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Chapter 5

THE ROLE OF NGOs IN INTERNATIONAL HEALTH DEVELOPMENT

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The nongovernmental organizations, or NGOs, are largely a post–World War II phenomenon. NGOs active before 1945 were mostly the Christian missions, such as the Salvation Army or the Catholic Relief Services (Fox, 1987). Immediately following the Second World War, a new generation of NGOs emerged which were secular in nature and initially provided relief in war-torn Europe and later in the Third World. Although the movement started in the developed world, NGOs are now present and playing important roles in many developing countries.

NGOs are not present in eastern bloc countries but have recently emerged in China and Vietnam. As the countries in the developed world became frustrated with United Nations agencies and Third World governments, their governments started directing multilateral and bilateral aid through NGOs. Donors in the developed world "turned to NGOs out of pragmatic considerations, seeing them as more efficient conduits for development inputs than the often discredited official agencies" (Masoni, 1985). NGOs

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which emerged in the Third World in large numbers are of very recent origin. Poverty, disaster, war, and other misfortunes provided grounds for NGOs to flourish in the developing world. "When someone perceives a need, an NGO is likely to follow" (Fox, 1987).

The most popular motto of most NGOs in the Third World is "empowerment of the powerless"—referring to the neglected and poorer sections of the community. But they have also involved themselves in a host of other activities, including infrastructure development, family planning, education, and growing livestock. Many others provide various services such as health care.

The relationship between the national government and NGOs varies from country to country and from region to region. Whereas NGOs derive much support and encouragement from governments in India and Bangladesh, they have functioned historically as an opposition to governments in Latin America (Drabek, 1987). In India, NGOs are considered as "partners in the movement to eradicate rural poverty" (Fernandez, 1987).

On the other hand, a few successful NGOs are becoming very large, powerful, and popular with donors and therefore influential with their own national governments. To donors, NGOs have become "the growth sector," as they receive as much as $3.3 billion from private sources and another $1.5 billion from official aid sources (OECD, 1986). In Canada, NGOs account for 22 percent of the public and private aid funds (Brodhead, 1987).

In this chapter, we review the activities of NGOs in the promotion of improved health, especially in poor countries. We provide examples from three countries—one developed and two developing—to illustrate the range of NGO activities in this field. Finally, we discuss the future of NGOs in health development activities. In this chapter we will consider only the nonprofit NGOs.

NGOs in Health Development

NGOs are important forces in many developing countries, and their contributions in Third World development are increasingly being recognized. There are probably about 3,000 international NGOs (OECD, 1981), half of which have a health component (Howard, 1981). The number of noninternational NGOs is much higher. In the following section we scan the activities of NGOs in the development of the Third World's health. NGOs have been active in the following sectors:

1. *Provision of curative services:* NGOs in developing countries

have been engaged in providing health care to specific populations, both in urban and rural areas. Methods have varied, from training village level health workers to setting up hospitals with sophisticated facilities. Expatriate physicians, nurses, and others work in some of these projects because of the dearth of local professionals.

2. *Preventive and promotive care:* Popular with many NGOs, this area has included teaching specific preventive and promotive measures as well as preventive services such as safe drinking water and sanitary latrines.

3. *Disease control:* NGOs have also been engaged in the control of many diseases such as diarrhea, leprosy, TB, or yellow fever.

4. *Family planning:* Family planning has been a most popular area of activity for NGOs. Many have been formed to work exclusively for family planning in developing countries. Indeed, in many Third World countries, such as Bangladesh, most of the national family planning programs were started by NGOs.

5. *Experimenting in health delivery systems:* Backed by high flexibility, NGOs have experimented with numerous models in order to innovate cost-effective health delivery systems. In many instances they have been able to influence the health policies of the respective governments, such as in India and Bangladesh (discussed later).

6. *Assistance to national governments:* Many NGOs consider their role to be catalyst and facilitator and hence have assisted national governments in executing health programs. Immunization is a particular example in this regard.

7. *Financial assistance:* Many NGOs, international and national, have provided funds to national governments and other NGOs to carry out selected health programs. The Swedish Free Church aid, for example, provided funds to local NGOs in Bangladesh for the control and prevention of lathyrism.

8. *Capacity and infrastructure development:* NGOs, mostly international, have also come forward to develop national capacities for health development by providing funds for training of doctors, nurses, technicians, and health researchers. They also provided funds for infrastructural development, such as hospitals, medical colleges, and the pharmaceutical industry. Funds provided by NOVIB, a Dutch NGO, helped Gonoshastha Kendra, an NGO in Bangladesh, to set up a pharmaceutical factory to produce essential drugs. The contribution of the Rockefeller Foundation is yet another example (discussed later).

9. *Awareness building:* Some NGOs, particularly a few private foundations, have done a catalytic job of creating public awareness about particular health problems, such as overpopulation, through

dissemination of information. The role of the Ford Foundation is an example in this regard (Caldwell and Caldwell, 1986). Increasing health awareness among the people has been a popular activity for most Third World NGOs.

Country Examples

In the following section, we present examples from three countries where NGOs have made a distinctive mark in the development of health. NGOs in the United States have supported or themselves carried out health development programs in developing countries, while NGOs in countries like India and Bangladesh have contributed to the development of health in their own countries. For each of these countries we first give a general introduction and then present the case of one NGO to exemplify the range of their activities.

NGOs in the United States

In the United States, NGOs have been born and nurtured as the product of some group's or individual's perception of a need and the desire to meet that need. For example, churches have created development organizations such as Lutheran World Relief and Catholic Relief Services. Groups of individuals have formed organizations like CARE, and philanthropists have created foundations like the Ford Foundation and the Rockefeller Foundation. In most of these cases the motivation of the founders was clearly to bring benefits to humanity, particularly in the Third World (Fox, 1987).

*The Rockefeller Foundation** The Rockefeller Foundation was launched in 1913. Its predecessor, the Rockefeller Institute for Medical Research, was created in 1901 and stimulated the future work of the foundation. The first global activities of the foundation were directed toward the control of certain prevalent diseases, starting with an antihookworm campaign in 52 countries. Although efforts did not completely wipe out hookworm, they demonstrated how to control it and helped to "restore to health millions of sufferers in such widely scattered places as China, Brazil, Australia, India and the Fiji Islands."

Malaria was the next target, and the foundation's activities soon included other diseases, such as typhus, tuberculosis, rabies, and

*Most materials in this section have been taken from Bolling (1982).

schistosomiasis. But the foundation's most important contribution was in the control and prevention of yellow fever. The development of a vaccine at its research laboratories revolutionized the prevention of the disease. The scientist who discovered the vaccine, Dr. Max Theiler, received the Nobel prize.

The next kind of contribution of the Rockefeller Foundation to national health was through the advancement of medical education in many countries of the world. It included the establishment of some prestigious institutions, such as the Peking Union Medical College ("The Johns Hopkins of China"), the American University Medical School in Beirut, the Hong Kong Medical School, the King Edward VIII Medical School in Singapore, and the Royal Medical School of Bangkok. Its grants helped public health departments in 68 countries to improve their facilities, their programs, and the competence of their personnel.

In the early 1960s, the Rockefeller Foundation launched a comprehensive effort to promote "restraints on human fertility." In 1970 it spent $15 million, roughly one third of its grant expenditures, on population programs around the world. One of the major forms of the Rockefeller investments in the population field has been in the development of contraceptive devices, drugs, and techniques.

NGOs in India

The nongovernment organizations in India have been working for more than a quarter-century. But the number increased dramatically during the 1970s. Although the actual number of NGOs working in India is not known, the number has doubled between 1977 and 1980 and their "action-demonstrations" have affected many government policies (Chatterjee, 1988).

Many NGOs working in India have made a distinctive mark on the development of health in India. These would include the Comprehensive Rural Health Project at Jamkhed and Pachod, the Christian Medical College Health Project at Vellore, the Child in Need Institute in West Bengal, and the Voluntary Health Association of India (VHAI). We present some of the activities done at Jamkhed.

Comprehensive Rural Health Project, Jamkhed The Jamkhed project, situated in a poor and drought-prone area of Maharashtra State in India, was started in 1971. Initially covering a population of about 40,000 in 30 villages (Arole and Arole, 1982), the project has now expanded and is serving a population of 275,000 (Walsh and Dayal, 1987).

The project works through a three-tier system of health care delivery:

1. *Village health worker* (VHW): Assigned to serve her village, the VHW provides primary health care to each and every person in the village. Mostly illiterate, these female workers treat villagers for minor ailments and receive a modest salary from the project. Their responsibilities also include preventive care, nutrition education, and family planning motivation.
2. *Mobile health team:* This is the second tier of the Jamkhed health project. This team consists of a nurse, a paramedical worker, and a social worker or doctor, who visit their assigned villages either weekly or biweekly. The team provides support to the VHW in her activity and takes care of ailments too complicated for her.
3. *Health center:* The third tier is the center and four subcenters. The main center at Jamkhed has a 30-bed hospital with essential equipments. Both the center and the subcenters meet emergencies and cases referred by VHWs or mobile teams.

The Jamkhed project also has activities not strictly health related. These include farmers' and women's clubs, nonformal education, and other services through which other rural problems are addressed.

What has been the impact of this project? Outcomes have been outstanding by any standard. At the time the project was initiated, the infant mortality rate (IMR) was 180 per 1,000 live births (Arole and Arole, 1982). By 1986, the IMR had been reduced to 28. At the same time, in a control area the IMR was 80, while it was 100 in India as a whole (Walsh and Dayal, 1987). The national level "Community Health Workers" scheme owes much to the experience of Jamkhed and other NGO projects in India (Chatterjee, 1988).

One drawback of the Jamkhed program is its restriction to a small area of a vast country and so its impact on a national level will be insignificant. Another uncertainty is its replicability: Is it feasible and possible to have similar Jamkheds in every state of India?

NGOs in Bangladesh

Most NGO activities in Bangladesh are a post–Liberation War phenomenon. Several thousand NGOs are now operating in differ-

ent parts of Bangladesh, of which about two hundred receive funds directly from overseas donors. Nearly all of these NGOs have a health component. Among the many engaged in health include Gonoshastha Kendra (GK), Family Planning Association of Bangladesh (FPAB), and Bangladesh Rural Advancement Committee (BRAC). The work of GK includes the establishment of a pharmaceutical factory to produce essential drugs. We will, however, consider the activities of BRAC because its activities are more diverse and widespread than most other NGOs and because of our own association with BRAC.

Bangladesh Rural Advancement Committee (BRAC) Unlike Jamkhed, which was originally a health program, BRAC in Bangladesh is a rural development organization. Established in 1972 in the aftermath of the Liberation War, the programs have undergone several qualitative changes, all based on experiences. The main strength of BRAC programs is the ability to identify problems facing the rural poor and to seek solutions locally. Such a strategy has led BRAC to initiate programs on conscientization and awareness building, institutional development, training, research, and so on. With nearly 3,000 staff on its payroll, BRAC is now one of the largest NGOs in the world. Here we discuss only the health component of the BRAC programs, which accounts for about 35 percent of BRAC's $8 million annual expenditures.

Health programs in BRAC have also undergone numerous revisions and changes. One of the early programs was a plan to allow villagers to take part in a health insurance scheme for all family members for a token fee. The plan was later discontinued after evaluations revealed that only the well-to-do villagers took advantage of the scheme. Family planning was another initial program. Although the contraceptive continuation rate was very high for any project in Bangladesh at that time (Chowdhury and Chowdhury, 1978), the project could not recruit more than 20 percent of the fecund couples. Recent results have put the figure as high as 38 percent compared to the national estimate of 29 percent.

The real impetus for BRAC's health program came from the nationwide oral rehydration program for diarrhea, which started in 1980. Groups of trained health workers visited each household in rural areas and taught mothers about the home preparation method of a simple oral rehydration solution (ORS) with home ingredients (Abed, 1983). This program has led BRAC staff to visit mothers in 10 million households to teach a health message. The evaluation results have been very encouraging. Nearly 90 percent of mothers are capable of making a "safe and effective" ORS (Chowdhury, 1988a). The impact of the program has been investi-

gated, with preliminary results indicating a reduction in childhood mortality (Chowdhury, 1987).

Although diarrhea is one of the major causes of death in children, BRAC has also recognized the need for interventions to deal with other health problems. The ORT (oral rehydration therapy) program has been broadened to include two other components: immunization and vitamin A. Through this selective primary health care program, BRAC is now covering about a third of the country.

BRAC, however, feels that a real impact can be made only if a comprehensive primary health care program is set up and sustained over time. Toward this end, BRAC is now experimenting with a new comprehensive program in six subdistricts covering a population of about 1.2 million. With eight components (ORT, immunization, vitamin A distribution, nutrition education, training of traditional birth attendants, pure water and sanitation, basic curative services, and family planning), BRAC is also trying to involve the villagers through the formation of village health committees and mothers clubs. To make it more comprehensive, BRAC is introducing this program to areas where other rural development programs (cooperatives, credit, education) are already present.

BRAC is an NGO and considers its role as such. BRAC feels that it also has a catalytic role in that it must assist the government where such help or assistance is needed. At the request of the government, BRAC is now assisting in social mobilization and training of staff for the Expanded Program on Immunization (EPI) and vitamin A capsule distribution. The major aim of this facilitation program is to raise awareness and create demand for government services not utilized to capacity now, and at the same time to activate the government systems to cater to this increased demand. BRAC is also training lower- and mid-level government field officers in management of health programs.

BRAC has also been able to influence government policies. Examples include government promotion of BRAC's method of ORT as well as of its own programs utilizing the standard one-liter packets and also half-liter packets.

Lastly, a mention may be made of how a small program to combat tuberculosis was designed and implemented within a primary health care setting. The National TB Control Program found a high prevalence of TB in 1982 in Manikganj, a BRAC program area. With advisory assistance from the national program areas, a small program was started in Manikganj to detect and treat TB cases. Village health workers collected sputum from suspected cases for testing. People with positive results were then brought

under treatment, medicines for which were provided free by the government. To ensure continuation of the treatment, a deposit of taka 100 ($3.00) was required from the patients. On completion of the treatment, taka 75 was returned to the patient and the remaining taka 25 was given to the health worker as a fee for her services (Ishikawa, 1986).

Like other NGOs, a large portion of BRAC's program is financed by overseas donors, which include foreign governments and bilateral and multilateral agencies. However, BRAC is trying to generate funds locally through commercial ventures so that if foreign funds are not forthcoming BRAC can continue some of its programs.

The Future of NGOs

While solutions to Third World problems are not in sight, the activities of NGOs will not, it can be safely said, cease or be reduced in the foreseeable future. Because most NGO activities have been stereotyped, however, they have not made a national impact. To broaden their scope and value, they will need to include in their agenda more innovative activities which hitherto were ignored, bypassed, or considered "not the work of NGOs." We want to draw attention to two aspects in which we feel BRAC should be involved in Bangladesh: facilitation assistance to government programs and development of health research capacities.

Facilitation Assistance A close look at NGO activities in developing countries reveals an "isolationism" in most of them, implying that they work in small pockets and that their successes and failures largely remain unknown (Chatterjee, 1988). But a few NGOs have played a more prominent and distinctive role in solving the health problems of a country, as illustrated by BRAC's program to teach every mother about oral rehydration therapy for diarrhea. Not all diseases, however, have a cure like ORT; most need outside assistance for their management. Take the examples of immunization and vitamin A capsule (VAC) distribution, which require a constant supply line from beyond the home. Because government facilities are established to provide such services to the people, the role of BRAC or any other NGO in these activities should be minimal.

But often these services are not provided because government staff are not motivated to work, are not adequately trained to carry out the job and manage the program, and/or do not perceive much demand for their services. To facilitate the strengthening of exist-

ing government programs, BRAC has recently started a program with two tiers. At the first level, demand for the services is created at the community level by making people aware of health problems, by informing people where the relevant services are available locally, and by creating village institutions (such as village health committees) to demand the relevant services. At the second level, government staff (in both lower and mid-levels) are trained by BRAC to better manage the program in order to cater to an increased demand.

In health and family planning, BRAC is doing facilitation assistance in 46 subdistricts with a total population of 10 million people. Apart from health, BRAC is providing this facilitation for other government departments, such as education and poultry and livestock. Through these programs, we expect we can have a quick impact over a larger area and at the same time maintain a good working relationship with the government.

Development of Health Research Capacities A recent review of existing health research capacities in Bangladesh (Chowdhury, 1988b) portrays a very disappointing picture. Little work is being done to contribute to our understanding of the health situation in this country, a major reason being the absence of a sound plan to develop research capacities in Bangladesh institutions. BRAC wishes to implement a 12-year plan to develop this capacity in Bangladesh. First, research capacities within BRAC would be built by developing staff in the fields of epidemiology, demography, health economics, and medical anthropology through training in recognized overseas institutions. Within five years we will have developed some people to undertake joint research with government departments such as the Bangladesh Medical Research Council, Directorate of Health and Family Planning, National Institute of Population Research and Training, National Institute of Preventive and Social Medicine, and Institute of Postgraduate Medicine and Research. We hope these institutions, through this joint research, will recognize the need to have an effective research wing for themselves. The staff we develop in BRAC over the years could then be deputed to or taken by these institutions to build their own capabilities. Such a program would contribute to better study of and solutions to health issues in this country.

Conclusion

The emergence of NGOs in the forefront of a movement is of recent origin—following the Second World War. Their large num-

bers and heavy promotion in the Third World are due to several factors. NGOs have their basis in rural areas, which often are not served or only superficially touched by the existing government service structure. Through this process of grassroots level work they understand the problems of development more clearly than any other agencies. "The development failures of the past have revealed that to pour money into dealing with the symptoms of poverty is not enough—it is the underlying problems of poverty which require actions" (Drabek, 1987). With their roots among the people, NGOs are clearly in a better position to understand and analyze the problems of underdevelopment.

NGOs have come forward because the elites have become dysfunctional. Political elites do not favor mass movements or work to raise the consciousness of the people; industrial elites do not create new jobs or increase production; and bureaucrats do not deliver their services to the people. Such a stalemate called for a "means of getting benefits more directly and cheaply to the poor than governments have been able to accomplish on their own" (Korten, 1987). In the health sector, for example, voluntary agencies are considered to have succeeded in getting things to work where the government has failed. Why? Flexibility and dynamism, dedicated leadership, professionalism, intensive management, and people's participation are some of the reasons (Chatterjee, 1988).

What are the limitations of NGOs? There are several. Most NGOs work in isolation, meaning that they work in small pockets and are not open to the outside world; hence successes and failures largely remain unknown. Many good NGO programs cannot be replicated or expanded because of cost and/or management problems.

Controversy is growing on the optimal size of NGOs. How large should an NGO grow? Traditionally they have been small and worked in small areas, but today scores of NGOs work nationally (such as BRAC) or regionally (such as AMREF in Africa). Advocates of small-scale programs maintain that an NGO should be kept small in order to remain effective and efficient. This will help keep it "politically independent" and allow it to be innovative and cost-efficient. Annis (1987), on the other hand, has refuted these contentions by saying that, in the face of pervasive poverty:

- "Small scale" can merely mean *insignificant*.
- "Politically independent" can mean *powerless* or *disconnected*.
- "Low cost" can mean *underfinanced* or *poor quality*.
- "Innovative" can mean simply *temporary* or *unsustainable*.

Over the past 16 years BRAC has grown quite large, but it has not sacrificed its innovative, low-cost, and politically independent

policies. The problems of Bangladesh and other Third World countries are so big and multifarious that small programs can hardly make a difference. When BRAC was started in 1972 we thought that it would probably be needed for two to three years, by which time the national government would consolidate and take control of the situation and the people would start benefitting from independence. But as time passed, such a contention appeared to be premature. After 16 years, we feel that we have not yet outlived our utility and need to do more and more.

NGOs are now working in most parts of the world, some in very difficult conditions such as in Kampuchea, and they are considered as partners in progress. Their work has also brought them recognition. The receipt of the Nobel peace prize in 1947 by two NGOs and of scores of other prizes (such as the Ramon Magsaysay award) are overt recognition of their work. It is certain that they will continue to do their best to help the suffering humanity.

We have briefly discussed areas in which NGOs are engaged for the development of international health; we observed that they are engaged in nine different types of activities. Three short case studies, from the United States, India, and Bangladesh, have illustrated the range of activities of NGOs and exemplify some of the contributions narrated in the early part of the chapter. In view of changed circumstances and realizations, we believe that NGOs need to change their strategies in order to respond to other larger and long-term needs.

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