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Nongovernmental Organizations and Health Delivery in Sub-Saharan Africa

Jocelyn DeJong

This paper sets out the distinctive characteristics — both positive and negative — of NGOs as institutions for providing health care in Africa. It raises questions about environments conducive to NGO activity and how the role of NGOs can be encouraged without sacrificing their strength in the development process.

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Although nongovernmental organizations make an important contribution to health care in Sub-Saharan Africa, there has been little detailed information about their activities. And few African governments set guidelines for NGO performance or coordinate activities with them. The lack of knowledge about NGO activities and the lack of coordination and policy oversight could impede African governments in achieving the most efficient use of national resources for health — whether public, private, or nongovernmental.

DeJong reviews the historical role of NGOs in health care in Africa and discusses the economic and political forces that have combined to bring the NGOs into greater prominence and increase the funds channeled through them. She examines the advantages and the disadvantages of NGOs operating in the health sector. Some of the advantages proponents of NGOs point out are greater motivation of staff, community-based structure, small scale, a willingness to work in peripheral areas, intersectoral scope, and greater efficiency. But NGOs depend on external funding, which may not continue indefinitely, and on foreign personnel, whose generally short stints with the NGOs create problems of continuity. NGOs typically fail to document their activities, making it difficult to evaluate the activities or to build on the NGOs' experience. And differing standards of qualification for personnel pose problems in transferring personnel between NGO and government facilities.

DeJong cautions that more rigorous assessment and evaluation of NGOs' capacity is of critical importance to ensure that the funds channeled through them are used efficiently. She suggests possible policy approaches that governments could adopt to reduce the likelihood of conflict with NGOs — and ways that governments can capitalize on the strengths of NGOs to increase their contribution to the national health care system. DeJong urges NGOs to view themselves as an integral part of the national health care system, to conform to national health policies, and to do more in policymaking. Finally, she encourages donors to consider how NGOs can be more than conduits for funds — and allowed to make the most of their strengths.

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by
Jocelyn DeJong

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The Role of Non-Governmental Organizations in Health Delivery in Sub-Saharan Africa

Jocelyn DeJong

1. Non-governmental organizations (NGOs) are major contributors to health care delivery in Sub-Saharan Africa, yet until recently, there has been a notable absence of knowledge about the nature of their activities.[1] This lacuna has critical implications, given the current trend among donors to channel funds to NGOs and encourage their role in social development. In an era of shrinking overall resources, governments' fragmentary knowledge about the activities of NGOs in the health sector is likely to impede their optimizing the use of *national* resources for health—be they public, private or non-governmental—within the framework of government policies.

2. There is tremendous diversity in the size, activities and political importance of the NGO sector in Sub-Saharan Africa. Many different government-NGO institutional arrangements exist, but it appears that in a majority of cases, few countries choose, or have sufficient information, to coordinate activities between governments and NGOs, or to set guidelines for the latter's performance. While weak state capacity may be a primary reason for this situation, the risk of such an approach is that there is little mutual exchange of information between health care providers, which may as a result duplicate services. In several African countries, for example, the mission sub-sector runs separate drug-procurement systems and there is often a lack of compatibility in policies or in personnel qualifications among the health sub-sectors. There are important exceptions to this scenario, however.

3. This paper attempts to set out the distinctive characteristics—both positive and negative—of NGOs as institutions for providing health care. It reviews the historical role of NGOs as vital contributors to health care delivery in Africa and looks at how the current environment has brought NGOs to the fore. It analyzes the implications of the trend among donors to channel resources to developing countries through NGOs and discusses

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1. In this paper, NGO refers exclusively to non-profit providers of health care, as opposed to for-profit or public providers. For a more detailed definition of the type of institutions included under this category, see paragraphs 4 and 5.

various policy options governments have employed in relation to NGOs. Finally, it raises some as yet unanswered questions about environments conducive to NGO activity and contributing to roles that NGOs can be encouraged to fulfill without sacrificing their very strength in the development process. This paper draws on limited information in several countries that have institutionalized cooperative relationships between the government and NGO health services. It considers Malawi, Ghana, Kenya (to a limited extent) and Swaziland as case studies. While these are by no means the only countries where government-NGO cooperation has been established, limited documentation on NGO activities, particularly in the health field, has made it difficult to compose a general picture for all of Sub-Saharan Africa.

History

4. The provision of modern health care in Africa remained largely in the hands of non-governmental providers throughout the colonial period. Before the mid-twentieth century, the main NGOs providing health care in Africa were Christian missions which were the first to extend health care services into peripheral areas. After World War II, a new wave of secular NGOs sprang up (Abed and Chowdhury 1988) which, in taking social development through community empowerment as their mandate, saw health as a natural part of their responsibilities. Indigenous "grassroots" organizations—cooperatives, and welfare and women's organizations—emerged largely in response to the waning of kinship ties that accompanied urbanization (Bratton 1989). In some cases, local organizations grew from the more traditional, tribal organizations. The church-affiliated organizations were and continue to be the most numerous in Africa, although secular NGOs offering health care have proliferated. Both church-affiliated and secular NGOs, however, tend to have international links and financial support, and are often staffed primarily by expatriates. National NGOs, although increasing, appear to be less strong in Africa than in either Latin America or Asia.

5. The heterogeneous nature of NGOs makes it impossible to generalize about the nature of their activities. Discussion of NGOs tends to be characterized by a plethora of preconceived ideas or generalizations, either by those who are convinced of the innovativeness, flexibility and appropriateness of NGO activities, or by opponents of NGOs who point to their limited scope or lack of documentation of activities or of accountability. Indeed, one indication of the limited consensus about NGOs is that the very nature of the type of institutions at issue is not agreed upon; the negative definition by exclusion (*non*-governmental) is not instructive in establishing positive common characteristics (Fowler in Kinyanjui 1985).

6. A range of NGOs is active in the health field and can be differentiated according to a number of dichotomies, such as international/national, religious/secular, research/action, community funded/externally funded, etc. But to a certain extent, all of the above are categories are cross-cutting; Moreover, it is not possible to obtain clear indications

of the preponderance of any given categories of NGOs. However, the dichotomies are relevant for analyzing a crucial constraint of NGO performance: from where do they obtain their funding, and as a result, to whom are they accountable? In contrast to government facilities which receive funding from only one source, the pattern of NGO funding tends to be much more diversified. As just one example of the consequences of types of organizational structure, one can contrast membership organizations (such as cooperatives or, at a national scale, the Christian health associations which act as umbrella organizations for NGOs) with organizations that depend on external voluntary assistance. The difference in accountability of the two types is critical: whereas membership organizations are accountable to local constituents on whom they depend for funding, international NGOs are beholden to the benevolence of a foreign (e.g., American, British, European, etc.) public.

Changing Environment of NGOs

7. Over the last decade the flow of resources destined to NGOs in developing countries has increased steadily. According to the OECD, private sources in DAC member countries are contributing more than US$3.5 billion annually to NGOs (OECD 1987 cited in Bratton 1989). As bilateral and multilateral levels of aid have declined, NGOs are donating a larger proportion of assistance to developing countries. A total of $1 billion is estimated to have reached Africa through NGOs in 1986 (Bratton 1989). Table 1 shows changes in NGO aid in relation to official aid disbursements in 18 countries from 19[illegible] 1986, revealing a marked increase in NGO aid in all but five cases (ODI 1988).

8. Complete data on flows of aid to the health sectorfrom through non-governmental agencies operating in Africa are not available, and the limited data which are available are subject to misinterpretation due to the lack of or discrepancies in the accounting capacity of NGOs and the risk of double-counting of bilateral aid figures.[2] However, evidence suggests that the trend towards channeling funds through NGOs has also reached the health sector and there are currently substantial flows to NGOs engaged in health-related activities (Tchicaya 1988).

9. Unlike most "fashions" in development thinking, the recent surge in the popularity of NGOs is shared by all shades of the political spectrum. On the one hand,

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2. Double-counting may occur, for example, when British Overseas Development Administration donates a proportion of its yearly budget to OXFAM or Save the Children. Similar problems arise in the U.S., where the government is often the main funder of NGOs. Certain NGOs, such as OXFAM in the U.K., have stipulated a ceiling on the proportion of funds they receive from government to maximize their autonomy from government.

Table 1. Changes in NGO Aid In Relation To Official Aid 1980 to 1986

Country	NGO Aid[a] (US$ million)		Official Aid (US$ million)		NGO Aid as Share of Official Aid (Percent)		Percent Change in NGO Aid in Real Terms 1980-86[b]
	1980	1986	1980	1986	1980	1986	
Australia	40	39	667	752	6.0	5.2	-5
Austria	23	19	178	198	12.9	9.6	-20
Belgium	45	23	595	549	7.6	4.2	-50
Canada	102	176	1,075	1,695	9.5	10.4	+68
Denmark	13	12	481	695	2.7	1.7	-10
Finland	16	28	111	313	14.4	8.9	+70
France	36	84	4,162	5,105	0.9	1.6	+127
Germany	421	545	3,567	3,832	11.8	14.2	+26
Ireland	—	20	—	62	—	32.3	—
Italy	3	11	683	2,403	0.4	0.5	+256
Japan	26	82	3,353	5,634	0.8	1.5	+206
Netherlands	79	140	1,630	1,740	4.8	8.0	+72
New Zealand	7	7	72	75	9.7	9.3	-3
Norway	33	57	486	798	6.8	7.1	+68
Sweden	59	85	962	1,090	6.1	7.8	+40
Switzerland	63	66	253	422	24.9	15.6	+2
United Kingdom	120	191	1,854	1,750	6.5	10.9	+55
United States	1,301	1,753	7,138	9.564	18.2	18.3	+31
Total (average)	2,387	3,338	27,267	36,677	(8.8)	(9.1)	(+36)

— = Not available.

a. Grants by private voluntary agencies.

b. Deflated by United Nations index of dollar export unit values of developed market economies.

Source: ODI 1988. Derived from data provided by the Development Assistance Committee, OECD.

the political left sees NGOs' emphasis on community involvement and the small-scale nature of their activities as conducive to community mobilization in contrast to bureaucratized government systems of health care. The political right, on the other hand, sees NGOs as a way around the state, a means of increasing private initiative and limiting state "dirigisme" (Bratton 1989). The widespread economic crisis has also altered the political situation, stimulating debate over appropriate roles for the public and private sectors in the economy at large and health care in particular. Donors, especially, are increasingly turning to NGOs for health care delivery in an effort to relieve the fiscal burden on governments, a trend which is consistent with adjustment policies in many developing countries. Governments, too, in the face of declining resources and their

difficulty in providing adequate services for the whole population have increasingly recognized the contribution of NGOs in the health sector in Africa, although the political acceptability of individual NGOs varies greatly.

10. The last decade has also seen changes within NGOs themselves because of the entry of a new cadre of trained technical people and professionals into NGOs, willing for idealistic reasons to accept lower salaries and difficult working conditions. This new wave of well-trained staff injected into NGOs new capacity and authority. Many observers have perceived a new assertiveness on the part of national NGOs in their relations with their international associates (Drabek 1987; World Bank 1988). A likely positive effect is that they will no longer be content to follow policies dictated internationally, but will call for more locally suitable approaches. NGOs are now seeking a louder voice in national policy making and, increasingly, in the international policy arena.[3]

11. However, as Cumper has said of NGOs in his characterization of their role as the "eunuch in the harem," NGOs may feel powerless to change the fundamental parameters within which they operate. In groping to find the appropriate roles in a new world political and economic context, many within NGOs are concerned about the implications for staffing and organizational structure of NGOs.

12. Africa has been on the forefront of the growing activities of NGOs, as its famines and economic crisis have drawn concern and attention internationally. Both the types and numbers of NGOs active in Africa have risen, particularly over the last decade (Baldwin 1988). In the health field, this broadening NGO role seems to have been particularly pronounced. As the impact on health of activities in other sectors drew increasing attention, the broad, inter-sectoral activities of NGOs at the micro level presented an example for possible replication on a national scale. Indeed the primary health care (PHC) movement was itself inspired by the small-scale successes of NGOs in mobilizing community involvement and in taking a broad perspective on health problems (Cumper 1986). The swift responsiveness and effective contributions of NGOs in famine situations in 1984 also contributed to their increased recognition (Cumper 1989).

13. The combined momentum of such forces has helped to assign NGOs more and more to the role of conduit for resources. However, in the African setting, such optimism about the capacity of NGOs to absorb funds and make up for deficiencies in government health services is somewhat at odds with the dearth of information about NGOs. There remains the threat that without more knowledge about the activities and capacity of

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3. Structural adjustment has provided a clear entry point, and NGOs have often found themselves as spokesmen for those experiencing the adverse effects of economic decline. International non-governmental organizations such as OXFAM have entered the international political discussion of such issues with their criticisms of donor policies in these areas. OXFAM's participation in the debate over essential drugs is another example (Cumper 1986).

NGOs, such a flow of resources may undermine the advantages of NGOs that are so lauded. More rigorous assessment and evaluation of NGO capacity, particularly in the health sector, is critical if the sudden surge of resources is not to be under used, perhaps to the detriment of NGOs themselves.

14. The following represents an attempt to outline the distinctive features of NGOs as providers of health services in contrast to public and for-profit providers. The discussion then continues with scrutiny of some of the misconceptions about NGOs and reasons for which caution is advisable when advocating channelling resources through them. Much of the discussion draws on literature on NGOs not specific to the health sector. This, in part, reflects the multi-sectoral nature of NGO activities. It also reflects the lack of literature due to a neglect, until recently, of analysis of the contribution of NGOs to the health sector.

Defining Characteristics and Comparative Advantages of NGOs

15. The economic crisis has put NGOs in the limelight because it is assumed that they provide a net increase in resources in health care, and because they do not put an additional strain on already over-stretched government budgets. In fact, however, this argument is disputable in many African countries, where governments frequently provide NGOs not only with direct subsidies but also "hidden subsidies" (Green 1987) in the form of relief from import duties, taxes and other financial obligations. Those who see NGOs as bolster their argument by pointing to the inherent advantages of NGOs in the health field as community-based, responsive and efficient providers of health care. Yet NGOs have been active in the health field in Africa long before the advent of the economic crisis, and their persistence is in large part explained by the niche they were able to carve for themselves. The following section attempts to enumerate some of the inherent advantages of NGOs in the health field that help to explain their persistence.

Motivation

16. Perhaps the strongest defining characteristic of non-governmental organizations is the presence of a shared ideology, be it religious or political, as the main motivating factor for NGO activities. As Brown and Korten have argued, in contrast to either the commercial or government sector, NGOs are guided neither by the pursuit of largely political or economic interests (Brown and Korten 1989). In the African setting, religion has clearly been a dominant value system inspiring the work of NGOs, yet even non-denominational NGOs share an *esprit de corps* derived from shared commitment to community empowerment which is often lacking among either commercial or government institutions. It is such overriding ideology which contributes to the capacity of NGOs to solicit community voluntarism and membership in their activities. In the delivery of health services, this commitment is likely to be reflected in the quality of care since genuine

altruism, rather than purely financial incentives, tends to motivate employees in NGOs or missions. This characteristic may instil trust in the clients of NGO services which may be lacking among clients of private health services where profit motives may pre-empt quality concerns.

Community Based

17. Consistent with their ideology, NGOs are typically community based, with their personnel residing and working in proximity to the population they serve. Their staffs are therefore much more likely than remote bureaucrats in capital cities to understand the social processes within their constituent communities, and to empathize with community members' perceived needs Such proximity also avoids value or lifestyle conflict of government bureaucrats who are socialized in a milieu foreign to that of the beneficiaries of the programs they design. Staff of NGOs therefore tend, on the whole, to be better equipped to adapt their programs to local circumstances. Moreover, because they know the members of the community, they are often able to identify their poorer beneficiaries and apply a sliding scale in fee collection. This flexibility may indeed be the key to the successful cost recovery systems prevailing in mission services.

Small Scale

18. NGOs' local autonomy—or their ability to make independent decisions—enables them to respond to expressed community needs, and is critical to their success. The limited resource base of NGOs means that few wield the cumbersome bureaucracies which slow government responses. Autonomy of operations enables NGOs to be more flexible and innovative in their activities. In addition their modest scale allows them to take risks which larger institutions are now allowed to take. It is therefore not surprising that NGOs pioneered some of the new technologies, such as oral rehydration therapy, which have become the hallmarks of PHC and have been adopted on a wide scale (Cumper 1986). Many fear, however, that if the resource base of NGOs is expanded too quickly, without the necessarily lengthy process of institution building, the price to be paid may be a loss of such valuable flexibility.

19. NGOs' small size and flexibility may also allow them to deliver services where government cannot, or for political reasons will not, and to respond quickly to emergency demands. Increasing the size of such NGOs would be likely to increase the threat they pose to government. Moreover, when NGOs function as part of an international network of NGOs, as most do in Africa, tension between the local branch and its developed-country headquarters may arise over agendas. As funds are increasingly channeled to NGOs from bilateral and multilateral organizations, constraints on their room for maneuver are likely to tighten. Indeed, Hellinger has observed a downward trend in local NGO autonomy in the 1980s (Hellinger 1988).

Reaching Peripheral Areas

20. While not consistently the case, NGOs, including missions, involved in health-related activities tend to be particularly represented in poorer, more remote areas, either out of commitment to serve the under privileged (e.g., religious missions often state this explicitly) or because they can fill a gap in such areas not already met by government services. In Ghana, for instance, while missions provide 25 percent of total hospital beds in the country, they provide about 46 percent of beds in the six under-privileged northern regions (Bradley 1989). NGO activities may also be concentrated in areas that the government is not serving for political reasons, thus potentially bringing themselves into conflict with the government (as in Ethiopia, for example, during the famine of 1984). NGOs may choose to be in a position to defend those discriminated against by government or to provide services to groups in conflict with the government (e.g., Medecins sans Frontieres) (Cumper 1986).

21. There is debate, however, on the extent to which NGOs really do reach the poor or the underserved. A Finnish evaluation found that aid provided to or through NGOs did reach the poor more successfully (Van der Jeijden cited in Hellinger 1988, p. 100), yet an analysis of U.S. private voluntary organization (PVO) projects concluded that many of these do not distribute benefits to the bottom third of the population (Tendler 1982).

Inter-Sectoral Scope

22. Perhaps one of the greatest strengths of NGOs is the inter-sectoral scope of their health activities—that they tend to see their mandate in terms of raising the social welfare of target groups or communities rather than along sectoral or professional lines. The perceived value of this approach of NGOs increased with the promotion of the primary health care movement and its emphasis on broader definitions of health and equity. Even where NGOs are not active in other sectors such as education, they often have more awareness of the wider, cross-sectoral determinants of health status, given their focus on small-scale activities.[4]

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4. NGOs often express frustration about their dealings with government precisely because they are forced to deal administratively according to strict sectoral lines, not reflecting the true nature of their activities. See articles in *World Development* supplement 1987 (Drabek 1987) for this and other complaints of NGOs regarding their dealings with governments.

Efficiency

23. Within health service delivery, there is some evidence that NGOs—both secular and religious—are more efficient in their operations than government services. Bradley found in his study on Ghana, for example, that missions tended to have lower cost per visit and to be more efficient in pharmaceutical procurement (Bradley 1989). However, as he, too, points out, such measures of efficiency are fraught with methodological difficulties, for inputs or the scale of activities may not be comparable. Missions, for example, often receive free donations of pharmaceuticals or other in-kind contributions from constituents or their international affiliates, or may call upon an network of volunteers. Moreover, NGOs are usually much smaller and often pay lower salaries than government facilities.

24. Perhaps the greatest contribution of NGOs for the development of Sub-Saharan Africa where government capacity is typically weak is that they are alternative institutions providing some channel for popular participation. In the health field, they fill a gap left by unresponsive and often unaccountable public services. They may provide a critical voice for social development and act as intermediaries between the public and government by putting public health issues on the political agenda. Many NGOs, however, are reluctant to exploit their potential influence on the public policy agenda. De Graaf, among others, has argued that now, more than ever, there is a need for NGOs to speak up in the policy arena, and that they should avail themselves of the necessary information and expertise in order to maximize their influence (de Graaf 1987). The question is whether they can expand their role in such a way without losing strengths unique to their type of organization and approach.

25. It is arguable, however, that many of the advantages of NGOs—their small size and flexibility—could apply to public sector institutions in a more decentralized organization of health care where the district level is the locus of accountability. Optimism about the capacity of decentralization rests inevitably on the ability of districts to gain some financial autonomy. Given that revenue-generating possibilities at the district level are limited and that few governments are willing to relinquish financial control, there are reasons for pessimism. Nevertheless, considerable impetus is now evident in Africa to push for decentralization and NGOs do provide an example of responsiveness for possible emulation by the public sector.

26. From governments' point of view, however, sustaining an NGO presence in the health sector may carry distinct advantages. First, in many African countries, the additional resources—particularly foreign exchange—which NGOs bring into the country are invaluable. In Chad, for instance, government has little choice but to rely on NGOs in health delivery. Anheier has attributed the presence of NGOs in Togo to the need for resources as well (Anheier 1989). Governments may also, ironically, recognize the flexibility which NGOs enjoy, and use them as innovators, particularly in politically risky areas or activities. NGOs may be free from the accountability constraints facing governments (James 1989). Likewise, NGOs' penetration into peripheral areas may relieve

government of that burden and leave them to concentrate on constituencies wielding greater political clout.

27. Clearly, the prominence achieved by NGOs is very specific to their political context; governments may need to compromise between the need for resources and the political threat posed by NGOs. In highly pluralistic societies, for instance, NGOs may provide services to different interest groups, thus insulating government from factional conflict. This is seemingly the case in Nigeria where ethnic and religious affiliations have been critical in determining the distribution of NGOs (Anheier 1989). The picture emerging of the determinants of the distribution of NGOs is complicated and research is only beginning on the issue.

Problems with NGOs

28. Despite the positive features of NGOs that make them particularly suitable for the provision of health care, the status of NGOs is often problematic. The following aspects of NGOs—though certainly not applicable to all—provide reason for caution in advocating increasing reliance on NGOs to provide health services rather than strengthening public services. The most fundamental question, perhaps, about the potential of NGOs concerns the time scale of their activities. Given NGOs' frequently weak resource base and their dependence on foreign funding (whether secular or religious), long-term planning is difficult—either for governments looking to involve NGOs or for NGOs internally. What mechanisms are there, then, to ensure that when NGOs leave the area or the country or run out of funding, that the government can take over their responsibilities in serving particular communities? Or, alternatively, if NGOs are to become a permanent component of a pluralistic health care system, where are the dividing lines between government and NGO jurisdictions? Finally, does donor emphasis on NGOs divert attention from strengthening the long-term viability and capacity of public sector services?

Dependence on External Funding and Personnel

29. In the current African setting, where self-reliant local institutions are few and government coffers nearly empty, many NGOs must increasingly turn to international financial support for their activities. While this support is vitally necessary during a period of economic downturn, the long-term implications of such dependence may be decreased autonomy of NGOs, more intrusion of foreign objectives into domestic activities and reliance on the benevolence of developed country constituents at a time when pressure is increasing to reduce economic assistance to developing countries. The drawbacks of dependence on external finance also manifest themselves in the project-to-project operations of many American PVOs, for example, which have difficulty squeezing out of project finance the requisite overhead with which to build institutional capacity

(Baldwin 1988). Moreover, such PVOs must continually spend time and staff resources to solicit funding.

30. One further consequence of such external financial dependence is the pressure brought to bear on NGOs to appeal to heterogeneous interests in developed countries. This is manifest, for example, in the portrayal of images to developed country audiences. These may not truly reflect the real nature of NGO activities. The "foster a child" message, for example, espoused by several NGOs, belies the fact that contributions are allocated more to community development than to individual children. Thus, however favorable the latter approach is, NGOs, like for-profit enterprises, may feel compelled to distort their public image, although the motivations for the two types of institutions obviously differ.

31. External dependence may also be due to a preponderance of expatriate staff, many of whom are seeking overseas experience for a few years but will return to their home countries. While in the past many missionaries and other NGO employees were willing to spend their careers serving underprivileged communities, this generation of idealists may in fact be disappearing and with it the continuity of care that was the hallmark of mission health services. While it is difficult to generalize about the proportion of expatriate staff, indications are that at least in missions they are predominant. Among the church facilities linked through the Private Health Association of Malawi, for example, only 30 percent of the senior staff are Malawi nationals. "

Lack of Documentation

32. Partly because of their small scale and weak resource base, NGOs characteristically fail to document their activities, whether failures or successes. Often, they do not conduct baseline studies or evaluations, or collect critical health information (USAID 1986). These shortcomings reduce any potential for replicating their successes on a larger scale and certainly do not aid governments in their assessment of national or regional needs. The lack of information is also an impediment to coordination with other NGOs, let alone with government.

33. On the other hand, donors may be overly stringent in their requirements for documentation as a condition of funding. This forces NGOs to comply with time-consuming administrative tasks which derive from the donors' own bureaucratic structure. There is little evidence that the ability to produce reports acceptable to agency bureaucracies corresponds with a capacity for community empowerment (USAID 1986).

Incompatibility

34. A further barrier to coordination between NGOs and governments is incompatibility between training which prevents transfer of personnel between health care institutions. In Malawi, after some discussion, the government agreed to allow government staff to be

seconded to mission facilities which were severely short of staff. Such an arrangement, however, is usually far from automatic. Movement of staff from missions to government services, for example, is often impossible because training given to missionaries does not conform to criteria and standards established by government (Akerele 1976). However, if these staff are expatriate, it is not clear that if they were not working for the missions, they would remain in the country. As another example, frequently mission services run separate drug procurement systems. Given the limited scale of NGO activities in comparison to government systems, this duplication is likely to be inefficient as the NGO systems are unlikely to achieve the economies of scale reached by government.

Lack of Skilled Personnel

35. NGOs may also lack specialized technical personnel in health but may justify their role in health by their greater knowledge of community processes and constituents' needs. Nonetheless, where the perceived needs of the communities, especially in peripheral areas, may lie particularly in rendering medical services, this staff deficiency may be critical. Mburu commented that in Sudan, after the famine during which a number of international NGOs flooded into the country, many chose to stay in Sudan after the famine ended and moved into the health domain, whether or not they had the appropriate staff to do so. Mburu contends that in a country such as Sudan, which exports skilled personnel, it is arguable whether they were responding to a real need (Mburu 1989).

Community Participation

36. Finally, NGOs may not be as participatory or bottom-up as they portray themselves. Particularly if staffed by expatriates, their relationship to the communities they serve may be problematic. NGOs are not always above being co-opted by local elites who may control the decision-making process. The projects an NGO chooses to undertake may be influenced more by their comparative advantage than the needs of the community. Where NGOs manage to achieve genuine community involvement and acceptance, it may not be sustainable if labor turnover within NGOs is high, if their activities are not sufficiently long term or if no mechanism is developed to ensure continued local support were the expatriate staff to leave.

Vulnerability to Political and Economic Change

37. In many cases, the ideological predisposition of many NGOs, such as religious missions for example, may make them particularly susceptible to political suppression by providing a pretext with which government may attack their activities. This has been the case in Kenya, where political declarations that missions had ulterior motives led to a period of tension in government-mission relationships, or in Ghana in June 1989 when the missions of the Jehovah's Witness and the Church of Latter-Day Saints were closed and

the missionaries forced to leave the country. (These, however, were not operating health care services.) Thus while ideology may be a galvanizing force for NGO personnel, it may also present a point of vulnerability in NGO-government relations. Ideological predilections may also affect the performance of NGOs in the delivery of health care. The refusal of several Catholic missions in Africa to provide contraception in their family health clinics is one such example (Bradley 1989).

38. It has been argued above that the change in the world economic context has increased the visibility and role of NGOs in developing countries. In Nigeria, for example, the government discouraged some NGOs and nationalized others in the health field during the oil boom, but as its fortunes began to decline, it found itself trying to attract them back. This effect of economic decline has also been noted in Zambia (Baldwin 1988). Yet economic change may have a detrimental effect on NGOs. Since the 1970s, for example, many missions have undergone severe financial difficulties, sometimes necessitating closure, because government grants have often failed to keep up with the escalation of costs and revenue from user charges is not sufficient to maintain their operations. Often, this financial pressure changes the nature of mission services towards an emphasis on rendering medical services rather than participation in promotive or educational activities.[5] Whatever the effect, therefore, the underlying point is that NGOs' vulnerability to the political and economic context prevents long-term planning of their activities in a stable environment.

39. Just as the successes of NGOs need to be seen in light of their dependence on the economic context of their activities, or on foreign associates or "parent organizations," so too they must be seen in the context of their relationship to the public sector. The work of the international NGO, Save the Children, for example, often builds on existing government facilities and reinforces them in turn (USAID 1987). The performance of NGOs may be made possible or facilitated by complementary activities of the public sector. As the example of Malawi and Ghana will show, governments frequently provide subsidies or personnel which enable missions to carry out their activities effectively and without which many would not survive. The deteriorating economic context is likely to put increasing pressure on governments to assist NGOs whose operations are ailing financially.

Government Policies Toward NGOs

40. The starting point for discussing policy options with regard to the non-governmental health sector is the fact that NGOs are already providing a high volume of services in most of Sub-Saharan Africa. Table 2 pieces together disparate estimates of proportions of health services provided by NGOs, although because of obvious

5. Mr. Ngatia of the National Council of Churches in Kenya in an interview with the author (June 1989) said that this has been the case for many missions in Kenya.

Table 2. Proportion of Health Services Provided by Non-Governmental Organizations in Selected African Countries

Country	Estimate of Volume of Services	Source
Cameroon	Church missions provide 40% of facilities.	Vogel 1989
Ghana	Mission hospitals have > 25% of beds and provide nearly 50% of outpatient care.	Bradley 1989
Kenya	NGOs deliver up to 35% of health care services.	Bratton 1988 Sheffield 1987
Lesotho	Private Health Association of Lesotho (PHAL) is responsible for 50% of the country's hospitals and 60% of its clinics.	Vogel 1989
Malawi	Private Health Association of Malawi (PHAM) is responsible for for 40% of all health services in Malawi.	PHAM documents
Uganda	NGOs provide approximately 40% of all health care.	Owor 1988
Zambia	Missions offer health care to 50 per cent of the rural population and 35 percent of total population.	WHO PHC Review

methodological difficulties in making such comparisons, this table gives only a very rough idea. Given the volume of NGO involvement, therefore, the major policy consideration lies first in how this existing resource can be integrated more within national health priorities, and second whether or not there is potential for expansion of the NGO role. This question is far from a technical one, for the relationship between NGOs and government and NGOs and donors are primarily political, and in all but very few cases both tend to be problematic. Governments are often jealous of resources being channelled to NGOs and wary of their oppositionist potential, while NGOs often live in fear of government intervention in their activities. Bearing this in mind, however, the following discussion tends to emphasize constructive options which enhance, rather than threaten, the NGO-government relationship.

Defining the Legal Basis for Registration

41. The fundamental parameters which governments can set for NGO operations concern the legal status given NGOs and the legal procedure NGOs must follow in order to be registered. It is at this stage, before the NGO even begins any health care activities, that governments can select those NGOs appropriate to established health care priorities, lay down the criteria for NGO accountability to government and control the distribution of their activities geographically within the country.

42. In reality, however, in Africa, registration of NGOs tends to be lax and "after-the-fact." In many African countries, the only reliable inventories of NGOs active within the country are compiled by donors. Frequently, there is no single locus within the government for communication with NGOs, but rather the information may stretch across disparate ministries, partly due to the inter-sectoral nature of NGO activities. One exception to this scenario is Mozambique, where the Ministry of Health refuses to deal with NGOs which are not willing to conform to government policy, despite the need for the resources which these NGOs represent.[6]

Monitoring

43. Ensuring regular contact with NGOs and submission of relevant health information is critical for health sector managers at the national level; NGO leaders have valuable information of use to managers if a suitable forum for dialogue can be arranged. Some governments tend, however, to impose needlessly cumbersome and time-consuming demands on often short-staffed NGOs by demanding detailed financial accounting and planning of activities.

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6. Dr. Leonardo Simao, Minister of Health for Mozambique, stated at the Africa Health Policy Study External Technical Advisory Group meeting, May 1989 .

Government Subsidies

44. Government support for mission health facilities has been long standing, although as noted, costs have tended to escalate and the value of such grants to decline. Governments have a variety of options for such subsidies, such as providing an annual grant, depending on operating size or budget of the institution, or paying for particular services or particular items of expenditure such as salaries or drugs (Green 1987). Indirect subsidies to NGOs may be in the form of waiving import duties for medical supplies or pharmaceuticals. In Malawi, the government gives all NGOs subsidies and, in return, NGOs give the government audited accounts for grants and declare all external resources. In several African countries, the government allocates a whole geographical area to the care of a particular NGO (usually mission) which it contracts out. District agency hospitals are run by missions in both Tanzania and Ghana, for example.

45. Through subsidies, the government can influence NGOs performance and encourage uses of resources which conform most to national priorities. The critical question for this and other types of government support is what strings are attached to the support given—that accountability or control does the government have to ensure that national policies are followed? For example, matching funds may be the best incentive to encourage NGOs to serve in under-privileged areas.

Sector-Specific NGO Consortia

46. The history of NGO consortia in Africa appears to be much stronger in population than in health, largely due to the instigation of International Planned Parenthood Federation. Umbrella organizations, both international such as the Christian Medical Commission and the League of Red Cross and Red Crescent Societies, and national, such as the Christian health associations and private health associations found in several African countries, have supported NGOs active in health. Nationally, these may provide a critical mass so that NGOs can approach government with a common voice. They can be very effective in providing a forum for exchange of information, and often provide training, outreach and assistance to communities to organize PHC programs or procurement activities.

47. Their effectiveness depends crucially, however, on who provides the impetus for their creation and to whom they are accountable. The dangers of creating so-called "DONGOs," or donor-organized-NGOs, is exemplified by the case of Voluntary Agencies in Development Assistance (VADA) in Kenya. VADA was intended to provide a forum and to be a conduit for funds for health NGOs. After the disbursement of over $12 million in a seven-year period, without sufficient knowledge of the absorptive capacity of the NGOs, USAID withdrew from the program, contending that VADA had neither the legitimacy nor the ability to pursue its intended role (Sheffield 1987).

48. A seemingly successful example of a health consortium comes from Ethiopia where the Christian Relief and Development Agency helps NGOs to obtain travel permits and customs clearance and has credibility with both the government and donors. Another successful example is the Private Health Association of Malawi described in the case studies. Such success is not easily achieved, for it requires compromises among NGOs (which are reluctant to sacrifice their autonomy) and between governments and NGOs, if these associations are to wield any authority vis-a-vis government.

Decentralization

49. Implementing policies such as those described here would be facilitated by decentralized organization and management of health care. The district level provides an entry point for involvement of NGOs and district committees are a forum for discussion of common problems. In Kenya, for example, since 1983 the district committees have been charged with accepting or rejecting NGO proposals. In Zimbabwe, too, NGOs must get permission from the district to operate there (Bratton 1989). This is not to say that the district focus eliminates potential conflict between government and NGO agendas, but it relaxes somewhat the bureaucratic constraints to their increased coordination.

Conclusion

50. This discussion has underscored the substantial contribution NGOs of various types have made to health care delivery in Sub-Saharan Africa and noted that the current trend seems to be to channel more, not fewer, resources to them. In the past, such contributions have been made largely either with mild support from government, with benign neglect of government or even despite government; few countries seem to have clearly articulated policies towards NGOs or have expressed specific guidelines for their performance.

51. The greater visibility of NGOs today has implications both for government policies and for the internal structure of NGOs themselves, as well as for the wider role of NGOs within African societies. Two tentative conclusions emerge. First, from the point of view of governments, while recognizing that the issue of government/non-governmental organization relations can be highly political, the question of how best to optimize the use of all national resources should be addressed. Can governments afford to continue a laissez-faire policy with regard to NGOs? Or is, indeed, this a better policy than an interventionist one which may jeopardize the very qualities of NGOs which make them suitable in the health field? It seems clear that NGOs often provide essential services during certain periods (e.g., during emergencies or during a drought) or in areas, especially in the periphery, where government services have not successfully penetrated. On the other hand, such services may not conform to national policy guidelines and therefore may limit the government's capacity to implement a coherent, nationwide policy.

52. Second, from the point of view of NGOs, do they see themselves as an integral part of the *national* health care system? Do they recognize the potential influence they have in the policy arena, especially within the context of decentralized, district-focussed health care organization? This paper would argue that it is now time for a self-examination on the part of NGOs to consider what the implications are for staffing, professional recruitment and management structure to enable them to increase their legitimacy and play a greater, more influential role in policy making to which they have such a valuable contribution to make.

53. Finally, caution needs to be exercised by donors to consider creative solutions so that NGOs do not become merely conduits for funds, but that their real strengths are allowed to prevail. This is particularly the case in Africa where the absorptive capacity of NGOs (in contrast to Latin America and Asia, perhaps) tends to be weak and governments' implementation or administrative capacity is greatly constrained. In such a context, then, there is a critical need for strengthening institutions, and this is necessarily a slow process.

Case Studies

Ghana

In Ghana, NGOs—particularly religious ones—play a major role in health care delivery.[7] As in many other African countries, the government provides substantial grants to NGO health facilities usually consisting of paying all salaries and allowances. Indeed, even during the recent sustained period of economic decline, government grants were increasing, unlike the situation in many African countries where government subsidies have not kept pace with inflation and the increases in public sector salaries.[8] Twenty-four out of the 38 NGOs listed as being active in health and population in Ghana are church-related. Many of Ghana's hospitals are mission hospitals; in 1986 they provided more than 25 percent of the hospital beds and nearly half of the outpatient care in the country. In the Ashanti region, 8 out of 10 district hospitals are run by missions. In addition, the Presbyterian hospital of Agogo has engaged in a joint venture with the Ministry of Health to support 3 out of 7 district PHC clinics in Ashanti. Missions tend to be disproportionately represented in the less privileged areas. While in the country as a whole, missions provide 25 percent of the hospital beds, in the six underprivileged northern regions they provide 46 percent of the hospital beds Moreover, mission facilities have expressed interest in expanding in underprivileged areas.

As elsewhere, the activities of NGOs often complement those of the government, which recognizes that they provide a net increase in resources to the country. Moreover, NGOs in Ghana are often involved in complementary health activities, such as sanitation, giving them an inter-sectoral effect on improving health. There is also evidence that the NGO facilities have lower costs per visit and may have tighter control over their expenditure than public sector institutions. This comparison of efficiency, however, is difficult to make.

Ghana has two coordinating bodies for NGOs involved in health care—the Christian Hospital Association of Ghana (CHAG) and the Ghana Association of Private Voluntary Organizations in Development (GAPVOD). As an umbrella organization, CHAG acts as an intermediary, arranging for the transfer of government funds to missions and for the procurement of essential drugs. GAPVOD's role in the past was to represent NGOs

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7. This case-study draws almost exclusively from Bradley 1989 and from an interview with David Berk of the World Bank.

8. Dr. Samuel Ofosu-Amaah, African Health Policy Study External Technical Advisory Group meeting, May 1989.

to government, but due to lack of funds this role has been reduced. Neither organization, however, participates in training or serves as an authoritative body in policy issues.

Despite the existence of umbrella organizations, there is little standardization of NGO activities, even within the same denomination. Many of the NGO facilities do not keep careful accounts. And despite the fact that the government subsidizes missions, there is not one locus in the government which has complete information on the size or activities of the NGO sub-sector. At present, there is no formal system of joint planning by NGOs and government. Reporting to the government is voluntary; some NGOs report, others do not. Until recently, there was incompatibility of personnel policy between government and NGOs making it unlikely that staff would switch from one to the other. The mission sector procures drugs separately from government. Because the mission sector does not have storage capacity, it does not buy drugs in the same quantities as the government, and therefore is not as efficient.

Swaziland

NGOs are very active in the health field in Swaziland.[9] They were the earliest providers of health services in the country and continue to do so, providing today an estimated 30 percent of health services in the country. The range of their activities extends from providing hospital, clinic and rural health center care to work in providing clean water, in offering counselling to the handicapped or drug-addicted to providing nutrition rehabilitation. Indeed, NGOs interviewed by Planning Assistance indicated that they wanted to move into primary health care, but could only do so once government took responsibility for medical services currently being provided by NGOs.

The growth rate in numbers of NGOs in health is high; 26 out of 59 NGOs interviewed by Planning Assistance in 1986 had been founded since 1980 and 15 out of those 26 have come into existence since 1983. This growth rate during a period of economic retrenchment is likely to indicate that their activities substitute for inadequate or limited government services.

Their relationship with government, however, tends to be constructive; 48 percent of the 59 NGOs interviewed by Planning Assistance received funds from the government and 14 out of the 59 received money from the government on a regular budgeted basis. Moreover, government often seconds staff to NGO facilities and a substantial proportion of all NGO staff are former government employees. The salaries in the two sub-sectors are competitive (exclusive of benefits which government workers receive). As in other African countries, NGOs also receive substantial levels of funds from international sources and a majority are staffed by expatriates (52 percent in the 59 NGOs interviewed by Planning Assistance).

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9. This case study draws almost exclusively on Planning Assistance 1986.

The strength of NGOs' health delivery in Swaziland, then, lies not in the coverage of the services but in the innovative and flexible manner in which they respond to these needs. In many cases, their programs provide a model for government services in, for example, providing inter-sectoral nutritional rehabilitation rather than tackling malnutrition strictly along professional lines. The role of NGOs in Swaziland is not merely to substitute for government services, but also to act as catalysts for community development. By being able to draw on pools of volunteer labor, they mobilize communities and may also help to broaden awareness of health problems.

Malawi

The Private Health Association of Malawi (PHAM) is a coordinating and advisory association of missions of various denominations operating health facilities in Malawi.[10] PHAM has three main purposes: 1) to expand and improve church health care facilities; 2) to run training programs for nurses, midwives and medical assistants; and 3) to implement primary health care programs. Member facilities pay a yearly fee, which supports 50 percent of the cost of running PHAM; the other half comes from donors. The building of health units is done by the missions themselves, with the help of the overseas church organizations, but PHAM helps advise in the daily running of the facilities and acts as a liaison between the missions and the government. Non-church-related NGOs or institutions—such as the University of Malawi and a sugar estate—are associate members of PHAM. Until 1981, PHAM was mostly involved in providing hospital-based services, but since 1982, with support from OXFAM, it has begun to act as a primary health care coordinator as well. With donor support, it is able to offer refresher courses every year.

PHAM services are spread throughout Malawi, though the hospitals tend to be more rural than government services. In deciding upon location, PHAM often establishes facilities where there was no previous service. There is no duplication between PHAM and government services, which tend to be located at least 15 km apart unless the need for them is greater.

All PHAM facilities charge fees, with the exception of under-five clinics and immunization. They apply a sliding scale, however, to allow the poorest access to their services. Revenue collected through fees is managed at individual units, although they report to PHAM their yearly budget. Foreign exchange comes from donors, for most missions have ties abroad. PHAM facilities procure their drugs from the government central medical supply or directly from donors.

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10. This case-study is based on an interview with Mr. Regent Gondwe, Executive Secretary of the Private Hospital Association of Malawi (PHAM), Lilongwe, June 1989 and PHAM's own literature.

PHAM is overwhelmingly staffed by expatriates, especially among senior professional staff, mainly due to the lack of qualified Malawian doctors. The government pays all Malawian staff of NGOs at the same salary scale as the government and has now begun to accept secondment of government staff to NGO hospitals. Because the salaries are low in Malawi, the PHAM tries to supplement low salaries with other benefits but still faces a severe staff shortage. One problem appears to be the lack of career structure for Malawian staff.

PHAM has been operating successfully for over 20 years, and has maintained a very constructive relationship with the Malawi Ministry of Health. The problems it has encountered are in many ways shared by government, such as low salaries and staff shortages.

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