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The long-term role of national non-government development organizations in primary health care: lessons from Bangladesh

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This paper discusses the future role of national non-government development organizations (NGDOs) in health development. Taking the case of Bangladesh it is shown how some national NGDOs have developed into large professional organizations and how their position relates both to foreign donor support and the state. It is argued that the future contribution of national NGDOs to the development of primary health care (PHC) may be considerable, including strengthening of health care delivery by government staff. A division of tasks and responsibilities between state and national NGDOs must be based on complementarity. The discussion also has relevance for countries where state involvement in development and sustenance of PHC is diminishing because of economic problems.

Introduction

The current view of the activities and role of indigenous non-government development organizations (NGDOs) in the health field is put forward in a recent article by Mburu (1989) on the situation in Africa. He mentions characteristics of NGDOs as small size, financial weakness, innovativeness, enthusiasm, lack of experience and short duration of projects. The situation in Asia is, however, different. In countries such as Bangladesh, India and the Philippines, strong national NGDOs have emerged which run large-scale health programmes with a long-term perspective. These organizations and their programmes are likely to exist for a long time and in the present article we discuss the implications of this proposition, focusing on issues such as the stability of the NGDOs and their organizational strengths and weaknesses. Next we consider their role with regard to the state and how they can support the achievement of good-quality primary health care (PHC) throughout the country. We concentrate on Bangladesh, where a few strong NGDOs play a major role in PHC.

Since Independence in 1971 indigenous NGDOs, in which national staff control policy making, organizational management and policy implementation, have played an important role in the development of Bangladesh. Gonoshasthaya Kendra (GK) is one of the best known and it has focused on improving health in the countryside. Others, such as BRAC (Bangladesh Rural Advancement Committee) and CCDB (Christian Commission for Development in Bangladesh) include health activities but in a broader spectrum of development-related ventures.

During the first decade of Bangladesh's existence the health-related work of the NGDOs contributed to the formation of a national health care delivery system in at least three ways. First, it contributed to the country's rehabilitation in a period during which the state was too weak to carry out this task alone. Second, the organizations developed and tested new options for rural health care in a situation where the government health care system did not seem able to cope with the staggering public health problems. Third, they trained a considerable number of health care staff in community-orientated health care, particularly females.

At that time the prevailing notion among public health experts was that the contribution of NGDOs in the public health sector was

necessary, but that their role would always remain peripheral. Their importance would, in course of time, diminish due to the state services gaining strength. Moreover, doubts were raised about the effectiveness of the NGDOs health-care activities (Briscoe 1980).

Now, almost 20 years after Independence, the public health problems are still staggeringly large in the villages of Bangladesh, even though some health-related indicators have improved. In spite of considerable efforts and foreign assistance, the coverage and the quality of the government services have not sufficiently increased or improved (Unicef 1987; MR Khan et al. 1985). In the meantime some national NGDOs with considerable financial support from abroad have increased the scope of their activities significantly. With a stable support base it is foreseeable that this growth may continue for some time to come, even if its speed may diminish. Accordingly, it may be assumed that national NGDOs can play a major and long-term role in PHC in Bangladesh.

International context of NGDO health-care activities

The support from foreign donors has created a dependency, which the national NGDOs tried to counterbalance by strategies of pursuing an income base within the country itself (such as BRAC Printers, a commercially run printing press) or by broadening the number of their donors. Dependency between NGDOs in the South and donor agencies in the North is mutual, however: the donors need good projects and continuity of relations for their own survival (Lissner 1977; Streefland 1989), and therefore foreign support for the NGDOs is likely to continue. It even may increase, as multilateral donors have emphasized the importance of NGDOs as brokers in reaching the local level (Epstein 1988). Some bilateral donors, for instance Canadian CIDA, have directly funded NGDOs in the South.

From the perspective of international donors the role of national NGDOs in public health care is determined by five considerations. Firstly, they are able 'to reach the grassroots', to act as brokers between the needs of the rural and urban poor and the objectives of the donors' policies. This consideration is especially important at a time when such policies are based on the principles of PHC, including community participation.

Secondly, the indigenous NGDOs are not only considered to be better able than the state to reach the poor, they are also assumed to do so more efficiently. In fact, both views are largely assumptions and do not always go undisputed. In 1987 the Dutch government's Co-financing Programme commissioned an enquiry into the efficiency and effectiveness of three large NGDOs in South Asia (BRAC, AWARE in India, and the Sarvodaya Shramadana Movement in Sri Lanka) and the major conclusions were as follows:

- These NGDOs have been able to resist a process of bureaucratization by using a managerial approach which includes decentralization of operations and responsibilities, bottom-level upwards planning, centralized control and support, application of an intervention strategy, and elaboration of a monitoring and evaluation system
- The big NGDOs, though comparable in scale to state agencies, were less politicized and corrupt, and less bureaucratic than the latter (Beets et al. 1988).

Thirdly, the NGDOs are valued for their innovative potential. They are considered to be both sources of new ideas and to have the possibility of testing them out. In the pre-1978 period, national NGDOs such as GK in Bangladesh and Jamkhed in India provided inspiration for the development of wider PHC policies.

Fourthly, the NGDOs are considered to be reliable and efficient channels for getting emergency aid to areas and people afflicted by natural disasters.

Fifthly, in public health programmes, such as the Expanded Programme on Immunization, NGDOs are often asked to help get them started and to achieve higher coverage in a situation where the state is unable to provide sufficient organizational support, especially in the peripheral areas.

International donors, therefore, have a serious interest in supporting NGDOs engaged in public health activities. This interest is stronger where the state is less able to implement public health tasks adequately. As long as coverage and community participation figure prominently in the donors' policy, it is likely that foreign donors will retain an interest in strong and large NGDOs.

Though the international funding climate may be good for a considerable time to come, ultimately this does not change the financial dependence of the NGDOs. This implies a vulnerability for their organizations and programmes. It is, therefore, not surprising that they are continuously seeking new ways to finance their operations and, especially, their large institutional costs (Beets et al. 1988). Whether a guaranteed financial basis for indigenous NGDOs and their operations will eventually come from international sources, through arrangements with the state, or from a form of cost-sharing with the users of services, or from a combination of the three, is an interesting issue which goes beyond the scope of the present article.

Growth and characteristics of the NGDO sector

One of the roots of the NGDOs in Bangladesh and other South Asian countries is a rich tradition of voluntary associations. A village or urban quarter usually has at least one *anjuman* or *samity* under whose umbrella inhabitants unite to take some form of collective action for the common good. But this tradition does not suffice as an explanation for the explosive growth of the NGDO sector in Bangladesh. Additional factors which have probably played a major role are:

- the war of independence resulted in a large demand for relief and rehabilitation assistance, which the state could not deal with adequately
- in reaction to this demand foreign donor organizations and implementing agencies in the non-government sector established themselves in the country and set out to finance and implement projects
- in the following years there were disasters (floods, cyclones, famine) and deepening large-scale poverty. Bangladesh continued to attract attention and funds from the expatriate non-government aid sector. Proposals of national NGDOs directed at poverty alleviation would generally meet with a positive financial response
- the non-government sector had room to manoeuvre due to the breakdown of state control. Such possibilities were eagerly taken up by concerned Bangladeshis (such as ex-freedom fighters) who wanted to pursue political ideals and innovative ideas.

After a period of intensive relief and rehabilitation activities the programmes of NGDOs became geared towards rural development. In this field four directions for policy may be distinguished.

Firstly, there originated two variants of integrated rural development projects, a 'middle of the road' community development variant, and an innovative variant. The innovative strategy includes the clear choice of a target category (for example, agricultural labourers and their households), emphasis on awareness-building and informal education, organization of male and female groups and providing these with a material basis through saving, and selective use of confrontations with the rural elite.

Secondly, a variety of health programmes emerged. One type, implemented by expatriate organizations such as Save the Children Fund, Concern and Terre des Hommes (Netherlands) emphasized health care provision. The other type, initiated and run by national NGDOs (BRAC, GK, CCDB) was more community-based and included innovative elements such as health insurance, manufacture and distribution of essential drugs and promotion of home-made oral rehydration solution.

Thirdly, there has been a rapid growth of credit programmes, especially those sponsored by BRAC and Grameen Bank (GB). By the middle of 1989 BRAC covered 3150 villages and GB 13 047 villages. They provided credit to small groups of men and/or women who all belonged to the same target category of rural poor. And fourthly, in the 1980s special programmes which aimed to improve the position of women were initiated.

The larger national NGDOs are at present strong organizations, with considerable management capacity. They operate on the basis of management information systems which regularly collect data from the field. They have their own training centres, where staff and representatives from among the rural poor are trained in subjects such as non-formal education and management techniques. A few NGDOs, for example BRAC and CCDB, have their own research and evaluation staff who participate in the international development debate.

Recently, BRAC started supporting selective health intervention programmes which aim at a large coverage, such as the Oral Rehydration Education Programme and the Expanded Programme on Immunization. BRAC is also engaged in the training of government health care staff, especially in the field of management of maternal and child health and family-planning (MCH/FP) activities. In the 1970s it was involved in the implementation of comprehensive community-based health programmes, but this approach was abandoned when it proved to be extremely difficult to realize equitable care in villages with large social, economic and political inequalities. Much more modestly than before, a comprehensive PHC approach has recently been taken up again, with BRAC staff trying to tackle the equity issue through formation of mothers' clubs and carefully composed health committees.

CCDB and GK have carried out comprehensive health programmes from the early 1970s onwards. Their efforts are aimed at finding a replicable model of affordable and equitable high quality care rather than at large population coverage. In fact, theirs may be called demonstration endeavours. Of the two organizations CCDB worked closely with the government shortly after independence when, from 1972 to 1978 it pursued the strengthening of rural government health services in the Companiganj Thana (administrative unit) in Southern Bangladesh. Using foreign donor funding, the project included integration of vertical programmes and regular curative care, recruitment and training of male and female staff from the area where they would be working, decentralization of services, and community participation. It achieved some encouraging results, especially in the field of recruitment and service delivery of female workers in this predominantly conservative Muslim area. Although some of the elements, such as decentralization, are recognizable in the present government health care system, the Companiganj model was not replicated in the country, and in Companiganj itself the innovative momentum withered away after the project was concluded (Amin et al. 1989; CCDB 1978; McCord 1976).

Both CCDB and GK have also engaged in important innovative activities. GK has produced and marketed generic drugs, for instance, and CCDB has trained traditional midwives. In fact, each in its own way, the large national NGDOs in Bangladesh have become what Korten (1987) calls the third generation. They are professionally dealing with strategic issues, have a long-term perspective and play a catalytic role towards the state on behalf of the rural poor.

National NGDOs and the state

Undoubtedly one major explanation for the present position and role of NGDOs in Bangladesh is the existence of an unmet need to take care of social development. This is created by the ineffectiveness of the state in realizing its service delivery responsibilities under conditions of massive and growing poverty.

In order to understand the specifics of government health care and the possibilities for its future development, we have to acknowledge aspects of Bangladesh's history of state formation and of Bangladeshi culture and society.

As to the process of the formation of the state, it is important to recognize that West Pakistanis, who dominated decision-making within government from 1947 to 1971, were not really concerned with the needs of the rural poor in East Pakistan. Since 1971 the state has had to deal with the consequences of various natural calamities, with increasing poverty and a rapidly growing population. The needs for health care, education and employment have risen dramatically. At the same time funding from foreign donors also increased, with a concomitant rise in international influence on government policy. The failure of the state to improve its distributional and service delivery

functions has, to a large extent, been determined by the considerable influence of various rural and professional elites. Rich and middle-income peasants are able to use private modern health care which is prevalent throughout the country (Ashraf et al. 1982). The medical profession is particularly interested in strengthening medical facilities in the urban centres and is strongly supported by the urban elite. As long as an ample labour force remains to till the land and work in the urban services sector, it is unlikely that a Bangladeshi group or class which could influence the state will emerge to exert strong pressure to improve and implement large-scale public delivery of services. It therefore seems likely that the niche which the national NGDOs have created will remain, at least for the foreseeable future.

To some extent the state does deliver public health services in the rural areas of Bangladesh. But those who are familiar with the health sector have ample stories about demotivated health staff who are unfamiliar with the conditions in the villages they serve and who talk about the poor as if they are a lower grade of people.

This negative 'public health culture' reflects hierarchical values which permeate society at large, and the lack of a strong counterbalancing social creed to play a motivational role in service delivery as Gandhiism and Socialism do in parts of India. Such cultural conditions do not change overnight.

Conclusion

National NGDOs have increased in size and professionalized in Bangladesh, and this situation seems likely to continue. The government health service delivery is of low quality and does not cover the total rural population, a situation which is not expected to change greatly in the near future. It is therefore both realistic and important to ask what would be the most constructive role for national NGDOs to play under the given circumstances. Points of departure for suggested roles are:

1 Making further use of the professional and managerial strengths of these organizations.
2 Approaching health problems with a comprehensive PHC policy, with temporary selective emphasis on some components, if necessary.
3 Supporting development activities in the fields of education, income-generation and provision of credit in order to create a solid background for the diminution of poverty-related diseases.
4 Pursuing public health policy through a dialogue with the rural population. This implies that national NGDO staff may find themselves in a position of having to defend the interests of the rural poor when these are threatened by government action.
5 Dividing tasks and responsibilities between the state and national NGDOs, based on complementarity. The state should give the NGDOs sufficient manoeuvring space for shaping and testing innovative public health policy. NGDOs need a good relationship with the state to facilitate large-scale implementation of innovative interventions which have proven to be effective (Tendler 1989); similarly, to enable the state to accomplish its responsibilities as well as possible, NGDOs should support the implementation capacity of the state.
6 Facilitating regular communication between the Ministry of Health and NGDOs at national, regional and district levels.

These roles and tasks of the NGDOs may include the following:

1 Routine training of government basic health services personnel in management skills, including attitudinal and behavioural aspects of dealing with poor rural communities.
2 Developing a viable health information system, to be used both by the state and the NGDOs.
3 Providing regional support for PHC in an area not (yet) adequately covered by government services. This support could include responsibility for the operation and integration of special PHC components, such as immunization and MCH/FP services, and the creation of community-based health care in the area. This would then create specific demand for health services at village-level, which in turn could mobilize effective government service delivery.

4 Strengthening and operating education and social credit programmes in the same region.

5 Finding answers to challenging questions in the field of public health, such as how to improve rational prescribing and use of drugs, and how to finance health care through collective insurance. For this NGDOs need a strong multidisciplinary research capacity, which could also play a catalytic role towards strengthening national health research capacities (Abed and Chowdhury 1989).

If we assume that an effective process of strengthening of government services is a realistic possibility, then after an initial period the situation may change and new tasks and responsibilities for NGDOs will have to be negotiated. Progress of course will sometimes be hindered by natural calamities and other unforeseen obstacles.

Lessons learned from the Bangladesh case may be applicable to other countries as well, especially those where economic crises and international curtailing policies of structural adjustment have negatively influenced state involvement in PHC. Clearly, however, in each country the context for the operation of national NGDOs, and the historical process which shaped the particular situation in that country will differ.

It is of great importance to take the role that NGDOs can play in the health field seriously, instead of clinging desperately to the idea that the state should look after public health in all situations and at all times. The conditions in many developing countries are such that this point of view, for the time being, is not realistic. Paying more attention to the role of national NGDOs in particular will result in better prospects for PHC, but the precise division of tasks and responsibilities between the state and the NGDO sector must be negotiated in each country concerned.

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