CHAPTER 3
REVIEW OF LITERATURE

The detailed review of research issues existing in the wide area of NGO involvement in health is the foundation of this research. It helped the researcher to explore the research theme, connect with the previous studies, define concepts, identify measures, and select appropriate research design for the current study. The researcher had used both printed and online sources in search of relevant studies, articles and case studies. The journals and books on Non-profit and voluntary sector helped in identifying potential sources of information. To make the best use of web based knowledge, the researcher developed a list of keywords such as “Non-Governmental Organization AND health”, “Health Project AND NGO”, “Project Evaluation of NGO”, “Process Evaluation of NGO”, “NGO Case Study” etc. and identified authentic and relevant information on the research area.

Research findings, papers and sources that followed the inclusionary and exclusionary criteria given by Yegidis & Weinbach (1996), were only selected i.e., ‘the literature that provide both researcher and reader with required information, literature that allow both to draw conclusions regarding the proposed research, and sources that are trustworthy and believable’. The existing literature is classified based on the various themes coming under the research problem. The global picture of NGO involvement in health sector is reviewed with due focus on the global health scenario, international health organizations especially the World Health Organization and their contributions. The researcher then narrows
down the focus to Indian context of NGO development and NGO involvement in health system strengthening. The last part of the chapter contains a review of previous studies that evaluate NGO strategies, and also an assessment of potential areas of involvement for health NGOs.

3.1 NGO Involvement in Health- The Global Picture

World Health Scenario

Health was a major concern throughout the man’s journey towards development. Mankind was affected by diseases irrespective of cast, creed, colour and economic status. The pattern of diseases changed from time to time and the efforts to eradicate these maladies varied according to the economic stability of the governments. Communicable diseases such as cholera, malaria, typhoid posed the major challenge to developing nations even in the previous century, but the role is now taken up by Non Communicable diseases (NCDs). The Global Status Report on Non-Communicable Diseases (World Health Organization, 2010) noted that,

“*The rapidly growing burden of NCDs in low- and middle-income countries is accelerated by the negative effects of globalization, rapid unplanned urbanization and increasingly sedentary lives. People in developing countries are increasingly eating foods with higher levels of total energy and are being targeted by marketing for tobacco, alcohol and junk food, while availability of these products increases. Overwhelmed by the speed of growth, many governments are not keeping pace with ever-expanding needs for policies; legislation,***
services and infrastructure that could help protect their citizens from NCDs” (p. 2)

The major NCDs now prevalent are cardiovascular diseases, Cancer, Diabetes, respiratory ailments and injuries. Economically and socially backward classes are severely affected by non communicable diseases that mostly demands lifelong medication, since they are not able to access quality treatment due to the high costs attached. Though NCDs gained more attention due to its increased prevalence in recent decades, communicable diseases are still a major cause of death in the developing and underdeveloped countries. Malaria, Typhoid, TB and AIDS are top in the list.

The various statistical observations on global health issues can be summarised as follows. Nearly two third of the total deaths per year is caused by NCDs, AIDS, TB and pneumococcal diseases are highly prevalent in Third World countries, a considerable percentage of the total population still lack access to health care systems and ageing of population is demanding long-term care options (World Health Organization, 2010). It is clear that these issues cannot be tackled by a bio-medical approach alone. A multilayered, multi sectoral approach addressing the social determinants of health was needed in the efforts for better health. This responsibility is shared by governments and non governments.

The health care systems in the developing countries are mainly funded by their governments or the voluntary sector. Only a minimal percentage of development aid flows from developed countries through the international health organizations. Apart from providing financial assistance these international health organizations implement
research and pilot projects, provide technical and professional assistance and supply or strengthen resources on global health issues. The role of various health organizations in the world health sector is discussed in the following session.

**International Health Organizations**

There are a number of organizations that work on global health issues and act as constant support to governments and the non governments in developing countries. These international entities are mainly categorised as multilateral organizations, bilateral organizations and nongovernmental organizations. The multilateral organizations collect and organize fund from multiple governments or non governments and dispense it to different countries for dealing with health hazards. World Health Organization is the prominent multilateral organization involved in health related development, with the aim of “attainment by all people of the highest possible level of health” (WHO, 1948). The next class of international health organizations are bilateral organizations that are located in a particular country and provide development aid to the developing countries. United States Agency for International Development (USAID) is an example. These organizations possess varied interests regarding the poor countries that affect their decision in distribution of financial aid. For example the Rockefeller Foundation, which was found by the US oil company Standard Oil Co.is said to have intervened in the public health scenario in many third world countries with the purpose of increasing labour productivity and to fulfil their research interests (Kabir, 2003). Among these agencies, the contributions of World Health Organization have been instrumental in fighting many deadly diseases around the globe.
World Health Organization, Alma-Ata Declaration and the Millennium Development Goals

World Health Organization is part of the United Nations. WHO directs and coordinates international health activities. “It develops norms and standards, disseminates health information, promotes research, provides training in international health, collects and analyzes epidemiologic data, develops systems for monitoring and evaluating health programs”(WHO, 1948) and also build partnership with NGOs working in health sector in different countries.

WHO initiatives in health sector have promoted and facilitated health system strengthening across the globe, especially in Third World countries. Certain milestones worth mentioning are the Alma-Ata declaration, Health for All by 2000, and the Millennium Development Goals. Through Alma-Ata declaration WHO called for urgent action by member countries to focus on comprehensive primary health care to tackle the existing disease burden and health inequalities. In the years followed by Alma-Ata, Health For All (HFA) by 2000 was introduced and followed as a campaign to promote the primary health care approach. HFA aimed at “attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”. The major principles proposed by WHO for the achievement of HFA were community participation in program planning and implementation, intense monitoring and use of appropriate technology.

But the effectiveness of the universalised primary health care strategy proposed by Alma-Ata was widely criticised and questioned even to an extend that in 1979 the Rockefeller Foundation sponsored the Health and Population Development Conference in Italy in the very next year and proposed a selective primary health care approach
instead of the WHO guidelines and later those who were dissatisfied with the effects of Alma-Ata gathered as People’s Health Movement in the 30th Anniversary of Alma-Ata. PHM was a global collective of health activists, civil society organizations, and academic bodies around the world, particularly from the low and middle income countries. They observed in 2000 that “the dream of Alma-Ata never came true and new threats emerged that were multiplied by the effects of globalisation”.

Another commendable intervention of WHO is the Millennium Development Goals. MDGs represent time bound, quantifiable targets aimed at poverty reduction through addressing the major determinants of poverty such as disease, hunger, lack of shelter, literacy, environmental degradation etc. The world’s concern for health was portrayed in the MDGs and three of the goals are directly focusing on health related development. They are- reduce child mortality, improve maternal health and combat HIV/AIDS, Malaria and other diseases. Other goals also had indirect implications on health system strengthening. The targets are expected to be achieved by 2015 and WHO keeps a constant watch and statistical follow up on the attainment of each goals.

Other International Organizations related to UN are the World Bank, The United Nation Children’s Fund (UNICEF), and the United Nation Development Program (UNDP) which are also highly committed to health activities on global level.

**WHO Code of Conduct for NGOs in Health Sector**

World Health Organization acts as the wide umbrella under which nongovernmental organizations involved in health sector find the required guidance and support. Though WHO is directly connected to international NGOs alone, they provide all kinds of
resources to the local NGOs around the world. One such resource is the Code of Conduct developed by WHO for NGOs working for Health Systems Strengthening. There are mainly six articles in this code of conduct, which are:

- NGOs will engage in hiring practices that ensure long-term health systems sustainability,
- NGOs will enact employee compensation practices that strengthen the public sector,
- NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work,
- NGOs will minimize the NGO management burden for Ministries of Health,
- NGOs will support Ministries of Health as they engage with communities,
- NGOs will advocate for policies which promote and support the public sector

(World Health Organization, 2012).

It proposes that the health care services must include entire population than certain selected groups alone, and the services must be multidimensional with due focus on preventive, curative, rehabilitative and promotive aspects. Though these guidelines mainly aim at NGOs collaborating with WHO, it finds wider applications in the case of all health NGOs. It serves as a source of reference for the nongovernmental organizations in framing their recruitment policies, human resource management practices, policy level interventions and networking strategies with government and other development agencies.
An overview of the international health scenario shows up that Non-governmental organizations are increasingly instrumental to the implementation of international health programs. They were able to reach areas of extreme need, promote participation of community members, implemented innovative programs at a low cost, and could exist as independent and sustainable entities in the milieu of development.

3.2 Health System Strengthening by NGOs- The Indian Scenario

Health Issues in India

India is a developing at a fast pace. Development is the mostly heard and used term by the political parties and development agencies. Though India is acknowledged for tremendous growth in all sectors of development the health sector is still lacking the capacity to cater to the needs of the poor in the country. Improvements in the social determinants of health mainly education have contributed to betterment in the overall health indicators of the nation. Though there are regional disparities in the achievement of appreciable health indices, the mortality and morbidity rates shows significant decline, and there is visible decrease in Crude Birth Rate and Crude Death Rate. But India is still struggling with periodic attacks by communicable diseases. Through intensive immunization campaigns the country could claim a decrease in vaccine preventable diseases and also eradication of poliomyelitis through Pulse Polio Immunization Programme (Kapilashrami, 2000). But there are more serious threats prevalent that needs targeted intervention. Tuberculosis is a threat to India and it was estimated as the second leading cause of deaths in 2013. Nearly half a million die because of TB and one and a half million new cases are reported every year. Malaria, Kalaazar,
waterborne diseases are still the major health challenges of the nation. Apart from this malnutrition and reproductive health hazards are serious cause of concern for the women population. Non Communicable diseases are on the rise and cancer was termed as the first leading cause of death among Indians in the previous years.

**Health Care System in India**

The health sector reforms in India started even before independence. The famous ‘Bhore Committee’ report (1946) outlined a system of primary health care for the country. And it is noteworthy that during the six decades after independence, government has built up an impressive health care system for the rural poor across the country. But ‘lack of political will, inadequate financial allocations, poor management capacity, poor logistics, inadequate training and human resource development, target driven nature of monitoring’ etc created deficiencies in achieving the goals of PHC program (Satia, Mavalankar, & Bhat, 1996).

The Governments from time to time have implemented various schemes with the aim of enhancing the health status of the country’s poor. National Vector Borne Disease Control Programme, School Health Programme, National Programme for Prevention and Control of Deafness, Universal Immunization Programme, National Cancer Control Programme, National AIDS Control Programme, National Mental Health Programme, Integrated Child Development Scheme are some examples. Reproductive and child health was a major concern of the government since it formed the basis of overall health of the family. The efforts of various governments in this area finally came out as National Rural Health Mission in 2005. Top-down planning,
bureaucratic loops that prevent proper execution, under consumption of resources and most importantly the great disparity between actual need of people and the felt need of the program planners, slowed down the government initiatives in health sector. The lack of clarity in program management, long delay in fund allocation to grass root levels, duplication and lack of coordination between various programs were also major reasons that defamed government driven health reforms. The National Rural Health Mission was also criticised for certain flaws in implementation, “mainly neglect of traditional practices in reproductive health, donor dependency, less importance to home-based delivery and inadequacy of medical professionals” (Shyam, 2008).

Altogether the health performance of India can be rated as low due to unequal distribution of public and private health care services. The country is poor in terms of the major social determinants of health such as nutrition, hygiene and gender equality. Thus the health care system is like an inverse pyramid where the bottom is the weak and narrowed primary health care services and the top bulged with super speciality hospitals that provide the most modernised treatment options but are not affordable by the poor.

When the government failed to meet basic health care needs of people, the non governments stepped in. They were present in the form of voluntary groups and charity interventions that slowly got institutionalised in to registered and organized entities and were instrumental in making revolutionary changes in the social development of the country (Bhatt, 1995) (Mane, 2004). The evolution and growth of NGO sector in India is discussed here leading to a description of NGO involvement in the country’s health scenario.
NGO Sector in India

India has a long tradition of voluntarism. The cultural values and traditions of ancient India promoted voluntarism and philanthropic activities. As in other parts of the world the first generation NGOs were born out of immediate needs such as assistance in the time of calamities or disasters. The communitarian values dominated individual’s self centred interests in ancient India.

Non Government sector in India have made commendable contributions in different areas of development such as income generating ventures, conscientisation of public on various issues, poverty reduction, women empowerment, health related development etc and their presence was always visible in the issues of the marginalised sections such as the tribals, destitute, vulnerable women, the aged, sex workers, the blind and the similar kinds. Though the NGO interventions were small scale in nature it was widely recognised that their efforts were successful in the limited areas of their operation (Bhatt, 1995). They performed various roles such as advocates, educators, catalysts, monitors, whistle blowers, mediators (Korten, 1992), lobbyists, activists, mobilizers, protectors of human rights, conscientizers, animators and conciliators.

The social reforms and religious reforms in the nineteenth century gave a new momentum to the voluntary sector. Revolutions were initiated against social evils by visionaries such as Raja Ram Mohan Roy, Sir Sayyed Ahammed Khan, Swami Vivekananda, Ranade and Jyotiba Phule and a number of voluntary organizations were established during this period namely, Sathya Sodhak Samaj(1830), Brahma Samaj(1828), The Indian Social Conference(1887), the National Council of Young
Men’s Christian Association of India (1891), and the Servants of India Society (1905) each of which have made commendable impacts in the social milieu of the country.

Christian Missionaries from various congregations such as Anglican, Wesleyan, Roman, Baptist and others expanded voluntary work through charity and welfare activities in all parts of the country. Their interventions were characterised by great concern for humanity and strong belief in the dignity of individuals and his values. They were pioneers in establishing orphanages and institutes for the old and infirm. Until 1985, only Christian missionaries had set up orphanages in the country (Gangrade, 1987). They also established a network of educational institutions across India (Ratnam, 1987).

There is research evidence showing that the missionaries were actively involved in health care services and allied activities to uplift the socially and economically marginalised groups. They started dispensaries and hospitals, stayed with tribals to empower them against the exploitations, founded welfare centres and rehabilitation institutes, constructed roads and infrastructure, and focused on women empowerment too (Ratnam, 1987).

Srivastava (1987) noted that voluntary action aimed at the socially handicapped children was marked by the setting up of orphanages and charitable institutions in the twentieth century. The establishment of Servants of India Society is said to have laid the foundation of secular voluntary action in India (Gangrade, 1987). The initial decades of twentieth century witnessed a shift from religious orientation to rationalist views in the voluntary sector. The secular dimension of voluntarism was nurtured by the spirit of nationalism and meaningful interaction between the inspired persons or groups.
involved in voluntary work. And it is worth mentioning that major policies for women, children and the vulnerable groups were formulated during this period as a cumulative effect of voluntary efforts and agitations across the nation.

India witnessed NGO involvement in almost all sectors of development since independence, though the thrust of activities varied from time to time. Income generation activities were the focus of voluntary organizations in the 1960s, and it then shifted to ecological, environmental and technological issues. Human rights became the major objective of NGOs in the 80s, and towards the end of the century women empowerment and health related development gained momentum (Mukherjee, n.d).

Sooryamoorthy and Gangrade (2006) observed that the causes of proliferation of NGOs in different periods, beginning in the 1950s, were not analogous. Soon after independence, it was mostly the national sentiments that lead people to voluntary work for development, but their concerns changed in 60s and 70s. Ecology, human rights and environment were the focus in the following decades. The socio economic backdrop of the country served as a fertile ground for the genesis and growth of the NGO sector, further facilitated by the democratic system prevailing in the country which granted ample space for its existence (Gupta, 2014).

It is noted that the spread and growth of NGOs was not in a uniform manner (Dhillon and Hansra, 1995, Gangrade, 1987). There was no connection between the size of population and number of NGOs and the voluntary activities mostly converged in the urban centres of the country (GOI, 1985), since they opted for regions where resource availability was better. Some states including Kerala had higher number of
s even in 70s which shows that the state provided a fertile environment for their growth and proliferation.

**NGO Statistics**

Regarding the number of NGOs, in 1997 it was reported that there are 1 million NGOs in the country (Jain, 1997). After one decade, in 2010, it was estimated that there is an NGO for every 400 Indians (Times of India, 2015), that is the total number of NGOs exceeding 3.5 million. More than 80 percent of the registration comes from 10 states, namely, Maharashtra(4.8 Lakh), Andhra Pradesh(4.6 Lakh), Uttar Pradesh(4.3 lakh), Kerala (3.3 lakh), Karnataka (1.9 lakh), Gujarat (1.7 lakh), West Bengal (1.7 lakh), Tamil Nadu (1.4 lakh), Orissa (1.3 lakh) and Rajasthan (1 lakh) (Shukla, 2010). One major reason for this large numbers is that these organizations can be registered under a number of acts such as the Society’s Act, 1860, Public Trust Act, 1950, Religious Endowment Act, 1863, Indian Trust Act, 1882, The Charitable and Religious Trust Act, 1920 etc. All kinds cultural, educational, technical, non-profit and philanthropic organizations are counted together in the above mentioned figures.

Lastly as per the estimates made by CBI in 2015, the number of NGOs in India registered under Societies Registration Act alone is 22, 39,971. Their distribution across states varies as 5.4 lakh NGOs are registered in Uttar Pradesh, 5.2 lakh in Maharashtra and 3.6 lakh in Kerala. The statistics of NGO registration in Kerala shows an increasing trend. As per the information obtained through the RTI queries, nearly 5000 organizations are registered per year under Society’s registration Act alone in the State.
With this understanding of the NGO sector in India, let us see how far they have contributed to the health sector development of the country.

**Health Interventions by Indian NGOs**

Health care in India has a long tradition of voluntarism. Traditional healers used the medicinal herbs and plants for healing ailments, and they served the health needs of the communities where they lived. Voluntary health organizations came in to existence much before independence, but most of them had an inclination to the western medicine. This resulted in neglect of the traditional healing practices prevailing in Indian villages. Still the efforts of Mahatma Gandhi in popularizing traditional healthy life style practices such as Yoga, Naturopathy and vegetarianism through the Gandhian Ashrams are worth mentioning in this context (Narayan & Narayan, 1993). The involvement of development planners and implementation of decentralised health care shifted the kind of service provided by voluntary sector that was focused on hospital-based services alone. Community health programs evolved and the concept of prevention was imbibed in the NGO interventions (Mukopadhyay, 2000).

The disasters in sixties and seventies challenged the medical model and NGOs were forced to initiate new approaches and models beyond the curative medical model (Viswanathan, 1992, Aug 30). During the seventies endorsement of Primary Health Care Concept influenced the Government as well as Non government sector. The health NGOs during this period are classified in to three major types by Narayan & Narayan (1993) that are organizations that focused on alternate appropriate technology,
coordination, networking and coalition building organizations and organizations focusing on lobbying, issue raising and advocacy.

During 1980s, the establishment of CAPART (Council for Advancement of People’s Action and Rural Technology) and the declaration of National Health Policy influenced the pattern of voluntary sector’s involvement in health. And also the World Bank and related international health organizations started to provide financial support to the local NGOs across the world. The nature of voluntary sector changed with this flow of foreign funds and with the entry of professionals in to the domain (Tandon, 1993).

From 1980s onwards India has witnessed an NGO boom in all the states, the reason of this increase in number being the presence of foreign donation. Both for-profit and non-profit organizations got registered under the existing acts and started receiving foreign aid mainly for disease prevention, rural development, human rights related activities and women empowerment. HIV/AIDS prevention was a major area that consumed a major percent of foreign aid to NGOs around the world and in India during the last decades of the 20th century.

It is proven that NGO sector in India have delivered innovative and quality services to the needy. The non profit organizations have been extending yeomen service with the aim of enhancing health status of people in India. The notable research attempts that come under the context of NGO involvement in health sector are discussed below.
**Research Attempts**

Duggal, Gupta and Jesani (1986) conducted a study on “NGOs in Rural Health Care” at the behest of the Indian council of Medical Research (ICMR) to gain a deeper insight into the role and functioning of the many different types of NGOs in the field of health located in Maharashtra, a state having the largest number of such agencies. That study brought out the largest variation between the aims and motivation of the various NGOs as well as their different approaches, which vary from the running of rural hospitals to community participation and conscientisation. An interesting finding of that study was that NGOs had hitherto neglected socially and economically backward districts as compared to their better concentration in the average and highly developed districts in the State of Maharashtra. It highlighted the need to pay more attention to the deprived masses in the backward districts where infrastructure was highly underdeveloped. In their research they have also mentioned about a study initiated by World Bank about 14 health, nutrition and family planning projects in India which highlighted the commonalities and differences among them (Duggal, Gupta, & Jesani, 1986).

Indian Institute of Management Ahmedabad (1987) conducted a comparative study among the NGO hospitals, government hospitals and private hospitals. It reported that, in general, the cost per hospital bed per day in the NGO sector was very less than the government and private sector costs. The study suggested that NGOs might be relatively efficient providers of hospital-based care compared to others (Sarkar, 2005).
Baru (1987) made a study on ‘Factors Influencing variations in health services’ in Andrapradesh. The study was limited in two well developed districts (Krishna and Gundur) as well as two backward districts (Mehbubnagar and Medak). It considered public, private and voluntary sectors providing health services. With regard to voluntary sector study explored that growth and distribution of NGOs were skewed in favour of well developed districts due to various political and environmental factors. They found that the well developed districts were under British Rule and more number of hospitals as well as dispensaries were set up by Christian Missionaries and the infrastructure facilities were better whereas the backward districts were under Nizam’s rule and very few hospitals were set up by missionaries and the resources were also meagre. They also noted that the severe cyclonic storm took place in Krishna as well as Guntur districts resulted in rapid growth of voluntary organizations for relief and rehabilitation work.

The Ford Foundation has been engaged with NGO programs in India since the 1970s. With a view to disseminate the experience of NGO experiences in health and community development, Mr. Alok Mukhopadhyay of Voluntary Health Association of India systematically analysed and documented the detailed case studies of selected health NGOs in India, and published them as ‘The Anubhav Series’ with the financial support of Ford Foundation (Sarkar, 2005).

Vikram Patel & R. Thara, (2003) combined a collection of experiences shared by various NGOs across the country regarding their innovative practices in mental health care. They depict that Non-governmental Organizations with their roots firmly entrenched in the community which is largely dependent on
them for their resources and activities, have pioneered and played a prominent part in the care and acceptance of the mentally ill and the distressed. The researchers used snow-ball sampling to select create a database of NGOs in mental healthcare across the country. From the list of 50 such NGOs, 20 were shortlisted and their interventions were qualitatively analysed. The health NGOs included in the study were AMEND (The Association for the Mentally disabled), ARDSI, Prerana, Sneha, Antarnad, Sangath, The Research Society for the Care, Treatment and Training of Children, Samahan, SCARF, Paripurnata and RSF. Their major findings were:

- The neglect to mental health care by government is apparent in the NGO sector also.

- The diversity of projects include various dimensions of mental health such as clinical care and treatment, rehabilitation, community outreach programs,

- For many NGOs, government support, both at the state and central level, is negligible and most are dependent on the general public for their financial resources.

- The limitations and problems are explained under three broad themes such as sustainability (issues of funding, high agency turnover, donor directed planning), accountability (poor monitoring & evaluation, less transparency), scope (models are only locally relevant, does not extend beyond cities).

Padmavathy in her article ‘Community Mental Health Care in India’ (2005) observes that NGOs and private services have complemented the Government’s effort to provide community mental health care, they were focusing primarily in urban areas.
She’s highlighting the activities of Schizophrenia Research Foundation (SCARF, India). The community mental health components of SCARF are, training of community voluntary workers for the identification of mentally ill from their area and to refer them for treatment; establishment of a mental health clinical service in the catchment area; Increasing awareness of mental health problems in the general public; training the community workers to implement simple rehabilitation measures; and networking with other medical and development organizations. Her case study reveals that involving lay community people belonging to the locality has promoted the acceptance of the program, both in rural and in urban areas and that delivering medicines at the patient’s home proved to be an effective strategy for treating the mentally ill in rural communities. She also drew attention to the fact that high cost of medicines is a major problem faced by NGOs involved in health care.

Pawar et.al (2004) summarised the involvement of voluntary organizations in social change through case study explanations from various parts of the country. Their work narrated NGO involvement in various sectors such as ideology, human rights, people’s participation, good governance, and empowerment through concrete experiments or case studies. Among the case studies the Maharashtra Arogya Mandal is a noteworthy example of an effective health intervention by a nongovernmental organization. Though MAM gave more focus on curative services to the poor, their interventions in preventive level are worth following. It is reported that “MAM had prepared a list of common diseases, which are prevalent among the local people. Similarly, it has made a list of 452 medical plants and their use in healing of diseases. It has also entertained cultivation of medicinal plants” (Mane, 2004, p. 174).
As part of the health sector reforms in Orissa, in 1997, PHCs in 2 districts were handed over to NGOs with an aim of better management of PHCs and better health care to the public, since the government found it hard to provide health personnel in remote locations. The experiment did not run for very long, as the NGOs did not have the resources and ability to run the institutions and handed them back to the government after some time. The evaluation report recommended trying out the experiment out in more places with suitable modifications (Gupta, 2002).

Sarkar (2005) explored the role of NGOs in health sector in West Bengal. He explored the historical context of NGO involvement in health sector development of West Bengal and also conducted a survey of health NGOs in the state. He observed that NGOs prefer to work in socio economically developed areas and are not able to work continuously in rural communities due to the lack of resources. He also noted that the awareness created by NGOs on health issues is detrimental in enhancing the health seeking behaviour of people. In this way the health services provided by government and private sector seems to be complementary for NGOs in West Bengal.

Alok Mukopadhyay (2000), the founder of Voluntary Health Association of India has made worthy contributions to the health NGO literature in India. He had classified the health intervention by Indian NGOs in to the following categories:

♦ Specialised Community Health Programmes
♦ Integrated Development Programmes, in which health is one component.
♦ Health Care for Special Group of People, such as cancer patients, drug addicts, disabled, terminally ill etc.
♦ Government Interventions such as NRHM, RCH etc.
♦ Health Programmes sponsored by entities such as Rotary club, Lions Club etc.

♦ Health Researchers and Activists, who organise workshops or similar kinds of academic activities, where they share and discuss health related issues.

♦ Campaign Groups who organize advocacy campaigns on specific health issues.

♦ Rehabilitation centres

The diverse programs and competencies of numerous organizations, not directly involved in health care, also contribute in one way or another to health system strengthening. They work on the determinants of health such as nutrition, safe water and food production, education, environment protection etc.

A number of researchers have attempted to explore the involvement of Non Governmental Organizations in strengthening the Health care system of Kerala.

The Doctoral study of Joseph, K.A (2004) dealt with the rehabilitation of disabled people in Kerala, with special focus on their needs, problems and legislations. Though his primary concern was the disabled, to substantiate his findings he also interviewed office bearers of associations of and for the handicapped. The fact that ten such individuals were selected from a list of 110 organizations working in the area of disability in one district alone is indicative of the large number of organizations involved in health sector.
Another doctoral research in Kerala (Anish, 2010) explored the psychosocial rehabilitation facilities and rehabilitation outcomes of homeless mentally ill in the state. He observed that several individuals and families in Kerala have been involved in providing food, clothing, shelter, medicine and occupational therapy free of cost for the homeless mentally ill and that no attempt has been made to systematically review their modus operandi and outcomes. He assessed the facilities in the rehabilitation centres, their methods of care, quality of their patient care services, and also the satisfaction of the beneficiaries. It followed an evaluation design, and did both process and outcome evaluation. The study documented the processes involved in unique rehabilitation model in Kerala. Twenty rehabilitation centres were selected from a list of 42 centres registered under Kerala Federation of the Care of the Mentally Ill.

Though there are limited research attempts that acknowledge the contribution of NGOs to the state’s health care scenario, it is evident that NGO sector in Kerala is playing key role in the progress of the state. The EBP approach is not so prevalent in the state, which can bring tremendous changes in the NGO performance if used wisely. Understanding the context of health NGOs, is incomplete without exploring their involvement in advocacy and their relationship with various stakeholders especially for profit organizations and the government and the following is a discussion in this line.

3.3 Advocacy and Networking by NGOs

Advocacy or policy level interventions are the second major dimension of the health system strengthening envisaged by WHO. Large experienced and active networks of NGOs and CSOs added an additional voice in policy debate on international and national level. As Stone & Sandfort (2009) observed increasing attention is paid to how nonprofits work together in networks with public and for-profit counterparts to
address public problems, implement public policies, and deliver programs (Huxham & Vangen, 2005) (Milward & Provan, 2000).

Public Private Partnership in health sector is gaining momentum all over the world as well as in India. Objectives of Public-private partnership in health sector are mainly, enhancing equity, quality, accessibility and availability of health services, efficiency in resource allocation, widening range of services, improving management of public health etc.

Sooryamoorthy and Gangrade (2006) observed that NGO networking and coordination of activities have not yet yielded desired results in India. Sharing the experience and knowledge gathered through micro-level action is yet to materialise fully. The situation has changed in the past decades, and there are organizations like Voluntary Health Association of India and Catholic Health Association of India that have branches in almost all states with the purpose of coordinating local health NGOs. The VHAI acts as a networking agency for health NGOs across the nation. They claim that more than 7000 organizations are part of their country wide network of health NGOs. CHAI also coordinates NGOs that work for health system strengthening. Credibility Alliance is an online consortium of voluntary organisations that aims at enhancing accountability and transparency of the NGOs through good governance. Further efforts are needed to strengthen the NGO networks in India.

Relationship with Business Sector

The rise of the business sector and its potential role in economic development has been highly visible to many civil society actors. Some NGOs have challenged business practices that exploit marginalized groups, as in the campaign against Nestlé’s
marketing of infant formula to clients without access to safe drinking water (Johnson, 1986). Although this critical focus continues to dominate some business-NGO relations, other relationship possibilities have emerged in recent years. Some NGOs have mobilized resources from business to implement programs that provide outputs valued by both NGO and business. Commercial bank support for NGO educational innovations in Brazil, for example, has enhanced the reach of the NGO and the reputation of the bank (Fischer, 1999). Other partnerships have produced “strategic alliances” that advance core goals of both parties. The initiatives of the Philippine Business for Social Progress, for example, have promoted political stability for the business community and sustainable development for grassroots groups (Tan & Bolante, 1997). Ashman (2001) suggested that “such alliances are difficult, but not impossible, to create and maintain”.

Indian NGOs are not an exemption to this trend. They are actively in connection with the for profit sector either as criticisers or as support seekers. In 2011 the SOS Children’s Village prepared a paper that compiled the trends in business NGO relationship in India in participation with the International Business Leaders Forum. They observed that the NGO business relationship is unique in India due to the following reasons- the business sector has a history of reliable social engagement, the large and vibrant NGO sector is often blamed for being non transparent and less accountable, the unequal society, and the corrupted government. They analysed the CONE/ECHO global corporate opportunity study that concluded that “there is a significant corporate responsibility opportunity in India as its citizens’ passion and optimism mean they are willing to be both a company’s fans and its evangelists and that the
environment is ripe for social entrepreneurism”. They summarised the emerging trends in NGO-Business relationship as listed below:

- CSR initiatives are gaining momentum in the business community and there is growing demand for engagement with NGOs

- Most of the company’s prefer charitable giving as part of the CSR. There is not much strategic alliance between the philanthropic activities and the core competencies of the company.

- The notion of ‘fortune at the bottom of the pyramid’ is gaining acceptance in the corporate sector and large firms are addressing social issues as part of their business strategies, for example low-cost housing or low cost health care facilities for the economically backward citizens.

- Corporate Foundations are being established with the sole aim of social development using the fortunes of their large business. Examples are ICICI Foundation, Bharti Foundation, Paul Foundation and the Tata Trust.

- Companies are encouraging their employees to volunteer for the CSR activities. There is also a trend that professionals gather out of their interest to volunteer, and work for a good cause in addition to their paid job.

- Intermediate organizations are emerging to link the NGOs and business firms. They facilitate the partnering process through matching the values and vision of both parties. Karmayog.in and Samhita.org are online platforms with this purpose (Pyres, 2011).
This trend analysis shows that the national environment is conducive to the growth of NGO business partnership aimed at social development.

3.4 Government – NGO Relationship in Health Sector

Non Governmental Organizations are often considered as alternative to the governments. Scholars have recognized the multifaceted relationship between government and non governments. In developing a political theory for the non-profit sector, Douglas (1987) explored why private entities need to exist, given the broad range of services provided by government. His answer suggests that nonprofits arise as an alternative to government where diversity of views, experimentation, and some freedom from bureaucratic constraints are valued by voters.

Government-NGO partnership can bring the people the combined advantages of both the voluntary sector and the government. Partnership is bound to be country specific and determined by factors such as the character and nature of the NGOs and a number of government and societal determinants (Clark, 1997). Researchers have brought out the major determinants of Government NGO relationship in different countries.

The non government sector interacts with the governments mainly through policy level interventions. When NGOs work on government contracting, it is important to check how the government policies, laws, funding patterns influence the NGOs’ goal, mission, staffing and governance. As Gilson et.al (1994) opined, NGO healthcare provisions are complex since they also suffer from resource constraints and management inefficiencies. They proposed that government and nongovernmental
sector must act complementary towards effective policy development, where strong governmental action is required to co-ordinate and regulate health care provisions and active NGO response is encouraged for policy implementation and sometimes modifications or even resistance.

Ejaz, Shaikh and Rizvi (2011) studied NGO-GO partnership in health system strengthening in Pakistan. They captured the perceptions of the government officials, NGO managements and the donor agencies about the role and position of NGOs in health system strengthening in Pakistan’s context. The researchers found that, both international and local nongovernmental organizations have been trying to fill the gap in health service delivery, research and advocacy. In their opinion NGOs have relatively performed better and achieved the results because of the flexible planning and the ability to design population based projects on health promotion, health education, community development, social marketing and advocacy. The study captured the need and the opportunity of public private partnership in Pakistan and presented a framework for a meaningful engagement of the government and the private and non-profits. They concluded that, involving the NGOs for health system strengthening will result in increased efficiency, equity and good governance in the existing health systems in the wake of Millennium development Goals.

Chowdhury and Streefland (1990) described a health programme in Bangladesh run by Bangladesh Rural Advancement Committee (BRAC), which is distinct in many respects. They are implementing primary health care (PHC) via a staff of more than 3000 men and women in thousands of villages. Instead of providing curative services, the programme was educational; it worked with the community in raising awareness, empowered people through transfer of knowledge and technology, created demand
for health care and services, and activated the existing service system to cater to this increased demand. Following a review of past health activities in Bangladesh, the paper discussed the details of the programme and looked at the organization that carries it out. After trying to introduce a comprehensive form of PHC which did not succeed because it proved impossible to realize equitable care in the villages due to large differences in power and income, the organization became involved in large-scale selective programmes, especially promoting oral rehydration therapy. BRAC is still pursuing this approach, whilst also trying once again to further a more comprehensive form of PHC. This could well be cited as a model for Government NGO partnership in health sector.

Zaidi et.al (2012) analysed the context matters in NGO–government contracting for health service delivery in Pakistan and described a policy analysis approach to examine the influence of policy and political factors on contracting health services. Evidence was drawn from a country case study of Pakistan involving extensive NGO contracting for human immunodeficiency virus (HIV) prevention services supported by international donor agencies. The study revealed that there were difficulties during implementation due to ownership and capacity issues within government. Also wide-scale contracting was mismatched with the capacity of local NGOs. The researchers suggested that a careful approach is needed in government contracting of NGOs, taking into account the NGOs acceptance in the community, the skills and capacity of the NGO and potential separation of NGOs from their traditional attributes under contracts.

Ullah et.al analysed the government–NGO collaboration in the case of tuberculosis control in Bangladesh (Ullah, Newell, Ahmed, Hyder, & Islam, 2006).
They covered the basic concepts and key issues of existing collaboration between government and non-governmental organizations in health care, using as an example the implementation of the DOTS (Directly Observed Treatment) strategy for tuberculosis (TB) control in Bangladesh. They analysed the Government’s efforts to cooperate with NGOs to improve health service delivery to the poor.

The data collection was part of Public-Private Partnership model development for TB care in the country during 2001 and 2002. The analysis found that the existing models are successful in TB control and the researchers emphasized that GO-NGO partnership improves access to quality services for the TB affected.

Baqui, et al., (2008) examined whether NGO facilitation of the government’s community-based health programme improved the equity of maternal and newborn health in rural Uttar Pradesh, India. The quasi experimental study conducted baseline and end line surveys to assess the health care practices before and after the program implementation. The difference in the values suggested that the antenatal and new born care practices have improved after the program. There was visible improvement in equity in health care utilisation by mothers and new born though notable socio-economic differentials remained, with the poor demonstrating less ability to access health services. The researchers concluded that When NGOs facilitate government programs outcomes are better in the case of maternal and child health care interventions. They also suggested that programs need to identify and address barriers to universal coverage and care utilization, particularly in the poorest segments of the population.

The above mentioned research findings bring to light certain common factors that are present in Government NGO relationship. The notable determinants are the
complementary nature of GO-NGO interventions, need to assess potential of NGOs to take up government programs, resource constraints faced by the NGOs and increased need for policy interventions by NGOs. The situation is similar in our country too with regard to Government–NGO Partnership in health. A historical review and current scenario of this partnership is detailed below.

**Government - NGO Relationship in India**

The Government NGO relationship in India has varied from time to time. It was evident in the form of monitory assistance, institutional support, policy formulation, cooption, and many a times, the adoption and application of innovative interventions that has made positive contributions to society.

NGOs that intervened in policy level activities and criticized government had to face restrictions in their working environment. There were occasions when NGOs were silenced by the mechanism of cooption. Allocation of grants in aid and respectable positions in government bodies with perks and privileges were used to woo voluntary workers. On the other hand incidents of confrontation have had a damaging effect on this interaction. Genuine partnership based on mutual respect, recognizing autonomy and pluralism of NGO opinions and positions between these two players is rarely observed in India (Tandon R., 1988).

Health is a state responsibility in India and the GO-NGO relationship in health sector has been uneven due to varying political ideologies of State Governments. As Alok Mukopadhyay opined, ‘the role of NGOs are specifically mentioned in all plan documents, policies and program implementation guidelines but their
representation is least encouraged in health planning. Thus the government fail to identify the grass-root level needs through these bridging organizations, and health challenges remain unresolved' (Mukopadhyay, 2000) even after big budget projects and programs.

The government is handing over the public health services and programs to the private health sector, more specifically the non-government organisations (NGO). But it is better the NGOs may concentrate more on creating awareness, than taking up the services that the government is entrusted to provide (Nandraj, 2012).

The Planning Commission of India has set up an online Partnership System, which invites NGOs/VOs to participate in developmental activities of various ministries. Nine Hundred and Forty Nine NGOs have signed up from Kerala. And the total number of NGOs/VOs signed up under Ministry of health and Family welfare are more than thirty thousand. The schemes offered under Partnership by the Department of Health & Family Welfare are

1. Mother NGO (MNGO) Scheme: The activities designed for NGOs in this scheme are addressing the gaps in information or RCH services in the project area, building strong institutional capacity at the state, district field level and advocacy and awareness generation

2. National Cancer Control Programme: The NGOs will implement the activities of Regional Cancer Centers by means of organizing of camps at periodic intervals in a well defined geographical area.
3. National Leprosy Eradication Programme: Grants-in-aid or other material benefits will be provided through the NGOs to the target population of this scheme.

4. National Mental Health Programme: Funds are given as grants in aid to NGOs for conducting research in mental health.

5. National Programme for Control of Blindness: Funds for implementation of the programme would be released through State health Societies in the form of Grant in aid to NGOs.

6. National Tobacco Control Programme: NGOs are expected to take up IEC and mass media campaigns, capacity building of labs, capacity building of health workers and School teachers etc.

7. NGO-PNDT Scheme: The scheme involves NGOs coming up with innovative ideas that may prevent the declining sex ratio of the country.

8. Service NGO (SNGO) Scheme: NGOs are involved in Setting up of IUD clinics, Adolescent Reproductive health, RTI, MTP services, Gender based violence reduction etc.

The Government NGO partnership in health system strengthening was strengthened through the National Rural Health Mission, which encouraged NGO partnership through the Mother NGO scheme. Funds were allocated to these Mother NGOs in selected districts which coordinated Field NGOs in the implementation of the mission components. About 5% of the NRHM resources were allocated to the NGOs involved. And it was reported that “such an allocation provided an opportunity
to build NGO capacity and leverage community linkages to develop/strengthen people’s organization for more active participation in enabling improved health outcomes especially for the poor and marginalized” (National Rural Health Mission, 2014). But the NGO-GO partnership in NRHM was subject to criticism which seems true in the case of other schemes too. The Mother NGO Scheme was introduced in the Ninth Five Year Plan to strengthen NGOs participation in the RCH programme. The Ministry in July 2003, revised the MNGO scheme and introduced the Service NGO (SNGO) scheme. The scope and coverage of involvement expected from SNGOs are different from that of MNGOs. They were expected to provide a range of clinical and nonclinical services (such as adolescent education, gender sensitisation etc.) under the integrated RCH package directly to the community, while the MNGOs provided only clinical services through the FNGOs, in particular service delivery areas. But this SNGO scheme is not implemented. The government did not frame proper system for the release of grant-in aid to NGOs and there were no detailed guidelines for the participatory role of the NGOs towards their functioning, cooperation, monitoring and supervision under the framework of the NRHM. The absence of accountability checks and monitoring mechanism, the NGO fund utilisations could not be tracked and verified. And also their involvement in capacity building and delivery of health services to marginalized sections in underserved and un-served areas could not be properly utilised.

Nandraj (2012) observes that health services outreach can be more wide ranging if involvement of NGOs is encouraged. However, their participatory role in the health sector needs to be defined, facilitated and monitored. He opined that “given the high risks involved in non submission of accounts and UCs by NGOs, there is a need for strong financial controls and a system of accountability to monitor the
activities of NGOs. Standards to evaluate NGOs’ performance should also be developed so as to ensure effective utilisation of Government grants”

Though performance accountability of NGOs is neglected, the government have implemented necessary accountability mechanism to monitor the financial activities of the NGOs. The Foreign Contribution Regulatory Act was declared with the aim of monitoring the flow of foreign aid to the country. Ministry of Home Affairs is dealing with the registration and renewal of NGOs under the FCRA Act. The agencies are required to submit relevant details annually, and those who fail to do so will be blacklisted after thorough investigation in to their financial performance. The Registration Departments have made it mandatory under the Society’s Registration Act that all NGOs registered under this act must submit their financial statements annually and renew their status. Recently 69 NGOs were blacklisted by the Government for misappropriation of foreign funds.

Apart from the accountability issues, problems exist with the focus of health interventions by governments and non governments. A research that discussed the impact of globalization on the health systems observed that the World Bank as a global donor implemented inefficient policies in the developing countries increasing the inequalities in access to healthcare. The government expenditure on health is meagre with the effects of new economic policy, structural adjustment Programs and liberalization and privatisation strategies by the government. And the allocated amount is misplaced. Family planning and welfare program gets the top priority, and the national disease control programs under each plan does not perfectly match with the disease profile of the country. Another issue highlighted is that the government is bothered about preventive and promotive aspects while the curative part is left to private sector,
an approach that is causing distress to the poor. As Nandraj (2012) observed “corporate hospitals are emerging across the country, especially in Kerala due to the realization that health could also be transformed into an industry with such desirable features as: a large and available market of illness, access to a ready qualified and trained labour, and the new miraculous state of the art medical technology”. They also boast of the latest diagnostic and therapeutic facilities. When NGO sector specially the for-profit NGOs take up the Government responsibility of health care, they are neglecting the voluntary aspect of their existence.

With this broad understanding about the research themes related to role of NGOs in health system strengthening, let us now see the previous studies and prevailing research issues in the area of NGO performance evaluation.

3.5 NGO Evaluation Studies

There have been research studies on health provision by the NGO sector in general (Anubhav Series, 1987; Green, 1987; Mburu, 1989; Steefland and Chowdhury, 1990). These studies have typically been concerned with investigating the role of NGOs in Health, their characteristics, strengths and weaknesses, and in some cases analyzing their relationship with government. The studies attribute an innovative role to NGOs to their closeness and familiarity with the community they serve, their flexible and non-bureaucratic style of operation, and their ability to target services to the poorer and more vulnerable sections of the community. A recent study concluded that there is considerable potential for an increased role for the not-for-profit private sector in health provision (Gilson and dev-Sen, 1993).
Barbara McPacke and Priti Deve-Sen (1993) reviewed the experiences of a number of NGOs in planning and managing community financing strategies for health care. The samples were selected from various countries across the globe. It documented the process whereby NGOs design, implement and manage financing strategies, including the types of information collected and used for making community financing decisions, the nature and scope of community involvement in financing decisions and operation and the means used for monitoring impact on service utilization and provision.

A study on ‘Organizational Performance in the Community Mental Health Care System’ (1997) analysed the performance of 40 CMHCs across the world. The researchers used fulfilment of community needs as a measure of effectiveness and utilization of various services as a measure of efficiency. The research focused on the effectiveness of publicly funded organizations, their efficiency in converting resources into services, the role of organizational structure in organizational performance etc. The findings suggested that the less the publicly funded service organizations meet community needs the more government funds are allocated to meet the needs.

The research titled, ‘a methodological approach and framework for sustainability assessment in NGO implemented primary health care programs (Sarriot, Winch, Ryan, Bowie, Kouletio, & Swedberg, 2004) evaluates the sustainability of NGO primary health care and community based projects through the CSSA (Child Survival Sustainability Assessment) methodology. This framework includes dimensions such as health outcomes (immunization coverage, child growth, healthy household behaviours, and improved knowledge), health and social services (quality, cost, accessibility, equity, appropriateness and coverage), organizational capacity (range of functions necessary to the life of an organization and its ability to perform its mission),
organizational viability (types of connectedness and support), community competence (cultural acceptance of positive changes, social cohesion, collective efficacy), and ecological-human-economic-political and policy environment.

American Public Health Association made an international study, which explored 180 health projects (31 in India) in the developing countries, and concluded that more detailed studies were necessary to understand the meaningfulness and feasibility of alternative low cost health projects.

### 3.6 SWOT Analysis of Health NGOs

There are global and national level observations regarding the common strengths, weaknesses, opportunities and Threats experienced by health NGOs. Jessica Malta an official writer on global health commented that though NGOs are supposed to be better than government in providing health care to the poor, their efficiency in this respect is doubted. She doubts that NGOs have become a burden to the health care system in developing countries. She justified her opinion with two statements: “NGOs are normally pressured by donors to produce short-term gains quickly (within 1 to 2 years) in a limited population, creating conflict with longer-term system strengthening. Showcase projects by NGOs are frequently designed as vertical programs with no plans for expansion or sustainability, and little integration with local health systems. The result is fragmented and inequitable health care delivery” (Pfeiffer, 2008)

During the NGO boom period a number of observations were made on the strengths and weaknesses of non government sector. The general potentials identified were ability to work as a collective force (Salamon, 1987), achievement of remarkable
results at grass root level, leadership in participatory training and research, linking up traditional systems of medicine in to community health, personalised approach, special charisma for working with people, non-bureaucratic structure, flexibility in operations, commitment and readiness to sacrifice, and proximity to people whom they are working (Sharma & Bhatia, 1996). They can adjust to the needs of the clients. Their smallness is also useful in that they can implement innovative micro level programmes that are rarely possible by government or business (Korten, 1992). The potential of creative talent within them facilitates a necessary opportunity to “design, experiment with, and amend their strategies to suit the needs of the people for whom the programs are intended. NGOs have the ability to ensure that the people, vulnerable groups in particular are involved in decisions that affect them” (Clark, 1997). NGOs use resources economically and appropriately and it has been widely acknowledged that NGOs are and always have the potential to be the trailblazers and pioneers of new untried developmental approaches (Alliband, 1983). As Bhatt (1995) has mentioned “Innovations in community health, indigenous medicine, techniques for delivery of services to poor in remote destinations, microfinance and banking systems, organizing workers in the informal sector, and evolving appropriate credit systems that benefited the poor had wide repercussions in the society at large”.

NGOs are believed to uphold high levels of altruistic motivation. Unlike government where officials organise around principles of hierarchy, competition (both within and among departments) and (more rarely) public spirit, NGO staff are often highly committed to a particular value or goal and will work well beyond the going rate of remuneration to achieve it (Brett, 1993). NGOs can also engage in activities for
which a rational economic actor would never invest. So it is mentioned that they are the best options to provide non profit services like natural resource management, micro credit and preventive health care services. Also NGOs are believed to be more flexible than large and hierarchically structured bureaucracies and firms. This reflects the fact that many NGOs are small organisations in which there is no bureaucratic code of conduct and the working environment is characterized by close interpersonal relationships. Because of this, NGOs can adapt their project priorities to suit local conditions (Edwards & Hulme, 1995) (Fisher, 1994).

Sharma and Bhatia (1996) noted that in the midst of growing debates on the strengths and weaknesses of NGOs they are accepted as an alternate source that attracts young professionals from various disciplines such as management, social work, sociology and law. They can now focus more on gender issues and health behaviour interventions, can adopt health planning models from other countries, can have greater role in policy development and ensure that government provide services with the best quality, and can also help communities to be self reliant in health related issues. These areas can be termed as the potential opportunities for NGOs in health sector.

Being a strong alternative solution to developmental issues, does not make NGOs perfect organizations. They face challenges within the organizational set up that can be called as the weaknesses. Donor dependence is cited as the most harmful weakness of voluntary organizations since it affects their sustainability (Mukhopadhyay, 1993). They also suffer from distribution of scarce resources, absence of mutual collaboration, lack of accountability to the people and absence of quantitative epidemiological baseline data of the community they serve (Duggal, Gupta, & Jesani, 1986). It is observed that youngsters join NGOs for comfortable living, secure working
conditions, money and a secure job instead of pure voluntary spirit (Roy, 1994). It is observed that the life span of Indian NGOs is limited. Some estimates that the average lifespan of an NGO is ten to fifteen years (Mukherjee, 1994), after that they show signs of aging and stagnation (Bhatt, 1995). Panikar and Soman (1987) observed that less community participation was identified as a problem, which could be solved if people were given role in selection and planning of programs according to their needs.

Leadership in NGOs is a topic of wide discussion. NGOs are mostly started and managed by a single person who maintains his charismatic or authoritarian control over the organization (Avina, 1993) (Wood, 1997). In the typical Indian experience a leader takes the initiative to form an organization and then remains the key person in the organizations. This minimises participation of staff and beneficiaries in the decision making process, affects the lifecycle of the organization and restrict the growth of the organization (Jain, 1997).

Brown and Kalegaonkar (2002) studied the external and internal challenges faced by civil society organization. Legitimacy and accountability with the general public, relations with institutions of the state, such as government agencies, relations with institutions of the market, such as businesses; and relations with international actors, such as development agencies that provide funding support to many development NGOs were identified as the challenges from the external environment. Amateurism, restricted focus, material scarcity, fragmentation, and paternalism were spotted as the problems that exist within the organizations. Gellert (1996) suggested that the major future challenges in international health that may be addressed by NGOs are tobacco-related disease, communicable diseases and the AIDS epidemic, maternal
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mortality and women’s health, injury prevention and control, and the need to secure durable financial support.

The credibility and accountability of the NGOs are under suspicion due to their craze for funds and closeness to donors. Many a times NGOs are formed as self-employment ventures for the founders, because it gives them an opportunity to grab foreign financial aid in terms of charity. NGOs are found to be visible greater in numbers where the possibilities for securing funds are better (Shourie, 1995) (Suresh, Sujatha, & George, 1996) it was estimated that under FCRA, over Rs.20 billion flows from foreign donor agencies to voluntary groups for rural development alone (Roy, Open Letter to Home Minister: Foreign funds and Threat to Voluntary Sector, 1996). This amount has doubled in recent years. Anyhow the dependence on donors helped the NGOs grow institutionally, employing professionals and experts, replacing volunteers with paid workers, increase in salaries to the staff, implementation of donor designed projects.

Sooryamoorthy and Gangrade (2006) have precisely summarised the challenges faced by Indian NGOs. In their opinion,

“The NGO sector today is subject to a number of issues that emanate both from within and outside the organizations that, jointly or individually, determine the existence, survival, or decline of the organizations. Internally NGOs confront problems relating to objectives, ideology, perceptions on the concerns of organization, management, volunteers, paid workers, staff programmes, resources and the like. As NGOs are formed with specific goals and objectives,
the raison d’etre is likely to be different for different organizations and depending on this the strategies and programs differ. In reality, organizations with similar objectives seem to have an altogether different orientation and programs. Parallel to this are external forces, including the state, whose influence on them cannot be overlooked. An NGO is indispensably an entity in a specific socioeconomic, cultural and political milieu” (p.152).

The above mentioned observations shows that though the characteristics of NGOs are mostly common irrespective of their locality, specific evaluations can reveal strengths, weaknesses, opportunities and challenges that are unique to each NGO.

3.7 Conclusion

The review of previous studies and articles has revealed that NGOs are helping to create conditions conducive to the protection, promotion, and maintenance of health and the prevention of illness. But the absence of updated database that portrays NGO interventions in health sector is a serious block for the government as well as social activists, in identifying and replicating the sustainable models implemented by them. So the need for a scientific and systematic documentation of the NGO involvement in health sector is exposed through the review process. With this understanding of the research issues and the theoretical framework discussed in the previous chapter, the researcher has outlined a suitable methodology for the proposed study and it is detailed in the next chapter.