also become a common way to target public subsidies to specific health intervention programs.

NGOs, governments, and international assistance agencies are seeking ways to improve the programmatic and managerial capabilities of NGOs. To achieve this objective, many of them are looking towards "NGO coordinating bodies". Coordinating bodies serve to increase contact and collaboration among NGOs, provide services to members, and improve links with governments. Coordinating bodies developed from a small groups of NGOs meeting in an effort to bring some form of coordination to their activities. With such a diversity of NGOs operating in many developing countries NGO coordinating bodies have become a logical point of contact. NGOs and international assistance agencies use coordinating bodies as intermediary organizations that can assist in program implementation and resource transfers. Example of coordinating bodies in Africa would be the Christian Councils, which group together church-related organizations, VOICE (Voluntary Organizations in Community Enterprise (Zimbabwe), and the Zambia Council for Social Development. While in Togo the government invited Le Conseil des Organismes non Gouvernementaux en Activite au Togo (CONGAT) to play a role in coordinating NGO activity with government policy. The role of coordinating bodies should be expanded to include an active role in pharmaceutical procurement. Coordinating bodies should help organize drug and vaccine procurement orders for groups of NGOs so as to receive volume discounts. Coordinating bodies also should develop procurement initiatives which go hand in hand with government orders so as to receive even larger discounts.
National governments should create the legal and political environment so that NGOs can operate efficiently. In many countries, governments are recognizing that NGOs can play a crucial role as a bridge between state structures and programs and local populations, particularly those which are isolated geographically, politically, or culturally. (For country examples of government policies towards NGOs see Appendix 1.)

Conclusion

Cooperation between governments and NGOs is important for the efficient provision of health services. NGOs have been important in sensitizing governments and international aid and finance agencies toward the social aspects of development. Many NGOs are experienced and efficient at providing services for which the government cannot satisfy. NGOs have their roots in the rural areas, where government services are virtually nonexistent. However, NGOs cannot fulfill all the gaps left by the public and commercial sectors and should thus not be viewed as a panacea. The importance of NGOs lies in their ability to involve communities and grassroots organizations more effectively in the development process. A closer look at NGO activities in developing countries reveals that NGOs operate primarily in small-pockets and so their successes and failures remain largely unknown.

Anecdotal evidence in the literature seems to indicate that NGOs operate more efficiently than the public sector. Many suggest that NGOs have the availability of drugs which gives people the impression that they are doing something positive and are less
constrained by political and legal obstacles. However, objective or quantitative evidence which would back these claims is extremely limited.

NGOs have many useful ideas for health development. Demonstrating that NGOs can operate efficiently will allow them the latitude to make suggestions for local resource mobilization, cost recovery, and program sustainability. By documenting these activities NGOs will not only provide some evidence of efficiency but will enhance government understanding of their local effects.

The fact that NGOs are independent is their strength and weakness. It allows them to be more flexible and expedient than a large government bureaucracy. However, the result is little quality control, accountability and evaluation. Collaboration with governments is good for both parties and it may also help NGOs increase their own acceptance and credibility within communities. Developing an NGO liaison office may strengthen communication and collaboration between governments and NGOs. i.e. Pakistan (NGO Coordinating Council, India (Planning Commission Document), Bangladesh (NGO Affairs Bureau).

Governments who actively discourage nongovernment providers or fail to encourage them reduce their own options. Expansion of nongovernment services can reduce the administrative and fiscal burden on the government sector and broaden consumer options. Competition from the nongovernment sector may even encourage government services to improve their efficiency. In assessing performance many NGOs have developed successful health interventions which have led to significant improvements in health status.
Governments and bilateral agencies should seek to improve assessment of NGO performance in an effort to help direct assistance toward the most efficient providers of health care.
Appendix 1

Country Examples of Government Policies Toward NGOs

**Ghana:** Ghana has two coordinating bodies for NGOs involved in health care, the Christian Hospital Association of Ghana (CHAG) and the Ghana Association of Private Voluntary Organizations in Development (GAPVOD). CHAG acts as an intermediary arranging for the transfer of government funds to missions and for the procurement of essential drugs (Dejong, 1991).

**Zambia:** The Zambian government has a strong association with Nongovernmental organizations in the health sector. They are referred to as "partners in health care" by the Ministry of Health. At the time of independence, policy in mission hospitals was to charge fees. However, based on the government declaration of free health care and government grants to mission facilities, the fee structure was abandoned, and all care was given free of charge. The government provides grants and personnel, and at the same time there is an obligation for the Churches Medical Association of Zambia to comply with government instructions and regulations as an integral part of the service delivery system. All church related health care providers are members of the Christian Medical Association of Zambia. It was established to act as a liaison between the missions and the government. The CMAZ is regarded as a "parastatal organization" and receives block grants from the government according to a level of services.

About 33 percent of the mission hospitals are formally designated District Hospitals, carries out regular

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6 All church related health care providers are members of the Christian Medical Association of Zambia. It was established to act as a liaison between the missions and the government. The CMAZ is regarded as a "parastatal organization" and receives block grants from the government according to a level of services.
district hospital functions on behalf of the government. These hospitals are provided with funding, vehicles, and equipment by MOH to carry out PHC as any other government hospital. Keeping with the policy of free health care to all citizens, the government of Zambia has regularly made annual budget allocations to the church/mission health facilities registered as members of the CMAZ. The government contributions include a "bed grant", allocated on the basis of the number of approved beds in the health facility, drug kits for rural health centers, trainee grants for operating training schools for health workers. In addition, Primary Health Care grants are allocated according to the specific roles, responsibilities and activities of each facility. The Ministry of Health allocated 7 percent of its budget to CMAZ. The main functions of CMAZ include: resource mobilization, representation of members, coordination of training programs, policy coordination for church related institutions. They made have administrative and advisory functions.

India: The Indian government has recognized the role of NGOs since the first 5 year plan in 1952. In 1952, the government launched the Community Development Programme. By 1980, 8,052 NGOs were receiving grants (Duggal, 1988). By the fifth plan encouraged NGOs to take over, on a contractual basis, the programs of the government in the social sector. In the health sector, the government began giving its PHC centers to NGOs to run. Further, certain national programs i.e. leprosy were given to NGOs to run. In addition, NGO representatives were made official advisors or nominated as experts in government committees and bodies, including the Planning Commission. As the number of NGOs working in the health field proliferated they formed their own lobby in parliament in order to get recommendations accepted by the government. When the seventh plan started to
be formulated NGOs obtained positions in government policy making bodies. NGOs also published articles and wrote to the prime minister thereby stimulating a public debate on the role of NGOs in the 7th plan. NGOs started using newspapers, journals and the media. The result was that NGOs were involved in the implementation of health programs such as Maternal and Child Health, Family Planning, communicable diseases, health education, and immunizations. Further, the 1983 National Health Policy recognizes the need for greater reliance on NGOs in order to achieve "Health for All". It is surprising that such a heterogenous body could come together, lobby, get its views known within the government and finally get official recognition in policy making.

The 1982 National Health Policy recognized that the government faced many financial constraints in its objective of providing effective and efficient health care services to its population. To mitigate the problem of limited resources, the policy recommended that the States should design processes which encourage investment by nongovernmental agencies in establishing curative centers. The policy also suggested that the states should provide an organized, logistical, financial and technical support to voluntary agencies active in health. The government wants the NGOs to become more involved in curative care so that they can expand into preventive health care. India’s national health policy has contributed to a 82 percent increase (from 3022 in 1983 to 5497 in 1988) in the number of hospitals owned by private and voluntary agencies (Bhat, 1991).

Pakistan: The Pakistani government has recognized that NGOs are playing a significant role in health and nutrition. The government has included NGO participation in its Social Action Programme. The government has recognized that NGOs work more
effectively and efficiently with the community in areas where the public sector is unsuccessful. The government has allocated 100 million Rupees to NGOs for programs in health and nutrition. Moreover, they have entrusted a billion rupee school feeding program to NGOs. The Non-Governmental Organization Coordinating Council was established to coordinate and oversee the NGO sector, and it will be supported by GOP through the ADP. The government will develop collaborative programs with NGOs.
References


Long, Lynellyn et al. 1991. "Non-Governmental Organizations' Involvement in Child Development in Developing Countries." USAID.


Save the Children Fund, The International Programs of Save the Children 1992.

Shepard, Donald, eds. 1986. "Mobilizing Resources For Health: The Role of User Fees In Developing Countries." Harvard Institute for International Development.


