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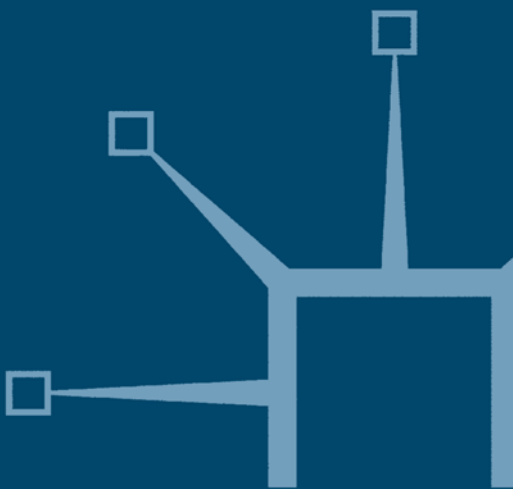
Non-Governmental Organizations and Health in Developing Countries

Andrew Green and Ann Matthias



NON-GOVERNMENTAL ORGANIZATIONS AND HEALTH IN DEVELOPING COUNTRIES

Also by Andrew Green

AN INTRODUCTION TO HEALTH PLANNING IN DEVELOPING COUNTRIES

Non-Governmental Organizations and Health in Developing Countries

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Preface

Interest in non-governmental organizations (NGOs) operating in the health sector of developing countries is growing rapidly. This is for a variety of reasons. Whilst twenty years ago health development strategies focused on the public sector, there is now increasing recognition of the role that NGOs play in many countries. This acknowledgement of NGOs is coupled with and indeed fed by a growth itself in the numbers of NGOs. Second, the health sector itself in many developing countries is currently undergoing intense scrutiny. Its failure in the last twenty years to make significant sustainable inroads into the low levels of health, together with wider and frequently more ideological concerns and international pressures, has led to challenges to the previously broadly accepted State domination of the health sector. If Primary Health Care was the issue of the 1980s, Health Sector Reform has replaced it in the 1990s. This interest in the configuration of the health sector and the desire for a fresh look at the roles of all the potential actors has confirmed, if not accelerated, an interest in NGOs in the health sector. These previously neglected actors in the health scene are emerging and often being hailed by donors as the vanguard of the way forward.

This growing attention to NGOs is not confined to the health sector. Indeed to some degree interest in the health sector has lagged behind that applied to NGOs working in the more general community development fields. This is reflected in the publications that have arisen out of and indeed fed the growing concern with NGOs. There is now a number of journals which either specialize in the NGO sector or particularly encourage contributions related to them.[1] There is also, as the bibliography at the end of the book demonstrates, an ever-expanding range of books on NGOs.[2] However, there are two clear gaps in the literature. First there is still little written which focuses on the specific characteristics of NGOs operating in the health sector. Second, a significant section of the literature focuses primarily on the NGO sector or its individual constituent organizations in isolation from its wider place within the overall health sector.

This book attempts to fill that gap, by focusing on NGOs operating in the health sector and on the relationships between health NGOs and the State. Whilst it deliberately avoids specific policy prescriptions, recognizing that policy must be context-specific, it sets out and discusses the main issues that need consideration in the development of policies concerning the role of NGOs in the health sector. Such policies are, in many countries,

sadly lacking and yet are clearly critical in such a period of structural change. As such the book is an introductory text aimed at people either working in the government, NGOs or donor agencies who have, or should have, a policy development role. While the book is primarily written for those working in or studying the health sector, it is hoped that a number of the issues cross sectoral boundaries and may be of interest to policy-makers in other sectors.

A number of themes run through the book. First there is, perhaps self-evidently, a belief that although the NGO sector does have an important role to play in many countries its potential can only be maximized through a *critical* acceptance and understanding of this potential. There was a period in the mid-1980s when the international policy pendulum swung from disinterest in the NGO sector to the other extreme of enthusiastic and unquestioning suggestions that NGOs provided a general panacea for all the problems of the health sector. We have already referred to the danger of policy blueprints; linked to this is the need for a recognition that each of the many agents in the development of health policy brings a different set of issues and backgrounds to the process. One of the potential consequences of the interest in alternative health care providers advocated by Health Sector Reformers is the danger that the critical need for a cohesive health policy is lost. Within the overall policy development process, we make no apologies for a stance that assumes the need for the development and regulation of such a cohesive policy. We believe that such an overarching framework needs to be set by government, and that in the absence of such a policy the efforts of individual agencies and organizations such as NGOs may not be maximized and indeed may be counter-productive.

There are, however, two important caveats to this. First, we recognize that in a number of countries the democratic processes are currently weak and that as a result government may not be accountable to the broader society. This causes difficulties for NGOs in terms of their view of the legitimacy of a government policy, and we recognize that in extreme cases of repressive authoritarian governments NGOs may need as a minimum to keep a distance from such a government. Indeed they may feel a responsibility to the broader public as a source of alternative perspectives which come close to oppositional politics. Whilst such positions are understandable, it is also important that NGOs themselves recognize that their own accountability to the general public may itself be fragile. Indeed the question of NGO accountability is one of the themes of the book. Within the context of this book, we concentrate on situations where there is a degree of democratic accountability within government, albeit one which may require strengthening.

The second caveat is that government's role as a policy-setter should be built on a process that encourages inputs from non-State organizations including NGOs. Government policy-making in many countries is characterized by introspective and defensive attitudes which fail to recognize the potential importance of alternative views.

* * *

The book draws on a number of sources. First of all, our own individual interests in the area stem from quite different professional backgrounds. The background of one of us (AG) has been predominantly work within the public health sector in the development of policy and planning systems. This has led to a recognition of the failure of many governments to address the question of their relationship with the NGO sector. In contrast, the other author (AM) has spent a considerable part of her working life in health NGO settings. Second, both have been involved since joining the University of Leeds with teaching, consultancy and research in the area of NGOs. A recently completed research project into the role of NGOs forms part of the material for the book. We also continue to be involved in various projects involving NGOs which provides opportunities for practical experience of the issues we have attempted to cover. Lastly we teach a postgraduate course in the area of NGOs in the health sector. The experience and insights of students from a variety of country and professional backgrounds on this course has been a continuing source of stimulus. It has also been one of the spurs to the production of this book as we realize the lack of suitable literature for students in this area. As such the book covers a broad spread of issues that are considered essential for an understanding of NGOs and health in developing countries. Those interested in pursuing any of these in greater depth are referred to the bibliography at the end of the book.

* * *

The book is broadly divided into two sections. The first (Chapters 1 to 7) looks at a number of issues facing the NGO health sector. It starts with a review of the history and development of the current situation facing the health sector in developing countries and the position of NGOs within it. Chapter 2 focuses on definitional issues of what is meant by the term NGO. The third chapter addresses the question as to whether NGOs have any comparative advantage over government in the health sector, a critical question for the development of policy. This is followed by two chapters

that focus first on international NGOs and then on country-based NGOs. Chapter 6 examines various aspects in the formation of policy by different organizations involved in the health sector including government, NGOs and donor agencies. The first section then concludes with a country case-study. We make no suggestion that Zimbabwe is (or indeed could be) representative of the situation in other countries. Indeed it would be impossible to find any such single representative given the diversity of contexts. However, the case-study is presented in order to illustrate a number of the issues which arise in the first set of chapters.

The second half of the book picks up and examines a number of themes. Chapter 8 looks at the question of resourcing NGOs. This is followed in Chapter 9 with an analysis of accountability, a theme to which we have already referred. Chapter 10 focuses on capacity-building in NGOs. The penultimate chapter addresses questions relating to the co-ordination of NGOs and mechanisms for this. The book concludes with a discussion of likely future trends in the area of NGOs and their role in the health sector.

Within the book we have attempted to avoid unnecessary jargon and acronyms. However, we have resorted to the use of three acronyms relating to NGOs throughout the book. We use the term NGO to refer to all non-governmental organizations, the term INGO where we refer specifically to International NGOs and CYNGOs to refer to NGOs that operate either at the national or community level within a single country.

It is well recognized by both of us that the book raises far more questions than it answers. This, however, is in the nature of the development of policy in new fields. It is hoped that readers will be encouraged themselves to seek answers to these questions in a manner that results in greater cohesion and effectiveness in the health sector.

ANDREW GREEN
ANN MATTHIAS

Notes

1. Examples are *Development in Practice* and *Voluntas*.
2. In this book we have referred to a large range of publications, and provided a long bibliography. Some very recent publications in the broad area of NGOs include: Bennett (1995), Edwards and Hulme (eds) (1995), Fowler (1996) and Hulme and Edwards (eds) (1996).

Acknowledgements

We would like to acknowledge a number of people and organizations who have in one form or another contributed to the completion of this book. First of all, colleagues at the Nuffield Institute and particularly those in the International Division and Information Resource Centre have helped in a variety of ways including ideas, information and general support. Second, we would like to thank staff of the Ministry of Health and the University of Zimbabwe for their collaboration during the field research which forms a part of this book. This research was funded by the UK Government's Overseas Development Administration for which we are grateful, though of course the usual disclaimers concerning the views expressed here apply. Third, we have benefited from ideas and comments from individuals too numerous to mention by name including staff of NGOs and students at the University of Leeds and elsewhere. Five individuals do, however, need mentioning by name. Margaret Kaseje and Sidney Ndeki, both PhD students whose positive criticisms were welcome, and Mike Edwards, Head of Information and Research at Save the Children Fund (SCF) whose comments on an earlier draft were invaluable. Mary Green, of Manchester University, and David Green, of Voluntary Service Overseas, both provided many helpful insights.

Lastly we would like to thank both our families for their support during many long weekends and late hours of writing. It has been much appreciated.

List of Abbreviations

AMREF	African Medical and Research Foundation
BRAC	Bangladesh Rural Advancement Committee
CAFOD	Catholic Fund for Overseas Development
CYNGO	Country Non Governmental Organisation
DDC	District Development Committee
DEC	Disasters Emergency Committee
DHE	District Health Executive
DHT	District Health Team
DRIC	Department of Regional and International Cooperation (of GOZ)
DSW	Department of Social Welfare
EC	European Community
ESAP	Economic Structural Adjustment Programme
FP	Family Planning
GAD	Gender and Development
GOBI-FFF	Growth monitoring, Oral rehydration, Breastfeeding, Immunisation-Family spacing, Female education, Food supplementation
GoZ	Government of Zimbabwe
ICRC	International Committee of the Red Cross
INGO	International Non-Governmental Organisation
IPPF	International Planned Parenthood Federation
JFS	Joint Funding Scheme
MCH	Maternal and Child Health
MoH	Ministry of Health
NANGO	National Association of Non-Governmental Organizations
NASCOH	National Association for the Care of the Handicapped
NGO	Non-Governmental Organisation
ODA	Overseas Development Administration (of UK Government)
ODI	Overseas Development Institute
OECD	Organisation for Economic Cooperation and Development
PHT	Provincial Health Team
PMO	Provincial Medical Officer
PVO	Private Voluntary Organisation
SAARC	South Asian Association for Regional Cooperation
SCF	The Save the Children Fund (UK)

SIDA	Swedish International Development Authority
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSA	Volunteer-Sending Agency
VSO	Voluntary Service Overseas
WHO	World Health Organization
WID	Women in Developmen

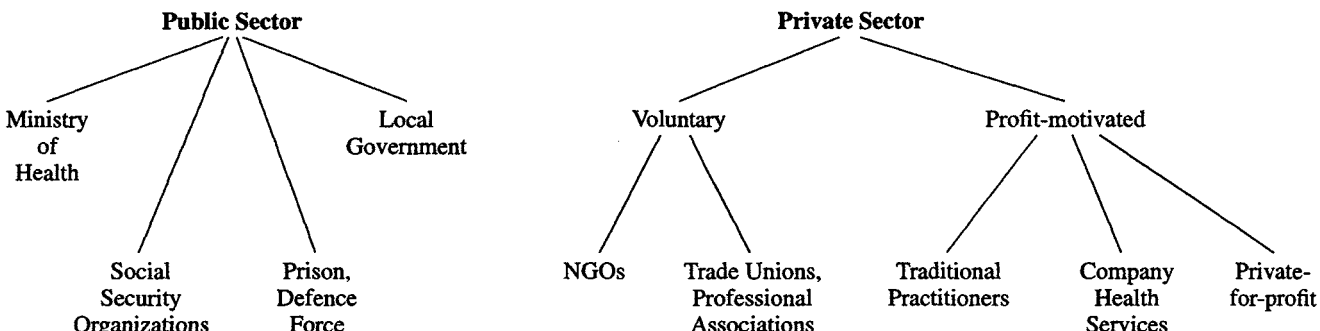
1 NGOs: The Emerging Third Sector?

Thirty years ago, it is unlikely that this book would have been contemplated. Though there already existed significant voluntary involvement within the health sector of developing countries, particularly in the form of missionary activities together with a few international organizations such as Oxfam and The Save the Children Fund, attention was focused heavily on the public sector. For many recently independent developing countries facing severe health challenges, the way forward was seen to be in the expansion and strengthening of Ministries of Health. International donors, though less interested in the health sector at that time than in the development of the economic infrastructure, put the bulk of the available health aid into the government sector. Health plans for that era rarely did more than almost grudgingly acknowledge the existence of a set of health care providers outside the government service, and the voluntary sector typically was bundled together with the private-for-profit sector and the industrial health sector.

Even 15 years ago such a book would have been hard pressed to find a publisher. The famous Alma-Ata Declaration of 1978,[1] signed by governments throughout the world, which set out a vision for health and the health sector, still was based largely on an assumption that the State would play the major role in the promotion of health, though WHO was beginning to recognize the need for greater dialogue between government and other actors both in the health sector and outside. This was despite the fact that in many developing countries there was evidence of a significant growth occurring in the activities of the voluntary sector at a variety of levels: internationally, nationally and at community levels. The last decade, however, has seen a dramatic surge of interest in the activities of so-called voluntary or non-governmental organizations (NGOs). Accompanying this has been a similarly rapid increase in the size and level of activities of the sector itself. The two events are undoubtedly linked.

This interest in the voluntary sector has unleashed a torrent of writing in the form of books and articles. There are even new journals aimed specifically at the sector. This book adds to that library but attempts to cover new ground in a number of ways. First, it is aimed specifically at NGOs which operate in the health field. Though the boundaries between sectors are far more permeable in the NGO sector than in the more rigid

Figure 1.1 Organizations providing health care



organizational categorizations of the public sector, NGO health activities *can* be distinguished and distinctive from those of other NGOs. Second, we are focusing on NGO activities targeted on developing health systems[2] and provided by either international NGOs (INGOs) or by NGOs from within the country itself (CYNGOs). Third, as individuals, we approach the subject with a mix of public sector and NGO backgrounds and, as will become apparent, with a belief that the rise of the NGO sector should not presage the demise of the State. Indeed we argue, to the contrary, the need for a strengthened State particularly in the area of policy leadership and regulation.

In the rest of this introductory chapter we explore a number of themes that have led to this rise in both the size and complexity of the sector itself and interest in it. First however we need to make clear our use of the term NGO.

Variations in the use of the term 'non-governmental organization' or NGO are explored in more detail in Chapter 2. At this stage of the book, however, it is important that, without being sidelined into a semantic jungle, there is common understanding of the way in which we intend to use the term.

HEALTH SECTOR ORGANIZATIONS

The health sector can be divided into a number of different organizational groupings. The main groupings are described below. The organizations are summarized in Figure 1.1.

It is important to recognize that the terms 'public' and 'private' are often used in loose and ambiguous ways. For some the term 'private' is used as the opposite of 'public' to refer to all non-State organizations, whether profit-seeking or not. Elsewhere the term is used to refer to that set of non-State organizations that seek profits. Indeed the way such terms are used can occasionally be deliberately vague to further particular policy ends. There is clearly no correct usage and we describe below the way in which we use the terms.

Public Sector

The public sector comprises those organizations controlled and financed through government, the main organization within this grouping for the health sector being the Ministry of Health or equivalent. The Ministry of Health is generally responsible for setting national health policy. Currently

in many developing countries, it is also involved in the direct provision of the majority of the heath care in the country. Whilst, for many countries, the Ministry of Health is still the major actor in the public sector, elsewhere the responsibility for the delivery of care, particularly at the lower levels of the service, is the responsibility of local government or semi-autonomous health boards. Furthermore, in many countries, particularly in Latin America and increasingly in Asia, there is also a significant semi-autonomous organization or government department responsible for social security which may include health care. The government also will have a number of other departments with significant health-related activities including water and sanitation, education and agriculture. Lastly, there are also likely to be departments with health care activities aimed at specific target groups, including prisons and the defence sector, whose justification for separate services is based primarily on security.

Though the development of the role of the public sector is inevitably the product of a number of factors operating to engineer incremental shifts rather than the result of a grand design, it is still possible to identify a strong underlying basis for State involvement in health care provision to the public. Such a rationale for a public sector rests largely on a view that health, and particularly public health, is in some way special and as such requires State involvement to ensure social interests are served rather than those of specific groups. Public sector activities still overshadow the rest of the health sector despite recent changes described later in the book.

Private Sector

The private sector can be further sub-divided into two broad groups, those set up primarily for profit and those whose motives are clearly not profit-seeking.

Profit-motivated organizations

This sector can be further divided into organizations (or individuals) providing allopathic health care to the general public through a fee system, services provided by companies for their employees and their dependants and traditional practitioners.

In the majority of countries, the first of these groups (often referred to as the private-for-profit sector) is still small, though its exact size is often hard to ascertain, given sensitivities to information related to issues such

as control and taxation. In many countries, however, it would appear to be growing, partly as a result of low morale and wages in the public sector, from which many of its health professionals have migrated, and partly in response to the growing demand from a small but wealthy middle class unhappy with the quality of public sector services. In developing countries the sector is still largely comprised of small businesses often with one or two private practitioners, though there is a increasing number of larger private health groups and hospitals. The distinguishing characteristic of these organizations is the driving motivation of the service providers who are primarily concerned to make profits either for distribution to the owners of or share-holders in the business or to ensure their continued employment at salary levels in excess of the public or NGO sector opportunities.

A second group is that of health services provided directly by employers for their employees, and in some cases their dependants, either in response to legislation or in recognition of the relationship between productivity and good health. Such company health services are still largely confined to sizeable industries such as mining or plantations.[3] These are clearly different from those organizations described above which are set up specifically to make profit directly from the general public, but their role within the profit-making productive sector places them within this sector. In some countries the predominance of a firm in an area (and in particular estate or mining companies) means that a significant proportion of the local population is covered by this health service. In such instances government may come to an arrangement with the company to provide, under contract, health care to those elements of the general public not covered directly by the company.

Lastly the sector also includes private practitioners practising non-allopathic or traditional forms of health care but whose prime motivation is still self-employment whether rewarded in cash or in kind.

Voluntary sector: the emerging third sector

The third sub-sector is that with which this book is concerned. Though, strictly speaking, the term 'non-governmental sector' comprises all activities outside government (and indeed occasionally is used as such), its more common usage refers to the sub-set of this wide group of organizations which is non-profit-making. This, together with other issues related to the organization's purpose, is discussed below. As we will see, however, even the concept of being 'outside' government is not simple.

Whilst it is possible to categorize this group as organizations which

formally have little to do with government, increasingly the boundaries between government and other outside organizations are being blurred. Whilst most NGOs claim to have a decision-making body which is self-governing and independent of government, there are degrees of influence which government can exert on such bodies. The most obvious of these is through the provision of funding. Thus at one end of the spectrum are organizations which receive no funding from government and deliberately maintain a distance as part of their advocacy role. At the other end are NGOs which receive significant amounts of funding and potentially are subject to greater influence. In a number of African countries, for example, church hospitals receive significant subventions from government and may even be designated as District Hospitals. Implicit, however, in the term 'non-governmental' is a notion of independence in an organizational sense from government. Even organizations which receive significant resources from government could break free from government control, though the consequences for the scale of the organizations' operations might be severe. This contrasts with, for example, semi-autonomous Hospital Boards or Trusts which are becoming increasingly popular as a mechanism to free operational decision-making from central government bureaucracy but which are formally still part of the public sector.

It is also important to be clear what we mean by 'profit'. Profit is normally defined as any surplus of revenue over costs which is distributed to owners of the business. This is not the same as the generation of income though they are occasionally confused. Many non-profit-making organizations sell goods and services to provide income to cover the costs of their activities. This should not be confused with the concept of profit-making as defined above.

As we shall see in Chapter 2, the non-governmental sector spans a wide variety of organizations with different characteristics in terms of size, type of activity and motivation. The spectrum is often seen as stretching from small community-located groups such as literacy groups, through national organizations concerned with service delivery or advocacy, to international organizations providing direct services or funding to country-based organizations. Two distinctions often made within this broad hotchpotch of organizations, and which we will also make, relate to the formal status of the organization and its underlying motivation. We only include in our use of the term 'NGO' organizations which are formally constituted (exemplified by a written constitution and a clear decision-making structure). This might exclude local issue groups that have informally coalesced around specific short-tem concerns. We also exclude organizations whose purpose

is primarily to support its own members. This therefore rules out organizations such as trade unions or professional associations and credit groups. It does not exclude, however, organizations such as those campaigning for services for specific groups who may be represented in the organization as long as the organization has a wider remit.

A wide variety of terms is used to cover this group of organizations though they often carry subtle differences.

The term NGO is primarily used in Europe and developing countries to refer to organizations operating in developing countries. In the USA the term Private Voluntary Organization (PVO) is used. PVOs are defined by the United States Agency for International Development (USAID) as:

> tax-exempt, non-profit organisations working in international development that receive some portion of their annual revenue from the private sector (demonstrating their private nature) and receive voluntary contributions of money, staff time or in-kind support from the general public (a demonstration of their voluntary nature). Not all non-profit organisations are necessarily PVOs.[4]

Elsewhere the term 'voluntary organization' is used widely to reflect both the important association with volunteers that many NGOs have or had and their non-statutory nature. The term 'charitable organization' is also used to reflect the specific legal status of some NGOs.

Included in the above set of organizations are both secular bodies that were set up primarily in response to humanitarian concerns and organizations with a religious connection. Oxfam is a good example of the first of these;[5] it was set up fifty years ago in response to the post-war European disaster and its remit was gradually widened to include broader developmental concerns. In contrast, religious organizations operating as health NGOs may do so for this and two further reasons: either as a manifestation of their faith or as part of a more deliberate evangelical and proselytization strategy.

To summarize, we are using the term 'NGO' within this book to refer to formal organizations which have corporate objectives concerned with humanitarian aims concerning groups outside the organization, which are non-profit-making and which are outside the direct control of government.

NGOs occupy a middle position between the State and the private-for-profit sectors as is demonstrated in Table 1.1, which summarizes some of the critical differences between the State, NGOs and the private-for-profit sector and to which we will refer later in the book.

Table 1.1 Alternative characteristics of public and private providers

	*Public sector**	*Private sector*		
		Voluntary	*Profit-motivated*	
			Private-for-Profit	*Company health services*
Objectives	Social, promotion of welfare	Social, promotion of welfare	Profit generation	Productivity increases
Target group	Broad with emphasis on the underserved	Specific target groups or locations	High income consumers of health care	Workers and their dependants
Structures and methods	Frequently rigid and homogeneous	Potentially varied and flexible	Varied and flexible	Varied and flexible
Regulatory mechanisms	Provider of regulatory mechanisms. Has legal powers	Regulated by outside bodies	Regulated by outside bodies	Regulated by outside bodies
Funding	Social means (e.g. tax), and service sales	Donations, service sales and government funding	Service sales, government funding in form of subsidies	Company budget, government funding in form of subsidies
Accountability	Electorate, service users	Donors, service users trustees	Owners of capital, service users	Company

* This assumes a democratically accountable government system. Totalitarian systems will have different characteristics.

We turn now to examine some of the major trends in health and development policy and thinking that have occurred over the last decade and which influence the position and role of NGOs in the health sector today.

HEALTH AND DEVELOPMENT POLICY TRENDS

The last two decades have seen a number of shifts internationally in development thinking and health policy which have had an important impact on

the current positioning of NGOs within the health sector. In particular we look at policies of Primary Health Care, Health Sector Reform, Good Governance and Plurality. Against these has been a recognition of changing health needs. These are outlined in what follows as an important backdrop to the rest of the book.

Primary Health Care Policy

A key date in the development of health policy within developing countries was 1978 when, at an international conference held in Alma-Ata,[6] ministers of health from throughout the world pledged their governments to a strategy to improve the health of their citizens. The Primary Health Care Strategy, as it was called, was the culmination of a number of trends in thinking about health policy in the previous decade and had various important components.

First, the strategy emphasises the links between ill-health and underdevelopment. Poverty, illiteracy and poor infrastructure, particularly in the form of water and sanitation, are major factors underlying the appalling health status of many in developing countries and particularly that of women and children. This suggested the need for a shift away from what is known as the (bio)medical model of health which emphasises medical interventions to individuals as the appropriate response to ill-health. In its place greater priority was needed for broader attacks on the causes of ill-health, engaging the efforts of sectors outside that of health care to work alongside the health services.

Second, the strategy drew attention to the gross inequities that exist both between countries and within countries. These inequities are evident both in terms of the health experiences and the levels of resources available to different groups in society. Table 1.2 illustrates this at the international level showing, for example, an average life expectancy at birth of 52 years in sub-Saharan Africa compared to 76 years in regions such as North America and Western Europe and health expenditure comparisons of $24 as against $1860. Within individual countries there are further inequities between different groups depending on factors such as age, sex, class and location. Groups living in shanty towns and remote rural areas are likely to have far worse health status than those in well-developed town areas; poor unemployed families contrast significantly with wealthier groups; young children are more likely to be ill than middle-aged men.

Third, the strategy recognized that historically resources within the health sector itself had been ill-used. Though true globally, this was of particular significance in countries with extremely limited resources. Resources

Table 1.2 Indicators of inequity in resources and health needs

Countries	*Per capita GDP $*	*Health expenditure per capita $*	*Health expenditure as % of GDP*	*Child mortality rate (deaths per 1000 under 5 years)*	*Life expectancy at birth in years*
Sub-Saharan Africa*	526	24	4.5	175	52
India	348	21	6.0	127	58
China	327	11	3.5	43	69
Other Asia and islands	1 358	61	4.5	97	62
Latin America and Caribbean	2 627	105	4.0	60	70
Middle Eastern Crescent	1 889	77	4.1	111	61
Formerly Socialist economies of Europe	3 945	142	3.6	22	72
Established market economies	20 201	1 860	9.2	11	76
World	4 040	323	8.0	96	65

* Includes South Africa.
Soure: Compiled from World Bank (1993) from Tables A.3 and A.9. Dates generally refer to 1990.

traditionally had been directed at curative care and in particular at large urban hospitals. Yet the health care interventions which were most needed and most likely to reach the under-served groups were simple measures of both a curative and preventive nature. Immunizations, oral rehydration therapy, basic midwifery care, simple health education messages and basic outpatient treatment for prevalent diseases such as malaria, tuberculosis and respiratory infections through paramedics working from primary care facilities were likely to have a greater impact on overall health status than far more expensive specialist facilities.

Lastly the strategy suggested that not only was it the right of communities to have an involvement in decisions which affected their health but it also made good sense in terms of ensuring that appropriate services would be provided which would then be supported and used. Concepts of community development were widened into the health field and there was,

within the primary health care strategy, a recognition of the importance of community participation in health care decision-making.

In many ways it is a tribute to the leadership provided by the World Health Organization (WHO) in the early 1980s and its then Director-General, Haldan Mahler, that such a strategy was accepted so broadly, on paper at least. The strategy clearly challenges a number of interests including the powerful medical profession, pharmaceutical companies, and those who benefited from the economic and political structures that led to the existing inequalities. Indeed it is surprising, given the political nature of the strategy, that it survived at all. However, for some time in the early 1980s it was viewed as a touchstone for measuring the appropriateness of a country's health policies. Early reformist attempts to water it down, and in particular that by Walsh and Warren[7] who argued for a 'selective' version of primary health care which bore little relationship to the broad original vision, substituting a set of cost-effective interventions in its place, were beaten off.[8] However these re-emerged later in the 1980s in the form of the United Nations Children's Fund's (UNICEF) GOBI-FFF[9] strategy which again emphasized a set of interventions and even more recently in elements of the World Bank's 1993 World Development Report which is further discussed below.

Though the original Alma-Ata Declaration did not highlight the NGO sector in particular, its general philosophy of multisectoralism and recognition of the need for multiple and varied inputs into the health process were entirely consistent with moves within WHO to bring NGOs closer into the policy and delivery process. WHO's special relationship with governments has, however, always implied that its prime considerations will be with the state health care process.

Primary health care, as a strategy, has in recent years been overtaken by other macro considerations to which we now turn. Indeed where primary health care *is* referred to, tones of embarrassment can often be detected. There has, however, been no real intellectual challenge to the internal consistency of the strategy. Its analysis of the underlying causes of ill-health, its 'upfronting' of inequity and its call for greater genuine participation in health processes are, if anything, more valid today than in 1978. The ruling values on which primary health care rested, however, have changed as a result of a global ideological shift to the Right, as we argue below.

Health Sector Reform

If Primary Heath Care was the talking point in the early 1980s, Health Sector Reform has replaced it a decade later as the major policy thrust

occupying donors. Interest in Health Sector Reform has arisen for a number of differing reasons.

First, there is genuine frustration with the apparent inability of the public sector to make significant inroads into (and even in some countries to halt a worsening of) the low levels of health status. The public sector is often characterized as inefficient, corrupt, centralized and unaccountable. Alternatives to the current hegemony of the public sector are sought. NGOs provide one such alternative.

Second, the public sector increasingly has faced a tightening of the resources available to it. Recession has hit many developing countries and in particular those of sub-Saharan Africa. This has had its effect on both increased ill-health and on the level of resources available to the public sector to provide services. At the same time policies of Structural Adjustment, which include a reduction in the size of the public sector (or – as it is euphemistically known – downsizing), have been insisted on by international agencies and in particular the International Monetary Fund. The term 'sustainability' has become a buzz word of the 1990s. This has led to interest in other non-State health care providers and alternative means of funding services. International agencies such as UNICEF have pushed approaches such as the Bamako Initiative[10] aimed at tapping into apparent community resources. Revolving Drug Funds and other means of 'community financing' which generally involve some form of user charge have been trialed. In this context, NGOs are portrayed as having both valuable experience in financing systems at the local level and access to additional funds from other countries.

Closely associated with the above, and indeed feeding off it, are wider ideological shifts. The late 1980s has seen a general movement in ruling powers towards the right. The New Right, as it has come to be called, has, as its intellectual basis, a belief in the power of the economic market to provide wealth and welfare. The incentive of profit maximization is seen to be the driving force behind efficiency. The operation of the market and its reconciliation of demand and supply is believed to provide a means by which the public can be satisfied and as such social welfare maximized within the resources available. Government, at worst, is seen as an interference in this process and at best as the guardian of a free market framework within which competition can be allowed to blossom.

This anti-Statism has flourished in countries like the UK. The ideology of Thatcherism, as it is now called, initially focused on the productive sectors of the economy. A host of policy initiatives from denationalization to legislation restricting trade unionism kicked off the process. This was echoed in the welfare sectors with a variety of policies designed to

allow the winds of the market at least to whistle through the State welfare processes (and in particular the National Health Service), if not to blow them down. This has had significant implications on the role of the non-government sector in such countries. In the UK, for example, voluntary agencies increasingly are seen as important. Community care policies which are aimed at the provision of a range of services outside long-stay public sector institutions for groups such as the elderly and the mentally ill rely heavily on the voluntary and private sectors for service provision with funding largely remaining a government responsibility. A report published in 1993[11] took this process to what it saw as its logical conclusion. It recommended an overt recognition by government of the two different functions of the voluntary sector as agents of change and as service providers. These functions, it argued, should be split structurally with NGOs acting as contracting agents continuing to receive government support, whilst the advocacy organizations would become entirely voluntary.

All of these trends have been mirrored, if somewhat hazily, in the policies of donors in developing countries. In the last 10–15 years, donors, both bilateral and multilateral, have shifted significantly in their general attitude to NGOs. Sollis contrasts the 1980 and 1990 World Bank Development Reports focusing on poverty. He suggests that 'a negative portrayal of NGOs and voluntary organisations in 1980 is replaced a decade later by a more positive picture'.[12] This is reflected in an increase in collaborative projects with NGOs by such donors. Sollis attributes this to a growing awareness of the financial capacity of NGOs and a heightened profile through emergency and disaster relief.

A number of agencies have put health sector reform high on their own agendas for support, if not as a conditionality for other forms of support, to developing countries. The most comprehensive and, indeed, given the economic muscle of the World Bank in the aid world, most significant statement of this is to be found in the 1993 World Development Report.[13] There are generally two broad thrusts to discussion about Health Sector Reform. First it focuses on at least a conceptual separation of the critical components of a health sector as development of policy, provision of finance, delivery of services and regulation of the type and quality of services provided. Whilst for many developing countries these have all been seen as the direct responsibility of the State, it is now suggested that there are a number of opportunities available to broaden out responsibility for activities in these roles. For example, whilst it may be argued that the public sector has a role to play in raising finance for health activities in order to meet equity objectives, it may not be necessary for the public sector itself to provide these services. The private-for-profit or the NGO sector can

develop services under contract to and financed by the State. Separation of these functions has come to be described as the purchaser-provider split. The second strand of health sector reform concentrates on the operation of the public sector itself. Its characterization as bureaucratic, unwieldy and inefficient is, it is suggested, amenable to improvement if private sector structures and management styles can be introduced. Internal markets within the public sector (again splitting internally the purchaser and provider functions) and performance-related pay are two examples of such policies. In many instances these have been harnessed to existing attempts to reform the public sector through decentralization policies using public management methods.

Such an opening up of the public sector's grip on the health sector has huge implications for the NGO sector which indeed frequently is singled out by donors as having a significant role to play in the reformed system. In particular, NGOs are seen as having many of the attributes of the private sector in terms of their freedom to operate without some of its less acceptable features, such as a primary concern with profits rather than welfare. As we have argued elsewhere[14] the NGO sector may even be viewed as the acceptable face of the private sector by donors who might wish to see New Right market solutions but are aware that too sudden imposition of these may be politically unacceptable.

Good Governance and Plurality

A third theme that has emerged on to the political agenda in recent years is increasing willingness on the part of industrialized donor countries to criticize not only the efficiency of the State, but also the legitimacy of a number of governments on the grounds of a lack of democracy. Following the political changes in Eastern Europe (and indeed possibly linked to these) attention has turned to what has been seen as a failure of post-independent governments in a number of countries to develop and apply systems of government that are accountable to the population. It is difficult to resist being cynical about this interest in democracy from some governments which have actively supported military dictatorships in the past. Indeed the conditionality that is now overtly linked to political processes is viewed by some as a dangerous precedent for the future. However, for others this recognition of the failure of a number of governments to recognize their accountability to the whole population is a welcome policy shift.

Part of what has in some quarters come to be known as the Good Governance Policy[15] has been a belief that robust political democracy requires a pluralistic society with a number of diverse views and means of

representation of these views. NGOs have been seen as an important means of potentially achieving such plurality thus providing another rationale for the current interest of donors in the development of the NGO sector. Whilst it is evident that in some countries, notably those in parts of Latin America, many NGOs (including the church) *have* provided an important alternative to government through links with popular political movements, elsewhere, as we shall see, there is less evidence that NGOs are themselves particularly accountable to any communities that they may claim to represent. Certainly it is difficult to sustain an argument that international NGOs (still the ones predominantly supported by donors) have clear systems of accountability to local communities, with policy-making still directed from their European or North American Head Offices.

Health Care Needs

The fourth important background element relates to changes in health care needs and in particular three that are frequently singled out. The first is the emergence of HIV and AIDS which, for a number of countries, has already had severe implications for health and health services. The scale of the problem and the type of responses required has resulted in a growth in the NGO sector around this health problem which has in turn led to an increased profile for the sector.

Second, during the 1980s and early 1990s, a number of countries suffered appalling disasters of either a natural or politically induced kind. Floods, earthquakes, civil war, famine and drought are examples of disasters that have occurred. Whether in terms of overall human suffering the last two decades have had a greater number of such tragedies than previous periods is open to question. However, undoubtedly there has been, through international communication and media, greater global awareness of these. In many of these disasters, NGOs have played an important role. Organizations such as Médecins sans Frontières, SCF and the Red Cross have all been heavily involved. As a result, as we shall see, not only has this affected their roles but has raised their profile as service providers.

Lastly, another dimension to health care needs relates to the particular experience of women in the health sector in many developing countries. Early policies in this area, espoused by donors, focused on women and attracted the description of 'Women in Development' (WID) policies. In the health field these focused on the very high incidence of maternal mortality rate coupled with lower access by women and girls to health care and family planning services. These policies have been criticized as being too narrow through their focus on women rather than on the power relations

between men and women which is seen as the cause of not only worse health experiences but a much wider set of gender-related disadvantages. They were also criticized for failing to involve women in decision-making in a manner other than tokenist. Attention has now turned in some quarters away from WID policies to GAD (Gender and Development) policies. Whilst the issue of gender relations is far wider than simply the health sector, its obvious manifestations in the health field have led to a particular focus in that area. Some NGOs have been seen as having particular expertise in this area by donors and this again has led to increased interest in the use of such organizations by aid agencies. Whilst, as we shall discuss in Chapter 3, there are a number of NGOs at both the national and international level which have been pioneering in this area (for example, the International Planned Parenthood Federation (IPPF) and Marie Stopes which were significant early on in the WID areas, and Oxfam, which has taken GAD policies as a critical element of its work, it is far from clear that all NGOs are gender sensitive either in their operations or indeed in their own internal staffing policies.

NGOs IN THE HEALTH SECTOR

At the beginning of this chapter we pointed out that the current high level of interest in NGOs is a relatively new phenomenon. In the preceding section we suggested that the last two decades have seen a significant amount of turbulence in the policy environment. This has in many instances led to an increased profile for NGOs both generally and in the health sector in particular. We turn now to look more specifically at a number of themes directly related to NGOs themselves.

The Growth of NGOs

Whilst the growth of the sector is not well documented, in part as a result of the legacy of a lack of general information and awareness, there are several country studies which demonstrate it. For example, a study in India[16] revealed how, over the five-year period between 1983 and 1987, the percentage of hospitals owned by the voluntary sector had increased from 8 to 10 per cent, and of hospital beds from 11 to 13 per cent. Similarly in Zimbabwe, Table 1.3 shows the growth in NGOs over the past century. This shows clearly a recent fast growth to secular NGOs with 50 per cent of them being formed post-1979.

For the purposes at least of scanning the history of the growth of NGOs,

Table 1.3 Growth in NGOS in Zimbabwe: dates of commencement

Date of commencement	*Church*	*Secular*	*Local*	*Local/ international*	*International*	*Total*	*% of total*
Pre-1900	7	–	7	–	–	7	7
1900–49	15	3	16	1	1	18	19
1950–79	17	16	29	3	1	33	34
post-1979	–	24	11	–	13	24	25
Not stated	9	5	12	2	–	14	15
Total	48	48	75	6	15	96	100

Source: Green and Matthias (1993).

we shall broadly divide them into three organizational groupings: religious organizations, international organizations and in-country organizations operating in developing countries. Later we will be analysing, in organizational terms, religious NGOs as part of either the in-country or international set of NGOs. However, given their particular historical development we treat them separately in this section.

For most developing countries, some of the earliest NGOs operating as formal organizations in the health sector were Christian missionary organizations. In some countries the history of Christian mission facilities goes back to the nineteenth century with what were often informal extensions of services to a local community primarily provided to missionaries by untrained staff. This was followed by more explicit development of health facilities with health professionals.

The legacy of most mission-based health care is now an infrastructure of facilities often including primary care facilities based around a rural hospital and often with a training component. Funding for such facilities is variable and increasingly fragile. Whilst mother churches (Northern missionary organizations) continue to provide funds and other resources, a number of the mission organizations are finding it harder to sustain their contribution to the running costs of such services. Indeed in some cases there is a clear strategy to change from a Northern-based mission organization to a local church-based organization. Alternative sources of funds such as greater local revenue generation through user charges in particular and government subsidies have been essential ingredients of the continued existence of such local church-based services.

Whilst the most widespread and well-known religious organizations are related to the Christian church, it should be recognized that other faiths and philosophies have also set up health facilities. These include the

Islamic Ismaili sect which funds the Aga Khan Health Service, providing extensive services ranging from large hospitals to rural health services in a number of countries including Kenya and Pakistan, and Hindus with, for example, the development of Dharmashalas and the development of Ghandi Grams.

International NGOs, in contrast to religious organizations, are a relatively recent development. Though there are a number which have been in existence for close to a hundred years, the major growth has been in the post-Second World War era. Such INGOs have developed or become involved in the health sector for a variety of reasons. One common stimulus has been as a response to emergency. The Red Cross was formed in 1863 to support victims of war; SCF was set up in 1919 specifically to respond to the needs of children in the post-First World War era; and Oxfam emerged during the Second World War. Others such as the Catholic Fund for Overseas Development (CAFOD), Christian Aid and War on Want were set up in the 1950s and 1960s, and there has been a surge of further international aid organizations in the 1970s and 1980s.[17] More recently there has been a number of such organizations responding to natural disasters such as Band/Live Aid set up as a funding agency to respond to the Ethiopian famine. Though some INGOs remain solely or primarily geared towards relief work (Médecins sans Frontières or the International Red Cross are examples), others have either shifted from relief work or extended it towards longer term development including activities in the health sector, partly in response to a recognition of the underlying causes of many emergencies. Thus Oxfam is as readily identified with long term development as with its longer standing emergency relief role. Other INGOs developed as extensions of services provided to domestic country groups. For example, the IPPF, which is the largest family planning NGO in the world, was formed in 1922 in response to a recognition of the need and greater acceptability for family planning in the UK.

Some international NGOs have been involved primarily in the health sector either as direct service providers or as funders to small country NGOs also acting as service providers. Increasingly some have seen the need to act as pressure groups on bilateral or multilateral donors, though in some countries this can be a sensitive role as a result of the legislative restrictions. However, a number of INGOs have now an established reputation as critical analysts of international policy developments, based heavily on their own field experience. Such INGOs are now routinely involved in major international conferences such as the 1994 Cairo Population Conference.[18] Other examples of the involvement of NGOs in policy development can be found in the input to the UN Convention on the Rights

of the Child,[19] and the development of the essential drugs policy.[20] SCF, for example, has taken an active role in policy debate, seeing its strength and legitimacy grounded in its project work. It was, for example, quick to develop a critique of the 1993 World Development Report.[21] The support of high profile NGOs can add significant credibility to international aid initiatives as was evidenced by the dismay amongst international donors at the threatened withdrawal by various NGOs from the 1995 Conference in Copenhagen.

The third group of NGOs which comprises country (here used to distinguish from international and hence to include both those working at a national level and at community level within one country) NGOs (CYNGOs) are, for the most part, a more recent development often associated with post-independence. In a number of countries the growth of some CYNGOs is linked to the independence struggle itself or a political liberation movement giving them greater credibility with a resultant government or with communities where the struggle continues. The differences between regions are often marked. For example, as Mosely-Williams puts it:

> the African experience has more to do with anti-colonialism, anti-racism and nation-building, whereas Latin-American NGOs were influenced more by class, anti-militarism, and anti-US feeling. In both regions, however, many of today's NGOs grew up in the decades after the 1960s, representing civil society excluded from representation in the state and in the socio-economic structures which dominated political process.[22]

The last decade, however, has seen not only a significant growth in the number and extent of activities of such CYNGOs but also in their self-confidence and desire to control their own destiny. An indicator of this can be found in the discussions of the London Symposium on 'Development Alternatives: The Challenge for NGOs'.[23]

We turn now to a number of themes in the operation of NGOs over recent years and to which we will return in the rest of the book.

Role of NGOs and their Relationship with the State

One of the key themes of this book concerns how NGOs and governments view their respective roles. This relates to NGOs as both individual organizations and as a sub-sector. One particular feature of this increasing interest, in part because of Health Sector Reform policies and in part because of the growth in size of the sector, concerns the relationship with the State. A spectrum of possible views can be encountered ranging from strong

antagonism to government through to a desire to support and strengthen the public sector, possibly with a concomitant reduction or at least change in the role of the NGO sector. For many NGOs and indeed governments these issues have only recently begun to be seen as critical for the role and development of the NGOs themselves.

Financing of NGOs

The growth of the NGO sector has been accompanied (and indeed in some instances prompted) by a growth in support from donors to some NGOs. At the international level NGOs are frequent recipients of aid funds from bilateral or multilateral donors. At the national level funding may be available from national governments, INGOs and in some instances bilateral and multilateral donors. At both the national and international level the change in funding base and levels has led to two issues. First, the increase in the organization's size and activity levels has often been at a speed that results in organizational difficulties associated with the management of change. The second concern relates to the change in funding base itself and anxiety related both to dependency on untested forms of funding and the dangers of a loss of independence which is held as an essential ingredient by many NGOs themselves. These issues of scaling-up[24] caused by the success of individual NGOs have wider implications for the sector as a whole. The overall growth of the sector does not imply, however, that all NGOs are finding finance easy to obtain. For many NGOs the search for sustainable sources of finance remains a critical issue, which will be discussed further in Chapter 8.

Professionalization of NGOs

One of the significant shifts that has occurred in a number of NGOs recently has been away from organizations that are volunteer-driven to organizations that are heavily dependent on trained and salaried staff. This shift in the composition of organizations has a number of effects. First, it has undoubtedly led to tensions in some organizations between these two groups with each feeling that they have a legitimate claim to decision-making powers. Second, it has led to the development of a new cadre or profession of NGO managers who move between NGOs as part of their career progression and whose loyalty to the NGO's objectives are professional rather than the more emotional one of the volunteer. Third, it may have been a factor in the increasing self-confidence in NGOs operating as policy advocates.

NGO Accountability

Earlier in the chapter we referred to enthusiasm towards NGOs on the part of donors by virtue of their contribution to the development of a pluralistic society with a diversity of organizational forms rooted in the community. Ironically, one of the issues that faces some NGOs as they grow, shift from being volunteer bodies and seek new forms of funding is their legitimacy in terms of accountability. Whereas accountability within the public and private-for-profit sectors is clear (in the former to the citizenry and in the latter to share-holders or consumers), with NGOs there are a number of groups or actors who may lay claim to being the group to whom the organization is accountable. Whilst accountability formally may rest with the Trustees this is only valid at one level. It raises deeper questions as to appointment mechanisms and more fundamentally the ultimate accountability of a Board of Trustees itself. Other groups laying claim include the donors (the general donating public, aid agencies or indeed other NGOs acting as donors), the communities being served and the professional officers and volunteer members of the organization itself. It is an issue to which we return in Chapter 9 but which has important implications for the strategic direction and organizational style and structures of NGOs.

North-South Issues

Lastly, increasingly the relationship between national or community-based NGOs and donors from industrialized countries is questioned. The North-South relationship as it is sometimes portrayed raises important questions as to the long term role of international NGOs operating in developing countries. Though the term 'partnership' is frequently bandied about, its real meaning is often questioned, with a concern that in fact at best dependency by southern NGOs on northern NGOs is being fostered and at worst that southern NGOs are being manipulated by their northern partners for their own ends. As Kajese[25] neatly describes it, the relationship may be seen as one of partners, but the form of partnership experienced is often that of a rider and horse.

SUMMARY

This chapter has introduced the book through setting out a number of themes that have been important in the development of the NGO sector in the health field. The recent and growing interest in NGOs as one element

of the more complex health sector is the product of a variety of ingredients which together constitute the policy-making process both at a global level and in particular countries. Whilst individual countries are at different stages in the development of their NGO sector and its place in the wider health picture, it is clear that, for many countries, NGOs are emerging as a third and significant sector within the health field. This raises a number of significant policy issues which we explore in the rest of the book. First, however, we turn in the next chapter to a more detailed examination of what we mean by the term 'NGO'.

2 What are NGOs?

The previous chapter painted a broad and general picture of the current situation in the health sector of developing countries. It highlighted a number of themes and issues affecting NGOs. As part of that introduction we examined briefly the term 'NGO' itself, recognizing that the concept was difficult to pin down. In this chapter we look in more detail at what is understood by the term and in particular what distinguishes NGOs from other organizations operating in the health sector.

There are two immediate problems that we have to contend with in the use of the term. These are the difficulties of dilution and of overlap. The first of these concerns the over-loose use of the term and subsequent inclusion within it of a very broad set of organizations. For example, the OECD, in a report published in 1988, remarked that: 'the term "NGO" may include profit-making organisations, foundations, educational institutions, churches and other religious groups and missions, medical organisations and hospitals, unions and professional organisations, business and commercial associations, cooperatives and cultural groups, as well as voluntary agencies.'[1] Such a wide usage of the term diminishes its usefulness, and yet the very description 'non-governmental', by its reductionist nature, encourages such breadth in definition.

The other difficulty relates to the fact that there is a number of terms which, though broadly similar, differ either in an explicit criterion or implicit nuance of usage. For example, Anheier and Knapp have a list of similar terms: 'voluntary associations, non-profit organisations, private non-profit organisations, non-governmental or non-statutory organisations, philanthropic bodies, foundations, charities, charitable trusts, local or community initiatives, third or independent sector agencies, the commons, and doubtless many more.'[2] Thus there are, in addition to the term 'non-governmental organizations', a number of terms used to describe what are largely similar types of organizations. Many of these may share a common core, and indeed some of the different terms may only often refer to usage in different contexts. However, where there *are* significant other factors, it is, as we shall see, important to recognize this.

Various authors have attempted therefore to pin down the term NGO with a precise definition. The importance of this stretches beyond any desire for semantic tidiness or to satisfy academic pedantry. There are two particular reasons why it is important. First, the NGO sector is still ill-understood. Whilst there are distinctive theories as to how the private-for-profit and

public sectors operate there is no such well-developed equivalent for the non-profit sector. The focus of attention for the provision of welfare (including health) services, in developing countries at least, has been (and for the most part, continues to be) firmly fixed on the public sector. Neo-classical and Keynesian economic theories of the firm and more management-oriented theories have been deployed to analyse the commercial and manufacturing private profit-motivated sector. However, there are no widely accepted comprehensive and research-tested theories which are able to explain or predict the behaviour of the not-for-profit sector. This is a clear gap which needs to be filled, particularly if, as we believe, the NGO sector is likely to grow in importance in developing countries. For the development of our understanding we need to have concepts and terms that are comparable and used in the same way by researchers and policy analysts.

Second, later in the book, we will be arguing that an understanding of the NGO health sector provides opportunities for governments, and indeed NGOs themselves, to develop and, more importantly, to apply a policy framework towards the sector. For example, it may be regarded as desirable to encourage the development of the NGO sector through tax concessions, as indeed some governments already do. This requires a clear understanding of what constitutes an NGO as opposed to, say, a private-for-profit organization. In practice the significant differences in a number of the attributes of NGOs result in an extremely heterogeneous sector which is difficult to capture in a simple definition. Fortunately it may only be necessary, for the development of such policy frameworks, to agree in any case on different sets of criteria (for example, non-profit-making) for different policies (such as tax concessions).

There are, as Salamon and Anheier[3] point out a number of ways in which definitions can be formulated. In particular they suggest there are four broad approaches:

- a *legal* definition by which is meant reference to the prevailing country law. However such definitions may be both complex and difficult to apply and are likely to differ between countries and as such limit the potential for inter-country understanding
- an *economic/financial* definition relying on, for example, National Accounts definitions. Whilst such an approach is rigorous and potentially easy to use it may limit constrain links into useful policy discussions
- a *functional* definition which defines according to the activities of the organizations (such as 'relief of the poor'). This suffers however from the likelihood of looseness and ambiguity
- a *structural/operational* definition which relies on a set of features related to the structure and operation of organizations to define them

It is the last of these approaches which Salamon and Anheier propose and we will adopt a similar approach here.[4]

We will, however, first of all give some examples of a number of definitions which throw up the key criteria and then attempt to draw out some of the possible variations in characteristics which may be important in policy formation.

SOME DEFINITIONS OF NGOs

Perhaps the most significant characteristics of NGOs are their 'non-governmental' position and their deliberate non-profit-making and welfare-promoting nature. For example, one of the authors has previously defined the term NGO as being outside direct state control and non-profit-making.[5] A third characteristic is also often identified: that related to its decision-making structures and processes. Smith, for example, sees them as having 'legal independence from government; a non-profit status; a voluntary decision-making structure'.[6] Different authors lay emphasis on different combinations of these. Cumper describes NGOs as 'organisations not mainly financed by governments . . . and not under the control of . . . governments'[7] thus stressing the sense of distance from the State. Tongsawate and Tips define the main characteristics of an NGO as: 'a non-profit, non-government, private group, at least partially formalised into an organisation, that an individual joins by choice'.[8] We will now look more closely at the three main characteristics that emerge from such definitions.

PRIMARY CHARACTERISTICS

There are three main characteristics that seem to be widely viewed as constituting the critical elements of an NGO. An organization that lacked one of these usually would not be regarded as an NGO proper. As we shall see, however, such key characteristics are not easy to capture or measure. There is a difficulty in each case in setting criteria that are applicable and generally acceptable.

Formal Organization

The first primary characteristic is that the body should be a formal organization. There are two reasons for such a criterion. The first is the pragmatic concern of limiting what otherwise would be a potentially infinite number of groups which could otherwise, taking it to its absurd limits,

include family groupings. The second reason, however, is related more to policy formation and a desire to distinguish organizations which have medium to long term objectives from informal groupings which may be temporary and mercurial. Clearly, a number of NGOs which are constituted as formal organizations started life as informal groups of individuals with a common purpose or interest. Transformation into formal organizations indicate a recognition that they were limited in achievement of their goals by their lack of structure or formalization.

Indicators for the recognition of an organization as formally constituted may vary but could include some or all of the following.

First, it is likely to require a constitution which sets out the objectives and decision-making structures of the organization. The latter would include a statement of how the holders of final responsibility for the actions of the organization are appointed. Such a governing body of the organization may be its Management Board or Board of Trustees.

In some countries the registration of the organization with a government or quasi-government agency may also be required. Such registration may be linked to tax or foreign exchange benefits or may act as a regulatory control set up to ensure that organizations have minimum quality standards and follow national policy.

Other indicators of the formal existence of an organization may include the drawing up of a budget, the maintenance of formal accounts and the existence of a related external independent audit process. It may also require the existence of a location for the organization, such as an office address or post office box. It might also include explicit and public availability of an annual report, plan statements and organizational structure, though some NGOs may deliberately minimize the formality of such documents on the grounds that they reduce the organic dynamism of the organization.

Objectives

The second criterion relates to the purpose or objectives of the organization, or what in business terms is known as its mission. This criterion can be sub-divided into two aspects, one reductionist and the other more positive. The reductionist element relates to the non-profit-making nature of the organization. As we explained in Chapter 1, the term 'profit' is here being used in its strict formal sense to signify any surplus of an organization's income over its costs which are distributed to individuals, such as share-holders, for their personal benefit. It should not be confused with income generation through, for example, trading activities or sales.

The second aspect relates to the nature of the objectives of the organ-

ization and their social, humanitarian or philanthropic nature. It may be considered that the non-profit-making criterion rules out activities other than those with broader community aims. However, there are various further considerations. First, a distinction needs to be made between general social good and the advancement of the cause of a group of individuals related to the organization. Some analysts exclude from the definition of an NGO those organizations which are set up primarily to benefit their own members. An obvious example is that of a trade union; an organization which is non-profit-making but is set up to promote the welfare of its members. Such an organization is here excluded from the definition of an NGO. This externality criterion is not intended to suggest that benefits have to be society-wide but rather that the benefits are external to the organization's employees, governing body or members. For example, an organization set up by disabled people to campaign for the rights of disabled people would not be excluded from the definition of an NGO *unless* the benefits were directed *solely* towards *members* of the organization.

Whilst groups such as trade unions, co-operative organizations or credit union bodies are straightforwardly excludable as having as their primary purpose the promotion of the well-being of their members, there are various grey areas. The most obvious of these relates not to the formal position of the organization but to its more hidden agenda. As we shall see later in the book, one of the less positive effects of the growth in donor funding available for NGOs as a sector has been a rise in small organizations tapping into this funding with the prime but hidden objective of providing employment for their founders. A case-study from the Philippines talks of: 'COME 'N GOs (fly by night entrepreneurs): these are paper organisations that never operated or operated only one project, and then disintegrated. There are also a growing number of NGOs who see funding as a lucrative opportunity, and can package large and expensive proposals for donors.'[9] Clearly also there is a fine distinction to be made between profit distribution and the provision of generous salary and in-kind benefits to the employees of organizations. This aspect of a definition, whilst conceptually clear, is harder to operationalize. It is no simple matter to determine the genuine motives of an organization's founders, or the acceptability of the levels of remuneration for its employees.

In part, the answer to the above lies in a recognition of a distinction between means and ends. The critical defining issue is whether the organization is set out with explicit social ends and with means that are consistent with this. If the means (such as internal salary levels) are inconsistent with the overall objectives or militate against their attainment, then it is difficult to adjudge such an organization as being an NGO under the objectives criterion.

Related to this is the question of treatment for religious motivations. An NGO that was set up with social welfare-promoting ends but operating under the direction of a religious organization would qualify under our definition as an NGO. However, in some cases, religious organizations set up such health services as part of a broader proselytization strategy. If the primary motivation for such an organization therefore were evangelical rather than social then it would not qualify under our definition as an NGO.[10]

Lastly, in many countries, there is a distinction made between organizations with social ends that are seen as being overtly political and those that are not. The distinction is not an easy one and is critically dependent on how one defines political activity. For most people the term 'NGO' excludes organizations that seek direct political power and which may therefore become governmental. This, however, should not be confused with attempts through advocacy to achieve policy changes. In countries which have weak or non-existent democratic processes, NGOs may in fact be used as a front for broader political activity. A number of countries in Latin America have experience of this. Unfortunately, even in countries with fragile democracies, this confusion can be (and in some countries is) used as means of political control: organizations which are seen as being critical of government policy are refused the status and privileges of other NGOs. Even in apparently well-established democracies the situation is not always clear or seen as acceptable.

Decision-making Processes

The last of the three main criteria relates to the process of decision-making and where ultimate authority lies. Again, using reductionist criteria, the term 'non-governmental' suggests that such organizations are independent of the control of government. It is clear, however, that we are operating in a murky definitional area. Whilst at one level it is possible to define formal decision-making processes as being independent, through the simple device of examining the make-up of the constituted final decision-making body, it is quickly apparent that at a variety of levels government is likely to have an influence on decision-making; indeed, one of the themes of the book is that we consider it necessary that governments *do* provide a policy framework within which NGOs operate and to which they contribute. Such influence may be exerted through the legislative or statutory powers of the government or through funding relationships.

However, the critical issue is not whether an organization is independent of influence of government or indeed of any other body. Indeed to suggest that such purity of action is possible for any organization is

Figure 2.1 Examples of decisions required by NGOs

Strategic decisions
What should be the long- and short-term aims of the organization?
How does the organization view its role in relation to the State and other providers?
Accountability
To whom is the organization accountable?
Funding decisions
How will the organization fund its activities?
Operational and technical decisions
What services will the organization provide?
What approach to the delivery of services will it adopt?
Managerial decisions
What type of organizational arrangements will be used?

naive. What is critical is whether it has the constitutional freedom to make decisions which may or may not take account of the government views. This is closely related to issues such as the appointment process for the Board Members of the organization. It is effectively this decision-making freedom which distinguishes a statutory body with government appointed decision-makers from an NGO.

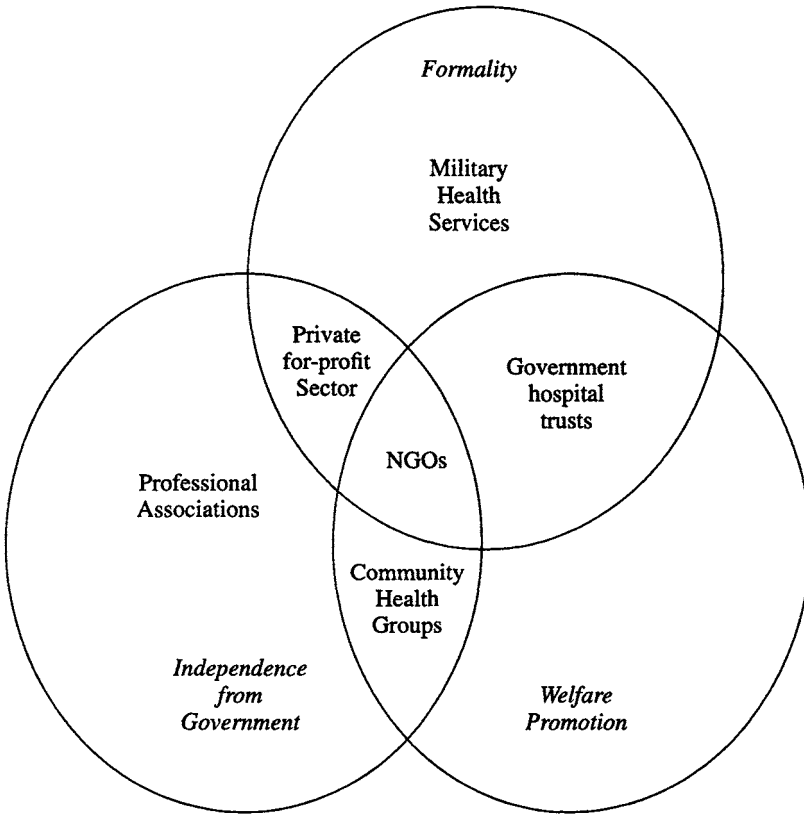
Whilst there is no single easy criterion that can be applied it may be helpful to distinguish between *types* of decision that an NGO may need to make and then analyse its freedom to *make* each of these decisions. Examples of these types of decision are outlined in Figure 2.1. One might, for example, argue that an NGO should be free to make all these decisions with the possible exception of those of a technical nature, where recognition of a wider policy and regulatory framework may be appropriate. Thus decisions, for example, regarding location of facilities, immunization schedules, training curricula and health education messages may all be seen as requiring a broader national view.

In the preceding we have set out three broad criteria that we feel are necessary in the definition of a NGO. Figure 2.2 sets out diagrammatically the interaction between the above three criteria and gives illustrative examples of organizations fitting into each of the permutations of combined criteria.

SECONDARY FEATURES

In addition to the three critical criteria of an NGO there is a number of secondary features which are occasionally identified with, but are not part

Figure 2.2 Primary features of NGOs and other organizations



of, the defining nature of an NGO. For many, a traditional characterization of an NGO is as a small, community-based volunteer-led organization with funding raised from the public through donations. Yet none of these features is essential, nor indeed is widespread among NGOs. Each of these is discussed in turn.

Volunteers

The first relates to the involvement of volunteers[11] in NGOs. For many NGOs an important characteristic at an early stage in their development is reliance on unpaid individuals. Such volunteers may or may not be 'members' of the organization. As NGOs grow, they are likely to employ an increasing number of salaried and waged staff. Indeed the relationship

between volunteers and employees working within an organization is frequently a source of organizational tension within an NGO. Volunteers are likely to give their time to the organization as a result of a commitment to the shared aims of the organization and it is this aspect of volunteers that is of particular interest.

There are three main areas in which volunteers may operate within an NGO. The first is as unskilled labour, carrying out routine tasks such as street collections as part of public fund-raising. The second is through the provision of skilled support (such as, for example, first-aid trained volunteers in a national Red Cross). The last level is as part of the decision-making process through serving on committees or Boards of Trustees. Given the externality requirement set out above, that the decision-making body of an NGO should not itself benefit from the decisions of an organization, the use of volunteers at that level is an important feature of an NGO.

Size

The second feature often identified with NGOs is small organizational size. However, there is a great diversity in the NGO sector in terms of size. At one end of the spectrum are small 'living-room' organizations with few if any employees, and heavily reliant on volunteers. At the other extreme are large international NGOs such as the IPPF or national level organizations such as the Bangladesh Rural Advancement Committee (BRAC). Though the size has important implications for the management structure and style, and possibly efficiency and organizational effectiveness, there is no size imperative within the definition.

Funding Base

The last feature relates to the funding base for the organization. Chapter 8 looks in more detail at the methods of financing NGO activities and their advantages and disadvantages. At this stage it is sufficient to recognize that NGOs have a variety of sources of funding and that the mechanism with the highest profile, public donations, may not always be the most significant. The sources of funding for health sector NGOs range from public donations, through charging for services provided to support from other organizations either in-country or internationally. These last sources may include other NGOs, national governments or international aid agencies. Though the funding base and mix have important implications for the sustainability of the organization's activities and its independence in

decision-making, there is no single method of funding which is a critical feature of an NGO.

* * *

The preceding has discussed a number of potential features of NGOs which could be argued as their defining characteristics. To summarize, within this book we will be using the term NGO to refer to organizations that are formally constituted, with the primary non-profit-seeking objective of improving the welfare of a group or community wider than the direct membership of the organizations and with a decision-making authority independent of government. They may achieve their aims in a variety of ways ranging from direct service provision through to the provision of support to other NGOs. Health NGOs are a sub-set of such organizations with a specific objective of health improvement.

We turn now to an examination, against this background, of the types of NGOs operating within the health sector in developing countries.

TYPES OF NGO OPERATING IN THE HEALTH SECTOR

A casual glance at the NGOs operating within the health sector of developing countries may give an initial impression of homogeneity and common purpose. The similarities arise from the definitional characteristics set out above. By definition they are all independent from government and all with an apparent drive to improve health conditions. However, closer examination reveals a number of levels at which there are marked differences within the sector with attendant implications for policy. These are now examined.

Area of Activity

NGOs may operate at a variety of geographical levels. For ease of analysis two broad categories are set out here, single-country and international, though there may of course be combinations of these and indeed intermediate levels such as regional or community.

Some writers use the term 'community-based NGO' to refer to informal indigenous organizations. For example, Bratton suggests that: 'A "national NGO" is distinguishable from a community-based group which is informally constituted and run solely by the members themselves. A national NGO possesses both a legal identity – usually as a registered non-profit or

welfare agency – and a professional staff.'[12] However, our definition above excludes such organizations (despite their clear significance in development terms) on the grounds of their lack of legal formal structure. Instead we are here defining community-based NGOs as those which operate solely within a prescribed sub-national locality.

National NGOs, in contrast to community NGOs, have a general objective that is country-wide rather than confined to a single sub-national area. This does not mean that all national NGOs are *active* throughout a country; resource constraints and different priorities may result in concentration of effort in certain areas. However a national NGO could *consider* operation in any area of a country. In broader terms both community-based and national NGOs operate within a single country, and can then also be categorized as country NGOs.

The third level relates to international NGOs which operate within more than one country. Typically, given international resource imbalances, this means that the bulk of such NGOs are based in industrialized countries whilst operating in developing countries either solely or in conjunction with activities in the home country. SCF, for example, provides services both within the UK and internationally. This contrasts with Oxfam, which has its prime focus at the international level (though it is involved in UK targeted development education, this is a means to improving wider development processes). One area of potential growth in the next decade, which has been called for by NGOs in developing countries themselves, is enhanced inter-country regional activity and particularly networking within developing countries.[13]

Stage of Development

The second frequent classification refers to the stage of development of an NGO. Whilst this approach to classification can be helpful conceptually in understanding organizational aspects of NGOs, there is a danger in translating this into a development track along which all NGOs will perforce move.[14]

Garilao[15] suggests three stages of organizational growth. These correspond to the formation and development of an organization, its consolidation and its institutionalization. During the first stage, individuals organize themselves to respond as a group to common problems; the second stage is characterized by the formation of leaders and the development of expertise within the organization and the final stage by the attainment of the necessary ingredients for a sustainable organization. It is questionable again whether the first stage would fall within our definition of an NGO, but it

does usefully provide an analysis of the conception process for a number of NGOs.

A similar analysis has been provided by Nogueira[16] with a three-stage process: gestation, institutional development and consolidation and transfer.

Perhaps the most well-known analysis[17] of the development of NGOs is that of Korten. Initially[18] he suggested three stages of development which has since been expanded to include a fourth stage. These are summarized in Table 2.1.

These four stages relate more to the activities or strategies of the organizations than to its organizational development. They are as follows. The

Table 2.1 Strategies of development-oriented NGOs: four generations

	Generation			
	First (Relief and Welfare)	*Second (Community Development)*	*Third (Sustainable Systems Development)*	*Fourth People's Movements*
Problem Definition	Shortage	Local inertia	Institutional and policy constraints	Inadequate mobilizing visions
Time Frame	Immediate	Project life	10–20 Years	Indefinite future
Scope	Individual or family	Neighbourhood of village	Region or nation	National or global
Chief Actors	NGO	NGO plus community	All relevant public and private institutions	Loosely defined networks of people and organizations
NGO Role	Doer	Mobilizer	Catalyst	Activist/ educator
Management Orientation	Logistics management	Project management	Strategic management	Coalescing and energizing self-managing networks
Development Education	Starving children	Community self-help	Constraining policies and institutions	Spaceship Earth

Source: Korten (1990), Table 10.1, p. 117.

first generation are organizations concerned with relief and welfare and typically formed after a disaster situation. As such it is particularly relevant to health sector NGOs which at this stage would concentrate on the provision of basic commodities to communities in need. The second stage is that of community development, and focuses attention on capacity-building within communities in order that they can themselves meet their own needs. The third strategy concentrates on sustainable systems development and goes further than meeting the needs of individual communities by looking for changes in institutions and policies. Korten suggests that this strategy may grow out of a sense of frustration within NGOs at the inability of second stage strategies to provide long-term sustainable change. He calls his fourth generation strategy that of People's Movements. This is, in a sense, a return to the second stage but building capacity *within communities* to recognize the wider constraints within which they operate rather than the immediate material concerns. As such it has similarities to Latin American conscientization movements.

It will be apparent from the above that Korten's classification relates to the strategies of an organization as related to its activities rather than its internal organizational development. It is to the range of such activities that we now turn.

Activities

There is a range of activities that health sector NGOs are involved in. We will look more closely at these later. However, as part of developing an understanding of NGOs, we outline here the main categories of activities in which health sector NGOs engage.

- Service provision
- Research activities
- Providers of support services
- Policy advocacy
- Fund-raising
- Co-ordination

Service provision

The first and largest is the provision of health services to the public. Within this set of activities is a number of sub-sets. These include primary health care services such as health education, hospital-based services, and relief and welfare in emergency or refugee situations. It is difficult to draw

a clear boundary between health and non-health activities as many spheres of activity have health implications. Well-known examples include the provision of clean water and sanitation. Each type of service provision, in turn, may be considered as mainstream or as innovatory pilot activities testing out new approaches on a small scale.

Research activities

Innovative pilot services can also be considered as one form of research activity at an operational level in which NGOs may engage. Within the health sector NGOs also may play an important role in clinical or laboratory medical research.

Providers of support services

A specific and different set of activities is that of services which support the direct provision of health care. Such services include professional training, provision of supplies and management consultancy. It also may provide services for NGOs which are too small to warrant in-house provision of such services. These include, for example, accountancy or publishing services.

Policy advocacy

A different form of activity in which health sector NGOs may engage is that of attempting to change public awareness of issues in order that policies of other organizations and, in particular, the government, change. Often such policy advocacy is firmly grounded in service provision. Indeed for many NGOs it is their field experiences in service provision that they believe gives them legitimacy to attempt to influence policy. Clearly, as we have seen, the boundaries between policy advocacy work and more general political activity are not always clear and in some countries have led to accusations of NGOs engaging in unacceptable political practice. A well-known UK example of this occurred when Oxfam initiated a campaign of public awareness about the situation in Southern Africa in 1990[19] and were reprimanded by the Charity Commissioners for contravention of their status as a charity.

Fund-raising

A critical issue for all NGOs is ensuring that funding is available to allow the achievement of their primary activities. Some NGOs specialize in the raising of funds for disbursement to other NGOs, and may have minimal

involvement in direct service provision. Some INGOs, using both their own resources from individual donations and those provided by their own national governments under joint funding schemes, effectively act as providers of resources to 'partner' NGOs in developing countries.

Co-ordination

The final set of activities relates to co-ordination between NGOs. Recognition of the need for such co-ordination has led, in some countries, to the formation of specialist NGOs which perform this function. There are various aspects of such co-ordination which may include information exchange between NGOs, development of joint activities and policy, and advocacy about service policies or policies regarding the NGOs sector. It is frequently also linked to the provision of support services to other NGOs.

* * *

It is important to stress that NGOs do not necessarily limit themselves to one form of activity. Indeed some would argue that it is breadth of activity that gives them important insights and a comparative advantage over other organizations. Such boundary-crossing can occur in a number of ways. For example, many NGOs argue strongly that it is their service delivery base that provides them with the legitimacy to act as policy advocates. It is this conviction that led to strong resistance to proposals in the UK[20] to encourage, through fiscal means, a distinction between voluntary agencies providing service delivery and carrying out policy advocacy. NGOs are also no respecters of functional boundaries. Unlike the traditional government structures common in many developing countries, with highly centralized vertical departments which sets up institutional boundaries between, for example, health care and education, NGOs can freely, as organizations, combine sets of activities where they feel this is appropriate. Given the rationale for a multisectoral approach, such a disregard for functional boundaries is often regarded (as we discuss in the next chapter) as a potential strength of NGOs.

It is to this and other questions of comparative advantage between the NGO sector and government that we turn in the next chapter.

SUMMARY

This chapter has examined a number of issues related to our understanding of what constitutes an NGO. It started by setting out three critical criteria

by which NGOs could be defined, and which will form the basis for the working definition within this book. These are the need to be a formal organization, to be welfare-promoting and to be independent of government decision-making. It then analysed a number of features commonly associated with NGOs. Lastly it briefly described the type of activities in which health sector NGOs engage.

3 Do NGOs have a Comparative Advantage in the Health Sector?

INTRODUCTION

Chapter 1 outlined various themes that have resulted in the spotlight being turned on NGOs in the last decade. One of these was the sense of frustration at the record of the public sector[1] in health care, and a concomitant belief that other non-State sectors could, and would, perform better under the right conditions. This chapter explores the thesis that NGOs possess such a comparative advantage over other actors in the health field and in particular the public sector.

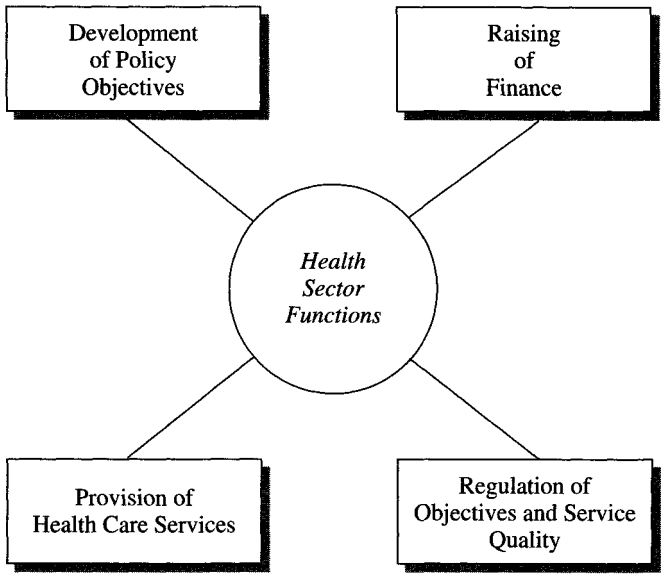
The chapter begins by describing different attitudes to the potential components of, or players in, the health sector. It then focuses on the various arguments as to why NGOs, either as individual organizations or as a sector as a whole, might be considered to have an advantage in one or more of the key functions in the health sector. The functions are those of policy-setting, financing, service delivery and quality assurance (see Figure 3.1). Various areas of potential disadvantage are also explored. For each of these, the arguments underpinning such a potential advantage or disadvantage, and any evidence for it, are examined. A critical distinction is also made between any advantage held by an individual NGO and by the NGO sector as a whole.

VIEWS AND ATTITUDES TO HEALTH AND HEALTH CARE

Before examining the arguments for and against the suggestion that the NGO sector possesses any potential comparative advantage, we need to recognize the differing schools of thought as to the nature of health care which has important implications for the appropriateness of different means of provision.[2]

There are three main views as to the nature of health care. The first sees it as a commodity to be bought and sold like any other, such as cars. Such a view (known by economists as a *consumer* good) of health care suggests that there is no reason why its means of provision should differ from that

Figure 3.1 Health sector functions



of other commodities. Under such a view, health care would be provided through market mechanisms to those who expressed a desire for it and could afford it. The second view sees health care as important as a means of keeping the workforce healthy and hence productive. This view (known as the *investment* approach) as a logical conclusion targets resources on those whose productivity can be most easily increased. The third view of health sees it as a fundamental aspect of human life and as such believes it should not be dependent on an individual's potential productivity or her/his ability to purchase health care.

The above views of health are deliberately put in a stark form to highlight their distinctive characteristics. The reality for most of us is that our view of health involves an element of all three and in part is dependent on the type of health care being considered. For example, it is widely accepted, with the exception of a very few, that access to basic[3] health care should not be denied through inability to pay. At the other extreme few would argue that certain types of cosmetic surgery should be available to all as a right. The philosophy of Primary Health Care set out at the Alma-Ata Conference in 1978 saw access to basic health care as a fundamental right and it is this view that still is espoused formally by most governments. In practice, however, their actions may be influenced heavily by

resource constraints (which make the consumer view of health conveniently attractive) and by economic development policies (which focus on growth and hence productivity: the investment or human capital approach). The World Bank 1993 Development Report[4] sets out a (powerful) donor view of health in which public health and preventive services, together with a basic minimum package of clinical health care, is seen as a right with additional services being available at a price to the user.

In assessing alternative means of providing health care it is critical that our view on health and health care is clear and explicit, as the potential advantages of different alternative approaches are heavily influenced by our views of the nature of health. Which view is chosen is, ultimately a subjective judgement based on our value systems. Within what follows, we are regarding access to basic health care as a right which should not be influenced by ability to pay or any other considerations other than health needs.

HEALTH SECTOR ROLES AND FUNCTIONS

As we have seen in Chapter 1 the component activities of the health sector can be divided into four main functions (see Figure 3.1).

- The setting of policy objectives
- The financing of health care
- The provision of health care
- The regulation of the sector to ensure that objectives are followed and standards maintained

Each of the main organizational sub-sectors (State, NGOs, and the private-for-profit sector) has a variety of potential roles to play in each of these functions. There are, therefore, a number of different possible models arising from different combinations of roles. The following sets out the main ones. These are summarized in Table 3.1.

Free Market

The most extreme is the free market view which corresponds to the view of health as a consumer good. Under this view optimal efficiency and performance are only possible under profit-motivated market conditions. Policy and objectives flow from the market mechanism itself, with health care providers providing services in response to economic demands for them. Funding for health care is also provided through the market mechanism.

Table 3.1 Alternative health sector models

Health sector models	*Health sector functions*			
	Policy making	*Financing*	*Provision*	*Regulation*
1. Free market	Responding to market forces; primarily concerned with maintenance of market	By individuals either directly or through insurance	By a number of private-for-profit competing providers	Minimal, primarily concerned with operation of free market
2. State	Strong equity-based role by State; use of planning mechanisms	Primarily through progressive taxation or social insurance	By State to ensure consistency and economies of scale	Primarily internal by State
3. NGOs as providers	Led by State with strong NGO inputs	May be through State mechanism, donations or charges	By number of NGOs	By central NGO mechanisms or by State
4. Short-term substitute for State	Led by State with strong NGO inputs	May be through State mechanism, donations or charges	By number of NGOs together with State	By State mechanisms
5. Mixed model	Led by State with strong NGO inputs	May be through State mechanism, donations or charges	By number of NGOs together with State	By State mechanisms

Assurance of quality may be provided by internal supply-side regulation itself or by the State. In its pure form this model leaves no role for the NGO sector under the definition that we are employing (that it is non-profit-oriented). There are few, if any, proponents of such an extreme position with most analysts accepting, at a minimum, a role for the State in the funding or provision of public health services, if not basic health services for groups which would be otherwise uncovered.

State Health Care

At the other extreme is a view that all four functions should be performed by the State. Proponents of this model view health as a right and are

concerned therefore to ensure the equitable distribution of, or access to, health care rather than its provision in response to market demands. As such, policies should be set by the government on behalf of the population as a whole. Health care should be financed through the State and preferably through progressive taxation, to promote equity. The arguments for the direct provision of health care by the State (as opposed to its contracting with other agencies) are less obvious, but include arguments related to the need for a homogenous and planned set of services and to capturing the potential economies of scale that exist in the health sector.

NGOs as Major Health Care Providers

The third model suggests that there is something inherent in NGOs as opposed to either the State or the private-for-profit sector which makes them the most appropriate providers of health care. Whilst this view rarely is encountered explicitly in such a pure form as this, it is important to include it here, as its sentiments occasionally underpin the generalized laudatory and unqualified comments about NGOs. Thus statements that NGOs are better at health care provision without suggesting that this is a function of a current short-term state deficiency (see the next model) or in certain health care fields (see the final model) effectively are suggesting a long term, wide-ranging role for NGOs. This view is often characterized as NGOs possessing the fortunate combination of social objectives similar to those of the public sector and the operational flexibility and freedom usually associated with the private sector. The thrust of the sentiments that underpin such a hypothetical model is usually focused on health care provision functions. The setting of policy and quality regulation may be led by the State or by the NGO sector itself. Either way NGOs are seen to have a significant role in the setting of overall health sector policies, and monitoring and policing standards. Financing of health care is seen frequently as more pragmatic with a variety of alternative sources including the State.

Short-Term Substitution for State Health Care

The fourth model accepts the rationale for State hegemony in health care but believes, however, that the under-development of the State has left it unable currently to perform adequately. Non-State organizations are needed in the short term to substitute for it, particularly regarding its health care provision functions. Given the arguments for a State-provided health care system, such support is provided most appropriately by the non-profit-motivated sector (that is, NGOs) rather than the private-for-profit sector. This school of thought suggests that ultimately the State will regain its full

role in health care. Indeed NGOs not only may act as short term substitutes for State activities, but, as Sollis suggests for Central America, 'the role assigned to NGOs is one that contributes to the transformation of a disabling State into an enabling one'.[5]

Mixed Provision of Health Care

The final model covers a variety of combinations. It suggests that NGOs, and indeed the private-for-profit sector, may be better than the State at the performance of certain types of activities within the health sector and vice versa. A pragmatic mixture of providers may be necessary operating under the umbrella of a broad policy framework which, whilst led by the State, is an inclusive and participative process. Finance for health care may again come from a variety of sources.

* * *

Given the theme of this book, we are not concerned here with the first of the above five options which has no role for NGOs. Furthermore it is difficult to escape the conclusion that under a philosophy of Primary Health Care and its attendant emphasis on equity, there is no place for such a model. There are, however, differences within the remaining ones which it is important to recognize.

First, the third and fifth models suggest that there is something inherent in (some or all) NGOs that gives them an *a priori* advantage (in either all or selected services). These intrinsic properties, this view suggests, will *always* surpass the State's (or the private sector's) ability to provide health care. This contrasts with the fourth alternative which suggests that NGOs have an advantage over the public sector *at this time* due to the insufficient development or the breakdown of the State capacity. This advantage may, over time, be lost if the public sector capacity is strengthened.

Second, whilst the third model takes a full-blooded view that the NGO sector has a comparative advantage over the State in *all* areas, the more common view is that the comparative advantage may only exist in *certain* health service activities (for example, rural primary health care or emergency situations).

Lastly there is an important distinction to be made to the suggestion that the NGO *sector* will perform better compared to the State sector. This is a recognition that whilst individual NGOs within the sector may have a potential comparative advantage, the sector, *as a whole*, may not live up to these expectations. This is discussed further later in the chapter.

In what follows in this chapter we look at the arguments for this comparative advantage and at the evidence for it. Much of the literature of the early 1980s which began extolling the virtues of the NGO sector made sweeping generalizations about the sector which were unsubstantiated. For example, Hyden[6] suggested a number of positive attributes of NGOs.

- They are much closer than government to the poorer sections of society
- Their staff are normally highly motivated and altruistic in their behaviour
- They operate economically
- They possess flexibility

Whilst there is now a much greater recognition of the heterogeneity of NGOs and hence difficulty in making such broad generalizations about their characteristics, such language is encountered still. For example, as recently as 1991, the World Bank suggested in its Development Report that: 'such organisations are more effective in bringing about popular participation, in working at the grassroots level, and in operating in remote areas. . . . The importance of NGOs lies in their ability to involve communities and grassroots organisations more effectively in the development process and in addressing poverty.'[7] In contrast to the above there is now more willingness to be critical of NGOs and their roles in the health sector. In 1980 Briscoe[8] wrote an account of voluntary agencies operating in Bangladesh which explored some of the paradoxes and dilemmas. These included, for example, those related to INGOs such as Oxfam operating in the area of community development. More recently, one of the hardest hitting accounts of the deficiencies of (particularly international) NGOs is to be found in a case-study of Mozambique[9] in which the author details accounts of inefficiency, lack of sensitivity to local needs, and prioritization heavily influenced by donor requirements. He concludes that 'on balance, NGOs have probably done more harm than good in Mozambique'.[10]

* * *

Thus there are a number of attributes which NGOs are considered potentially to possess and which are perceived by some to bestow on them an advantage over the public sector and, in some instances, the private sector. There is also a number of potentially distinguishing features of NGOs which may disadvantage them in relation to the public sector. A useful summary of some of the advantages and disadvantages can be found in de Jong.[11]

Several of the reasons advanced as to why NGOs should be better performers are interlinked, but for the sake of simplicity we will start by examining each individually. In order to provide an analytical framework,

these are related back to the functions of the health sector outlined earlier and concern the ability of an NGO to develop policy, generate resources (either hidden or real) for the organization, the provision of services and in particular the efficiency with which an NGO is able to use these resources and the nature of the output provided in relation to social objectives.

Lastly, it is important to distinguish between comparative advantage that results from a *current* situation (such as a weak public sector) and circumstances and which may thus be improvable, and an advantage that emanates from the *intrinsic* nature of an NGO itself.

POLICY SETTING AND SERVICE OBJECTIVES

The first function is that of setting policy: that is, determining and prioritizing what services will be provided, in what manner and where. Health sector policy can be viewed at a number of levels – national policies, policies concerning the NGO sector as a whole and those of individual NGOs. We are particularly interested here in the role and ability of NGOs in setting policy objectives for themselves both as individual organizations and their inputs into the policy setting processes for the sector as a whole.

Policy formation which is consistent with the principles of Primary Health Care needs to attain a balance between the needs of individual communities and the broad equity concerns of the country as a whole. Thus fully meeting the expressed needs of one community may result in an inability to meet needs of other communities. Some NGOs are often viewed as having particular competence in community empowerment. Others have developed competencies in policy advocacy at the national level. All actors in the health sector, including NGOs, need to recognize these two, sometimes competing, pulls.

We divide what follows into, first, an examination of the ability of NGOs to develop their own policies and inputting into the wider priority setting processes. This is followed by a discussion on the products of this process, the decisions made and hence the *nature of the service* provided. These outputs are, predominantly, health services but also include research, policy advice and support to other NGOs.

Policy Setting Processes for Individual NGOs

All organizations within the health sector have to recognize the inevitability of limited resources and hence the need to make priority decisions as to the types of service to be provided. There is a number of potential

factors to be taken into account in making such prioritizing decisions.[12] These include an assessment of need and the availability of feasible and cost-effective interventions. In fact, there is a nested family of such decisions that faces any organization ranging from the macro level decision as to the broad aims of the organization (such as improvement in child health), through the more specific and time-bound objectives (such as a reduction in communicable diseases) to the strategies for achieving these aims and objectives (such as a focus on mobile immunization programmes). For organizations operating in more than one area there may be variations in the priorities between such areas depending on local assessment of need.

For any particular NGO the broad level objective is largely determined by the governing instrument or organization's mission. However, how this is translated into detailed activities depends on the policy and planning processes within the organization. The manner in which this is conducted depends on both decisions as to how open the planning process is (and hence the groups allowed access to it) and the strength of the managerial processes within the organization. This latter depends in part on the existence of robust yet flexible systems (for example, information systems) and the quality of management staff.

Small and young NGOs may have undeveloped management systems. They frequently rely heavily on either a charismatic leader or an informal management process. This may work well in such organizations, but is less likely to be suited to larger NGOs. For a number of growing NGOs, one area of weakness emanates from their lack of such systems allowing clear prioritizing processes. One of the casualties of such a lack of clarity is uncertainty as to which groups have access to the decision-making processes concerning priorities.

Two further issues are of importance here: first, the relationship between NGOs as individual organizations and the health sector as a whole. It is critical that NGOs are aware of the wider environment in setting their priorities and strategies. This is to ensure that their objectives are both relevant to the rest of the sector, and are feasible. Where government has a well-developed, open and accountable policy process, then we would suggest that the NGO should take particular note of this, as it provides a means for the ensuring relevance and complementarity. Some NGOs confuse independence in decision-making with isolationism and disregard the wider environment.

Second, the Primary Health Care philosophy suggests the need to involve communities in such decisions and NGOs as individual organizations may feel that they are well placed to carry out such prioritizing because of their apparent links to the community. Whilst within the State sector of

many countries there has been since the Alma-Ata Declaration (formally at least), commitment to providing processes for communities to voice their needs, these are all too often mechanistic processes with little genuine empowerment involved. Though a decentralized and genuinely democratically accountable State would provide such a process, this is rarely encountered.

NGOs often are seen as having a greater sensitivity to the needs of communities. They are frequently viewed as being community-based organizations. Terms such as 'grass-roots organizations' may be used to describe them. Certainly, organizations which have grown out of specific communities and maintain links to those may well have a greater sensitivity than centralized government agencies. Such links are dependent in structural terms on the nature of the accountability of the organization. Where the organization is a membership organization, with local community members, then sensitivity is likely to be enhanced. However, it is also clear that organizations which fail to maintain these links or whose genesis is at a national level may be unable to speak genuinely for communities. Indeed at the extreme it is hard to accept that INGOs which have no direct accountability to local communities have a greater potential than local public services *if properly constituted* to recognize local community needs.

For many of the types of communities that a Primary Health Care strategy would see as being of high priority, the very level of disadvantage will have in itself been disempowering, thus reducing their opportunities or capacity to express priorities. Some NGOs are seen as being more committed and better equipped to function as empowerment facilitators than government. Community empowerment increasingly is being recognized as an important ingredient in the development process, through facilitating communities to take control over their destiny. This differs from sensitivity to community needs as outlined above, in that the aim of empowerment is to remove the need for outside agents or organizations acting as advocates for, or interpreters of, the needs of such communities. Some NGOs see this as an essential element of their approach. However caution again is needed before we generalize that NGOs are better at facilitating empowerment. Thomas[13] discusses two approaches to empowerment, that of Freire and of Schumacher. The first uses methods of participatory action research related to Freire's concept of conscientization, whilst the second is seen as promoting tools for self-reliance, associated with ideas on gifts of knowledge. Thomas argues that neither on its own can form the basis of a development model; development, he argues, needs to be seen as a process rather than a set prescription. He also argues, using a number of examples, that NGOs cannot operate in isolation from other development agents and notably the State.

However, whilst some NGOs *de facto* may have links with a community, the formal lines of accountability may be less rigorous. By comparison with an effectively operating democratically accountable public sector, NGOs have less clearly defined accountability. For many NGOs, however, there is no clear single external body to which it is accountable. The most obvious and explicit group to which the staff of an NGO may be accountable is the Board of Trustees or its equivalent. This body, usually set up in accordance with legal requirements, has ultimate responsibility for the actions of the organization. However, its own wider accountability is less clear. Some potential groups to which the Trustees may be seen as being accountable include, in some form, the community or target group with which the NGO is concerned and the providers of funding.

Policy Setting for the NGO Sector as a Whole

The NGO sector is comprised of a set of different individual organizations, each with differing objectives and methods of operating. Whilst this allows each of them, individually, a degree of freedom and flexibility to operate, it also reduces the possibility of unified and concerted action and increases the potential for, at best, duplication and at worst destructive competition. NGOs are not well known for their ability to co-operate with each other in a way which would allow for coherent policy-making. This contrasts with the public sector with its potential for unitary policy-making processes.

The NGO sector, however, may have a particular role to play in providing input into the overall policy processes of the health sector as a whole led by the government, if appropriate processes are available. The specialisms of individual NGOs may provide them with insights into particular health issues and make them strong policy advocates for that corner of the health sector. Bratton in a series of case-studies of three NGOs[14] (two in Zimbabwe and one in Kenya), suggests that NGOs may be able to influence public policy if certain conditions are met. These include the following.

- The organization must exist or be created to represent a homogeneous and cohesive sub-group among the poor
- The structure should ideally be based on membership accountability and federated representation
- Leadership cultivates formal and informal ties with political actors
- Every effort would be made to attract financial support from domestic sources, especially from the NGOs' own members, and thus reduce foreign reliance

Services Prioritized

The second issue relates to the actual priorities which the NGO sets arising from the priority-setting process. NGOs have a reputation for serving the poorest and most disadvantaged groups in society. This contrasts with the private-for-profit sector which will target the wealthy and advantaged elements of society. It is possible to advance the argument that government services are more likely to be targeted at the *majority interests* in a society than at small minority elements. By contrast, specific NGOs may take a more narrow view of their target. One particular group that NGOs is often perceived as targeting are women who, though not a minority group, are clearly frequently disadvantaged both in terms of power relations and hence access to services, and in terms of employment. Whilst it is clear that some NGOs, such as groups that provide support such as safe houses or legal advice to women who have been subject to domestic violence, do have a particular focus on women, it is difficult to find an a priori reason why NGOs should have an advantage over the public sector in terms of either service provision or equal opportunities. Indeed there would appear to be little evidence of a particular relative success by the NGO sector. One writer has suggested that 'nowhere is the gap between rhetoric and practice starker than in the field of women and development'.[15]

The evidence that NGOs have a particular advantage in reaching the poorest and have a grassroots base and a role in the targeting of disadvantaged groups would appear to be scanty. Whilst undoubtedly there is a number of NGOs which does succeed genuinely in addressing such groups, it is important to recognize that *intention* is not always synonymous with *effective action*. An example is given by Pratt[16] in which Oxfam, some years back, had made the mistake of assuming that, because they had Indian staff, they had improved their contact with the poor in India. However, the staff were high caste Brahmins and the social chasm between them and the poorest members of the community was difficult to bridge.

Research outside the health sector also tends to question this more general myth about NGOs. A report on three showpiece Swedish International Development Authority (SIDA) projects concluded that:

> they [NGOs] have the reputation of reaching the poorest in society, and of having the capacity to develop and strengthen groups at grassroots level, to offer new and unconventional solutions, and to carry out their projects at low cost, but tough proof is still lacking that this is in fact so.[17]

Research[18] on NGO impact on rural poverty alleviation suggests that whilst some of the NGOs studied may have had an impact in improving the economic status of the poor, many of the projects failed to reach the *poorest.*

A different aspect of the services provided concerns the actual types and distribution of services within a country. The lack of good published country case-studies analysing the role of NGOs within a country means that it is difficult to make any sustainable generalizations in this area. Whilst there are numerous examples of NGOs providing services consistent with the principles of primary health care, there are also examples of NGOs providing less appropriate secondary or tertiary services.

An advantage often related to the choice of services is that NGOs are considered to possess greater potential for innovation. For example, one area in which it has been suggested that some NGOs have been innovators is in the means by which they raise finance.[19] This is clearly a product of necessity as they search for funding. However, the argument that NGOs may have greater innovative capacity tends to rest on the greater flexibility that they are considered to possess and the smaller scale of operations. These are often considered to provide the conditions under which innovation is possible in a way that larger and more homogeneous state organizations may find less easy. Against this, however, any fragility over future resources may lead to greater conservatism in the organization and risk aversion.

ABILITY TO RAISE REVENUE AND RESOURCES

NGOs are seen sometimes as having an ability to raise revenue or tap into resources not available to the State or the private-for-profit sector. Chapter 8 looks in more detail at the sources of resources, both in terms of financial resources and in-kind resources such as staff time and goods.

Many northern NGOs started operating initially by raising funds through public donations. This is a source of funding open to NGOs which is rarely associated with either government or the private sector and therefore a potential source of advantage. However, this route is less obviously available to NGOs in countries with lower levels of income and consequently limited opportunities for public fund-raising. Such NGOs are heavily reliant on either external INGOs or governments (either the national government or those represented by donor agencies). Their apparent advantage in raising revenue is then dependent on the policies of other agencies rather than innate characteristics of the NGOs themselves.

A second argument occasionally advanced relates to the ability of NGOs operating in the health sector to charge fees to users. A significant number of church-related NGOs have done this for many years (and indeed pressure to do this may have increased) as initial funding from overseas has failed to keep pace with the requirements of their in-country health services. Positive experiences within such organizations have led to suggestions that NGOs are particularly well placed to levy fees. However, this may be a function of perceptions in the community mind of a better service provided by such agencies. This, of course, suggests that it is the quality of services rather than the nature of the NGO itself which is critical and we need to consider why NGOs may (or are perceived to) be able to provide better services and whether this, in turn, is an innate NGO quality. There may also be a view that whilst public services should be funded from tax payments and hence free at the point of use, services provided outside government could legitimately charge. However, the ability to raise fees carries with it a trade-off with equitable concerns. There is clearly a limitation on the level of fees which an NGO may be prepared to levy if it is to stay true to social objectives. The private-for-profit sector's main source of income is through user fees, and as such any comparison with the NGO sector relates to their ability to charge for such services and perceptions of the demand for the service. The private-for-profit sector has few scruples about the promotion of inequity and as such is in a position to raise revenue from clearly targeted and high income members of society.

There is one further means, however, by which NGOs have the potential to gain access to resources which are less available to the public or private-for-profit sector. This is through the use of volunteers. For a number of NGOs, particularly, but not exclusively, at the early stages of the organization's development, volunteers provide an important substitute for paid staff. Whilst there is also a tradition of volunteers in the public health sector in some countries (for example, in the UK's National Health Service, where hospital libraries and canteens are frequently supplemented by volunteer staff) any significant use of volunteers is likely to be *through* an NGO as the public sector is rarely equipped to deal with volunteers on a large scale.

One disadvantage that NGOs, in comparison with the public sector, face is a degree of fragility concerning their sources of revenue. Whilst the public sector may be limited in its ability to increase significantly its resources for health care, its core tax-based or social insurance funding is likely to be more predictable and sustainable than the sources of funding available to NGOs who, unless possessing significant endowment funding,

are forced to search continuously for funding. Indeed it is partly this sense of sustainability about tapping into government funding through grants or contracts that may be attractive to NGOs.

COMPARATIVE ADVANTAGE IN SERVICE PROVISION

There is a series of interlinked arguments put forward as to why the NGO sector should have a comparative advantage in the actual delivery of services.

One frequent assertion about NGOs is their relative efficiency when compared with government. Interestingly a similar comparison with the private-for-profit sector is less frequently made. The term 'efficiency' is often loosely used. However, behind such assertions is usually an understanding that NGOs are able to achieve more with their resources than alternative providers. Expressed in economic terms, the ratio between inputs and outputs, it is suggested, is likely to be better if managed by NGOs than by the public sector.

In part this is a reaction against features of the public sector which appear inefficient. The public sector frequently is viewed as centralized, bureaucratic and corrupt. For proponents of a market system it is also seen as lacking the essential driving force of the market, pursuit of profits, which is considered to be the engine of apparent efficiency within the private-for-profit sector. Whilst NGOs are not seen as sharing the organizational deficiencies of the public sector, neither, by our definition, do they possess the profit motivation. As we discuss below, they are frequently characterized as small organizations with flexible management and high standards of staff probity. Such characterizations are viewed by some almost as an immutable given. Yet the situation is by no means as clear as this. First, it is unclear that the public sector *is* inefficient in all situations. Nor is it clear that the profit motive is a necessary ingredient to efficiency.[20] Even where inefficiency can be demonstrated, this does not prove it to be an inherent feature, but at most suggests a situation of inefficiency *under prevailing conditions*. Thus the current symptoms of managerial rigidity that are a frequent feature of centralization of the public sector do not discount the possibility of improvements under more decentralized conditions.

There is, in fact, little evidence available to demonstrate this comparative advantage, though studies are beginning to appear as interest in NGOs grows. One study,[21] for example, in India concluded that costs for primary health care were comparable between the NGO and government sectors. Hospital costs, however, were lower in the NGO sector. This general lack

of good evidence is largely the result of three factors: the difficulty in identifying genuinely comparable activities, the need to demonstrate that any greater efficiency discovered is directly the result of being an NGO rather than the activity itself and the difficulty in identifying *all* resources used[22] (including volunteers and goods provided in kind). For example, research on the costs of training[23] showed a lower cost per trainee in an NGO programme compared to a government one. The research compared the cost effectiveness of the Tanzanian government training scheme for village health workers and that of the Kilombera Project of an NGO, the Swiss Tropical Institute Field Laboratory. However it is unclear as to whether the lower cost per trainee resulted from the method of providing *local* training rather than centralized training or the result of greater efficiency on the part of the NGO.

The context also appears to make a difference to levels of comparative efficiency. For example, two separate studies examining the costs of drug supply and prescribing systems had different results. In Swaziland, research showed that government hospitals were notably more wasteful than mission hospitals.[24] Similarly the study in India,[25] referred to earlier, suggested that voluntary hospitals were lower cost than government (though the study did not measure quality and effectiveness). In contrast to the two studies, a project in Kenya was set up by the government to improve the drug supply at mission hospitals to bring it up to the level of existing and well-developed public hospitals.[26]

More broadly there appears to be a lack of evidence[27] for efficiency differentials between government and NGO hospitals or other aspects of health delivery as measured by unit costs.

* * *

We turn now to look in more detail at a priori arguments for the potential for greater efficiency in the NGO sector. These focus on four areas: greater specialist experience, more appropriate management structures and systems leading to leaner cost structures, sectoral flexibility and staff motivations. As we shall see it is difficult to discover any intrinsic reasons why the NGO sector should be more efficient than government. Bennett *et al.*, at a more general level referring to both for-profit and non-profit providers, comment as follows: 'While policy analysts continue to debate the comparative efficiency of the public and private health care providers, it is becoming more evident that neither provider is inherently more efficient. Their performance is contingent on factors external to the provider, and factors dependent on the internal organization of the provider.'[28]

Efficiency from Specialism

Some NGOs appear to have an apparent advantage over public sector services where they can draw on specialist experience in a field not available to government. Such experience may be derived from at least two sources. The first is the experience gained by an organization in the provision of services which have not been prioritized and hence not provided by government in the past. An NGO's longevity in the field may provide it with an edge over government. An example might be the provision of family planning services in a country in which the government in the past has felt unable, perhaps for political reasons, to develop this aspect of health care and has left it to the non-governmental sector. Ability to draw on such experience may be equally true of private-for-profit organizations.

The second potential source of such experience (and one not as readily available to private-for profit organizations due to their tendency to remain as small in-country organizations, rarely becoming international) is from branches of the same organization operating in other countries. The most obvious example of this is relief and emergency work in natural disasters or conflict situations. A country which rarely experiences natural disasters may have little experience in government on which to draw. The very nature of conflict situations may in themselves suggest that the government is not in a position to provide services itself.[29] Similarly the spread of HIV in different countries is a further example of where an NGO, having gained experience in service provision related to AIDS in one country, may be able to offer this experience in a country where the problem develops later.

Efficiency from Sectoral Flexibility

In contrast to the previous point, some NGOs may gain their efficiency as organizations by their ability to ignore sectoral boundaries and respond in a multifaceted way to health needs. Government health services are frequently organized through hierarchical departments which militate against the possibility or probability of responses that, for example, combine the forces of education, community development, water and the health service. Whilst individuals in the government service may appreciate fully the importance of an intersectoral approach to health problems, the bureaucratic structures rarely encourage this. NGOs, by contrast, are able to be more problem-focused, bringing technical resources to bear from a variety of sectors, in a way that is likely to enhance the success of the intervention.

The preceding describes a common situation for many governments in

developing countries. Current policies of decentralization of public services may improve the possibility of locally-based intersectoral action as accountability and service management are lodged at the same level. There is clearly also a danger that large NGOs may themselves develop similarly rigid institutional skeletons which allow little flexibility of movement.

Efficiency from Management Structures and Systems

The third efficiency theme relates directly to management structures and systems and their ability to translate resources into services in the most efficient manner possible. NGOs are often portrayed as having tighter cost structures than the public sector. This is seen as achieved, in particular, through a low ratio of managers to health care workers with a lack of bureaucracy allowing greater flexibility and speed of response and participative flat management structures. Comparisons with the private-for-profit sector are often made. Small to medium sized NGOs are seen as being able to capitalize on their size to do this, often with the use of multifunctional staff who carry both professional and managerial roles. However, one of the difficulties NGOs face as they scale up from a small size organization is how to maintain efficient management processes without being sucked into a bureaucratic bog.

The counter to this, of course is the potential source of inefficiency from small NGOs unable to capture the economies of scale open to large organizations and, in particular, government. Within the health sector the obvious sites of such economies of scale are in the medical supplies area (usually the second largest category of expenditure after personnel) and training.

There are significant economies of scale potentially available in the health sector in areas such as training and drug purchases which the public sector is able to exploit. It is, of course, possible for the NGO sector to achieve some of these economies of scale with co-ordinated action, but their success in attaining this is dependent on their ability to accept some loss of flexibility or autonomy as a price for such co-ordination.

In addition, as is discussed further below, NGOs may have access to the use of unpaid volunteers thus reducing overall wage bills. Such volunteers are rarely available to government or the private-for-profit sector. This gives the impression of greater efficiency in terms of the output of services provided in relation to the inputs of paid staff and costs when in fact the real resources available to the organization are greater than is apparent. However, this is not genuine *efficiency* but rather an ability to generate additional and special resources as discussed earlier.

Efficiency from Staff Motivation

A fourth reason for the potential advantage of NGOs is related to the motivation of staff committed to the objectives of the organization. The output of such staff may be higher than in either the public or the private-for-profit sector. Staff may be prepared to work additional hours, or accept lower pay levels than equivalent positions elsewhere, and the quality of work may be higher as a result of staff identification with the aims of the organization. Staff motivation within NGOs may also be a function of the management culture within the organization.[30] Some staff, who may be attracted to NGOs because of the management culture, may function best within an organization that allows a high amount of personal operating freedom with few managerial constraints. Whilst some small NGOs are able to provide such operating space for their employees, this becomes increasingly difficult as the organization grows. Staff are also often considered to have greater levels of probity and to be less open to corruption.

One thematic trend in the NGO sector is the shift towards greater professionalism amongst staff, accompanied by the development of an NGO managerial cadre which may result in a lessening of loyalty to the *specific* objectives of the organization (as opposed to the organization as an employer). This is discussed later.

QUALITY ASSURANCE AND REGULATION

The fourth area of potential functional comparative advantage relates to the quality of the services provided. There are two separate aspects to this: the ability of the NGO sector to set up quality assurance and regulatory mechanisms, and the actual level of quality of services provided.

Assurance and Regulatory Mechanisms

Whilst interest in quality assurance within the health sector is not new,[31] the introduction of formal and comprehensive systems has only recently climbed up the policy-maker's agenda. In order to set standards which are monitorable, information systems are needed which are appropriate to the health system. Few developing countries have yet set up such comprehensive systems of quality assurances although attempts have been made to look at specific aspects.[32] There is no evidence that NGOs have any advantage over the public sector in the development of such systems.

Evaluation

In recent years there has been a growing criticism that NGOs fail to carry out sufficiently broad evaluations or engage in serious analysis of their overall activities, including impact studies. A number of suggestions have been made to explain this apparent lack of interest in evaluation and analysis. First, many NGOs do not have the resources, either financial or human, to carry out these activities. Sometimes NGOs are not able to carry out evaluations because it is not specifically budgeted for in project/programme funding. Second, even where funds are provided for evaluations, these tend to take place only at the end of a project cycle and review project activities rather than the organization or programme as a whole. Third, it may be in the interests of NGOs, especially those highly dependent on voluntary income, that the thesis of NGO success and assertions of comparative advantage over governments remain unchallenged. Thus whilst some NGOs are concerned that they do not know much about their successes or failures, others appear content (as Clark suggests) not to 'scrutinise magic too closely, otherwise it loses its charm'.[33]

Quality of Service Provided

One of the frequently paraded virtues of NGOs is their apparent higher level of quality of services attainable in comparison with the public sector. The causes of this are predominantly attributed to the higher level of staff motivation and management. A study in Papua New Guinea[34] assessing availability and range of services offered showed church health facilities had a higher quality of care than government. Newbrander and Parker[35] suggest that many of the quality differences between public and private health facilities are perceived to result from amenities such as staff attitudes, cleanliness and age of equipment, rather than of the actual health care itself.

It is, however, likely that, for some NGOs, access to greater levels of resources (real or hidden) also provides the ability to generate higher level quality services. The converse is also true. One of the concerns of many church-related hospitals, including those provided with government grants, is that their level of resources has dropped to a point where quality of care is suffering.

It is also the case that government may in fact see its greatest responsibility as being to provide generally accessible services and that in the trade-off between coverage and quality, different decisions are made by individual NGOs concerned with quality from those of government concerned with equity.

Assertions about comparisons of quality of services with the private-for-profit sector are less frequently made. Indeed, whilst it may be argued that the private-for-profit sector has access to greater levels of resources and therefore is in a position to develop high quality services, it is also apparent that the profit motive may result in emphasis of the more visible (to the consumer of the care) aspects of quality (such as those known as the hotel aspects of care) rather than the less obvious components of health care itself.

One recent study on quality of health care throws up interesting findings. In a study carried out to assess the quality of primary curative care in Dar es Salaam,[36] differences were discovered between government and NGO facilities. However, though there were better buildings and supplies of drugs and equipment within the NGO sector, these services were also more likely to be providing services contrary to established norms. There was also a danger in the NGO sector of donated drugs from abroad being used which were ineffective.

COMPARATIVE ADVANTAGE OF INDIVIDUAL ORGANIZATIONS VERSUS THE SECTOR

Lastly an important distinction needs to be made between the potential advantages possessed by individual NGOs and the sector as a whole, for two reasons. First, whilst individual organizations may, for example, be efficient in providing services, we clearly cannot assume from this that all such NGOs possess this advantage. Second, however, and perhaps less obvious, it is possible to have all organizations acting efficiently *as individual separate organizations* but, through duplication or a lack of co-ordination, the total output arising from the effort of the sector may be less than the sum of the parts.

THE WAY FORWARD

The above has examined a number of reasons why NGOs may be seen, in theory, as having a comparative advantage in one way or another over the public sector and the private-for-profit sector. Whilst there are arguments for the potential existence of such a comparative advantage, there is also a number of counter-arguments. Indeed it is difficult therefore to draw any firm and generalizable a priori conclusions about the NGO sector as a whole, or indeed about any proclivities of individual NGOs themselves.

One of the underlying difficulties is that attributes which are regarded as positive in certain circumstances may be negative in others. This is put well by Annis who, in commenting on NGOs in Latin America, said: 'In the face of pervasive poverty, for example "small-scale" can merely mean "insignificant", "politically independent" can mean "powerless" or "disconnected", "low-cost" can mean "underfinanced" or "poor quality" and "innovative" can mean simply "temporary" or unsustainable'.[37] Furthermore the evidence for NGOs, as a group of organizations having a consistent general comparative advantage over the public sector or indeed the private-for-profit sector is, as we have seen, hard to find.

This lack of evidence in the health sector would appear to be the result of three main factors. First, the diversity of NGOs themselves is a major handicap to research that allows general conclusions to be drawn. Second, the range of activities and countries in which NGOs are operating, as we have seen, is extensive, leading to similar difficulties. Third, there are significant difficulties in separating the characteristics of NGOs themselves from those of the activities in which they are involved.

Fowler[38] in quoting Uphoff,[39] however, sets up an alternative and more pragmatic approach which, rather than trying to suggest innate comparative advantages, suggest that there may be particular contexts in which such advantages may exist. He describes seven situations in which NGOs can appear to have a comparative advantage over government.[40] These are shown in Figure 3.2. However the existence of these conditions does not guarantee comparative advantage. Fowler identifies three constraints in addition to favourable government conditions for the realization of such a comparative advantage. These are project funding, multiple donors, inappropriate organization and management.

Figure 3.2 Situations in which NGOs may have a comparative advantage over government

The government is weaker than usually found in developing countries
The government is not interested or able to work in a sector or area
The government lacks technical skills the NGO has or can develop
The government is supportive of certain work but lacks needed knowledge and capacity to be effective
The government cannot co-ordinate activities well for whatever reason
The social setting is dominated by 'traditional' values and relation, and
The government is favourably disposed to NGO initiatives

Source: Derived from Fowler (1990).

SUMMARY

This chapter started by setting out a number of hypothetical models to demonstrate the range of attitudes to the different sub-sectors and their possible roles within the health sector. In order for governments, NGOs themselves and donors to develop their policies towards the NGO sector and individual NGOs, it is important to recognize first that this range of attitudes exists even if they are not explicitly formulated. Having done this the assessment of the alternative models depends to a large degree on the potential comparative advantage that NGOs may possess over the public sector in carrying out the different functions required of a health sector. Whilst there are some areas where it can be seen that some NGOs may possess an inherent comparative advantage (for example, disaster relief as a result of experiences gained elsewhere) it is apparent that the innate characteristics of NGOs do not necessarily lend themselves to the wider set of advantages that are often suggested. This, however, is not to deny that individual NGOs will under certain circumstances achieve such advantages, and it is important in the development of such sectoral polices to attempt to identify in particular circumstances what these would be.

Lastly we have suggested that it is important to distinguish between advantages possessed by individual organizations and the sector as a whole.

4 International NGOs: Doers or Donors?

In Chapter 2 we suggested that NGOs could be divided by operational geography into two broad groups, international NGOs (INGOs) and country NGOs (CYNGOs). This chapter will look more closely at the first of these, INGOs. We define INGOs as *NGOs which operate mainly, but not necessarily exclusively, outside their own country of origin.* Most INGOs were originally developed by concerned individuals in response to particular historical circumstance and opportunities. The characteristics of any particular INGO reflect both its particular origins and stage of organizational development. Most of the more well-known INGOs are products of the twentieth century, and very few had a role in the initial development of modern health care in the countries in which they now operate. Many, however, were involved in the introduction of Primary Health Care policies. Although INGOs are a very heterogenous group and thus difficult to describe in all their complexity, this chapter will consider a number of broad issues relevant to the work of INGOs in the health sector of developing countries. These will include their various types, origins and particular characteristics. Not all aspects will be applicable to all INGOs.

TYPES OF INGO

INGOs working in the health sector can be sub-divided according to particular characteristics, such as by organization type, operational style or religious orientation.

By Organizational Type

Divided by organizational type, INGOs fall into two main groupings. The first group are truly international and tend to be organized as a number of autonomous local centres of activity which share a mission and beliefs and yet work with minimal direction from their central structures. Examples include the International Committee of the Red Cross (ICRC) and the IPPF.[1] The second, and much larger, group are in effect nationally accountable NGOs carrying out activities in other countries. Despite

their international focus, many of this latter group demonstrate national or regional characteristics in their operation which reflect their country of origin.[2] These national roots can be used to advantage in that they may enable INGOs to attract funding from the general public and also to draw upon their own government's aid funds.

By Operational Style

INGOs can be divided by their operational style into those which are themselves directly active in other countries, through their own individual workers or projects, and those which provide funding to developing country NGOs. This can either be through clearly recognized partner CYNGOs, such as the funding of church health care programmes and projects by northern missionary societies, or more loosely to CYNGOs which apply for funding on a project-by-project basis. It is this funding relationship between INGOs and CYNGOs which often creates considerable confusion as to the role of INGOs. It may also result in INGOs being considered primarily as alternative sources of project funding, rather than as organizations with particular expertise, altruistic objectives or operational focus.

By Religious Orientation

There are two main divisions by religious orientation, INGOs formed for religious purposes and INGOs with secular motivation. Religious groups, particularly Christian missions, are still an important sub-set of INGOs in the health sector and merit a more detailed review.

If this book had been written 100 years ago, without doubt it would have identified Christian missions as the most widespread type of INGO involved in health care delivery. They are usually nationally accountable organizations, but some are also truly international, such as Interserve which has an international headquarters and separate country-based administrations in a number of northern countries, including Australia and Canada.

Whilst it can be argued that Christian missions fit uncomfortably within the general NGO structure, their health related activities nevertheless have played a significant role in the development and provision of health care services in many countries. Even if only by default, at the beginning of this century and sometimes earlier, mission personnel were frequently the sole source of allopathic medical care in many countries, particularly in rural areas. What is frequently overlooked is that this was often provided

by individuals without formal medical training, as most missionary societies were slow to recognize the need for trained medical people. Despite devastating levels of mortality amongst both their own workers (as the graveyards of most early mission stations will testify) and the local population, some missions actively resisted the involvement of medical workers.[3] Even one of the best known early medical missionaries, Albert Schweitzer, was only finally and reluctantly accepted by the Paris Missionary Society on condition that he would cover all his own expenses. Christian missionary societies usually had one of three main reasons for developing their medical work: (a) as a practical expression of faith carried out alongside other activities, (b) as a primary focus (for example, the Leprosy Mission), or (c) primarily as an evangelistic tool.[4] Around the turn of the twentieth century, another wave of Christian organizations began to be established, many of which are today still involved in relief and development work (for example, the various national Roman Catholic aid agencies).[5] These generally differ from traditional missionary societies as they more clearly had social welfare rather than evangelism as their primary mandate.

Important and often pioneering work was done by medical missionaries,[6] and this innovative practice was not restricted to clinical medicine. Many missions entered into informal partnerships with national governments[7] and these have laid the foundations of current co-operation. Today, especially in Africa and the Indian sub-continent, these same mission health facilities continue to play an important role in health care delivery. What has changed is that most of these facilities are no longer managed and staffed by international missionary organizations, but by the national church or similar indigenous body.

Amongst secular INGOs, it is perhaps also necessary to mention a particular type of INGO of more recent origin. These are *media INGOs*. A discussion of INGO sub-sets would be incomplete without mention of the public response to the African drought of the mid-1980s. The drought contributed to a significant shift of bilateral and multilateral donor aid away from national governments towards NGOs, and stimulated a massive increase in funding for NGO development activities. It also demonstrated a new role for television in emergency and relief situations. Despite their obvious lack of field experience in relief and development work a new group of INGOs, such as Band Aid and Comic Relief, came into being through the media of television. They were able quickly to command enormous public support and not only stimulated cross-national multi-million dollar appeals, but also established a pattern for a number of other media-based appeals.

INGO ROLES

Recent media attention and the fund-raising approaches of some INGOs have led many members of the public to believe that INGOs not only are heavily involved in relief work but also are the primary actors. However, despite their move to a more central position on the international aid stage during the last 10–15 years, INGOs are still minor actors in relief on a global scale. Even with respect to their significant development activities Edwards and Hulme[8] suggest that 'the impact of NGOs on the life of poor people is highly localised, and often transitory'. Thus, despite their current high profile, it is perhaps important to recognize that even where INGOs are operational in a particular country, they are not lone actors. They work in a complex environment, shared not only with other INGOs, but also with local NGOs, multilateral and bilateral donors and of course with the national government.

The roles which INGOs adopt are varied, and may in part reflect the organization's stage of development. These operational roles include relief work, technical assistance, development education, advocacy or policy influencing, and the funding of partner organizations, either from their own resources or using donor funds. Whilst many INGOs appear to have similar roles, they may differ in basic philosophy, objectives or mode of operation. For example, some INGOs favour an operational approach of hands-on activity whilst others prefer to work indirectly through (that is, funding and supporting) partner organizations in developing countries. In addition, most INGOs also have to consider their domestic role, even if it is only one of attracting funding. For example, five British INGOs formed a Disasters Emergency Committee (DEC) in 1963 to coordinate public appeals to fund disaster relief activities.[9]

INGOs as Relief Organizations

In most situations where relief is required, health-related activities are essential. The care required for refugees would be an example. In the first instance the provision of medical care is an obvious need, as are the supply of food and water, sanitation and shelter. These can be provided either by INGOs or by a variety of other agencies, including donors and host governments.

An important early example of an INGO with a particular focus on relief is the ICRC[10] which was founded to serve as a neutral organization providing assistance to victims of war and other situations of crisis. It was not only military personnel who suffered as a result of war; civilians too

had their own needs and, especially after the First World War, other organizations were formed in response to these. During and immediately after the Second World War more NGOs were established to carry out relief work in European countries devastated by war.[11] Even in the 1990s new organizations continue to emerge. This is usually in response to specific situations such as the recent conflicts in the Middle East, changes in Eastern Europe and the war in former Yugoslavia. Here the process has come full circle and these newer INGOs work alongside older INGOs, many of whose origins lie in a war-torn Europe of a previous age.

Although in the past most INGO relief work has been small scale (in comparison to the activities of bilateral or multilateral donors) and has often occurred initially because of their existing involvement in the area,[12] increasingly INGOs are being used as the operational agents of bilateral and multilateral donors in relief situations.[13]

Development Work

The mid-twentieth century saw the independence of many previously colonized countries. It also saw the establishment of the United Nations and the development of bilateral and multilateral aid mechanisms. In the 1970s, the limitations of development policies based on economic growth began to be recognized and brought new types of development approaches addressing basic human needs rather than narrow economic development. This period also saw significant growth in the number of INGOs in many 'northern' countries, focusing not only on relief but also on development activities and development education.[14] In addition some INGOs originally created to provide relief[15] recognized the limited and short term impact of these activities and enlarged their focus to include development.

Increased emphasis by multilateral and bilateral donors on social sector activities, including health, had much in common with NGO grassroots approaches to development. This has resulted in a number of bilateral donors initiating co-financing or matching grant arrangements with their own national INGOs[16] for development activities by INGO themselves or by their southern partners. Consequently, much INGO health work has been in the form of time-bound projects, with tight budget cycles.

Technical Assistance through Individuals

Another broad role is that of providing technical assistance. The historical role of expatriate medical professionals working as missionaries perhaps could be seen as an early form of technical assistance.[17] Apart from

this, technical assistance was an area traditionally occupied by bilateral or multilateral donor agencies. However, INGOs have increasingly moved into this area.

Smith[18] suggests that many newly emerging nations, although wishing to maintain economic links with their former colonial patrons, were keen to protect their newly won independence and so were attracted by INGO offers of assistance. This need, for assistance in newly independent countries was instrumental in the development of Volunteer-Sending Agencies (VSAs), concentrating on sending people to work on a short-term basis. One well-known British example is Voluntary Service Overseas[19] (VSO). Most of these originally independent VSA[20] NGOs now receive significant government grants for their activities. More recent trends have seen the longer-term deployment of INGO staff as counterpart staff or advisors within government departments and the establishment of a number of new INGOs with a much sharper technical focus or target group. In the health sector these new INGOs tend to reflect either a specific sectoral focus (for example, water supply) or a particular disease focus, such as HIV/AIDS.[21]

Where INGOs are seen to be moving into areas previously occupied solely by donors there is a possibility that this may create confusion for recipient governments concerning their understanding of the role of NGOs. The situation becomes even more confused where individual staff or INGOs themselves are contracted or directly funded by donors to implement projects, including joint-funding arrangements. In some countries it would seem that INGOs are merely perceived as funders by government officials rather than as the international counterparts of CYNGOs. As we shall discuss later, this has consequences for the development of appropriate national policy for the NGO sector.

Development Education

A further INGO role is that of development education in their country of origin. This role is rarely government funded, the rationale being that it has only an indirect impact upon developing countries. Perhaps more pertinent, however, is that it usually seeks to highlight the causes rather than the results of poverty, which can be uncomfortable for northern governments. However, whilst it is important for INGOs to maintain the informed support of their 'home constituency' they may have seriously to consider the consequences of such activities. This is especially a concern in the UK, where INGOs registered as charities have to conform to the particular restrictions of their status. In the UK this has resulted in some INGOs splitting their activities between two organizations, one of which

retains its charitable status and another which does not seek such status.[22] This second organization is therefore freer to address what may be considered contentious issues related to government policy.

International Advocacy and Policy Influencing

Even though the high public profile of INGOs is relatively recent, their influence as advocates and policy influencers has been evident for some time. This has been aimed primarily at aid agencies, either bilateral or multilateral, though it has also targeted commercial organizations. Smith[23] records their ongoing association with United Nations organizations which dates back to the 1940s. INGOs were also associated with the development of the Primary Health Care approach by actively contributing to the Alma-Ata Conference in 1978.[24] More well known perhaps is their involvement in the development of the concept of essential drugs, the drafting of the international Declaration of the Rights of the Child,[25] and their campaign against the inappropriate use of free supplies of infant formula. INGOs were also consulted in the preparation of and subsequent critiques of the 1993 *World Development Report*.[26] A number of international bodies, such as United Nations organizations, the WHO and the World Bank, have set up structures through which they liaise with selected INGOs.[27]

Conducting Research

Some INGOs also carry out research in areas relevant to their own operation, but only a few are research specific organizations. Examples from the UK would be the Overseas Development Institute (ODI), a registered charity and important policy research organization, and organizations dedicated to medical research such as the Imperial Cancer Research Fund. Some INGOs whose prime role is the delivery of programmes have developed a complementary research role building upon their programme experience. A recent example would be the research on sustainability in the health sector conducted by The Save the Children Fund (UK).[28] This research was carried out to support their broader mission and interests as a policy influencer, rather than as a research specific organization.

Funding Southern Partners

We noted earlier that some INGOs have no operational activities of their own in developing countries but provide funding to their southern 'partners'. This funding, as we discuss later, can be either raised directly by the

INGO itself or be acquired through joint funding arrangements with aid donors. The precise nature and balance of these partnerships can vary. The North-South relationship usually involves some degree of northern operational oversight and southern reporting requirements. However, as southern NGOs strengthen their own organizational structures, they increasingly are articulating the need for more direct access to aid donor funding without northern brokerage.

INGO ISSUES

There are a number of issues concerning INGOs that deserve particular mention.

Donor Influences

A major feature in the work of INGOs over the last 10–15 years has been their increasing involvement in donor-funded relief activities and their receipt of substantial bilateral donor funding for development work. INGOs are being regularly asked to function in relief and emergency situations as the operational agents of bilateral and multilateral donors, even in locations where they previously have not worked. This is in stark contrast to their more traditional role of providing relief in situations with which they were already familiar, or where there were needs unmet through regular sources. This has resulted in a number of difficulties.

First, some INGOs are being drawn into working on a scale for which they may be unprepared and sometimes ill-equipped, particularly in terms of human resources and the prior experience of their organization.[29] Second, INGOs are being strongly influenced through these external pressures to fuse their development and relief roles. Whilst this can be viewed as a positive move, it can have implications for quality and effectiveness. An example would be where it creates the need for specialist development workers to carry out emergency relief activities or specialist emergency relief workers to carry out, or at least prepare the groundwork for an ongoing rehabilitation and development phase. This can be illustrated within the health field by the example of moving from an initial curative emergency response to a more long-term developmental and community-based primary health care approach. Third, as Smillie suggests,[30] there is an additional danger of creating a situation of increasing INGO uniformity that is achieved not through shared understanding and common principles but through pressure to conform to standardized procedures and practices

which reflect the donor's primary short-term need to achieve results. This can conflict with the longer term desire of most INGOs to contribute to lasting change.

NGOs have traditionally viewed themselves as apolitical, and sometimes the use of INGOs by donors reflects their desire to assist in a situation without the political restraints of direct funding. One possible example might be in a situation of conflict where bilateral aid may be seen to imply a level of acceptance of one side or the other, such as the situation reported during the civil war in Nigeria.[31] Another example might be where there are active restrictions on donor aid (for example, Kampuchea in 1979). Alternatively, and more cynically, the use of NGOs by donors can be interpreted as a desire to encourage private sector activity. However, whilst a high level of donor interest in INGOs could be seen as negative, both by supporters of public sector activity and by those wishing to maintain a high degree of NGO autonomy, it can also have its compensations. It may, for example, provide an opportunity for INGOs to influence donor policies relating to development aid and emergency relief.

Another related issue is that in some ways INGOs are trapped by their own success.[32] Once active in a situation, it often is difficult to withdraw.[33] Many INGOs, especially those which have grown in response to donor funding, now have to spend considerable resources in maintaining their activity levels. There would appear to be increasing competition for funding and INGOs may even find themselves tendering for projects against private-for-profit groups. In addition, whilst access to donor funding, especially for development activities, may appear to contribute towards greater financial sustainability, it also demands a high degree of organizational integrity. If INGOs are to retain their freedom of decision making and ability to speak out on issues of public policy, they cannot allow themselves to become overly dependent upon donor funding. Neither can they neglect to differentiate clearly between donor provided and supporter provided funding. This is particularly important in their relationships with partner NGOs in developing countries as it can affect the nature of their partnership.

Relationships with National Governments

We suggested earlier in this chapter that INGOs work within a complex environment, shared with a number of other actors, including national governments. We would agree with Edwards and Hulme[34] who suggest that the maximization of NGO 'contribution to the development of people around the world' cannot not take place 'in isolation from the national and

international political process and its constituent parts'. It is therefore a concern that one criticism levied against INGOs is that they can be used to bypass existing State mechanisms.[35] Whilst this may be condoned on humanitarian grounds in situations of extreme emergency, it is harder to excuse for longer term work. However, INGOs cannot be expected to shoulder all the responsibility, nor can they or any other type of organization be held accountable for failing to seek government permission to operate if there are no procedures in place through which such permission can be obtained or dialogue maintained.

Bypassing State mechanisms may reflect more a passive approach on the part of recipient governments[36] than an active desire by INGOs to bypass the State. National governments must first possess the ability to regulate INGOs before they complain of their isolationist approach. National governments not only need to be able to acquire accurate knowledge about the various capabilities of INGOs and their activities, but also to assess and channel their contribution to national priority concerns. In order to do this, recipient or host governments themselves need to be skilled, and if necessary adequately supported, to enable them to maximize the effectiveness of INGOs. The increased potential promised by those who advocate the increased use of NGOs as alternative health care providers cannot be fully achieved in an unplanned policy vacuum.

It can be argued that not all governments are sufficiently amenable to INGOs, or alternatively that not all governments are sufficiently democratic for NGOs to wish to work with them. Nevertheless, several experiences have shown that 'even under the most authoritarian governments there are often opportunities'[37] for INGOs to contribute effectively.

From a broader perspective, whilst an ability to bypass the State mechanisms may be welcomed by those wishing to reduce the responsibility of the State, particularly as a provider of health services, INGOs need to consider the situation carefully. In particular, but not exclusively, when responding to an emergency relief situation, INGOs need to be aware that their stakeholders include not only the organization itself and all its donors (including the public at large) but also the recipient government. INGOs, if they are to maintain their credibility as supporting organization, need to guard against what can be interpreted as breaches in accountability, such as where they may have reduced government capacity by 'poaching' staff.

Approach to Development Work

In contrast to relief a development approach, such as Primary Health Care, requires long term, locally-based activities which reflect the particular and

often unique needs of selected communities. Many INGOs have developed a special expertise in participatory approaches to development and have worked closely with grassroots communities, either directly or through partners. Commenting on the situation amongst refugees in Somalia during the early 1980s, Mister[38] suggests that, other than in the most urgent relief situations, the greatest long term benefits in refugee assistance provided by Oxfam came from taking a developmental approach based on the active participation of the refugees themselves in planning and needs assessment. Unfortunately, because of the limited scale on which most NGOs work and the high level of adaptation to local conditions, few NGO projects can be successfully scaled up or be used to impact on the institutional capacity of the State. However, the process of NGO involvement in project work may provide useful insights for wider policy formulation.

INGO Co-ordination

Although there is evidence of INGOs co-operating in their relief work in a number of countries[39] there has been criticism elsewhere of their failure to coordinate effort. Certainly much of the language used to describe NGO involvement in relief situations implies a less than coherent approach. Expressions such as 'money and NGOs poured in', 'The NGOs flocked to . . .', 'organizations stumbling over each other' or 'there was a rush among NGOs to get into the country' are all too familiar.

Another concern about INGO activity is that although many are similar in name and function, and may also be linked together informally at an international level, they maintain their own autonomy. There is very little evidence of shared administrative structures at an in-country level, and in many countries it is not uncommon to find more than one INGO with similar names,[40] but from different countries, operating independently (that is, working from separate offices each with their own policy, plans and administrative procedures). This can be very confusing and frustrating for their partner CYNGOs and indeed for developing country governments. One obvious result has been a range of isolated and often duplicative INGO projects in many countries.[41]

A further issue is that even where attempts at decentralization have taken place within individual INGOs, this usually has been only at the level of implementation, with overall policy-making and budget-setting remaining at a central level in the country of origin.[42] Thus even in organizations where in-country activity planning is encouraged, managements at country level are often working to external priorities.

The CYNGO Challenge

Today many of the traditional functions of INGOs in development are being challenged by southern NGOs, who believe that they are now ready to take on these activities. It is a time for reflection and review. INGOs today are each the product of their own particular history and there is a need once more to reconsider their role, especially in grassroots development activities. It can be argued that the role of INGOs in development should be that of intermediary between northern donors and southern CYNGOs, a sensitive and sympathetic conduit providing donors with a mechanism for administering smaller amounts of aid and southern CYNGOs with a channel through which aid can be accessed. This would complement the role INGOs have established already for themselves in relief and emergency situations, as the acceptable and often preferred implementors by national governments and donor agencies.

SUMMARY

This chapter has looked at the differences between INGOs, the various factors that have influenced their establishment, growth and the roles they undertake. Evidence of continued change in the nature of the INGO community has been presented and a number of issues raised regarding their involvement in health related activities. These include their current and potential relationships with other actors in the situation such as aid donors, other NGOs and national governments.

5 Country NGOs: Is There Strength in Diversity?

In the last chapter we looked at international NGOs (INGOs) but this chapter will look more closely at country NGOs (CYNGOs), alternatively referred to elsewhere as indigenous or national NGOs. We define CYNGOs as *NGOs which are totally operational, managed and accountable within a single country.* Even working within the limitations of our definition of an NGO this is an extremely diverse set of organizations. Our discussion therefore will concentrate on providing a framework to assist understanding the CYNGO sector within a single country or situation. Wherever possible, we limit our discussion to CYNGOs within the health sector.

CROSS-CULTURAL DIVERSITY

When considering CYNGOs from an international perspective, it is obvious that situations differ by particular geographical location. Korten[1] divides developing countries into three groups – Latin America, Africa and Southern Asia – and points out the particular regional differences in the focus and role of CYNGOs. For example, in Latin America CYNGOs have been prominent as agents of political opposition, but in Africa they have tended to respond to the apparent inability of governments to deliver basic services. In Southern Asia, CYNGOs have often concentrated on self-help for grassroots groups, as well as working in independence struggles, people's empowerment and relief activities. Thus, before examining CYNGOs in any particular country, it is important to seek first an understanding of the broader socio-political situation and the role of NGOs within this.

DIVERSITY WITHIN COUNTRIES

In most countries there is usually no single source of information regarding the NGO sector. Even the exact number of existing CYNGOs frequently is unknown. The majority of CYNGOs are the products of the latter half of the twentieth century and, in common with INGOs, were

originally developed by concerned individuals or groups in response to particular needs, historical circumstance and opportunities. The scale and range of CYNGO roles will differ therefore from country to country. Even within a single country, there is often a significant range of CYNGOs in terms of their size, structure, funding sources, motivation, activities and their relationships with government and the for-profit sector.

Within the health sector the longest established CYNGOs are often religious bodies such as Christian missions, Islamic or Hindu organizations. These older CYNGOs are frequently involved in secondary provision, such as hospitals. More recently established CYNGOs are more likely to focus on primary level services including water, sanitation, income generation, adult literacy and primary health care programmes. CYNGOs established in the last 5–10 years, in common with their INGO counterparts, are more likely to be very specific in their focus, such as membership associations of the disabled or AIDS/HIV-related support and information organizations.

Size

Our own research experience[2] has demonstrated that comprehensive comparisons of NGO size are difficult to calculate. In Zimbabwe, for example, we were unable to establish a clear hierarchy of NGOs based on a number of possible units of measurement. These measures included size indicated by either annual recurrent budget, number of employees or by the number of volunteers used. Whilst each of these units may be a useful indicator of size in its own right, collectively we found no correlation between them.[3] In addition, whilst CYNGOs do differ in size, their relative size can only be assessed with regard to their own situation. Thus a CYNGO considered to be large in one country may only rate as a medium or small sized CYNGO were it to be located in another.

Structure

As we have already discussed, some CYNGOs work at a country level whilst others may operate only within a small localized area. Country level CYNGOs may be centralized, working from one office covering the whole country, or alternatively decentralized, working either through a number of branches or as a federation of autonomous groups. Local level or community-based CYNGOs are most likely to work from a single location, and cover only a small geographic area.

Funding

As we discuss in more detail in Chapter 8, CYNGOs may be resourced from their own fund-raising, from their own national government subventions, or from external sources, such as donor agencies or INGOs. In most countries there is likely to be a limited but potentially increasing number of CYNGOs which have been very recently created in response to opportunities presented by donor funds. Whilst the motivation of many such CYNGOs may be altruistic, the creation of some CYNGOs is a means of self-advancement for the founder(s), with little to distinguish it from a for-profit company.

Activities

In most developing countries CYNGOs may be involved in a variety of health activities, even including, in some situations, specialized tertiary care. Because they operate within a single country CYNGOs are less likely than their INGO counterparts to be involved in major relief activities, unless particular circumstances require it. In many countries of Africa,[4] where religious organisations are heavily involved in health care, differences have been observed in the activities of church NGOs and their secular counterparts. Church NGOs not only are more likely to be involved in a much narrower range of activities than their secular counterparts, but also to be particularly involved in hospitals, maternal and child health care, the supply of health personnel, health education and nutrition. Table 5.1 demonstrates some of the findings of our Zimbabwe study.

Other activities reported, and mainly carried out, by secular CYNGOs

Table 5.1 NGOs in Zimbabwe reporting activities (%)

Activity	*Church*	*Secular*	*Total*
Health care	85	58	72
Health education	81	44	63
Training	48	69	58
Other	15	42	28
Fund-raising	8	44	26
Emergency relief	38	15	26
Co-ordination	31	15	23
Research	13	23	18
Policy advice	10	17	14
Total (number)	48	48	96

include advocacy for change (especially in government policy), counselling, the care of the aged, water, sanitation and income-generating projects, and the care, education and employment of the physically and mentally challenged.

Relationships with Government

Although most CYNGOs in carrying out their activities work within government structures and are supportive of national health policies, others are critical and occasionally even confrontational in their relationship with the government sector. Interaction between NGOs and national governments can take a number of forms and occur at a number of different levels. Relationships can be formal or informal, and can be driven both by NGO and government interests. Relationships can develop both at organizational and personal levels, either through national or local structures. Most countries have some form of registration process, but this may not encompass all CYNGOs. For example, in some countries religious organizations are exempt from registration.

SUB-GROUPS WITHIN THE CYNGO SECTOR

The diversity of the CYNGO sector is a challenge for policy-makers. In order to develop appropriate policy within the health sector, they need to find means of classifying CYNGOs into smaller groups. One way would be to divide NGOs according to the particular activities they undertake. However, this is problematic in that it would be difficult exactly to categorize those NGOs involved in a number of different activities. Other possibilities include classifying NGOs according to their operational relationship with their particular client group, their human resources (and in particular the use of volunteers and regular staff) and their function within the health sector, especially in relation to the public sector. Each of these offers a different perspective on the NGO, and is discussed below.

Classification by Client Relationship

The consideration of client/NGO relationships gives a broad indication of the NGO's approach and mode of functioning. We have identified four main client types (individuals, groups, communities and other NGOs) and five operational relationships (of, with, for, on behalf of and to).

'Of' type NGOs

Individuals are likely to join or create such NGOs not only because they agree with the work they are doing but also because they themselves have a personal stake in the work of the NGO. These NGOs tend to have a relatively intimate relationship amongst their membership. Such NGOs do not usually involve themselves with service provision but rather work to bring particular issues and concerns to the attention of governments and the public in an attempt to have them placed on the policy agenda. An example would be a group of individuals with disabilities working to improve public awareness of the concerns of disabled people and to create a change in their situation. Such groups, whilst working closely with health professionals, because of their particular philosophy are more likely to employ individuals who themselves have a disability.

'With' type NGOs

These are NGOs which provide external resources and technical inputs to groups and communities. Such NGOs are usually in their origins external to the groups or communities with which they work. Although working closely with communities, these NGOs frequently have a core of professional staff, work to achieve specific objectives and may be dependent upon specific project funding. Examples of such NGOs would be ones involved in the development of community level structures such as village health committees. Community financing activities such as those advocated under the Bamako Initiative[5] also would fall into this category.

'For' type NGOs

These are NGOs which work to improve the situation of or provide services to individuals, groups or communities. There are two kinds of *for* type NGOs. The first are those involved in service delivery level and the second those involved in advocacy. There are also many examples of NGOs that carry out more than one of these roles. Indeed, in some cases the performance of one role is seen as critical to the success of the other. For example, for some advocacy organisations, their base in service provision is seen as critical both in terms of its learning potential and its credibility. Indeed the recommendations of the recent Voluntary Action Report[6] which recommended the split of UK voluntary agencies into these two distinct types has been heavily criticized for removing this linkage.

Within the health sector *for* type NGOs can be involved in a variety of direct service provision activities such as curative care and family planning

clinics. In any country, these organizations are usually the largest and most obvious type of CYNGO. Some of these are so large and have so many staff that it is hard to tell them apart from their statutory counterparts. One such example would be the Bangladesh Rural Advancement Committee[7] in Bangladesh. Such organizations clearly need careful management, and often pride themselves on their professionalism, effectiveness and efficiency. Individuals usually cannot join the service delivery part of such organizations merely because they agree with their work, but require appropriate professional qualifications. In return such people would expect to receive a salary equivalent to that which they could obtain in most other employment situations in the country. Volunteers can of course help with other activities, such as fund-raising or publicity, but again cannot by their own choice alone join the service delivery core. In contrast, advocacy NGOs usually attract individuals because they agree with the work they are doing but may not necessarily themselves have a personal share in the issue. Thus, whilst possibly having a small core-staff, advocacy NGOs may be less dependent upon specific inputs from health professionals than service delivery organizations.

'On behalf of' type NGOs

We distinguish 'on behalf of' NGOs as NGOs which have other organizations as their client group: for example, co-ordinating NGOs or NGOs which serve to bring organizations together for the exchange of information such as NGO networks. Co-ordinating NGOs have a very particular role and are discussed in detail later in Chapter 10. Networks are less formal, and often work as a form of clearing house for information collection and dissemination on specific topics. This service is often conducted from a single centre using the postal system and thus with minimal direct contact between individuals or organizations served.

'To' type NGOs

There are some NGOs which act as service or support organizations to NGOs. These differ from *'on behalf of'* NGOs in that they operate independently, and concentrate only on providing additional resources such as finance and supplies to other NGOs. Examples would be Rotary Clubs or Hospital Friends. Such organizations are often overlooked when seeking to classify NGOs as many of their fundraising activities are carried out on a very local scale.

A summary framework of NGO-client relationships within which to locate potential relationships is outlined in Figure 5.1.

Figure 5.1 Framework of NGO-client relationships and activities

Type of Client(s)	Type of Operational Relationship with Client(s)				
	Of	**With**	**For**	**On Behalf of**	**To**
Individuals	Awareness Raising	Counselling	Service Delivery	Representation	Donation
Groups	Policy Advocacy	Training	Service Delivery	Policy Advocacy	Funding
Communities	Campaigning	Grassroots Development	Service Delivery	Campaigning	Funding
Other NGOs	Networking	Training	Service Provision	Co-ordination	Funding

Classification by Human Resource Balance

NGOs are different from most private-for-profit organizations or the public sector in terms of their human resources. The use of unpaid volunteers is considered by many to be a major feature in the operation of many NGOs. Indeed some organizations prefer to consider themselves as voluntary organizations rather than use the classification NGO. In the NGO context, the term *voluntary* can of course also be applied to the income of an organization.[8] Increasingly a large proportion of CYNGOs are using regularly employed staff, though others continue predominantly to use unpaid or underpaid volunteers to carry out some or all of their activities. When considering the division of CYNGOs into sub-groups, an understanding of the human resource balance within an NGO can be a useful tool for planners, policy-makers and NGO managers. Such an understanding not only can provide an assessment of the NGO as a potential resource in the health sector but also identify particular strengths and weaknesses. This balance needs to consider three main elements, the proportion of volunteers, the level of skills and the division of tasks.

It is necessary first to recognize the balance between regularly employed staff and volunteers. This can be complex as there is often confusion around the term volunteer. Houghland[9] defines voluntary by what it is not: that is, 'non-coerced' and 'non-economic'. We suggest that the term volunteer includes *all* who *choose* to offer their services for less remuneration than they potentially would receive in the wider employment market. This therefore includes both those who receive payment and those who do not. An example of the former would be an expatriate[10] doctor working in a church hospital, who although receiving payment[11] would still be considered a volunteer because he or she *has chosen* to receive less than he or she could potentially earn elsewhere. Thus the use of the term voluntary in the context of human resources always will include the 'non-coerced' concept of volunteering services but not necessarily the 'non-economic' concept of giving 'unpaid' service. Therefore, when attempting to distinguish different types of CYNGO by balance of human resources, it is necessary first to understand the range of personnel and identify volunteers.

As individuals who volunteer their services to NGOs can range from those who are completely unskilled to those who are already professionally qualified, such as doctors or nurses, it is important that volunteer status is not equated with *unskilled* or *amateur*. A second stage therefore in understanding the human resource balance is to review the level and range of skills available in each group. CYNGOs will differ in that

Figure 5.2 Skill-status framework

Skill Level	Employment Status: Volunteer	Employment Status: Employed Staff	
	Unpaid	Less than Market Rate	Full Market Rate
Unskilled			
In-service trained			
Qualified			

some will use volunteers only for unskilled tasks whilst others will use volunteers for professional tasks. A suggested skill-status framework within which to map out and quantify the staffing patterns of individual CYNGOs is outlined in Figure 5.2.

The third stage reviews the division of tasks between these various groups of people: for example, the numbers involved in governance, policy-making, technical, administrative, fund-raising or 'other' activities. The full results of this analysis of human resource balance can be set out in a task-skill-status framework as demonstrated in Figure 5.3.

Classification by Function in the Health Sector

We have already suggested that CYNGOs can be either supportive, critical or even confrontational in their relationship with the State. This will clearly differ from country to country and will obviously affect the nature of their contribution to the health sector. In some countries, CYNGO are found mainly at community level, involved in small, scattered, grassroots developmental-type projects, often funded by external donors. In other countries, CYNGOs function as important elements of a national health service, often with high levels of dependency upon government funding. In such situations CYNGOs provide a wide spectrum of health services ranging from hospitals (some of which may be designated by governments as district or regional hospitals) to village-level primary health care programmes.

When seeking to identify sub-groups within the CYNGO sector, for policy-making and management, a useful mechanism is to consider the services provided in relation to those provided by the State (public sector). For example, it may be helpful to establish whether CYNGO activities are:

(a) similar and supplementary to those of the public sector (for example, hospitals);

Figure 5.3 Task-skill-status framework

Tasks	Skill Status					
	Unskilled		**In-Service Trained**		**Qualified**	
	Volunteer	Employed	Volunteer	Employed	Volunteer	Employed
Governance						
Policy-making						
Technical						
Administrative						
Fund-raising						
Other						

(b) dissimilar but complementary to the public sector (for example, hospices);
(c) providing services which it would be politically unacceptable for the public sector to provide (for example, work amongst refugees);
(d) apparently antagonistic towards government policy (for example, campaigning).

It would also be possible to compare the CYNGO sector with the private-for-profit sector. From both a State and a CYNGO perspective, the division of the CYNGO sector into these functional relationships should assist in the development of appropriate policy within the health sector. This will be further discussed later, but as a minimum it is necessary to identify:

(a) functions in which CYNGOs as a group appear to have an advantage;
(b) why NGOs as a group appear to have an advantage;
(c) functions in which governments are likely to have an advantage;
(d) functions in which neither government nor CYNGOs are perceived to have a clear a priori advantage, other than their scale of operation;
(e) functions where NGO involvement may be considered harmful to the national good.

CYNGO ISSUES

There are a number of issues relevant to our consideration of policy-making and management of CYNGOs.

CYNGOs and External Institutional Donors

In common with their INGO counterparts, over the last decade CYNGOs have been increasing their involvement with bilateral and multilateral donors. Indeed Baroness Chalker, the UK's Minister for Overseas Development, suggests that: 'Donors are increasingly looking at possibilities for bypassing failed public sector structures entirely. Where public sector services have effectively broken down, they have to consider how they can effectively direct more support to NGOs or the private sector, to strengthen self-help efforts at community level.'[12]

This has two main consequences. First, as we discuss later in Chapter 10, CYNGOs are being drawn into working on a scale for which they are unprepared and ill-equipped. Second this interest (rather than the traditional stimulus of observed need) has resulted in an unprecedented increase in the numbers of new CYNGOs being established. These trends have obvious

implications for CYNGO operations and may in the longer term contribute to the downfall of CYNGOs as they potentially become trapped by their own success. A third type of external institutional donor can also be identified: the INGO. Increasingly CYNGOs are seeking greater independence from their northern partners, preferring to set their own agendas rather than conform to northern demands and conditions. In more equal partnerships, this could probably be negotiated, but where INGOs are acting as sophisticated clearing houses for bilateral donors, the situation is more complex.

Mission-Church Relationships

In many countries church health care facilities provide services which are similar and supplementary to those provided by the public sector, such as hospitals and primary health care programmes. Despite this, however, international Christian missions continue to be viewed as external organizations, a type of minor-league donor. Recent times have seen significant changes in the relationships between international missionary organizations and national Church bodies. Most international mission organizations have shed their quasi-parental responsibilities, and national Church bodies have become autonomous organizations. Whilst this may be seen by some as a positive step, enabling the stimulation of truly national expressions of Christian experience, it also has major implications for the management and organization of mission health facilities. No longer are these health facilities managed and resourced by bodies external to the country, but they have become the responsibility of national Church bodies. This has important implications, especially in the current climate of economic recession in countries of the North and structural adjustment in countries of the South. The recurrent costs of providing health care are rising rapidly, international funding has been reduced and in most countries the funding of church facilities by national governments is subject to the rigorous constraints imposed by Structural Adjustment programmes.

Role of National Governments

We suggest elsewhere in this book that national governments need to develop appropriate policies for NGOs and that they need to provide two main types of structures: first, organizational accountability structures such as the regulation of NGOs, which could include regulation by NGOs themselves, and second, structures that will enable the technical and operational oversight of some or all of the NGO's activities.

Regulation

This is often wrongly equated with *control*, but this is not what we are suggesting. Governments need to set a broad framework within which NGOs are free to operate in their own way. This is more fully discussed in Chapter 11, but in the context of CYNGOs we contend that in order to maximize the effectiveness of all NGOs there is a need for mutual acceptance and understanding of the roles and functions of both governments and NGOs. Even where CYNGOs appear to be antagonistic towards government policy, the purposes of both parties may be pursued more efficiently through dialogue than through confrontation.

Technical and operational oversight

This is particularly important where CYNGOs are involved in service delivery. This probably can be best carried out by governments because of their national coverage and access to trained staff, but equally could be carried out by a CYNGO if they had access to adequate resources. Such oversight should have three basic objectives. The first is to ensure that CYNGO activities are compatible with national health policies, especially, but not exclusively, those providing services which are supplementary and complementary to those of the public sector. Second, there is a need to ensure that activities are offered with a satisfactory degree of professional competence and quality. Third, it is necessary to ensure that activities are planned and implemented with due regard to equity and without unnecessary duplication.

SUMMARY

CYNGOs are a heterogenous group of organizations, even within the health sector of a single country, and this chapter first examined the various aspects of this diversity. It then examined various ways of dividing CYNGOs into sub-groups. In order to facilitate planning, policy-making and management three classifications were considered; client relationships, human resource balance and health sector function. It is believed that such divisions enable the particular characteristics of individual CYNGOs to be more clearly assessed and understood. Finally, the chapter discussed a number of issues of concern for CYNGOs in their relationships with donors and national governments.

6 NGOs and Health Sector Policy

The development of policy is the product of analysis and value judgement, the latter heavily influenced by ideology. Policy should be set in the context of time and place. Blueprints are neither feasible nor desirable. Chapter 3 set out a number of scenarios for the health sector as a backdrop to the discussion of the potential comparative advantage of overall health sector NGOs as individual organizations and as a sub-sector. The chapter concluded that there was no firm evidence that NGOs do have an a priori advantage over the State in any of the four broad functions, though they may be better equipped for certain activities under particular sets of conditions. All the actors involved in the development of national policy – the State, NGOs themselves (both from industrialized countries and from developing countries) and bilateral and multilateral donor agencies – need to ensure that they adopt a policy stance which is firmly grounded in the conditions prevailing in each particular country.

For these reasons we do not set out any detailed prescriptions for policy. Such a course of action not only would be presumptuous but, given the above, foolish. However, we do believe that the mixed model (see p. 44) is the most likely to prevail in the majority of countries, with significant differences amongst countries arising mainly from the balance between levels of activity, the cohesion of the NGO sector and the relations between the State and the NGO sector. In all cases, however, there is a clear need for a State role in the health sector which at a minimum is concerned with the development of policy frameworks. It is against this background that we focus, in this chapter, on a number of critical issues around the development of macro level policies concerning NGOs in the health sector.

The above view about the State role is predicated on the assumption that the State has a legitimacy to set policy on behalf of society which is derived in some manner through a democratic process. It would be naive, however, to consider that all governments fit this democratic paradigm. For some political theorists the importance of democratic accountability is to minimize the natural tendency of a ruling power to further its own particular interests by forcing other interests on to the agenda. Democracy becomes a constraining feature which governments have to take into account in their decision-making. Put in stark terms, the experience in a

number of countries is of governments whose primary interest is in securing and maintaining their position of power for purposes of self or class gain. In such circumstances, policies and services are designed to achieve this with, in the absence of a functioning counter-balancing democratic process, the provision of broadly-based welfare services likely to have a low priority. Such tendencies, of course, exist in all countries. For example, for many commentators, the UK over recent years, with its strong central government position, has witnessed a rewarding of factional and class interests in a manner that was thinly disguised and largely impervious to wider protests.

NGOs in all societies are seen by many therefore to have an important role to play in exposing the narrow interests of particular ruling parties. In countries with a weak democratic process this role may be difficult and even dangerous. The most obvious examples of such situations have been found in a number of countries in Latin America. Here NGOs have, in the absence of a democratic process, taken on a far more political role than in other countries, to the point of becoming quasi opposition parties. In what follows we concentrate, however, on situations where there is at least a degree of democratic accountability.

These areas of policy formation have been divided into a number of areas.

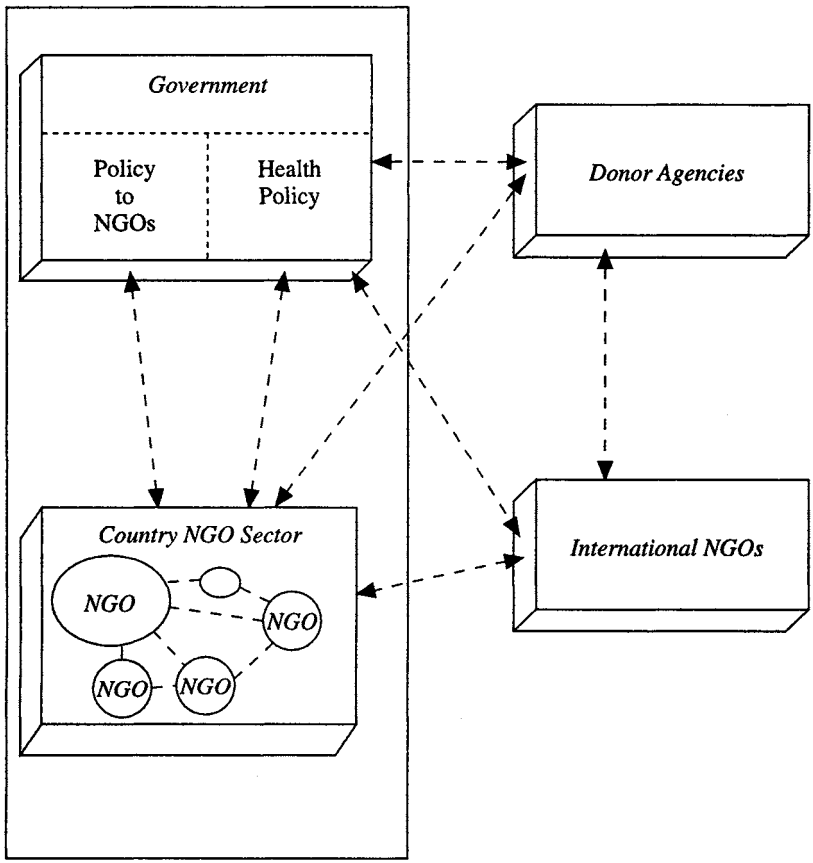
- Government policy concerning NGOs
- Policies of NGOs concerning their role
- Role of NGOs in setting government health policy
- Policies of NGOs relating to government
- Policies of CYNGOs/NGOs towards other NGOs
- Policies of INGOs
- Donor policies related to NGOs

These are illustrated in Figure 6.1.

GOVERNMENT POLICY CONCERNING NGOs

As Chapter 1 pointed out, governments in many developing countries have been slow to develop policies towards all elements of the non-public sector including the NGO sector. There are various reasons for this, ranging from ignorance as to the current and potential impact of the sector to more pressing concerns with internal service delivery within the public sector itself. A number of factors in recent years have combined to give the NGO

Figure 6.1 Policy relationships



sector a higher profile. Policies of Structural Adjustment and Civil Service Reform have led to reconsideration generally of the role of the government as a direct provider of services. Within the health sector the current interest in Health Sector Reform policies in particular has opened up the debate concerning how the State should view the NGO sector.

For many civil servants, and indeed politicians, there is ambivalence towards NGOs. On the one hand, they are viewed as a threat on three levels: service delivery, political and personal. At a service delivery level, their success in the public's eyes and the more recently found favour with external donors, inevitably raises worries over the implications for the public sector, both in terms of unfavourable comparison and in terms of

changes in funding flows. At a political level, NGOs can be an uncomfortable thorn in the flesh of politicians both in terms of specific policy challenges and more general criticism of any lack of democratic accountability.

There are also issues at the personal level. Holloway captures the tensions in Indonesia between civil servants and NGOs as follows:

> While government officials generally agree that NGOs have a role to play in welfare . . . they generally consider that NGO efforts outside the field of welfare are likely to:
>
> (i) encourage a split between the people and the government;
> (ii) encourage religious extremism and disunity;
> (iii) confuse the people about the aims of the government and destabilize the people;
> (iv) expose government mistakes and shortcomings and cause government officials to lose face; and
> (v) be of no significance at the national level since all important decisions are made by the government.[1]

NGOs for their part have their own suspicions:

> Programmes are thought likely to:
>
> (i) benefit only civil servants and the village elites;
> (ii) have the funds subverted by civil servants;
> (iii) put monopolistic control over development activities into the hands of civil servants and village elites;
> (iv) be badly targeted because they are usually based on bad research; and
> (v) be based on an unclear understanding of the local situation because centralized planning is based on civil servants reporting problems up the chain of command with scant regard to reality.[2]

These negative suspicions may, however, be counter-balanced at a different and more personal level, with many in the public sector having a high regard for, or interest in, the welfare of specific NGOs. This may stem from personal involvement in the past (perhaps through education or professional employment) or indeed from possible interest in future employment. It may also reflect current usage by families of civil servants of NGO services. At a different level some NGOs have civil servants as (non ex-officio) members of the Board of Trustees, thus creating informal links

and loyalties. Some NGOs have even been set up by government officials themselves. In some countries the NGO sector may have played an important role in the liberation or independence process which resulted in the current government and this in turn may help to create particular linkages.

All of these threads weave together to create within government a complex pattern of attitudes to NGOs. In the past this often has been passively dealt with by an unstructured *laissez-faire* attitude. Today this lack of policy towards NGOs has consequences for all sectors of government. It is perhaps most clearly and obviously felt in the health sector, given the particular role that NGOs have played in health care provision and relief services. The current spotlight on the structure of the health sector also is forcing governments to take a more proactive stand towards all other actors, including NGOs. Unfortunately the very lack of capacity within governments (itself part of the cause of the failings of the public sector and which has influenced the development of alternative scenarios to the public sector hegemony) has also meant that the public sector may not be equipped adequately to develop such policy. The resultant policy vacuum carries a danger that it may encourage other actors such as donors to attempt to fill it in ways not always appropriate for the specific country conditions. Thus, it is essential that governments do recognize the need for a clear policy framework towards NGOs.

The following suggests a number of steps that governments need to take to maintain or recapture control over the policy process. It is followed by a brief look at a variety of policy tools that the government may have at its disposal to implement policies emanating from the policy process.

Development of Government Policies towards the NGO Sector as a Whole

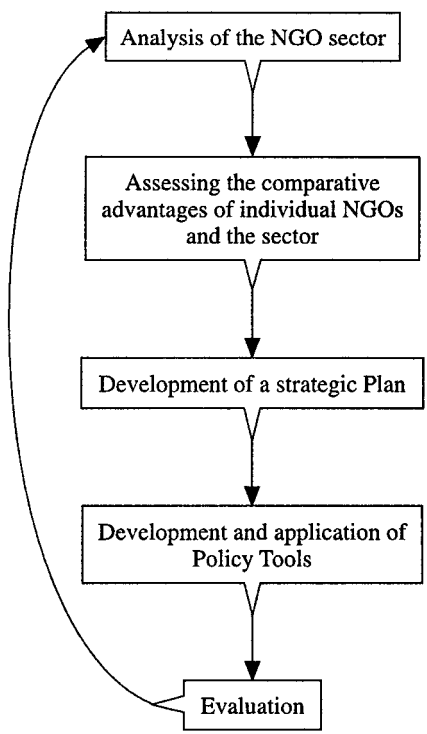
It has been suggested above that in a number of countries there is still a lack of a clear cross-government view as to the broad role of NGOs within the socio-economy and their relations with government. This has led to an incremental and often internally inconsistent set of policies and procedures largely focused on registration requirements. Ideally one would wish for a clear central government lead as to how the NGO sector as a whole is viewed. This would then form a backdrop to individual sectoral policies as developed and implemented by technical ministries. In some countries attempts have been made to do this with often a lead being provided by a central government ministry such as the Prime Minster's Office; however, elsewhere this is still weak. Individual technical ministries such as the Ministry of Health (MoH) have to assess in such situations whether

they should encourage and support the development of such a broad government policy prior to the development of a more specific sectoral policy or should push ahead alone with their own sectoral agenda. Whilst the latter may be more attractive in the short term there are potential disadvantages, and the danger of subsequent policy developments at the central government level which may run counter to the ministry's own approach.

Development of Government Policies towards Health Sector NGOs: A Framework

The following sets out a schema for the development of policies within the State sector regarding the NGO health sector. Though set out as a series of steps (see Figure 6.2), in practice this is unlikely to be chronological. There are, however, various under-pinning assumptions which are critical to the success or worth of carrying out such a process. First, it assumes a starting point of a recognition of the possibility that elements of

Figure 6.2 Development of government policies towards NGOs



the NGO sector *can* complement or support the public sector in the health field either in particular areas or in the short term. Without such an explicit recognition at both the political and technical levels within the government there is little point in the following process. Second, it also assumes a willingness on the part of government to engage in dialogue with the NGO sector and where necessary to persuade the NGO sector of its genuinely supportive desire to develop a policy framework which incorporates them. Lastly it assumes that the government has a capacity and system of health policy formation and planning, albeit one which in the past has focused internally on the public sector. In the absence of any of the above assumptions it is difficult to see how sustainable and broadly accepted policies are likely to emerge.

Understanding the sector

For many governments the first step in the development of policies towards the NGO sector must be an improvement in their understanding of the sector and its characteristics. There are three aspects to such a situational analysis. First, it is critical that a clear national understanding of what constitutes an NGO be developed, agreed and commonly shared. Whilst the bulk of NGOs are likely to occupy commonly agreed ground as to what is an NGO there are a number of organizations that sit on the fringes of such a definition. It is important that the boundaries of the definitional area are well demarcated, to ensure that any ensuing policy regarding NGOs can be clearly and fairly pursued. These issues were discussed in Chapter 2 and it is for governments, with the involvement where possible of the NGO sector, to set out, for their own country, the criteria that defines an NGO. This is a task that should, ideally, be led from the central government level, but in the absence of such an initiative, Ministries of Health may be forced to take the lead. A second definitional issue relates to what constitutes an NGO operating in the health sector. This, however, should be a far more fluid and time and policy-related definition, for, as we have seen, one of the potential strengths of NGOs is their ability to straddle and shift between sectoral boundaries. Once this has been done, there is a need for basic information as to the number, type, size and activities of NGOs. Equally important is qualitative information as to their activities in order to assist appraisal of policy options. Few developing countries appear to have up-to-date and comprehensive information as to the composition and activities of the NGO sector, let alone the quality or advantage of such activities in comparison with other potential actors including government itself. Such information is not easy to obtain. Whilst specific government

departments may have information on NGOs operating within the country, this usually reflects the particular needs of these different departments and is rarely comprehensive. For example, there is frequently, within government, a single department set up to register NGOs, although registration may be restricted to those seeking government funding or bringing in foreign aid. Where it is a more general requirement, often as a result of government concerns as to the development of political opposition or to ensure organizational probity, then information may be restricted to constitutional and financial arrangements with little on actual activities.

NGOs themselves are an important potential source of information, though clearly the degree of information that they will be prepared to share will depend on the prevailing attitude to government of the NGO sector. NGO co-ordinating bodies may be a particular source of information, though this will only be as complete as their membership. As we see in Chapter 11, the varying functions of existing co-ordinating bodies means that this is rarely comprehensive. It is possible that weaknesses in such existing sources of information mean that the government has to develop this information from source. In such instances a brief survey may be necessary, though even this brings with it methodological problems of identifying the NGOs in the first place. Whilst national NGOs will be well known and easily identifiable, local or community-based organizations are less obvious. Snowball techniques which start with well-known NGOs asking for information on other existing NGOs, who in turn are asked for information, is one useful though time-consuming method. Health service workers also can be a potentially good source of information as to the existence of NGOs in the particular locality within which they are working.

Assessing the advantages

Once a broad picture of the sector has been painted, the second step in the development of a policy is to determine the areas in which the NGO sector or individual NGOs possess an apparent comparative advantage over other actors in the implementation of overall health policies for the country. This overall health policy should have been developed as part of a national health planning process referred to above. The degree to which this involved the NGO sector is again critical to the appropriateness and feasibility of the plan and is discussed later in the chapter.

The issues raised in Chapter 3 are critical as a starting point. The overall framework of the health sector and the different functions need to be considered. In particular it is important that a distinction is made between any advantages held at this time and those that may change in the future,

particularly through a strengthening of the public sector. It is unlikely that such assessment will be easily amenable to quick 'scientific' methods, and a more useful approach is likely to be generated through dialogue with the NGOs themselves as to where they see their particular strengths in a sector.

As part of this process, it is also important to attempt to distinguish between the strengths of individual NGOs or sub-sectors and the NGO sector as a whole. It is possible for a series of individual NGOs to be efficient in organizational and technical terms, but *as a group* to be inefficient through a lack of co-ordination or duplication of effort, either amongst themselves or with the public sector. An example well known in many countries is provided by various church hospitals and clinics which may offer similar services in close proximity, and indeed compete for patients. As individual organizations they may be well managed, but as a group they are failing to achieve maximum efficiency through their competitive strategies.

Strategic planning

From this assessment should emerge a strategy for the role of the NGO sector within the broader health policy framework.[3] Any particular weaknesses or dangers associated with the sector should also be analysed. It is important that such a strategy is made public, and indeed is subjected to a consultation process to allow NGOs to air their views.

Policy tools

The penultimate stage of such a policy formation process is the development and application of policy tools on the part of government which would allow for the implementation of the policy framework. Such tools can be divided into those that:

(a) provide general support to the sector as a whole or elements within it;
(b) provide mechanisms for ongoing dialogue with government over the formation of health policies in specific areas or fields;
(c) provide incentives for specific activities;
(d) contract with NGOs for specified services and activities;
(e) regulate quality and adherence to overall government policies.

Table 6.1 gives examples of the different policy tools available.[4]

Table 6.1 Examples of policy tools available to government

Policy tool	*Resource implications for government*	*Advantages and disadvantages*
Provision of opportunities to engage in policy discussion	Minimal resource implications	Provides source of advice to government and channel of communication between NGOs and government
Foreign exchange controls and imports policy	Minimal marginal costs	Non-specific in application unless tied to specific aid flows
Fiscal policy	Minimal marginal costs	Non-specific in application
Provision of non-specific grants	Grant costs; minimal administration	Allows support to specific NGOs without but not specific activities
Contracting for service provision	Costs of services contracted for May substitute those provided by government Transactions costs of contracting	Allows possibility of more efficient service provision Provides opportunity for specifying services without management responsibility Difficulties of contract specifications and monitoring
Registration requirements	Costs of developing and maintaining system	Provides mechanism for ensuring organizational accountability Provides mechanism for gathering information about NGOs

Regulatory planning tools	Marginal administrative costs, if existing well-developed planning system and inspectorate	Provides opportunity and mechanism for ensuring NGO plans are consistent with broad policy
Quality Inspectorate:	Requires development of capacity particularly in terms of human resources Costs of inspectorate	Explicit system of quality assurance
organization	Significant costs unless linked to existing registration processes (see above)	Provides mechanism to ensure that NGO is maintaining organizational accountability and probity
services	Significant costs unless linked to public sector in-house monitoring processes	Provides mechanism to ensure minimal quality standards
Requirements for NGOs to provide health information	Minimal costs	Provides important source of information for planning and policy development
Human resource controls and training	Marginal costs of training	Provides opportunity to ensure standards of training and cohesion of curriculum
Medical supplies, controls and provision	Costs of providing medical supplies	Ensures standardisation of pharmaceuticals, can be used to standardize treatment protocols and to encourage particular treatments and immunizations

Evaluation

The last and ongoing stage of the process is that of frequent reassessment and adaptation of the policies, including the development of structures and processes for dialogue with the NGO sector itself. It is important that the policies developed regarding the place and role of NGOs are seen as context- and time-specific and as such do not become fossilized. As part of this the MoH needs to develop mechanisms for ensuring up-to-date information on the sector and contact with it.

One of the specific issues which a Ministry of Health needs to address in the development of such sectoral policies is the organizational level at which dialogue and contact with NGOs is encouraged. Recent trends towards greater decentralization suggest that a distinction needs to be made between the roles of the centre and the local level. For example, policies towards the sector as a whole need to be set at the national level as part of the development of national health policies and plans. Local levels in the public sector under genuine policies of decentralization should have responsibility for the development of district health plans which involve and incorporate NGOs operating within the district. This would include, for example, decisions on levels of subventions to particular NGOs or the development of service contracts being made at the level of the district as part of the overall district's resource allocation rather than, as is often the current situation, through separate and parallel allocative systems.

Resource Implications and Implementation Issues

For the above process to be followed by an MoH requires considerable skilled resources in areas in which there may be little experience. Indeed one of the paradoxes of the drive often associated with Health Sector Reform to a reduced provider role for the State and diversification of actors operating within the health sector is that, for it to operate successfully, it is likely to require additional resources at the government level for policy framework development and regulation. The role of donor agencies in the strengthening of this capacity is discussed later in this chapter.

Furthermore, the temptation for an MoH, recognizing the significant policy gap already existing and hence concerned to develop policies in this area, is to carry out the process over-hastily in a centralized and top-down fashion. The danger in such a non-participative approach is not only that it is likely to miss or misinterpret key information but that the process will increase any existing suspicions on the part of the NGO community about government.

POLICIES AND PLANS OF NGOs

Internal policy-making and planning is not a strong feature in many NGOs. In part this may reflect an identification of planning with bureaucratic and cloying procedures. Yet it is essential for all organizations that they have a clear sense of purpose coupled with strategies as to how to achieve their objectives. NGOs exist in order to attain certain pre-defined ends. Indeed one might argue that the implication of this is that once these ends have been achieved the organization should close, though in practice frequently its Trustees or staff may decide to adopt a new purpose or end. Indeed, if better means exist to achieve the ends than the NGO itself, such as through the provision of government services, it may be hard to justify the continued existence of the NGO. This contrasts with private-for-profit organizations, the objective of which is to generate profits; such organizations may shift between quite disparate activities as market conditions change.

It is therefore particularly important that NGOs continuously reassess their purpose and the implications of this for their role and set of activities. We have seen that NGOs within the health sector may have a number of potential types of activity in which they may engage, ranging from direct service provision through to advocacy. In deciding which of these activities they carry out they need to ask various strategic questions. These are outlined in Figure 6.3.

For example, an NGO may be set up to improve levels of child health. There may be a number of other organizations involved in this area including government. Possible activities may include the provision of child health clinics, inpatient services and advice to government on heath strategies; however, the NGO may have little experience in hospital management and few resources. It may decide therefore to concentrate on an incremental development of clinics. As part of this strategy it should consult with

Figure 6.3 Strategic questions for NGOs

1. What is the overall purpose that the NGO is attempting to achieve?
2. What is the current and likely future environment in the health sector surrounding this area and who are the potential organizations involved?
3. What particular strengths and weaknesses, if any, does the NGO bring to the achievement of this purpose?
4. What alternative strategies exist to build on these strengths and minimize the weaknesses?
5. Which strategies are preferable?
6. What are the implications of this for the relationships of NGO with other organizations and government?

government and other providers to determine the most appropriate form and location of such clinic services. It may also look for means of providing regular input to government child health planning within the areas and fields in which it operates.

ROLE OF NGOs IN THE SETTING OF GOVERNMENT POLICY AND PLANS

This focus of this book is not on the development of specific health sector policies.[5] However, the mechanism by which such policies are set have important implications for the NGO sector. There are two aspects of policy-making that are of critical interest. First, the policy-making process is still often regarded as the sole prerogative of government. Whilst we argue throughout this book that government has a clear responsibility to drive the policy process and ultimately through the political process to set policies, we recognize that this has often resulted in isolationist and introspective policy-setting processes. In part this is a consequence of a (misplaced) belief that the State was the major if not sole actor in the health field. It has also in some instances arisen from a defensive concern to exclude challenges to what may otherwise be a weak policy formation process. Current interest in both 'Good Governance' policies and Health Sector Reform is leading to a recognition that such processes need to be opened up. The second aspect concerns the recent trend towards decentralization which has implications for the locus of policy-making and planning. Whilst the previous pattern has been almost universally towards highly centralized decision-making processes, decentralization offers possibilities of different sets of planning and policy decisions being made at different levels in the health system.

Both of these shifts have potential implications for the role of NGOs in the policy-setting processes. Policy debates need to be opened up to allow for the structured inputs of NGOs. Governments also need to recognize that of the many potential influences on health sector policy, NGOs may turn out to be their closest ally, or at least the most likely to provide 'loyal opposition'. For many NGOs the frustration with government over the policy process has been due as much to a sense of exclusion from the process as the policies set.

Where in the past NGOs have been able to influence government policy, their ability has often been related to both a national or international profile and a presence in the capital city close to the government structures.

The decentralization process in turn is likely to provide more locally-based small NGOs at a local (district or regional) level with an opportunity to influence policy-making and planning.

POLICIES OF NGOs RELATING TO GOVERNMENT

The next broad area of policy formation concerns how NGOs view their desired relationship with government. There are a number of difficult issues here which are discussed elsewhere in the book. The first relates to the degree of democratic accountability existing within a country. In countries in which this is weak, then NGOs' ability, and indeed desire, to engage directly with a ruling power may be limited. The experience of many NGOs in a number of Latin American countries where oppressive regimes have transformed them into organizations with a role of political opposition contrasts with that of many African NGOs. Here, until recently, for many their experience has been less politically taut, in part because of their greater involvement in service delivery rather than policy development issues, and in part because of the slower development of genuinely indigenous NGOs.

Second, the relationship between the NGO and government will depend on the objectives of the NGO. Where an NGO sees its role as primarily in the delivery of mainstream services, then it deliberately may seek a policy of close co-operation, and indeed may look for contracts from government. In contrast, however, where an NGO sees its role as an advocate for policy reform, then it may want to maintain a balance between independence from government and an ability to interact with it at the level of policy dialogue. This will depend in part on how it assesses the alternative mechanisms for policy influence. Such mechanisms include direct formal involvement in government decision-making structures, informal dialogue and influence through professional bodies or the public at large.

The situation will also be contingent on the legal situation concerning the activities of NGOs within a country. For example, legislation in some countries has strict controls on advocacy in the political arena by NGOs.

NGOs need to set their current approaches to government against a long term view of the sector and in particular whether they see themselves as short term substitutes for a strong public sector or as providing long term parallel services. Chapter 3 referred to case-studies in Zimbabwe and Kenya and, based on these, conditions under which NGOs may maximize their influence on public policy were suggested.[6]

POLICIES OF CYNGOs TOWARDS OTHER NGOs

The next broad category of issues in the policy arena relates to the relationships between NGOs themselves.

NGOs sometimes display a schizophrenic tendency of wishing to co-operate with other NGOs whilst being fiercely jealous of their own independence. As a result of this, NGOs are often poor at developing clear policies towards other NGOs, either as individual organizations or as a sector as a whole. Whilst it is, of course, poor management for any organization to ignore the external environment and in particular other organizations occupying similar strategic space, this is particularly so in the health sector. Here resources are tight and the result of blinkered organizational development can be a lowering of overall sectoral efficiency, with potential consequences for individual NGOs.

The three main broad alternative strategies that NGOs can adopt regarding other NGOs are competitive, co-operative, and control.[7] These are further discussed in Chapter 11, where in particular co-operative strategies are broken down further. Competitive strategies are portrayed as a symptom of health by free market proponents. It is important, however, to remember that the rationale for competition flows from market-based objectives of profit maximization, growth in market share and long term organizational growth. These objectives, we have argued, are not those of the NGO sector. There is a real danger that flirtation on the part of NGOs with private sector management philosophy and principles may result in a distortion of the NGO's objectives. To illustrate the contrast between private sector and NGO approaches in a stark manner, an NGO Board of Management could decide, entirely legitimately, that other NGOs were better placed to perform the function of the NGO and close down or merge operations. Such action, which would result from consideration of the social objectives of the NGO, would not be countenanced by a profit-maximizing organization which is more likely to respond to a reduction in demand for its services by shifting its activities into another field. We would suggest therefore that competitive strategies are unlikely to be appropriate in most instances for NGOs.

This is not to suggest that there will be agreement between all NGOs, either concerning objectives or manner of achieving them. NGOs may not agree on either the ends or the means to achieve them. This, however, is not synonymous with a strategy of competition.

Co-operation strategies between two or more NGOs sharing similar objectives have a number of potential advantages to the NGOs. In particular there is the potential for achieving economies of scale, enhancement of service quality through standardization and, particularly in areas involving

significant health promotion (such as HIV/AIDS), minimization of the dangers of mixed messages to the public. Where there are differences in approach to the same objectives, co-operation based on a recognition of the potential advantages of offering a range of alternatives can also be healthy. Advocacy, in an attempt to influence government regarding specific health policies, may also be more effective if carried out by a group of NGOs acting together. Co-operative strategies may also be an important means of protecting the rights of the NGO sector in the face of an unsympathetic government or MoH.

However, in many developing countries, despite the weakness of the NGO sector in the health field, there is still a strong tradition of independence among NGOs which often is interpreted as being the opposite of co-operation. Furthermore, there is all too often a failure on the part of larger and more well established NGOs to acknowledge any responsibility on their part towards the development of fledgeling NGOs. It is this attitude in part that militates against the development of strong co-ordinating bodies.

The last strategy is that of control, whereby an NGO (either formally or informally) exerts control over another NGO. This may be through the power and influence derived from its size and public profile within the sector, or more explicitly through provision of funding or other 'support' to smaller NGOs. Strategies of co-operation between NGOs of differing power or influence can be transformed easily in practice into a controlling relationship. Such strategies or actions are inconsistent with the ethos of independent decision-making that is important to NGOs, and in many respects is more closely associated with the tactics of profit-seeking firms.

Unfortunately, there is an appearance (at least) of a failure on the part of a number of NGOs to consciously develop strategies of any sort towards other NGOs, other than one of cordial distance. This, we would suggest, is unfortunate and short-sighted, through lessening the opportunities for greater impact. In Chapter 11 we look in more detail at mechanisms of co-ordination between NGOs.

One of the examples of the relationships between NGOs concerns donor INGOs from the North providing support to developing country NGOs and we turn now to this aspect of policy.

POLICIES OF INGOs

In Chapter 4 we discussed the potential roles of INGOs in the health sector in developing countries. INGOs may carry out directly managed programmes, support other NGOs or government programmes either with

finance or technical support and may possibly attempt to influence policy processes. INGOs need to carry out similar strategic planning exercises particularly concerning directly managed programmes as those described earlier in the chapter. However, the role of INGOs acting as donors in what are described as partnership relationships carry particular dangers. Increasingly Southern NGOs are questioning the role and manner of executing that role. The role of resource provider inevitably creates a power imbalance which it would be naive to pretend can be spirited away. Furthermore the existence of unscrupulous NGOs seeking support is well recognized, and well-informed scrutiny is necessary to exclude support to such organizations and ensure that assistance is channelled in the direction of organizations with genuine social objectives. For any INGO, therefore, there is a tension between wishing to act as a partner and carrying out necessary monitoring. Under such circumstances it may be useful to make a distinction between assessment at the time of setting up, or renewing, the relationship and the management of such ongoing support. This may be a more useful and appropriate way of satisfying the needs of both Northern donor NGOs and recipient NGOs.

There are, however, other important considerations. At a minimum, INGOs that provide grants with no strings attached still have to set and interpret the parameters for the field in which they will provide funding. In addition, INGOs, in assessing the areas in which they can provide support in a country, need to take a broad sectoral view rather than restrict their assessment to the performance of an individual NGO. Indeed INGOs, prior to determining the exact nature of support to the particular NGOs in the sector, ideally should be carrying out a process of country review, followed by a sectoral review. Where feasible this should include consultation with the MoH and the overall NGO community as to national policies and their views of current and future gaps. This broader scan also may lead to a more proactive view of support in a country seeking out suitable partners rather than responding solely to requests for support. Lastly, as most northern INGOs are only too aware, their own policies regarding support to other NGOs may be influenced by any support they get from other bilateral or multilateral donors through, for example, joint funding schemes. All of this suggests a number of policy decisions that northern INGOs have to make regarding their activities within the south. These are summarized in Figure 6.4 in the form of a number of questions. Answers to these questions will depend to a large degree on the view that the donor NGO takes of the long-term sectoral composition as epitomized in the models set out earlier. Indeed, it is critical that donor NGOs take a long-term policy view which will form the backdrop for short-term action.

Figure 6.4 Key policy questions for INGOs

1. Do they act solely as funding agencies or actively manage in-country activities?
2. Where they have their own in-country operations, how independent of the parent body are the local country offices in terms of management and planning decisions?
3. How tight are the funding criteria and monitoring arrangements?
4. Should partners be actively sought or a more reactive stance taken?
5. Is support provided solely for project activities or also for the core development of an NGO?
6. Is support restricted to individual NGOs or to the development of sector as a whole, including strengthening of support NGOs such as co-ordinating bodies?
7. Is support restricted to NGOs or available also to the public sector?

DONOR POLICIES RELATED TO NGOs

The last group of policies related to the NGO sector concerns the donor community of bilateral and multilateral agencies. As we saw in Chapter 1, their interest in NGOs operating in the health sector has increased significantly over recent years. Some of this interest has arisen out of understandable frustration with the ability of the public sector to deliver, in the parlance of the World Bank, 'health gain' and also a search for alternative conduits for aid. There is also, undoubtedly, a wider and more ideological shift away from the use of the public sector in at least the delivery of health care, if not in other health sector functions. This is tinged with a view that the development of institutions outside government will enhance the political pluralism of the country. Donors therefore enter the relatively new arena of support to the NGO sector with a variety of what may be contradictory aims. It is thus critical that donors are clear as to the main rationale for support to the sector before deciding on strategies for delivering such support.

There are two major issues that face donors as they work through the policy implications of this shift. Each of these will be looked at in turn.

Means of Providing Support to the NGO Sector

The first relates to how they can best provide support to the emerging NGO sector within a country. There are various alternative methods.

Table 6.2 Alternative mechanisms for donor support to NGOs

Support mechanism	*Advantages*	*Disadvantages*
Through government to country NGOs	Enables government perspective	Loss of NGO autonomy
Through international NGOs for own activities	Neat, single country payments	Not necessarily country-focused
Through international NGOs to partner NGOs	Minimizes donor administration	Can be controlling partnership
Development of in-country capacity to provide support to NGOs	Long term support	Difficulty of identifying suitable agency

- Support channelled through government to CYNGOs
- Support through INGOs for their own direct activities
- Support through INGOs for their partner country NGOs
- The development of an in-country capacity to provide support to NGOs directly

The advantages and disadvantages of the alternative approaches are summarized in Table 6.2.

Under-pinning decisions as to the appropriate way forward are various considerations linked to the rationale for support. If the support is seen primarily as a mechanism for expanding an existing service base, then donors will look for means to provide support to well-established NGOs with the capacity to expand their activity levels. This may include support through international NGOs, or may be through country NGOs.

If, on the other hand, enhancement of pluralism is a critical objective of the support, then a mechanism for the identification and nurturing of small NGOs may be seen as desirable. This is by no means an easy process. It requires not only skills in community and organizational development but also a willingness to accept high risks with potential failure. It also requires a recognition of the likelihood of long term rather than short term results, something which donors may not find politically acceptable. The administrative costs of providing support to small NGOs itself can be high, and may lead donors to use other agencies such as INGOs to carry out this function.[8] Donors are also conscious of the inherent paradox of an external government providing support for the development of pluralism in another country, as is well-expressed in the following quotation from the UK's Overseas Development Administration (ODA) report on collaboration with NGOs:

> There are two possible drawbacks with a close ODA involvement with, and the funding of a local NGO. Firstly, in many developing countries NGOs are viewed with suspicion by government. We will not aid their long term sustainability, or their ability to assist the poorer sectors of the community, if their association with ODA is seen by government as a way of enabling them to bypass their wishes. Secondly, care must be taken to ensure that these organizations do not assume too great a role as agents for our programmes to the extent that they lose their potential as a force for the promotion of pluralism and as leaders of local people and articulators of their grievances and needs in the process of participative development.[9]

Direct support from an in-country institution is an approach which has been widely practised by USAID with its mechanism of contracting with US PVOs to provide support from within the country to indigenous NGOs. The UK's ODA has tried a variation on this approach in Bangladesh where it has set up a Project Office under the management of the British Aid Office to channel support to small NGOs operating in the Mother and Child Health (MCH) and family planning field. There are various potential dangers that such approaches face, including that of imposing standard delivery systems on recipient NGOs, distortion of their own management strategies in response to a significant and yet time-limited influx of external funds, and the political dangers for the NGO of too close an association with an external donor. The more general dangers associated with a sudden influx of fresh funding, and in particular the possibility of less than scrupulous organizations setting up to benefit from the funding, must also be recognized, although they are often hard to avoid.

Donors also need to consider the relative merits of providing support to the development of the NGO as an organization as opposed to support to direct service provision. NGOs, as we see in Chapter 10, face managerial strains as they scale up activities. Support which builds up their managerial capacity may be more important in the long run than short term funding for projects. Indeed, given the short-term nature of most donor support, dependent as it is on political cycles, one of the most critical areas of institutional capacity is the development of the ability in NGOs to access alternative sources of resources. At a broader level, donors also need to consider seriously the possibility of providing resources to 'support' NGOs, including co-ordinating bodies.

Lastly, donors need to recognize that in taking on support to NGOs they face certain longer term responsibilities for resource support, if they are not to be guilty of increasing volatility rather than stability in the sector.

As Chapter 8 argues, there are few magic sources of resources for NGOs in developing countries, and hopes of financial self-sustainability are unlikely to be realized in the short term. Taking on support to such NGOs must therefore be treated as a long term commitment.

Whichever mechanism, or combination of mechanisms, donors choose, it is almost inevitable that a culture shift will be required in aid agencies which previously have been concerned primarily with bilateral aid support or support to large international NGOs. Donors are rarely tooled up, either administratively or culturally, to provide support to small, low profile organizations and increasingly it is recognized that some re-engineering may be necessary.

Complementary Support to Government

The second broad issue relates to the need for donor agencies to recognize the importance of the development of complementary support to the public sector. Policies of support to the NGO sector inevitably imply a reduction in, at the very least, potential support to the public sector. At the same time the public sector faces new challenges, arising directly from the shifting health sector structures and pattern of health care provision, for which it may not be equipped. Whichever long term visionary model the donor is working to, and in particular whether it sees NGOs as a short term or long term substitute as a service provider for the public sector, there is, or needs to be, a general recognition that the public sector needs to retain a role in policy-setting and regulation and (though perhaps less generally accepted) raising of finance. The changing composition of the health sector has important implications for the development of capacity and new skills within the public sector which needs ongoing support from donors. It is critical that the development and maintenance of planning and policy-making skills in the public sector is seen as high on the agenda of donor agencies.

SUMMARY

In many countries, there is not a particularly strong record on policy-making concerning NGOs in the health sector. There are various aspects to this, and the chapter has examined the main issues from the perspective of the key actors: government, NGOs from the developing countries themselves and NGOs from the North and donor agencies. The situation has often been characterized either by short-termism or by an assumption that

the present situation will continue. However, the significant rise in interest in the sector over recent years has provided the catalyst for a much closer look at the policies which each of these actors has towards each other. Under-pinning all such policy development is the need for a long-term view of how inputs to health are best provided, and flowing from this the development of a strategic view as to the current positioning of NGOs in order to support the long-term sectoral vision.

7 Zimbabwe: A Country Case-study

This chapter, through a single country case-study, seeks to draw together issues in the broad policy environment in which NGOs are functioning. This case-study is based upon research carried out by the authors in Zimbabwe.[1] Although country-specific, the discussion echoes the situation existing in many countries. First the background to the research is presented, including a review of the NGO sector in Zimbabwe, and an over-view of the context in which national policy regarding NGOs has been made since independence. It then considers health policy in Zimbabwe, NGOs in the health sector and their particular contribution to the delivery of health care.

BACKGROUND TO THE RESEARCH

It is appreciated that some issues may have changed since the research was conducted in 1991. Nevertheless, the use of this case-study to provide situationally-specific information is considered important as it enables the issues discussed in other chapters to be placed within a specific context. The original research was not designed to be a detailed evaluative study of the health and population sector in Zimbabwe. Rather, it was intended to identify issues in the development of policy concerning NGOs and to contribute to the development of rapid assessment tools for investigating the role of NGOs. The field work involved a number of different but related elements.

- A review of documents
- Semi-structured interviews with:
  - central government staff from the Ministry of Health (MoH) and other Ministries;
  - Ministry of Health and Department of Social Welfare (DSW) field staff;
  - representatives of donor agencies in Zimbabwe
- A postal questionnaire survey of NGOs in the health sector, with selected follow-up interviews

The questionnaire provided information on the activities and characteristics of NGOs and investigated broad policy issues relating to NGOs and their work in Primary Health Care. However, it was very difficult to ensure that all relevant NGOs were identified as there was no single source of information. The survey was conducted on a country-wide basis and questionnaires and guidance notes were sent by post to 254 NGOs identified as health-related NGOs using three criteria (96 questionnaires were returned). The criteria used for selection were that organizations should be:

(a) non-profit making;
(b) not directly controlled by government; and
(c) involved in health care, which included rehabilitation activities but not basic education.

Zimbabwe is a country in Southern Africa which achieved its independence in 1979 following a long liberation struggle and 15 years of guerrilla war. In 1991 Zimbabwe was a country of around 10 million people with a per capita gross national product of US$650.[2] At independence the new Government of Zimbabwe (GoZ) inherited a grossly inequitable urban-based health sector which was racially divided and class ridden. This sector, despite providing the best possible health care services to meet the health needs of the privileged white minority, failed to address the diseases of poverty suffered by the black majority. There was a First/Third World split in morbidity and mortality patterns between the two populations. Evidence from available indicators would support a conclusion that there have been considerable improvements in overall health status of the Zimbabwean people since independence. For many Zimbabweans, particularly those who are of the age to be in senior management positions, experience of the liberation struggle has had a significant influence. Many NGOs, especially Christian missions, were supportive to the cause during this time and thus are favourably placed in their relationship with the current government. Over the last decade the number of NGOs working in Zimbabwe has increased considerably, especially secular ones and the majority of NGOs perceived a positive attitude by government towards them.

Although the GoZ has taken a number of steps towards the formulation of policies for particular groups within the NGO sector, there would appear to be no single widely accepted definition in Zimbabwe of what in fact constitutes an NGO. This absence of a definition is probably a reflection of the lack of recognition of a specific and separate NGO sector. This has a number of consequences, including the fact that there is no single Department or Ministry with a mandate to over-see the NGO sector as a

whole. This results in unclear and imprecise policies and requirements for the registration of NGOs and involves a number of different government agencies. In addition, the influence of Economic Structural Adjustment Programmes (ESAPs), recent rapid changes in the development aid policies of donor governments towards NGOs and the growing emphasis on the private sector have combined to limit the impact of existing legislation on the NGO sector as a whole. In particular there does not appear to be recognition in the Zimbabwean policy context that NGOs, whilst predominantly non-profit-making, are still an integral part of the private sector.

THE HEALTH SECTOR IN ZIMBABWE

Health policy is shaped by a wide variety of social, economic and historical factors of both external and internal origin. In Zimbabwe the widespread inequalities perpetuated during the colonial era and its legacy of urban-focused, racially segregated policies clearly have been important influences on those with the responsibility to implement policy change. This is reflected in the recognition of health as a development issue and the radical ideological, economic and structural changes to the health services and the commitment to equity introduced by the GoZ after independence in 1980. Overall there seems to be good working relationships between the MoH and NGOs. Reasons for this include the role played by the Church and missions in the war and their post-independence involvement in local level development planning committees. These relationships appear to being maintained despite the current economic climate and the Economic Structural Adjustment Programme.

Zimbabwe now has almost two decades of post-independence experience, and significant improvements have occurred in the health status of the population. However, despite the apparent success of the implementation of socialist ideology that has framed government policy, external influences and economic pressures are increasingly forcing change.[3] This is typified by a change in stance by the government on the issue of private medical practice. For although an original policy document[4] and the 1986–1990 Five year MoH Development Plan opposed growth of this sector, this attitude has since changed. Attempts are now being made to encourage responsible growth of a private sub-sector (private medical practitioners) in order to relieve pressure on the State-run health system. However, if the private sector is to have a supportive role to the public sector, the MoH must give attention to overall infrastructure development, such as legislative and fiscal provisions and technical supervision.

Within GoZ documents relating to the health sector it is usually recognized that modern and traditional health care in Zimbabwe is provided through six sub-sectors.

- MoH
- Local government authorities
- Missions (church health facilities)
- Industrial medical services
- Private medical care
- Traditional health care practitioners

What is immediately obvious from this list is that the MoH does not appear to recognize a separate NGO sector in health, but only a specialized part of that sector, Missions. Although it would seem probable that INGOs are not included as a sub-sector because they are regarded more as sources of support to government programmes than as individual providers of health services, it is less clear why secular Zimbabwean NGOs are also excluded from these sub-sector divisions. From the focus taken in this book, it is possible to redefine these six sub-sectors into three alternative groupings:

Public sector:	MoH and local government authorities
NGO sector:	Church and secular NGOs
Private-for-profit sector:	Industrial medical services, private medical care and traditional care

NGOs IN THE HEALTH SECTOR

There were a number of key findings from the survey of 96 health-related NGOs. These are summarized and discussed below.

Types of Activity

The NGO sector in Zimbabwe has an urban bias and includes both the Church and secular NGOs. Within the NGO sector, church NGOs are traditionally more involved in mainstream health service provision such as hospitals and MCH, with secular NGOs being more involved in other aspects of health care such as community development, advocacy for the disabled or rehabilitation. Zimbabwean secular NGOs are less likely than international secular NGOs to be involved in community development or primary health care.

NGOs and Policy Development in the Health Sector

Key findings from the survey were that direct consultation of NGOs by government on issues of policy seems to occur only rarely, and that although the majority of NGOs report regular visits by government officials, very few NGOs and none of the INGOs saw policy advocacy as an activity. In addition, just over half of all NGOs believed that they had a good informal relationship with government policy-makers. Although these findings may be linked, it is difficult to discover how such a situation originated. It is not possible to say whether NGOs are unable to see that they have any role in policy advice *because* they are rarely consulted or whether NGOs are rarely consulted *because* they feel that they have no role in giving policy advice to the government. This could reflect:

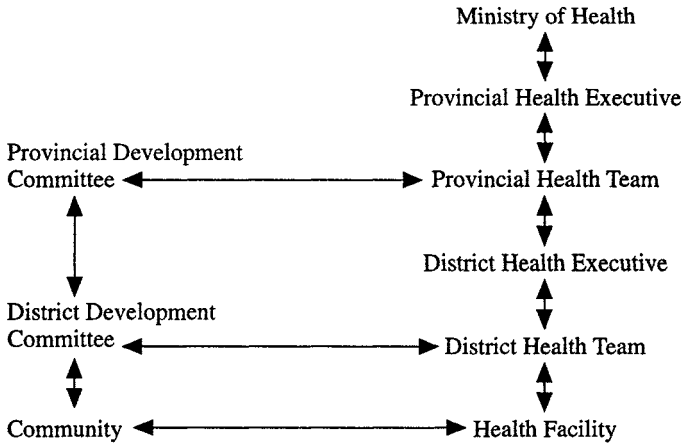
(a) a level of general apathy amongst NGOs towards policy-making;
(b) a total acceptance of the government's exclusive role in policy-making;
(c) a rejection by government of an NGO role in policy-making;
(d) failure to distinguish actual involvement in policy-making from routine activities;
(e) a lack of a suitable framework for dialogue with government policy-makers; or
(f) that survey respondents were not directly involved in or aware of policy discussions.

Interviews with government officials at central level indicated a clear view that NGOs in the health sector should work within government policy and that policy decisions are government's responsibility. However, no formal mechanisms seem to exist at central level to enable input to policy on a regular basis, or indeed a clear framework within which NGOs could contribute to policy-making at central level. This may be related to the failure to acknowledge a separate NGO sector. It was, however, pointed out that the input can come from NGOs to the MoH through the District Health Teams (DHTs) and Provincial Medical Officers (PMOs), and that decisions made at such levels are usually supported by the central administration.

Health Sector Planning

The lack of cohesion at central government level (with regard to the NGO sector) which is reflected at individual ministry, provincial and district

Figure 7.1 Zimbabwe health planning process



levels has a particular influence upon health sector planning. Since independence, the Zimbabwean government has attempted to develop a decentralized system of planning and implementation. This has been the case in the MoH.

Planning in the MoH involves a hierarchical process of planning from village or ward level through to the central planning pool at national level. At each level there is guidance from the level immediately above. In the MoH process, discussions with their respective community groups are held from the lowest level health facility. Facility staff then develop plans for submission to their DHT. Following discussions with their own District Development Committee (DDC), the DHT submit district level plans through the District Health Executive (DHE) to the Provincial Health Team (PHT). At provincial level there is a further equivalent series of discussions and planning before plans for the whole province are forwarded to the central level (see Figure 7.1).

Whilst such a process would appear to be comprehensive, allowing for the exchange of ideas between health workers and community representatives, it has inherent weakness with regard to the NGO sector.

First, it represents the views of the health sector only through facility-based personnel. Whilst a church hospital will be automatically assigned representation on the DHT, there is no equivalent formal opportunity for community-based local NGOs (which may or may not be receiving funds from the MoH) or INGOs to be represented on the DHT, although informal representation is acknowledged. Such organizations are not

usually facility-based but are involved in wider health sector activities such as water supply, advocacy for the disabled, AIDS support, geriatric care or rehabilitation. If non-facility-based NGOs are not represented on the DHT, this restricts not only the input of these NGOs to the planning process, but also the input of the district or provincial health staff into the NGO's planning processes, which could result in duplication or maldistribution of services.

Second, although many NGOs are small with self-contained management structures, less than half of all NGOs surveyed had a written plan. In addition, a number of NGOs had service delivery points in a number of districts with a central management structure involved in planning. The planning capabilities of individual NGOs need to be strengthened so that they can participate fully in district level planning.

Third, it is also possible for large organizations to take advantage of their relative size and deal directly with central level government departments, rather than a number of district or provincial offices. This may hinder the established decentralized government planning processes as it would be possible for health activities to be carried out without the direct involvement of the DHT or DHE.

Fourth, a number of INGOs have set up projects at district level through direct negotiations with the District Administrator and the DDC rather than the staff of the relevant line ministries. Should these projects have some form of health-related component they could be operated without the prior consent of the DHT. In addition, some INGOs have chosen to work through municipalities, which again adds a further dimension to the planning system. Such action by international NGOs reduces the possibilities for comprehensive and representative health planning.

Finally, receipt of funds by CYNGOs, directly from donors or INGOs, can confound the decentralized planning process, especially for capital projects. Such occurrences are often condoned because they may provide a more expedient solution to some problems than working through more bureaucratic channels. However, if there is no obligation to report such activities to the relevant government representatives or committees this will also hamper attempts to set priorities, not only within sectors but also districts or provinces.

Financial Support to NGOs

Whilst the relationship between governments and international donors in bilateral or multilateral programmes is overt and clearly understood, the channelling of funds through NGOs is a less visible process. This is especially true where an INGO receives funding from its own government as

part of a joint funding arrangement. In such a situation, the government of Zimbabwe deals only with the NGO and not the donor government. Although the majority of government officials interviewed expressed a positive view of INGO activities, some did comment that at times NGOs appear to have their own agendas which may be different from that of the government of Zimbabwe. It was also noted that the existing mechanisms for registration and inspection of INGOs and their liaison with government were extremely weak and often ignored, even by government officials, for the sake of expediency. Thus it is possible for Zimbabwean NGOs to receive funding either directly from international donors or through INGOs without the knowledge or control of the Zimbabwean government. Direct MoH involvement with international NGOs is usually as a recipient of either financial or human resources. This is in contrast to the MoH's policy in involvement with indigenous NGOs, particularly church hospitals, which is to provide direct financial support for mainstream health services.

The survey also demonstrated a high level of dependence upon single sources of funding. INGOs were the most dependent upon single funding sources. Just over half of all NGOs in the survey received some form of government funds, but NGOs registered with the Department of Social Welfare were less dependent upon government as a single funding source than those providing mainstream health care. Lack of funding was seen as a major constraint even amongst NGOs receiving significant amounts of government funding. Church NGOs were more likely than secular NGOs to receive government funding and over half of all church NGOs receive additional donations of goods and materials that are essential to their operation.

Funding for church health care comes from two main sources, the Church and the government (in the form of subvention). Indigenous churches have less resources available to them since independence and the majority are now almost entirely dependent upon funds raised within Zimbabwe. However, in addition, and possibly because the government has been prepared to support the work of church hospitals, church authorities appear reluctant to allocate their own funding to health facilities. Church health facilities in Zimbabwe are therefore being used primarily as a component of government health care provision. There is also widespread recognition and agreement that, despite full support to GoZ-approved salaries in church facilities, they are underfunded because the level of approved staff in church facilities is much less than in equivalent government facilities. Indeed, a quarter of all NGOs surveyed would like the government to take over their services.

A further difficulty relating to the role of church facilities in the health sector is the duality of planning and financing systems within the MoH.

There is a separate and centralized accounting and budgeting system for church health care which places severe restrictions on the potential for integrated planning by health managers at district and provincial level. Although represented on the DHT, church facilities are isolated within district level planning because of their parallel financing system. Thus, whilst there is some local control over capital expenditure at provincial level, the central earmarking of funding for church facilities prohibits the complete integration of church facilities within provincial priorities. The provincial role in church recurrent funding is even more restricted. In addition, the pressures imposed by the ESAP are likely to reduce the possibility of resolving all these issues in the short term.

Observed Comparisons Between Government and NGO Health Services

Unfortunately, figures easily available about health services provided by NGOs tend to relate only to church health facilities and not to the total contribution of the NGO sector. Additionally, the sub-divisions referred to above are not used consistently throughout government documents. It is difficult therefore to produce comparable figures. Comparisons are easier to draw when considering similar types of facility. This has been done within one province[5] for three church facilities designated as district hospitals and two government-run district hospitals. From this comparison clear differences emerge between the two types of service provider.

Figure 7.2 Comparisons between different health service providers

1. In hospitals with similar bed capacity, mission hospitals reported at least twice as many inpatients as government hospitals.
2. Despite a similar establishment of two doctors, the number of outpatients per doctor at mission hospitals was double that at government facilities.
3. In mission hospitals, bed:nurse ratios range from 8:1 to 5:1 whilst comparable figures for the government are only 2:1.
4. The number of inpatient:nurse ratios in mission hospitals ranges from 148:1 to 112:1, whilst the comparable figure for government facilities is 66:1.
5. When deliveries are added, the inpatient:nurse ratio in mission hospitals ranges from 217:1 to 122:1, and government facilities are only 84:1.

Data from another province[6] also indicates that the ratio of nursing posts to bed numbers display similar disparities between church and government. This province reports figures for church hospitals of bed:nurse ratios ranging from 11 to 5 whilst comparable figures for government facilities are again much less (at only 3). Despite these figures less than half of all NGOs perceived themselves to be more efficient, innovative or closer to communities than government. It may be that although disparities can be observed, they do not reflect an estimate of quality of care offered by each facility. It is possible that the high demands placed on church staff could serve to reduce the quality of service they are able to offer.

NGO Regulation

One of the basic policy tools available to any government is the registration or regulation of NGOs. Although such registration can be used as a mechanism of control it can also enable government departments to work more effectively with the NGO sector and vice versa. The lack of both a single government Department or Ministry with a mandate to oversee the NGO sector results in the absence of a comprehensive framework within which NGO activities can be planned. Central government officers in Zimbabwe, especially in line ministries, demonstrated a recognition of these difficulties and a desire for greater co-ordination. However, this is counterbalanced by a reluctance actively to improve co-ordination of activities, especially with large international NGOs which' are able to access considerable sources of funds. In the survey, few NGOs considered themselves accountable to the GoZ, and even amongst NGOs receiving the majority of their funding from government only half mentioned accountability to government for their plans and budgets.

In Zimbabwe, in common with most countries, the registration of NGOs seems to be *ad hoc*. In Zimbabwe the Welfare Organizations Act 1967 covers the registration of Zimbabwean NGOs, but excludes religious organizations, clinics, nursing homes and hospitals.[7] This registration of Zimbabwean NGOs is the responsibility of the Department of Social Welfare (DSW) and is related specifically to organizations that can be defined as 'Welfare Organizations' under the above Act. Where organizations are registered under this Act there is a recognized basic regulatory framework enforced by the DSW. However, many organizations currently working in the health sector are not eligible for such registration. The register of welfare organizations is centralized, but many of the activities relating to the vetting and monitoring of these organizations is decentralized to Social Welfare Departments at District and Provincial level.

Secular NGOs

The existing legislation is identified by most people primarily with the legitimization of public fund-raising activities. It is in fact focused upon broader concerns of organizational legitimacy, such as the NGO's constitution, funding sources and whether its activities reflect its stated purpose. It does not seek to provide qualitative supervision of technical competence. Provincial officers from the DSW are required to submit NGO monitoring reports quarterly to their central office. In reality, pressure of work often precludes close involvement. In normal circumstances monitoring is often reduced to an annual visit, and in extreme circumstances restricted to the receipt of annual accounts and reports. Thus it is possible for an organization to be administratively correct under the current regulatory mechanism and yet provide inferior or even dangerous standards of service delivery.

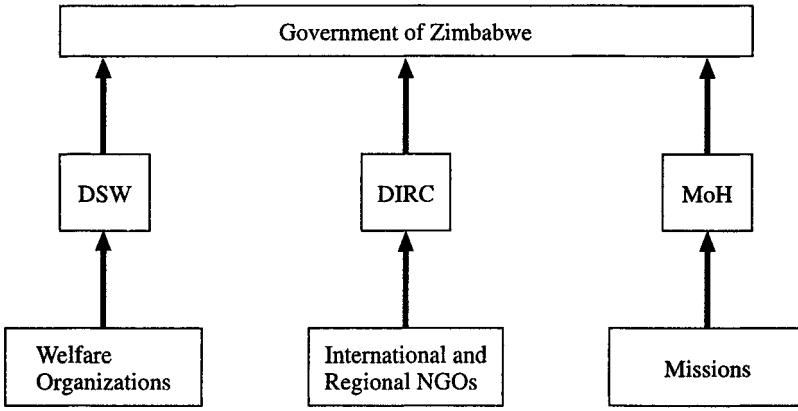
Church NGOs

Under the existing structure, church organizations are not covered by a formal registration procedure, although in our survey six church NGOs had registered with the DSW. There appears to be no complete listing of NGOs working within the health sector, and the MoH tends to focus on the role of mainstream health care providers such as churches. The research suggests that there could be at least as many secular health NGOs as church NGOs. If this is correct, then it would seem that the MoH has direct and regular dealings with only about half of the NGOs working in the broad area of health. However, even church facilities are not fully integrated into the health sector, but instead work within the MoH through a parallel system of financial management and planning.

INGOs

The GoZ has a Department of Regional and International Co-operation (DRIC) at central level for INGOs. This Department has the task of coordinating INGOs of all kinds and the maintenance of a register of external NGOs. In addition, this department is concerned with the geographical dispersion of NGOs and their service provision over all sectors. The methodology of NGO assessment is based upon questionnaires and field visits. It is understood that some INGOs additionally are required to register with the Ministry of Foreign Affairs. The various registration relationships of NGOs to government are outlined in Figure 7.3.

Figure 7.3 Government–NGO registration



Technical Accountability

Whilst regulation is practised to some degree in most countries, ensuring technical accountability is much more difficult. There is, of course, an element of organizational accountability in regulation, but scrutiny of the standards of service delivery provided by each NGO ideally should be the responsibility of line ministry staff at district and/or provincial level. However, where the activities of NGOs do not fit into the structure of a single line ministry, this is difficult to organize. In Zimbabwe, whilst co-operation with the DSW may give line-ministry staff information about Zimbabwean NGOs, the observed practice of INGOs directly working through District or Provincial development committees complicates further any initial information-gathering process. Even if satisfactory arrangements could be made for all NGOs to register their activities with the appropriate line ministry at district or provincial level, the actual supervisory relationship may be difficult to implement, especially with INGOs. INGO staff and government officials both felt that some expatriate staff experience a tension between not wishing to step out of line and not wanting to be told what to do. Similar difficulties were reported amongst expatriate staff in church hospitals.

Co-ordination for NGOs

There are several NGO co-ordinating bodies in Zimbabwe, but the overall pattern of co-ordination is not systematic and mirrors the incremental

development of the NGO sector. The three main co-ordinating bodies in Zimbabwe are:

(a) National Association of Non-Governmental Organizations (NANGO);
(b) Zimbabwe Association of Church Related Hospitals (ZACH); and
(c) National Association for the Care of the Handicapped (NASCOH).

These three main Zimbabwean co-ordinating bodies are very different; each has its own priorities, *modus operandi* and composition which reflects its particular co-ordination functions.

NANGO, a general co-ordinating body, attempts to co-ordinate dissimilar types of NGOs within a single national body operating at both local and national level. As a result of the diversity of its client group, NANGO is unable to focus its attention on specific sectors and has to relate to a number of government ministries at central level. This is less of a problem at the local level, where its officers can relate to provincial and district officials through development committees.

ZACH, a sectoral body, working for church NGOs, has been more able to build up good working relationships with a single ministry at national level, but has less influence on NGO-government relationships at district and provincial level.

NASCOH, an interest-based body, is faced with the task of co-ordinating a small group of NGOs with similar client groups but different perspectives. Without the resources to maintain and facilitate close working relationships between the group as a whole, NASCOH finds itself able only to create a limited impact at either national or local level. In addition, there are a number of other interest-based co-ordinating bodies including:

(a) Zimbabwe Federation of the Disabled;
(b) National Council of Disabled Persons Zimbabwe;
(c) Council for the Blind;
(d) Zimbabwe National League of the Blind;
(e) National Council for the Care of the Aged;
(f) Food and Nutrition Association of Zimbabwe;
(g) Zimbabwe Council on Alcohol and Drug Abuse;
(h) Zimbabwe AIDS Network.

Most of these bodies are quite specific in their areas of interest, although some identify their function more as networking than co-ordinating. Many of these bodies are also members of, or represented on, one or more other co-ordinating or networking groups whether nationally, regionally or

internationally. Despite clear recognition that current arrangements needed strengthening, the majority of NGOs saw a role for co-ordinating bodies. Their most important functions were seen to be information-sharing and support.

SUMMARY

This chapter has presented a brief summary of some findings from a research study carried out by the authors in 1991. From an overview of the context in which national policy regarding NGOs has been made since independence the chapter considered health policy, NGOs in the health sector and their particular contribution to the delivery of health care. It concludes with a discussion of regulation, accountability and co-ordination. We make no suggestion that this study of Zimbabwe is illustrative of other countries but rather that it enables the broad issues discussed in the previous chapters to be placed within a single country focus.

8 Resourcing NGOs

One of the critical issues facing all NGOs is the question of how they generate resources to carry out their activities. As we have seen in Chapter 3, one of the potential advantages of NGOs is their ability to obtain and utilize resources not available to government. This chapter starts by examining the main sources of resources available to NGOs, and trends in funding patterns for both international and national NGOs. It then analyses various implications and tensions for NGOs arising from these trends in terms of their sustained ability to carry out their objectives, and whether their putative comparative advantage over government as a raiser of resources is justified.

SOURCES OF RESOURCES

There are a number of sources of resources potentially available for NGOs. In this chapter we are taking a deliberately wide view of resources to include, alongside finance, non-financial resources and subsidies that are available to NGOs. Though not all of these result in direct *financial* income to the organization, they may have a similar effect through releasing funds that would have been otherwise tied up, though their freedom to decide on the precise use may be constrained. Each of these sources will be looked at in turn, with a summary of the advantages and disadvantages set out in Table 8.1.

Donations in Cash and Kind

Donations, both in cash and goods, are the most obvious sources of resources in which NGOs may have a comparative advantage over government or indeed the private sector. For many NGOs based in the wealthier nations, including those concerned with support to developing countries, it forms a significant part of their resource base. Furthermore, it may provide an important element of operational freedom for the organization. For NGOs in the poorer countries, however, where income levels constrain the ability to donate, it is less important.

Cash donations

The first source of resources to an NGO, and that with which NGOs are most closely associated, is through gifts to the organization. These donations may be in the form of either money or goods.

Table 8.1 Advantages and disadvantages of alternative sources of resources

Form of funding	*Advantages and disadvantages for NGOs*
Individual or corporate donations in cash and kind	General fund-raising may provide freedom of operation May be tied to specific appeals Requires fund-raising administration and profile Can lead to inter-departmental tensions Donations in kind may be inappropriate
Charges to direct users for services provided	Provides income related to service provision Provides apparent accountability to users May raise equity issues
Charges for the provision of services to other organizations	Provides income related to service provision May lead to loss of freedom to operate and innovate May carry contracting and accounting costs May not contribute to overhead costs
Non-specific grants	Provides freedom to operate within broad parameters related to types of service May not be regular
Subsidies and tax relief	Reduces overhead costs Provides freedom to operate within broad parameters related to type of NGO
Lotteries and other fund-raising mechanisms	Provides freedom to operate within broad parameters related to type of NGO Administrative costs May displace other fund-raising activities

Financial donations may occur through a variety of mechanisms. Street collections, media appeals and targeted soliciting of support are some of the more well-known approaches used by NGOs in seeking funding support. This support may be given as a one-off donation, or, as is more useful to the NGO, as part of a regular and long-term commitment. Whilst some donations may be in response to particular appeals and such funding reserved for activities related to that appeal, other donations may be more open-ended and available for the general use of the organization. Donations may be made by individuals or corporately by organizations. In some countries government encourages such donations by allowing relief on tax for covenanted donations.

The ability of NGOs to tap into both individual and corporate funds is a function of a variety of factors. These include the level of income of the country and its citizens, the presence of other NGOs also seeking funds,

the objectives of the NGO and lastly the skills of the NGO in presenting the appropriate image. Key amongst these is the economic profile of a country and hence the ability of its citizens and companies to donate. Developing countries clearly are less able to support a level of funding through this source comparable to that of richer countries, as is well demonstrated by the per capita gross domestic product figures in Table 1.2 in Chapter 1. Important also for any individual NGO is the presence of other organizations also reliant on donations. The overall number of active NGOs in a country is thus a factor, with individuals being likely to have a personal limit to their ability or desire to donate. Those competing for funds for similar causes are especially at risk, as donors may have their favourite NGOs in a particular field. Indeed, over-exposure to an issue may lead to a phenomenon now dubbed donor fatigue.

An NGO's skill in persuading individuals or companies to donate cash is also a function of the cause itself. Some areas in the health field traditionally have been able to attract significant funds. For example, those such as SCF focusing on children's ill-health fare well, and indeed UNICEF, although not an NGO, has been a major beneficiary of this interest in children. This contrasts with NGOs concerned with the elderly who are less able to attract public interest. NGOs concentrating on particular diseases also encounter differing levels of interest. For example, in the UK, charities researching into cancer are able to attract wide ranging support in comparison to those focusing on mental illness. Furthermore, while some corporate donations may reflect genuine interest (often on the part of a key senior manager) in a certain field, interest in donations may also be linked closely to any commercial advantage that can be gained through, for example, the presentation of an image of a socially caring organization. The Executive Director of the UK Alzheimer's Disease Society once remarked:

> the British public is immensely generous but a business adviser told me recently that we have a 'negative product image'. This is particularly difficult in the area of corporate donations: it is much better for a company to be associated with animals or children than dementia.[1]

The ability of NGOs to transform latent interest into cash donations depends not only on the field but also on the ability of the NGO to project to the general public an image which strikes a nerve. For some time the large NGOs have been aware of the importance of maintaining a high profile and using effectively the types of marketing strategies and activities widespread in the commercial world. As we discuss below this can lead to tensions within an organization over these strategies, and in

particular the belief by fund-raising elements of an NGO in the importance of certain images which may conflict with the aims and activities of the programme department.

NGOs also face a dilemma as to the proportion of funds which they put back into further fund-raising efforts. While such investment in what the commercial sector would view as legitimate marketing effort may be entirely rational, it carries with it overtones (albeit often unfair) of high administrative costs and may attract criticism from the general public as to the failure of such NGOs to use funds for direct activities.

Donations in kind

Until now we have concentrated on the donation of *cash* to NGOs. Donations may also be given in the form of either goods or an individual's time. Volunteering has always been an important aspect of many NGOs and in particular small community-based organizations. Volunteers may provide an important resource in terms of their time. This may be either in the form of unskilled labour or from individuals with a professional skill to offer. Indeed NGOs rely on volunteers to form the Board of Trustees. The labour brought in by volunteers not only may reduce the need for the organization to employ staff but has two other important side-effects: it may strengthen ties between the NGO and the community it serves; it may also generate a particular management culture within the organization which can be creative but can also lead to destructive tension between the volunteers and the employed staff.

One particular area in which NGOs may use volunteers is for income-generation projects in which a proportion, or all, of the income accrues to the NGO. The use of volunteers to staff trading shops in the UK is an example of this. In developing countries, however, given the economic structures, there are limits to the opportunities for such activities, and indeed, should the funding raised become significant through the donation of labour, may be in danger of appearing as exploitative of the volunteers. NGOs also may receive resources in the form of second-hand goods either for the direct use of the organization or for resale. The latter has become an important source of funding for some organizations in the UK, of which the best know is Oxfam with its chain of shops. Missionary health facilities in developing countries have also benefited for many years from gifts of medicine and equipment either bought from funds raised by their home church or solicited from health services in the sending country. Whilst this may be an important source of resources for such organizations it can lead to difficulties ranging from serious quality deficiencies to an inability to

sustain a standardized list of drugs and equipment. The procurement of maintenance parts for equipment is a problem well known to such recipient organizations.

Charges to Users for Services Provided

The second source of funding for an NGO is from the sale of services provided to individual users. Within the health field this is predominantly the provision of curative personal health care. Some organizations which either provide services in particular situations (for example, emergency relief) or are not concerned with direct services to the public (research or advocacy organizations) will have little opportunity to charge the users or beneficiaries. The generation of income from such sales through user charges has, of course, always been the basis of the operation of the market for the private sector. Increasingly it is also used by the public sector either through the implementation of national schemes of user charges or, particularly since the Bamako Initiative,[2] through more local community financing schemes. A variety of financing measures fall under the general term of 'community financing', ranging from user charges, drug revolving funds to community-based insurance or pre-payment schemes.[3] Dave, in research into 12 voluntary organizations in the health sector in India,[4] showed that such means of funding can be significant for a number of NGOs. Indeed, in eight of the 12, it represented the only source of funding.

The arguments for and against the use of charges as a means of procuring income are well-rehearsed in the more general literature on health care financing.[5] Two arguments are, however, worth referring to. First, proponents of user charges suggest that through linking the provider and the user directly through payment, it may develop a greater responsiveness of the service to the wants of the user, and enhanced attention to quality issues. While the levying of user charges potentially may ensure that the service is more attentive to the user, in some areas (such as remote rural areas) where the NGO is the only provider, the lack of a competitor may reduce the need for responsiveness suggested by the theory of market forces. Furthermore, it is important to recognize the difference between the *wants of an individual user* around which market theory revolves and the *needs of a whole community.*

Second, there are strong equity reasons for being wary of user charges, particularly if they are required to be the major source of income for the NGO and hence are levied at levels close to the cost of service provision. Though exemption mechanisms are often seen as the way to minimize the equity damage, in reality they are extremely difficult to operate fairly and

effectively. For NGOs with an objective to serve the poorest, such concerns should be paramount.

For some NGOs, and particularly church organizations whose initial missionary organization is unable to continue providing adequate support, the need to generate in-country funding has often led to the adoption of user charges. Indeed it has been a significant issue for certain NGOs for some time. Where they have adopted such strategies, their experience on occasion has been seen as providing a model for government to emulate.

Charges for the Provision of Services to Other Organizations

A third source of finance for NGOs comes from the provision of services to, or on behalf of, other organizations for which the latter pay. Contracting organizations may be government ministries, other NGOs or indeed the private sector. In some countries, the MoH has recognized, for some time, the potential for using existing NGOs as agents for government. Tanzania, for example, has had for may years a system of designating certain mission hospitals as quasi-governmental and providing a grant to compensate them for this function. The specificity of such arrangements varies between countries, with some being so vague as to constitute almost an open grant. Others, however, have clear contractual requirements to provide, for example, primary health care cover to a specified population or formal district surgeon duties for the judicial system. There is also a difference between time-limited project funding and open-ended programme funding.

The use of such contracting procedures accords closely with the current trend to separate the provider and funding functions of health care espoused by enthusiasts of particular models of Health Sector Reform and in particular the World Bank with its 1993 World Development Report.[6] Such models, outlined earlier, suggest that whilst government may need to finance the provision of basic packages of health care, other organizations, such as NGOs and the private-for-profit sector, may be better placed to provide at least some of the services on a contractual basis. Such gilded opportunities are not only open to national NGOs operating in developing countries but are also a feature of the international scene. For a number of INGOs which are seen by donor agencies as attractive service providers, opportunities exist, and have been accepted, to enter into arrangements to carry out projects.

Whilst the operation of such contracts may appear as a welcome source of (relatively) secure income to NGOs there are various dangers associated with moves in this direction. First, there is an inevitable trade-off that

NGOs will have to face. For such funding to be a significant element of their resource base carries with it the contractual obligations to the funder, in this case, government and hence a restriction on the freedom of operation often held up as an important and unique aspect of NGOs. This concern is readily understood when the views of a donor using NGOs as contractors are expressed as follows: 'He told me: "Italian NGOs receive all their money from the government. So from my point of view they are no different from a firm, except that they do not make a profit. They are just implementation agencies for us."'[7]

Such constraints may range from a requirement to provide services in a particular fashion to a restriction (implicit or explicit) on advocacy activities critical of government policy. At a more general level there are potential contradictions around the acceptance of funding from governments of the Right[8] which face NGOs which may have a different value base.

Second, there are a number of costs associated with such project funding or contracting which may reduce the net benefit to the NGO. These include the costs of preparing project submissions in the donor agency's format, reporting and auditing requirements. Where NGOs are funded from a variety of sources they may be required to maintain separate information and budget systems to meet the needs of individual donors. Where formal contracts for service provision are required this may also lead to the need for expensive legal input. The transactions costs of contracting can be significant if contracts are highly specified. Donors may be unwilling to pay the full costs of such administrative charges even where they can be associated with the project activity. They may be even less willing to pay general non-attributable administrative costs. Where the donor is only prepared to fund a project for a short period or where the funding level itself is small, these administrative costs may make the overall benefit of the funding less attractive to the NGO.

For donors themselves the administrative costs of funding small-scale operations may be prohibitive, and as a result they may focus more on large-scale NGOs and operations. For example the UK government's ODA provided £8.4 million to the Aga Khan Rural Support Programme in Pakistan between 1991 and 1993.[9] Alternatively they may provide looser forms of funding. Such programme funding is discussed in the next section. They also may use NGOs themselves as intermediary funding agencies. American PVOs have been used in this role for some time. For example, in Bangladesh organizations such as Pathfinder act as conduits for American support to smaller CYNGOs. Such support is usually highly regulated and effectively the PVO acts as a contracting agent for USAID. UK-based NGOs are also used to channel government development assistance to small

NGOs in developing countries, under schemes such as the Joint Funding Scheme. Such arrangements, however, are typically much looser with the intermediary or partner NGO presenting schemes for funding within broad parameters. They also involve funding raised by the INGO itself. Increasingly donors interested in providing support to CYNGOs are looking for new forms of providing support directly to NGOs. The ODA, for example, in 1988 set up a project, under the Bangladesh Population and Health Consortium, to support small in-country NGOs operating in the maternal and child health field. The average level of annual support to each such NGO is small but is clearly significant for the organizations themselves, some of which are totally reliant on this source of funds for their project funding.

One of the dilemmas facing donors is how to find a mechanism for funding NGOs which does not change the nature of the NGO in the process. As the World Bank has put it:

> NGOs have demonstrated a flexibility and dynamism . . . they are seen as helping the poor directly – without the costly bureaucratic intermediation of donors and recipient governments . . . The danger is that northern NGOs will be used more actively as channels for donor assistance, which would threaten to suffocate the flexibility, independence and low bureaucratic costs that have made them so effective.[10]

Donors also may require recipient NGOs to contribute a proportion of the costs of an activity. Such joint funding mechanisms are common practice, though the details and required level of contributions vary between donors.

* * *

The preceding has focused on services provided by an NGO on behalf of government. Contracts are also held between NGOs both within a country and internationally. Within a country, one NGO may be contracted to provide support services to another. Such services may include training, administrative services or clinically related services such as laboratory testing or procurement of medical supplies. At the international level, however, the NGO may take on the role of a purchaser of overall services, effectively acting as a donor agency. Whilst such arrangements are often described as 'partnership' arrangements, the funding aspects are clear: the provision of funds is in respect of an understanding that services will be provided in return. Furthermore, there is a growing awareness amongst southern recipient NGOs that despite the veneer of partnership between NGOs, there is an

inevitable power imbalance between provider and purchaser which carries with it similar disadvantages to those outlined above concerning government-to-NGO contracts. An African proverb sums this up well: 'If you have your hand in another man's pocket, you must move when he moves.'[11]

Lastly, however, and perhaps most importantly, the use of such contracts represents a transfer of funding from governments or other NGOs to the contracting NGOs rather than a net increase in funds to the health sector as a whole.

Non-specific Programme Grants

In contrast to the preceding source of funding, NGOs may receive funding from various institutional sources (including their country government, donor agencies and international NGOs) which are effectively non-tied programme grants. The provision of such support to an NGO is in many ways analogous to the first category we examined, the difference lying in the nature of the donor and its general expectations. Though the donor expects the NGO to provide services which are in line with its general stated objectives, no more specific constraints are placed on them. Block grants have the benefit of flexibility for the NGO though still impose an often unstated but real requirement that the organization works in a way that is consistent with the donor's own policies. They also overcome for the donor some of the administrative costs associated with funding specific project activities, as discussed above. Whilst some donor agencies and indeed governments recognize the opportunities for innovation and speed of response afforded by such flexibility, demands for greater governmental accountability and transparency make it harder for such grants to remain unspecified. International NGOs acting as donors are in a particularly difficult position. As NGOs they are expected to share the aspirations of the recipient NGOs and to be sympathetic to their desires to maximize freedom of operation and control and hence minimize accountability to the donor. As we have seen, the concept of partnership is often bandied about. However, at the same time donor NGOs have their own accountability pressures which suggest that it is perhaps naive to expect a relationship of equal partnership ever to be possible.[12]

Subsidies and Tax Relief

An important source of effective, though hidden, funding comes to NGOs in the form of tax relief or subsidies from governments with policies of

general support to NGOs. Organizations which can satisfy the government that they meet certain criteria may be eligible for relief from tax such as corporate income tax or import duties which may represent a significant real benefit. In addition government may provide subsidies to NGOs which may or may not be available to the private-for-profit sector. Examples often include access to government training schemes and provision of medical supplies at no-cost or subsidized prices. Government may in theory be able to use access to such benefits as a policy tool to control the sector and individual NGOs. In practice, however, in many developing countries the operation of these more general fiscal schemes lies outside the direct control of the health ministry and as such is not effectively used as a health policy tool.

Again it is important to recognize that such subsidies and benefits may not represent a real net gain to the health sector but a transfer of resources from the government to the NGO sector.

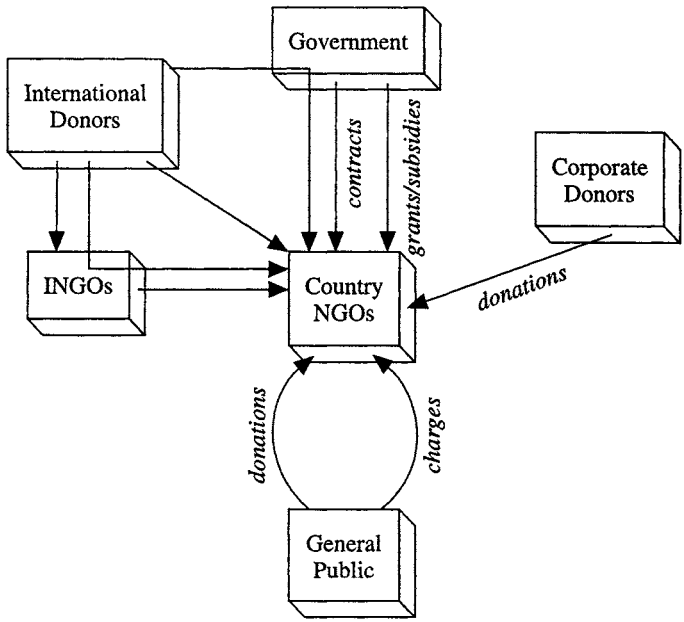
Lotteries and Other Fund-raising Mechanisms

The last category of funding source varies in importance between countries. In some countries individual voluntary organizations can carry out lotteries for fund-raising. Elsewhere it may be under the control of the state or quasi-state organizations which then distribute funds to voluntary organizations. As recent UK experience has demonstrated, mechanisms such as state lotteries at first sight provide an easy means of tapping into individual pockets. Such a mechanism, however, effectively operates as a government grant to NGOs, the difference being that it is possible to argue that individuals would not enter the lottery unless they were assured that some of its proceeds went to charitable causes. Whilst such mechanisms therefore may provide new sources of funding for the government and NGO sectors, there is also a danger that it may displace direct donations to voluntary organizations by the same lottery-playing individuals. As such it may not represent as large a net increase in funding than at first sight is apparent.

FUNDING FLOWS

The above has set out the main forms of funding available to NGOs. The specific actual funding patterns of individual NGOs are likely to vary

Figure 8.1 Funding flows



greatly, leading to complex overall funding flows. This is demonstrated in Figure 8.1 which sets out the main channels of funding within a country.

The complexity of the flows shows the tremendous potential for double-counting in assessing the ability of an NGO to access new funds. In particular it is important to differentiate between funds, such as government grants to NGOs, which are not specific to the NGO itself but, in the absence of the NGO, could be channelled directly into the public sector.

Differences between International and National NGOs Funding Patterns and Recent Shifts in Patterns of Finance

The lack of data makes it difficult to make generalizations about any overall pattern of funding of NGOs. Indeed the heterogeneity of the sector suggests that it may be that there *are no* generalized statements to be made other than that the search for funding is likely to involve, for any individual NGO, a number of sources.

For example, at the in-country level, Dave-Sen and McPake[13] analysed

Table 8.2 Sources of funding for health sector NGOs in Zimbabwe

Source	*Percentage of NGOs receiving specified percentage of funding from source*				
	None	*<10%*	*10–50%*	*51–89%*	*>90%*
Government Grant	43	3	18	15	22
Donor	54	18	19	6	3
Parent NGO	67	10	10	5	9
Fund-raising	67	16	10	6	2
Sales	74	10	10	4	2
Other	77	7	10	2	3

Source: Green and Matthias (1993), modified from Table 15.

20 NGOs operating in the health field in a variety of countries. They found a mix of methods of funding including government support, donor financing and a variety of community financing methods of which user fees and drug charges were the most common. Overseas support of church facilities was seen to be declining, leading church facilities to search for alternative sources of finance. One of the particular difficulties facing NGOs which shift from overseas funding to in-country sources, such as community financing, is the availability of foreign exchange in countries where there are restrictions. Diskett and Nickson,[14] in a survey of projects supported by Oxfam, had similar findings and saw an important role of external NGOs as providers of foreign exchange.

This mix of funding method in part is a reaction to a recognition of the inability of any of the potential sources available and discussed earlier to provide, on their own, sufficient and sustainable funds. It is also potentially a deliberate strategy to avoid dependence on any single source of funding.

As an example of the type of pattern of funding the following sets out the pattern of funding for one country's NGOs, Zimbabwe.[15] Table 8.2 shows the distribution of funding sources for all the 96 respondents in a survey of NGOs.

It can be seen from the table that whilst there is a wide diversity of sources of funding, half of the NGOs received some form of direct financial support from the government with over a fifth receiving more than 90 per cent from government subventions and grants, and over a third receiving more than half their funds from government. These are predominantly the

Church NGOs which act as designated hospitals for government. Only 14 per cent could be said to self-sustaining in financial terms (that is, they receive the bulk of their funding from either sales or fund-raising). In addition to the financial sources of funding, 63 per cent of Church NGOs and 54 per cent of secular NGOs received donation of goods or materials which were regarded as essential by the majority of these NGOs.[16]

At the international level, again there is a wide diversity in the sources of funding amongst NGOs operating in the health field in developing countries. The following, which is derived from Robinson (1994) and Brophy and McQuillan (1993), sets out the situation in the UK as an example of the situation of INGOs. Clearly, however, the situation facing INGOs based in other countries will differ, though many of the issues are similar. There are over 300 international organizations based in the UK involved in relief and development work.[17] Amongst these is a small number of large well-known charities which account for the bulk of the activity. This sector has grown over the last decade with non-trend peaks at times of disasters. Figure 8.2 sets out the total income for the top 45 charities involved in aid work from the 1993 survey[18] of the top 500 charities. The graph illustrates the dramatic decline in size of INGO beyond the first third.

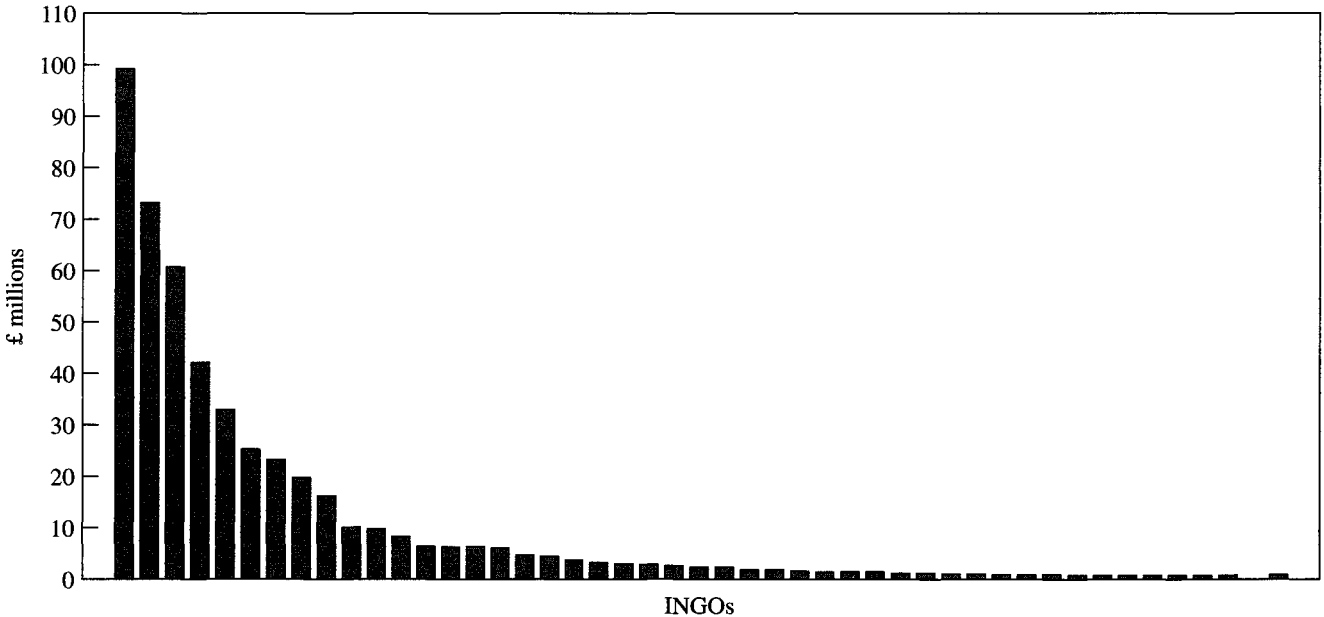
Tables 8.3 and 8.4 show the distribution of income by source of funding for these 45 INGOs grouped into three bands by size. What is immediately apparent from the tables is the differences in importance of source by size. The large INGOs receive significant government funding (over a quarter), with less than half of their funding being derived from covenants, legacies and other donations. By contrast the small INGOs are heavily reliant on this source and receive little government funding.

Table 8.5 and Figure 8.3 set out the main sources of income for the fifteen largest (in terms of total income) international aid agencies operating significantly in the health field. Table 8.6 presents the same information for each NGO as a percentage of its total income.[19]

The first obvious point to make about the tables is the significant difference in size of the NGOs, and the steep gradient in size reduction. The largest three (SCF, Oxfam and British Red Cross Society) are significantly bigger in financial terms than the rest, and the smallest of the group (Leprosy Mission) is over 15 times smaller than the largest (SCF).

Second, the sources of income are diverse. They can be grouped into three broad categories: donations, sales and government funds. For the majority, the first of these is by far the most significant with all but three (Care Britain, VSO and Order of St John) receiving over 40 per cent of their income from donations. The bulk of this comes from individuals in a variety of ways. For example, the Tear Fund relies almost entirely on

Figure 8.2 Income levels for top 45 UK-based INGOs



Source: Derived from Brophy and McQuillan (1993).

Table 8.3 Sources of funding for top 45 UK-based INGOs by band

NGOs	*Sources of income in £ million*						
	Total income	*Donations*		*Sales*		*Government funds*	*Other*
		Covenants, legacies, other donations	*Fund-raising income*	*Trading charity shop income*	*Sales of goods and services*		
Top 15 INGOs	440.9	218.2	25.1	28.8	20.3	126.8	21.6
Second 15 INGOs	41.4	25.8	3.1	0.0	1.0	5.5	6.0
Third 15 INGOs	9.8	8.0	0.6	0.0	0.1	0.5	0.5

Source: Derived from Brophy and McQuillan (1993).

Table 8.4 Sources of funding for top 45 UK-based INGOs as a percentage of total

NGOs	*Sources of income as a percentage of total*						
	Total income	*Donations*		*Sales*		*Government funds*	*Other*
		Covenants, legacies, other donations	*Fund-raising income*	*Trading charity shop income*	*Sales of goods and services*		
Top 15 INGOs	100	49.5	5.7	6.5	4.6	28.8	4.9
Second 15 INGOs	100	62.4	7.5	0.0	2.4	13.4	14.4
Third 15 INGOs	100	82.0	6.6	0.0	1.1	5.1	5.2

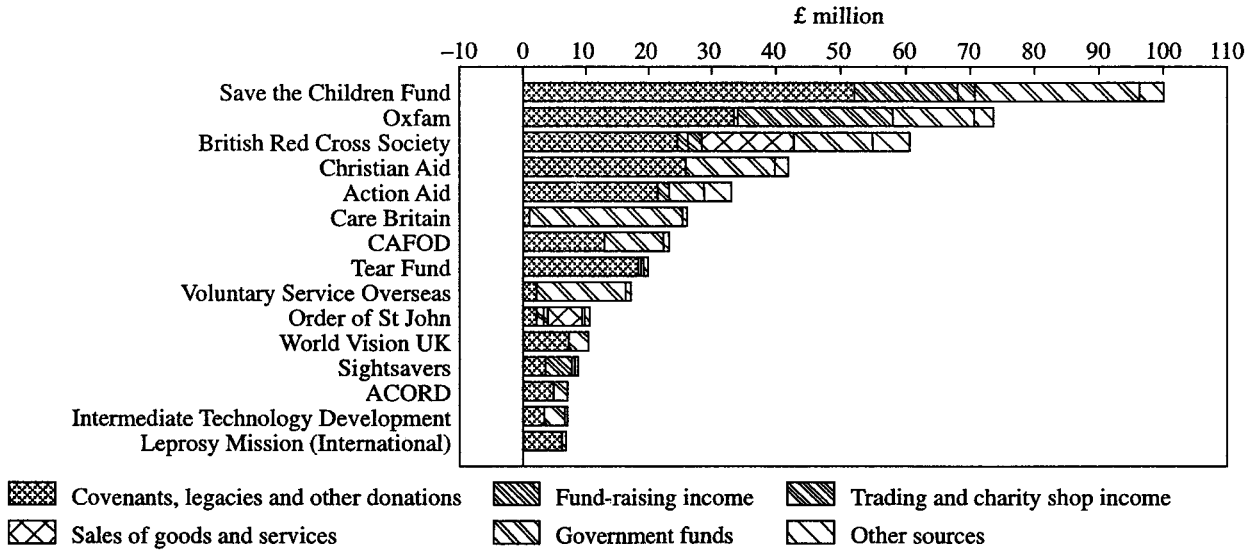
Source: Derived from Brophy and McQuillan (1993).

Table 8.5 Sources of funding for 15 major UK-based INGOs

NGOs	*Sources of income in £ million*						
	Total income	*Donations*		*Sales*		*Government (EC and UK) funds*	*Other*
		Covenants, legacies, other donations	*Fund-raising income*	*Trading charity shop income*	*Sales of goods and services*		
Save the Children Fund	99.6	51.6	16.7	2.5	0.0	26.0	2.8
Oxfam	73.3	34.1	0.3	23.5	0.0	13.1	2.3
British Red Cross Society	60.7	24.6	1.6	2.2	14.6	12.0	5.7
Christian Aid	42.1	26.4	0.0	0.0	0.0	13.6	2.1
Actionaid	32.9	21.6	1.5	0.1	0.0	5.5	4.3
Care Britain	25.4	0.7	0.1	0.0	0.0	24.3	0.2
CAFOD	23.2	12.7	0.0	0.0	0.0	9.5	0.9
Tear Fund	19.7	18.7	0.0	0.2	0.0	0.2	0.6
Voluntary Service Overseas	16.3	1.4	0.2	0.0	0.0	14.1	0.6
Order of St. John	10.3	2.3	0.9	0.4	5.6	0.2	0.9
World Vision UK	10.0	7.0	0.0	0.0	0.0	3.0	0.1
Sightsavers	8.0	3.6	3.9	0.1	0.0	0.2	0.3
ACORD	6.6	4.6	0.0	0.0	0.0	1.9	0.1
Intermediate Technology Development Group	6.4	3.1	0.0	−0.1	0.0	3.2	0.2
Leprosy Mission (International)	6.3	5.9	0.0	0.0	0.0	0.0	0.5

Source: Derived from Brophy and McQuillan (1993).

Figure 8.3 Sources of funding for 15 major UK INGOs



Source: Derived from Brophy and McQuillan (1993).

Table 8.6 Sources of funding for 15 major UK-based INGOs as a percentage of total

NGO	*Sources of income as percentage of total*					
	Donations		*Sales*		*Government (EC and UK) funds*	*Other*
	Covenants	*Fund-raising income*	*Trading charity shop income*	*Sales of goods and services*		
Save the Children Fund	51.8	16.8	2.5	0.0	26.1	2.8
Oxfam	46.5	0.4	32.1	0.0	17.9	3.1
British Red Cross Society	40.5	2.7	3.6	24.1	19.7	9.4
Christian Aid	62.7	0.0	0.1	0.0	32.2	5.1
Actionaid	65.5	4.5	0.3	0.0	16.7	13.0
Care Britain	2.7	0.4	0.0	0.0	95.9	1.0
CAFOD	54.9	0.0	0.0	0.0	41.1	4.0
Tear Fund	95.1	0.0	0.9	0.0	1.0	3.1
Voluntary Service Overseas	8.8	0.9	0.0	0.0	86.7	3.6
Order of St. John	22.3	8.8	3.8	54.3	2.1	8.8
World Vision UK	69.6	0.0	0.0	0.0	29.7	0.7
Sightsavers	44.9	48.8	0.8	0.0	2.2	3.2
ACORD	69.2	0.0	0.0	0.2	28.6	2.0
Intermediate Technology Development Group	47.9	0.0	–1.6	0.0	50.1	3.6
Leprosy Mission (International)	92.8	0.0	0.0	0.0	0.0	7.2

Source: Derived from Brophy and McQuillan (1993).

covenants, which has advantages in terms of tax benefits and stability of funding and other donations, whilst Sightsavers raises nearly half of its income from fund-raising activities. Legacies are not yet a major source of income for most UK aid INGOs. Corporate donations are less significant. This was demonstrated by a survey carried out in 1993.[20] With the

exception of SCF, corporate donations are not a major source of funding for such INGOs. The survey indicated that less than 3 per cent of total corporate donations go to international agencies; the researchers suggest that corporate donations are targeted at local community projects and as such not internationally. This suggests that donations from companies in developing countries, in the future as their economies grow, may be a significant source of funding for CYNGOs.

In order to generate future donations, it is important for NGOs to invest in fund-raising activities. As we have seen, this can be a sensitive issue if the level of investment is regarded by the general public as excessive. In fact for many NGOs the proportion of funds going into such activities is relatively small, as Table 8.7 shows for the 45 banded INGOs. There is a slightly higher level of resources devoted to fund-raising in the larger INGOs.

At the individual level, however, there are significant differences between organizations, as Table 8.8 shows for the selected UK INGOs. Variations range from no expenditure by ACORD through less than 3 per cent for Leprosy Mission and VSO to 22 per cent for Sightsavers.

For other NGOs, trading is a major source of income. Oxfam, for example, raises nearly a third of its income from trading activities, with a network of UK shops and a mail order business.

The third group of funding sources is government. Government funds are significant for many of the large INGOs, as Table 8.6 shows, with over half of these receiving more than 25 per cent of their income from government (including European Union) sources. However, again there is a range of significance, with, at one end, NGOs such as Leprosy Mission, Tear Fund and Sightsavers receiving very little government funding. At the other extreme government funding (including both UK and EC funding) is the major source of funding for Care Britain and VSO, which receive 96 per cent and 87 per cent respectively from government sources.

Government funding is increasing for UK-based INGOs. In the period between 1977 and 1991 private grants to international organizations increased from £29 million to £215 million whilst government grants increased from £0.8 million to £32 million, the latter growing five times as fast.[21] Such funding may come in a variety of forms. These include the Joint Funding Scheme (JFS), including block grant funds, funding for specialized volunteer agencies and for disaster relief and EU funding. The most common is the ODA's JFS in which government funding of up to 50 per cent of the total costs (and more in the case of projects in the family planning and population) may be obtained. Despite the growth of funding under the JFS it is currently significantly over-subscribed. For example,

Table 8.7 Main categories of expenditure for top 45 UK-based INGOs by band

NGO	*Expenditure in £000s*				*Expenditure as percentage of total*		
	Total expenditure	*Charitable*	*Fund-raising*	*Admin. and general*	*Charitable*	*Fund-raising*	*Admin. and general*
Top 15 INGOs	421.6	361.3	40.7	19.6	85.7	9.7	4.6
Second 15 INGOs	49.0	41.6	3.3	4.1	84.9	6.8	8.3
Third 15 INGOs	9.9	8.0	0.7	1.2	80.9	6.9	12.2

Source: Derived from Brophy and McQuillan (1993).

Table 8.8 Main categories of expenditure for 15 major UK-based INGOs

NGO	*Expenditure in £ million*				*Expenditure as percentage of total*		
	Total expenditure	*Charitable*	*Fund-raising*	*Admin. and general*	*Charitable*	*Fund-raising*	*Admin. and general*
Save the Children Fund	93.7	84.1	7.5	2.1	89.7	8.0	2.2
Oxfam	72.3	56.5	12.0	3.8	78.2	16.6	5.2
British Red Cross Society	56.8	48.5	5.7	2.6	85.4	10.0	4.5
Christian Aid	38.8	34.2	3.7	1.0	87.9	9.5	2.6
Actionaid	30.0	25.2	2.7	2.1	83.9	9.0	7.1
Care Britain	25.3	24.2	0.4	0.7	95.7	1.7	2.6
CAFOD	22.9	21.7	0.8	0.4	94.9	3.3	1.7
Tear Fund	19.2	15.8	2.1	1.3	82.3	11.1	6.5
Voluntary Service Overseas	16.0	14.5	0.3	1.2	90.4	2.0	7.6
Order of St. John	10.3	8.6	0.9	0.8	83.2	8.9	7.9
World Vision UK	10.0	7.5	2.0	0.6	74.4	19.5	6.1
Sightsavers	7.2	4.6	1.6	1.0	62.9	22.7	14.4
ACORD	6.6	5.8	0.0	0.8	88.2	0.0	11.8
Intermediate Technology Development Group	5.8	4.5	0.8	0.5	77.5	13.8	8.7
Leprosy Mission (International)	6.6	5.7	0.2	0.7	85.9	2.8	11.3

Source: Derived from Brophy and McQuillan (1993).

Table 8.9 The share of official aid going to NGOs: selected donors

Country	*% of official aid channelled to NGOs*	*Year*
Sweden	30	1993/4
Switzerland	29	1994
Norway	25	1992
Canada	14	1992
Netherlands	10	1993
USA	9	1992
Germany	7	1992
Finland	6	1993
Australia	6	1993/4
UK	4	1993/4
Japan	1	1992

Source: ODI (1995).

in 1991 over £10 million of projects which were considered worthy of support were not funded due to a shortage of funds.[22] Five UK international agencies (of which four, Christian Aid, CAFOD, Oxfam and SCF, are active in the health field), are also beneficiaries of a particular set of arrangements known as the block grant scheme,[23] which effectively allocates approximately half of the JFS funds to these NGOs allowing them a fast track mechanism for approval of projects.

In addition to the JFS, NGOs may access similar forms of funding from the EU, though at present this is not a major part of funding.

This increase in importance for official funding is not unique to UK-based NGOs. OECD figures[24] suggest that around 5 per cent of aid is channelled through NGOs. However, Table 8.9 shows marked differences between donor agencies.

The importance of official funding for NGOs also differs between countries, as is shown in Table 8.10.

The two last categories of government funding for UK-based INGOs are for specialized volunteer agencies such as VSO and for specific disaster relief programmes. A number of volunteer agencies in the UK have always relied heavily on government funding. Indeed, one of these, VSO, is the UK charity with the highest level of statutory income (87 per cent) as a percentage of total income.[25] Disaster relief programmes increasingly involve NGOs acting as agents for the UK government. In 1990/1 nearly 30 per cent of such government aid was channelled through NGOs, compared to less than 1 per cent in 1980/81.[26]

One of the difficulties with voluntary funding facing such NGOs is

Table 8.10 The share of total NGO income derived from official funds: selected donors

Country	*% of total NGO funds obtained from official aid sources*	*Year*
Sweden	85	1994
Belgium	80	1993
Italy	77	1991
Canada	70	1993
USA	66	1993
Australia	34	1993/4
Austria	10	1993
UK	10	1993

Source: ODI (1995).

the volatility of donations related to high profile disasters. In 1984/5, for example, SCF's income rose from £16.5 million to £40 million as a direct result of the disaster in the Horn of Africa.[27] There is a recognized danger that such volatility can result in later financial problems due to over-commitment.

IMPLICATIONS

The implications of the above are significant on a variety of fronts, and we now turn to an examination of four of the most important of these, the sustainability of funding, external pressures related to funding mechanisms, internal pressures on an organization and effects on aid to governments.

Sustainability

One of the strategic concerns facing any NGO is the sustainability of their funding and hence their activities. In contrast to government which, through its tax mechanisms, is assured a minimum level of funding (though recession and policies such as Structural Adjustment may have serious effects on this), NGOs are reliant on sources of funding over which they have little direct control. For INGOs donations may be linked to particular appeals which can lead to difficulties in long-term planning. As we have seen, in contrast to NGOs from wealthier countries with access to donations,

the main forms of funding for many developing country NGOs operating in the health sector are user charges, grants or contracts from governments, donor agencies or international partner NGOs. Of these, the introduction of user charges is a seemingly attractive option for those organizations which are involved in direct service provision. If successful, it provides a long-term source of controllable funding. However, one of the features that distinguishes an NGO from the private-for-profit organization is a concern for equity. Such concerns inevitably limit the level and breadth of charges which NGOs are prepared to levy with consequent implications for the level of cost recovery. As such, by itself, user charges are unlikely to provide reassurance regarding sustainability. As Diskett and Nickson put it:

> recent experiences in the health sector[28] support Oxfam's own observations that some degree of self-financing which reduces dependency on donors and governments is necessary, but total self-sufficiency or self-financing is neither possible in the current economic climate nor desirable, because higher charges would be needed, which would penalise too many people. This is not compatible with the aim of equity, on which the whole philosophy of primary health care is based.[29]

It is evident, therefore, that for many developing country health NGOs, the prime source of funding is likely to be through the provision of grants or contracts by external agencies. Whilst NGOs may be able to negotiate long term support (particularly from partner NGOs), such relationships bring with them both a degree of uncertainty about long term prospects and, more importantly, potential restrictions on operation. The price for sustained support may therefore be some loss of the independence that is often viewed as one of the NGO sector's important features, and it is to this that we now turn.

External Pressures

Elsewhere we suggest a number of reasons why donor agencies, and indeed government, may be interested in supporting the NGO sector through either non-specific grants or more commonly through contract funding for specific projects. This interest, which has led to increased levels of funding, also carries with it a requirement that, to varying degrees, the operations of the recipient NGO are consonant with those of the donor, thus creating pressures on the NGO and limiting its freedom to act. Where

NGOs have resisted such policy pressures donors may withdraw funding. A famous example of this was US funding for the family planning organization, IPPF, which was withdrawn on the grounds that the organization would not commit its members to refusing to carry out abortions. Elliot (quoted by Kobia in van der Heijden) sums up the situation as: 'Many NGOs depend on right-of-centre money, while acknowledging the need to apply the funds to left-of-centre objectives; there is hardly a major development agency that in one form or another does not face the starkness of this contradiction'.[30] Some NGOs recognize this and face it explicitly. For example, SCF states:

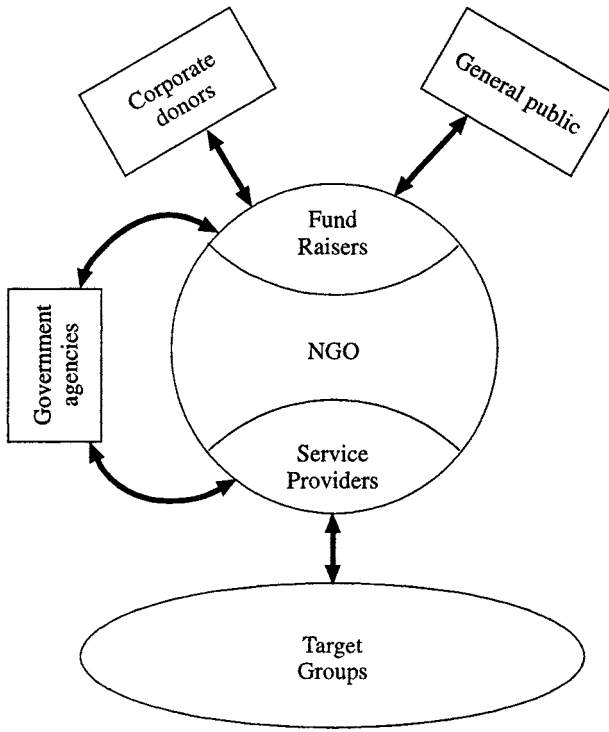
> SCF values and strives to preserve its independence as a non-governmental organisation, which allows it the freedom to act in all cases only with regard to the Rights of the Child. This independence is exercised as much with regard to sources of funding as to the nature of programmes.[31]

Internal Pressures

The third area of concern arising from the funding patterns and pressures relates to internal organizational pressures. Unlike the private sector, where the funding is derived from the service recipient, NGOs are likely to derive a significant proportion of their funding from a third party. This creates organizational tensions as the section of the NGO concerned with fund-raising has different immediate objectives to those on the service provision side of the organization. The different relationships externally are shown diagrammatically in Figure 8.4.

This has led, in a number of organizations, to clashes between the fund-raisers and service providers. The former, for example, may wish to portray the organization in a manner that is perceived as maximizing its donor attraction (either to agencies or individual donors). This may lead to pressure to reduce radical advocacy activities in order not to alienate donor agencies, or to present images of development which are perceived as being conducive to maximizing public donations but which are viewed by service providers as being inaccurate and counter-productive in development terms. Examples of emaciated children may result in donations, but may not help the general public to understand the reality of the causes of under-development or the development process. It may also lead to pressure to accept contracts for projects that are not seen as priorities by the service providers or field staff.

Figure 8.4 Sources of internal tensions within NGOs around funding and service provision



Effects on Aid to Governments

As we have seen, governments in the North, operating both through bilateral donors, or through multilateral donors in concert with other governments, are increasingly channelling funds through NGOs. This has significant implications for developing country governments at a number of levels.[32] First, they may be concerned and even feel threatened by the growth in the size of the NGO sector. As we discuss later, such concern may arise from a recognition of a fragmented and unco-ordinated NGO sector but may also reflect the less legitimate concerns by undemocratic regimes over the growth of the civil society. Concerns may also stem, understandably, from a government's own reliance on aid and a recognition of the opportunity cost that increased funding to NGOs inevitably represents.

SUMMARY

For NGOs, one of the critical issues that faces them is how they can resource their activities in a manner that it sustainable and consistent with their objectives. This chapter has outlined the main forms in which NGOs seek their funding, and has illustrated with data from Zimbabwe and the UK some of the issues that face NGOs in their attempts to juggle their desire for a long-term perspective (with accompanying sustainable funding) with the reality of short-term funding patterns.

9 External Accountability: A Neglected Dimension?

The term 'accountability' increasingly is used in the context of NGOs. However, rarely is it defined. This could be mere oversight, but we would suggest that it is more likely due to the difficulty of locating NGOs within the normal paradigms of accountability. For example, it is a basic expectation that *all* governments should be accountable to their electorate. Similarly, it is expected that private-for-profit organizations should be accountable to their share-holders. In these situations the various actors are clearly identified and common to all governments or for-profit organizations. By contrast, NGOs as organizations have no inherent requirement to be accountable either within a political or a market environment, and have no common or obvious external stakeholder. Whatever requirements do exist for NGOs to be externally accountable are usually situationally-specific and involve a variety of different stakeholders. Donors, clients or consumers, governments and the public can all claim to be NGO stakeholders. These various differences have two main consequences: first, a very loose usage of the term 'accountability' and, second, an inability to use the term consistently between dissimilar organizations.

This chapter will focus on external accountability. For its purpose we would define accountability as *an obligation or requirement to give an explanation for all actions taken, including, but not restricted to, the use of resources.* Such a process cannot be enforced retrospectively as it requires the prior identification of the person or organization with a right to call for an account. Day and Klein[1] suggest a similar identification of who owes a duty of explanation and against what standards the explanation is required.

THE CONCEPT OF ACCOUNTABILITY

One possible reason as to why there would appear to be little consensus as to the meaning of accountability is that it is a rather elusive, multi-dimensional concept. Accountability can be assessed according to three main aspects. These are financial, organizational and technical/operational accountability. Each of these can be considered either singly or in combination. In its most basic and limited dimension, financial accountability can

relate simply to giving some form of report for the use of money received; operational accountability relates to the relationship between the organization and its stakeholders, and technical/operational accountability relates to the services provided or activities carried out.

Financial Accountability

Financial accountability is probably the most widely understood interpretation of the concept of accountability, but it is also its most basic and limited dimension. It is concerned with giving some form of statement for the use of money received and is limited therefore to what can be recorded on a balance sheet or inventory. Such a report is presented therefore in quantifiable terms, often with little or no explanation as to why specific actions have been taken. Thus financial reporting in most cases merely reflects the disbursement of funds rather than *how well* it has been spent or *why* it was spent in a particular way. Because of this limited focus there is a danger of over-concentration on identifying the diversion of funds to 'wrong' purposes which does not allow for any questioning as to whether the original purpose was the 'right' one.[2] Another drawback is that such reporting does not include an assessment of the use of time, skills and other resources, against either the pursuance of known objectives or standards of efficiency and effectiveness other than an ability to spend money.

Organizational Accountability

In the NGO context, this relates to being externally accountable as an autonomous organization. This may involve multiple levels of accountability to a number of different stakeholders, as is discussed in more detail later in the chapter. At this stage we concentrate on issues of policy and planning and thus only discuss NGO accountability to the State and to the general public.

To the State

NGOs need to be organizationally accountable to the State within a legislative framework in two main respects. First, NGOs need to ensure that they conform to broad legislation covering issues such as health and safety, conditions of employment, equal opportunities, foreign exchange and taxation. Such requirements may be generally applicable to all organizations irrespective of their type. Second, they need to ensure that they are conforming to the specific requirements of their organizational status (for

instance, as a charity, trust or welfare organization) both in the country in which they are registered and where they are operating. This might, for example include the conditions of their governing instrument such as the composition of their board. Accountability to the State is situational, depending upon the legal framework existing in each country.

Whilst it can be argued that NGOs, as organizations operating independently of government control, should not be accountable to the State, we do not, in general, agree. At times, and with regard to particular issues such as human rights, NGOs may feel that it is necessary to oppose the State. However, if they are to retain their organizational legitimacy their actions must be within the existing national legislative framework. In addition, to maintain their 'non-governmental' status they must ensure that their activities are apolitical[3] (that is, distinct from those associated with oppositional politics).

Difficulties, of course, can occur with regard to NGO accountability where legislation is specifically drafted or manipulated to limit NGO activity, or where non-democratic processes or policies are present. Our endorsement of NGO accountability to the state would exclude situations where these occur. Indeed, in such circumstances NGOs may have a very particular oppositional role to play with regard to the political situation, as has been demonstrated in a number of countries, especially in Central and South America. Such roles include consciousness-raising and alternative care provision.

To the general public

Within a democratic society the concept of 'political accountability' implies an assertion that the authority and power of the political office is derived from the people and can thus be removed by the people. Political accountability seeks to ensure that public authorities remain responsive to both the substantive and procedural needs of society.[4] However, in contrast to the public sector, there is a marked absence of formal mechanisms through which NGOs are directly accountable to the general public. This is the case not only for CYNGOs but also for INGOs who potentially have two sets of general public (those in their own home country and those in the country in which they are operating). It is this lack of accountability to the general public that makes donor support for NGOs, on the basis of their widely acclaimed ability to enhance democracy and increase plurality, slightly ironic.

As autonomous organizations, with decision-making processes independent of government control, NGOs have three potential sources of linkage

with the public at large. If they are organizations which have some form of membership or encourage the involvement of volunteers, then they will have direct links with these people. However, these links are based upon the desire of these individuals to be associated with the NGO and therefore at best are unstructured and tenuous. Second, they also may have links with the individuals who provide contributions on a voluntary basis. This group is even more fluid than the first, for though many of these people may donate loyally over a long period of time, their continued support is by no means certain, and indeed many may make only a one-off contribution in response to a particular appeal. This type of popular support cannot be compared with government links to the electorate as it is only where NGOs are heavily dependent upon voluntary contributions that they have any pressing commitment to ensure that they have a visible public profile. The third link is with individuals, groups or communities to whom the NGO may directly provide services or whom it may seek to represent. These are again likely to be unstructured, as is evident in most types of service provision. Unless NGOs, or indeed any service-providing organization, actively seeks to maintain contact with clients or customers, links are usually very tenuous and feedback limited.

Technical and Operational Accountability

Most NGOs may accept the need to conform to government imposed procedures such as registration, not least because of the benefits such as tax concessions that registration often brings. However, they may be less willing to accept the suggestion of NGO accountability to government for the actual technical or operational activities. Yet, if quality services are to be provided with due regard for equity, access and without unnecessary duplication, then such collaboration is necessary. Theoretically this could be carried out by a CYNGO, but in practice is probably best done by national government, not least because of their national coverage, access to information and also their responsibility for maintaining standards of care. Where NGOs were providing services complementary or supplementary to those provided by the public sector, the practical application of such accountability would probably include an expectation that NGOs would:

(a) work within national sectoral policies;
(b) plan and implement services in consultation with government; and
(c) provide a satisfactory degree of professional competence and quality.

There is a danger where NGOs attempt to ignore the State, not only for governments but also for the NGOs themselves. Such situations fail to provide opportunities for mutual support, such as the exchange of information or ideas. Even where NGOs find it possible independently to run a parallel system, most NGOs have neither the resources to replicate the State's nation-wide provision nor the legitimacy of its public mandate. Nevertheless, given the independent nature of NGOs, it is not surprising that there are many reports of NGOs operating in complete isolation from government. However, although such independent activity may be the active choice of the NGO, this is not always the case. There are a number of reasons why such situations may have occurred, often reflecting government inactivity rather than as a result of deliberate NGO policy. These include the following situations.

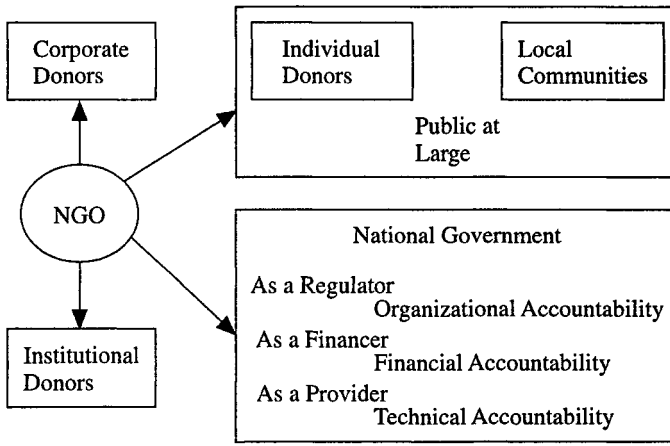
- An absence of mechanisms through which NGOs *can be* accountable
- Accountability mechanisms exist but are neglected and not enforced
- Governments actively choose, possibly in emergency situations, to rescind accountability mechanisms
- Accountability is organizational and does not extend to technical and operational issues
- NGOs actively choose to oppose the State

EXTERNAL STAKEHOLDERS

We have already recognized that NGOs have many external stakeholders to whom they may feel or need to be accountable. These are demonstrated in Figure 9.1.

Accountability is not divided clearly either between organizational and technical forms or amongst the various categories of stakeholders. The degree of involvement and commitment of the various stakeholders also may differ, with no single model. Given our definition of accountability as an obligation or requirement to give an explanation for actions taken, then it follows that this must involve arrangements between at least two different parties and the recognition of a certain set of rules or previously agreed expectations about the acceptable level of response. Such previously agreed rules are especially important for NGOs with multiple external stakeholders. Each of these stakeholders can be expected to have different perspectives on the '*for what and to whom*' questions and their own particular sanction over the NGO, such as the withdrawal of funds, or removal of permission to operate.

Figure 9.1 NGO external stakeholders



Whilst organizations might wish to be equally accountable to all their stakeholders, this is not practical and priorities have to be set. Clark[5] suggests that perhaps the first priority for NGO's management boards should be their responsibility to the government. This is particularly important where the requirement of accountability, such as the submission of annual financial accounts, is obligatory as a condition of registration.

With so many stakeholders, it is therefore critical for NGOs to identify the individual or group to whom to give account, at each level. This is not easy, as most NGOs are seeking to meet multiple goals and respond to the often conflicting yet simultaneous requirements of stakeholders. Such a situation leads Knight[6] to suggest that many voluntary organizations are 'effectively responsible to no one' because of their multiple stakeholders, except perhaps internally to their board or management committee. This, of course is unlikely to impose the ultimate sanction of closure.

We now examine in turn each of the potential stakeholders.

Institutional Donors

Whether multilateral or bilateral aid agencies, government departments, or large INGOs, most donors are usually unable, partly for logistical reasons, to monitor regularly the activities of every NGO project or programme to which they provide funding. They also need to have measures of achievement that are comparable between projects and indeed between

very different situations and locations. In addition they themselves may be required to be accountable to other government agencies or other funding bodies, usually having to demonstrate only that they have obtained 'value for money'. In order to meet these various requirements, and because of the relative remoteness of donors from day-to-day activities of the NGO, most donors use the strict regulation of expenditure as a mechanism for ensuring NGO conformity to project agreements.

For most NGOs, and especially those with a high degree of donor funding for project activities, maintaining the requirements of donors for accountability, especially financial accountability, is in itself a major activity. Indeed, in some cases, it may be seen as the NGO's first priority within the project agreement. This apparent over-concentration on financial accountability by donors is perhaps understandable, and may even be welcome to some organizations. However, it also can be frustrating and may create specific difficulties for recipient NGOs, not only reducing their organizational sustainability but also the quality of their accountability to clients and communities.

First, whilst donors place heavy demands on NGOs for regular monitoring of the flow of project funds, they may be less concerned with more detailed activity reporting, or the capacity of the NGO to meet non-financial project outcome targets. This is frequently relegated to periodic evaluations, often only at the end of a project cycle. Whilst this approach may result in reports of satisfactory fund disbursement, because it neglects other aspects of project activity, it may not achieve satisfactory levels of operational effectiveness. Such a situation has led observers to conclude that, for some donors, 'the disbursement of funds is often more important than putting funds to effective use'.[7] Second, NGOs are usually unable to respond quickly to changes in local conditions. This is because there often can be a considerable period between the submission of project requests and the receipt of funding. Furthermore, once projects are agreed, NGOs are restricted to the financial structures of particular project agreements.

There is a major exception to this donor pattern. That is where donors are national governments, such as through the subvention of church hospitals practised in a number of African countries. In such a situation, NGOs are accountable to their donors at a number of different levels. At one level, because governments themselves are accountable through their public mandate, they legitimize the role of NGOs in carrying out the funded activities. At another, NGOs are also organizationally accountable to the government through the system of regulation. Finally they are technically and operationally accountable to the government for the quality of service provision.

Individual and Corporate Donors

Where donations are made directly to the NGO by corporate supporters such as local businesses, apart from the provision of a receipted acknowledgement, there are rarely any formal accountability mechanisms. In the case of smaller donations from individuals, the means by which the NGO maintains its accountability is likely to depend upon the availability of resources. Many do not provide even the receipted acknowledgment of donations, and the provision of detailed information to and the seeking of consensus from such a large and diverse group of supporters requires considerable time and money. This level of expenditure may be disproportionate to the potential benefits received. However, NGOs do need to consider the degree of their dependence upon such voluntary public support. Where such dependence is minimal – for example, because of a high level of donor funding – this may reduce, although not obliterate, the apparent need for the provision of public information. However, where dependence is high, NGOs often have no option but to divert a large proportion of their voluntary income to such activities. Unfortunately, where the necessity for such activities is not fully appreciated, NGOs can be criticized for such expenditure.

Local Communities and the Public at Large

Unlike national government agencies, which would be expected to relate to existing State power structures, NGOs have a distinct advantage in being able to develop innovative accountability mechanisms with the public. Although many NGOs are acclaimed for their work at the grassroots level and their participatory approach to service delivery and development, there is little evidence of such mechanisms. One exception would be work on participatory evaluation. However, apart from this, little has been recorded concerning their own accountability to specific client groups or target communities. Even less has been recorded regarding their accountability to the public at large. This is an area of concern, and is perhaps indicative of an implicit and rarely articulated aspect of accountability, its association with sanctions. Client groups, communities and the general public are all limited in their ability to impose sanctions on NGOs and may therefore frequently be omitted from accountability mechanisms.

In the health sector, despite the acknowledged desirability of accountability to local communities, this is rarely achieved. Active participation in health care is notoriously difficult to achieve. It may, for example, be difficult because a large proportion of health facility clients are drawn

from a very wide geographical area and not from local communities. Even where local advisory committees have been established, they may not be able to represent local opinions fully, especially if they do not do not involve less powerful groups, or have an appropriate gender balance.

It has been suggested that NGO accountability to communities can be maintained more through attitudes and approaches than visible mechanisms. Carroll[8] suggests that a degree of technical accountability is possible without formal mechanisms, such as committees or board membership, if sensitive and respectful attitudes in informal day-to-day interactions with clients are practised. One suggestion is for NGOs providing services to have a code of ethics, understood and practised by all members of the organization. Individual items could include, for example, punctuality, quality standards for communication between staff and clients and between direct service providers and those responsible for management.

National Regulators, Policy-makers and Service Providers

NGO relationships with national governments cover a number of functions. Governments not only are regulators but are also planners, policy-makers and service providers. NGO accountability to national governments needs to be considered on two levels, their accountability as an organization and their technical accountability for operational activities.

Organizational accountability to national governments

As discussed earlier, NGOs need to ensure that they are conforming to the limits of their declared status as understood within the legislative framework of the country in which they are registered, and also any other countries in which they operate. Most countries have legislative requirements for groups of people wishing to associate together for a formal purpose. Examples include Charity Law in the UK and many other similar statutes throughout the world. One major weakness of this type of legislative accountability is that it is usually focused on the internal workings of the organization, its finances and powers rather than its activities or impact, except where these are seen to exceed the organization's mandate, such as political activism. Another limitation of organizational accountability at national level is that whilst CYNGOs only have to work within the framework of a single State, INGOs may have to work within a number of such frameworks, including that of their country of registration.

Where NGOs are known to be recipients of bilateral or multilateral donor funding, difficulties can arise between national governments and

NGOs, especially where national governments do not have mechanisms for ensuring the organizational integrity of externally registered organizations. This frequently creates distrust and suspicion between governments and NGOs. Conversely, where national governments attempt to develop organizational accountability mechanisms to regularize their relationship, they may be met with opposition and accused of rigid bureaucracy. For example, it is reported that the Live Aid organization was unable to accept the registration regulations laid down by the government of Niger[9] and therefore did not carry out activity in that country. Increasingly mechanisms for organizational accountability are being developed. Examples of these are the NGO Bureau in Bangladesh which seeks to be the key linkage between NGOs and government departments, or the NGO Board set up by the Kenyan government in collaboration with NGOs.

Technical accountability to national governments

Whilst many governments enforce some form of financial and organizational accountability, few have established any kind of mechanism for technical accountability of NGOs. There would seem to be two reasons for this.

- The ambiguity of the NGOs' position between the State and private-for-profit organizations, especially in the area of service delivery
- The contentiousness of the issue, especially in terms of NGO autonomy and much vaunted independence from governments

However, there would seem to be an increasing consensus that such accountability is a vital ingredient to NGO success. Several writers suggest that even governments classified by outsiders as 'bad' do have some 'good' departments with which NGOs can work.[10] This realization has come about as a result of practical evidence of situations where NGOs have not been required, or have been allowed to refuse, to be accountable for their activities to national governments. In such situations, although the outcomes appear to be satisfactory in the short term, these have tended to develop long term negative consequences. For example, a situation is reported in Kampuchea where, although NGOs did try to work through government institutions, the long-term impact and sustainability of their situation was secondary to their need to maintain a distinctive individuality at operational level:

> during the emergency period, thousands of irrigation pumps were imported into the country by the international organizations and NGOs . . .

> and though each organization ought now to know better, each one opted to import its preferred brand of pump. Some NGOs were constrained by the donating agency . . . others chose a different brand of pump for visibility's sake, and so that they could easily identify the pumps which *they* had donated . . . and so on.[11]

The results of such independent action are obvious and perhaps similar to Hanlon's[12] description of the role played by INGOs in Mozambique. Similar experiences are reported from the health services sector, where donors are able to provide large scale financial inputs, including equipment and drugs without government regulation or control.[13] Based upon experience in Burkina Faso, Twose[14] comments that, although most NGO work is useful, it will remain marginal unless it is integrated to some degree into the overall strategy of the State.

MECHANISMS FOR MEASURING ACCOUNTABILITY

We have argued that accountability must be measured against previously agreed expectations or standards. Thus the performance of private-for-profit organizations is primarily measured by a single criterion (that is, the level of return on capital), and the public sector's performance is likely to be measured by carrying out government policy or administering the law. However, NGOs are more likely to be measured against both their wider more altruistic purposes such as increasing the participation of the poor in decision-making, or improvements in health status, and their organizational performance. These are difficult features for NGOs to measure in quantifiable terms, and as a result are frequently substituted by proxy measurements such as financial statements.

Measuring Against Governing Instruments

There may be some general criteria against which NGOs have to be organizationally and technically accountable to external stakeholders: for example, the extent to which they engage in political activity, or the availability of annual audited accounts. However, the main measure against which NGOs are measured is their governing instrument. We have already suggested that one of the primary characteristics of NGOs is that they are formal organizations and that in most countries there are mechanisms by which organizations can set themselves up as such. A common feature of these mechanisms is a requirement that the organization develops, and

conforms to, some form of governing instrument, which sets out the objectives of the organization and how it should be run, especially in terms of the decision-making structures.[15] Typical examples would be:

(a) trust deeds;
(b) articles or memoranda of association;
(c) a constitution.

However, such an approach is not without flaws. First, for some NGOs these instruments are considered merely as administrative necessities for the purpose of registration, and obtaining the consequent benefits such as tax concessions. Because of this, during their formulation, little attention is given to their value as genuine instruments of accountability. A second concern is that even where advisory guidelines[16] for the development of such an instrument have been followed closely, in its final form the instrument is unique to the organization and its value directly related to the quality of its formulation. Third, whilst such an instrument is meant to enable an organization to maintain its original mission over time and with new personalities, it can lack the flexibility required to enable necessary alteration should circumstances change. The limitations of a specific governing instrument were discovered by Oxfam (UK) in the early 1960s when it attempted to move from famine relief into broader development work.[17]

Despite these difficulties and its obvious fragility, the governing instrument is the only available standard against which the activities of the NGO can be monitored by external regulatory authorities, such as (in the UK) the Charity Commissioners. This can be problematic, particularly where the motives of any NGO are not entirely honest. The existing systems in many countries, including the UK, may be slow to recognize this and probably even slower to react because they are passive rather than proactive. Thus much of the organizational monitoring of NGOs is dependent upon the vigilance of the general public rather than regular investigation.

Measuring Against Project Documents

Another measurement for external stakeholders is the documentation associated with projects. Ideally a project proposal would normally include some form of operational plan, project objectives and budget outline. In some cases this information may be represented, as some donors prefer, within a logical or project framework. Clearly such forms of measurement do not cover all aspects of NGO activity, but can be useful as an indicator for specific activities. This would be particularly useful for accountability to the project donor.

Measuring Against Publicity Documents

Actual or potential individual supporters are unlikely to have access to either the NGO's governing instrument or original project documents and are dependent therefore upon the NGO to provide them with information. This is limited in value as an accountability measurement as it is a rather one-sided process, rather than a joint activity. NGOs seeking further funding are likely to report only their successes, and not their failures. Alternatively, they focus on those facets that will encourage further support. As well as presenting a biased view, such a tendency can create tensions between NGO fund-raisers and field staff.

Other Qualitative Measurements

As we have seen, accountability, in its fullest sense, involves not only the presentation of audited accounts, minutes of meetings or a listing of activities (all of which can be easily reported), but also less tangible aspects of organizational performance. Activity-based quantifiable measurements, such as numbers of health committee meetings held or ante-natal attendance figures, merely address the issue of minimal achievement and do not consider issues of quality, or give any estimate of how accountable the activities were to external stakeholders such as clients or governments. Useful in this context are Johnson's[18] suggestions that external accountability should also include some recognition that the organization is avoiding the improper or excessive use of powers, demonstrating fairness and lack of bias on the part of those who take decisions, and ensuring adequate consideration of complaints. Johnson[19] also argues that there is a need to define accountability in terms of easily measurable outputs.

THE ROLE OF GOVERNING BODIES IN MAINTAINING ACCOUNTABILITY

Whilst there are differences between countries and also between organizations as to the name given to governing bodies, for simplicity we shall use the term 'board'. Boards are the final level of internal NGO authority, ultimately accountable for the protection and management of NGO assets, for ensuring that its purposes or objectives are fulfilled and for all other aspects of the NGO's conduct principally measured against its governing instrument.

There are several areas of weakness in this situation. First, as we have

already noted, many governing instruments often are drawn up with regard to the macro-level purposes and eligibility for registration. As such they may give little consideration to internal accountability issues of quality and efficiency, or major issues of external accountability such as national policy priorities in service delivery or local micro-level impact and community needs. Second, whilst most people recognize the need for a governing body, there is some disquiet as to the composition and selection procedures of many boards. Research with a sample of British voluntary organizations working in social welfare in the UK demonstrated that although election processes for board membership were established, in reality there was very little competition for places. Often, rather than other representatives of the NGO such as members or volunteer helpers, existing board members made nominations for new board members.[20] Finally, although in some countries there may be legal exclusions from eligibility for board membership,[21] there are rarely any positive requirements for board membership. Such a situation fails to ensure that board members are selected for the particular skills or expertise they bring to the organization. Indeed, on the contrary, there is some evidence[22] that board members may be selected merely to bring a level of probity or enhance the profile of the organization, and thus attract funding. All this is particularly worrying as the board is, in the legal sense, the 'owner' of the organization. Unlike public representatives, who can be relatively easily removed by the same processes that brought them to power, board members, selected without wide representation, are very difficult to remove.

SUMMARY

This chapter first defined our use of the term accountability, in particular the requirement of NGOs to be examined against previously agreed expectations about 'appropriate' conduct. It then examined various aspects of the concept and discussed the role of various external stakeholders and expressed concern that, because of their multiple stakeholding, NGOs may find themselves accountable to no one. The chapter looks particularly at the accountability of NGOs to national governments and identifies various mechanisms for measuring accountability. It concludes with a short discussion of the role of governing bodies. It is clear that both governments and NGOs need to pay greater attention to developing the processes by which NGOs can be externally accountable to their various stakeholders.

10 How do NGOs Need Strengthening?

We have discussed elsewhere[1] that much of the current interest in the role of NGOs is derived from a widely accepted, if largely unproven, thesis of NGO comparative advantage over government. This is usually associated with a number of frequently quoted and generalized positive attributes of NGOs.[2] The recent widespread promotion of NGOs as effective alternative service providers, especially within the health sector, is part of this assumed paradigm of inherent competence. What, however, is less frequently discussed is the unlikelihood of *all* NGOs possessing *all* of these attributes. Whilst any country-based assessment of individual NGOs is likely to identify individual examples of well organized and carefully managed NGO projects and programmes, there is little evidence to support claims that this can be generalized throughout the whole NGO sector, or for all types of activity. Unlike government agencies, NGOs cannot call upon the support of experienced civil servants. The large body of management theory and training available to the private-for-profit sector is inappropriate, and, until very recently at least, there has been no management theory developed specifically for the NGO sector.[3] Nevertheless NGOs have to balance the need to conform to their governing instrument and the altruism of their original organizational objectives with maintaining managerial legitimacy and the ability to respond to changing situations.

We use here the term *institutional strengthening* to refer to active intervention to promote the organizational development of individual NGOs. Elsewhere it may be alternatively expressed as capacity building, management strengthening or institutional development.[4] For NGOs it should include consideration not only of the basic aspects of management common to most organizations, such as policy and planning, human resources and finance management but also other aspects, peculiar to NGOs, such as maintaining their legitimacy and managing the general insecurity of their funding base.

Our experience and research[5] amongst NGOs in developing countries would indicate that, irrespective of their size or variety of activities, many NGOs would benefit from some degree of institutional strengthening. Furthermore, these would include not only newly emerging NGOs but also established NGOs as they respond to changes in their external environment. Such a situation is, of course, hardly surprising, given the complex

array of organizational type and operating environment of NGOs in the health sector. This chapter looks at the various components that need to be considered both by NGOs as they work towards their own institutional strengthening and by those who seek to assist them in the process.

NGO GROWTH AND DEVELOPMENT

Most NGOs first come into being as informal responses to particular unmet needs, driven either by internal (that is, self-generated) or external support.[6] It is not surprising that such groups, especially in their formative period, prefer to concentrate effort on activities in response to these needs rather than on developing tightly ordered systems. Where the situation is limited and the response required short term, most informal groups can function adequately without such systems, and are able to fulfil their obligations to supporters.[7] Many groups do not move further than this stage, and indeed may disband once the initial need is met. Such groups do not qualify, under our criteria, to be classified as an NGO.

Other groups, however, recognizing that the needs are longer-term and more extensive than their initial response, find themselves scaling up in activity, ultimately to become NGOs. Scaling-up can take a number of forms, including (Avina[8] suggests) increasing beneficiary coverage in the same location, increasing the number of services to existing beneficiaries or expanding into new locations. Whilst any group is small, communication and consensus between the various individuals involved is likely to be informal and relatively uncomplicated, especially as they are all likely to share a common commitment to the group's aims. Under such circumstances, more formal mechanisms, such as an organizational structure, are not required. When it becomes obvious that scaling-up or growth in activity is necessary, changes usually have to take place, and a more formal and structured organization emerges, such as an NGO. Specific action is needed to achieve this transformation.

First, informal structures and practices have to be tightened and more formal structures developed. For example, NGOs are likely to have to arrange for the formal appointment of leaders and managers, the selection of a board, the preparation of a governing instrument, and the setting of objectives (that is, the clarification of their mission). In order to maintain the integrity of the organization, attention must be given to ensuring that there is a clear understanding of accountability as *an obligation or requirement to give an explanation for all actions taken.* It is of vital importance that NGOs identify by whom the explanation is required and against what standards the explanation will be measured. Indeed the ability to respond

to these questions can be a useful indicator of NGO maturity, especially in emerging NGOs where there is the danger of powerful individuals, sometimes charismatic founders, attempting to control the organization.

Second, either because of the sheer volume of activity or degree of specialized knowledge required, many NGOs may have new personnel requirements. In order to meet these requirements, NGOs may have to move away from the use of unpaid volunteer staff towards the employment of more permanent paid staff. This relative reduction in the use of volunteers is likely to be gradual, incremental and specific to technical or professional positions. Where feasible, and certainly whilst the NGO is small, the overall aspects of maintaining and servicing the NGO as an organization – such as fund-raising – are likely to remain the responsibility of volunteers. The employment of staff can create tension between those who remain as volunteers, and are often wrongly perceived to be amateur, and those who are paid professionals. One particular potential area of conflict lies between paid professionals and lay governing boards.

Third, such scaling-up is likely to require additional external funding, through one of the mechanisms discussed earlier.

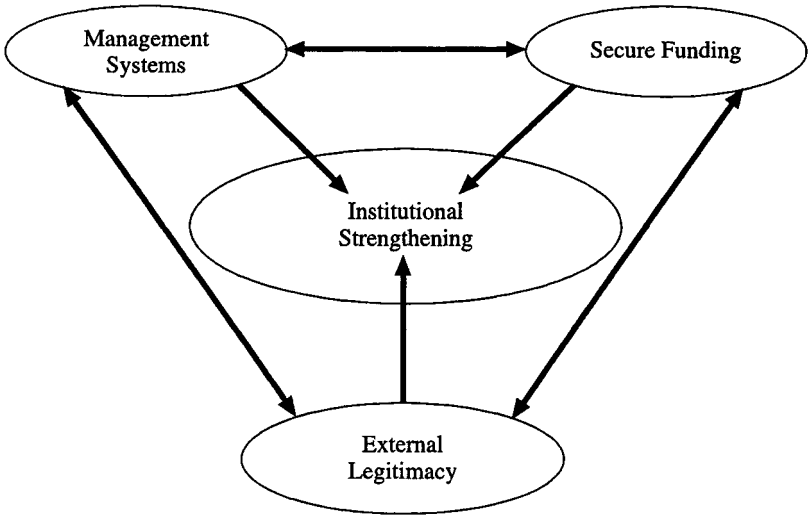
BASIC FEATURES OF NGO INSTITUTIONAL CAPACITY

In order to meet new demands, created either through growth or response to changing circumstances, NGOs have to pay particular attention not only to their activities but also to ensuring that they have sufficient institutional capacity to support their overall mission. From their study of INGOs in the UK, Billis and MacKeith conclude that: 'growth and change within non-profit making organizations is a highly complex process in which activities, mission, structure, governance and resources are knit together in a complex and mutually dependent web. Change in one aspect inevitably has knock-on effects on other aspects.'[9]

The main purpose of institutional strengthening is to enable NGOs to satisfactorily fulfil their particular mission. NGOs need to be flexible to new demands, respond to change, and yet maintain their voluntary ethic and autonomy. This is a complex issue for NGOs and can have major consequences. Korten[10] suggests that, for example, as its donor funding grew, IPPF was 'killed by money' because of the energy it had to expend on financial matters rather than on advocacy and innovation. NGOs need to develop their own approach, which would be different to, but drawing from, both the promotion of the 'social good' approach of the public sector and the management freedom of the private-for-profit sector.

It should not be a surprise to discover a close link between the features

Figure 10.1 Interdependent components of institutional strengthening



identified as contributing towards the institutional capacity of NGOs and those suggested as contributing towards their sustainability[11] as organizations. For example SCF(UK),[12] specifically considering the sustainability of health care in a developing country context, define it as 'the *capacity* of the health system to function *effectively over time* with minimum external input'. Mogedal[13] suggests that sustainability requires 'a match between activities and *capacity* to *maintain* them in a *given context* over *a period of time*'. The key issues are the importance of developing an adequate capacity to maintain an effective system over time in a given context. Three distinct but interdependent areas emerge as needing to be addressed in ensuring the ongoing operations of NGOs (see Figure 10.1).

- External legitimacy
- Secure ongoing programme funding
- Appropriate management systems

External legitimacy

The externally perceived legitimacy of an NGO and its activities is dependent upon a number of features. These include, though not exclusively, the

external accountability features of the NGO. In order to ensure their continuity as organizations, and to operate effectively in a given context over a period of time, NGOs have to demonstrate successfully to their external stakeholders that they are operating effectively and offering valuable service.[14] NGOs therefore have to give attention to their accountability as organizations. Such accountability involves a number of issues.

- Avoiding accusations of improper or excessive use of powers, or unfairness and bias on the part of those who take decisions
- Having locally appropriate objectives, and operational strategies which strengthen rather than weaken local structures and institutions
- Providing services which are valued by beneficiaries, users, local communities and possibly also by government officials

NGOs have to ensure that they have the capacity to maintain the continued endorsement and support, both formal and informal, from individuals in the community, local power structures and donors. Bratton argues that NGO managers need to concentrate on strategic issues of programme scope and external organizational relations because 'NGOs do not exist in a vacuum, but in a complex institutional environment with actors both more numerous . . . and more powerful . . . than themselves.'[15] These external stakeholders are broadly the same as those discussed in the chapter on accountability and fall into three groups: those who use the services or benefit from the activities of the NGO, those who support and donate to the NGO and those who regulate the NGO. The importance of the continued support of these various stakeholders in maintaining an NGO's ongoing capacity is outlined below.

NGO users and beneficiaries

If NGOs fail to convince users or potential beneficiaries that they are operating effectively and providing valuable services then such individuals are likely to take one or more courses of action:

(a) passively discontinue their use of the services;
(b) actively complain or agitate to improve service provision; or
(c) actively seek to have activities of the NGO discontinued.

Such actions are more likely to be carried out by individuals than by organised groups, and, whilst creating difficulties for the NGO, may be limited

in consequence. Nevertheless, discontinued patronage on a significant scale could have the potential of forcing the NGO to cease the activity, though this would be an extreme outcome. Active agitation, either for improvements or closure, would force the NGO not only to examine seriously its activities, but also to take some form of corrective action. Whatever the form or degree of such dissatisfaction, it should, even as a minimum response, result in the NGO assessing its total situation.

NGO supporters and donors

Individual supporters and donors are more likely to be concerned primarily with the activities carried out by the NGO rather than by its internal operation. An exception to this might be where there are severe problems, such as the misappropriation of funds. If supporters and donors are dissatisfied with the NGO activities they can choose between three main courses of action, which differ mainly in the time-scale and degree of impact.

- Suspend funding and/or support until changes are made by the NGO
- Not provide new funding and/or support beyond the existing contract
- Immediately withdraw funding and/or support without fulfilling the existing contract

The sanctions available to these stakeholders are more powerful and potentially more immediate than users and beneficiaries. Their intervention would require urgent corrective action by the NGO. However, because their relationships with the NGO are likely to be more formal and potentially more tangible and direct than those of users and beneficiaries, it is unlikely that such sanctions would be applied without some form of prior discussion or warning.

NGO regulators

The third group of external stakeholders is those empowered to regulate the NGO as an organization or to have technical oversight over some or all of the NGO's activity. This is usually a government department or agency. An NGO, for example, providing preventive or promotive health services, needs to maintain links with the local official responsible for public health as well as those responsible for NGO registration. If any of these regulators is dissatisfied with the NGO it could take some form of punitive action. Such action would depend upon the powers granted to them by

the particular legislation under which they operate, but would be similar to sanctions deployed by supporters.

- Enforcement of a temporary suspension of NGO activities pending change
- Refusal to renew the NGO's authority to operate beyond existing contract
- Total and immediate removal of the NGO's authority to operate

Secure Ongoing Programme Funding

We have discussed the advantages and constraints of the various sources of NGO funding earlier. Without secure ongoing programme funding it is difficult for NGOs to develop as strong organizations. Unfortunately, as Korten points out, there is likely to be some degree of conflict between the widely recognized donor priority of 'moving money'[16] and the NGO's need to build capacity. However, unless NGOs have the capacity to meet the demands placed upon them by their type of funding, the overall sustainability and local credibility of the organization itself can be at risk.

Smillie,[17] discussing the needs of a large African NGO, African Medical and Research Foundation AMREF (for which example one could substitute most NGOs), suggests that NGOs have a need for funding that is seen to contribute to the totality of an organization's activities. This concept of totality can be a particular problem for NGOs which are heavily dependent upon project funding. It is important that they have the capacity to work within the inherent drawbacks of the aid project approach. These drawbacks have been widely discussed in the literature.[18] External funders tend to favour project funding because projects are well defined and can be isolated from other activities.[19] Whilst this may be a positive factor for donors, it is not so for NGOs. Where NGO funding is primarily dependent upon time-limited resources, there is a number of constraints that have been identified as mitigating against institution building.

- Funds are provided only for project-related activities and not for wider organizational overheads
- Considerable time and effort is directed towards ensuring the continued availability of such funding and reporting on funds received
- Short term project cycles limit the ability to develop long-term strategic planning, policy-making and human resources

- Little opportunity exists to adapt plans as circumstances change and to make effective use of scarce resources

Over-concentration on individual projects for purely financial reasons carries the danger of displacing the original purpose for which the organization was formed. Less relevant projects may be undertaken primarily to secure funds, and other, more appropriate, projects are not developed because they are unacceptable to donors. Some NGOs, in order to counter-act such problems, impose a degree of self-regulation and limit the proportion of donor funding that they will accept.

Appropriate Management Systems

In view of the diversity of the NGO sector it would be unrealistic and inappropriate to suggest model management systems. Whilst there is a number of particular management-related issues which may concern NGOs more than other types of organization, they still need to operate within the basic management framework required of any good organization. These include policy-making and planning structures together with systems required for managing resources (financial, human and physical), logistics, information, monitoring and evaluation.

NGOs appear to have a number of difficulties in various aspects of their organizational management. Some NGOs are accused of improper or excessive use of powers, and of unfairness and bias on the part of those who take decisions. Others are accused of having objectives that are not locally appropriate, and of weakening local structures and institutions. Bratton[20] suggests that NGOs need to strengthen internal management procedures, in particular planning, programming, budgeting and financial control. From our own research[21] we discovered that many NGOs are reactive rather than proactive in their management.

Whilst many NGOs possess the basic features essential for external accountability purposes, this does not necessarily imply the existence of effective management tools. This could be due to a number of factors. First, some benefits, such as tax concessions, are available to NGOs only by conforming to registration requirements. NGOs usually are required, for example, to have a governing instrument and an audited annual statement of accounts. Thus NGOs have an incentive to ensure that these are available. Similarly, supporters and donors require evidence of NGO activities, and therefore NGOs produce annual reports, and promotional material. Third, the absence of management tools, such as written implementation plans and organizational charts, may reflect the emphasis on separate

activities (or projects) rather than on overall organizational functioning and policy-making. Short term project cycles do not always fit easily with long term strategic plans. Finally, these pressures combine to limit the ability of staff and/or the board to recognize the need to develop their management systems at an organizational rather than project level.

Without adequate and appropriate management systems, NGOs are unlikely to achieve their full potential as dynamic and proactive organizations. Knight[22] suggest that there are three challenges for management in the NGO sector. These are the need to:

(a) ensure achievement;
(b) maintain internal authority; and
(c) be externally responsive.

Particularly where service provision is involved, this requires that all staff within the organization have a clear understanding of their individual roles and responsibilities. This necessitates a clear structure for internal accountability and, as Day and Klein[23] suggest, requires those at the point of delivery to be carrying out well-defined tasks. They then can be answerable for the achievements of these tasks to a higher level of managerial responsibility. Appropriate management systems should enable the NGO to be responsive to change and local conditions, make effective use of scarce resources, and develop its human resource potential.

It is beyond the scope of this book to give an extensive account of all aspects of organizational management, but there are distinctive aspects of NGO management that need to specifically be addressed with regard to institutional strengthening. Whilst we shall discuss them separately, many of these features are interdependent.

NGO objectives

For management systems to be appropriate they need to be related closely to the objectives of an organization. Earlier we identified the external welfare-promoting objectives as being one of the primary characteristics of NGOs, pointing out that they must be consistent with not only the ends but also the means of the organization. For example, a hospital run by a private-for-profit organization would not fit our concept of an NGO because, although providing health care services, its motivation is primarily directed towards the creation of profit rather than social good. In addition, whilst a for-profit organization would be free to change its 'product' (for example, a hospital may decide to offer only facilities for plastic

surgery), an NGO is both constrained by its stated mission, and is limited in flexibility with regard to its means. This presents a particular challenge for an NGO in responding to changing circumstances whilst at the same time maintaining its original objectives. If the changes create a situation where the NGO no longer can satisfactorily fulfil its mission, there would seem to be only two possible courses of action. Either the NGO actively changes its objectives, or it ceases to function.

Organizational structures

In order to fulfil their mission and carry out their activities, it is important that NGOs have a suitable organizational structure. Structure should reflect both the organization's function and its operational environment. As NGOs differ widely in objectives, methods and context, there can be no one single best organizational structure for an NGO. Butler and Wilson,[24] looking at organizational structures amongst voluntary organizations in the UK, identified four dominant types; functional, divisional, federal and matrix or project based, each of which serves particular, but different, organizational needs.

Functional structures. These are represented as hierarchical and bureaucratic, with a managerial and executive apex. It is suggested that these work best in relatively predictable contexts where there is limited prospect for change or competition. This type of structure is also commonly found in government departments.

Divisional structures. These allow distinct divisions of the organization, such as regional offices or health care services, to operate relatively independently but be controlled and co-ordinated by a head office. Such structures often are the result of adaptation and a process of planned growth. Some INGOs work to this type of model.

Federal structures. These usually have a number of local centres of activity with little or no central co-ordination. Consistency and control are achieved by shared and common beliefs. The major problem of such structures is the maintenance of a strategic coherence between the individual units.[25] Some NGO co-ordinating bodies work to this type of structure.

Matrix or project-based structures. This type of structure, if organized around specific projects rather than around a hierarchy or divisions, can be extremely flexible. However, whilst providing for integrated project

management, it can lead to a neglect of the overall focus and purpose of the NGO.

* * *

The actual structure selected must serve the overall interests and purpose of the NGO and thus may have to be revised over time. The important issue is that few organizations can exist satisfactorily without a clear organizational structure. For an NGO to be institutionally strong, this needs not only to be available but also to be understood by all in the organization.

NGO boards

Whatever the actual structure of an NGO, almost all NGOs will have some form of board. NGO boards, in addition to their responsibilities for external accountability, have a natural and key role in maintaining the overall direction of an NGO. This can be contentious, as there are often conflicting views as to whether the board's function is to support or lead. Staff may expect a lead whereas lay board members, frequently because they feel a lack of specific 'professional expertise', may see their role as supportive rather than directive. Research in the UK towards clarifying the role of boards in voluntary organizations has identified a method known as the 'Total Activities Approach'.[26] This involves the coming together of board members and staff to discuss the functions of the organization and to identify who should be responsible and, if possible, to set criteria by which responsibility for activities can be divided between staff, board and sometimes members. Key decisions would relate to the responsibilities for policy-making and strategic planning.

Broader management systems

The actual day-to-day processes of managing financial, human and physical resources within the NGO may be no different from many for-profit or government organizations. Where differences occur, they generally relate to procedure, priority, scale and overall organizational sustainability. These are outlined in Table 10.1 below. Government health care providers, for example, would have to work within a fixed budget set ultimately by the treasury or finance ministry, and for-profit providers within a variable amount raised from sale of services, dependent upon market forces. NGO providers, in contrast, are more likely to have the task of balancing a variety of funding sources with different conditionalities and reporting structures.

Table 10.1 Differing operational opportunities and constraints

	Government	*For-profit*	*NGO*
Operational procedures	Standardized across all sectors and departments	Self-selected (for greatest efficiency)	Self-selected (perhaps to meet donor requirements)
Organizational priority	Supporting national policies	Ensuring profit	Fulfilling mission
Scale of activity	National	As required (profit maximization)	Resource dependent
Organizational security	Long term	Market dependent	Resource dependent

From Table 10.1 it can be seen that, of these three main types of organization, NGOs have the least security and greatest dependence upon external factors. This in turn has an obvious impact upon management systems. Whilst government systems may be criticized for their intransigent bureaucracy, their general security of tenure allows them a long term perspective, especially for planning and human resource development. In contrast, as we have already discussed, most NGOs have to expend considerable effort on developing plans which do not extend beyond time-limited projects. Even where NGOs are not tied into a project system (such as church hospitals receiving government subventions), their lack of a secure and independent resource base similarly limits their opportunity for strategic long term planning.

Another factor, linked with their ability to plan, is a recognition that, despite their coveted autonomy, NGOs do not exist or function within a vacuum. This is particularly important where NGOs are providing services, but is also relevant for other types of NGO. Clark[27] suggests that NGOs have three choices in their relationships with the State. They can either oppose, complement or reform it. Whichever approach is chosen, however, they need to understand and communicate with the State. This includes, as far as possible, an active involvement in planning processes, especially at local level. Whilst some NGOs in particular situations see opposition as their only realistic relationship, we believe that this can only be a short term approach, especially as they thus forfeit any opportunities they may have had for participation in decision-making and effecting change. NGOs also need to be aware of, and communicate with, other NGOs. This is dealt with in greater detail in the next chapter. Where communication does not exist, NGOs are often both isolated from each other

and from governments, resulting in duplication and competition. In service delivery this usually results in 'worthy targets' being bypassed by all providers.

Human resources

It has been suggested that NGO managers are more likely to be visionary and energetic individuals than their government counterparts[28] and that NGO management styles and systems are more often a direct reflection of their leadership than other types of organization. Such situations also have generated negative, but usually unsupported, suggestions that the survival of some NGOs may be more dependent upon personal links between their articulate leaders and funding agencies[29] than their successful performance. If this is so, then this raises serious concerns, especially for the long term sustainability of such organizations.

Clark[30] categorizes two distinct and diametrically opposed stereotypes of NGO leaders, '*charismatic*' and '*collegial*'. Both extremes have inherent weaknesses. Charismatic leadership can develop a dictatorial decision-making style with an ill-defined organizational structure, largely dependent upon a single individual. Whilst the individual is present and able to manage the organization single-handed, and if staff are happy with this style, then problems are minimal. However, a charismatic leader tends not to develop the leadership capacity of other staff, or to be willing to delegate responsibility. Thus in the absence of the leader, decision-making is halted. The style preferred by collegial leaders is to manage through collective decision-making, sometimes referred to as 'management by committee'. This style, whilst giving staff opportunities to take a primary role in directing the organization, is often unstructured and may not develop individual leadership potential amongst staff. It also has an inherent danger that the division between the roles of ownership and employment may be eroded. This can create conflicts of interest between staff and also between professional staff and lay board members. Examples of such conflicts would be conditions of employment or operational policies.[31]

However, whilst leadership is of great importance, it cannot operate without a nucleus of staff. Although one reported attribute of NGOs is the motivation of staff, this may not be true in all cases. Although NGO founder leaders often are highly motivated, many of their paid staff may view their own appointment merely as a useful, and often remunerative, career move. Even where their commitment to particular causes and to the work they are doing is beyond question, many NGO staff may demonstrate

only a limited concern for the wider organizational environment. This could stem from a number of causes.

- Staff see themselves as being specially recruited for particular aspects of NGO activity, such as projects or departments, rather than to the organization as a whole
- Fragmentation of human resource management within the NGO
- Limited opportunities for communication between NGO staff (for example, through staff meetings)
- Lack of planning mechanisms for the NGO as a whole

All these have implications for human resource management within the NGO and are likely to result in an unstructured and *ad hoc* approach to human resource development.

Evaluation

In recent years there has been growing criticism that NGOs fail to carry out sufficiently broad evaluations or to engage in serious analysis of their *overall* organization and activities. There is a number of possible reasons for this apparent lack of interest in evaluation and analysis.

- Project evaluations are considered to be a proxy measurement of overall NGO organizational achievement
- There is little recognition by NGOs of the usefulness of evaluation for organizational or management purposes
- There are insufficient financial and human resources to carry out these activities
- It may be in the interests of NGOs seeking funding that assertions of comparative advantage remain unchallenged

Where the availability of future donations depends on visible results NGOs have to provide some evidence of achievement. However, as many NGOs work in situations where clear achievements cannot be guaranteed and certainly are not easily demonstrated, this is difficult and can result in reports of what management believes donors want to hear rather than what is actually happening. NGOs need the ability to demonstrate with confidence, accuracy and honesty how they are fulfilling their mission as an organization. This requires a much broader analysis than project evaluations, and is key not only to demonstrating the organization's legitimacy

to its external stakeholders but also to developing appropriate management systems and attracting ongoing funding.

OPERATIONALIZING INSTITUTIONAL STRENGTHENING

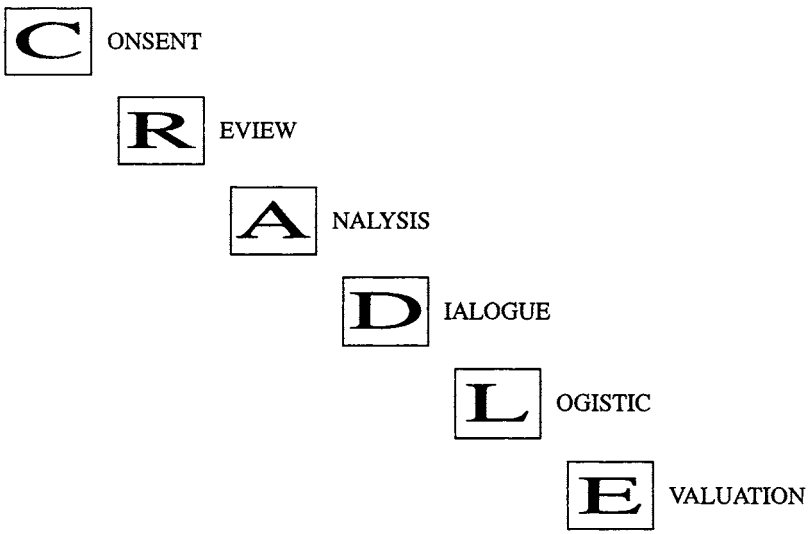
We have used the term institutional strengthening to refer to active intervention to promote the organizational development of individual NGOs, the development of more effective, financially viable, situationally legitimate and well-managed organizations with a long term perspective. We have seen that there are several interrelated issues, none of which either can be comprehensively considered in isolation, or considered as the sole determinant of NGO success or sustainability. For example, although most NGOs are heavily dependent upon external resources, an NGO placing greatest emphasis on the activity of securing ongoing funding may be in danger of losing sight of its overall mission and thus potentially jeopardizing its external legitimacy. Alternatively, where NGO funding is secure, but time-limited and project focused, there is the potential of over-concentration on the short term with little opportunity to develop a strategic overall approach to planning, policy-making and human resource development for the NGO as a complete unit.

Institutional strengthening of individual NGOs therefore requires more than merely providing funding, even if this includes the provision of some management training. As a process it needs the active cooperation of most external stakeholders. We suggest it has six phases:- consent, review, analysis, dialogue, logistical implementation and evaluation. These phases together form the appropriate acronym CRADLE.

Consent

It is unlikely that an NGO can carry out an institutional strengthening exercise without the involvement of a number of other actors or stakeholders. This does not reflect a lack of skill on the part of the NGO, but rather the complexity of the process. For example, a complete assessment of the external legitimacy of service delivery requires input not only from health professionals but also from beneficiaries. Securing funding for the organization is primarily an external exercise, and the development of management systems is likely to involve comparison with other systems. Thus, to ensure that the implementation of institutional strengthening is not frustrated by antagonistic or unprepared external responses, their prior consent should be obtained.

Figure 10.2 The six phases of institutional strengthening



Review

Institutional strengthening requires a complete and comprehensive overview of all aspects of NGO functioning. This includes not only reviewing the actual activities of the NGO, but also its external legitimacy, including accountability mechanisms, its management systems, especially planning and staff development, and its funding arrangements. Whilst this *must* involve NGO staff and board members, it would be beneficial to include external personnel, such as the managers of other NGOs or local management trainers.

Analysis

As the process is one of institutional strengthening, it is important that it identifies potentially weak areas in NGO functioning. These should be analysed in terms of the particular context of the NGO and its mission. In particular, consideration should be given to identifying the strengths and weaknesses of all the relevant actors involved, such as NGO staff, the board, donors and users; and, where possible, recommending changes that could be made.

Dialogue

There are likely to be a number of external and internal actors involved in institutional strengthening. It is particularly important that the process should have ownership within the NGO. Once the analysis phase is complete, a process of dialogue should take place with all relevant actors. This must include discussion of the analysis itself, the recommendations made and any other specific concerns. This phase should lead on to the development of a number of NGO institutional strengthening strategies and, if necessary, the soliciting of active support to carry these out.

Logistical Implementation

The penultimate phase is of course the implementation of these strategies by the NGO. As institutional strengthening is complex and multi-faceted, its implementation is usually a structured but incremental process. This needs itself to be carefully planned and adequately resourced.

Evaluation

No process is fully complete without a thorough evaluation. Institutional strengthening, whilst often perceived as a single activity, is an ongoing and long-term process. Evaluation needs to include both the process of institutional strengthening itself, and also the outcomes of the process.

SUMMARY

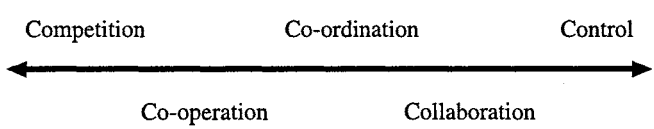
This chapter began with a brief discussion of the lack of distinctive management theory and support for the NGO sector, and presented a definition of institutional strengthening. It then reviewed the recent growth and development of NGOs and identified the three basic features of institutional capacity. This was followed by consideration of the distinctive features of NGO management and the operationalizing of institutional strengthening.

11 NGO Co-ordination: No Easy Answer

INTRODUCTION

In the last chapter we considered institutional strengthening of individual NGOs. Another constant theme in discussions regarding NGOs is co-ordination which, again, is rarely fully defined. This may be because there is an inherent assumption that everyone understands what is meant by the term. But is it such an easily understood concept? How does it, for instance, differ from co-operation and collaboration or even control and competition? This is not the place for detailed semantic discussions, and most dictionaries offer adequate individual definitions of these terms. Here it is more important to understand the terms in the context of inter-organizational relationships. Nevertheless, although in this chapter we consider only co-ordination, in order to understand the concept it is important to be able to distinguish between the various related terms. There are five key terms which form a continuum of increased structure, decreased autonomy and an intensified communication. The continuum begins with competition, progresses through co-operation to co-ordination and then on to collaboration,[1] finally ending in control.[2]

Figure 11.1 The competition–control continuum



The structure of relationships between organizations provides the basic framework for understanding these different terms.

Competition

This is perhaps the easiest to conceptualize. Where organizations are competing with each other, there is little likelihood of any structural linkage between them. Each organization will function in a completely autonomous manner with minimal communication. This term, although positively

promoted in a market driven economy, can be perceived as having negative connotations in the NGO context, where the driving forces are altruism and public good. Certainly it is rarely used by NGOs to describe positive relationships with other organizations.

Co-operation

A more positively perceived concept is co-operation. Organizations may co-operate around certain issues or at certain times, but this is not an ongoing process. Whilst co-operating, individual organizations maintain almost complete autonomy and communicate only as much as is required.

Co-ordination

The third type of relationship along this continuum is discussed in detail in this chapter. It represents an ongoing and structured relationship between independent organizations for mutual benefit. It is more in keeping with the welfare-promoting ethos of the NGO sector than the often brutal interaction of market forces.

Collaboration

This, the fourth type, could alternatively be labelled joint activity. Where two or more organizations collaborate, they work closely together and share resources and responsibility. Inevitably, collaboration involves the relinquishment of almost all individual organizational autonomy and requires continual communication between all parties.

Control

The final type of relationship can also be seen to have negative overtones. Indeed, a fear for organizations attempting to co-operate, co-ordinate or collaborate is that it might result in a situation in which one organization achieves control.

* * *

Although co-operation, co-ordination and collaboration are all relevant to the operation and management of NGOs in the health sector, especially with regard to service delivery, this chapter only considers co-ordination. The reason for this selection is that it is the most structured form of

relationship and the most likely to involve a large number of NGOs. Co-operation and collaboration, on the other hand, are more likely to involve only a small number of NGOs on an *ad hoc* basis. This chapter examines the policy environment and the technical and operational context of co-ordination and looks at co-ordination between NGOs and governments and between NGOs themselves. Collins defines co-ordination as 'working together in a systematic fashion towards common goals'.[3] In the NGO context we would like to extend this and define co-ordination as *the process by which autonomous organizations work together in a formally structured manner on a regular and ongoing basis for mutual benefit.* This definition has four critical elements. These are that co-ordination:

(a) will be a formal and *structured* process, in which all parties are agreed upon the nature of interactive protocol;
(b) will not destroy the *autonomy* of individual organizations;
(c) involves regular and long term *communication*, and is not *ad hoc* and situational; and
(d) should be for the benefit of all parties involved.

The complexity of these issues for the five types of inter-organizational relationship is outlined in Table 11.1.

From this it should be obvious that, contrary to what many people may believe, co-ordination is not a cost-free activity. Even at a minimal level, individual organizations seeking to co-ordinate with each other will be required to contribute; perhaps not financially, but certainly staff time

Table 11.1 Inter-organizational relationships

	Elements of inter-organizational relationships			
	Structure	*Autonomy*	*Communication*	*Benefit*
Competition	None	Complete	Minimal: Antagonism	Individual
Co-operation	Informal	Almost Complete	Occasional: Equality	Mutual
Co-ordination	**Formal: Loose**	**Limited**	**Regular: Equality**	**Mutual**
Collaboration	Formal: Integrated	Minimal	Continuous: Equality	Mutual
Control	Formal: Top-down	One-sided	Continuous: Domination	Not mutual

and some degree of their absolute autonomy. Co-ordination also has a number of other clear constraints, which have been outlined by Collins.[4] These include issues of differing organizational structures and procedures, unequal and irregular access to resources, and differing priorities and interests between organizations and individuals.

BENEFITS OF CO-ORDINATION

The most visible benefit of co-ordination, either NGO-NGO or NGO-government, can perhaps be demonstrated, certainly within the health sector, by evidence from situations where co-ordination has not occurred. We are all familiar with situations where there may be two or more health facilities, situated in very close geographical proximity, each carrying out similar activities, whilst in much of the surrounding area there are no facilities at all. We ourselves have seen MCH clinics separated only by a rice field, or, even worse, two which could be reached in less than five strides from each other. Clearly the reasons for such situations vary. Whilst some are simply the result of historical development, others may reflect more a difference in operational philosophy or target groups, and others merely the outcome of blatant competition.

As a process of historical development, many NGOs in the health sector existed long before governments were prepared to take responsibility for the health care of national populations. When national governments later made commitments to pursuing a policy of placing hospitals in *all* district headquarters, this required active co-ordination, because it had to take into account the fact that some districts were already served by NGO facilities. Where this did not occur the result was duplication. Mburu,[5] in a case study of emergency aid to Sudan, suggested that an absence of government policy on co-ordination created a number of the results, including:

(a) no accountability, both for governments and NGOs;
(b) 'worthy targets' bypassed by both sides; and
(c) reduced equity, because different criteria were employed by government and NGOs for determining type and level of relief.

In other cases, especially where NGOs are providing duplicative services, they occur because of differences in philosophy or organizational objectives. Health facilities established by a particular religious group, such as the Catholic Church, may create a demand amongst non-Catholics that their own denominations provide similar services. Other situations may be

provider driven and clearly competitive: for example, clusters of for-profit pharmacies, or hoards of INGOs responding to emergency situations.

For whatever reason, and irrespective of the parties involved, the absence of co-ordination does have obvious negative consequences for equitable health service delivery and also serious resource implications. There are, however, some less obvious consequences. In particular, for both NGOs and governments, there are missed opportunities to co-ordinate:

(a) policy-making, policy change and planning;
(b) the exchange of information and experience;
(c) innovative idea sharing; and
(d) the development of new approaches to common problems.

Many NGOs not only are isolated from governments but also from each other. Working alone, such NGOs are unlikely to receive support and technical assistance from any source. In addition, as we discuss in Chapter 10, many CYNGOs operate on a small scale, with limited and unsustainable access to resources, including funding, staff, information and training, and with weak and often untrained management support, and would greatly benefit from the economies of scale that could be produced through co-ordination. They are also, as individual organizations, unable to make adequate representation of their issues to the national governments, donors or other organizations.

DIMENSIONS OF CO-ORDINATION

There are a number of dimensions that have to be identified in any process of NGO co-ordination.

First it is necessary to establish the purpose of the co-ordination and differentiate between issues relating to:

(a) the operation of individual NGOs (for example, in order to provide processes for institutional strengthening);
(b) all sectoral NGOs (for example, the integration of NGOS into a national Family Planning programme); and
(c) all NGOs (for example, relating to policy issues such as NGO registration).

The second dimension of co-ordination relates to whether the co-ordination is at a primary or secondary level. Primary co-ordination

would involve all concerned NGOs on an individual basis, but secondary co-ordination would involve some degree of delegation or representation.

Third, there is a need to identify all relevant actors involved in the process of co-ordination. These could include, for example, not only individual NGOs and NGO co-ordinating bodies, but also national governments, regional co-operation groups (such as the South Asia Association for Regional Co-operation), multilateral and bilateral donors. Finally, the level at which co-ordination is taking place needs to be identified, such as local, national or international level.

NGO CO-ORDINATING BODIES

We have established that co-ordination is the process by which organizations work together in a formally structured manner on a regular and ongoing basis for their mutual benefit. If NGOs are to co-ordinate with other organizations, then it requires some form of structure that will enable all NGOs access to the process. One way in which this can be achieved is through an NGO co-ordinating body. Whilst most NGO co-ordinating bodies have their origins within the NGO sector, some are stimulated in their development by governments. An example would be Kenya. Co-ordinating bodies are very different in their composition and operation, clearly illustrating distinct co-ordination functions. The coming together of NGOs to form NGO co-ordinating bodies can therefore have a variety of forms. The various different perspectives are outlined below and relate to membership, structure and roles.

Membership

NGO co-ordinating bodies, whether they are local, national, regional or international, can be divided into three main types by their membership, according to whether it is general, sectoral or interest-based.

General co-ordinating bodies

Some co-ordinating bodies attempt to co-ordinate dissimilar types of NGOs within a single body, and thus welcome all NGOs. These therefore have an extremely diverse membership and can take the form of national councils or associations of NGOs. Some of these bodies also have members who are themselves carrying out a co-ordinating function, usually at an operational or technical level. Within a particular country, these types

of non-specific co-ordinating body ideally should be able to focus on organizational aspects of co-ordination such as research, advocacy, legal advice, information-gathering and exchange, issues of NGO policy and technical assistance including training. Unfortunately, they can be distracted in their purpose and attempt to be all things to all people. This can create tensions, as members fail to recognize the limits to the effectiveness of such a broadly-based group. Attempts to present a common voice are often diluted by NGOs continuing to use their individual contacts in parallel to the co-ordinating body channels.

Sectoral co-ordinating bodies

These work within a single sector amongst NGOs with similar motivation or interests. There are two main types: those with a specifically defined membership by type of activity (such as health sector NGOs like the Voluntary Health Association of India) and those which focus on a specific type of organization (such as the Church Hospital Association of Nigeria). This approach tries to address the specific needs of health care providers and professionals, such as guidance in interpreting changes in health care policy, training opportunities, liaison with the appropriate line ministry, multilateral and bilateral donors, international bodies and so on. Their specialized membership enables them to work more effectively within a particular sector than bodies with non-specific memberships and also allows them to give greater attention to operational and technical issues. Ideally they should liaise with, or even be members of, co-ordinating bodies involved in more general NGO policy issues.

Interest-based co-ordinating bodies

These bring together groups of NGOs with similar client groups or interests. Examples would be groups concerned with AIDS or disability, such as the UK NGO-AIDS Consortium or the National Association for the Care of the Handicapped in Zimbabwe. Such bodies are able to focus on very specific issues and be effective advocates for policy changes, such as issues of mobility and access for disabled people. Problems can occur, however, because of the different perspectives and approaches of members for, whilst they may share a concern, they may view the issues differently. For example, there is widespread tension between organizations which see themselves as being 'of' the disabled and groups 'for' the disabled. The former are more likely to be concerned with empowerment and policy, whilst the latter are more likely to concentrate on technical issues such as equipment and training.

Co-ordinating Body Structure

Whatever their particular membership group, NGO co-ordinating bodies also differ from each other by their choice of structure. Some only operate at a local level: others may be national, regional or international bodies operating a centralized structure from a single office; whilst others are decentralized organizations with local groupings. These local groupings can have two characteristics, and can be either independent units loosely associated with the central structure or merely branches of the central organization. Unfortunately, the particular model of operation adopted by an organization is frequently determined by history and resource limitations rather than by actual need. This is the case in some centralized bodies which, whilst recognizing the need to be in closer contact with their members at a local level, do not have the resources to function in this way. There are clearly advantages and disadvantages with each type of structure. Decentralized bodies, whilst exercising a strong local influence, usually find it difficult both to maintain contact between their various groupings and also to represent a single NGO voice at national, regional or international level. By contrast, centralized bodies, whilst recognized at national, regional or international level, may not have sufficient understanding of the needs and concerns of individual members at local level.

Co-ordinating Body Roles

NGO co-ordinating bodies have both internal roles, to support their members, and external roles, to represent their members. Each of these roles involves a variety of activities, the nature of which is usually dependent upon the particular situation and more especially on the purposes for which the body was originally created. NGO co-ordinating bodies, like NGOs themselves, have to fulfil basic organizational requirements, including working in accordance with a particular mission or set of objectives.

Internal roles

It is a widespread expectation that a major role of co-ordinating bodies is to provide some degree of support to their members in the form of particular services. The provision of services by a co-ordinating body to its members from a single source has a number of advantages such as:

(a) reducing cost through economies of scale;
(b) giving access to facilities not affordable to individual NGOs;

(c) avoiding the necessity of all NGOs spending time on the same activity;
(d) enhancing impact; or
(e) enabling the development of NGO-specific expertise.

There are two main types of support offered by co-ordinating bodies to their members. The first type is practical help, and the second is a more abstract type of internal support. Practical help would include offering:

(a) legal advice and assistance with registration procedures;
(b) central support services and facilitating the sharing of NGO resources at local level;
(c) technical assistance such as policy advice, research, evaluation or auditing;
(d) to facilitate the sharing of information and experience between NGOs;
(e) to contribute towards the institutional strengthening of individual NGOs by providing relevant training and other support.

The second more abstract type is to bring NGOs together around particular issues enabling a single NGO voice. NGO co-ordinating bodies can also be used to resolve conflicts between NGOs (for example, by offering to act as arbitrators). This is particularly important in countries where the most likely alternative would be expensive, virulent and protracted legal proceedings.

External roles

The main external role of NGO co-ordinating bodies is essentially as communicators or catalysts. It might, for example, seem inappropriate for a small CYNGO to seek direct representation at a national or international forum, or to expect them to be in direct contact with national or international bodies.[6] However, it is possible for them to appropriately represented to these bodies through an NGO co-ordination body and also to receive information in the same way. For example, co-ordinating bodies representing NGOs concerned with specific issues, such as HIV/AIDS, can not only contribute to the development of policies and approaches but also can be used to ensure that these are understood and practised.

In addition, whilst the coming together of NGOs, through NGO co-ordinating bodies in an advocacy or campaigning role, could be considered threatening by some governments, their focused expertise also can be positively channelled (for example, through involvement in policy-making).

This has two aspects, policy for the NGO sector itself, and policy for specific sectors such as health. The development of such policies is discussed in greater detail in Chapter 6.

ISSUES FOR NGO CO-ORDINATING BODIES

Whilst there is an obvious role for NGO co-ordinating bodies, especially in the health sector, they are vulnerable as organizations. This is the case because of the instability of their funding base, the diversity of their membership and the operational difficulty of working with multiple stakeholders.

Funding Base

Most NGO co-ordinating bodies have three main sources of funding. These are grant aid, membership fees and service charges.

Grant aid

NGO co-ordinating bodies can only attract grant aid in relation to their perceived usefulness to potential funders and the ability of potential funders to provide support. Many co-ordinating bodies find this aspect of convincing potential donors very difficult. Although perceived usefulness relates to the particular benefits ensuing from the particular roles which the co-ordinating body adopts, and the degree of success with which it carries these out, it is also dependent upon the willingness of donors to support non-project activities. Thus a large proportion of co-ordinating body funding is dependent on the goodwill of others, such as their members, their own government, and multilateral or bilateral donors.

Membership fees

We established earlier that co-ordination was the process by which autonomous organizations work together. NGO co-ordinating bodies can therefore neither control the actions of their members nor enforce their loyalty. If members consider that their continuing membership has little perceived usefulness to them, they are likely to terminate their membership. Furthermore, small NGOs, who are most likely to benefit from the support of a co-ordinating body, are least likely to be able to afford membership fees. In contrast, larger NGOs, who are most likely to easily afford membership

fees, are least likely to need the support provided. Co-ordinating bodies are therefore dependent upon the goodwill of larger NGOs, and indeed may stand in danger of being dominated by them.

Service charges

Where an NGO co-ordinating body is able to provide practical services such as training or central purchasing it is usually able to charge members for these, with utilization depending on the ability of NGOs to pay. Where co-ordinating bodies are providing services to organizations which are able to afford their charges, such as to their own government or larger NGOs, then there may be little difficulty. However, where services are required by small NGOs with limited resources, but probably the greatest need, the situation is more problematic. Even greater difficulty is experienced, however, in directly charging members for less specific activities and possibly those most vital to fulfilling its mission and external role, such as advocacy and policy development.

Diverse Membership

As we discussed earlier in this chapter, NGO co-ordinating bodies have different types of membership. Even in the most homogeneous groupings, where NGOs come together because they share a specific organizational type, such as mission hospitals, they are still likely to be extremely diverse in their resources, views and objectives. This results in most co-ordinating bodies not only being composed of individual NGOs with very different perceptions as to the role of an NGO co-ordinating body, but also with different motivations for membership. NGOs can, for example, view their membership from two extremes, first as a positive and altruistic reinforcement to the influence of NGOs within their social and political environment, or alternatively merely as a means of easily accessing specific services and support. Whilst the former group may be more resilient in their membership, the latter are more likely to see their membership as dependent upon the meeting of their specific individual needs.

Another difficult issue, which can potentially threaten the existence of a co-ordinating body, concerns power struggles between individual members. As discussed above, there is always a danger that larger NGOs may seek to use their position to force the co-ordinating body in a specific direction that may not be in the best interests of all members. We have already established that co-ordination is not a cost-free activity. We need to recognize also that neither is it a value-free activity.

Stakeholder Conflicts

We have already established the difficulty of maintaining a high degree of internal cohesion within NGO co-ordinating bodies, especially between members, but also between local and national issues. There also is often an external dimension: co-ordinating bodies have to work not only with members but also with other stakeholders, such as regulators and donors. This is especially difficult when representing the views of what can be a very diverse membership. In addition, co-ordinating body officials or representatives will have to meet external stakeholders who may themselves hold views which are contrary to each other or to the co-ordinating body. In such situations co-ordinating bodies, especially those without a clear understanding of the mandate they hold from their members, are extremely vulnerable, especially where these stakeholders may have access to power without public accountability.

OPERATIONAL CO-ORDINATION

NGO co-ordinating bodies have been presented as one way of structuring both internal co-ordination between NGOs and other NGOs and external co-ordination between NGOs and other actors, such as governments. Whilst this is the most familiar structure, and the most frequently discussed in the context of co-ordination, another structural mechanism is where individual NGOs co-ordinate with national governments at operation levels. This can occur at all levels, and the structure within which co-ordination occurs is predominantly that which already exists within government. It can take place for the three purposes already identified: that is, assisting in the operation of individual NGOs; ensuring the integration of sectoral NGOs into the government system; and establishing policy with regard to all NGOs as organizations.

Within the health sector, co-ordination of this kind is generally to assist in the operation of individual NGOs. This can relate to funding issues – for example, the subvention of mission hospitals – or at district level, to issues of planning through bodies with varying names, but often called the DHT. Unfortunately, in many situations, this type of NGO-government co-ordination does not take place on a regular and ongoing basis; neither does it always appear to be of mutual benefit. Similar criticisms can be levied here as have been expressed of the relationship between northern and southern NGOs: that is, it is not so much between equals but rather of the senior/junior variety. This is not always a one-way process and,

whilst many NGO representatives express concern about government dominance, similar concerns can be heard from government workers, especially about externally funded CYNGO or INGO activities.

In addition studies[7] have shown that the views held by NGOs and those held by government officials as to the nature of their relationships are extremely diverse and clearly indicate a lack of understanding of NGOs' perceptions by government officials, and vice versa. Thus operational co-ordination is frequently most successful where there are good local relationships between government officials and NGO staff. Unfortunately, many of these, usually informal relationships, are undervalued and consequently, when there are changes of staff, new staff may not be well informed about previous personal relationships.

Another potential area for NGO-government co-ordination at operational level is in the sharing of resources: for example, sharing vehicles for supervision visits. This is another contentious area, even within government circles, and there is little evidence of success. Resource sharing is also linked with co-ordination between NGOs and governments with regard to human resources. Whilst in some countries there are procedures for staff secondment from government to NGOs, especially in the health and education sectors, there is little evidence of local NGO staff being accepted on equal terms in government establishments. Access to government sponsored in-service and other training courses may also be very limited for NGO staff.

Successful NGO-government co-ordination does therefore depend on the willingness and ability not only of governments but also of individual NGOs to work with each other and with governments. In order for NGOs to be effective and complementary to public sector services it is important that governments:

(a) are favourably disposed to NGO initiatives;
(b) have a clear policy regarding the role of NGOs and the areas in which the two sectors can co-operate; and
(c) provide structures which can enable co-ordination and dialogue with NGOs at all levels, especially relating to policy formulation, planning and resource sharing;

and that NGOs are:

(a) prepared to participate in open dialogue with government; and
(b) co-ordinate among themselves and identify legitimate representatives or bodies.

SUMMARY

This chapter has looked at co-ordination, both as it occurs between NGOs and between NGOs and governments. It began by examining a number of related concepts and compared their implementation. It then considered the various benefits and dimensions of co-ordination. Particular attention was given to NGO co-ordinating bodies, their structure, roles and operating styles. A number of issues were identified relating to the operation of co-ordinating bodies, and then the chapter concluded with consideration of how co-ordination can be operationalized.

12 NGOs in the Next Millennium: Will the Bubble Burst?

In this final chapter we draw together the issues we have raised in the book and look ahead to the next millennium and, in a speculative fashion, suggest some of the issues that are likely to face the health sector. We start by examining some of the possible trends in the health sector. Speculation is, of course, a risky activity. We engage in it here without any sense that the projections are either inevitable or universal. It is instead intended to provide scenarios to stimulate country-based analysis. Finally, we set out a number of key issues that we suggest need consideration by policy-makers from all organizations concerned with the health sector.

FUTURE SCENARIOS

Shift in Health Problems

It is of course inevitable that the pattern of health problems will change in the future. As the demographic patterns shift towards older populations, so will the associated health problems. Shifts in the other factors that determine the health of a nation, including income levels, provision of water and housing, and political stability, will all lead to different health problems. Technology will also affect the responses of the health service to health problems, with the potential development of a response to AIDS perhaps being the most obvious.

All of these shifts have implications for the activities of the health service in general and NGOs in particular. One might, for example, expect to see greater emphasis on services for the elderly and those with chronic disabilities. There may also be greater focus on adding quality to life (life to years rather than years to life) and thus on care rather than cure.

Composition of the Health Sector

The current interest in reforming the health sector appears unlikely to abate. The interest of international organizations such as the World Bank

will ensure that it remains on the agenda of countries dependent on international aid. Of course health sectors need to periodically re-examine their structures and assess their appropriateness in the light of changing external environments. As such one would expect a process of reform to the health sector to be never-ending. However, the current package of reform measures, which is often bundled together under the name of health sector reform, represents a significant shift in the structure of the sector, and one might assume that for many countries movement towards this new paradigm is likely. The critical feature for the area under discussion in this book is the reduction in the hegemony of the State as a provider with consequent potential for both the private-for-profit and NGO sectors. There are likely to be significant variations between countries. In some the purchaser-provider split will remain largely within the public sector, with greater decentralization providing opportunities for a split in function. Elsewhere the State will retain an overall financing role, contracting with a mix of the private-for-profit and NGO sector to provide services on its behalf. The most extreme shift would be where the State gives up any responsibility for financing health care and encourages a market for health care based on user charges with perhaps a safety net system for certain specified groups in society.

One variation on the above is the possibility that full-blooded, over-enthusiastic or over-hasty reform may lead to a breakdown in the health sector and, in particular, exacerbation of existing inequities in access to health care. Elements of the prescribed 'package' of Health Sector Reform have a propensity to such failures. User charges, for example, are likely to lead to greater inequity, and the development of service contracting may result in administrative chaos with greater potential for corruption. Under such circumstances it is entirely feasible to conceive of a backlash towards an enhanced public sector role in health care provision.

All these scenarios have potential implications for the NGO sector and its overall role in health. In particular it raises important issues as to the degree to which individual organizations wish to become effectively contractors for government.

Composition and Growth of the NGO Sector

We have suggested that in many developing countries the NGO sector is growing, with activities in the health field being a significant element of this. Given the requirement that NGOs, like all organizations, need to fund their activities, this expansion can only continue if potential funding increases. Whilst in time it is expected that growth in domestic economies

in developing countries will lead to an increase in donations as a component of NGO income, this is unlikely to be significant for some time. As such, the major sources of growth are likely to be international donors (either through INGOs or through aid agencies), government contracts or subventions and user charges. Of these, the first only seems likely to increase if donors maintain their interest in the NGO sector. Government funding will become more significant only as a result of Health Sector Reform shifts in provider responsibilities from the State. User charges may appear as an attractive option but, as we have seen, are likely to be rejected on equity grounds as a major source of income.

Growth in the NGO sector may be accompanied by a shift in composition. The nature of the funding patterns described above is such that they favour medium to large sized NGOs, and it is likely therefore that the sector's growth will be skewed towards such NGOs in which there will be accumulation and concentration. Organizations that attempt to scale up too quickly without the management capacity are likely to collapse. Changes in funding composition towards donor funds may also encourage the growth of organizations which occupy the grey area between for-profit organizations and genuine welfare NGOs, and in particular those that are interested primarily if not explicitly in providing employment opportunities.

Relations between NGOs

We have seen earlier in the book that relations between individual NGOs are often informal and may not always be well-considered. Co-ordination of activities is often absent. Wider consciousness of the emergence of a Third Sector with specific characteristics and concerns may lead to greater recognition of the potential for a more cohesive sector, particularly as a more effective means of relating to government. As CYNGOs (and particularly the larger ones) grow in self-confidence there is also likely to be increasing scrutiny of the role of INGOs both as donors and as external organizations providing services directly. This may be accompanied by increased recognition of resources within neighbouring developing countries, improved NGO solidarity and greater networking within regions.

KEY MESSAGES

Having set out some potential movements in the health sector, we conclude the book with a drawing together of a number of key messages that we suggest need to be taken into account by policy-makers in the health sector.

State Role in Health Care

First, we have argued throughout the book that policy shifts away from the previous hegemony of health care provision by the public sector towards greater involvement and recognition of the organizations outside government should not imply a reduction in the role of the State in the development and implementation of policy. Indeed the paradox is that a freeing of, or reduction in, the State role leads to greater need for an over-arching framework. Policy movement towards greater diversity should imply an enhancement rather than diminution in the role of the State in policy formation.

One critical element of this is the development of policy, accompanied by appropriate policy tools, towards the NGO sector. Such policy (which is frequently under-developed) needs to set out clearly the role that the NGO sector is expected to play within the overall health strategies.

Strong policy development by the State does not, however, imply that this should exclude inputs from other agencies involved in health care. In particular NGOs which are likely to share many of the welfare objectives of government, and which may have particular insights into health strategies, should be given a special place at the policy table.

It is also important that it is recognized that there *are* likely to be potential areas or functions, in addition to that of national policy formation, in which the State possesses a comparative advantage over the NGO sector: for example, its ability to exploit economies of scale. Whether these advantages are currently being realized may reflect existing weaknesses with the public sector. Such weaknesses should not necessarily be interpreted as inherent and insurmountable. Full pendulum swings away from the public sector can be dangerous and should be resisted as they may lead to the neglect or complete dismantling of essential national infrastructure. The implication of this for donors, governments and indeed NGOs is that strategies for the strengthening of the public sector need to be pursued alongside an opening-up of the general health sector to other actors. It is indeed dangerous if NGOs see their role as an alternative to democratic government.

There is one caveat to the above which relates to those situations in which there is a clear lack of democracy. Democracy is not an absolute concept, and its forms will be culture-specific. However, inherent in it is a requirement of accountability to the general public by one means or another. Where there are gross abuses of power by a ruling party with no sense of accountability, NGOs will need to reassess their role in relation to government and may, in extreme situations, take on an oppositional role. It is important, however, that this is seen as a time-limited response to the

democratic failures and one which would be reversed once acceptable levels of democracy are in place.

Regulation

One of the currently undeveloped responsibilities of the public sector is that of ensuring, through regulatory mechanisms, that policies are pursued and that standards of service delivery are maintained at pre-determined and acceptable levels. This role is frequently ill-developed. With the growth in the non-State sector it becomes even more essential that this is strengthened. Responsible NGOs recognize the importance of this.

There are two main aspects of such regulation. One concerns the services provided (consonance with overall policy, location, and quality of care provided). The second concerns the accountability of the organization. NGOs, as we have seen, have complex webs of accountability, and it is important, as the NGO sector grows and potentially changes its role, that these accountability relationships are clear and robust.

How such regulation is carried out will vary between countries. Indeed, it is possible that the State delegates responsibilities to the NGO sector itself, through, for example, a co-ordinating body.

NGO Relations

The next issue is that of NGO relations with other organizations. As we have seen, NGOs are often not good at developing clear relationships with other organizations. The growth of the sector and the potential for destructive competition or duplication in situations of scarce resources suggest that this is an area to which NGOs need to devote more energy. Such relationships include both those with government and with other NGOs. It also has implications for the role of NGO co-ordinating bodies. We have suggested earlier in the book that there is unrealized potential for such bodies but that they may need greater explicit support, perhaps from external agencies.

Sustainability

The fragility of the resource base of many individual NGOs means that sustainability is a constant strategic issue for most organizations. There are, however, two critical issues that NGOs need to bear in mind as they assess their strategies. First, sustainability should be viewed in terms of sustainability of activities rather than of organizations. The existence of

NGOs should be viewed as a means to an end rather than as an end in itself. If an organization is not best placed to continue the provision of particular services, it should not hesitate to consider the closure of its operations. There is a danger that organizations develop their own momentum and lose sight of their purpose. Second, though the critical element in sustainability is often seen as funding, the development of strong managerial and technical capacity may be equally important. Indeed they may be critical for the development of a strong resource base itself.

Roles of INGOs and Donors

The last issue is that of the changing roles of donor agencies and INGOs. Both these sets of organizations differ from CYNGOs and the MoH in that they are external to the country and thus possess less legitimacy in terms of their accountability to the population. Donor agencies in recent years have embraced NGOs in terms that make them appear as the panacea for the health sector. This brings dangers in terms of a possible reduction in their traditional support for the public sector. Donors need to be clear as to their rationale for support to the sector as this has important implications for the mechanisms and means of support.

There are dangers in terms of large donors dictating (not necessarily explicitly or deliberately) the direction of NGOs through the attraction and leverage of external funding. Many donors also have little experience of working directly with NGOs and may not appreciate the specific needs of individual NGOs. For such donors increased investment in their own organizational capacity may be necessary to develop such an understanding.

The changing NGO scene also has particular implications for INGOs. The growth of country NGOs suggests that INGOs' direct service provision role may be time-limited. Increasingly there are also questions being raised concerning their 'partnerships' with CYNGOs, with calls for a rebalancing of such relationships. INGOs also face strategic questions as to whether they have a responsibility to develop the NGO sector itself through, for example, support to co-ordinating bodies or through the development of country NGOs in place of direct in-country involvement by INGOs. One growing and significant role for such INGOs is as advocates acting as a voice of NGOs to global organizations such as the World Bank.

LAST WORD

The last decade has seen a shift in attitudes to NGOs. From a situation in which their role in the health sector of developing countries was largely

ignored, attitudes are now moving through a position of uncritical acclaim towards a healthier recognition of their potential strengths and weaknesses. Attitudes are shifting from dogmatic rejection or acceptance of the NGO sector to a more realistic and useful pragmatism. There is still much to learn about NGOs and their operations, and it is hoped that this book has contributed in some way to this process if only by raising more questions.

Notes and References

1 NGOs: The Emerging Third Sector?

1. WHO (1978).
2. In this book we use the term developing countries to refer to countries which share a set of characteristics including those of low and maldistributed income and consequent poverty, ill-developed services, and high un- or under-employment. We share the concerns expressed by many over the connotations of the term 'developing' particularly when used in association with the term 'developed'. However, none of the other widely used terms such as 'Third World' or 'South' escapes this fate either. We also use the term 'developing health system' to refer to a country which may have made significant progress in other aspects of development but which still has an ineffective health sector.
3. Health services provided for the defence force and government employees could be included within this category though the non-profit making nature of their activities distinguishes them from the others included here.
4. USAID (1992), quoted in Smillie and Helmich (1993), p. 306.
5. See Black (1992) for an account of the history of Oxfam.
6. WHO (1978).
7. Walsh and Warren (1979).
8. See, for example, the special issue of *Social Science and Medicine* (1988) Vol. 26.
9. Wisner (1988).
10. UNICEF (1988).
11. Knight (1993).
12. Sollis (1992), p. 164.
13. World Bank (1993).
14. Green and Matthias (1995).
15. Chalker (1991) and Chalker (1994).
16. Bhat (1993).
17. Robinson (1994).
18. Black (1994).
19. Cohen (1990).
20. See, for example, Black (1992), pp. 255–6.
21. SCF (1993).
22. Mosely-Williams (1994).
23. See Drabek (1987).
24. Scaling-up can take many forms, including that of straight expansion. This is further discussed in Chapter 10.
25. Kajese (1987).

2 What are NGOs?

1. OECD (1988), p. 14.
2. Anheier and Knapp (1990), p. 4.

3. Salamon and Anheier (1992). This work is part of an international study of the Johns Hopkins Comparative Nonprofit Sector Project which is exploring the scope, structure and role of the nonprofit sector in various countries. See Kendall and Knapp (1993) for an application of the research to the UK. See also Kendall and Knapp (1995) for a useful discussion of definitional issues and typologies.
4. Salamon and Anheier use five key features. Organizations defined as part of the third Sector are seen to be formal, private, non-profit-distributing, self-governing and voluntary. These are similar to those used in this chapter.
5. Green (1987), p. 38.
6. Smith (1989), p. 395.
7. Cumper (1986), p. 337.
8. Tongswate and Tips (1988), p. 402.
9. Constantino-David (1992).
10. Whilst it might be argued that proselytization is still a social end, we would reject such a definition of a social end within the context of our discussion of health NGOs. A wider definition of NGOs which encompassed objectives outside of the promotion of health might include such organizations.
11. By volunteer we are referring here to the unpaid nature of the work rather than the sense of 'offering' service. The term is confusing when used in connection with organizations from industrialized countries operating with paid 'volunteers' in developing countries. Later in the book we look more closely at the nature of volunteering and widen its usage to include staff paid at below their market rate.
12. Bratton (1990) p. 106.
13. See various articles in Drabek (1987).
14. Development economists fell into a similar trap with the theory of the Stages of Growth of a country, implying that there was single route through which development could be attained.
15. Garilao (1987).
16. Nogueira (1987).
17. A number of other authors have developed approaches to classifying and analysing types of NGOs. See, for example, Ritchie *et al.* (1995) which uses a systems model to examine the potential different approaches of four different types of NGOs: relief and welfare, community development, sustainable systems development and people's movements.
18. Korten (1987).
19. See Black (1992), pp. 278–83.
20. Knight (1993).

3 Do NGOs have a Comparative Advantage in the Health Sector?

1. See Brodhead (1987).
2. For further discussion of this see Green (1992), Chaper 1.
3. It should be recognized, however, that the definition of 'basic' health care is contentious.
4. World Bank (1993).
5. Sollis (1992), p. 174.

6. Hyden (1983), pp. 120–1.
7. World Bank (1991), p. 136.
8. Briscoe (1980).
9. Hanlon (1991).
10. Hanlon (1991), p. 218.
11. de Jong (1991).
12. Green (1992), Chapter 8.
13. Thomas (1992).
14. Bratton (1990).
15. Clark (1991), p. 63.
16. Pratt (1988).
17. Milwood and Gezelius (1985).
18. Robinson (1992).
19. Dave-Sen and McPake (1993).
20. This book is not the place to discuss this in any detail, but we reject the argument that maximization of efficiency requires a profit motive. This is primarily based on neo-classical economic arguments that efficiency is a function of competition driven by the forces of market supply and demand. This theory is in fact dependent on rigorous conditions of perfect competition which rarely exist, and certainly are not fulfilled in the health sector. Further, there is no a priori reason why, for example, the costs of competition (related to features such as advertising) should be outweighed by greater productive efficiency generated by attendant profit-seeking motives.
21. Berman and Dave (1990).
22. In order to make a fair comparison of relative efficiency, *all* resources need to be identified, whether they have financial implications for the organization or not. The ability of an NGO to generate low cost resources is a separate attribute and is discussed later in the chapter.
23. Mayombana, Jenkins and De Savigny *et al.* (1990).
24. Gilson (1987).
25. Berman and Dave (1990).
26. Hogerzeil (1987).
27. Mills (1990).
28. Bennett, Dakpallah and Garner *et al.* (1994).
29. For a discussion of the role of NGOs in conflict resolution see Mawlawi (1993). For an interesting analysis of the different stages of conflict and NGOs roles in them see Agerbak (1991).
30. Butler and Wilson (1990).
31. Donabedian (1966).
32. Garner, Thomason and Donaldson *et al.* (1990).
33. Clark (1991), p. 53.
34. Garner *et al.* (1990).
35. Newbrander and Parker (1992).
36. Kanji, Kilima and Munishi (1992).
37. Annis (1987).
38. Fowler (1990).
39. Uphoff (1987).
40. Fowler (1990).

4. International NGOs: Doers or Donors?

1. IPPF was first established in 1922.
2. For example, the 'corporatist' approach of Scandinavian society greatly contrasts with the more 'pluralist' approach of the USA or Canada. See Smillie and Helmich (1993), pp. 16–18 for an interesting discussion of these various characteristics.
3. See Brown (1992), pp. 233–9 for discussion of the difficulties encountered by those first wishing to include medical activities in Baptist Missionary Society work.
4. We would argue today that whilst the first two meet our NGO criteria of having 'social good' objectives, the third type does not (i.e., medical work is not a pragmatic response to observed need but a means towards a purely spiritual end).
5. These are usually collectively known by the one name CARITAS. Examples would be CARITAS (Germany) established in 1897, and CARITAS (Netherlands) established in 1914.
6. For example, Stanley Browne's work on leprosy and Chesterman's on sleeping sickness; see Brown (1992), p. 357.
7. Chesterman's work in the 1920s on sleeping sickness was not only conducted in the name of the Congo government, but was also largely financed by them (Brown, 1992), p. 357. See also Gelfland (1973), pp. 117–20 for a discussion of co-operation between missions and government health services in Zimbabwe (Rhodesia).
8. Edwards and Hulme (1992), p. 13.
9. These were the British Red Cross Society, Christian Aid, Oxfam, SCF and War on Want.
10. Originally known as the International Standing Committee for Aid to Wounded Soldiers, the ICRC was founded in Switzerland in 1863.
11. In the UK, for example, organizations like Plan International, Oxfam and Christian Aid (originally known as Christian Reconstruction in Europe) and in America, Lutheran World Relief and CARE. For details of dates of establishment of many European and North American INGOs see B.H. Smith (1990), Appendix C.
12. For example, Bangladesh in 1971: see Rohde and Gardner (1973), or Sudan in 1984: see El-Bushra (1988).
13. See Black (1992), Chapter 6 for a discussion of Oxfam's involvement in relief work in the 1960s. See also Jansson, Harris and Penrose (1987).
14. Early examples would be War on Want in the UK, or Bread for the World in Germany. This trend for the establishment of new development focused INGOs continued through the 1960s, notable examples being CAFOD in the UK, and Oxfam Canada.
15. For example, Oxfam: see Black (1992), Chapter 5.
16. Joint funding schemes for INGOs commenced in Germany in 1962, the Netherlands in 1965, Canada in 1968, Australia in 1974, and the United Kingdom in 1975.
17. This has changed, however, with the transition from mission to church control. Although this change has been justified in the language of 'part-

nership' and 'local ownership', many facilities can no longer access either external technical expertise or external funding. Consequently many church health facilities today, rather than providing additional resources, are almost exclusively dependent upon national government subvention.

18. B.H. Smith (1990), pp. 85–6.
19. Other examples would be the Australian Volunteer Graduate Scheme (which later changed its name to the Overseas Service Bureau), the Canadian University Service Overseas and the German Volunteer Service.
20. One exception amongst volunteer agencies is the US Peace Corps, which is not an NGO but a government agency.
21. New INGOs responding to HIV/AIDS tended to be co-ordinating groups or networks such as the UK NGO-AIDS Consortium.
22. In the UK Charity Law places restrictions upon organizations registered as charities with regard to their activities (for a discussion of specific UK cases see Williams (1989), pp. 152–61). This is a contentious area and reflects our discussion in Chapter 2 that organizations actively seeking *ultimately* to take the role of government cannot be classified as NGOs. What is contentious is the extent to which an NGO (or registered charity in this case) is free to campaign for ends which are ultimately not party political, such as human rights. See also Black (1992), pp. 154–62 regarding this type of conflict in Oxfam and the split of the World Development Movement from the registered charity Action for World Development.
23. B.H. Smith (1990), pp. 77–8.
24. See WHO (1978).
25. Cohen (1990).
26. World Bank (1993); SCF (1993).
27. An example would be the United Nations Non-Governmental Liaison Service.
28. See LaFond (1995).
29. See Borton (1994) or Mysliwiec (1988) and El-Bushra (1988).
30. Smillie and Helmich (1993), p. 23.
31. See Black (1992), pp. 117–31.
32. Smillie and Helmich (1993), p. 19.
33. Smillie and Helmich (1993), p. 34 and Mysliwiec (1988), p. 156. In order to minimize this problem, at a very early stage in each new situation there is a need for the NGO to establish criteria to answer the question of when to withdraw.
34. Edwards and Hulme (1992), p. 14.
35. Hanlon (1991), p. 204.
36. Jansson, Harris and Penrose (1987), p. 26.
37. Edwards and Hulme (1992), p. 18.
38. Mister (1988).
39. See Borton (1994), Chapter 6.
40. For example, Oxfam Canada and Oxfam UK or USA.
41. Poulton (1988), p. 140.
42. Research by the authors in Zimbabwe revealed that INGOs were no more likely than CYNGOs to have country-level plans or control over budget allocation.

5 Country NGOs: Is There Strength in Diversity?

1. See Korten (1991), pp. 26–9.
2. Green (1991); Green and Matthias (1993).
3. This was shown by statistical testing of the survey data from Zimbabwe. This demonstrated that an organization's rank for recurrent budget has very little correlation with its rank for number of employees. This may be due to the variety in levels of pay for employees between NGOs or the different nature of demands on the budgets of organizations.
4. Certainly in Zimbabwe and Swaziland (where the authors have research experience) and also in other African countries such as Tanzania, Malawi, Ghana and Zambia.
5. UNICEF (1988).
6. Knight (1993), Chapter 11.
7. BRAC is a very large NGO involved in health, education, income generation, credit and other development activities. It has service centres throughout Bangladesh and large research and training departments.
8. Voluntary financial support for NGOs has traditionally been generated through active public fund-raising. Today NGOs are increasingly receiving significant funding from governmental or quasi-governmental sources (sometimes through northern NGOs) and yet are still considered to be maintaining their voluntary status.
9. Houghland (1979), p. 84.
10. It is also important to reflect on possible reasons for the employment of expatriate staff, especially by CYNGOs. If, for example, the employment of such staff is indicative of a lack of ability to pay or recruit appropriate indigenous staff, then high numbers of expatriate staff should be interpreted as a negative rather than as a positive attribute.
11. Sometimes partly from an external body.
12. Chalker (1993), pp. 26–7.

6 NGOs and Health Sector Policy

1. Holloway (1989), p. 154.
2. Holloway (1989), p. 156.
3. This overall health policy should have been developed as part of a national health planning process. The degree to which this involved the NGO sector is again critical to the appropriateness and feasibility of the plan and is discussed later in the chapter.
4. See Bennett, Dakpallah and Garner *et al.* (1994) for discussion of some of these regulatory tools.
5. Readers are referred to Green (1992) and Walt (1994) for discussion of policy and planning processes.
6. Bratton (1990).
7. The first of these two is discussed in Butler and Wilson (1990) in a review of the business management literature in this area.
8. See ODA (1992b) and Good (1994) for interesting insights into this concern-

ing the UK government's support through its block grant system and Joint Funding Scheme.

9. ODA (1992a).

7 Zimbabwe: A Country Case-study

1. This research in Zimbabwe was part of a larger NGO research project funded (but not commissioned) by the UK ODA (see Green and Matthias, 1993). The work in Zimbabwe was conducted in collaboration with the University of Zimbabwe with the permission of the GoZ and the MoH. The findings and opinions expressed are the responsibility of the researchers and may not reflect those of the funders.
2. World Bank (1993).
3. See Loewenson, Saunders and Davies (1991).
4. GoZ (1984): 'The government has remained firm in its determination to control private practice and limit its further expansion so that available resources are distributed in line with government policy of equity in health.'
5. Masvingo Province: see MoH, GoZ (1989).
6. Mashonaland Central Province: see MoH, GoZ (1990).
7. Welfare Organizations Act 1967, section 2.

8 Resourcing NGOs

1. Quoted in *The Observer*, 'A better way of giving: charity in the Nineties', 2 October 1994.
2. UNICEF (1988).
3. For a review of such methods with particular reference to the NGO sector see Diskett and Nickson (1991) and Dave-Sen and McPake (1993).
4. Dave (1990).
5. See, for example, Creese (1990), Hanson and McPake (1993) and McPake (1993).
6. World Bank (1993).
7. Quoted in Hanlon (1991), p. 204.
8. It is interesting to note that in an article written ten years ago (Twose, 1987) the author suggests that NGO staff have not yet fully recognized this dilemma. Today, however, this is far more clearly an overt strategic question for NGOs.
9. Robinson (1994), p. 91.
10. World Bank (1989), p. 182.
11. Quoted by van der Heijden (1987) from Kramer (1981).
12. These issues are well aired in various articles in Drabek (1987) and more recently in Mosely-Williams (1994).
13. Dave-Sen and McPake (1993).
14. Diskett and Nickson (1991).
15. The following is taken from Green and Matthias (1993).
16. Green and Matthias (1993).
17. Giles (1990) quoted in Robinson (1994).
18. Brophy and McQuillan (1993).

19. The NGOs are classified by CAF as international. It should be noted that some of these, such as SCF and the British Red Cross Society, have significant programmes within the UK, whilst others, such as Oxfam, are almost entirely aimed at activities outside the UK. It should also be noted that the organizations rarely are involved solely in the health field. The figures are, however, in each case for the organization as a whole.
20. Lane (1994).
21. Robinson (1994), p. 84.
22. ODA (1992a).
23. For interesting reviews of the advantages of such a scheme and insights into the policy thinking of a major bilateral donor, see ODA (1992b) and Good (1994).
24. Quoted in ODI (1995). ODI suggests that these figures are in fact underestimates.
25. Brophy and McQuillan (1993), Table 4, p. 15.
26. Robinson (1994), p. 92.
27. Robinson (1994).
28. Bossert (1990).
29. Diskett and Nickson (1991).
30. Quoted by Kobia (1985) in van der Heijden (1987), p. 107.
31. SCF (1992), p. 2.
32. ODI (1995).

9 External Accountability: A Neglected Dimension?

1. Day and Klein (1987), p. 5.
2. Clark (1991), p. 72.
3. By this we mean that their activities are not directed towards the formation of an alternative government.
4. Johnson (1974), p. 9 suggests that: '*substantive needs* include responsiveness to changing perceptions of what services people require and a capacity to make use of scarce resources effectively', and that '*procedural needs* are the avoidance of the improper or excessive use of powers, of unfairness and bias on the part of those who take decisions effecting individuals or organizations, and accessibility to the consideration of complaints'.
5. Clark (1991), p. 73.
6. Knight (1993), Chapter 11.
7. LaFond (1995), p. 124.
8. Carroll (1992), p. 85.
9. Johnson and Johnson (1990), p. 38.
10. See Clark (1991, p. 72), Edwards and Hulme (1992, p. 18), Roche (1992, p. 187).
11. Mysliwiec (1988), p. 155.
12. Hanlon (1991), p. 218.
13. LaFond (1995), p. 119.
14. Twose (1988), p. 148.
15. Including the composition and appointment of a Management Board or Board of Trustees and the roles and powers of officers. For such instruments to be effective, however, requires not only that they exist but also that

there are viable standards against which organizational performance can be measured.

16. These are usually available from statutory bodies, such as the UK Charity Commissioners, or supportive organizations such as co-ordinating bodies.
17. This is documented in Black (1992), pp. 85–92.
18. Johnson (1974), p. 9.
19. Johnson (1974), pp. 7 and 13.
20. Mellor (1985), p. 85.
21. For example, UK charity legislation restricts undischarged bankrupts from serving as Charity Trustees.
22. Mellor (1985), p. 84.

10 How do NGOs Need Strengthening?

1. Matthias and Green (1994).
2. For example, that NGOs, in their operation and organization are regarded as effective, efficient, flexible, cost-effective, autonomous, small scale, motivated, community focused, and innovative. They are also said to work with the poor, the disadvantaged, minority groups and women. See Chapter 3, which looks at their suggested comparative advantage in service provision.
3. For example: Batsleer, Cornforth and Paton (1991); Butler and Wilson (1990); CRONER (1989); Poulton (1988); Pratt and Boyden (1985).
4. A term suggested by Campbell (undated).
5. By the authors in Zimbabwe, Green and Matthias (1993).
6. Avina (1993), p. 456.
7. See Chapter 2 for a discussion of NGO stages of growth.
8. Avina (1993), p. 461.
9. Billis and MacKeith (1992), p. 125.
10. Korten (1991), p. 126.
11. Bossert (1990) from a study of donor supported health projects in Central America and Africa lists a total of five project characteristics which he believes enhance sustainability. Brinkerhoff and Goldsmith (1992) suggest a slightly different framework, but one which is closely parallel to the Bossert study. Mogedal (1992) from her research suggests three major 'clusters' of factors related to sustainability. Stefanini (1995), from research in Africa, suggests a number of areas for appraisal of the contribution of health programmes to sustainable health care. Bowden (1990), in a study of NGOs in Asia, identifies five problems associated with sustainability in participatory programmes.
12. LaFond (1995), p. 17.
13. Mogedal (1992), p. 49.
14. See Chapter 3 for a discussion on NGO comparative advantage on service provision.
15. Bratton (1989), p. 115.
16. Korten (1991), p. 140.
17. Smillie (1988), p. 12.
18. For example, see Conyers and Hill (1986), p. 195 or Catlett and Schuftan (1994).

19. Conyers and Hills (1986), p. 11.
20. Bratton (1989), p. 115.
21. This was amongst NGOs in the health sector in Zimbabwe, using four proxy indicators of NGO institutional capacity, the reported presence of a constitution (i.e., governing instrument), an annual report, a written plan and an organizational chart.
22. Knight (1993), p. 272.
23. Day and Klein (1987), p. 18.
24. Butler and Wilson (1990), pp. 23–30.
25. Butler and Wilson (1990), p. 162.
26. For more detail of the Total Activities Approach see Harris (1993).
27. Clark (1991), p. 75.
28. Whittaker (1983).
29. Sanyal (1991), p. 1375.
30. Clark (1991), p. 66.
31. Hodson (1992), p. 130.

11 NGO Co-ordination: No Easy Answer

1. Butler and Wilson (1990), p. 53 use the term 'coalescing' in a similar way to collaboration.
2. Collins (1994), Chapter 4 has a detailed and interesting discussion of intersectoral co-ordination within the context of developing health systems. However, he uses the terms co-ordination and collaboration interchangeably and does not separate them as we do in our model.
3. Collins (1994), p. 116.
4. Collins (1994), p. 122, Fig. 4.3.
5. Mburu (1989), p. 595.
6. A number of international organizations, such as the World Bank and the WHO, have established formal mechanisms through which they co-ordinate with NGOs, as does the EC.
7. For example Asamoa-Baah (1989) and Tongsawate and Tips (1988).

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