GO-NGO Collaboration
in
Health Sector Management of Bangladesh:
An Evaluation of BRAC's Health Programme

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Disclaimer

I here declare that no part of this study has been published elsewhere. This dissertation is prepared for the partial fulfillment of the MAGD degree, and is submitted to the IGS authority with due acknowledgement of the cited text and norms of standard research work.

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MD. Hasan Maruf

Table of Contents

CHAPTER 1	Setting and Background	PAGE
1.1 Introduction		**1**
1.2 Background		**1**
1.3 Objectives of the Study		**7**
1.4 Research Questions		**7**
1.5 Justification of the Study		**7**
1.6 Limitations of the Study		**8**
1.7 Methodology		**9**
1.8 Plans of Study and Structure		**9**
CHAPTER 2	An Overview of Healthcare Sector of Bangladesh	PAGE
2.1 Introduction		**11**
2.2 Primary Health Care		**13**

Preface

Institute of Governance Studies (IGS) of BRAC University offers Masters of Arts in Governance and Development (MAGD) Course for the career civil servants of Bangladesh. Preparing a dissertation on a contemporary subject is a requirement for attaining the final degree. From this point of view this current study is entirely an academic endeavor.

This study has mainly focused on the present condition of GO-NGO coordination in managing the health sector of Bangladesh as per the 'Health Policy—2011'. And, to attain this objective, this study has attempted to find out the answers of (I) how far the existing GO-NGO collaboration is effective in managing the healthcare sector in the present condition of Bangladesh ?, (ii) what is the role of BRAC, the world-leader Bangladeshi NGO, within the GO-NGO interface framework in running the health programmes in Bangladesh ?,and (iii) whether the present state of GO-NGO coordination in healthcare sector management is supportive for achieving the policy-goals stated in the 'Health policy—2011'?

From this study, we can trace out some very successful GO-NGO partnership programmes between GOB and health sector NGOs. For example, the existing GOB and BRAC's partnerships in TB-control, EPI, FP, and Maternal, Newborn and Child Survival Projects manifest the success stories of GO-NGO collaboration in health sector of Bangladesh.Its key achievements including the reduction of child mortality rates through campaign for oral rehydration in the 1980s and taking immunization from 2% to 70% in Bangladesh. In Bangladesh, 78% of births occur in the home. BRAC has implemented a program in which midwives are trained to work in the homes of women to ensure that births are as risk-free as possible. As on December 2012, 1,00000 community health volunteers and 58,000 health workers have been trained and mobilized by BRAC to deliver door-to-door health care services to the rural poor.

The study reveals that without proper coordination and collaboration between the GO and NGO sector, especially in the healthcare sector, it is impossible to ensure necessary health

services to all. '***Health for All***' is one of the main preconditions of balanced development of any nation. Health is an essential component of individual and societal livelihood. To meet the health care needs of the people is one of the main preconditions for building a developed nationhood. As a developing country, the limited resources and inefficiencies of the public and private sectors, close collaboration between the GO and NGOs can be an effective solution to address the ever increasing public health problems in Bangladesh. Collaboration or partnership is needed to fully exploit the potential strengths of all the sectors towards fulfilling the health care needs of the people. It is always a challenging task for any developing country as usual. It is a fact that most of the world diseases falls to the developing countries, and adding considerably to the national problems. All these problems have a profound impact on the standard and quality of the human life, particularly for the poor.

Limitations of government efforts towards development management due to the scarcity of resources encourage searching for alternative institutional framework all over the world. The NGOs are now recognized as organizations alternative to the governments of the developing countries to address the needs of people otherwise unreached by official development programmes. It is a fact that government of a developing country like Bangladesh is not in a position that it alone can manage and fulfill all the demands in the healthcare sector, and this is why GOB has been engaging the NGOs in partnerships for smooth implementation of its different development programmes.

MD. Hasan Maruf

EXECUTIVE SUMMARY

'Health for All' is one of the main preconditions of balanced development of any nation. Health is an essential component of individual and societal livelihood.And, in any sovereign state, it is the responsibility of the government to assure healthcare provision for the whole population. But the public health agenda has become so large that the governments of most of the countries have been unable to provide adequate health care. This has expedited the organizations outside the government to assume part of that responsibility. In fact, lack of proper response on the part of the public sector to meet the hopes, desires and aspirations of the poor of the society has treated as one of the main reasons for the emergence and growth of NGOs in Bangladesh. Thus in the present socio-economic context of Bangladesh, NGOs have earned a significantly firm position and have played a catalytic role towards national development. It is a proven fact that working in isolation can result in duplication of efforts and failure to accomplish health goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of information. Moreover, it is a must to establish a vibrant and effective networked-governance in the health care sector of the country to achieve the related goals of the much-talked MDGs within the stipulated time frame and bring about the desired qualitative change in the country's health care sector.

'Governance' is now a tripartite and shared endeavor in which each sector has its own comparative advantages and fulfills roles that are most appropriate to it. In this multi-sector governance regime, each sector specializes in what it does best without detracting from the government's role as a guarantor of social justice and well-being of the people. The government needs to constantly explore the best means, to achieve its ultimate goal of ensuring the basic needs, fulfillment of its citizens ,and with a view to fulfill its obligations and responsibilities to the citizens. In the face of declining economic conditions, budget

constraints and shrinking expenditures in social sectors, governments in developing countries are turning to the private and non-profit sectors as potential partners in healthcare delivery.

Governments in developing countries are gradually expanding their vision of NGOs from mere contractors, or supplementary or complementary agents for the government, to respected

or valued partners in the design and implementation of all inclusive Medicare facilities for all the citizens of the country. Some NGOs provide successful example of sustainable model for the provision of comprehensive primary healthcare services, in which healthcare services are financed through private financing and cost recovery. Bangladesh is no exception in this regard. Bangladesh government has been trying to establish fruitful networks with the NGOs for smooth implementation of various nation building programmes.Hence, collaboration or partnership is needed to fully exploit the potential strengths of all the sectors towards fulfilling the health care needs of the people. It is always a challenging task for any developing country as usual. And, all these problems have a profound impact on the standard and quality of the human life, particularly for the poor.

It is a fact that ensuring *'Health for All'* is a gigantic task, and the central role in this regard lie with the government because of its legitimacy, constitutional obligation, revenue money, coercive power and public support in running the country. But, as a result of the changing geo-political situation over the past few years, the interface between the government and the NGOs has increasingly been playing a vital complementary role in bringing about positive changes in the healthcare sector of Bangladesh, and thus in achieving the Goals of MDGs and national targets as well.

 This study has mainly dealt with the assessment of the present condition of GO-NGO coordination in managing the health sector of Bangladesh as per the 'Health Policy— 2011'.And, to attain this objective, this study has attempted to find out the answers of (i) how far the existing GO-NGO collaboration is effective in managing the healthcare sector in the present condition of Bangladesh ?, (ii) what is the role of BRAC within the GO-NGO interface framework in running the health programmes in Bangladesh ?,and (iii) whether the

present state of GO-NGO coordination in healthcare sector management is supportive for achieving the policy-goals stated in the 'Health policy—2011'?

From this study, we can trace out some very successful GO-NGO partnership programmes between GOB and health sector NGOs which are also supportive to the policy-goals of the **Health policy-2011.** For example, the existing GOB and BRAC, the world-leader

Bangladeshi NGO, partnerships in TB-control, EPI, FP, and Maternal, Newborn and Child Survival Projects manifest the success stories of GO-NGO collaboration in health sector of Bangladesh.

To sum up, in order to ensure '*Health for All'* and achieve the goals of the MDGs, we do need proper and pragmatic initiatives to utilizing the potentials of both the sectors. A genuine partnership can be developed between the GO and NGOs on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to be recognized that collaboration is a long-term affair and it needs to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits. The need for such collaboration to a great extent is supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large.

LIST OF FIGURES AND TABLES

ACRONYMS AND ABBREVIATIONS

ADB	Asian Development Bank
AHI	Assistant Health Inspector
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BDHS	Bangladesh Demografic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CC	Community Clinic
C-EmOC	Comprehensive Emergency Obstetric Care
CSBA	Community skilled Birth Attendant
DGHS	Director General Health Services
DGFP	Director General Family Planning
DOTS	Directly Observed Treatment Short Course
DP	Donor Partner
EMOC	Emergency Medical Obstetric Care
ENC	Essential Newborn Care
EOC	Emergency Obstetric Care

EPI	Expanded Programme on Immunization
FP	Family Planning
FWV	Family Welfare Visitor
FWA	Family Welfare assiatant
GO	Government Organization
GOB	Government of Bangladesh
HA	Health Assistant
HFWC	Health and Family welfare Centre
HI	Health Inspector
HNPSP	Health,Nutrition and Population Sector Programme
HPDSP	Health,Population development Sector Programme
HPNDSP	Health,population,Nutrition development Sector programme
HPNSSP	Health,Population,Nutrition Sector Strategy Programme
HPSP	Health and Population Sector Programme
HR	Human Resources

IMNCS	Improving Maternal,Neonatal and Child survival
	Low Birth weight
LBA	Maternal and Child Health
MCH	Mother and Child Welfare Centre
MCWC	Millennium Development Goal
MDG	Ministry of Health and Family Welfare
MoHFW	Maternal Mortality Rate
MMR	National AIDS/STD programme
NASP	Non-governmental Organization
NGOs	Newborn Health Worker
NHW	Neonatal Mortality Rate
NMR	Non State Providers
NSP	National Tuberculosis control Programme
NTP	Primary Health Care
PHC	Postnatal Care
PNC	Public Private Partnership
PPP	Sub Assistant Community Medical Officer
SAMCO	Sector Wide Approach
SWAP	Trained Birth Attendant

TBA	Tuberculosis Bbacillus
TB	Total Fertility Rate
TFR	Upazila Familt Planning Officer
UFPO	Upazila Health Complex
UHC	Upazila Health and Family Planning Officer
UHFPO	Union Health Family Welfare Center
UHFWCS	United Nations International Children Emergency Fund
UNICEF	
	Urban Primary Health Care Project
	Union Sub Center
UPHCP	
	World Health Organizations
USC	
WHO	

Government–NGO Collaboration in Health Sector Management: An Evaluation of BRAC's Health Programme

CHAPTER 1

Setting and Background

1.1 Introduction

Bangladesh is a densely populated (152.5 million people presently living in only 1,47,570sq. km area) developing country with low per capita income ($848 only), all pervasive poverty, frequent natural disasters, almost regular man-made disasters, low literacy rate, and socio-political instability. But the most valuable asset of its citizens is their indomitable mental strength and resilience to overcome all odds that come in their way. In order to steer this invaluable resilience for achieving the long cherished dream of developed-Bangladesh, it needs a favorable socio-economic and politico-administrative environment and good governance at all levels in every sector. Unfortunately, now-a-days Bangladesh Government is unable to produce adequate and quality public goods and services efficiently as per the citizens' expectations due to resource constraints and overall overall governance scenario in the country. The basic needs fulfillment of all the citizens of the country is yet to achieve. Still more than 30 percent people live below the poverty line, the literacy rate is not up to the satisfactory level, near about half of the people are out of the reach of the Government's healthcare facilities till today. In this context, there is still a long way to go for ensuring quality health-care facilities for all citizens of the country.

1.2 Background

Now-a-days no Government even in the developing world is in a position to run the country efficiently and effectively by doing everything, i.e. operating all service sectors; running trade and commerce; industries and so on. And, this is why governments are switching over to the role of regulators and facilitators from their earlier role of operators and managers for producing better public goods and services, and in this way they are trying to satisfy the needs of the citizens. Bangladesh is no exception in this regard.

Governance is now a shared endeavor between the Government, private sector, NGOs/ CSOs and citizens in which each sector has its own comparative advantages and fulfills roles that are most appropriate to it. In this multi-sector governance regime, each sector specializes in what it does best without detracting from the government's role as a guarantor of social justice and well-being of the people. The government needs to constantly explore the best means to achieve its ultimate goal of ensuring the basic needs of its citizens with a view to fulfill its obligations and responsibilities to the citizens, Bangladesh Government has been trying to establish fruitful collaboration with the NGOs for smooth implementation of various nation building programmes. At present, Government of Bangladesh has been implementing some health-sector programmes in collaboration with some 300 NGOs (Talukder et al., 2008: 45.) Among them, BRAC is in the leading role as far as total coverage and performance are concerned. Some of the NGOs are in fact playing pro-active roles in the promotion of health, sanitation, and population control activities. These NGOs has been implementing innovative programmes, such as community healthcare project, maternal and child health, family planning service delivery programmes, communicable diseases, HIV and AIDS programmes, TB-control, Malaria control, Eye-care Intervention project, Reproductive Healthcare, Nutrition, doorstep services through female service providers, installation of water-sealed sanitary latrines and arsenic-free tube wells, Health Insurance scheme and cost recovery scheme and so on.

In the face of declining economic conditions, budget constraints and shrinking expenditures in social sectors, governments in developing countries are turning to the private and non-profit sectors as potential partners in healthcare delivery. Over the last two decades, the growing trends of decentralization of the health systems and the increasing importance of the private sector in expanding the access, coverage, quality, and sustainability of health sector services have resulted in an expanded service delivery role for NGOs in many developing countries. NGOs, specially the non-profit ones, often operate successfully and at low cost, offering a 'service perceived to be of higher quality' and achieving acceptable levels of medical care. In general, NGOs and private sector are involved to act as supplementary or complementary agents for the government at the

local level. Governments in developing countries are gradually expanding their vision of NGOs from mere contractors, or supplementary or complementary agents for the government, to respected or valued partners in the design and implementation of all inclusive Medicare facilities for all the citizens of the country. For example, BRAC, the leading NGO in Bangladesh, started providing public healthcare in 1972 with an initial focus on curative care through paramedics and a self-financing health insurance scheme. The programme went on to offer integrated health care services, its key achievements including the reduction of child mortality rates through campaign for oral rehydration in the 1980s and taking immunization from 2 percent to 70 percent in Bangladesh. BRAC currently provides a range of services that reach more than 31 million rural poor and include services for mothers in reproductive health care and infants. In Bangladesh, 78 percent of births occur in the home. BRAC has implemented a program in which midwives are trained to work in the homes of women to ensure that births are as risk-free as possible. As on December 2012, 1,00000 community health volunteers and 58,000 health workers have been trained and mobilized by BRAC to deliver door-to-door healthcare services to the rural poor. It has established 37 static health centres and two Limb and Brace Fitting Centres that provide low cost devices and services for the physically disabled (BRAC, 2012). Just after the Liberation War of Bangladesh, when the new government was not in a position to provide the health care and other essential facilities to all the citizens because of its economic disability, BRAC emerged as a voluntary humanitarian organization to provide health related services to the nation. In response to the continuing burden of disease and illness within the populace, health components were incorporated into BRAC's development interventions commencing in the early 1970s to promote community level healthcare services and health education programs. BRAC's healthcare programs outlined that low cost, low-key and simple technology integrated within a development context could generate similar results in comparison to high cost, sophisticated intensive methods. This ideology towards a sustainable health care system through active community participation has remained constant throughout BRAC's continuing health interventions.

BRAC's Health Program combines promotive, preventive, curative, rehabilitative healthcare. It focuses on improving maternal, neonatal and child health, combating

communicable diseases and common health problems. BRAC's Health Program is the result of an integrated approach, including several interventions to provide a health service that supports human development and works in partnership with its comprehensive approach to development. The key areas of the program are: essential health care; tuberculosis and malaria control; maternal, neonatal and child health; family planning; immunization; health facilities and limb and brace center.

BRAC has adopted an epidemiology-experimentation-expansion evaluation model to develop and deliver the program. Lessons learned from own experiences in public health, like the bare-foot doctors of the 1970s, Oral Therapy Extension and Child Survival programs in 1980s, Women's Health, Reproductive Health and Disease Control programmes in 1990s, have enabled BRAC to expand sustainable and accessible health care to more that 100 million people across Bangladesh. BRAC also collaborate on national projects such as Vitamin-A supplementation and family planning initiatives.

By choosing health volunteers, or *Shasthya Shebikas*, from BRAC's own Village Organizations (VOs), BRAC is making effective use of resources and is able to ensure sustainability unlike other programmes in the health sector. Volunteers receive basic training and provide door-to-door health education, treat basic illness, refer patients to health centers and provide essential health items and medicines; which contribute towards an income for the volunteer. BRAC's *Shasthya Shebika* (SS)s are assessed and monitored by Shasthya Kormi(SK)s who are paid a monthly salary to supervise 10-12 SSs. SKs conduct monthly health forums and provide antenatal and postnatal care. Around 7,000 SKs are supervised by Program Organizers who are supervised by the Upazila and District Managers. Medical Officers provide overall technical supervision whilst SKs are supported by a team of public health professionals (BRAC, 2010).

The **Health Policy-2011** of the Government of Bangladesh has also opened the avenues of GO-NGO collaboration in health sector management of Bangladesh. It has 15 objectives, 10 policy principles and 32 strategies. Among them the followings advocate in favour of NGOs and Private Sector integration in implementation of the health policy. The Objectives of the Policy are:

1. To make necessary basic medical utilities reach people of all strata as per Section 15 (A) of the Bangladesh Constitution, and develop the health and nutrition status of the people as per Section 18(A) of the Bangladesh Constitution.

2. To develop a system to ensure easy and sustained availability of health services for the people, especially communities in both rural and urban areas.

3. To reduce the intensity of malnutrition, especially among children and mothers; and implement effective and integrated programs for improving nutrition status of all segments of the population.

4. To undertake programs for reducing the rates of child and maternal mortality within the next 5 years and reduce these rates to acceptable levels.

5. To adopt satisfactory measures for ensuring improved maternal and child health at the union level and install facilities for safe and clean child delivery in each village.

6. To formulate specific policies for medical colleges and private clinics, and to introduce appropriate laws and regulations for the control and management of such institutions including maintenance of service quality.

7. To explore ways to make the family planning program more acceptable, easily available and effective among the extremely poor and low-income communities.

Principles

1. To create awareness among and enable every citizen of Bangladesh irrespective of cast, creed, religion, income and gender, and especially children and women, in any geographical region of the country, through media publicity, to obtain health, nutrition and reproductive health services on the basis of social justice and equality through ensuring everyone's constitutional rights.

2. To make essential primary health care services reach every citizen in all geographical regions within Bangladesh.

3. To ensure equal distribution and optimum usage of available resources to solve urgent health-related problems with focus on the disadvantaged, the poor and unemployed persons.

4. To facilitate and assist in collaborative efforts between the government and the non-government agencies to ensure effective provision of health services to all.

5. To ensure the availability of birth control supplies through integration, expansion and strengthening of family planning activities.

6. To establish self-reliance and self-sufficiency in the health sector by implementing the primary health care and the essential service package, in order to fulfill the aspirations of the people for their overall sound health and access to reproductive health care.

Strategies

In keeping with goals, objectives and principles, the following strategies were adopted:

1. Obtain mass-scale consensus and commitment to socio-economic, social and political development to facilitate appropriate implementation of the Health Policy.

2. Prevent diseases and promote health to achieve the basic objective of "Health for All". The Health Policy focuses on provision of the best possible health facilities to as many as possible using cost-effective methods, and will thus ensure effective application of the available curative and rehabilitative services.

3. Adopt PHC as the major component of the National Health Policy in order to ensure delivery of cost-effective health services.PHC is the universally recognized methodology to provide health services.

4. Integrate the community and the local government with the health service system at all levels.

5. Provide need-based, people-oriented, updated medical education and training.

6. Disseminate information on health education through incorporating the community leaders   and other departments/organizations of the government in the health system.

7. Encourage NGOs and Private Sector to perform a complementary role to the public sector.

<div align="right">(Wikipedia, accessed on 26/12/2012)</div>

1.3 Objective of the Study

The overall objective of this study is to assess the present condition of the GO-NGO coordination in managing the health sector in Bangladesh as per **'Health Policy—2011'**.

1.4 Research Questions

To achieve the objective, this study will attempt to find out the answers of the following questions:

a) What is the state of GO-NGO collaboration in managing the health sector in the context of Bangladesh?

b) What is the role of BRAC within the GO-NGO interface framework in running health programmes?

c) Whether the present state of GO-NGO coordination in health sector management is supportive for achieving the policy-goals stated in the 'Health Policy—2011'?

1.5 Justification of the Study

In any sovereign state, it is the responsibility of the Government to assure health care provision for the total population. But the public health agenda has become so large that the governments of most countries have been unable to provide adequate healthcare for all. This has expedited the organizations outside the government to assume part of that responsibility. In fact, lack of proper response on the part of the public sector to meet the hopes, desires and aspirations of the poor of the society can be indentified as one of the main reasons for the emergence and growth of NGOs in Bangladesh. Thus in the present socio-economic context of Bangladesh, NGOs have earned a significantly firm position and have played a catalytic role towards national development. In Bangladesh, the NGO

sector can influence the mainstream of development through collaboration with official bodies. Greater collaboration can be beneficial to both the parties. Given the rich experiences of the NGOs in Bangladesh, it is difficult to ignore the role of NGOs in development management especially in a critical sector like health and family planning. Realizing the potentials of NGO sector, there is a growing recognition by government and international organizations that involvement of all stakeholders is needed if health services are to effectively reach the poor. Furthermore, continued partnerships between donors and NGOs have created a window of opportunity for GO-NGO collaboration. Working in isolation can result in duplication of efforts and failure to accomplish health goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of information. Moreover, it is a must to establish a vibrant and effective networked-governance in the health care sector of the country to achieve the related goals of the much-talked MDGs within the stipulated time frame and bring about the desired qualitative change in the country's healthcare sector.

In the case of Bangladesh, BRAC's Health Program combines promotive, preventive, curative, rehabilitative healthcare. It focuses on improving maternal, neonatal and child health, combating communicable diseases and common health problems. BRAC's Health Program is the result of an integrated approach, including several interventions to provide a health service that supports human development and works in partnership with its comprehensive approach to development. Since BRAC's healthcare programs outlined the low cost, low-key and simple technology integrated within a development context could generate similar results in comparison to high cost, sophisticated intensive methods, it can be of great importance for studying and replicating the model for establishing a sustainable health care system in Bangladesh. That is what this study will try to do.

1.6 Limitations of the Study

The study was a part of the Masters in Governance and Development (MAGD) Programme. Within the limited timeframe allocation of time for research was not enough. As there was a time constraints, comments and views of relevant scholars,

bureaucrats, and development-workers could not be incorporated. Apart from the 'Focus Group Discussion' and 'Case Study' methods, mainly secondary sources are used to complete the research. In terms of secondary data scarcity of extensive academic materials and meager government documentation on the topic were drawbacks. Thus this study is qualitative in nature and it hardly utilizes quantitative data.

1.7 Methodology

This study aims at explaining the existing practical situation of the GO-NGO interface in managing health sector of Bangladesh. For the purpose of the study no single methodology will suffice to respond to the research need rather a combination of methods will be of useful for bringing desired level of methodological sophistication. This is why the methodological framework with which the study will be conducted includes the primary as well as secondary sources. Accordingly the following three methods will be used here:

a) Content analysis
b) Focus group discussion
c) Case-study

The methodology will largely be used in this study is based on secondary data through content analysis from reports, reviews, books, journals, existing policy and practices. The primary data will mainly be relied on the focus group discussions with the stake-holders. These responses will be the main sources of primary findings. There will also be some pictures of real life experiences which would be unearthed during the survey in the form of cases to validate the study by exposing the ground reality of the health sector of Bangladesh.

1.8 Plan of Study and Structure

After this introductory chapter which contains the background of the study, the second chapter gives an overview of the healthcare sector of Bangladesh; after this introductory chapter which contains the background of the study, the second chapter gives an

overview of the healthcare sector of Bangladesh; third chapter discusses the concept of GO-NGO Collaboration and its application in the health sector of Bangladesh; wherein a literature review clarifies the very concept with all its facets. BRAC's contribution in the healthcare sector has been discussed in the fourth chapter; the fifth chapter deals with the analysis of the findings, and the concluding chapter presents the recommendations and the policy options.

CHAPTER 2

An Overview of Healthcare Sector of Bangladesh

2.1 Introduction

Health is an essential component of individual and societal livelihood. The overall situation in health and population sector in the developing countries is alarming.To meet the health care needs of the people is one of the main preconditions for building a developed nationhood. As a developing country, the limited resources and inefficiencies of the public and private sectors, close collaboration can be an effective solution to address the ever increasing public health problems in Bangladesh. Collaboration or partnership is needed to fully exploit the potential strengths of all the sectors towards fulfilling the health care needs of the people. It is always a challenging task for any developing country as usual. It is a fact that most of the world diseases falls to the developing countries, and adding considerably to the national problems. All these problems have a profound impact on the standard and quality of the human life, particularly for the poor. There continues to be significant disparities in the health status of various sub-groups of population of developing countries. For the future, public health concerns are advancing a more complex set of problems and interventions. These includes meeting social and reproductive health needs of women and men, addressing the needs of the children, adolescents and older population, and the increasing demands for care and prevention of HIV and AIDS. Moreover, the health and epidemiological transitions continue their advance and will place new demands on health system in countries at all levels of development. These demands may appear more acute in developing countries, because the health systems in most of these countries are not in the state to efficiently deal with these demands. Inadequate financing, poor quality of services, lack of efficiency and inappropriate equity measures are the major problems of the health systems in developing countries. The quality, quantity and balance of human resources for health care are important concerns too. To improve the functioning of the health sector, various reform initiatives are required. Among the world-wide prevalent health sector reform initiatives, Government and NGO interface or public-private partnership is the most effective and encouraging one. Now-a-days, NGOs are considered by development thinkers, researchers and practitioners as a new as well as efficient actor

to achieve the goals of development (Korten 1988,1991; Paul 1991; Farrington and Babington 1993).The NGOs of the third world are identified as alternative development agent(Garilao1987).They call the NGO sector as "growth sector"(Brodhead 1987).Gradually the NGOs have been achieving the worldwide recognition of their contribution towards development. Governments of the developing countries are also aware of what the NGOs can contribute to national development. At the very same time, the NGOs are also realizing the fact that in order to scale up their activities at the national level there is no alternative but to involve the government. Both the limitations and strengths of the public sector and NGO sector bring an opportunity for GO-NGO collaboration, because balanced development is a complex undertaking that cannot be achieved by any single sector. Collaboration or partnership across sectors is an attractive means of using the special capacities of different sectors in development (Brown and Korten 1991). Since 1990s, growth of a new ideological discourse has witnessed the flowering of the idea that public and private sectors should work together for better service delivery. International bodies now advocate 'public-private partnerships' (PPPs) as the policy innovation of recent times and are 'actively lobbying to have partnerships be accepted as the way forward' (HAI 2000). Although the dynamics of public-private partnership arrangements are generic across social sectors, international literature has been persistently emphasizing on country specific study on partnership to gain more insights, to know more about its effectiveness and to mitigate the challenges of partnership.). In the same fashion, there exist varieties of models of public-private partnerships in health care sector in Bangladesh. Some of them have produced highly encouraging results and some are challenging.

Government of Bangladesh (GOB) has been pushing for public-private partnership in health service delivery since 1980s (GOB 1985).The health care system of Bangladesh is a mix of public and private initiative. In terms of physical infrastructure, public sector is stronger than the private sector although in terms of coverage, the health care system of the country should be termed a privatized one (Osman 2004).Although public health services aim to make health care accessible and affordable for the poor and marginalized, it has largely failed to do so. On the other hand, high out of pocket expenditure and unpredictable quality of care by the private sector has limited access to health services

for the poor. Non-Government Organizations (NGOs) have emerged as an effective option to make health services accessible to the poor. To improve efficiency in the use of public funds and expand coverage of health services through utilizing the potentials of all the providers available, GOB during the two decades has opted for public-private partnerships. In particularly the health sector, public-private partnership has taken a variety of forms producing diverse results.

2.2 Primary Health Care

In recent years Primary Health Care (PHC) has emerged as the core strategy for providing health care to the public.PHC includes both preventive and service delivery aspects. The basic premise of PHC is that it must address all causes of poor health, not just specific diseases and injuries. The eight core elements of PHC are:

- Education about health problems and solutions
- Adequate food supply and nutrition
- Maternal and child care; reproductive health
- Immunization against major diseases
- Prevention and control of endemic diseases
- Treatment of common diseases and injuries
- Provision of essential drugs.   (Alam .2007).

So, PHC is an important component of the health sector programme. In Bangladesh providing PHC facilities at a cheap and accessible rate is a challenge to both state and Non State Providers (NSPs)/NGOs. Indeed PHC facilities in rural and urban areas are provided by both the state and NSPs/NGOs in Bangladesh.

2.3 The Context of Primary Health Care (PHC)

"The emphasis has to shift from showing immediate results from single interventions to creating Integrated, long-term, sustainable health systems, which can be built from a more selective primary health-care, start."

—Walley et al. (2008). *Lancet.*

The early years of independence of Bangladesh witnessed disarray in the public health care system due to the accumulated backlog in the aftermath of the Independence War. There was a lack of well developed policy package to serve rural and urban people alike.

In this period, state policy was mainly geared towards providing low cost and even some free health care services. During the late 1970s, attempts were made to reorganize health care services from a curative into a curative-preventative approach and also to redirect these services from the urban to the rural populations, from the privileged to the under-privileged, from vertical mass campaigns to a system of integrated health services and from the village level to the national level (Fakir 1987:27)

There is now growing recognition among politicians, government officials, health policy planners and members of civil society that health care services need to address ground level needs. The following are some of the related issues:

- Development of institutional mechanisms linking community level to the national levels.
- Understanding people's expectations of the health care delivery system
- Recognition of the existence of parallel "traditional' and "modern "systems of healthcare, raising the question how they can be made complementary.
- Along with state provision there are a large number of non state providers/NGOs, again raising the question how these can be made complementary.
- Discovering a mechanism to make existing systems accessible and affordable to the poor.

2.4 Types of Health Service Provider

Bangladesh is the most densely populated country in the world with a population of approximately 160 million people in a geographical boundary of only 1, 47,570 sq.km, 31 percent of whom are living in poverty (HIES 2010). Now-a-days both state and non-state providers/NGOs are providing health service both in the urban and rural areas. State provision includes services provided by hospitals, clinics, and other organizations managed and established by the state. These establishments are structured and managed through rules and regulations formulated by government. Health services are also delivered by a wide range of non state providers in Bangladesh, including: traditional healers, *palli daktar* (village doctor), private general practitioners, private hospitals both in the urban and semi urban areas, and NGOs providing both clinic based and outreach services.

2.5 The State's Role in the Health Sector

The state has always been the major provider of health services to the rural and urban areas before the emergence of NGOs in mid 1980s.These services are provided through a network from community to the national levels (Fakir 1987 and Bangladesh Health Watch 2006).

There are three tiers in the health administration of Bangladesh. The statutory responsibility for the health sector is vested in the Ministry of Health and Family Welfare (MoHFW) headed by a Minister. The ministry is responsible for policy formulation, decision-making, maintaining liaison with donors and other line ministries, and also looking after the activities of directorates and departments under its jurisdiction. The ministry has a Health Division and a Family Welfare Division, each headed by a director general (DG). DGs are responsible for health programmes and projects under the directorates. Below the DG, the Civil Surgeon is the team leader and chief of health services at the district level. The Upazila Health and Family planning Officer (UHFPO) is responsible for technical and administrative supervision of health and family planning activities at the Upazila level and constitutes the last tier in health administration. There are other two officers namely Deputy Director, Family Planning and Upazila Family Planning Officer (UFPO) who work in collaboration with the Civil Surgeon and the UHFPO in the district and Upazila levels respectively.

The Ministry of Health and Family Welfare (MoHFW), through its two wings ----Health Services and Family Planning—sets policies, develops implementation plans, and provides rural public health services. Since 1971, the health infrastructure has developed though not in a uniform pattern and despite policy shifts overtime. Under the Family Planning wing of the MoHFW, the number of Maternal and Child Welfare Centers has not increased but new services, such as caesarean-section surgery, have been integrated. The Health Services wing of the MoHFW has ensured that all district-level public-health facilities, e.g., district hospitals, and medical colleges, can provide comprehensive essential obstetric care(EOC) and have targeted to upgrade the rural Upazila Health Complexes to also provide such services. In 2001, they initiated a programme to train the

Government's community workers (Family Welfare Assistants and Female Health Assistants) to provide skilled birthing care in the home.

The Bangladesh National Strategy for Accelerated Poverty Reduction (NSAPR 2005) considers in particular the human dimensions of poverty (deprivation of health, education, nutrition, gender gaps) and commits the MoHFW to reach the poor and vulnerable, especially women and children. The Health and Population Sector Strategy (HPSS), which commenced in 1998, sets the stage to develop the Sector Wide Approach (SWAp) and for the development of the Health and Population Sector Programme (HPSP) which was to include reforms such as improved and more efficient service delivery by unifying the two wings, health and family planning (FP), under MoHFW. The current Health, Nutrition and Population Sector Program (HNPSP) outlines activities from 2003 to 2010, with objectives to improve health outcomes, reduce health inequities, enhance quality of care, modernize the GoB health sector, and the health related MDGs. The revised program Implementation Plan (RPIP) of Health, Nutrition and Population Sector Program(HNPSP) 2003-2010,proposed budget for the whole sector by dividing it into four sub-sectors: Health Program(HP),Nutrition Program, Population Program(PP) and Ministry Level Sector Development. Major Reproductive health (RH) components are under HP and PP (HNPSP 2005).

There are mainly four levels of health facilities in Bangladesh which are Primary Healthcare(UHC,UHFWC,USC and CCs),Secondary Healthcare(District hospitals),Tertiary Healthcare(Medical College Hospitals),and Super Specialized Care (Specialized Institutions).Under Health and Population Sector Program(HPSP),about 13,500 new community clinics, each for 6,000population,were supposed to be constructed. Currently near about 6708 CCs are functioning with Director General of Health Services (DGHS) Health Assistant (HA) and Director General of Family Planning (DGFP) family Welfare Assistant (FWA) and another 7156 CCs are handed over to NGOs. The HA and FWA are performing home visits and working from CCs (if operational) and providing family planning services ,maternal and child health care, including immunization, communicable disease control, symptomatic curative care for common complaints, and upward referrals(HNPSP 2005).

At union level there are 3622 Union health and family Welfare Centre (UHFWC) under DGFP and upgraded UHFWC (formerly called Union Sub-centres, USc under DGHS.UHFWC has one Sub-assistant Community Medical Officer(SACMO),one Family Welfare Visitor(FWV),one Pharmacist, one Aya and one MLSS. In the unions, where no UHFWC has been constructed, there is a post of FWV only (HNPSP 2005). The training of FWVs in FWV Training Institutes managed by NIPORT started in 1970s but unfortunately stopped since 1997.The termination of the training of FWVs is expected to have adverse effect on maternal and child health in Bangladesh as FWVs provide services to mainly rural women. Each of the 1275 upgraded UHFWCs has the posts of a Medical Officer, a Medical Assistant and a Pharmacist (HNPSP , 2005).

There are Upazila Health Complexes(UHCs) with 31-50 beds in almost all the Upazila headquarters and 60 Rural Health Centers (RHCs) with 10-20 beds in each facility, and providing both outpatient and inpatient care in Upazila level. On the health side there are nine doctors including one dental surgeon, nursing supervisor and senior and senior staff nurses, two Medical Assistants, Medical Technologists (pharmacy, radiology, dental) and an EPI technician along with other support staffs in each of the UHCs. The UHCs also have the post of Upazila Family Planning Officer (UFPO), Medical Officer (MCH), Assistant Family Planning Officer, Senior FWV and two FWVs on the family planning side.

There are 64 district Hospitals (DHs) which constitute the third layer on the health side in the country. DHs are larger facilities in comparison with UHC, with an average bed size of 133(range 48 to 375+). The districts also have maternal and child welfare centers (MCWCs) based in the district town which offer Comprehensive Emergency obstetric Care(C-EmOC) and clinical contraception run by DGFP.

The fourth layer of public health system includes Medical College Hospitals (MCHs0 and Post graduate Institutes and Hospitals. In Bangladesh there are also some specialized hospitals (child, dental, mental, leprosy, Infectious disease, chest diseases , etc.).

The vacant posts of MBBS doctors in the Upazila level hospitals have been creating serious problems in service delivery in the health care sector of Bangladesh. Moreover, the skilled health personnel, especially nurses and qualified medical technologists, is one

of the main challenges in the health sector of Bangladesh. The density of qualified providers, including doctors, dentists, and nurses, in the country is 7.7 per 10,000 population. The distribution of qualified providers is highly urban biased. There are 18.2 physicians,5.8 nurses and 0.8dentists per 10,000 population in urban area while the corresponding figures in rural area are1.1 , 0.8 ,and 0.08respectively.The data also show that the number of male physician per 10,000 population is five(5)times higher than the number of female physician per 10,000 population(BHW, 2007).

There are also high regional disparities in the distribution of physician, nurse and dentist in the country. The highest number of physician is concentrated in Dhaka division (10.8 per 10,000 populations) followed by Chittagong division (4.8 per 10,000 population).The availability of qualified provider is lowest in Barishal followed by Sylhet and Rajshahi (BHW 2007). There are also 65 nursing institutes, 45 run by the Government and 19 by private entrepreneurs, in the country offering three years Diploma in General Nursing and one year Diploma in Midwifery/ Orthopedic. There is one college of Nursing affiliated to the University of Dhaka offering two years Bachelor of Science Degree (BSc) in Nursing and Public Health Nursing (BHW 2007).More nursing colleges are under construction. The country spends 3.2 percent of GDP on health and the per capita health expenditure is $12 (NHA 2000).Detail analysis of health expenditure show that 46% spending is on drug retail outlets, 305 on curative care, and 11% on public health services. There is inequity in healthcare expenditure in Bangladesh. People belonging to the poorest income decile spend only 8% of health expenditure while the people from the richest income deciles spend more than 15% (NHA 2000).There are also regional disparities in MoHFW spending. The per capita spending is highest in Barisal division (Taka160) and lowest in Dhaka division (Taka113) (PER 2007).

Figure 1. Organogram of Directorate of Health Services: district level and below (2005) (CS=Caesarian section, EPI=Expanded Programme on Immunisation; TB=Tuberculosis
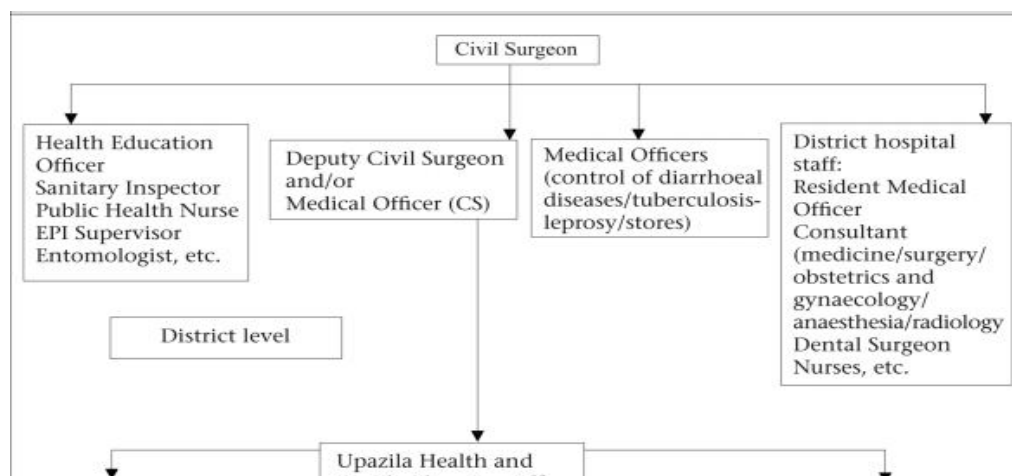
Figure 2. Organogram of Directorate of Family Planning: district level and below (2005)

(FWA=Family Welfare Assistant; FWV=Family Welfare Visitor; HFWC=Health and Family Welfare Center; MCH=Mother and child health; SACMO=Sub-Assistant Community Medical Officer)

Deputy Director

Assistant Director, Family Planning

Assistant Director, Clinical Contraception

Medical Officer, Clinical Contraception
Medical Officer, Clinic

District level

Assistant Upazila Family Planning Officer

Upazila Family Planning Officer

Medical Officer, MCH-Family Planning

Family Planning Inspector

Senior FWV

Upazila level
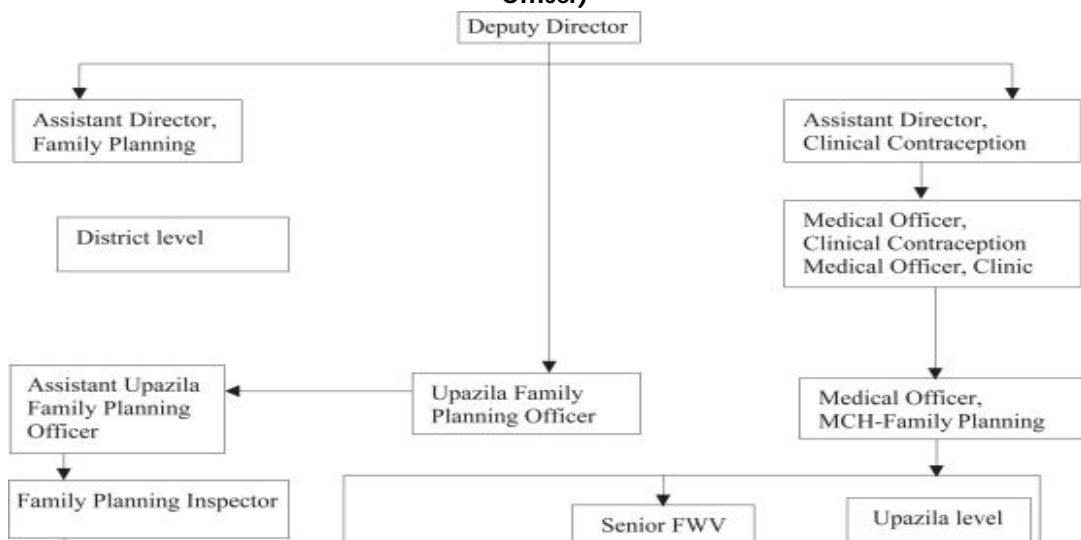
2.6 The National Health Policy (NHP)–2011: Scope of GO-NGO Collaboration

Bangladesh Health Policy was approved in 2011 and adheres to the following principles:

Health is defined as "*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*" (Source: WHO. Definition of health from WHO Constitution. http:// en.wikipedia.org/wiki/ Alma-Ata Declaration)

1. Every citizen has the basic right to adequate health care. The state and the government are constitutionally obliged to ensure health care for its citizens.

2. To ensure an effective health care system that responds to the need of a healthy nation, health policy provides the vision and mission for development.

3. Pursuit of such policy will fulfill the demands of the people of the country, while health service providers will be encouraged and inspired. People's physical well-being and free thought process have proved to be a precondition for the growth and intellectual enrichment in today's human society.

4. To integrate NGOs and the Private Sector, and plan for resource mobilization and utilization of funds.

5. Bangladesh expressed agreement on the following declarations:
   - The Alma Ata Declaration(1978)
   - The World Summit for Children(1990)
   - International Conference on Population Development(1994)
   - Beijing Women's Conference (1995)

The **'National Health Policy–2011'** of Bangladesh has 15 goals and objectives, 10 policy principles and 32 strategies.

Among them the followings advocate in favour of NGOs and Private Sector integration in implementation of the health policy.

Objectives

To make necessary basic medical utilities reach people of all strata as per Section15 (A) of the Bangladesh Constitution, and develop the health and nutrition status of the people as per Section 18(A) of the Bangladesh Constitution.

1. To develop a system to ensure easy and sustained availability of health services for the people, especially communities in both rural and urban areas.

2. To reduce the intensity of malnutrition, especially among children and mothers; and implement effective and integrated programs for improving nutrition status of all segments of the population.

3. To undertake programs for reducing the rates of child and maternal mortality within the next 5 years and reduce these rates to acceptable levels.

4. To adopt satisfactory measures for ensuring improved maternal and child health at the union level and install facilities for safe and clean child delivery in each village.

5. To formulate specific policies for medical colleges and private clinics, and to introduce appropriate laws and regulations for the control and management of such institutions including maintenance of service quality.

6. To explore ways to make the family planning program more acceptable, easily available and effective among the extremely poor and low-income communities.

(Wikipedia, accessed on 26/12/2012)

Principles

1. To create awareness among and enable every citizen of Bangladesh irrespective of cast, creed, religion, income and gender, and especially children and women, in any geographical region of the country, through media publicity, to obtain health, nutrition and reproductive health services on the basis of social justice and equality through ensuring everyone's constitutional rights.

2. To make essential primary health care services reach every citizen in all geographical regions within Bangladesh.

3. To ensure equal distribution and optimum usage of available resources to solve urgent health-related problems with focus on the disadvantaged, the poor and unemployed persons.

4. To facilitate and assist in collaborative efforts between the government and the non-government agencies to ensure effective provision of health services to all.

5. To ensure the availability of birth control supplies through integration, expansion and strengthening of family planning activities.

6. To establish self-reliance and self-sufficiency in the health sector by implementing the primary health care and the essential service package, in order to fulfill the aspirations of the people for their overall sound health and access to reproductive health care.

Strategies

In keeping with goals, objectives and principles, the following strategies were adopted:

1. Obtain mass-scale consensus and commitment to socio-economic, social and political development to facilitate appropriate implementation of the Health Policy.

2. Prevent diseases and promote health to achieve the basic objective of "Health for All". The Health Policy focuses on provision of the best possible health facilities to as many as possible using cost-effective methods, and will thus ensure effective application of the available curative and rehabilitative services.

3. Adopt PHC as the major component of the National Health Policy in order to ensure delivery of cost-effective health services. PHC is the universally recognized methodology to provide health services.

4. Ensure distribution of birth control supplies and improve the management of the domestic entrepreneurs.

5. Integrate the community and the local government with the health service system at all levels.

6. Provide need-based, people-oriented, updated medical education and training.

7. Emphasize nutrition and health education since they are the major forces of health and FP activities.

8. Disseminate information on health education through incorporating the community leaders and other departments/organizations of the government in the health system.

9. Encourage NGOs and Private Sector to perform a complementary role to the public sector.

<div align="right">(Wikipedia, accessed on 26/12/2012)</div>

2.7 Organizational Relationships and the Health Sector Reform

The notion that health systems, particularly those in low- and middle-income countries, are in urgent need of reform is now firmly entrenched. However two to three decades of health sector reform appear to have done little to improve the stated problems of health system effectiveness, efficiency and responsiveness. In developing countries, the package of suggested health sector reforms has generally included (Cassels 1995; Gilson and Mills 1996; Mills et al. 2001):

- organisational reform and restructuring (decentralisation, downsizing, introduction of performance related incentives, 'corporatisation');
- broadening health financing options (introduction of user fees, community financing or social health insurance);
- encouraging greater diversity and competition in health service provision (privatisation, establishment of public-private partnerships); and
- increasing the role of health service consumers (prioritisation of user choice, mechanisms to increase community accountability and participation).

In both developed and developing countries, health sector reform is usually part of a broader programme of public sector reform which has come to be known as New Public Management (NPM) (Mills et al. 2001). Minogue *et al* (2000) have defined the key themes of NPM as:

"The achievement of the objectives of economy and efficiency, in the context of relations between the state and the market, and an explicit emphasis upon the dominance of individual over collective preferences (pp 4-5**).**

Therefore, NPM reforms have focused on privatisation, the restructuring of public services, and the introduction of private market disciplines into public administration

(Minogue 2000). In sub-Saharan Africa and developing countries, NPM and the strengthening of civil society are presented as essential for the development of 'good governance' (World Bank 1989; Landell-Mills and Serageldin 1991).

2.8 Health System Relationships

Current perspectives seem to provide only simplistic and partial insights into the complicated social world of health systems. More complex, multi-disciplinary approaches are required to understanding the motivations of health workers and health managers and improve health system performance. Rather than relying on simplistic assumptions, this should be an important area of theoretical and empirical enquiry within health systems research. In this section we can focus on relationships in the health system which may be one way of interrogating different assumptions and taking the debate further. The intention is to develop a framework for multi-disciplinary enquiry and not to produce a grand unified theory. Current work on relationships is limited. Our initial framework simply focuses on categorising and characterising different types of relationships. An influential framework developed by Frenk (1994) defined the health system as a set of relationships among five major groups of actors: health care providers; the population; the state; resource generators; and other sectors. This outline is helpful but focuses more on the actors and functions than on different types of relationships.

More useful is a model provided by Newman (1998) which categorises public sector relationships into four key domains (Figure below):

- Service relationships: frontline interactions between providers (health care workers) and users (patients);
- Organisational relationships: relationships within the health service – interactions between managers and workers, between colleagues, or between different categories of health workers;
- Inter-organisational relationships: relationships with external organizations such as suppliers, private sector providers and non-governmental organisations (NGOs); and

  Political relationships: broader relationships between the government and citizens.

Figure 3: Relationship domains in the Health System

Drawn from (Newman 1998)
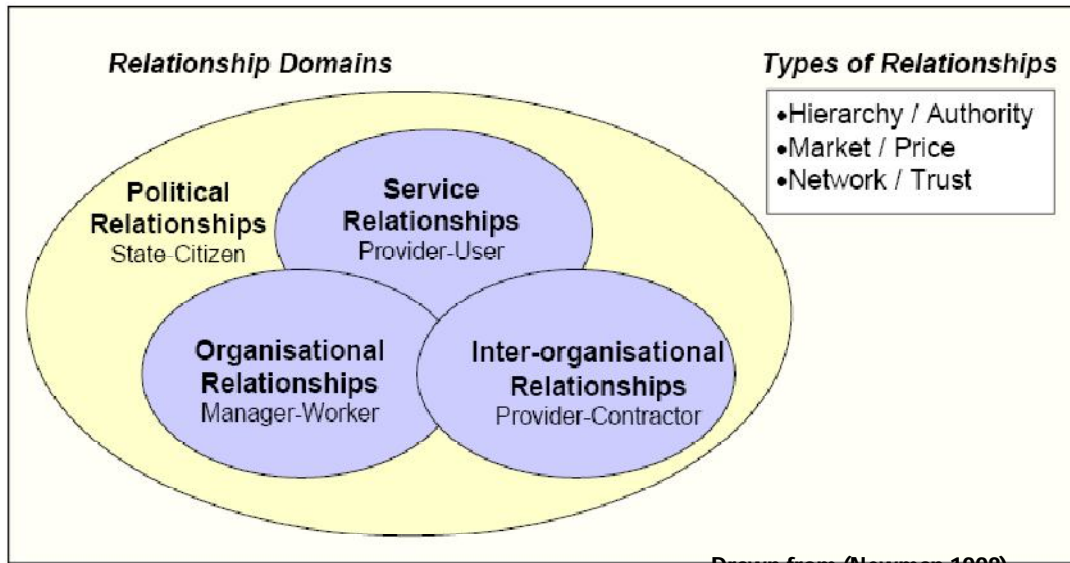
Overall public sector, or health service, performance is dependent on successful relationships in all of these areas. Importantly, the different domains are interconnected. By way of example, a clinic nurse's interaction with her patient is influenced by internal organisational dynamics such as the management style of her supervisor, or her relationships with her colleagues, as well as the relationships that the clinic has with community NGOs or local private practitioners, and the patient's general trust in government institutions.

2.9 Chapter Summary

In the face of declining economic conditions, budget constraints and shrinking expenditures in social sectors, governments in developing countries are turning to the private and non-profit sectors as potential partners in healthcare delivery. Over last two decades, the growing trends towards the decentralization of the health systems and the increasing importance of the private sector in expanding the access, coverage, quality, and sustainability of health sector services have resulted in an expanded service delivery role for NGOs in developing countries. NGOs, specially the non-profit ones, often operate successfully and at low cost, offering a 'service perceived to be of higher quality' and achieving acceptable levels of medical care. In general, NGOs and private sector are

involved to act as supplementary or complementary agents for the government at the local level. Governments in developing countries are gradually expanding their vision of NGOs from mere contractors, or supplementary or complementary agents for the government, to respected or valued partners in the design and implementation of all inclusive Medicare facilities for all the citizens of the country. Some NGOs provide successful example of sustainable model for the provision of comprehensive primary healthcare services, in which healthcare services are financed through private financing and cost recovery.

BRAC, the biggest NGO in the world, has been working in collaboration with GOB in the healthcare sector since the independence of Bangladesh. Moreover, Bangladesh government has already opened up the avenues for GO-NGO collaboration in the healthcare sector through framing fitting Health Policy in 2011.

The prime objective of the study is to assess the present condition of the GO-NGO collaboration in managing the health sector as per policy directives of 'Health Policy 2011', and BRAC's contribution in this sector.

CHAPTER 3

DIMENSIONS OF GO-NGO COLLABORATION

3.1 The Rise of NGOs

Lack of proper response on the part of the public sector to meet the hopes, desires and aspirations of the poor of the society has treated as one of the main reasons for the emergence and growth of NGOs in the developing countries. The significant role played by the NGOs in these countries can be explained through the "consumer control theory". This theory explains the existence of NGOs in terms of the patron-control, when the public and private sectors are unable to ensure the desired performance. Thus in the

present socio-economic context of the developing countries, NGOs have earned a significantly firm position and have played a catalytic role towards national development and the NGO sector can influence the mainstream of development through collaboration with official bodies. Greater collaboration can be beneficial to both the parties. Given the rich experiences of the NGOs, it is difficult to ignore the role of NGOs in development management especially in a critical sector like health and family planning. Realizing the potentials of NGO sector, Governments of the developing countries have initiated to undertake various programmes with NGOs. Donors also play an important role for GO-NGO collaboration. A healthy GO-NGO relationship can only be conceived where both parties share common objectives and strategies. With a view to utilizing the potentials of both the sectors, a genuine partnership can be developed between NGOs and the GO on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to be recognized that collaboration is a long-term affair and it need to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits.

The dearth in quality of human life, lack of proper response on the part of the public sector to meet the hopes, desires and aspirations of the poor of the society has treated as one of the main reasons for the emergence and growth of NGOs in Bangladesh. NGOs have earned a significantly firm position and have played a catalytic role towards national development. In Bangladesh, the NGO sector can influence the mainstream of development through collaboration with official bodies. Greater collaboration can be beneficial to both the parties. Given the rich experiences of the NGOs in Bangladesh, it is difficult to ignore the role of NGOs in development management especially in a critical sector like health and family planning. Realizing the potentials of NGO sector, Government of Bangladesh has initiated to undertake various programmes with NGOs .Donors play an important role for GO-NGO collaboration.GOB has engaged different NGOs in various sectors of national development.

NGOs are not a new phenomenon. Arguably, nongovernmental institutions probably predate governments in both form and function (Hodkinson 1989). What is new, however, is (a) the realization that there is a rapid and sustained growth in their numbers

across the globe (Fisher 1993; Edwards and Hulme 1996; Uvin 1996); (b) the recognition that they are becoming increasingly prominent in an ever growing number of areas (Drabek 1987; Clark 1991; Livernash 1992); and (c) their concurrent 'discovery' by scholars and international institutions (Brodhead 1987; Cernea 1988; Charlton and May 1995).

The 1990s has been quite a decade for the term **nongovernmental** organizations. The acronym 'NGO' has been elevated from a code-word used by a sizeable, but dispersed coterie of development practitioners, aid agency staff, and academics to a term that politicians and media-people around the world have become increasingly fond of. Scholars of the subject are basking in the glory of the sector as much as practitioners. Princen et al. (1995: 54), for example, inform us that "by supplementing, replacing, bypassing, and sometimes even substituting for traditional politics, NGOs are increasingly picking up where governmental action stops—or has yet to begin**."** Lester Salamon (1994: 109) chimes in with the proclamation that "a striking upsurge is underway around the globe in organized voluntary activity and the creation of private, nonprofit or nongovernmental organizations.... Indeed, we are in the midst of a global 'associational revolution' that may prove to be as significant to the latter twentieth century as the rise of the nation-state was to the latter nineteenth." Rosenau (1995: 23) goes even further to predict that "NGOs may serve as the basis for, or actually become, nascent forms of transnational governance." For most part, even those who tend not to be as enthusiastic as the above do agree that although "claims about NGOs' eclipsing the role of the state are exaggerated, but significant change is nonetheless taking place regarding their weight in world politics" (Gordenker and Weiss 1996: 26).

At the very same time, probing questions are being asked about NGO accountability and performance (Edwards and Hulme 1996; Najam 1996c). In fairness, most such concerns are not criticisms on the intrinsic nature of NGOs as much as concerns about whether idealism may not have gotten the better of pragmatism, and whether reality may not have been overextended by rhetoric. John Clark (1991: 52-53) provides a useful analysis of why so many people tend to be so unquestioningly enamored by the NGO phenomenon, when he points that : "...the bias is overwhelmingly pro-NGOs. After all it is

governments that we, the public, love to hate; non-government organizations can't be suspected. It is large bureaucracies we mistrust; small, voluntary organizations are our friends. It is the profit-motive that we find vulgar; altruism is noble." Moreover, he adds that much of what is written on the subject is written by those who "have an implicit faith in the 'NGO approach' which they don't want rocked. After all, one doesn't scrutinize magic too closely; otherwise it loses its charm."

3.2 A Definitional Note

Its definitional impoverishment stems from the fact that by insisting on using different terms to describe it, scholars and practitioners alike tend to focus on different aspects of its essence--very often at the cost of ignoring other aspects (Hodgkinson, 1989; Salamon 1992; Najam, 1996b). In all fairness, trying to define the sector is, at best, a confounding exercise (Douglas, 1987; Brown and Korten, 1991; Clark, 1991). The operational definition of the NGO sector adopted the broad institutional boundaries of voluntary associations which are entirely or largely independent of government and are not primarily motivated by commercial concerns. These organizations are principally motivated by the desire to articulate and actualize a particular social vision and operate in the realm of civil society through the shared normative values of their patrons, members and clients.

According to Najam (2000) the institutional landscape is understood as constituting three distinct sets of organizations—those of **the Prince**, **the Merchant**, and **the Citizen**. The first of these—**the state sector**—is primarily concerned with the preservation of social order; does so through its legitimate authority and coercive sanction from society; represents the interests of the majority (or dominant groups); and operates in the realm of the political system. The second—**the market sector**—is concerned with the production of goods and services; does so through mechanisms of negotiated economic exchange and profit maximization; represents individual self-interest; and operates in the realm of the market system. The third—**the voluntary associational sector**—is most concerned with the articulation and actualization of particular social visions; and it does so through the shared normative values of its patrons, members and clients; represents the interests of those who consider their interests marginalized, and operates in the realm of civil society. This conception is designed to be expansive and makes no distinction between organizations by size, geographic locale, financial base, or

substantive interest and would include industrialized as well as developing country groups.

3.3 NGO-Government Flirtations

As they make their way through the policy stream, the goals, interests, priorities, resources, and other policy paraphernalia of NGOs and of governments collide-- sometimes in harmony, sometimes in discord. It is a postulate of this paper that the nature and conditions of this interaction shape the NGO-government relationships that emerge. As their very nomenclatures flashes out, one can neither ignore nor camouflage the necessary tension that must exist between governmental and nongovernmental organizations as they float through the same policy stream. Even when they work in unison and demonstrate the friendliest of relations the tension remains palpable; when they don't, it becomes inescapable. This tension—sometimes latent, sometimes patent; sometimes constructive, sometimes destructive; but always present—is a defining feature of all NGO-government relations. Arguably, if it were to somehow disappear, it would only mean that at least one of the two has ceased to be what it essentially is.

This tension is our subject. The need to conceptualize it has become all the more urgent because—partly due to the increase in the sheer number of NGOs and partly because of governments' newfound desire to engage them--governments and NGOs are 'colliding' far more often in the policy stream than before; sometimes by intent, sometimes by default.

The Third Sector has an abiding interest in public policy. According to McCormick (1993: 142), "the fundamental objective of an NGO is to influence public policy from outside the formal structure of elected government." Hall (1987: 3), defines nonprofit organizations firmly as policy entrepreneurs, as "a body of individuals who associate for any of three purposes: (1) to perform public tasks that have been delegated to them by the state; (2) to perform public tasks for which there is a demand that neither the state nor for-profit organizations are willing to fulfill; or (3) to influence the direction of policy in the state, the for-profit sector or other nonprofit organizations."

Indeed, it can be defined NGOs as '***para-policy organizations***' on the basis of their principal normative characteristic being (a) the bringing together—in associations—of actors with shared normative values (b) for the purpose of actualizing particular social visions (Najam 1999). NGOs as para-policy organizations are not dissimilar to notions of nonprofits as semipublic institutions or 'third-party government' as used by Salamon (1987, 1994). Similarly, the work of Smith and Lipsky (1993: vii-viii) on the rise of public service contracting in the US strengthens this view of NGOs as policy entrepreneurs:

That government should be as central to the activities of the very group that self define itself as *non*governmental should not be a surprise. The 'non' in nongovernmental is as much a statement about what these organizations *are not* like in form, structure, vision and values as it is a statement about what they *are* most like in the issues and activities that motivates them. As James (1989: 290) points out "the semantics perhaps arise from the NGO's functional similarity to, and therefore need to differentiate itself from, the government." That they are, in themselves, not governmental is seen to be a badge of honor by most NGOs; this, however, does not imply that they are not interested in the government. Far from it, much of NGO action and aspiration—in developing as well as industrialized countries—can be boiled down to doing itself, or wanting the government to do, things that the government either (a) refuses to do, (b) does not do enough of, (c) is incapable of doing, or (d) is unable to do. Such reasoning can be linked back to theories about 'government failure' being the rationale for nonprofit organizations (Douglas 1987; Weisbrod 1988**).**

One of the most important insights from the recent literature on NGO-government relations is the global trend towards greater--and largely more cooperative--interaction between the two sectors. Salamon (1994: 120), for example, points out that contrary to popular opinion this relationship "has been characterized more by cooperation than conflict." This trend can be viewed as an expected corollary of increasing NGO presence in the policy domain. Indeed, it is *de facto* recognition of NGOs having come of age and being taken seriously by other, especially governmental, actors in the policy stream. Although the trend is obvious, it is not monolithic.

3.4 Towards Understanding NGO-Government Relations

Despite a now burgeoning literature on the subject, Lester Salamon's (1987) lament about the absence of a firm theoretical basis for government-nonprofit relations still rings true. Much of the literature still comprises of case descriptions rather than means to analyze, organize and explain the universe of cases. For most part, scholars have shied away from theory-building explorations into the nuances of NGO-government relations. Where such excursions are taken, the dominant approach is to focus either on the '*comparative advantage*' of the Third Sector (Cernea 1988; Weisbrod 1988; Clark 1991; Lindborg 1992) or simply on fears of threat to NGO autonomy by the coercive abilities of the state (Tandon 1989; Bratton 1990; Commuri 1995).

Because of the structural differences in the way the Government and the NGOs do business in Bangladesh, their respective advantages need to be exploited to their full potentials. NGOs are rated highly on their originality and creativity. They are criticized for their weak sustainability and their inability to scale up activities so as to make a significant dent to the enormous national problems. The Government, on the other hand, is criticized for being mechanistic and rigid. It is vulnerable to political capture or interests. Its strength is that it can influence large numbers of the population. It has been particularly effective in replicating successful projects, mounting nationwide campaigns and advocating special issues. Notable among these are oral rehydration, immunization, and the expansion of girl's education. Recognition and appreciation of the different approaches and skills required to accomplish common goals between Government and NGOs are important elements in the development of healthy GO-NGO relations. Some of the 'Comparative Advantages' of NGOs can be described as follows:

a) Targeted development: NGOs are able to concentrate on specific population groups (in particular, vulnerable groups) in specific geographic areas. This can lead to a particularly close relationship between the NGOs and the target groups;

b) Experimental and innovative approaches: Because of lighter bureaucracy and decision making structures, NGOs are often able to test new approaches and be creative.

c) Advocacy: NGOs can argue for a stronger poverty focus to the growth process.

More recently, however, efforts have been made to organize this literature into categories and typologies. For example, Seibel (1992) organizes the scholarship on NGO-government relations as emerging from three major perspectives: analyses of resource flows, of inter organizational interaction styles, and of comparative advantage. Jennifer Coston (1998) suggests an eight-point typology spectrum of relations that range from repression to rivalry to competition to contracting to third-party government to cooperation to complementarity to collaboration. Refreshingly, she does not lump the entire NGO or government sector in any given society into one homogonous blob and recognizes that "governments are not monolithic: regimes of all types may incorporate agencies and actors that are more cooperative or repressive than the overall regime" (p. 363).

For most part, scholars have tended to look at NGO-government relations only from the perspective of one of the two sides. Clark (1991: 75), for example, notes that NGOs have only three options: "They can oppose the state, complement it, or reform it—but they cannot ignore it." Others focus on the other side of the coin, i.e. governmental attitudes towards NGOs. Commuri (1995) suggests a continuum of governmental attitudes ranging from supportive, to facilitative, to neutral, to regulative, to repressive. Fisher (1998) provides a more nuanced model that ranges from government repression of NGOs, to ignoring them, to co-opting them, to taking advantage of them without trying to take control, to being genuinely collaborative and indulging in an autonomous partnership.

There exist some mutual concerns between the Government and the NGOs which can be delineated as the following:

Government thinks NGOs
- lack accountability
- practice insufficient inter-NGO coordination
- spend too much money on their operations
- rely too much on foreign funds
- exclusion of the extreme poor
- fragmented coverage

- too few bridges with the rest of the community

NGOs think Government

- is rigid, bureaucratic and tries to over-regulate NGO activities
- unnecessarily requires prior approval for foreign funded projects
- lacks appreciation about the differences in approach and style of NGOs' project management
- does not differentiate between NGOs with a proven record of performance and less-committed NGOs.

(Source:ADB,1992)

Dennis Young (1998 and 1999) is amongst the very few scholars who does look at both sides of the relationship. His simple but elegant model characterizes the relations between the two sectors as '***supplementary, complementary or adversarial***'. In acknowledging that the final shape of the relations is a function of decisions made by government as well as NGOs, he takes a major step beyond most of the literature.

The framework being proposed here for explaining different forms of relationships between NGOs and government is based on (a) the empirical findings of the case literature from around the world,(b) earlier scholarly attempts to classify and organize the learning from this literature, and (c) the conceptual construction of the nongovernmental sector and of the policy process as elaborated above. This framework is different from many earlier attempts in that it tries to do more than just codify the case evidence--which, although substantial, is far from complete--into the most intuitively obvious categories. It is conceptual, in that it derives directly from an explicit theoretical construction of nongovernmental organizations and of the policy process. It is distinct from the dominant strands of the literature is that it is based not on theories of comparative advantage, resource flows, or inter organizational interaction styles but on a theory of strategic institutional interests.

Stemming directly from the earlier definitional discussion is a view of governmental and nongovernmental organizations vying within the policy arena for the articulation and actualization of certain goals. On any given issue, these goals will either be similar or not. Each will also have certain preferences for the strategies, or means, they wish to employ in pursuing these goals. These, too, will sometimes be similar, and at other times not.

Essentially, the model boils down to a question of ends and means. Institutional actors—governmental and nongovernmental--each pursue certain ends (goals) and have a preference for certain means (strategies). Floating within the policy stream they bump into one another in one of four possible combinations: a) seeking similar ends with similar means; b) seeking dissimilar ends with dissimilar means; c) seeking similar ends but preferring dissimilar means; or d) preferring similar means but for dissimilar ends. Adil Najam's **Four C's Model**, depicted in Figure below, posits that these four combinations-- which correspond to (a) cooperation, (b) confrontation, (c) complementarity and (d) co-optation, respectively--encompass the realm of possible NGO-government relationships.

Figure 1:   The Four C's of NGO-Government Relations
             Goals (Ends)

		Similar	Dissimilar
Preferred Strategies (Means)	Similar	Cooperation	Co-optation
	Dissimilar	Complementarity	Confrontation

Figure 4.   Najam's 4 C's Model

Cooperation

A **cooperative** relationship is likely when, on a given issue, government agencies and nongovernmental organizations not only share similar policy goals but also prefer similar strategies for achieving them. Essentially, a convergence of preferred ends as well as means .

The literature tends to use a number of different words for what this model labels as NGO-government cooperation; 'collaboration' and 'coproduction' being just two of them. At a minimum, these entail an acceptance of institutional pluralism (Coston, 1998), common goals (Sanyal 1994), and shared norms, open communication, and some coordination of activities (Waddell 1998). Sometimes, however, the words are used very differently. Coston (1998), for example, considers 'cooperation' and 'collaboration' to be different forms of NGO-government relations. Cooperation is a much milder notion in her typology which merely requires that a) there is a free flow of information, b) NGOs follow

the government's rules, and c) government policy is neutral towards NGOs. Her distinction results from the importance she places on power symmetry and the assumed need to be somehow equally powerful and totally in agreement in order to be collaborative. Others, however, use a more relaxed definition. Waddell (1998: 7), for example, believes that "the popular meaning of collaboration emphasizes that although parties are working together, they have significant differences." Moreover, the dictionary definitions--collaboration as "to work jointly with others" and cooperation as "to act jointly with others"-- suggests that the distinction may be somewhat construed.

Najam's model does not consider perfect power symmetry between NGOs and government as a prerequisite for collaboration or cooperation. For this model, the issue of perfect power symmetry is less important than the absence of perceived threat--on the part of either NGOs or government--from the means or ends being pursued by the other. It is assumed that irrespective of power symmetry where both ends and means are in sync, cooperative behavior is likely since neither will consider its intentions or action to be under challenge.

Confrontation

A **confrontational** relationship is likely when governmental agencies and nongovernmental organizations consider each other's goals and strategies to be antithetical to their own. Essentially, total divergence of preferred ends as well as means.

Confrontational, or adversarial, relations between NGOs and government are repeatedly discussed in the literature. In fact, some tend to consider this to be the 'natural order of things.' While much recent work has argued against this general view (Smith and Lipsky 1993; Salamon and Anheier 1996; Opoku-Mensah 1997) it remains nonetheless true that governments and NGOs often find themselves in explicitly or implicitly adversarial relationships (Bebbington and Farrington 1993; Pearce, 1997). Governments possess, and are sometimes willing to use, their coercive powers for outright repression and harassment (Fisher 1998). At the same time, confrontational relations are also to be expected in those many situations where NGOs emerge precisely as forces of reaction or

resistance to particular governmental policies (Najam 1996b) or to press for policy change that is otherwise not forthcoming (Young 1998).

Najam's model defines ***confrontation*** as encompassing not just acts of coercive control by government but also policy defiance and opposition by NGOs. One can easily imagine examples of either as being legitimate or otherwise, since opposition is as much a defining feature of the nongovernmental sector as coercion is of the state apparatus. The important determination is not about which form of confrontation is 'just', but the proposition that wherever the preferred ends and means of the two are dissimilar, they are likely to feel threatened by the intentions and actions of the other; and, therefore, more likely to sink into confrontational behavior.

Complementarity

A **complementary** relationship is likely when governmental and nongovernmental organizations share similar goals but prefer different strategies. Essentially, divergent strategies but convergent goals.

Both Coston (1998) and Young (1998) identify complementarity as one of their categories. Young (1998:5) defines it as "a partnership or contractual relationship in which government finances public services and nonprofits deliver them." Coston (1998: 371) quotes Gronbjerg's (1987: 66) description of complementarity being similar to symbiosis, "coexisting to mutual advantage, sometimes to the point of mutual exploitation." However, both also restrict the concept to instances where the government pays and NGOs perform. In doing so, they implicitly define the relationship in terms of theories of comparative advantage (Weisbrod 1988; Clark, 1991) as well as resource flow (Kramer 1981; Salamon 1987).

Najam's model defines complementarity in differently. It rejects the simple one-way resource flow approach and instead also considers what Young (1998, 1999) calls, ***'supplementary'*** relations within complimentarity. In Young's conceptualization the difference between the two is that the resources in supplementary relationships do not come from government, while they do under complementarity. However, from the

perspective of our interest-based means-ends model what is being complemented is ends much more than means--because ends trump means; after all, the defining purpose for both NGOs and governments is not just the procurement of resources but the provision of services. This model defines complementarity as a function of ends, i.e., goals. It is postulated that where the goals of government and NGOs are similar, they are likely to gravitate towards an arrangement—either independently or contractually--where they complement each other in the achievement of a shared end, even through dissimilar means. Where the preferred means are also similar, complementarity will blossom into cooperation. As such, our conception of complementarity embraces the comparative advantage theory much more fully than resource flow explanations.

This notion of complementarity is most common in the service provision arena where NGOs, in developing as well as industrialized countries, move in to fill a function that might otherwise be expected of government but which government is unable or unwilling to perform (Douglas 1987; Weisbro, 1988).

Co-optation

A **co-optive** relationship is likely when governmental and nongovernmental organizations share similar strategies but prefer different goals. Such situations, based on divergent goals but convergent strategies, are essentially unstable and often transitory.

Co-optation is a strong theme in the literature that looks at developing countries (Tandon 1989; Bratton 1990; Commuri 1995; Pearce 1997; Fisher 1998). A word that is also used with similar frequency in this literature is '*catalyzing*'. Being a catalyst for change in society (including government) is presented as what NGOs do, and it is considered a universally positive attribute.

Within the context of the above mentioned conceptual framework, both can be classified as using a power asymmetry to change the preferences that others have about particular ends and means. NGO activists are no less desirous of converting government agencies to become more like them than government bureaucrats are of doing the same to NGOs. Arguably, there exists a positive face of co-optation; as a necessary feature in the tug-of

war of ideas in the policy marketplace. While the use of particular tactics may be questionable, influencing the views of other participants is an entirely legitimate goal. In fact, NGOs have been no less successful in their attempts to 'catalytically' influence government agencies, than the latter have been in 'co-opting' NGOs. Third Sector organizations have a long and illustrious record of influencing (i.e. co opting) government policy to reflect their interests (*see* Hall 1992; Bramble and Porter 1992; Sands 1992).

The postulate of Najam's model regarding co-optation is simply that those--relatively few, although not insignificant--situations where governmental and nongovernmental organizations seem to have similar preferences regarding means but dissimilar ends, are likely to be unstable and one or both parties will attempt to change the goals of the other. The relationship could linger into mutual manipulation, turn into outright confrontation, or one could become convinced that its ends are a sub-set of the ends of the other. The situation is unstable, or 'contrived', because it is the ends (which trump means) that are in conflict here. As each side tries to change the goal preference of the other the discomfort is likely to be directly proportional to the power asymmetry. It is the power asymmetry that will decide whether and which side gives in or gives up. But if, and when, that happens the instability would be resolved as the relationship moves to one of the other three boxes.

3.5 Focus on Strategic Institutional Interests within the GO-NGO relationship

It is important to stress that the above are *likely*, rather than *necessary*, conditions for each behavior. In reviewing the archetypes, all standard caveats about any exercise at this level of generality must be kept in mind. In building on the emerging consensus that the most important roles of NGOs—especially, but not solely, in policy—are institutional and political rather than economic (Cernea 1988; Brown and Korten 1991; Salamon 1994).Moreover, it argues in understanding confrontational, co-optive, complementary or cooperative NGO-government relations as a matter of strategic institutional choice and explaining them by diverging and converging institutional interests 0ne can likely to arrive at a more relevant and robust explanations. According to Adil Najam, the key feature of this **4-Cs** model is that it is based on a theory of strategic institutional interests. Beyond that, three key points are also particularly important.

First, the model does not take 'sides', in that it looks at the perspective of *both* NGOs and government in any given relationship rather than focusing unduly on the motivations of any one party. Implicit in many earlier conceptions, there is a strong assumption that it is the government which defines both the 'space' for NGO action and the nature of its relations with NGOs; and that the dominant tendency of government (except in the most democratic polities) is to feel threatened by NGOs and try to co-opt them (Fisher 1998; Biggs and Neame 1996). For example, Annis (1987: 132-3) argues that, "it may well be that wildflowers grow by themselves. But grassroots organizations do not. They are cultivated, in large measure, by just policies and competent government agencies that do their job." While Najam's model agrees that the attitude of government agencies towards the voluntary sector is extremely important, it stresses that even where government is the dominant and dominating institutional player, the ultimate nature of this relationship is a *strategic institutional decision* made by *both* the government and the NGOs in question. One party, often the NGO, may have fewer options to play with but it's very choice to stay in the game is, in itself, a conscious strategic decision. After all, when they choose to form a relationship—whatever it may be—both the government and the NGO are acting as consenting adults.

This is closely related to a second important point. This model is based on the premise that the NGO sector is certainly not monolithic, and nor is the government. On any given the issue, different agencies and actors within the same government can nurture different types of relationships with a given NGO, and vice versa. This is why in the very same polity one is liable to find various types of NGO-government relations. If the nature of the political context were, in fact, a strong explanatory factor then this variance in the nature of NGO-government relations would not have been as widespread. The same NGO may have a confrontational relationship with one state agency and a cooperative one with another. Similarly, different NGOs are likely to have different relationships with the same agency. This is not a weakness of the model, but a testimony to the heterogeneity of the two sectors that we are dealing with. Implicit in the construction of the model is the notion that NGO-government relations are best understood at the level of particular issues and organizations, instead of generalizations at the level of societies,

nations, or continents. Accepting the heterogeneity, resisting the temptation to paint the entire NGO sector or all parts of a government with one broad brush, and focusing on strategic institutional interests also helps us explain what Julie Fisher (1998) has called the '*schizophrenic*' nature of NGO-government relations.

Finally, there is the question of advocacy which is a critical issue in studies of NGO-government interaction (Clark 1991; Fisher 1995; Ritchie 1996). Without denying its importance, this **4-Cs** model refuses to accept advocacy as a '*relationship*' but views it as a '*function*'. Moreover, it is a function that NGOs are likely to undertake under different forms of relations with government. In fact, an NGO could undertake the advocacy function under any of the four types of relationships identified here. The nature of the advocacy function would obviously change depending upon whether it is undertaken within a cooperative relationship (in which case it is likely to be persuasive advocacy) or within a confrontational relationship (activist advocacy). The importance of advocacy notwithstanding, the key point is to clearly distinguish between advocacy as an NGO *function*--sometimes its defining function--and the four C's identified in this model as relationships.

As per Adil Najam's view, "this **Four C's Model** of government-third sector relations stems from the premise that organizations- -whether governmental or nongovernmental- -are driven not just by the grand schema of sectors and polities; but by the reality and rationality of their institutional interests and priorities. Scholars of the subject will do well to focus on this reality and rationality as they seek to decipher the complex relations between such organizations."

3.6 Government, NGOs and collaboration: definitions

In order to analyze the collaboration between the government and NGOs, it is important to define these three terms in the context of broad health care activities. The diversity of NGOs strains any simple definition. In wider usage, the term NGO is applied to any organization which is: (1) self-governing and independent from government, (2) not explicitly created for profit, and (3) has meaningful voluntary content (Green 1987; Mburu 1989; Smith 1989; Asian Development Bank 1999; Gomez-Jauregui 2004). For the purpose of this article, we conceive NGOs as those civil society organizations which

basically accord with all the above criteria and are providing health care in Bangladesh. The 'government' represents both central (e.g. Ministry of Health, Directorate General of Health Services) and local government (e.g. Districts, Municipalities) health authorities.

In order to conceptualize '***collaboration***', different terms are being used by the scholars to express the relationship between the government and NGOs. Green and Matthias (1997) have argued that relationships between organizations form a continuum of increased structure, decreased autonomy and intensified communication. The continuum starts with competition, progresses through cooperation to coordination and then on to collaboration, finally ending in control (Figure 5 below).

Figure 5. Competition-Control Continuum Model

Source: Green and Mathias (1997)
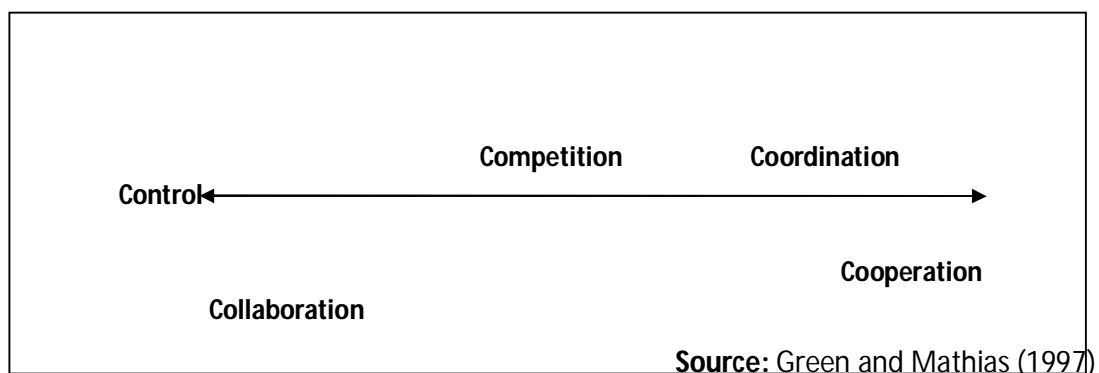
'***Competition***' is perhaps the easiest to conceptualize. Organizations compete with each other and there is almost no functional linkage and communication between them. '***Cooperation***' can be seen as a one-off relationship where organizations cooperate around certain issues or at certain times; although the organizations communicate with each other, they maintain almost complete autonomy (Green and Matthias 1997). Another view is a deliberate relationship between otherwise autonomous organizations for joint accomplishment of individual operating goals (Rogers and Whetten 1982). The World Health Organization referred to '***coordination***' as 'keeping each other informed' to avoid duplication of efforts (WHO 1999). It also represents an on-going and structured relationship between independent organizations for mutual benefit (Green and Matthias 1997), or 'a structure or process of concerted decision making or action wherein the decision or action of two or more organizations are made simultaneously in part or in

whole with the same deliberate degree of adjustment to each other' (Rogers and Whetten 1982). '**Collaboration**' is often described as 'joint activity' or 'working together', where two or more organizations work closely together and share resources and responsibility for common goals and purpose (Omondi et al. 1993; Green and Matthias 1997; Magagula et al. 1997; WHO 1999). It implies temporal accomplishment of jointly agreed tasks, where continued institutional linkage is not important (Bhattacharya and Ahmed 1995). Collaboration can take place at different stages and in different ways. It is increasingly recognized, however, that collaboration should not mean 'sub-contracting', but a genuine partnership between organizations based on mutual respect, and acceptance of the independence of the collaborating organizations concerning their vision and approaches (Korten 1988; UNFPA 1995; Magagula et al. 1997; Begum 2000). For this study, we have used the term 'collaboration' broadly to encompass cooperation and coordination. Finally, '**control**' is a relationship where one organization gains control over others (Green and Matthias 1997; Begum 2000).

Go-Ngo Collaboration In The Health Sector In Bangladesh

Since 1990s, an ideological growth has been occurred in the realm of the governing spheres of the developing countries that public and private sectors should work together. International bodies now-a-days advocate "public-private partnerships' (PPPs) as the policy innovation of recent time and 'actively lobbying to have partnership be accepted as the way forward' (HAI,2000).To face and overcome the challenges in the Health Sector, "public-private partnerships' (PPPs) can be the source of great help for a densely populated developing country like Bangladesh .

In the same way, because of scarcity of resources and inefficiencies of the public and private sectors, cooperation and collaboration can be a straightforward solution to address the growing public health problems in Bangladesh. Effective collaboration is required to exploit the strengths of all the sectors towards fulfilling the health needs of the people, which is always challenging. There exist varieties of models of public private partnerships (GO-NGO Collaborations/partnerships) in service delivery in Bangladesh. Although the dynamics of public-private partnership arrangements are generic across

social sectors, it would be wise and logical for emphasizing on country specific study on partnership to gain more insights, to know more about its effectiveness and to mitigate the challenges of collaboration and partnership.

Government of Bangladesh (GOB) has been in some sort of public-private partnership in health service delivery since 1980s (GOB 1985).The healthcare system of Bangladesh is a mix of public and private initiative. In terms of physical infrastructure, public sector is stronger than the private sector although in terms of coverage, the health care system of the country should be termed a privatized one(Osman 2004).Although public health services aim to make health care accessible and affordable for the poor and marginalized, it has largely failed to do so. On the other hand, high out of pocket expenditure and unpredictable quality of care by the private sector has limited access to health services for the poor. Non-Government Organizations (NGOs) have emerged as an effective option to make health services accessible to the poor. To improve efficiency in the use of public funds and expand coverage of health services through utilizing the potentials of all the providers available, GOB has opted for public-private partnership. In the health sector, public private partnership has taken a variety of forms producing diverse results.

Since the independence in 1971, the voluntary nongovernmental sector started working in the field of relief, rehabilitation, and in health care sectors. Over the years this sector has been flourishing in almost all the service and voluntary sectors. In the mean time, some sorts of partnerships have evolved between the GOB and the NGO sectors (see Table 1.).

Table 1.   Types of government-NGO relationships existing in Bangladesh

Types of relationships	Description of relationships
Competitive and parallel activities	• Activities in the public and private sectors are run within the same geographic area, targeting the same clients and competing for the same resources. This type of relationship is more applicable to those NGOs which depend on service charges for their sustainability. • GOB and NGOs carry out activities without any mutual contact or acknowledgement of each other's work. For example, some local NGOs and voluntary organizations are providing general healthcare services without any linkages with government services or programmes.
Coordination and complementary service provision	• The nature and types of services complement each other either by design or by coincidence. For example, community-based outreach and distribution of contraceptives carried out by NGOs contributed significantly to the success of national family planning programmes. Coordination through different committees and stakeholders meetings at various levels.

Coordination and complementary service provision	• In the health sector, NGOs work together with GOB in planning and implementing health programmes. Under the Health and Population Sector Programmes, NGOs are assigned to deliver ESP through an agreed contractual framework. For example, CARE-Bangladesh is collaborating with GOB to improve reproductive health services in four districts, and BRAC,DFB,HEED,NSDP and UPHCP are collaborating with the National TB Control Programme to implement DOTS in 259(56%) Upazilas and four metropolitan cities through a Memorandum of understanding signed in 1995.

Based on data from World Bank (1998); Asian Development Bank (1999); Perry (1999); UNICEF (1999); NTP (2002); Zafar Ullah (2002).

3.7 Government–NGO Collaboration – Common Ground and Differences

A number of studies have shown that the government and NGOs have common goals and vision with respect to social sector development, particularly in health and nutrition, poverty alleviation, human resources development, environmental protection, non-formal education and women's development (Perry 1999; Begum 2000; Ahmad 2001). However, the basic institutional approach to addressing the social and health problems is different between government and NGOs (Table 2).

Table 2. Differences in basic institutional approaches and structures between the GOB and NGOs in health sector

Area	Government	NGOs
Health, nutrition and sanitation concerns	Within policies and strategies of overall health development, for example, Health and Population Sector Strategy, National Health Policy.	Most NGOs focus on specific public health problems, geographic area and targeted population.
Resources	Capability to generate own resources plus donor assistance.	Mostly dependent on donations, contracts and donor funding.
Management	Guided by rules and regulations with limited scope for flexibility in operations.	Guided by organizational constitution but relatively simpler and more flexible.
Compliance and effectiveness	Although a centralized bureaucratic structure is in place, the quality of services depends on the nature of governance. Reform is in progress under the HPSP.	Effectiveness determined by ability to mobilize target groups at the grassroots level.

Compiled from UNICEF (1999), Asian Development Bank (1999), Begum (2000), WHO (2000 a.), Zafar Ullah (2002)and key stakeholders' discussions

3.8 Benefits and contributions of collaborating partners

To develop and sustain government–NGO collaboration, both government and NGOs must see considerable gain from it, and that if both stand to gain from the collaboration, they have much to contribute. Table 3 below summarizes the benefits gained and the contributions offered by each sector in a government–NGO partnerships.

Table 3. Benefits gained and contributions made by the agencies in government-NGO collaboration

	Government	NGOs
Benefits	• Better services to the people with higher coverage leading to improved health; • Re-allocation of funds to other priorities, especially for the poorest; • More opportunity and availability of tools and techniques for service delivery and research; • Change of attitudes and management style; learning from mutual strengths; • Programme efficiency improved; • Greater programme sustainability.	• Enhanced image to the community of responsiveness towards social and health issues; • Team motivation, shared risks and results; • Influence in national development agenda; • Publicity received from government-run media; • Higher visibility and credibility; • Competitive advantage gained.
Contribution	• Legitimacy/institutional support; • Facilitative regulatory mechanisms, less bureaucracy; • Resources channeling and resource allocation; • Grants and cash-flow mechanisms; • Best practices and global vision; • Access to public media networks.	• Management and marketing expertise; • Client-oriented services and product development; • Resources; • Helping sustainability and low-pricing of services; • Training facilities and expertise; • Community sensitization and awareness building.

Based on information from UNICEF (1999), Begum (2000), Zafar Ullah (2002);and discussion with the focused group members.

3.9 GO-NGO Partnership Models in Bangladesh

The existing GO-NGO relationships in Bangladesh has been maintaining, more or less the working process depicted in the following flow chart:

Figure 6: Functional Flow of Collaboration between GOB and NGOs

```
┌──────────────────┐      ┌──────────────┐      ┌──────────────────┐
│ 1. All kinds 0f  │ ◄─── │ 10. Preparing│ ◄─── │ 9. Analysis of   │
│ information       │      │ future plan  │      │ present situation│
│ collection by    │      │              │      │ through feedback │
│ both GO and NGO  │      └──────────────┘      └──────────────────┘
│ side             │                                      ▲
└──────────────────┘                                      │
        │                                       ┌──────────────────┐
        ▼                                       │ 8. Monitoring &  │
┌──────────────────┐                            │ evaluation of the│
│ 2. Jointly       │                            │ program in joint │
│ Situation        │                            │ meeting          │
│ analysis         │                            └──────────────────┘
└──────────────────┘                                      ▲
        │                                                 │
        ▼                                       ┌──────────────────┐
┌──────────────────┐                            │ 7. Joint         │
│ 3. Weakness of   │                            │ supervision      │
│ GOB  and NGO     │                            │ through field    │
│ programs are     │                            │ visits           │
│ identified       │                            └──────────────────┘
└──────────────────┘                                      ▲
        │                                                 │
        ▼                                       ┌──────────────────┐
┌──────────────────┐      ┌──────────────┐      │ 6. Helping each  │
│ 4. Planning      │      │ 5. Preparing │ ──►   │ other  to        │
│ meeting,         │ ──►  │ work plan    │       │ implement the    │
│ workshops etc.   │      └──────────────┘       │ project          │
│ with GO-NGO      │                             └──────────────────┘
│ staffs for       │
│ providing better │
│ service          │
└──────────────────┘
```

(Source: Begum 2000)

The above figure presents the working process of the existing collaboration model in healthcare sector of Bangladesh. For example, BRAC's ongoing TB-control and MNCH Programme.

3.10 Public Private Partnership: Conceptual Framework

Partnerships refer to public and private sector actors work together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, usually through the formation of a new joint entity for implementation (Ahmed 2000). It is a contract between two partners, where the public sector plays the stewardship and regulatory role and the private sector provides services under certain conditions.

Partnership has significant potentialities for achieving effective and efficient high quality health services. It aims to establish a functional integration and a sustained operation of a pluralistic health care delivery system by optimising the equitable use of the available resources and investing in comparative advantages of the partners. It ensures the utilization of the potentials of both the public and private sectors. Partnership between public and for-profit private sector is fostered to tap into resources and efficiency in management, while the non-profit private sector for technical expertise or outreach. Thus partnership is increasingly becoming essential as both the public and the private sector recognize their individual inabilities to address emerging public health issues. Research evidence also indicates that working in isolation can result in duplication of efforts and failure to accomplish health goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of information (Begum 2004).

To discuss public private partnership, defining or clarifying the partners is indispensable. The term 'public' refers to government including both central and local level state institutions. Defining private sector has become complicated due to the emergence of a large number of institutions called NGOs. The distinction between the private sector and NGOs is often blurred due to various sizes, functions and objectives of NGOs. The simplest way to distinguish between these two is: for-profit private sector encompassing commercial enterprises of any size and NGOs referring to not-for-profit private sector, which provides voluntary services. Thus for a broad and comprehensive analysis of the basic trends of functioning of the institutions in health service delivery, the study has grouped both the for-profit private sector, and non-profit NGOs under the term 'private sector'.

3.11 Mechanisms to involve NGOs in health sector programming

Within the perspective of government–NGO collaboration, several mechanisms or frameworks have been tried to involve NGOs in the health sector programmes. Due to the diversity of NGOs and their differing relationships with the government, these mechanisms have evolved over time (MOHFW 1998; World Bank 1996, 1998; Perry 1999; Begum 2000; Barkat and Islam 2001; MOHFW 2001; NTP 2002):

- **Networking and representation***: This is the simplest form of collaboration. NGOs participate in different taskforces and committees, especially under the Health and Population Sector Programme. NGOs also serve as effective linkages between the planners/ financiers of a project and its beneficiaries.

- **Contractual agreements**: Under this mechanism, government requests or assigns NGOs to undertake a specific task on its behalf. Usually, this is achieved through soliciting proposals or one-to-one negotiation. This is the commonest form of collaboration mechanism, and in general, GOB defines partnership as such. Examples include the Bangladesh Integrated Nutrition Project, and the Reproductive Health, Extended Programme of Immunization and TB/Leprosy programmes of the ESP under the Health and Population Sector Programme.

- **Patronage***: This form of collaboration evolves when one institution expresses interest in supporting another institution to strengthen its institutional capacity. Here they bind together to deliver some defined service, and also share ideas about common vision. This form of collaboration, though uncommon, has been practiced to some extent by the Ministry of Health and Family Welfare (MOHFW) in supporting NGOs for innovative programmes during the Fourth Population and Health Project (1992–98). Although it achieved high levels of success, it was discontinued during the Health and Population Sector Programme.

- **Partnering***: This requires the perception that each partner has something to contribute. Partnering implies sharing both risks and benefits, and its guiding principle is based on commitment to reciprocity, sovereignty and equity. Although this is rare in the Bangladesh health sector, some NGOs, such as BRAC, CARE-Bangladesh, Oxfam and CONCERN Bangladesh, are promoting this type of

partnership in their health and family planning programmes. Their health and family planning programmes.

3.12 NG*O* Involvement – Risks and Challenges

Despite the availability of evidence indicating government-NGO collaboration to be successful, there are still serious concerns over the continued involvement of NGOs in the health field. NGOs are not a homogeneous category. They differ from each other in terms of size, site, nature and characteristics, and their commitment towards the communities they serve. About 24000 NGOs are registered with the Department of Social Services and about 1300 NGOs are registered with the NGO Affairs Bureau. This heterogeneity of the NGOs has made the task of developing workable policies and mechanisms difficult (Barkat et al. 2000; Begum 2000; Neaz 2004).

Under the Health and Population Sector Programme the government recognized that client-centered provision of the ESP would require an effective sector-wide partnership with NGOs, but no clearly defined framework for collaboration has so far been developed. Moreover, the lack of government capacity (including technical capacity and manpower) to adequately manage the process of NGO involvement poses a big challenge.

One of the most noteworthy trends in Bangladesh is the increasing role of NGOs in economic and social activities, including health. More schools, health and economic (mainly micro-credit) programmes, and environmental services are now being managed by NGOs; while the government's conventional role has shrunk considerably. While the advantages of this paradigm shift are widely recognized, there is also recognition of the risk of further weakening government health care delivery and thus increasing the health care system's vulnerability to the changing priorities of NGOs and their donors.

3.13 Government–NGO Collaboration – Key Considerations

Based on the review and analyses of different government–NGO collaboration models in the health sector of Bangladesh, we identify certain essential preconditions which are critical to successful and sustainable collaboration between the government and NGOs (Begum 2000; WHO 2000; Barkat and Islam 2001). These are:

- mutual respect and trust;
- recognition of mutual strengths and values, and comparative advantages;
- favourable policies, laws and regulatory frameworks;
- effective mechanisms to monitor, measure and learn;
- transparency and accountability;
- involvement of all stakeholders at every step;
- continued commitment of collaborating partners.

3.14 Scope of NGO Participation in Healthcare Sector of Bangladesh

In most of the developing countries, health systems have also evolved upon the establishment inherited from the erstwhile colonial rulers. A central role of the state in health service provision, a strong bias towards curative and hospital services, and the development of powerful constituencies within the health sector characterize the health system in these countries (Mills, Bennet and Russell 2001).Interestingly, while each country after independence at least formally espoused a strong state role in health sector, attitudes towards the development of a private health sector varied among countries. In effect, in the colonial period private medical practice had not been discouraged, but a network of state services was gradually built up and the dominance of modern medicine was linked to that of the colonial power (Mills, Bennet, and Russell 2001).Bangladesh's case is not different in this regard.

As a newly independent country, Bangladesh also formally adopted a strong state role in the health sector and established National Health Service delivery system and also implemented various vertical primary health care interventions. After the Liberation War of 1971, the policy makers in Bangladesh faced many serious health problems. Infectious and parasitic diseases such as cholera, diarrhea, malaria, tuberculosis, skin diseases, polio, measles, and tetanus, and so on diseases were rampant. In a newly independent

war-torn country, widespread malnutrition associated with abject poverty led to weaken immune systems that further worsened the seriousness of illness. High fertility rates and shorter birth intervals endangers the health of both mothers and children in the country. At the national level, policy planners over the past four decades have responded, by funding and sometimes implementing immunization drives, pest-control activities and health education campaigns. In addition, some governments also implemented comprehensive family planning programs.

In the mid 1970s, Bangladesh adopted the policy of 'Health for All' through comprehensive primary health care as an equitable measure to ensure access to basic and preventive health care for the poor. Ensuring comprehensive primary health care continues to be an elusive and costly goal in Bangladesh. The concept of primary health care remains by and large well supported, but the actual achievements have been modest. It has been found that in about 30 years since Alma Ata Declaration, health reform has had a limited contribution to the realization of 'Health for All'—which still remains a distant goal.

Historically, health care systems in a developing country like Bangladesh suffer from serious deficiencies in financing, efficiency, equity, and quality. The quality, quantity and balance of human resources for health care are important concerns. In this context, reforms in health system service delivery to meet the current and emerging challenges in the health sector have been in progress in Bangladesh too. These reform initiatives include primary health care, sectoral finance, and organizational review, rationalizing the role of the private sector and non-governmental organizations (NGOs), resource mobilization, and making better use of available resources (Asian Development Bank 1994).

As far as Bangladesh's health sector is concerned, Sir Fazle Hasan Abed founded BRAC (Bangladesh Rural Advancement Committee) in 1972 in response to the acute needs of the millions of refugees who returned Bangladesh from India after the Liberation War. BRAC's mission was to improve the quality of life for the poor by working with the community. From its founding days, health care interventions have been an integral

aspect of BRAC's holistic and right based approach to development. BRAC has success stories with respect to promoting access of the poor to quality essential healthcare services, especially for women and children. BRAC's community based health care and population programme utilizes community volunteers, and makes use of community partnership in successful provision of the different elements of the ESP (Essential Service Package) over the decades. BRAC's health programme is a combination of preventive, curative, rehabilitative and promotional health services.

Since the Government of Bangladesh is not in a position to meet the growing health care needs of all of its citizens because of resource constraint, it requires active support from the private and non-governmental sectors. Several leading NGOs, namely BRAC, *Gono Shasthaya Kendra*, *Grameen Kalyan* have been working in collaboration with the Government of Bangladesh for a long time to meet the healthcare needs of the underprivileged people, and playing a complementary role in government service delivery system. These NGOs are also playing pro-active roles for the promotion of health services, especially for the rural poor. Both *Gono Shasthya Kendra* and *Grameen Kalyan* programs are successful examples of private financing and cost recovery to support essential health services. BRAC community health program has become a sustainable model for the provision of comprehensive primary health care services through fixed facility and doorstep services in rural areas. The health service delivery roles of three prominent Bangladeshi NGOs suggest that the government is gradually expanding their vision of NGOs from supplementary or complementary agents for the government to valued partners in the health sector.

The comparative advantages of NSPs/NGOs to government are said to be:
- NGOs have a base at grassroots level and have better knowledge of the community;
- NGOS have network all over the country to serve all segments of the population;
- NGOs have a large number of workers/ *karmis* with access to the remotest areas of the country;

- NGOs have developed good expertise in the delivery of PHC and also in certain other areas which include TB, leprosy, immunization, family planning etc;
- NGOs are innovative in linking health services with credit and other services;
- NGOs are effective in imparting training, developing Behavioural Change Communication(BCC) and IEC materials which have an impact on health service provision;
- NGOs are relatively efficient in the utilization of the funds;
- NGOs are more innovative in ensuring participation, gender equality and accountability;
- NGOs health service provision is less bureaucratic and efficient;
- NGO service are affordable and within the reach of the poor.

(Alam, 2007**).**

In fact, the necessity of the people and the efficiency of the NGOs in fulfilling them create the scope of NGO participation in the health care sector of Bangladesh.

3.15 Emergence of GO-NGO Interface in the Healthcare Sector of Bangladesh

From the mid 1970s the NSPs/NGOs began to expand their activities beyond relief and rehabilitation, and the provision of basic health care services by NGOs had growing importance in their programmes. During this period and also in later years, the emphasis was on family planning, immunization, and maternal and child health (MCH).there were instances of Government-NGO collaboration in immunization and family planning (Fakir 1987, Huda 1987, Barkat et al 2000).

Their activities were directed towards promotive, preventive, curative, and rehabilitative healthcare and also towards the promotion of family planning services. Some NGOs (e.g. BRAC, *Gonoshasthya Kendra*) have implemented their own, independent programmes, while many others are collaborating with government in strengthening as well as in implementing government programmes. Government-NGO collaboration increased in the 1970s and 1980s on national programmes relating to tuberculosis, leprosy,

immunization, family planning and nutrition(Mercer et al.2004:187).Indeed, the NSPs/NGOs have significant roles in providing health care services to the poor. For example in 2003, 88% of households seeking health care went to NSPs/NGOs while another survey undertaken in 2001 found that 82%of the sampled households received treatment from NSPs/NGOs (Chowdhury et al 2004:24).

Quite a large number of NGOs have been involved in providing basic health services, including the components of PHC, as a part of their normal activity. Recently they have also taken on new roles such as raising awareness of sanitation, hygiene and arsenic contamination of water, and providing medical services to the arsenicosis patients. So far, NGOs have provided PHC services either with their own funding or with donor supports, but not necessarily entering into a partnership or any kind of relationship with government. Public contracting by government of NGOs for health care delivery is a new phenomenon which illustrates government's trust in NGOs effectiveness and grassroots accessibilities.

During the implementation of HPSP the concept of the Essential Service Package (ESP) was introduced with the goal of increasing responsiveness to the needs of clients and especially children, women and the poor(Alam et al 2002:2).The ESP provides reproductive and child healthcare services, communicable disease control, limited curative care, and behavioural change programmes (Alam et al 2000, Mercer et al 2004).The ESP seeks to provide PHC services in an integrated way at the Upazila level and below for close to client(CTC) facilities. Currently, the ESP constitutes around 48% of the MoHFW's total expenditure (World Bank 2005b:5).

Along with the ESP, another GO-NGO partnership-based programme known as Urban Primary Health Care Project (UPHCP), supported by donors and local NGOs, has gained momentum since 2000.The UPHCP is based on the rationale that health indicators of the urban poor were worse than those of the rural poor because of poor urban living conditions, and limited urban PHC. The UPHCP is expected to improve the health status of the urban population in all the city corporations and some selected municipalities. In Dhaka there are 10 partnership areas and 8 NGOs are involved in implementing project

activities. The NGOs were chosen through process of competitive bidding. So, in the implementation process of UPHCP there are four types of stakeholders: government, city corporations and municipalities, NGOs and the donors.

Yet another relevant health related programme is the USAID-funded NGO Service Delivery Programme (NSDP) which is a partnership of eight international and Bangladeshi organizations. NSDP delivers family health services in 62 districts of the country with 41 participating NGOs (World Bank 2005).The principal aim of NSDP is to expand the range and improve the quality of the ESP which is provided by NGOs at the clinic and community levels and also to influence the GOB policy, and complement and supplement the existing health sector programmes, in coordination with other donors.

Although the health sector has made impressive progress toward most of the health related MDGs the sector is beset with weak governance and its services remain beyond the reach of the most of the people(World Bank 2005a).This impressive progress in health related MDGs is mostly due to the proactive and participatory role of NGOs outside the public sector and delivers 60-70 percent of health care services in Bangladesh. The public sector has failed to serve the poor and public sector spending going to delivery of primary health care has actually declined over recent years. World Bank report suggested several reasons why public health services are non-responsive to service users.

During the mid 1990s, development partners have become increasingly interested to involve NSPs/NGOs in policy dialogue, programme formulation and implementation. There have been instances where NSPs/NGOs, and civil society more generally, have participated in policy discussion and formulation of Health and Population Sector Programme (HPSP),HIV/AIDS policy and UPHCP.NGOs have also played an important role in the formulation of the National Drug Policy in the early 1990s and also in the National Health Policy (Chowdhury et al 2004:25).

The involvement of NGOs in the implementation of large donor funded health projects has shown a significant increase in recent years. The HPSP, HNSP, HIV/AIDS prevention

and care, MNCH and Tuberculosis Control are a few major examples of these projects, where special project mechanisms were created for the involvement of NGOs in the implementation process. NGOs have become crucial players in provision of basic health services to the poor. They have proved effective and efficient in reaching out to target groups, who are mostly poor and live both in the rural and urban areas.NGO programmes are mostly at grassroots level and community based. They tend use community health workers who have good access and rapport with the community and are able to provide door to door services.

A large number of NGOs have collaborated with government in a number of important health care projects. These include diarrhoreal disease control, distribution of vitamin-A capsules for blindness prevention, tuberculosis and leprosy control, and nutrition. The success of immunization programmes is cited as an example of fruitful GO-NGO collaboration. NGOs have also proved effective in disseminating health messages through grassroots level initiatives. There are examples of NGOs using their micro credit groups to disseminate health messages, which have been found quite effective.

The Health and Population Service Sector (HPSS) which was launched in 1998 marked a radical departure from the previous government's health plans: it moved away from a project-based approach to supporting the health sector towards coordinated donor support of a sector wide plan (Chowdhury et al 2004:27) it recognized that proper coordination and implementation of HPSS would require effective sector wide partnership between the government and NGOs. In the Project implementation Plan (PIP), 10 broad principles for GO-NGO collaboration were spelled out (World Bank 2006:25).The Project Implementation Plan (PIP) listed a total 14 different areas of activities where NGOs were to be utilized. Some of these areas are related to Behavioural Change Communication (BCC), service delivery, training and research.

Another key strategy of HPSP was the establishment of a new tier of health facility at the village level called the 'Community Clinic". Although community clinics were an important new tier of health facility at the village level, they remained ineffective for some time and in 2003, the MoHFW asked three intermediary NGOs to take over the

management of the clinics on a pilot basis. Six community clinics were contracted out to NGOs by BPHC to develop an effective, sustainable and replicable model of community clinic that could be rolled out on a national basis (Chowdhury et al 2004:34).

Government was involved in the contracting process in different ways. At the national level, MoHFW assigned areas where NGO services were required, government officials participated in the tendering process and also received quarterly progress reports from the BPHC. At the district level, partner NGOs reported to the civil surgeon and to the Upazila Health and family Planning official. NGOs received important support from government both at the national and local levels(Chowdhury et al 2004: 100.BPHC as intermediary demonstrated that an NGO programme could provide ESP services effectively good health outcomes(Mercer et al 2004:196).

A DFID funded research report (Chowdhury et al 2004:43) describes the NSPs/NGOs performance in the health sector as follows:

> The NGO sector has grown considerably over the last decade and is taking on an increasingly important role in health care provision. It has many advantages over the public sector, including the willingness to serve in remote areas, and ability to target and reach the poor, facilitate community participation in health care planning and management, and address health needs of special client groups, such as sex workers of different categories.

3.16 Analytical Framework
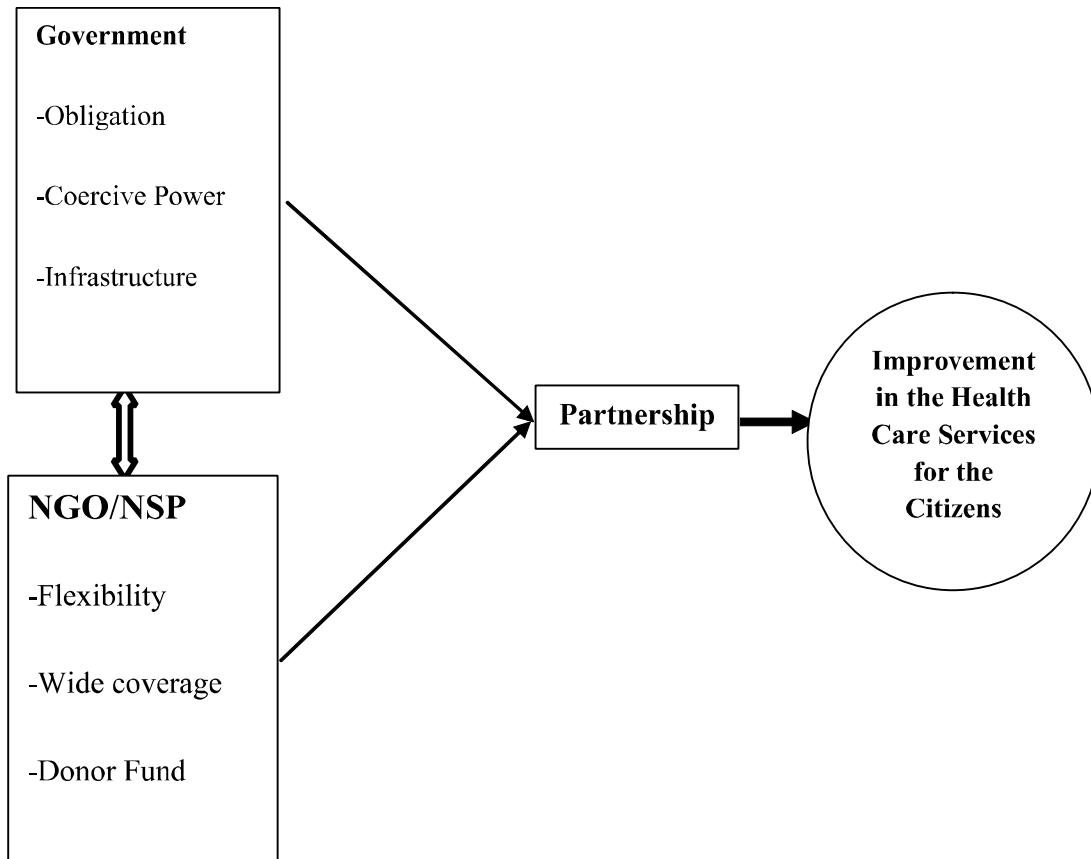
Figure -7 Analytical Framework of GO-NGO Collaboration in the Healthcare Sector of Bangladesh

In recent years, NGOs have emerged as a significant force in the development initiative of many developing countries. In these countries NGOs have been considered either as *'the institutional alternative*' or as '*the alternative strategy*' for accelerating development. NGOs are important because of their genuine contribution to beneficiary-oriented grassroots level development. The importance of NGOs in the development process stems from the perceived failure of donors and of national government to effectively promote development and to raise the standard of living of the poor. NGOs are now a reality and a strong force in the socio-economic development of a developing country like Bangladesh. All over the world opportunities are growing for NGOs to work together with GOs. In the present global environment, GO-NGO relationship is considered vital for national development. Government alone cannot address all the problems with its

limited resources. NGOs by virtue of its innovation, efficiency, flexibility, adaptability, wide coverage and donor funds contribute significantly towards development at the grassroots level. This is why, for ensuring overall development, the government efforts need to be complemented by NGOs, which is only possible if there is a sound GO-NGO relationship. A healthy GO-NGO relationship needs a positive attitude from GO and effectiveness from NGOs.

If we go through the Constitution of any democratic country, we would see that the government has the constitutional obligation or responsibility for ensuring the fulfillment of the basic necessities of life, including, food, clothing, shelter, education and medical care of its citizens. Likewise,as per the Constitution of the People's Republic of Bangladesh, under the Fundamental Principles of State Policy(Part II), the government of this country is pledged bound to materialize the spirit of Article 15(a) : "15. It shall be a fundamental responsibility of the State to attain,through planned economic growth,a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people,with a view to securing to its citizens—(a) the provision of the basic necessities of life ,including food,clothing,shelter,education and medical care."And,of the Article 18(1) : "The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties ...." In line with these two Articles, the government of Bangladesh has been implementing different development projects for ensuring health related infrastructures, recruitment of skilled manpower, training of the health-personnel as well as of the citizens for overall health care improvement.Moreover,government of any democratic country possesses legitimacy, revenue-money,and coercive power which help in creating conducive atmosphere for taking necessary initiatives,such as promoting partnership with the NSPs/NGOs in achieving Health Policy objectives.In addition to that,Government can build medium and mega infrastructures for providing healthcare facilities in different growth centres on government lands with revenue money or with the help of the private sector using the concept of PPP.

On the other hand, the NSP/NGO has flexibility,wide coverage and donor funds at its disposal.It is well known that the government departments do not have the scope of

going beyond the prescribed rules and regulations in doing businesses.But the NSP/NGO enjoys the freedom or flexibility in the way to achieve their desired goal/s and objectives.NGOs have network in the village or ward level now-a-days,while government do not possess adequate manpower in the health sector even in the union level in Bangladesh.In a developing country like Bangladesh, the government almost all the time suffers from scarcity of funds for implementing the necessary development projects,while after the fall of the USSR the NGOs receive adequate funds from the donor countries/agencies for implementing their projects.

From the above discussion, we can clearly trace out the comparative advantages of both the GO and NGOs as far as development management is concerned, and these are:
Comparative advantages of the GO-

- It has peoples' mandate;
- It has constitutional obligation;
- It has coercive power;
- It has revenue money; and
- It can unite the whole nation on any important issue or programme.

On the other hand, the NGOs enjoy the comparative advantages:

- NGOs have a base at grassroots level and have better knowledge of the community;
- NGOS have network all over the country to serve all segments of the population;
- NGOs have a large number of workers/ *karmis* with access to the remotest areas of the country;
- NGOs have developed good expertise in the delivery of PHC and also in certain other areas which include TB, leprosy, immunization, family planning etc;
- NGOs are innovative in linking health services with credit and other services;
- NGOs are effective in imparting training, developing Behavioural Change Communication(BCC) and IEC materials which have an impact on health service provision;
- NGOs are relatively efficient in the utilization of the funds;

- NGOs are more innovative in ensuring participation, gender equality and accountability;
- NGOs health service provision is less bureaucratic and efficient;
- NGO service are affordable and within the reach of the poor.
- NGO enjoys the support of donor funds

(Alam, 2007)

In fact, the necessity of the people and the efficiency of the NGOs in fulfilling them create the scope of NGO participation in the health care sector of Bangladesh. And, Government has the responsibility to steer this combined force with a view to achieve the desired development of the country as a whole.

3.17 Chapter Summary

Limitations of government efforts towards development management encourages searching for alternative institutional framework all over the world. The NGOs are now recognized as organizations alternative to the governments of the developing countries to address the needs of people otherwise unreached by official development programmes. It is a fact that government of a developing country like Bangladesh is not in a position that it alone can manage and fulfill all the demands in the healthcare sector. Because of resource (e.g. adequate amount of funds, skilled and motivated manpower, necessary technologies and equipments, infrastructures, wide area coverage, awareness building and professionalism and so on) constraint, governments of the developing countries are engaging gradually the NSPs / NGOs in partnerships to achieve greater success for improving the overall condition of the citizens of their respective countries. The Central role in this regard must lie with the government, because only government has the legitimacy, constitutional obligation, revenue money, coercive power and public support in running the country. But, as a result of the changing geo-political situation over the past few years, the interface between the government and the NGOs has increasingly been playing a vital complementary role in bringing about positive changes in the healthcare sector of Bangladesh, and thus in achieving the Goals of MDGs and national targets as well.

Greater collaboration can be beneficial to both the parties. Given the rich experiences of the NGOs, it is difficult to ignore the role of NGOs in development management especially in a critical sector like health and family planning. Realizing the potentials of NGO sector, Governments of the developing countries have initiated to undertake various programmes with NGOs. Donors also play an important role for GO-NGO collaboration. A healthy GO-NGO relationship can only be conceived where both parties share common objectives and strategies. With a view to utilizing the potentials of both the sectors, a genuine partnership can be developed between NGOs and the GO on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to be recognized that collaboration is a long-term affair and it need to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits. The need for such collaboration to a great extent is supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large.

The phenomenal growth of the NGOs in Bangladesh over the past two decades is attributed to two sources. The first is the limited success of the government by itself to respond effectively to the enormous challenges of poverty. Thus an opportunity has been created for the NGOs in Bangladesh to play an important role in this context. The second is the emerging preference of multilateral and bilateral development partners for channeling foreign assistance through the NGOs as a result of the demonstrated effectiveness of many NGOs in delivering services to the poor. This is an age of co-produced or networked governance, and hence to produce desired and fruitful results, collaboration between the government and the NGOs is a must for ensuring sustainable development in the healthcare sector of Bangladesh.

CHAPTER 4
BRAC AS A HEALTH SERVICE PROVIDER IN BANGLADESH

4.1 Introduction
BRAC's History

Known formerly as the Bangladesh Rehabilitation Assistance Committee and then as the Bangladesh Rural Advancement Committee (currently, BRAC does not represent an acronym), BRAC was initiated in 1972 by Sir Fazle Hasan Abed at Sulla in the district of Sylhet as a small-scale relief and rehabilitation project to help returning war refugees after the Bangladesh Liberation War of 1971. In nine months, 14 thousand homes were rebuilt as part of the relief effort and several hundred boats were built for the fishermen. Medical centers were opened and other essential services were ensured. At the end of 1972, when the first phase of relief work was over, BRAC turned towards long-term development needs and re-organized itself to focus on the empowerment of the poor and landless, particularly women and children.

By 1974, BRAC had started providing micro credit and had started analyzing the usefulness of credit inputs in the lives of the poor. Until the mid-1970s, BRAC concentrated on community development through village development programmes that included agriculture, fisheries, cooperatives, rural crafts, adult literacy, health and family planning, vocational training for women and construction of community centres. A Research and Evaluation Division (RED) was set up by BRAC in 1975 to analyze and evaluate its activities and provide direction for the organization to evolve. In 1977, BRAC shifted from community development towards a more targeted approach by organizing village groups called Village Organizations (VO). This approach targeted the poorest of the poor – the landless, small farmers, artisans, and vulnerable women. Those who own less than half an acre of land and survive by selling manual labor were regarded as BRAC's target group. That same year BRAC set up a commercial printing press to help finance its activities. The handicraft retail chain called '**Aarong**' was established the following year.

In 1979, BRAC entered the health field by establishing a nation-wide Oral Therapy Extension Programme (OTEP), a campaign to combat diarrhoea, the leading cause of the high child mortality rate in Bangladesh. Over a ten-year period 1,200 BRAC workers went door-to-door to teach 12 million mothers the preparation of home-made oral saline. Bangladesh today has one of the highest rates of usage of oral rehydration, and BRAC's campaign cut down child and infant mortality from 285 per thousand to 75 per thousand. This initial success in scaling up propelled rapid expansion of other BRAC programmes such as Non Formal Primary Education which BRAC started in 1985 – a model that has been replicated in about a dozen countries.

In 1986 BRAC started its Rural Development Programme that incorporated four major activities i) institution building including functional education and training, ii) credit operation, iii) income and employment generation, and iv) support service programmes. In 1991 the Women's Health Development program commenced. The following year BRAC established a Centre for Development Management (CDM) in Rajendrapur. Its Social Development, Human Rights and Legal Services programme was launched in 1996 with the aim to empower women with legal rights and assist them in becoming involved with community and ward level organizations. In 1998, BRAC's Dairy and Food project was commissioned. BRAC launched an Information Technology Institute the following year. In 2001, BRAC established a university called BRAC University with the aim to create future leaders and the BRAC Bank was started to cater primarily to small and medium enterprises.

In 2002 BRAC launched a programme called Challenging the Frontiers of Poverty Reduction – Targeting the Ultra Poor (CFPR-TUP) designed specifically for those that BRAC defines as the ultra poor - the extreme poor who cannot access conventional microfinance. The same year BRAC also went into Afghanistan with relief and rehabilitation programmes. It was the first organization in Bangladesh to establish, in 2004, the office of an Ombudsperson.

4.2 BRAC Health Programme: A Picture of Progress

Bangladesh has made remarkable strides in healthcare sector in the four decades since independence. Since the 1990s maternal mortality in Bangladesh has dropped from 574 to 194 deaths per 100,000 live births, and child mortality from 133 to less than 53 per 1,000 live births. Over four decades, the contraceptive prevalence rate has gone up seven to eightfold. In the 1980s, when immunization coverage was two per cent, the shared roles and activities of BRAC and the government improved the status to 70 per cent within the last four years. The current status of fully immunized children is at 82 per cent. Despite the achievements, Bangladesh still suffers a high burden of deaths and diseases. The country is ranked as sixth among the 22 highest burden countries for tuberculosis (TB). Over 70 per cent of people seek care from informal health care providers and 62 per cent of those health providers practicing modern medicine have little or no formal schooling. Two thirds of births take place at home, mostly assisted by unsupervised, untrained birth attendants. Recognizing these problems, we have created a pool of frontline health workers, the **Shasthya Shebikas** and **Shasthya Kormis**, who strive to address the crisis of human resources in the health sector by playing a substantial role in providing accessible and affordable services to the majority of the population.(BRAC 2011)

Following the broad concept of primary health care, essential health care (EHC) has evolved to be BRAC's core health intervention where our CHWs offer low cost essential health care services to over 100 million people across the country with a special emphasis on ultra poor families. We have started maternal, neonatal and child health (MNCH) programmes in 10 rural districts with the government and UNICEF and in urban slums with various partners. We have demonstrated that with limited resources, it is possible to change behaviour and practices to lower the incidences of maternal and neonatal deaths within a short period. With the active engagement of community health workers and birth attendants, we ensure high coverage of antenatal and postnatal care while supporting skilled birth attendance. More importantly, a referral system is developed which facilitates transfer of acute emergency cases to hospitals. Within three to four years, we have observed a decline in maternal and neonatal deaths in both urban

slums and rural districts. Bangladesh is on track for achieving the sixth MDG, with TB deaths declining from 76 to 43 per 100,000. The contribution of **Shasthya Shebikas** in detecting suspected TB cases, collecting sputum for lab diagnosis and ensuring community based directly observed treatment short courses (DOTS) for TB is tremendous.(BRAC 2011)

Managing the demand and supply chain and ensuring quality are the major challenges. Our collaborative efforts reach all the 13 malaria risk prone districts, accounting for direct service provision in four districts. The CHWs identify malaria symptoms, conduct blood tests using the rapid diagnostic test and provide treatment at the community level. Working in close partnership with the government and various NGOs in fighting TB and malaria creates a successful example of public private partnerships. The situation of malnutrition is gloomy, as for many years it has remained above 40 per cent among under five children. For addressing malnutrition, BHP has started to implement the community component of **Alive & Thrive**, a programme for reducing under two malnutrition in partnership with FHI 360. BHP has reached well over 12 million people in 50 sub districts to reduce stunting by promoting exclusive breastfeeding and complementary feeding, which is alarmingly low in Bangladesh. The prevalence of anemia is also daunting. In an attempt to prevent and control anemia of under five children, we distribute Sprinkles for ensuring intake of iron and other essential elements with the support of BRAC's CHWs in 61 districts. Bangladesh is one of the highest ranking countries in the world when it comes to ocular (eye) morbidity along with tremendously low rates of cataract surgery. About 750,000 people suffer from blindness, 80 per cent due to cataracts with 3.3 million adults with uncorrected refractive error. Aligned with the government's commitment to Vision 2020, we are implementing Vision Bangladesh, which reduces the backlog of cataract blindness by carrying out surgeries in Sylhet. In addition, to correct presbyopia (faulty near vision), we screen people above 35 years and provide them with reading glasses through *Shasthya Shebikas* in 24 districts. Through collaborative eye care projects, BHP strives to avert preventable eye problems. (BRAC 2011)

4.3 Public Healthcare

BRAC started providing public healthcare in 1972 with an initial focus on curative care through paramedics and a self-financing health insurance scheme. The programme went on to offer integrated health care services, its key achievements including the reduction of child mortality rates through campaign for oral rehydration in the 80s and taking immunization from 2 percent to 70 percent in Bangladesh. BRAC currently provides a range of services that reach an estimated 31 million rural poor and include services for mothers in reproductive health care and infants. In Bangladesh, 78 percent of births occur in the home. BRAC has implemented a program in which midwives are trained to work in the homes of women to ensure that births are as risk-free as possible. As of December 2007, 70,000 community health volunteers and 18,000 health workers have been trained and mobilized by BRAC to deliver door-to-door health care services to the rural poor. It has established 37 static health centres and a Limb and Brace Fitting Centre that provides low cost devices and services for the physically disabled.

4.4 BRAC's Role in the Healthcare Sector of Bangladesh

Just after the Liberation War, in response to the continuing burden of disease and illness within the populace, health components were incorporated into BRAC's development interventions commencing in the early 1970s to promote community level healthcare services and health education programs. BRAC's healthcare programs outlined that low cost, low-key and simple technology integrated within a development context could generate similar results in comparison to high cost, sophisticated intensive methods. This ideology towards a sustainable health care system through active community participation has remained constant throughout BRAC's continuing health interventions.

BRAC's Health Program combines promotive, preventive, curative, rehabilitative healthcare. It focuses on improving maternal, neonatal and child health, combating communicable diseases and common health problems. BRAC's Health Program is the result of an integrated approach, including several interventions to provide a health service that supports human development and works in partnership with its comprehensive approach to development. The key areas of the program are: essential

health care; tuberculosis and malaria control; maternal, neonatal and child health; family planning; immunization; health facilities and limb and brace centre.

4.5 BRAC's Approach in Healthcare Sector

An awareness of the changing health needs, adaptation of technology, cost effectiveness, sustainability and delivery through partnerships with communities and Government are key features in BRAC's approach to providing healthcare to poor people.

BRAC has adopted an epidemiology-experimentation-expansion evaluation model to develop and deliver the program. Lessons learned from own experiences in public health, like the bare-foot doctors of the 1970s,Oral Therapy Extension and Child Survival programs in 1980s,Women's Health, Reproductive Health and Disease Control programs in 1990s, have enabled BRAC to expand sustainable and accessible health care to more that 100 million people across Bangladesh. BRAC also collaborate on national projects such as Vitamin-A supplementation and family planning initiatives.

By choosing health volunteers, or *Shasthya Shebikas*, from BRAC's own Village Organizations (VOs), BRAC is making effective use of resource and is able to ensure sustainability unlike other programs in the health sector. Volunteers receive basic training and provide door-to-door health education, treat basic illness, refer patients to health centers and provide essential health items and medicines; which contribute towards an income for the volunteer.

BRAC's *Shasthya Shebika (*SS)s are assessed and monitored by *Shasthya Kormi*(SK)s who are paid a monthly salary to supervise 10-12 SSs. SKs conduct monthly health forums and provide antenatal and postnatal care. Around 7,000 SKs are supervised by Program Organizers who are supervised by the Upazila and District Managers. Medical Officers provide overall technical supervision whilst SKs are supported by a team of public health professionals. (BRAC 2010)

4.6 BRAC's Ongoing Program Components

Essential Health Care (EHC) forms the core of BRAC's health program, combining preventive, promotive, basic curative and referral care, aimed at improving the health of poor people, especially women and children.EHC has seven components: health and

nutrition education; water and sanitation; family planning; immunization; prenatal care; basic curative services and tuberculosis control. In 2002, EHC was adapted to fit the needs of the ultra-poor, BRAC's poorest members, by offering basic health care and health awareness services as well as financial assistance towards clinical care. (BRAC 2009)

Improving Maternal, Newborn and Child Survival (IMNCS) Project (Rural):

Despite unfavourable socio-economic situation such as low literacy rate, poverty,low status of women,religious barrier,gender disparity,the MCH-FP programme has made remarkable success over the time.In line with this success, BRAC in collaboration wit GOB has been implementing the MNCH programme.Rates of morbidity and mortality among pregnant women,mothers and newborns remain high in Bangladesh,particularly among poorer groups.Access to skilled and timely care is the key to reduce the toll of maternal and neonatal deaths.The MDGs on maternal health and child mortality helps circumscribe the MNCH in Bangladesh.Under the HNPSP ,the government has undertaken five sub-programmes including a)family planning services,b) clinical family planning services,c)MCH care and services,d) adolescent healthcare ,and e) support services and coordination,which are being implemented through countrywide facility network .BRAC and other bilateral agencies have been providing hospital or community – based services or both in order to supplement and complement government's initiatives in this field.Some major MNCH interventions are as follows:

A) Maternal health intervention
- Reproductive health:MCH-FP services
- Emergency obstetric care
- Menstrual regulation programme
- Skilled birth attendant programme
- Community midwifery programme
- Urban primary healthcare project
- NGO service delivery programme
B) Child health interventions
C) Saving newborn lives programme

D) Kangaroo mother care project

E) National communication campaign programme

F) National nutrition programme for mother and child

<div align="right">(BRAC 2011)</div>

BRAC has been successfully scaled up to ten districts across the country since its launch in 2005; working with the Government and UNICEF. This project aims to provide quality maternal, newborn and child health care using a community based approach to reach the rural poor. Major interventions include capacity development of community health resources, empowerment of women through support groups, provision of maternity and child health related services and referrals to nearby health facilities. SSs, SKs, newborn health workers and skilled birth attendants all work together to deliver these services to the community. Preventive and curative practices are promoted through targeted household visits. BRAC's approach has significantly improved pregnancy identification and antenatal care as well as ensuring safe and clean deliveries in rural communities. (BRAC 2011)

Manoshi: Maternal, Newborn and Child Health Initiative (Urban)

It was launched in Dhaka in 2007 and provides community based maternal and child health care services in urban slums, with the support of slum volunteers, skilled community workers and Program Organizers based in nearby hospitals for emergency cases. Birthing huts provide clean and private birthing places for slum women who usually live in small shacks, with large number of family members, which offer unhygienic conditions for giving birth. Each of the huts have two birth attendants, covering around 2,000 households (approx 10,000 people), whilst community midwives are on hand to provide skilled care during deliveries. (BRAC 2008)

Tuberculosis Control

Tuberculosis is one of the leading killers of adults in Bangladesh. Through prompt diagnosis and completion of six months of daily medications, it can be effectively treated. BRAC pioneered a community-based model in order to bring these services to the doorsteps of common people, including those in the rural areas in 1984.Since then BRAC

has formally supported the National Tuberculosis Control Programme in implementation of TB treatment with supervision, often called the Directly Observed Treatment Short course (DOTS) strategy. BRAC implements the programme primarily through the activities of community health volunteers and the community health workers who disseminate messages regarding TB during their household visits and in health forums, identifying presumptive TB patients, referring them for diagnosis, and ensuring daily intake of medicine at the community.

Malaria Control Program

It operates in 13 districts across the country including the Chittagong Hill Tracts (CHT).The SSs receive a 3-day training course on malaria treatment and prevention to help achieve early diagnosis and prompt treatment of cases. (BRAC 2008)

Sushasthya (Health Centers)

These health centers provide accessible and quality outpatient and inpatient services, general laboratory investigations and essential life-saving drugs to the local community. The BRAC authority has also upgraded nine centers to offer emergency caesarean section or newborn care and advanced diagnostics such as electrocardiograms and ultra sonograms.

Limb and Brace Fitting Centers

These centers provide low cost, accessible, quality artificial limbs and braces. They provide physiotherapy services and education and counseling to patients and their family members. BRAC's work aims to improve the livelihood capabilities of the physically challenged and help their integration into mainstream society. BRAC currently has two centers in Dhaka and Mymensingh.

Reading Glasses for Improved Livelihoods

Working with Vision Spring, covering 15 districts, specially trained SSs use simple charts to identify near-vision deficiency. They sell ready-to-use spectacles at a nominal price, educate people on eye problems and are trained to refer complicated cases to medical professionals. (BRAC 2008)

Vision Bangladesh

This is a partnership program between BRAC and Sightsavers aiming to eliminate preventable blindness in Sylhet by 2014.To date, 1,300 poor people have undergone cataract operations and 7,000 people have been successfully screened. (BRAC 2008)

Alive and Thrive

This is an initiative to reduce malnutrition in children under the age of two by promoting exclusive breastfeeding and healthy feeding practices. This includes community level counseling, coaching and demonstrations. Following a successful year long pilot this initiative has been expanded to 50 rural Upazilas.

Micro-Health Insurance

This is a sustainable community health financing model, to empower and improve the well being of poor women and their families, giving poor people access to affordable and quality health care.

Water, Sanitation and Hygiene (WASH) Program:

The program, which has reached over 38 million people, provides sustainable and integrated WASH services in rural and isolated areas, breaking the cycle of contamination caused by unsanitary latrines, contaminated water and unsafe hygiene practices. (BRAC 2008)

Breastfeeding and vitamin-A Campaign:

Breastfeeding has a direct link to neonatal illness and nutritional status. Although breastfeeding is almost universal in Bangladesh, providing *colostrums* to the newborn, along with increasing duration of exclusive breastfeeding, is very crucial. Due to its thick and concentrated texture, it is believed that the baby would not digest *colostrums*. It is also considered to cause fever and illness of the mother if she feeds *colostrums* to the baby. In this regard, special programmes should be developed based on qualitative and quantitative studies on mothers so that interventional measures are well-understood and well-directed. Severe vitamin A deficiency has long been recognized as a potentially-lethal but preventable nutritional disease. Vitamin A is an essential nutrient needed in small amounts for normal cellular function and is especially required for the visual system, growth, and development, maintenance of epithelial cellular integrity, immune function, and reproduction. The current status shows that this area needs further increase in coverage of vitamin A supplementation. Promoting the production and consumption of vitamin A-rich fruits and vegetables by poor households through home-gardening should be encouraged. Although there is the Agricultural Support Services Programme, encouragement through media is also required in this regard. In Bangladesh, there have not yet been any effective measures which have sought to address the problem of vitamin A deficiency through fortification of foods. However, one of the major underlying problems, in this regard, has been the need to identify a suitable vehicle by which foods can be fortified with vitamin A and be made available to most people at risk. Recently, the United Nations Children's Fund has assessed the feasibility of vitamin A fortification and invited owners of the vegetable-oil and wheat-flour mills to explore the possibility of developing the fortification of food with vitamin A. However, it needs more focus. (BRAC 2008)

Areas of GOB-BRAC Collaboration in TB Control

Tuberculosis Control:

Tuberculosis is one of the leading killers of adults in Bangladesh. Through prompt diagnosis and completion of six months of daily medications, it can be effectively treated. BRAC pioneered a community-based model in order to bring these services to the

doorsteps of common people, including those in the rural areas in 1984.Since then BRAC has formally supported the National Tuberculosis Control Programme in implementation of TB treatment with supervision, often called the Directly Observed Treatment Short course (DOTS) strategy. BRAC implements the programme primarily through the activities of community health volunteers and the community health workers   who disseminate messages regarding TB during their household visits and in health forums, identifying presumptive TB patients, referring them for diagnosis, and ensuring daily intake of medicine at the community. This DOTS is an example in the field of networked governance, or successful example of PPP in the national health sector of Bangladesh. This partnership approach ensures efficient use of limited resources. Avoidance of functional overlapping, high cure rate and quality assured sputum microscopy.

Advocacy, communication and social mobilization (ACSM) is implemented targeting a wide range of clients and other members for enhancing case detection and treatment adherence. Orientation sessions with local public opinion leaders, religious leaders, NGO workers, girl's guides and scouts are conducted to create demands and to improve programme participation. Routine internal monitoring, and standardized formats and registers provided by NTP are used as record along with modern Management Information System for record keeping and to facilitate the programme for tracking and guiding towards punitive action. In 2011, BRAC treated 93,464 TB patients with a success rate of 93 percent .As a result of these accomplishments and success of the entire partnership, Bangladesh is currently on track to achieve the Millennium Development Goal   of   having   the   TB   mortality   and   prevalence   by   2015. (Zafar Ullah,. et al.2006**).**

Table 4.   Areas of GOB-BRAC Collaboration in TB-control and MNCH Programme in Bangladesh

Area of allocation	Government	BRAC
Policy	-National policies and strategies supporting collaboration in Maternal and Neonatal care -National TB guidelines and protocols	-Programme and management policies based on national guidelines -Utilization of resources
Implementation	-Equipment and lab supplies -Specialized health services (Advice, diagnosis ,OT facilities) -Overall coordination	-Specific areas
Case finding and case holding	-Referral centres -Reference laboratory/Health facilities	-Identification, diagnosis, treatment, follow-up and referral -Late patient tracing in TB-control
Training	-Training materials -Training of trainers(TOT)	-Local training -Training of SK,SS,CSBA,NHWs
Drug supply	-Central procurement -Distribution	-Local storage and distribution -Supply indent
Monitor and supervision	-Registers/forms -Overall monitoring and supervision	-Registration/reporting -Local monitoring and supervision
Behavioural change communication	-National campaigns	-Local campaigns for awareness building and ensuring community participation

Based on data from MoHFW (2001); Hussain (2001); NTP (2003); and discussions with the key stakeholders.

4.7 Challenges for BRAC

There is an emerging need to tackle the increase in non-communicable diseases, alongside the ongoing burden of communicable diseases, coupled with a lack of accessible and quality health care and medical facilities in Bangladesh. Lack of coverage, skilled workers and accessibility to remote parts of the country continue to present major challenges in how BRAC can provide health care to the poor people. Developing effective

referral facilities with adequate well trained human resources and logistics will prove essential in reducing maternal and newborn mortality.

4.8 BRAC's Future Plans

BRAC's approach in developing community based interventions recognizes that work places and urban slums are becoming new settings for delivering effective health interventions. BRAC's approach with EHC, continuing as its core health program, will be adapted to accommodate the emerging needs of non-communicable diseases, elderly health care, climate change and nutritional initiatives. In its shared effort to build a more 'Digital Bangladesh' BRAC has identified the mobile phone as a key medium for exchanging information. Using ICT will enhance BRAC's ability to provide efficient and effective health care, whilst opening up new channels of communication for a lower cost higher reach service.

4.9 New Initiatives of BRAC

BRAC has developed a Mobile-Health Project, in partnership with Click Diagnostics Inc., where SKs can use mobile phones to share real-time information about their patients, mainly pregnant women and newborns, helping to improve the process of diagnosis and treatment.

Working in partnership with GE Healthcare, BRAC took initiative to introduce a portable oxygen support device, at community level, in an effort to fight birth asphyxia in newborns. The pilot was launched in January 2011.

## 4.10 Health Human Resources(HHR): Backbone of BRAC's Health Program

BRAC has employed staff at districts level and Upazilas for coordination,management,and supervision of field activities as well as to liaise with Government and local stakeholders.They also work along with the Government health staff at the field level to provide services and arrange special support for reffered cases at the facility level

Organogram at Community Level

BRAC delivers services at community level with the help of a group of community health workers; Shasthya Shebika (SS), Shasthya Kormi (SK), Newborn Health Worker (NHW) and Community Skilled Birth Attendant (CSBA). The activities have been supervised by Program organizers (PO). Upazila and District Managers play both administrative and supervisory roles.

Figure: Organogram from district to village level

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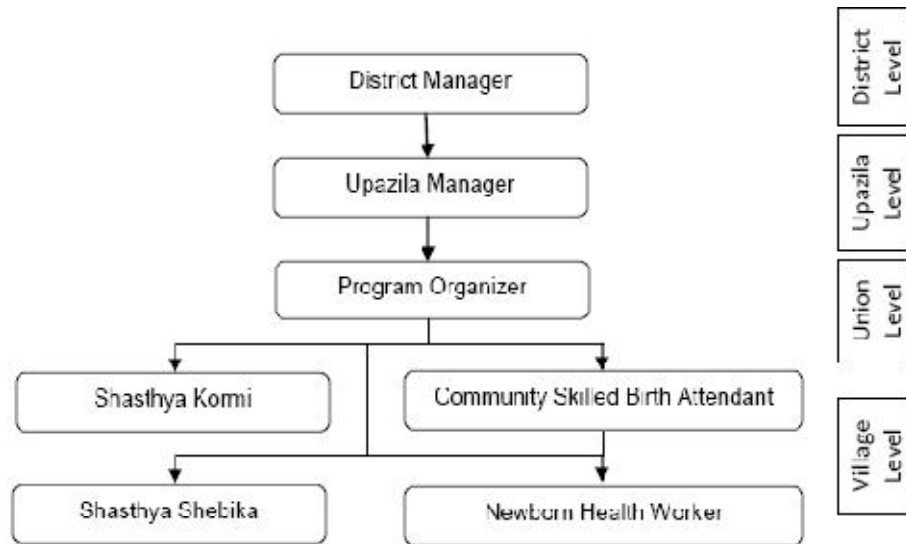
(BRAC 2011)

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The Community Health Workers (CHWs) are the direct service providers reaching target populations with simplistic techniques and approaches. CHWs include Shasthya Kormi(SK), Shasthya Shebika(SS) and Newborn Health Worker(NHW).They are selected from the community and local vicinity with the assistance of BRAC Microfinance group members (Village Organizations-VOs),community people and BRAC field staffs following certain criteria detailed in the table below:

Table 5. Selection Criteria for BRAC's Community Health Workers (CHWs)

Shasthya Shebika(SS)	Shasthya Kormi(SK)	Newborn Health Worker (NHW)
1.Selected from BRAC Microfinance groups 2.Married and youngest child not less than 2 years 3. Age 25-45 years 4.Reading and writing skills 5.Willingness to provide voluntary services 6.Acceptable to community	1. Selected from localities 2. Age 20-40 years 3. Married 4. Minimum SSC 5. Willingness to work 6.Acceptable to community	1. Selected from localities. 2. Age 25-45 years 3. Married 4.Previous knowledge and skills 5. Willingness to work. 6. Acceptable to community.

(BRAC 2011)

4.11 Tasks

After receiving training, the CHWs execute their tasks by providing services to mothers, newborns and children at households.

Table 6. Tasks of BRAC's Community Health Workers (CHWs)

Shasthya Shebika(SS)	Shasthya Kormi(SK)	Newborn Health Worker(NHW)
1.Follow-up of couples and distribution of material related to family planning 2. Pregnancy identification 3. Attend delivery and provide immediate newborn care 4. Provide tablet Misoprostol to mother 5. Detect and refer maternal complications 6. Inform SKs for first postnatal visit 7. Detect, manage and refer	1.Antenatal care 2.Postnatal care 3.provide health education 4.Arrange referral of complications to hospitals 5.Supervise activities of SS and NHWs	1. Attend delivery and provide immediate newborn care 2. Detect and refer maternal and newborn care 3. Provide Misoprostol 4. Detect, manage and refer for birth asphyxia 5. Inform SKs about new births for postnatal care

birth asphyxia and neonatal sepsis 8. provide special care to LBW babies 9. Mobilise for immunization and vitamin A 10. Detect, treat and refer children suffering from ARI and diarrhoea		

(BRAC 2011)

The BRAC experience suggests that perhaps vertical and horizontal approaches can be synergistic if there is a unifying agent at the community level with appropriate:

- Training
- Supervision
- Logistical support
- Incentives to carry out her work

Existing GOB-BRAC Collaboration in Healthcare Sector

Upazila: Trishal, District: Mymensingh

Area:338.73 skm,Population:4,41,248(BBS-2011), Union:12, Village:153, Literacy Rate:

56%

Upazila Health Centre: 01(50 beds)

Table 7. Comparison of Skilled Man-power Strengths of GOB and BRAC in Trishal Upazila

MoHFW Organogram in Trishal: Sanctioned Post of Doctors -- 33	BRAC-Health Programme Organogram at Community Level:
i) Upazila Health and Family Planning Officer (UHFPO): 01	i)Upazila Manager: 01
ii) Residential Medical Officer (RMO): 01	ii)Programme Organizer (PO): 21
iii) Dental Surgeon: 01	iii)Shasthya Kormi (SK):83
iv) Medical Officers & Consultants: 30	iv)Shasthya Shebika (SS): 670
(Working at present: 27, Deputation: 04, and Vacancy: 2, total=33)	v)Newborn Health Worker (NHW):334
Community Clinic: 41	vi)Community Skilled Birth Attendant (CSBA):12
Health Inspector: 04	
Assistant Health Inspector: 12	
Health Assistant (HA): 40	
Skilled Birth Attendant (SBA):03	
Family Welfare Centre (FWC): 8	
Rural Dispensary (RD): 4	

Source: UHFPO, Trishal, Mymensingh (2013) and Upazila Manager, BRAC Health Programme, Trishal, Mymensingh (2013)

A focus group discussion meeting was held on the existing condition of healthcare service delivery and GO-NGO collaboration among the local level healthcare service providers in

presence of the concerned stakeholders of the Trishal Upazila in the said Upazila Health Complex premises of Mymensingh District. The focus of the meeting was on the GO-NGO partnership in the health sector management with special emphasis on BRAC's MNCH Programme. In this group discussion on the healthcare service delivery system run by the Government (GO) and Non-Governmental Organizations (NGOs) in the Trishal Upazila, the UHFPO told that the access to Tuberculosis Care; Maternal Health, Neonatal Health, Child Health Care; EPI; Vitamin-A Capsule Campaign; Nutrition Programme; WASH Programme, and Family Planning Services have been running in a collaborative way with BRAC. He told that the access to TB care services is a key factor in achieving the objectives of DOTS (Directly Observed Treatment, Short Course) under the National TB Control Programme (NTP), in the light of the movement towards wider collaboration to achieve national health goals. He described how the HAs are working side by side with the *Shasthya Shebikas* in creating awareness about the TB and its treatment facilities. As per the UHFPO's information only three HAs are working in each union of Trishal Upazila, whereas around 50 SSs are doing the same job in each UP. The UHFPO told that the HAs and the SSs identify the people who have been suffering from fever, chronic cough, chills, night sweats, loss of appetite, weight loss, fatigue, and significant finger clubbing for at least 03(three) weeks, and bring them to the Upazila Health Complex (UHC), or to the BRAC's permanent Smearing Centre/s or Outreach Sputum Collection Centres for diagnosis, and provide with DOTS for the individuals diagnosed as TB patients. This Directly Observed Treatment, Short courses (DOTS) are given by the *Shasthya Shebika* (SS) s, usually at her house, under the guidance of the field level staff of government and BRAC or BRAC medical officer.

At this stage, the Upazila Manager of BRAC Health Programme in Trishal, Mymensingh informed that BRAC's approach for TB diagnosis and treatment focuses on community level education and engagement. Information, Education and Communication (IEC) materials are used regularly during health education sessions and individual communication. During health education sessions, symptoms of TB and information on the facilities available for its diagnosis and treatment are discussed, he added. The UM said that BRAC conducts orientations with different stakeholders of the community to engage them in efforts to identify patients, ensure treatment adherence, and reduce

stigma. He also added that to broaden the reach of TB messaging, BRAC also utilizes local popular theatre shows and folk songs. These activities have shown marked involvement and responses from the community members regarding TB control and have led to increased referral of suspects and thereby better adherence to treatment. He informed about the duty and responsibility of the SS, community health volunteer-who plays the pivotal role of connecting individuals with TB control services; Maternal Health, Neonatal Health, Child Health Care; EPI; Vitamin-A Capsule Campaign; Nutrition Programme; WASH Programme, and Family Planning Services during household visits and health forums. Each SS receives a basic training and a one-day refresher training every month. As far as TB control is concerned, during household visits, SSs identify suspects of TB and refer them for sputum examination to the Upazila health complex or BRAC laboratory services, and ensure proper treatment. And in the cases of Maternal Health, Neonatal Health, Child Health Care, the SSs sequentially follow the method of household visit & pregnant mother identification, their registration, Antenatal Care (ANC) with the help of the SKs, Interpersonal Communication(IPC) with spouse, ensuring necessary arrangement for safe delivery with the help of the CSBA, referral activities, informing referral PO over cell phone about complicated pregnancy and critical state of the would be mother with the help of the *Shasthya Kormi*(SK)s, necessary arrangement in the UHC through cell phone communication with the PO, arrangement of transport for shifting the patient to the service centre, birth weight taken, Postnatal Care(PNC), newborn care, ensure EPI, and regular arrangement of the Health Forum with the male-female members of the catchment area. He concluded by saying that the role of the SSs is vital as well as crucial as far as BRAC' Healthcare Programme is concerned.

BRAC Programme Organiser of Khathal UP, Trishal, informed that the entire TB care programme; from household visits and identifying the pregnant mother to newborn care; EPI; nutrition programme and WASH programmes are implemented through a team-work done by the Government's health sector officials and BRAC's Health Human Resource (HHR) members. He also praised the role of the SSs in BRAC's healthcare programme for their crucial contribution in ensuring healthcare facilities for the poor living in the grassroots level of the country.

A *Shasthya Kormi* (SK) of Dakkhin Singrail of Khathal UP told that the Union Parishad should be strict and transparent in registering the newborns, issuing birth certificate with original date of birth, and playing significant role in controlling child marriage and related complexities. While, a *Shasthya Shebika* (SS) of Dakkhin Singrail of Khathal UP, informed that the male members of the families should be much more cautious and well aware about ensuring proper nutrition of the pregnant mothers, children, adolescents, and allowing them to acquire health knowledge through participating in the BRAC's health forums regularly

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Noresh Risi (70), son of late Jogoth Risi, Vill.Vhati Para, Narayan Pur, Trishal told that he had been suffering from night-time fever, chronic cough, night sweats, loss of appetite, fatigue and some other physical problems for the last 03(three) weeks, and the SS of his area Rina Rani brought him to the UHC for collecting sputum to diagnose whether his disease is TB or not. He also expressed satisfaction about the services provided by the SS and the TB & Leprosy Control Assistant (TLCA) of the UHC.

Sharmin (19), Wife of Rashed (26), Vill. Dakkhin Singrail, Khathal UP informed that during her second pregnancy like the first one, she also received all sorts of healthcare services from identification of pregnancy to giving birth to the child, and following other services from the BRAC's healthcare programme and the UHC. She told that she fed her just-born baby with the 'Shaldudh' and subsequently provided the newborn with breast-feeding only. Now the newborn namely Rubaida is 8(eight) months old, and she started feeding her with normal food.

Upazila Family Planning Officer (UFPO) of Trishal, Mymensingh, told that BRAC's SSs work in every nook and corner of the Upazila and achieved considerably good level of success in healthcare sector over the years through hard work and efficiency. He also told that the government of Bangladesh is aware of BRAC's contribution, particularly achieving success in MNCH-programme by following the method of household visit & pregnant mother identification, their registration, Antenatal Care (ANC) with the help of the SKs,

Interpersonal Communication(IPC) with spouse, ensuring necessary arrangement for safe delivery with the help of the CSBA, referral activities, informing referral PO over cell phone about complicated pregnancy and critical state of the would be mother with the help of the Shasthya Kormi(SK)s, necessary arrangement in the UHC through cell phone communication with the PO, arrangement of transport for shifting the patient to the service centre, birth weight taken, Postnatal Care(PNC),newborn care, ensure EPI and birth-spacing measures, and regular arrangement of the Health Forum with the male-female members of the catchment area for motivational and awareness raising activities.

The UHFPO concluded by saying that lack of resources, i.e. dearth of fund, skilled manpower, logistics etc. usually cause various types of problems in health-related service delivery by the government sector service providers, but BRAC is free from all these shortcomings. BRAC's contribution, particularly achieving success through motivational and awareness raising activities with the help of its grassroots level Community Health Workers(CHWs) in healthcare sector esp. in MNCH-Programme is commendable and a glaring example of successful GO-NGO interface in managing health sector of Bangladesh, he further added.

Case Study-1

Asma (22), W/O-Shamol (27),Vill- Dakkhin Singrail, P.O. Khathal, Trishal, Mymensingh. She is a member of the local Dakkhin Singrail VO. Asma told that she was going to be mother for the second time. Her EDD is 22-02-2013.Right from the very beginning of her pregnancy, she has been suffering from severe anemia and other complexities and had to go to the nearby UHC, Trishal and Mymensingh Medical College Hospital for better treatment, and BRAC's Health Human Resources (HHR) i.e., SS, SK, PO, UM and related staffs helped her in all possible ways in this regard. In her 9 months of pregnancy period, she has already received the Antenatal Care (ANC) service for 7 times provided by the local SK. The SS has also been monitoring her health condition regularly, she added. Asma is very hopeful about giving birth to her second child safely with the help of the SK, SS and CSBA.

Case Study-2

Aamena (25), W/O- Nur Muhammad (29), Vill.Dakkhin Singrail Purbo Para P.O. Kathal, Trishal, Mymensingh recently gave birth safely to her second child Aabir (54 days old) with the help of BRAC's CSBA in her own home. She told that the SK and SS took good care of her during pregnancy period, and provided her with ANC and PNC as per requirement and gave necessary advice regarding her health. She fed the just-born baby with '*Shaldudh*' which contains colostrums, and adopted temporary birth control measure within 45 days of her delivery as per the instructions given by the concerned CHWs of the locality, she added.

Case Study-3

Sathi (25), W/O-Tofazzal, Vill.-Singrail, P.O. Kathal, Trishal, Mymensingh received necessary healthcare services(Pregnancy detection, ANC, PNC and so on) from both the government and BRAC healthcare service providers while giving birth to her boy child Sajal (11months).Her Puerperal Sepsis and the newborn's Neonatal Sepsis were detected by the SK and SS after 7days of her delivery while they came to give her routine PNC, and they shifted her along with her baby to the Upazila Health Centre(UHC) for better treatment under the Medical Officer and Child Specialist there. The UHC authority could not provide all the medicines prescribed by the physicians, and BRAC Health Programme supplied the necessary medicines free of cost. The conveyance of the patient was also paid by the BRAC health programme. Sathi told that she was very satisfied and grateful for the services she and her baby received from both the CHWs of BRAC and government's health sector officials.

Case Study -4 : Story of becoming a Shasthya Shebika

Mst. Khaleda Khatun (29), D/O- Late Ruhul Aamin & late Nurjahan Begum, Vill.-Khathal, P.O.-Khathal, Trishal, Mymensingh got married to some Dulal on some Friday in 1997 with lots of dreams and hopes. But all her dreams were shattered like sand-made dam just after 7days of the marriage. This untoward incident transformed the newly married young lady to 'Divorced Khaleda' which added a new dimension to her life. From the very

childhood, she was an ever smiling, jolly and full of life young lady, but after getting divorced she became very gloomy and lonely overnight. This abrupt and unwanted change made her almost a lifeless human being who saw everything with a vacant look. She started walking in the course of life with unbearable pains in her heart. Her days were stagnant and still. She could perceive how long the days full of mental agony were. She herself witnessed and endured all these sufferings inwardly with a stoical acceptance. She found no interests in taking food, sleeping or talking to others. Her parents tried to arrange marriage for her again and again, but she refused to marry again very bluntly fearing the possible break-up. Even she once decided to commit suicide for getting permanent relief from all sorts of agonies of life. Amid this unfavorable environment, long 11 years she passed like a lifeless creature. Once sitting in the her yard, while she was pondering about the charming days she enjoyed before her marriage, a man came to her house to talk to her. He was a worker of BRAC. He asked her some questions and gave her condolence her for all the sufferings she had to undergo. Later on he asked her to join BRAC as a Shasthya Shebika (SS) and explained the scope and opportunities of a SS for doing something for the community as well as for herself. Hearing all the facts about the role and scope of performing social work as an SS, she suddenly experienced a great psychological relief; her long agonised soul gradually came out of the state of despair. She took a decision that she would not sit idle anymore; rather she would join BRAC as an SS to serve the pregnant and new mothers, children, TB patients and the common people of her locality, and thus would forget the sad memories of the past and would achieve a meaningful end of life. With a view to fulfill these dreams she took training of SS from BRAC Health Programme in 2009, and started performing her duties in her working area. People of that locality began to like her for her cordiality and dedication to her work, and they were in habit to come to her for solving their health related problems. And, she always tries her level best to provide them with all sorts of help within her reach. Once some Shofiqul Islam H/O-Shefali Begum came to her for informing that her wife's labour pain had started, and she rushed there to help Shefali to help her. But, the labour pain prolonged and time passed without delivery. Then Khaleda informed the existing situation to the concerned SK and PO by mobile phone, and the PO arranged a vehicle for shifting the patient to the nearby Upazila Health Complex, where Shefali gave birth to a male child under the supervision of

the concerned medical officer. After some days, she came to know that some Rozina, W/O-Enamul encountered a serious problem of post-delivery bleeding , she went there immediately and made necessary arrangements for shifting her to the nearby UHC for better treatment, and this mother also became safe. After this incident she became more popular and her social acceptance increased a lot. She usually provides healthcare services for at least 10 common diseases among the people of her area, and they call her 'Doctor Khaleda'. Now-a-days, she has forgotten all her past sorrows and pains. Now she has been passing her days amid mental peace and happiness by giving healthcare services to the common people and thus earning her livelihood in a decent way. She thinks all the children of the locality as her own, and all the people as her near and dear ones. Her world is big enough now. Hearing about all her success story as an SS, the UM of BRAC Health Programme, Trishal one day to her house and wanted to make her the 'Model Shebika'.It gave her immense pleasure. The UM sent her for higher training meant for the 'Model Shebika', and after completing the training, when she came back to her working area, her office gave her BP machine, Thermometer, Eye-chart, Pregnancy-detecting Kit for using in her area to ensure better service delivery for the people. People from the locality come to her house for getting preliminary treatment of common diseases, for examination of eye-sight, BP-check, Pregnancy test, fever check and so on. She feels proud for being able to serve the common people. Now both of her name, fame and income have increased. Though she herself does not have any child of her own, yet she owns all the children of the locality as her own. Now she is not known as the 'Divorced Khaleda', rather now she is popular among thousands of people of the locality as SS 'Khaleda Aapa'.

4.12 Main Challenges Identified by BRAC Health Programme

- Low rate of deliveries by skilled birth attendant.
- High rates of neonatal deaths, malnutrition and micronutrient deficiencies.
- Emerging and re-emerging diseases and impact of climate change.
- Rise in non communicable diseases (NCD) including cardio-vascular diseases, diabetes, cancer and injury

- Diversification of family planning (FP) service and high rate of discontinuation and unmet needs.
- Ineffective urban primary health care service delivery.
- Gender sensitive and equity based service delivery.
- Inadequacies in human resources.
- MIS functions along with sustained M&E system.
- Quality assurance system, medical auditing, accreditation and weak legal framework.
- Low utilization of public health facilities by the poor.

4.13 Chapter Summary

Bangladesh, one of the most densely populated countries on the planet, nearly 160 million people in a 1, 47,570 Skm areas, is somehow creating a miracle. Over the last decade the deaths of new mothers has dropped dramatically by 40 percent. Today Bangladesh is one of just 16 countries on the path to achieve the United Nations' Millennium Development Goals, including cutting maternal deaths by 75 per cent by the year 2015. As a whole, maternal mortality and child mortality has dropped; the contraceptive prevalence rate has gone up to eight fold; immunization coverage increased to 82 per cent; TB-programmes's success rate is near about 80 per cent; and in the field of using sanitary latrines, access to safe drinking water and cultural change in personal hygiene practices changed tremendously. All these achievements occurred because the GOB and the NGOs like BRAC have been working in the healthcare sector with a holistic approach over the last four decades.

Situation specific planning; dedicated and well motivated CHWs and volunteers; fitting training programmes; mass awareness building; community participation; need based interventions; low-cost and easily accessible services; effective small-scale social enterprises running by the SSs; well-designed partnership programmes with the government; and above all visionary as well as pragmatic leadership are the main causes behind BRAC's tremendous success in the healthcare sector of Bangladesh. BRAC has reached to the height of excellence in the field of healthcare programmes by valuing the

genuine needs and aspirations of the target people and inculcating the learning gathered from the rural people of Bangladesh.

CHAPTER 5
Analysis of the Findings

5.1 Introduction

The previous chapters reflect the context, setting, background, theories, issues and specific example concerned with GO-NGO collaboration in the healthcare sector management of Bangladesh. It is a fact that government of a developing country like Bangladesh is not in a position that it alone can manage and fulfill all the demands in the health sector. Due to resource constraints (e.g. adequate amount of funds, skilled and motivated manpower, necessary technologies and equipments, infrastructures, wide area coverage, awareness building and professionalism and so on), governments of the developing countries are engaging gradually the NSPs / NGOs in partnerships to achieve greater success for improving the overall condition of the citizens. The central role in this regard must lie with the Government, because only Government has the legitimacy, constitutional obligation, revenue money, coercive power and public support in running the country. This is an age of co-produced or networked governance, and hence to produce desired and fruitful results, collaboration between the Government and the NGOs has become a norm. But, as a result of the changing geo-political situation over the past few years, the interface between the Government and the NGOs has increasingly been playing a vital complementary role in bringing about positive changes in the healthcare sector of Bangladesh, and thus helping in achieving the Goals of MDGs and national targets as well.

From the Field Visits, Focused Group Discussion(FGD)s, Case Studies and concerned literature reviews, it is obvious that the relationship between NGOs and the GOB has been and is mixed, varying from having parallel or competitive activities to cooperation and collaboration for social sector programmes (Asian Development Bank 1999;UNICEF 1999; Begum 2000; Zafar Ullah 2002). Among the types of GO-NGO relationships existing in Bangladesh, some of them correspond with Green and Mathias' *Competition-Control Continuum Model*, some with Adil Najam's **Four-Cs Model** (based on cooperation, confrontation, complementarity, cooptation), some are context specific and have clear overlaps, and in some cases the Government and the NGOs consider each other as their

opponents, where the relationships often become hostile. But, the recent trend is different from earlier, and there is increasing cooperation and collaboration between the GO-NGOs, especially in poverty reduction, healthcare, education and other social welfare activities (Asian Development Bank 1999; UNICEF 1999; Begum 2000; Zafar Ullah 2002).

The Government's policies and legal frameworks within which these relationships take place inevitably affect its day-to-day relations with NGOs. Furthermore, local government structures and local administration play an important role in maintaining good relationships with NGOs in coordinating health and other NGO-run activities at local levels. In particular, local governments and local administration are actively collaborating with NGOs in selecting sites for CCs, in implementation of sanitation programme, in social mobilization, and in awareness building activities in the healthcare sector. In the present socio-economic context of Bangladesh, NGOs have earned a significantly firm position and have played a catalytic role towards national development. Now-a-days the NGO sector can influence the mainstream of development through collaboration with official bodies. While greater collaboration can be beneficial to both the parties, given the rich experiences of the NGOs in Bangladesh, it is difficult to ignore the role of NGOs in development management especially in a critical sectors like health and family planning. Realizing the potentials of NGO sector, GOB has already framed a national health policy (Health Policy 2011) incorporating provisions for undertaking various programmes with NGOs and has already engaged different NGOs in various sectors of national development. From the experience achieved so far, it is evident that a healthy GO-NGO relationship can only be conceived where both parties share common objectives and strategies. With a view for utilizing the potentials of both the sectors, a genuine partnership can be developed between NGOs and the GOB on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions to ensure overall development of the country.

We can easily trace out the facts relating to the existing GO-NGO relationship in the health sector of Bangladesh from the following data and ground-level realities collected from the Trishal Upazila of Mymensingh District.

5.2 Findings from the FGDs, Case Studies and Concerned Literature

From the field visits, discussions with the stakeholders, hearing the real-life case-histories from the beneficiaries, and reviewing the literature concerning GOB-BRAC collaborative partnership in different healthcare programmes, it is very conspicuous that Bangladesh has to establish well-defined partnerships with the NGOs/ NSPs to ensure necessary healthcare facilities for the people of the grassroots level. The experiences achieved by this researcher during the field-level study of TB-control and MNCH programmes run by BRAC in collaboration with the government of Bangladesh very clearly indicate that common people like to have immediate access of healthcare facilities, and they are in favour of more stronger GOB-BRAC collaboration in the health sector programmes. The beneficiaries of the said partnership of GOB-BRAC also praised very highly of the sincerity and caring attitude of the SSs of BRAC Health Programme. The UHFPO of Trishal, Mymensingh also spoke very highly about the effective role of the SSs and CSBAs of BRAC Health Programme (BHP) in the peripheral areas of the country. He termed the role of the BRAC's health functionaries as the '*gap-filling*' work, where GOB health functionaries were unable to address properly because of resource constraint and skilled manpower shortage. The UM of BHP, Trishal, Mymensingh expressed his gratitude to the government health functionaries for all sorts of help especially in connection with the implementation of TB control and MNCH programmes in his area. The stakeholders of the GOB-BRAC collaborative health programmes emphatically stressed for designing more effective mechanisms in order to ensure healthcare services for all the people, esp. the poor of the country. So, it can be said that in the present socio-economic context of our country, the existence of the NGOs/NSPs is a burning reality, and GO-NGO collaboration is a felt need, an appropriate necessity of time.

In the time of field visits, discussions with the focused groups and hearing the real-life experiences (Case Study) from the stakeholders, the researcher tried to find out the mechanisms of successful GO-NGO collaboration in the health sector. And this is why the concerned beneficiaries as well as the officials of the GOB-BRAC run collaborative healthcare programmes in Trishal Upazila were asked to express their views regarding

the successes and failures of the healthcare services so long provided to them. The beneficiaries were of the opinion that Improving Maternal, Neonatal and Child Survival; EPI; TB-programme, Family Planning; ARI; WASH, and so on health related programmes were successful because of the effective collaboration between the government and BRAC officials. The beneficiaries told that the BRAC's health functionaries helped a lot and even more than the government's health functionaries as far as safe home delivery, newborn care, family planning, and other common diseases are concerned. But while the cases were not so simple and common, they were referred to the nearby government health facilities (UHC) through BRAC's referral-arrangements, and they were immensely benefitted by the government medical professionals working there, almost all of them added. They expressed their gratitude and thanks for BRAC's very effective referral system for the complicated cases as well as modern healthcare facilities provided by the GOB healthcare professionals of the nearby UHC.

The most of the BRAC's health functionaries expressed their positive views in favour of contractual collaboration with the government and they also supported the provision of providing financial help to the NGOs by the government to make the GO-NGO collaboration successful. Moreover, the NGO functionaries expressed their opinion in favour of having consultation from the government side with the NGOs during planning stage.

Given the facts of bureaucratic inertia, lack of logistics, distrust and other supplementary skills, in general, most of the field level functionaries of both the GOB and NGOs (for example, BRAC) involve in the collaborative projects noted the importance and necessity of such collaborative projects in the health sector.GOB and NGO functionaries however noted several strengths of such collaborative projects. According to their opinion, collaboration between GO and NGO has developed a unique grassroots level network for program implementation. They made the assessment that the approach of GO-NGO collaboration has introduced an innovative program management style in Bangladesh. One of the major strengths of such collaboration is it has created a condition of mutual learning and transfer of knowledge and technology both ways. Collaboration has also ensured quick response to local need and the system has helped in mobilizing local

opinion and ideas. As a result, it has reduced the extent of red-tapism and ensured greater degree of people's participation. Moreover, GO-NGO collaboration has introduced an efficient planning system and has enhanced the overall efficiency in identification of target groups/clientele needs and problems. Through collaboration a professional environment and capacity for implementation, monitoring and evaluation has created. Such collaborative program has enhanced local accountability in program delivery system.

5.3 The potentials and constraints of Government–NGO collaboration in Bangladesh

Next we can analyze the potentials and constraints of government–NGO collaboration in the healthcare sector of Bangladesh. Here it should be noted that in this section of the paper, 'BRAC' would represent the NGO-sector in general. During the analysis, the researcher has focused on the strengths as well as weaknesses of collaboration in relation to access, efficiency, quality and coverage of the healthcare services provided by the GOB and the NGOs.

Table 8 summarizes the strengths and weaknesses of the government–NGO collaboration, and its future opportunities and potential threats.

Table 8.   SWOT analysis for GOB-NGO collaboration in health sector in Bangladesh

Strengths	Weaknesses
Access related	Process related
• Increases people's participation, and enhances the accessibility of health services to the poor; • Gives GOB and NGOs access to each other's expertise and resources; • Creates demand among the poor and disadvantaged for health services;	• Difficult to choose partners because of diversity and abundance of NGOs in the health sector in Bangladesh; • NGOs' dependency on external funding; • Unwillingness of some NGOs to work with the government; • NGOs are afraid of being exposed to government;

Coverage related	• Lack of mutual trust between the government and NGOs;
• Joint implementation of health programmes increases coverage;	• Fear of losing philosophical independence.
• Ensures utilization of knowledge and abilities of collaborating agencies;	
• Provides opportunity for rapid expansion of PHC.	Capacity related
	• Inadequate initiative on sharing lessons from PHC approaches;
Efficiency related	• NGOs are mostly maternal and child health/family planning focused; only a few NGOs have experience of working in a broader canvas like PHC;
• Improves institutional capacity of government and NGOs from sharing of technology and information;	• Lack of uniformity of standards or capacity for providing quality health care services Amongst health NGOs.
• Government functionaries come in contact with the flexible management from NGOs	
• Encourages cost-effectiveness.	
Quality related	
• Competence-based training and technical assistance provide to the government by NGOs;	
• Collaboration around areas of excellence between GOB and NGOs improves quality.	

Opportunities	Threats

Policy related:	Process related:
• Health Policy-2011 encourages the GO-NGO collaboration • Paradigm shift for wider collaboration among government, NGOs and private sectors; • Current health sector reform programme calls for greater government-NGO collaboration. Practice related • A viability of global experiences on successful collaborative approaches in Improving Maternal, Neonatal and Child Survival; TB-Control programme etc. • Support from international development partners for PHC; • Growing political awareness for communicable disease control programmes.	• Resistance from some NGOs; • For contractual forms of collaboration, there will be competition between NGOs to 'win' the same pot of money; • Lack of sustained government focus on public health issues. Outcome related: • Slow progress of health sector reform; • Over-controlling of NGOs' flexibility by the government.

Evidence suggests that access to health services has increased through Government–NGO collaboration by ensuring people's participation in the health and development programmes. NGOs have proven ability to improve people's capacity to seek and utilize health care (UNICEF 1999; Begum 2000; MOHFW 2001; Newell 2002; Mercer et al. 2004.). Almost all of the stakeholders believed that collaborative activities ensure people's participation, the mobilization of resources and increased coverage of services. In course of the research, the fact has been unveiled that if the government and NGOs, while collaborating, share tasks among themselves based on their knowledge and skills, which in turn can free up resources for other social welfare activities, thus widening the

spectrum of services for the poor and the disadvantaged. It is also widely acknowledged that concerted and collaborative efforts are needed to address public health problems. Without collaboration, the differing interests and ideologies of government and NGOs can lead to confusion and disparities (Bratton 1989; Honandle and Cooper 1989; Barkat and Islam 2001). Alter and Hage (1993) argue that organizational individualism has been seen as an inadequate response to the problems. Efficiency is strength of collaboration. There is less duplication among government and NGO activities, especially in a context of resource constraints (Ross 1990; Begum 2000; Barkat and Islam 2001). Moreover, harmonization of both procedures and reporting mechanisms makes monitoring and evaluation easier (MOHFW 1998; World Bank 1998; Begum 2000; NTP 2002).

Government–NGO collaboration enhances institutional strengthening of the collaborating agencies through the interaction and sharing of information, technology and expertise (Ross 1990; Begum 2000; Barkat and Islam 2001). However, collaboration can affect organizational freedom to act independently as a result of prioritizing collaborative activities. It can expose one partner to others. In Bangladesh, NGOs are afraid of exposing themselves to government bureaucracy, and there is a mutual lack of trust. In addition, from the GOB side it is difficult to choose partners from the large number of NGOs available in the health sector. A major potential threat to government–NGO collaboration is the slowness of implementation of health sector reform. The absence of simple, realistic collaborative mechanisms can pose a high hurdle in the pathway of collaboration. Over-controlling the flexibility of NGOs by the Government, and lack of continuity of GOB's priorities, are other potential threats to collaboration.

5.4 Problems Identified in Collaborative Programmes

Some weaknesses of the collaborative model have also been identified by the GOB and the NGO functionaries working in the health sector of Bangladesh. First of all, they identified that collaboration has developed inter-organizational conflict. It has created a scenario of donor dependency on the part of the GOB as well as NGOs. Besides, in the time of dual supervision and monitoring it has created a situation of mutual mistrust. Most of the functionaries thought that it is not cost-effective and has created a dualism in program operations. Because of personality clashes between the GOB and NGO

programme officials, decisions in many cases are delayed and project implementation is adversely affected. Because of strong donor connections, NGOs tend to dominate the implementation and monitoring process. The system of joint supervision and monitoring have created some confusion in terms of unity and chain of command; and because of design errors in supervision, support, and decision- making process, the model has created a situation of cold war between the GOB and NGO staff. It seems a strong "*we*" versus "*they*" feeling persists in the programmes. This feeling of mistrust has affected the performance of the programmes significantly.

Based on the preliminary observations drawn from the case studies, focused group discussions during this study and concerned literature, following conclusions can be drawn:

- ➢ There appears to be some built-in design errors in the GO-NGO collaboration project model.
- ➢ Faulty design has caused problems of dual authority, supervision and decision making.
- ➢ GOB officials at the grassroots level have not been properly oriented with the spirit, content and operational modalities of the project.
- ➢ The GOB officials at the grassroots level never had any structured monitoring system to appraise their role and functions. With the introduction of joint monitoring and supervision system, on-the-job training by an external agency, most MoHFW officials felt threatened and unsecure and thus resisted the project.
- ➢ The project as a matter of fact failed to take into account the dominant bureaucratic culture of the GOB functionaries at the grassroots levels.
- ➢ The NGO officials maintain very good relations with the clientele for their working system. They undertake extensive field visits and follow-up trips. NGO officials also enjoy a very good logistics support like transport, office and other support services. On the other hand, their GOB counterparts do not have enough logistics support. Thus at the operational level, the GOB staff become 'frustrated' and 'demoralized' and consequently developed a passive resistance to the project as such and NGO counter parts in particular.

5.5 The Possible Way-out to Bridge the Gap between the GO and NGO functionaries

Both the GO and NGO officials have to develop a positive attitude towards the collaboration. Openness, welcoming the ideas and opinions, and giving recognition of the work for both counterparts become helpful to solve the behavioral problem and also to increase the mutual understanding .Openness about the project objectives, policies and strategies would ensure better understanding between the two partners. More training courses need to be arranged for GOB staff. Impartial and perfect situation analysis is to be recommended. Introduction of proper follow-up and monitoring system is necessary which would ensure the feedback of the programmes and also help to remove the structural barriers of the system. The potentials of community workers need to be utilized.

With a view to addressing the existing problems, the following measures can be followed:

- Review of the basis premises and working assumptions of the collaboration project, which enable the concerned counterparts to have a clear idea about their respective roles and responsibilities.
- Examine carefully the project operational manual and the built-in structural limitations of the project in order to find out probable solutions based on the practical experiences of the concerned functionaries of both the counterparts.
- To organize an elaborate orientation and de-briefing sessions for both GOB and NGO functionaries at the grassroots level.
- To bring more transparencies and openness as regards to the project goals, objectives, policies and strategies—this would develop a better understanding between the two partners.

5.6 Impacts of GO-NGO Collaboration

One of the main objectives of this study was to focus on the impacts of GO-NGO collaboration with a focus on BRAC and GOB in health sector. With a view to assessing

the positive as well as negative impacts of GO- NGO collaboration, the researcher asked the stakeholders some related questions in course of discussions with the focused groups. And both the GOB and the NGO functionaries were asked to assess the positive impacts of GO-NGO collaboration programmes from their experiences. And, both the counterparts assessed the positive impacts of the said partnership as follows:

a) People's participation;
b) Quick response to local needs;
c) Local resource mobilization;
d) Exchange of ideas;
e) Mutual support;
f) Contribution to the government policy formulation.

At the very same time, the stakeholders also identified some weaknesses or negative impacts of GO-NGO collaboration, and they were identified as follows:

a) Political interference;
b) Undue interference of the NGOs and the donors;
c) Delay in project completion;
d) Undue pressure.

Though it is very difficult to generalize the attitudes of GOB as well as NGO staff about GO-NGO collaboration; most of them realize the need for collaboration for better as well as effective service delivery to the concerned customers.

The findings of this research indicate that the collaboration qualifies for some, but not all the conditions of institution building (IB). This requires a fresh look at how to collaborate better in pursuit of national interests. The **Collaboration Model** has indeed developed a new institutional framework. The second feature of institution building i.e., introduction of new strategy and tactics can also be traced in the model. The collaboration model however could not demonstrate any significant change and major addition during the implementation stage, which is indeed a variation from the IB approach. But the Collaboration Model has been fairly successful in installing some new values and approaches in the operational structure and processes, which again complements one of

the major features of IB. However, it is very difficult to argue that the model has had enjoyed a strong political support from the national level. A thorough analysis of the background materials provide the evidence that the model was basically a "***push-forward***" idea from the respective donor agencies .Thus strong political support and commitment, a prerequisite for the IB approach, is unfortunately missing in the emerging model of GO-NGO collaboration in the health sector of Bangladesh. The final feature of IB is to establish a trust and confidence between the participants and the administration. Objectively speaking, because of the built-in bureaucratic attitude, processes and practices of the GOB functionaries, this model has partially achieved this feature of IB.

In the final analysis, the findings of the study reveal that the collaborative model in the health sector does indicate some of the significant features of IB, though some supportive features and conditions are yet to be there. With the given premise and experience, a serious attempt and corresponding commitment on the part of the GOB and the NGO concerned could easily shape the collaboration into a full blown model of institutional approach of development management in healthcare sector in Bangladesh.

5.7 Government–NGO collaboration – Key considerations

Based on the review and analyses of different government–NGO collaboration models in the health sector of Bangladesh, we identify certain essential preconditions which are critical to successful and sustainable collaboration between the government and NGOs (Begum 2000; WHO 2000; Barkat and Islam 2001). These are:

- ➢ mutual respect and trust;
- ➢ recognition of mutual strengths and values, and comparative advantages;
- ➢ favourable policies, laws and regulatory frameworks;
- ➢ effective mechanisms to monitor, measure and learn;
- ➢ transparency and accountability;
- ➢ involvement of all stakeholders at every step;
- ➢ continued commitment of collaborating partners
- ➢ exchange of views and experiences

The following are some commonly agreed lessons learnt from the government–NGO collaboration in implementing DOTS and MNCH programme in Bangladesh (Hussain 2001; MoHFW 2001; WHO 2001b, BRAC 2011):

a) the collaboration ensures greater coverage and access through NGO service facilities and community based infrastructures.

b) NGOs are able to increase awareness among the general population about TB-control, family planning, MNCH programme, leading to increased numbers of TB suspects and complicated pregnancy cases at different health facilities.

c) Unified reporting systems enable a full account of both the NTP and MNCH's programmatic performance.

d) Although NGOs are following national guidelines, they decide the operational strategy appropriate to their philosophy and thinking. This allows organizations to retain their independence while being accountable to the MoHFW.

5.8 Principles of NGOs involvement

This study has critically analyzed government–NGO collaboration models in the health sector in Bangladesh, including those existing in Improving Maternal, Neonatal and Child Survival (IMNCS, formerly MNCH), TB control, FP and EPI programmes. As a result of the analysis, the following *principles* can be followed for NGO involvement:

Principle 01. The Government has the constitutional obligation for ensuring the healthcare facilities for its citizens. It must, therefore, take the lead in developing supportive policies and strategies for involving NGOs in health care programmes.

Principle 02. The NGOs' role is to build the capacity of individuals, communities and the government, and to facilitate and support community action.

Principle 03. The involvement of NGOs should be based on mutual strengths, philosophies, objectives and the nature of the collaborating agencies.
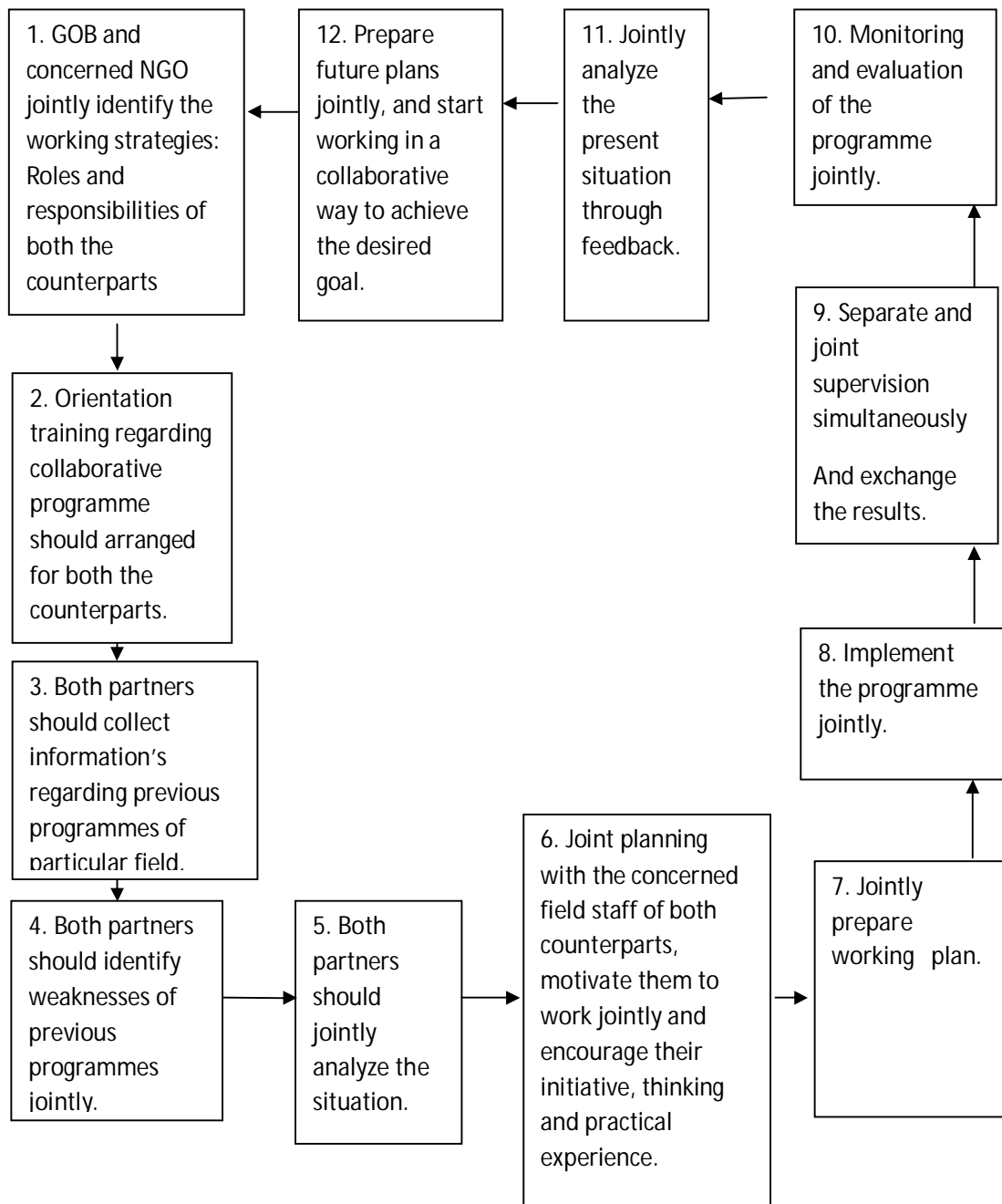
Principle 04. There is no ideal model for government–NGO collaboration in health care sector; the most suitable one should evolve through a transparent and iterative process. And, it must be situation specific and peoples' friendly.

5.9 A Proposed Model of GO-NGO Collaboration

The working GO-NGO collaboration model in Bangladesh is mostly based on similar goals (ends) of *Cooperation and Complementarity* **of** Adil Najam's **Four C's Model**, which with all its limitations can emerge as an institutionally viable model in development management through addressing these problems. The findings of the study reveal that the collaborative model in health sector indicates some of the important features of IB. Some supportive features and conditions are though yet to be there, a serious attempt and corresponding commitment on the part of both the counterparts could make it possible to shape the collaboration in the full blown model of institutional approach of development management in health sector.

With a view to making the existing collaboration model more practical, useful and active, the following alternative working flow is prescribed to follow.

Table 9.   Prescribed Alternative Working Flow for GO-NGO Collaboration:

1. GOB and concerned NGO jointly identify the working strategies: Roles and responsibilities of both the counterparts	12. Prepare future plans jointly, and start working in a collaborative way to achieve the desired goal.	11. Jointly analyze the present situation through feedback.	10. Monitoring and evaluation of the programme jointly.

2. Orientation training regarding collaborative programme should arranged for both the counterparts.

3. Both partners should collect information's regarding previous programmes of particular field.

9. Separate and joint supervision simultaneously

And exchange the results.

8. Implement the programme jointly.

4. Both partners should identify weaknesses of previous programmes jointly.

5. Both partners should jointly analyze the situation.

6. Joint planning with the concerned field staff of both counterparts, motivate them to work jointly and encourage their initiative, thinking and practical experience.

7. Jointly prepare working plan.

(Source: Begum, 2000)

The prescribed working flow would be able to address the existing problems of collaboration model. There are twelve stages in this prescribed working process and in

every stage; both the counterparts are suggested to work jointly. One of the major weaknesses of the existing model is the faulty design that has caused problems of dual authority, supervision and decision –making. In the prescribed process, both the partners begin their collaborative work through identifying the working strategies jointly. In this stage, both the counterparts would also have a clear idea about their respective responsibilities would ensure better understanding between the two partners.

In the second stage, suggestion has been given to arrange orientation training for both concerned GOB as well as NGO personnel about the collaborative programme. This suggestion would solve another major problem, GOB officials at the grassroots level have not been properly oriented with the spirit, content and operational modalities of the project. So, the GOB functionaries appear to be passive and reluctant about the projevct.GOB field functionaries are found to be very much self-guarding and conservative as regards to the relationship with their NGO counterparts. Through arranging orientation training, the prescribed process would be able to solve the problem.

5.10 Chapter Summary

Given the rich experiences of the NGOs of Bangladesh, it is difficult to ignore their role in development management especially in a critical sector like health and family planning. With a view to utilizing the potentials of both the sectors, a genuine partnership can be developed between the NGOs and the Government on the basis of mutual trust, respect, and acceptance of autonomy, independence and pluralism of opinions and positions.

Based on the observations of the above study, the following broad conclusions can be drawn:

- In line with the global trends, the NGOs in Bangladesh are emerging as a strong contender of resources and increasingly getting recognition by the donor communities.
- GOB has also in principle accepted the NGOs as partner of development, but does not, as yet have any specific policy as how the NGOs should involve in

development activities. Consequently, the NGOs are getting involved in almost all development activities in the peripheral Bangladesh.

- The NGOs in Bangladesh do have proven records of achievements in organizing poverty alleviation projects, income generating activities for the poor and disadvantaged and community mobilization. However, in health sector the role and involvement of the NGOs are limited. Though BRAC has shown spectacular success in implementing the EPI, TB-control, maternal and child health care and family planning programmes, rest of the local and national NGOs have not been able to show such significant achievement.

From the findings of the study, it can be said that the GOB-NGO collaborative projects are running through an emerging model. However, there are some built–in design-errors in the model which include-

- inter-organizational conflict;
- a dualism in operation management;
- negligence towards monitoring and evaluation from GOB side;
- delayed decision making;
- confusions in chains of command;
- problems of dualism in authority; and
- lack of orientation of GOB staff about the spirit, content and operational modalities of the collaborative programmes.

Chapter 6
Conclusion

6.1 Introduction

Over time, the nature, scope and role of Public Administration have been changed. In keeping with the gradual shifts of focus, nature, methods and parameters, Public Administration (PA) has changed and at the same time eventually accepted the role of the NGOs as partners in development. From different perspectives, various schools of thoughts analyze the emergence and role of the NGOs. One school considers NGOs as a potential alternative institutional framework that can play a catalytic role for macro-level social transformation. Another school of thought acknowledges the role of the NGOs as efficient social mobilize and also effective deliverers of goods and services towards the poor. Again there is another school that raises the complaint against the NGOs that the NGOs serve the interest of international corporate capital. Whatever the analyses are, there has been a significant worldwide growth and expansion of the NGOs who are treated as one of the primary institutional sectors alongside government and business. In fact, limitation of government efforts towards development management encourages searching for alternative institutional framework all over the world. The NGOs are now recognized as organizations alternative to Government to address the needs of people otherwise unreached by official development programmes. Governments are recognizing the need to work with the NGOs. The need for such collaboration to a great extent is supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large.

The phenomenal growth of the NGOs in Bangladesh over the past two decades is attributed to two sources: the *first* is the limited success of the Government by itself to respond effectively to the enormous challenges of poverty. Thus an opportunity has been created for the NGOs in Bangladesh to play an important role in this context. And, the *second* is the emerging preference of multilateral and bilateral development partners for channeling foreign assistance through the NGOs as a result of the demonstrated effectiveness of many NGOs in delivering services to the poor.

The significant role played by the NGOs in this country can be explained through the "***consumer control theory***". This theory explains the existence of the NGOs in terms of patron-control, when the public and private sectors are unable to ensure the desired performance. Thus in the present socio-economic context of Bangladesh, the NGOs have earned a significantly firm position and have played a catalytic role in the national development. In Bangladesh, the NGO sector can influence the mainstream of development through operational coordination and collaboration with official bodies. Greater collaboration can be beneficial to both the parties.

Established linkages between the objective of the study and the research questions, and the findings:

From the researcher's point of view, it can be said that GOB-NGO collaboration has been proving its worth to exert positive impact towards removing the weaknesses of the GOB and limitations of the NGOs. For example, BRAC has been working successfully in the health sector of Bangladesh in close collaboration with the GOB.And,this type of coordination in health sector management has been proved as supportive for achieving the policy-goals stated in the '**Health Policy-2011**'.

With a view to assessing the positive as well as negative impacts of GO- NGO collaboration, the researcher asked the stakeholders some related questions in course of discussions with the focused groups. And both the GOB and the NGO functionaries were asked to assess the positive impacts of GO-NGO collaboration programmes from their experiences. And, both the counterparts assessed the positive impacts of the said partnership as follows:

  g) People's participation;
  h) Quick response to local needs;
  i) Local resource mobilization;
  j) Exchange of ideas;
  k) Mutual support;
  l) Contribution to the government policy formulation.

At the very same time, the stakeholders also identified some weaknesses or negative impacts of GO-NGO collaboration, and they were identified as follows:

e) Political interference;

f) Undue interference of the NGOs and the donors;

g) Delay in project completion;

h) Undue pressure.

e) Bureaucratic inertia.

Though it is very difficult to generalize the attitudes of GOB as well as NGO staff about GO-NGO collaboration; most of them realize the need for collaboration for better as well as effective service delivery to the concerned customers.

In the time of field visits, discussions with the focused groups and hearing the real-life experiences (Case Study) from the stakeholders, the researcher tried to find out the mechanisms of successful GO-NGO collaboration in the health sector. And this is why the concerned beneficiaries as well as the officials of the GOB-BRAC run collaborative healthcare programmes in Trishal Upazila were asked to express their views regarding the successes and failures of the healthcare services so long provided to them. The beneficiaries were of the opinion that Improving Maternal, Neonatal and Child Survival; EPI; TB-programme, Family Planning; ARI; WASH, and so on health related programmes were successful because of the effective collaboration between the government and BRAC officials. The beneficiaries told that the BRAC's health functionaries helped a lot and even more than the government's health functionaries as far as safe home delivery, newborn care, family planning, and other common diseases are concerned. But while the cases were not so simple and common, they were referred to the nearby government health facilities (UHC) through BRAC's referral-arrangements, and they were immensely benefitted by the government medical professionals working there, almost all of them added. They expressed their gratitude and thanks for BRAC's very effective referral system for the complicated cases as well as modern healthcare facilities provided by the GOB healthcare professionals of the nearby UHC.

The most of the BRAC's health functionaries expressed their positive views in favour of contractual collaboration with the government and they also supported the provision of providing financial help to the NGOs by the government to make the GO-NGO collaboration successful. Moreover, the NGO functionaries expressed their opinion in favour of having consultation from the government side with the NGOs during planning stage.

Given the facts of bureaucratic inertia, lack of logistics, distrust and other supplementary skills, in general, most of the field level functionaries of both the GOB and NGOs(for example, BRAC) involve in the collaborative projects noted the importance and necessity of such collaborative projects in the health sector. GOB and NGO functionaries however noted several strengths of such collaborative projects. According to their opinion, collaboration between GO and NGO has developed a unique grassroots level network for program implementation. They made the assessment that the approach of GO-NGO collaboration has introduced an innovative program management style in Bangladesh. One of the major strengths of such collaboration is it has created a condition of mutual learning and transfer of knowledge and technology both ways. Collaboration has also ensured quick response to local need and the system has helped in mobilizing local opinion and ideas. As a result, it has reduced the extent of red-tappism and ensured greater degree of people's participation. Moreover, GO-NGO collaboration has introduced an efficient planning system and has enhanced the overall efficiency in identification of target groups/clientele needs and problems. Through collaboration a professional environment and capacity for implementation, monitoring and evaluation has created. Such collaborative program has enhanced local accountability in program delivery system.

Evidence suggests that access to health services has increased through Government–NGO collaboration by ensuring people's participation in the health and development programmes. NGOs have proven ability to improve people's capacity to seek and utilize health care. Almost all of the stakeholders believed that collaborative activities ensure people's participation, the mobilization of resources and increased coverage of services. In course of the research, the fact has been unveiled that if the government and NGOs,

while collaborating, share tasks among themselves based on their knowledge and skills, which in turn can free up resources for other social welfare activities, thus widening the spectrum of services for the poor and the disadvantaged. It is also widely acknowledged that concerted and collaborative efforts are needed to address public health problems. It has been perceived that without collaboration, the differing interests and ideologies of government and NGOs can lead to confusion and disparities in the health sector management of Bangladesh. The main objective of this study was to focus on the impacts of GO-NGO collaboration. Based on findings of this study, the following suggestions/policy options can be put forward.

6.2 Recommendations and Policy Options

From the study, it can be said that GOB-NGO collaboration would be able to exert positive impact towards removing the weaknesses of GOB and limitations of the NGOs. Experience has shown, however, it is simply impossible to come up with a set of general recommendations, which would be appropriate in all circumstances. Solutions, which work well in one context, may perform poorly in others. There is a felt need to examine the project operational manual and address the built-in structural limitations of the projects to make it a viable model. However, with a view to promoting an effective and viable collaborative model from the experience of above mentioned study, the following suggestions may be made.

- Collaborative relationship between GOB and NGO need to be formalized within a legal framework. For this purpose, an institutional arrangement is very much essential for successful GOB-NGO collaboration model. At the same time, all existing laws and regulations concerning NGO need to be harmonized.
- Establishment of a separate planning and monitoring cell is very much essential for effective collaboration, which is responsible for the planning, evaluation, and monitoring of all collaborative programmes with the NGOs from the GOB side. While drawing up collaborative schemes, role and responsibilities of participating agencies should be clearly defined.
- Local level GOB officials need to actively participate in the collaborative programmes.

- Arrangements for orientation programme is needed for concerned GOB and NGO staff at the grassroots level with a view to making them aware of the spirit, content and operational modalities of the collaborative programmes. Joint orientation programme would be helpful to remove the mutual mistrust of both the counterparts.
- With a view to ensuring fruitful collaboration, the NGOs also need to participate at the evaluation and monitoring stages. But counterparts need to realize that a genuine partnership/collaboration is a long–term affair. Openness about the project objectives, policies and strategies would ensure good understanding between the two partners.
- More transparency is needed in collaborative programmes.
- Donors may play an important role by encouraging both GOB and NGOs to undertake more collaborative programmes.
- NGOs can be made to accountable to GOB not as a subordinate since there is no superior-subordinate relationship between them but as a partner who has been delegated to undertake development projects for GOB.

In order to achieve desired results in health sector management, both the GOB and the concerned NGOs have to be responsible in discharging their respective duties to:
- Ensure proper nutrition for both the mother and the new-born;
- Register every birth and death immediately and with proper transparency and accountability of the LGIs;
- Stop Child-marriage with the help of the Kazis with zero tolerance, and create awareness against this heinous social crime in the communities;
- Set up well-equipped 'Blood Bank' in every Upazila and growth-center; and, last but not the least--
- Set up separate Television Chanels only for telecasting development related programmes for disseminating up to date knowledge.

This study has revealed and established that development-NGOs **can and do** play a vital role in creating awareness, organizing and managing development projects at

micro level and in peripherals of the country with better efficiency. And, in order to ensure balanced and equitable development throughout the country, it is a must to build up a healthy and effective GO-NGO collaboration in Bangladesh.

New Framework for Fruitful GO-NGO Partnership Strategy:

a) GOB and concerned NGO can jointly identify the working strategies; roles and responsibilities of both the counterparts.

b) Orientation training regarding collaborative programmes should be arranged for both the counterparts.

c) Both the partners should collect information regarding previous programmes of particular field/s.

d) Both partners should identify weaknesses of previous programmes jointly.

e) Both the partners should jointly analyze the situation.

f) Joint planning with the concerned field staffs of both the counterparts, motivate them to work jointly and encourage their initiatives, thinking and practical experience.

g) Both the counterparts should jointly prepare the working plan.

h) Jointly implementation of the programme.

i) Simultaneously separate and joint supervision, and exchange the results.

j) Jointly monitoring and evaluation of the programme.

k) Jointly analyze the present situation through feedback.

l) Jointly preparing the future plans and starts working in a collaborative way to achieve the desired goal.

6.4 Further Scope of Study

There are many pertinent issues relating to GO-NGO collaboration in the development arena of a country. Now-a-days, GO-NGO collaboration may be identified as the most crucial way to implement various nation-building programmes in any developing country. In the case of Bangladesh, just after the independence the NGOs started working in various fields of development in isolation. But in the early 1990s, GOB established partnerships with different NGOs for smooth implementation of various development

programmes. Tthe EPI,FP,TB-care,Ort and MNCH programmes are some of the glaring examples of successful GO-NGO collaboration programmes. In this context, This study tries to explore the existing problems and prospects of GO-NGO collaboration in implementation of various nation-building programmes. Responses and feedbacks of this qualitative study reveal that a healthy GO-NGO relationship can only be conceived where both parties share common objectives and strategies. With a view to utilizing the potentials of both the sectors, a genuine partnership can be developed between NGOs and the GOB on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to recognize that collaboration is a long-term affair and it needs to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits. The need for such collaboration to a great extent is supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large. Since the Government is the central authority of all the activities in a democratic country, it has to assume the role for leading from the front to ensure a conducive atmosphere for establishing fruitful GO-NGO collaboration in all the possible ways. This study also points out some policy options which may be adopted by the MoHFW and other concerned authorities for creating congenial atmosphere to utilizing the respective comparative advantages of both the GO and NGOs in managing the healthcare sector of Bangladesh properly.

In fact, the GO-NGO partnership in development management is one of the vast and important issues as far as Bangladesh is concerned, but due to time constraints the researcher could not address all the concerned points. So, there is greater scope for the future researchers to work on the GO-NGO relationship in Bangladesh' perspective.

6.5 Conclusion

In Bangladesh, socioeconomic factors, shortages of skilled workers, irregular drug supplies and the absence of an effective referral system limit people's access to proper healthcare services including TB control, MNCH,ARI, and so on health related problems. Taking treatment closer to patients and increasing the availability of required treatment at every point of service delivery can improve accessibility. One way of achieving this is to

involve NGOs in a wide range of healthcare service delivery activities, from TB-control and maternal care, neonatal care, child healthcare service provisions to operational research. Lessons learnt from existing collaboration models reveal that government collaboration with NGOs in the delivery of healthcare services has enhanced case finding, treatment success, supervision and community participation. It is widely acknowledged that collaboration between the government and NGOs is the key to success in the TB-control, MNCH programme, EPI and FP in Bangladesh. More widely, NGOs play a significant role in providing healthcare and social welfare services in Bangladesh. There is compelling evidence that the Government and NGOs are '**complementary forces**' to each other in achieving national health goals. The role of NGOs, for example, in delivering the ESP, and more recently in the fight against TB, maternal and child mortality has been pivotal and effective. Therefore, although NGOs are diverse in their strategic vision and interests, there is great potential to develop collaborative approaches to improve access to and quality of healthcare services in Bangladesh. NGOs can be instrumental in establishing links between national programmes and patients. They can also have a crucial role in advocacy and in mobilizing policy makers and the community towards expansion of control programmes. Through building a powerful lobby with the government and the community, NGOs can raise awareness about causes of ill health, and create demand for services and help provide those services.

Now-a-days no government in the developing world is in a position to run the country efficiently and effectively, while operating the service sectors; trade and commerce; industries and so on. And, this is why the governments are switching over to the role of regulators and facilitators from their earlier role of operators and managers for producing better public goods and services, and in this way are trying to meet the expectations of the mass people. Governance is now a tripartite and shared endeavor in which each sector has its own comparative advantages and fulfills roles that are most appropriate to it. In this multi-sector governance regime, each sector specializes in what it does best without detracting from the government's role as a guarantor of social justice and well-being of the people. In the face of declining economic conditions, budget constraints and shrinking expenditures in social sector. Thus, governments in developing countries are turning to the private and non-profit sectors as potential partners in

healthcare delivery. Governments in developing countries are gradually expanding their vision of NGOs from mere contractors, or supplementary or complementary agents for the government, to respected or valued partners in the design and implementation of all inclusive Medicare facilities for all citizens of the country. Some NGOs provide successful examples of sustainable model for the provision of comprehensive primary healthcare services, in which healthcare services are financed through private financing and cost recovery. Bangladesh is no exception in this regard. Bangladesh government has been trying to establish fruitful networks with the NGOs for smooth implementation of various nation building programmes. As a developing country, the limited resources and inefficiencies of the public and private sectors, close collaboration can be an effective solution to address the ever increasing public health problems in Bangladesh. Collaboration or partnership is needed to fully exploit the potential strengths of all the sectors towards fulfilling the health care needs of the people. It is always a challenging task for any developing country as most of the world diseases occur in the developing countries, thus adding considerably to the national problems. All these problems have a profound impact on the standard and quality of the human life, particularly for the poor.

The **Health Policy 2011 in Bangladesh** has opened the avenues of GO-NGO collaboration in health sector management of Bangladesh. It has 15 objectives, 10 policy principles and 32 strategies, and a good number of them advocate in favour of NGO and Private Sector integration in implementation of the Health Policy in Bangladesh. In any sovereign state, it is the responsibility of the government to assure health care provision for the whole population. But the public health agenda has become so large that the governments of most of the countries have been unable to provide adequate health care. This has expedited organizations outside the government to assume part of that responsibility. In fact, lack of proper response on the part of the public sector to meet the hopes, desires and aspirations of the poor of the society has been pointed as one of the main reasons for the emergence and growth of NGOs in Bangladesh. Thus in the present socio-economic context of Bangladesh, NGOs have earned a significantly firm position and have played a catalytic role towards national development. However, Working in isolation can result in duplication of efforts and failure to accomplish health- care goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of

information. Moreover, it is has become crucial to establish a vibrant and effective networked-governance in the health care sector of the country to achieve the related goals of the much-talked MDGs within the stipulated time frame and bring about the desired qualitative changes in the country's health care sector.

Limitations of government efforts towards development management encourages searching for alternative institutional framework all over the world. The NGOs are now recognized as organizations alternative to the governments of the developing countries to address the needs of people otherwise unreached by official development programmes. It is a fact that government of a developing country like Bangladesh is not in a position that it alone can manage and fulfill all the demands in the healthcare sector. Because of resource constraints (e.g. adequate amount of funds, skilled and motivated manpower, necessary technologies and equipments, infrastructures, wide area coverage, awareness building and professionalism and so on) governments of the developing countries are engaging gradually the NSPs / NGOs in partnerships to achieve greater success for improving the overall condition of the citizens of their respective countries. The central role in this regard must lie with the government, because only government has the legitimacy, constitutional obligation, revenue , coercive power and public support in running the country. But, as a result of the changing geo-political situation over the past few years, the interface between the government and the NGOs has increasingly been playing a vital complementary role in bringing about positive changes in the healthcare sector of Bangladesh, and thus in achieving the Goals of MDGs and national targets as well.

A healthy GO-NGO relationship can only be conceived where both parties share common objectives and strategies. With a view to utilizing the potentials of both the sectors, a genuine partnership can be developed between NGOs and the GO on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to be recognized that collaboration is a long-term affair and it need to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits. The need for such

collaboration to a great extent is supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large.

It is a fact that ensuring **'Health for All'** is a gigantic task and the central role in this regard lie with the government because of its legitimacy, constitutional obligation, revenue money, coercive power and public support in running the country. But, as a result of the changing geo-political situation over the past few years, the interface between the government and the NGOs has increasingly been playing a vital complementary role in bringing about positive changes in the healthcare sector of Bangladesh, and thus in achieving the Goals of MDGs and national targets as well.

To sum up, in order to ensure '**Health for All'** and achieve the goals of the MDGs, we do need proper and pragmatic initiatives to utilizing the potentials of both the sectors. A genuine partnership can be developed between the GO and NGOs on the basis of mutual respect, acceptance of autonomy, independence and pluralism of opinions and positions. Both the partners need to be recognized that collaboration is a long-term affair and it needs to be developed on mutual trust and respect, which would ensure to utilize the potentials of both the sectors and also ensure mutual benefits. To flourish such effective GO-NGO partnerships, transparency and accountability are the inseparable preconditions of long-cherished 'Good Governance' in every sector of development. The need for such collaboration to a great extent require to be supported by the major stakeholders, including donors; disadvantaged people themselves, and the civil society at large. Only then would such collaborative efforts would prove to truly fruitful in the long run to help achieve strategic vision and goals of this country.

REFERENCES

Ahmad, A. (2003). Provision of primary health care in Bangladesh: an institutional analysis. Paper presented at the Conference on Development Research, Lund University, Sweden.

Ahmad, M. M. (2001). The state, laws and non-governmental organisations (NGOs) in Bangladesh. *International Journal of Not-for-Profit Law* . Washington DC: International Center for Not-for-Profit Law.

Ahmed, M. (2000). Promoting Public-private partnership in health and education: The case of Bangladesh, Paper presented to the seminar Public-Private Partnerships in Health, Ayutthaya, Thailand, ADB Institute and the National Economic and Social Development Board.

Alam, S.M. Nurul (2007). *Whose Public Action? Analyzing Inter-sectoral Collaboration for Service Delivery,* International Development Department (IDD), School of Public Policy, University of Birmingham.

Alter C, Hage J. (1993). *Organisations working together.* Thousand Oaks, CA: Sage Publications.

Asian Development Bank, (1999). *A study on NGOs in Bangladesh.* Dhaka: Asian Development Bank.

Bangladesh Bureau of Statistics, (1999). *Statistical Handbook.* Dhaka: Bangladesh Bureau of Statistics, Government of Bangladesh.

Bangladesh Health Watch, (2006). *The State of Health in Bangladesh: 2006- Challenges of Achieving Equity in Health.* Abridged Report. James P. Grant School of Public Health BRAC University, Dhaka, Bangladesh.

Barkat, A, Islam K. (2001). *Government-NGO Collaboration in Health and Population Sector Programme.* Dhaka: University Research Corporation (Bangladesh).

Barkat, A. Karim, M.A., Khan, S.H., and Hoque, M. (2000). Role of NGOs in delivery of essential services package: an issue paper. Dhaka: Human Development Research Centre (HDRC) and Ministry of Health and Family Welfare (MOHFW), Dhaka, Bangladesh.

BDHS (Bangladesh Demographic and Health Survey) (2007). *Preliminary Report,* National Institute of Population Research and Training Dhaka, Bangladesh, Mitra Associates Dhaka, Bangladesh, MEASERES DHS, Macro International Calverton, Maryland, USA

Bebbington, A., and Farrington, J. (1993). Governments, NGOs and Agricultural Development: Perspectives on Changing Inter-Organizational Relationships. *Journal of Development Studies,* Vol. 29, pp.199- 219.

Begum A. (2000*). Government-NGO interface in development management – experiences of selected collaboration models in Bangladesh.* Finland: University of Tampere, Department of Administrative Science.

Begum, A. (2004). *Government-NGO Interface in Development Management: Experience of Selected Collaboration Models in Bangladesh*, AH Development Publication House, Dhaka.

Bhattacharya D., and Ahmed, S. (1995). GO-NGO Collaboration in human development initiatives in Bangladesh. **BIDS Research Report No. 139**. Dhaka.

BRAC Annual Report, 2009-11

Bratton M. (1989). The Politics of Government and NGO relations in Africa. *World Development* Vol. (10), pp.141–52*.*

Bratton, M. (1990). Non-governmental Organizations in Africa: Can They Influence Public Policy?" *Development and Change*, Vol. (21). pp. 87-118.

Brodhead, T. (1987). NGOs: In One Year, Out the Other? *World Development*, Vol. (15), pp.1-6.

Brown,L. and Korten, D.C. (1991). Working More Effectively With Non-Governmental Organizations" in S. Paul (et.al.) Non-Governmental Organizations and the World Bank: Cooperation for Development, Washington D.C.: World Bank.

Buse K, Waxman A. (2001). Public-Private Health Partnerships: A Strategy for WHO. Bulletin of the World Health Organization, Vol. 79.pp 748–54.

Cassels,A. (1995). Health Sector Reform : Key Issues in less developed countries. *Journal of International Development, Vol,* 7, pp. 329-348.

Cernea, M.M. (1988). Nongovernmental organizations and Local Development. World Bank Discussion Paper # 40.Washington D.C.

Charlton,R. and May, R. (1995). NGOs, Politics, Projects and Probity : A Policy Implementation Perspective. Vol. 16(2), pp.237-255

Clark, J. (1991). *Democratizing Development: The Role of Volunteer Organizations*. London: Earthscan.

Commuri, C. (1995). State Repression and the Limits of Voluntary Action: Case Study of the 'Save Narmada Movement' in India. Paper Presented at the 1995 Annual ARNOVA Conference, November, Cleveland.

Constitution of the Peoples' Republic of Bangladesh

Coston, J. M. (1998). A Model and Typology of Government-NGO Relationships. *Nonprofit and Voluntary Sector Quarterly*, Vol. 27(3), pp. 358-382.

Douglas, J. (1987). *Economic Theories of Nonprofit Organization*. In The Nonprofit Sector: A Research Handbook, edited by Walter W. Powell, pp. 43-54. New Haven: Yale University Press.

Drabek, A.G. (1987). Development Alternatives : *The Challenges for NGOs. Supplement Issues of World Development*, Vol.15.

Edwards, M. and Hulme, D. (1996). Introduction: NGO Performance and Accountability. In M. Edwards and D. Hulme (Eds*.), Beyond the Magic Bullet: NGO Performance and Accountability in the Post- Cold War World*. West Hartford, CT: Kumarian Press.

Fakir, Gulam Samdani. (1987). The Role of NGOs in Health and Family Planning in Bangladesh. ADAB News. May-June 1987.pp.25-37

Farrington J. and Bebbington A. (1993). *Reluctant Partners: Non-Governmental Organizations, The State and Sustainable Agricultural Development, Non-Governmental Organizations Series,* ODI,London.

Fernandez A. P. (1987). NGOs in South Asia: people's participation and partnership. *World Development*, Vol. 15, pp. 39–49.

Fisher, J. (1993). *The Road from Rio: Sustainable Development and the Nongovernmental Movement in the Third World*. Westport, CT: Praeger.

Fisher, J. (1995). Government Policies Towards NGOs in the Third World: Politcal Context and the Growth of Civil Society. Presented at the 1995 Annual ARNOVA Conference, November, Cleveland.

Fisher, J. (1998). *Non-governments: NGOs and the Political Development of the Third World*. West Hartford, CT: Kumarian Press.

Fisher, J.(1993). The Road from RIO : Sustainable Development and the Non-governmental Movement in the Third World.Wesport,CT : Praeger.

Frenk, J. (1994). Dimension of health system reform. *Health Policy*, Vol. 27, pp.19-34.

Garilao,E.D.(1987). Indigenous NGOs as Strategic Institutions: Managing the Relationships with Government and Resource Agencies, *World Development*, Vol.15.

Gilson, L. and Mills,A. (1996). Health Sector Reform in Sub-Saharan Africa: lessons of the last 10 years.

GOB (2000). The National Health Policy of Bangladesh, Ministry of Health and Family Welfare (MOHFW).

GOB (2001). National TB Control Programme of Bangladesh: Review and Strategic Plan 2001–2005. Dhaka: Ministry of Health and Family Welfare (MOHFW).

GOB (2002). Project Proforma (PP) National Nutrition Project, Government of the Peoples' Republic of Bangladesh, Ministry of Health and Family Welfare (MOHFW), p. 31, November.

GOB (2005). National Nutrition Programme (NNP), Ministry of Health and Family Welfare, Dhaka.

GOB (2006). National Nutrition Program (NNP), Monitoring Report, August 2006 Ministry of Health and Family Welfare, Dhaka.

GOB (2011), *Health Policy*. Dhaka.

GOB, (1985). The Third Five Year Plan 1985-90; Planning Commission, Ministry of Planning, Dhaka

Gomez-Jauregui J. (2004). The feasibility of government partnerships with NGOs in the reproductive health field in Mexico. *Reproductive Health Matters,* Vol. 12, pp. 42–55.

Gordenker, L. and Weiss, T. G. (1996). Pluralizing Global Governance: analytical Approaches and Dimensions. In *: NGOs,the UN and Global Governance* edited by Thomas G.weiss and Leon Gordenker,pp. 17-47, Boulder, Co :Lynne Rienner.

Green A, Matthias A. (1997). Non-governmental Organisations and Health in Developing Countries. London.

Green A. (1987). The role of non-governmental organizations and the private sector in the provision of health care in developing countries. *International Journal of Health Planning and Management,* Vol.2, pp. 37–58.

Hadi A. (2000). A participatory approach to sanitation: experience of Bangladeshi NGOs. *Health Policy and Plannin*g, Vol. 15, pp. 332–7.

Hall, P. D. (1987). A Historical Overview of the Private Nonprofit Sector. In The Nonprofit Sector: A Research Handbook, edited by Walter W. Powell. Pp. 3-26. New Haven: Yale University.

Hodgkinson, V. A. (1989). Key Challenges Facing the Nonprofit Sector. In V. A. Hodgkinson, R. W. Lyman and Associates, The Future of the Nonprofit Sector: Challenges, Changes and Policy Considerations. Pages 3-19. San Francisco: Jossey-Bass.

Honandle G, Cooper L. (1989). Beyond coordination and control: an inter-organisational approach to structural adjustment service delivery and natural resources management. *World Development,* Vol. 17, pp. 1531–41.

Hulme, D., and Edwards, M. (1997). NGOs, States and Donors: An Overview. In D. Hulme and M. Edwards (eds.), NGOs, States and Donors: Too Close for Comfort? New York: St. Martin's Press.

Hussain A. (2001). NGOs and tuberculosis control. Dhaka: Bangladesh Rural Advancement Committee (BRAC), unpublished.

 Hussain, T. (192). Community Participation: The First Principle. Pakistan National Conservation Strategy , **Sector Paper #1. Karachi, Pakistan: IUCN**-The World Conservation Union.

James, E. (1989). The Nonprofit Sector in Developing Countries: The Case of Sri Lanka. In *The Nonprofit Sector in International Perspective: Studies in Comparative Culture and Policy* edited by Estelle James. New York: Oxford University Press.

Kingdon, J. A. (1984). *Alternatives, and Public Policies.* New York: Harper Collins.

Korten DC. (1988). New roles and challenges for Asian NGOs. ADAB News (Bangladesh).

Korten, D. C. (1991). The Role of Nongovernmental Organizations in Development: Changing Patterns and Perspectives. In S. Paul and A. Israel (eds*.), Nongovernmental Organizations and the World Bank.* Pp. 20-43. Washington DC: The World Bank.

Korten, D.C. (1991). The Role of Non-Governmental Organizations in Development: Changing Patterns and Perspectives, in Paul, S. (eds.).

Korten, D.C. (1998). The Roles and Challenges for Asian NGOs, ADAB News, Vol. July-August.

Korten, D.C. (1998). The Roles and Challenges for Asian NGOs. *ADAB News, Vol. July-August.*

Landell-Mills, P. and Serageldin. (1991). Governance and the development process . *Finance and Development.* Pp. 14-12.

Magagula, C.M., Odumbe, J.O., Marshall, S. (1997). The nature of collaboration between the public, private, and nongovernmental organisation sectors in the provision of family health education in Swaziland. Kwaluseni, Swaziland: University of Swaziland.

Majone, G. (1989). Evidence, Argument and Persuasion in the Policy Process. New Haven: Yale University Press*.*

Mburu, F.M. (1989). Non-government organizations in the health field: collaboration, integration and contrasting aims in Africa. *Social Science and Medicine* Vol. 29, pp.591–7.

McCormick, J. (1993). International Nongovernmental Organizations: Prospects for a Global Environmental Movement. In S. Kamieniecki (ed.), *Environmental Politics in the International Arena: Movements, Parties, Organizations, and Policy.* Pp. 131-43.

Mercer, A., Khan, M.H., Daulatuzzaman, M., and Reid J. (2004). Effectiveness of an NGO primary health care programme in rural Bangladesh: evidence from the management information system. *Health Policy and Planning* Vol. 19, pp.187–98.

Mercer, et.al. (2004). Effectiveness of an NGO primary healthcare Programme in rural Bangladesh: Evidence from the Management Information System. *Health Policy and Planning.* Vol.19, No.4, pp. 187-198.

Mills ,A. et.al. (2001*). The Challenges of Health Sector Reform. What must government do ?* , Basingstoke: Palgrave.

Najam, A. (1996a). Nongovernmental Organizations as Policy Entrepreneurs: In Pursuit of Sustainable Development. PONPO Working Paper No. 231. New Haven, CT: Program on Non-Profit Organizations, Yale University.

Najam, A. (1996b). Understanding the Third Sector: Revisiting the Prince, the Merchant, and the Citizen. *Nonprofit Management and Leadership*, Vol. 7(2), pp.203-19.

Najam, A. (1996c). NGO Accountability: A Conceptual Framework. *Development Policy Review*, Vol. 14(4), pp.339-353.

Najam, A. (1999). Citizen Organizations as Policy Entrepreneurs. In D. Lewis (ed.), *International Perspectives on Voluntary Action* , p. 142-181.

Newman, J.(1998). The Dynamics of trust. In: Coulson, A., (Ed.) Trust and Contracts : Relationships in local government, health and public services, pp.35-52 Bristol : The

Policy Press Non-Governmental Organizations and the World Bank: Cooperation for Development, Washington D.C.: World Bank.

NTP (2001). The National Tuberculosis Control Programme (NTP) in Bangladesh – Annual Report 2001. Dhaka: Government of Bangladesh.

NTP. (2002). The National Tuberculosis Control Programme (NTP) in Bangladesh – Annual Report 2002. Dhaka: Government of Bangladesh.

NTP. (2003). The National Tuberculosis Control Programme (NTP) in Bangladesh – Annual Report 2003. Dhaka: Government of Bangladesh.

Opoku-Mensah, P. (1997). Allies or Adversaries? NGOs and the African State--The Case of Ghana. Presented at the 1997 Annual ARNOVA Conference, December, Indianapolis, 1997.

Osman, F. A. (2004). *Policy Making in Bangladesh: A Study of the Health Policy Process*, AH Development Publication House, Dhaka.

Paul, S.(1991). *NGOs and the World Bank: An Overview*, Paul, S. and A. Israel (ed.) Non-Governmental Organizations and the World Bank; Cooperation for Development, Washington, D.C. World Bank.

Paul, S., and Israel, A. (1991). Nongovernmental Organizations and the World Bank, pp.44-93. Washington DC: The World Bank.

Pearce, J. (1997). Between Co-option and Irrelevance? Latin American NGOs in the 1990s, in D. Hulme and M. Edwards (eds.) NGOs, States and Donors: Too Close for Comfort. London: Macmillan Press.

Perry, H. B. (1999). Reaching ''Health for All'' in Bangladesh: Lessons in primary health care for the twenty-first century. Dhaka: University Press Ltd.

Perry, H. (2005). Health for All in Bangladesh: Lessons in Primary Health Care for the Twenty First Century, UPL, Dhaka.

Price, R. (1998). Reversing the Gun Sights: Transnational Civil Society Targets Landmines. *International Organization*, 52(3): 613-44.

Ritchie, C. (1996). Coordinate? Cooperate? Harmonise? NGO Policy and Operational Coalitions. In T. G. Weiss and L.Gordenker (eds.), NGOs, the UN and Global Governance. Pages 177-88. Boulder, CO: Lynne Reiner.

Rogers DL, Whetten DA. (1982). Inter-organisational coordination, theory, research, and implementation. Ames, IA: Iowa State University Press.

Rosenau, J. N. (1995). Governance in the Twenty-first Century. *Global Governance,* 1(1): 13-43.

Rosenau, J.N. (1995). Governance in the Twenty First Century. *Global Governance*, 1(1): 13-43.

Salamon, L. M. (1987). Partners in Public Service: The Scope and Theory of Government-Nonprofit Relations. In The Nonprofit Sector: A Research Handbook, edited by Walter W. Powell. Pages 99-117. New Haven: Yale University Press.

Salamon, L. M. (1992). America's Nonprofit Sector: A Primer. New York.

Salamon, L. M. (1994). The Rise of the Nonprofit Sector. *Foreign Affairs*, 73(4): 109-22.

Salamon, L. M., and Anheier, H. K. (1996). The Emerging Nonprofit Sector: An Overview. Manchester, UK: Manchester.

Sanyal, B. (1994). Cooperative Autonomy: The dialectic of State-NGOs relationship in Developing Countries. **Research Series No.100**. Geneva: International Institute for Labour Studies.

Smith K. (1989). Non-Government organizations in the health field: collaboration, integration and contrasting aims. *Social Science and Medicine*, 29: 345–402.

Smith, S. R. and Lipsky, M. (1993). Nonprofits for Hire: The Welfare State in the Age of Contracting. Cambridge, MA: Harvard University Press.

Talukder MN[1], Rob U, Mahabub-Ul-Anwar M. (2008) Lessons learned from health sector reform: a four-country comparison, *Int Q Community Health Educ.* 2007-2008;28(2):153-64

Tandon, R. (1989). The State and Voluntary Agencies in Asia. In *Doing Development: Government, NGOs and the Rural Poor in Asia* edited by Richard Holloway. London.

Todaro, M.P.(1990). *Economics for Developing World.* London.

Ullah, A. N. (2002). **MPH Thesis**: GO-NGO collaboration for effective involvement of private medical practitioners in the National TB Control Programme (NTP) in Bangladesh. University of Leeds.

UNFPA. (1995). Workshop report: collaboration between government and non-governmental organizations in population and development in Bangladesh. Dhaka: United Nations Population Fund (UNFPA).

UNICEF. (1999). Public-private partnership in the social sector – part two: country experiences. Dhaka: UNICEF Bangladesh, pp. 219–91.

Uvin, P. (1996). Scaling Up the Grassroots and Scaling Down the Summit: The Relations Between Third World NGOs and the UN. In NGOs, the UN and Global Governance edited by Thomas G. Weiss and Leon Gordenker, pp. 159-76.

Waddell, S. (1988). Tri-Sector Coproduction Collaborations: A New Type of Development Organization. Presented at the 1998 Annual ARNOVA Conference, November, Seattle.

Walley, J. et.al. (2008). Primary health care : making Alma-Ata a reality, *The Lancet*, Vol.372, Issue 9642, pp.1001-1007.

Weisbrod, B. A. (1988). The Nonprofit Economy. Cambridge, MA: Harvard University Press.

WHO (1999). NGOs and TB control. Geneva: World Health Organization.

WHO (2000). NGOs and TB control – principles and examples for organisations joining the fight Against TB. New Delhi: World Health Organization.

WHO (2001a). Involving private practitioners in tuberculosis control: issues, interventions, and emerging policy frameworks. Geneva: World Health Organization.

WHO (2001b). Tuberculosis control in the South-East Asia Region – Report of the Sixth Meeting of National TB Programme Managers, Kathmandu, Nepal, 19–22 October 2000. New Delhi: World Health Organization.

WHO (2003). Community contribution to TB care: practice and policy. Geneva: World Health Organization.

WHO (2004). World Health Organization Report 2004: Global tuberculosis control-surveillance, planning, financing. Geneva: World Health Organization.

World Bank (1989). Sub-Saharan Africa :from crisis to sustainable growth, Washington D.C., World Bank

World Bank (2000). Bangladesh: Breaking the Malnutrition Barrier, Key to Development, Bangladesh Development Series, Health, Nutrition and Population Unit, South Asia Region, The World Bank.

World Bank (2005). The Bangladesh Integrated Nutrition Project: Effectiveness and Lessons, Bangladesh, **Development Series, Paper No.8**. World Bank, Dhaka.

World Bank (2006). Economics and Governance of Nongovernmental Organizations in Bangladesh, **Bangladesh Development Series, Paper No. 11**, World Bank, Dhaka.

World Bank. (1993). World Development Report 1993: Investing in health. New York: Oxford University Press.

World Bank. (1996). Bangladesh: Pursuing common goals, strengthening relations between government and development NGOs. Dhaka: University Press Ltd.

World Bank. (1998). Project appraisal document for Health and Population Programme Project. Dhaka.

Young, D. R. (1998). Alternative Models of Government-Nonprofit Sector Relations: Theoretical and International Perspectives. Presented at the 20th Anniversary Symposium of the Center for Voluntary Organization, London School of Economics and Political Science.

Young, D. R. (1999). Complementary, Supplementary, or Adversarial? A Theoretical and Historical Examination of Nonprofit-Government Relations in the United States. In E. T. Boris and C. E. Steuerle (Eds.), Nonprofits & Government: Collaboration and Conflict, Washington, D.C.: The Urban Institute Press.

Zafarllah, A. N. et al. (2006). Government-NGO Collaboration: the case of tuberculosis control in Bangladesh. *Health Policy and Planning*, Vol. 21(2), pp.143-155.

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