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State of the Practice:

Public-NGO Partnerships in Response to Decentralization

Riitta-Liisa Kolehmainen-Aitken, M.D., Dr.P.H.
February 2000

This publication was produced as part of the LAC Health Sector Reform Initiative by the Family Planning Management Development Project (FPMD), a project of Management Sciences for Health (MSH) in Boston Massachusetts.

Funding for this publication was provided by the U.S. Agency for International Development under cooperative agreement number: CCP-A-00-95-00000-02.

The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.

ACKNOWLEDGEMENTS

FPMD would like to acknowledge all of the organizations that responded to the questionnaires and contributed to the discussions in the working group meeting in Bolivia for their contributions and insights. In addition, FPMD would like to acknowledge Dr. Ana Maria Aguilar and other MSH colleagues in La Paz, whose technical and logistical support and management of the meeting was key to its success.

ACRONYMS

APOLO	**Apoyo a Organizaciones Locales, Ecuador**
APROFAM	**Asociación Pro-bienestar de la Familia, Guatemala**
APROFE	**Asociación Pro-bienestar de la Familia Ecuatoriana**
BEMFAM	**Sociedade Civil Bem-Estar Familiar no Brasil**
CEMOPLAF	**Centro Médico de Orientación y Planificación Familiar**
CEPEP	**Centro Paraguayo de Estudios de Población**
CERSS	**Comisión Ejecutiva de Reforma del Sector Salud**
CIES	**Centro de Investigación Educación y Servicios, Bolivia**
COF	**Centro Obstétrico Familiar**
DDM	**Data for Decision Making (Harvard School of Public Health)**
EPS	**Empresas Prestadoras de Salud, Colombia**
FPMD	**Family Planning Management Development**
HSR	**Health sector reform**
HMO	**Health Management Organization**
IDB	**Inter-American Development Bank**
IESS	**Social Security Institute, Ecuador**
IMSS	**Instituto Mexicano de Seguro Social**
LAC	**Latin America and the Caribbean**
MOH	**Ministry of Health**
MSH	**Management Sciences for Health**
NGO	**Non-governmental organization**
PAHO	**Pan American Health Organization**
PHR	**Partnerships for Health Reform (Abt Associates)**
SESPAS	**Secretaría de Estado de Salud Pública y Asistencia Social, Dominican Republic**
SIAS	**Comprehensive Health Care System, Guatemala**
SSA	**Secretariat for Health, Mexico**
USAID	**United States Agency for International Development**

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1. INTRODUCTION

THE LAC HEALTH SECTOR REFORM INITIATIVE

The Latin America and Caribbean Health Sector Reform Initiative (LACHSR) is a five-year endeavor (1997 - 2002) to promote equitable and effective delivery of basic health services through the development of an effective regional support network. The LACHSR is a combined initiative of the Pan American Health Organization (PAHO), the United States Agency for International Development (USAID), and the Partnerships for Health Reform (PHR), Data for Decision Making (DDM), and Family Planning Management Development (FPMD) projects. The Initiative funds regional support activities up to the total sum of $10.2 million. Its target countries include Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

The LACHSR focuses on four key strategic areas. These are:

- Developing, testing and disseminating methodologies and tools for the analysis, design, implementation and monitoring of national health sector reforms in order to enhance public, private and NGO-sector interaction, strengthen health finance decisions, and improve policy analysis and planning.

- Gathering, processing and disseminating information on national health reform efforts, and making this information widely available through an electronic resource center, a series of topical bulletins, a clearinghouse on health reform papers, and an electronic network.

- Monitoring reform processes and outcomes as well as equitable access to basic health services by developing and implementing tools, and providing feedback to countries, donors, and other partners.

- Helping countries to share experience and advice through regional conferences and workshops, institutional links, a regional forum for researchers, and study tours.

HEALTH SECTOR REFORM AND NON-GOVERNMENTAL ORGANIZATIONS

Health sector reform (HSR) always incorporates a deliberate effort to change the role of the public sector. As a result, HSR also implies a change in the role of other institutions involved in the organization and delivery of health services. The interaction of both of these sets of changes will generate the impacts of reform. It is in this context that the LAC HSRI addresses the issues related to public/NGO partnerships. The activities that have been identified reflect the assumption that such partnerships, both formal and informal, have the potential to form an important component of HSR strategies. They can directly impact on the reform in terms of equity and access to services, the primary focus of the LAC HSRI.

For HSR planners, the key issues relate to the potential of NGOs to support and reinforce the objectives of reform. Some of the Initiative activities are directed at providing planners with more information about NGO roles and experience in the region, and to develop materials which can support a more informed assessment of potential NGO linkages. For NGOs, key issues relate to impacts on

existing operating activities and resources and the potential new roles, implicit in reform. Initiative activities to address these needs emphasize improved management capacity for NGOs, and greater familiarity with reform processes in the region. Overall, an objective of the LAC HR Initiative is to strengthen the ability of NGOs to contribute to effective health sector reform by working on both the demand and supply sides.

Four aspects of public/NGO partnerships were identified for specific consideration:

- Participation in health policy dialogue
- Impacts of decentralization
- Contracting out for service provision, and
- Quality assurance activities.

A 'state of the practice' paper was written for each area drawing on the experiences of a selected group of NGOs in the region. These documents develop a general overview of essential issues that need to be addressed, if public sector / NGO partnerships are to be developed, where one of these four aspects is applicable.

It was recognized that although NGOs in the LAC region have an extensive involvement in the health sector, the experience with explicit "partnerships" is just developing. The 'state of the practice' papers were designed to identify a valid set of characteristics that have to be addressed in the context of every similar public/NGO partnership, although the specific solutions will vary with the context. We sought to develop useful guides to assure that these relationships are as effective as possible. At this stage, we drew on selected experiences and the assessment of a diverse group or NGOs in the region to provide a structure for beginning to generalize. This process will be continued as the regional experience develops.

The 'state of the practice' as regards the impact of decentralization on NGOs and their capacity to form effective partnerships with the public sector under health sector reform is the focus of this paper.

2. OBJECTIVES AND METHODOLOGY

OBJECTIVES

This decentralization 'state of the practice' paper draws from the global experience with public/NGO partnerships in response to decentralization, but focuses on the evolving regional experience with such partnerships in the target countries of the LAC HSR Initiative. Its specific aims are to:

- Document local experience with public/NGO partnerships is response to decentralization in the LAC region,
- Examine the possible impact of decentralization policies on NGOs, and
- Identify critical themes that NGOs should consider prior to establishing such partnerships with the public sector.

The paper serves as an input to further LAC HSR Initiative activities, and is made available to NGO managers, as well as to interested reform planners in the public sector.

METHODOLOGY

Data were collected in early 1999 through phone interviews with top managers of 35 non-governmental organizations in the LAC HSR target countries. A questionnaire, designed to guide the discussion, was sent to these managers prior to the phone interviews. The 'state of the practice' paper was then drafted on the basis of these phone interviews.

The NGOs that were interviewed provide a wide range of primary care and family planning services, training and technical support. More than three-quarters of them are engaged in direct service delivery to patients or clients. Two NGOs in the sample no longer provide services directly, but instead work through partners, such as other NGOs and the public sector. One NGO represents a consortium of non-governmental organizations.

Following the interviews, selected NGO representatives from the region were invited to a meeting, in which the draft paper was reviewed. The meeting was held in La Paz, Bolivia, from April 12 to 14, 1999. The final document benefited greatly from this review process, and from the extensive discussions during the meeting. The NGOs that were invited to La Paz were selected on the basis of their demonstrated interest and emerging experience with public/NGO partnerships in a decentralized or decentralizing setting, their technical reputation, and geographic representation. Public sector participants were not invited to the Bolivia meeting, because of a concern that their participation would hinder a frank exchange of experience about such partnerships among the invited NGO leaders.

3. HEALTH SECTOR REFORM AND DECENTRALIZATION

Health sector reform is a process that brings substantial changes in the way health services are managed. For the purposes of this 'state of the practice' paper, health sector reform is defined as:

> *The systematic redesign of the role of the public sector in the organization, provision, and financing of health services, and the design and implementation of the structures and financing strategies needed to effect these changes.*

Health sector reform may result from domestic pressures within the health sector itself or within the whole public sector. In many countries, however, reforms can be directly linked to the influence of donors. Regardless of what motivates the reforms, a nation's commitment to the proposed changes is crucial for their sustainability, as well as for the eventual success of health sector reform in reaching its goals. Sectoral reforms are sweeping through the Latin American and Caribbean region, but individual countries are at very different points in the reform process. Some have barely engaged in planning the reform, while others are well on their way to implementation.

Health sector reform inevitably alters both the location of responsibility for health service delivery and the authority over resource allocation. Decentralization is one of the main tools that reformers in almost all the LAC Initiative countries have used to transfer responsibility and authority. It is important to recognize, however, that decentralization is not the same as health sector reform. The latter involves many other initiatives, e.g. broader health financing options, collaboration with the private sector, and expanded health insurance coverage.

Decentralization, as a concept, lacks a clear and uniformly accepted definition. . (See Kolehmainen-Aitken and Newbrander[1], 1997.) Different forms of decentralization (such as political, market, spatial and administrative decentralization) take place simultaneously in any one country. Furthermore, decisions that reformers make about the types of administrative decentralization that they will adopt have different implications both for the relative distribution of power between central and peripheral levels and for the entities to which power is transferred. Some countries are *deconcentrating* responsibility and authority from the central ministry of health to its local-level offices. Others are *delegating* defined powers from the central level to organizations that are substantially outside the regular bureaucratic structure of the government, such as hospital boards. Some are *devolving* considerable powers to subnational units of government, such as municipalities, that are substantially outside the central government's direct control. Commonly, a mixture of different forms and types of decentralization is being implemented simultaneously.

Decentralization at a country level thus emerges in different forms and types. The speed with which countries shift power to lower levels is also highly variable, as is the capacity of new stakeholders to take on their revised responsibilities. (See Kolehmainen-Aitken[2], 1999.) This diversity is illustrated in the following brief review of decentralization experience in the region. (For more information, see the LACHSR Web-site at http://www.americas.health-sector-reform.org.)

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[1] Kolehmainen-Aitken, Riitta-Liisa and Newbrander, William. Decentralizing the Management of Health and Family Planning Programs. Lessons from FPMD Series. Management Sciences for Health, Boston, MA, 1997.

[2] Kolehmainen-Aitken, Riitta-Liisa (ed.), Myths and Realities about the Decentralization of Health Systems. Management Sciences for Health, Boston, MA, 1999.

In *Bolivia*, the process of decentralization started already in 1982, as part of the return to democracy. The strategy included the development of Popular Health Committees, which would emerge from the community itself to support health interventions. In 1985-1993, various initiatives arose to focus attention to the most vulnerable groups, namely mothers and children who suffered high indices of mortality. The process of district development in the health sector was part of the process of decentralization and delegation of authority. Ninety-three Sanitary Districts were identified, and 12 Sanitary Units consolidated at the regional level. The Sanitary District was defined as the minimum management unit of the health system, and management training and multidisciplinary district team development were started.

The Law of Administrative Decentralization and the Law on Popular Participation were passed in 1994. They transferred the administration, maintenance, and equipment of local health facilities to 311 municipalities. Municipalities were, for the first time, awarded economic resources from tax revenue. A health sector reform unit was created in the Ministry of Health, with financing from the World Bank and the Inter-American Development Bank (IDB). As part of the reform, this unit was made responsible for designing and developing an insurance which would cover a minimum packet of maternal and child health services, delivered by the public sector, social security institute, and NGOs.

In 1998, the national government of Bolivia defined social development strategies on the basis of the strategies of Institutionalization, Dignity, Opportunity, and Equity. Health sector reform was framed by defining the Basic Health Insurance (Seguro Basico de Salud), Free Medical Insurance of the Elderly (Seguro Medico Gratuito de Vejez), the Epidemiological Shield (Escudo Epidemiologico) and Family and Community Health. The Basic Health Insurance defines 70 services, and multiple service providers, allowing the possibility of NGO participation, as well as an investment fund through a mechanism of resource allocation. This marks the start of a gradual health sector reform in Bolivia.

The 1988 Federal Constitution of *Brazil* defines the country as a federal republic with autonomous regional and municipal governments. Management decentralization to municipalities is a main component of the health reform. The 1990 Health System Law, which defined the structure and financing of the new health care system, has, however, not yet been implemented in full. The decentralization strategy of the Ministry of Health defines three levels of municipal decentralization. Municipalities have to fulfill certain requirements to demonstrate their capacity, and only the third level municipalities can autonomously decide how to spend their budget.

One of the most important aspects of the Brazilian reform is incorporating the participation of social organizations in the health system. The Organic Law on Health no. 8.080 of 19 September 1990 defined the roles of non-governmental organizations in the promotion, protection and recovery of health. Where public services are insufficient to guarantee service coverage for the population of a defined area, the health system at different levels can provide the coverage by using NGO services, provided under formal agreements.

The *Colombian* health sector reform is very complex. Law 100 of 1993 established the General Social Security System, based on the expansion of coverage through two systems, a contributive and a subsidized system. Health Promotion Enterprises were created as the organizational core of the Contributory System. They enroll the population, mobilize financial resources, promote health, and organize delivery of health services. The Subsidized System through its Collective Health Enterprises is slowly replacing the traditional state-funded health system.

The Health Promotion Enterprises can be public, private, collective, or mixed. They compete among themselves to enroll the population. Public hospitals are being transferred into State Social Enterprises. In 1998, PAHO reported that decentralization had been achieved in 17 out of 32 departments (53%), all 4 districts, and 150 out of 1,065 municipalities (15%), according to data from the National Planning Office.

Health sector reform in the *Dominican Republic* is still in its early stages. A legal decree has created Provincial Directorates of Health (DSPs) as the new provincial health authority. The DSPs are being strengthened in order to transfer responsibilities, capabilities, and resources to them. The decentralization process does not involve municipal authorities.

In *Ecuador*, the Law on Government Decentralization and Social Participation intends to progressively transfer authority, responsibility, and resources to lower levels. The details of translating these intentions into a new national health care system are still being worked out. The decentralization model of the Ministry of Health is based on technical decentralization and deconcentration of certain administrative activities, programming and budgeting to health areas with small service networks. The Social Security Institute (IESS), in contrast, is decentralizing its administrative aspects at the level of large regions.

El Salvador is currently engaged in defining and putting into operation a new model for its health system. It has already started the decentralization of administrative processes. In January 1999, the Ministry of Health signed agreements with five local NGOs to deliver primary health services in rural areas of the country.

The government in *Guatemala* is promoting the Comprehensive Health Care System (SIAS), as the most important initiative within the IDB-funded Health Services Modernization Program. The SIAS is intended to provide a basic package of services to the population that currently lacks them. It is based on a network of community workers and on subcontracting with NGOs for service delivery. The Ministry of Health has established management commitments with the country's Area Authorities, which are increasingly given the responsibility to contract with local NGOs for service delivery, funded through a predefined cost-per-user. The SIAS is reported to have contributed to important improvements in health indicators. Primary health coverage has increased from 54% to 85% from 1996 to 1998, and vaccination coverage from 75% to 91%, while infant mortality has decreased from 51 per 1000 to 37 per 1000 in the same period.

Decentralization in *Mexico* commenced in 1988, when the Secretariat for Health (SSA) transferred functions and resources to 14 states. After several years of inaction, decentralization resumed within the framework of health sector reform, and a broader political process known as the "New Federalism." The Federal Executive Branch and the state governments signed the National Agreement on Decentralization of the Health Services in 1997. Decentralized public agencies, which were new administrative entities with legal status and their own resources, were created in every state. These agencies are responsible for the health facilities transferred by the SSA to the state governments. The IMSS (Instituto Mexicano de Seguro Social) also decentralized functions and responsibilities, but to its seven administrative regions, not to states.

4. NGOS AND DECENTRALIZATION

Decentralization, one of the tools of health sector reform, alters the role of the central-level health authorities. Inevitably, the role of NGOs also changes. Decentralization can impact NGOs in several ways. First, it changes the *authorities* that are responsible for planning local health programs, and making decisions about NGOs' role in local service delivery. NGOs can no longer be content to deal solely with a central-level government health authority. Instead, they must develop relationships with local-level governments and health authorities. This requires a greater understanding of local politics, and of the key actors in local decision-making.

Second, decentralization often changes the *funding* of health services. Local authorities are given a much bigger role in making decisions about the use of public sector revenue in financing the response to local needs. The work of an NGO in support of the public sector may now be funded through a block grant to the NGO from a municipal or state government, a contract, or a central government subsidy.

Third, decentralization can change the *competition for services*. New funding and service delivery mechanisms may increase the competition for clients between NGOs themselves, and between NGOs and public facilities. Conversely, decentralization may substantially expand the demand for NGO services, especially when the NGO is locally well known and respected.

Fourth, decentralization often changes the *legal and regulatory framework* in which the NGO works. National laws and regulations underpinning the decentralized health care system can have a great impact on the capacity of NGOs to become creditable partners to the public sector. Such laws and regulations are, however, frequently drafted without any input from the NGO sector itself. NGOs operating in a federal country, such as Brazil, are also subject to legislation drafted by the federated states.

Fifth, decentralization may change the *appropriateness of existing management systems*. This holds true for both the NGOs and the public sector. The organizational structure of an NGO and its management systems and processes may need to change in response to its new role, the changed demand for its services, and the way the services are funded and supervised.

But NGOs are not all the same! The term 'NGO' covers a diverse group of organizations who pursue a multiplicity of goals, and no agreement exists about the way NGOs should be categorized. Andrew Green[3] of the Nuffield Institute in the U.K. divides the health sector NGOs into:

a) religious organizations

b) international (social welfare) NGOs

c) locally based (social welfare) NGOs

d) unions and trade and professional associations

e) other non-profit making organizations; and

f) non-profit making (but pre-paid) health care (e.g. HMOs).

[3] Green, A. The role of non-governmental organizations and the private sector in the provision of health care in developing countries. *International Journal of Health Planning and Management*, 2: 3-58, 1987.

David Korten[4], another keen observer of the NGO sector, groups them into:

a) voluntary organizations

b) public service contractors

c) people's organizations; and

d) governmental NGOs.

No matter how we choose to classify NGOs, the different NGO groupings and individual NGOs within each group vary greatly in their mission and goals, in their capacity and resources and in their age and reputation with the public sector. They are unlike each other in the extent to which they have prior links with central and local governments and with other NGOs locally and internationally. And they contrast in the extent to which they depend on government grants or donor support for their survival. An important consequence of all this diversity is that the willingness of NGOs to engage in public sector partnerships, and their credibility in the eyes of the government as a valuable partner are also highly variable.

[4] Korten, D. *Getting to the 21st Century: Voluntary Action and the Global Agenda*. Kumarian Press: West Hartford, 1990.

5. BUILDING PARTNERSHIPS IN RESPONSE TO DECENTRALIZATION

The nature of the health sector reform process, the speed with which it proceeds, and the extent to which decentralization is used as a reform tool vary greatly between the LAC countries. Thus, the impact of decentralization on NGOs in the region is not uniform from country to country. The changing relationships bring the potential for expanded partnerships between the public sector and the NGOs. This 'state of the practice' paper has been developed to explore these experiences and to identify some critical issues that need to be addressed in developing such relationships.

In reviewing the experience in their own countries, the participants in the Bolivia meeting noted that decentralization might:

- Increase the number of NGOs operating in a country, thus diluting the influence of any individual NGOs
- Reduce the number of NGOs in the long run due to increasing competition
- Bring more money to NGOs at the municipal level, where management capacity and skills are often lacking
- Make it easier to negotiate with a municipality than with a central government
- Stimulate better strategies for big NGOs to collaborate with small local NGOs in NGO to NGO partnerships
- Provide the public sector with a formal mechanism to resist the actions of NGOs, and to stop previous support to them.

The following pages provide several examples of public/NGO partnerships that the participating NGOs in the LAC region have thus far developed. They also illustrate the challenges NGOs are experiencing, and the way they have responded to these challenges.

EMERGING PUBLIC/NGO PARTNERSHIPS

Many NGOs in the LAC region have proven themselves to be creditable and trustworthy partners to the public sector. They have a wealth of valuable experience in delivering services that are of high quality, and focus on disadvantaged populations. They often pioneer attention to issues that the public sector has found difficult to take on, such as HIV/AIDS, reproductive health, etc. They are usually more flexible and innovative than the public sector, and can pioneer new approaches to service delivery, which the public sector can benefit from. Thus, the NGOs have much to contribute within the context of health sector reform.

The discussions in the Bolivia meeting made it very clear that not only do NGOs have much to offer the public sector, they are also very interested in developing real partnerships. The NGO leaders emphasized, however, that these partnerships must be genuine partnerships, with each partner

contributing its share openly and willingly. The NGOs are very definitely not interested in absolving the state from its responsibility toward the health of the nation!

The emerging public/ NGO partnerships reflect the diversity of NGOs in terms of their mission and goals, as well as their funding and staffing. While no uniform type of relationship emerged as predominant between government health services and the NGOs in the LAC region, the interviews and discussions revealed five specific areas of NGO contribution to the public sector. These are 1) direct service delivery, 2) training and capacity building of government staff, 3) demonstration projects toward health reform, 4) technical advice and advocacy, and 5) NGO coordination.

Direct service delivery in areas of NGO strength

Several of the NGOs interviewed have taken advantage of new openings in direct service delivery that decentralization has opened up at the local level in their countries. These public/NGO partnerships take a number of different forms. They may be between the NGO and the central government or between the NGO and the municipal or state government. The relationship with the public sector may be based on a contract between the two entities or it may use more informal arrangements.

Profamilia in Colombia now sells its family planning and sexual health services to Empresas Prestadoras de Salud (EPS) which are responsible for provision of services and health insurance. The government established thirty of these ESPs, as part of its new decentralized health delivery model. *Bemfam* in Brazil has a well-defined strategy to complement the government sector, rather than compete with it. It provides sexual and reproductive health services in almost 900 municipalities in twelve states, including those for HIV/AIDS.

In El Salvador, where decentralization is still in its early stages, *Fusal* signed a formal agreement three years ago with the central Ministry of Health, taking full responsibility for primary health services in the municipality of San Julian. This responsibility includes the administration of the municipal Unidad de Salud. In 1999, Fusal and four other NGOs signed a contract with the Ministry to deliver services in additional areas. In Bolivia, *Prosalud* works at the municipal level under locally signed agreements within a central agreement (Convenio Marco). In some municipalities, the local government has provided land for a Prosalud clinic, and at least in one municipality, it has provided the actual clinic facility.

Decentralization of power to the municipal level has sometimes resulted in NGOs replacing the public sector for some aspects of service delivery. *CEMOPLAF* in Ecuador provides voluntary surgical contraception services in two government hospitals under a contract with the Ministry of Health, under which the public sector delegates this responsibility to CEMOPLAF. It also provides cytology services to public sector clients in the Hospital of Pujili, and vaccination services in Otavalo, using supplies and equipment of the Ministry of Health. *CIES* in Bolivia provides medical and training services in sexual and reproductive health at the municipal level. These services were previously provided by the public sector.

Training and capacity building for government staff

Decentralization places new demands on local-level government staff in terms of planning and managing health services. Many NGOs play a valuable role in training and capacity building of such public sector staff. NGOs have been most active in providing in-service and continuing education in the areas of their technical expertise, and in management training. A few of them have created or supported academic training programs in support of health sector reform.

Bemfam has formal contracts with 900 municipal governments to improve their capacity in sexual and reproductive health. It provides these municipalities with its methodology for training doctors, nurses and social workers. Municipal health departments in turn agree to use Bemfam's norms, standards and treatment protocols. In Ecuador, *CEMOPLAF* provides both theoretical and practical training in sexual and reproductive health to rural physicians who work in the public sector. It has also participated in the development of national manuals on these topics. *Mexfam* trains Mexican government staff in adolescent and sexual health. *CARE/Bolivia* has provided training for municipal-level public sector staff in planning, monitoring and evaluation, supervision, and diagnostic skills. It has also organized Training of Trainers workshops.

Some NGOs are planning and implementing academic training programs in support of the public sector. Funded by the USAID-funded APOLO (Apoyo a Organizaciones Locales) project, *CARE/Ecuador* has collaborated with the Catholic University to develop an interesting specialist training program for physicians from small towns in Ecuador. These doctors study family health in their own facilities under the guidance of a University faculty member, and receive their specialist qualification at the end of the three-year training program. The government of Ecuador is now interested in replicating this training concept. *Fusal* has created a number of academic programs of different scope and target audience to support health sector reform efforts in El Salvador. In 1999, for example, it offers two diploma level courses, one in health management and the other in epidemiology.

Demonstration projects of new health delivery models

One of the key goals of decentralization is to encourage service providers to improve their response to local needs. NGOs can generally be much more innovative and flexible than rigid government health systems in defining the services they wish to deliver to meet such needs. NGOs also suffer from fewer bureaucratic restrictions than the public sector in targeting their financial and human resources toward locally identified needs. NGOs can thus play a very useful role in designing and implementing demonstration projects of new ways to deliver services in countries where health sector reform, and with it decentralization, are still under development. Public sector reformers can use these demonstration projects to learn valuable lessons for future reforms. The capacity of NGOs to undertake such demonstration projects is obviously closely tied to the resources that they can mobilize for such activities.

CARE/Ecuador has been implementing the APOLO project since April 1995. The project's strategic objective is to develop demonstration models of service delivery and financing which contribute to the definition of policies in the health sector reform process. This project is implemented in association with local NGOs (CEMOPLAF, Fundación Pablo Jaramillo, ASME-CX), municipalities (Chordeleg, Bolívar, Pedro Vicente Maldonado, Santa Elena), the Catholic Church and the communities.

CARE has designed three different demonstration models, and developed a strategic plan for each model. This plan is implemented under the supervision of Consejos Cantonales de Salud, which have been created for this purpose. One of the demonstration models that APOLO implements is decentralization and social participation in the city of Chordeleg. The working hypothesis of this experimental model states that "through decentralization of health services, the quality of health service delivery can be improved, coverage increased, resource management made more effective and efficient, equity and solidarity ensured, community participation in health decision making increased, and a sustainable impact achieved on the health situation and on improving the quality of life in the community." The results of this demonstration project are soon ready to be shared with others.

Technical advice and advocacy

Provision of technical advice in the areas of their expertise is another way in which NGOs partner with the public sector. The experience of the NGOs interviewed for this paper appears to be mixed in this regard. A few of them stated that they have been able to influence public sector decisions either by working directly with the decentralized level managers or by participating in national level committees and meetings. Many of the reproductive health NGOs, such as *CEMOPLAF* and *APROFE* in Ecuador and *COF* in El Salvador, have participated in developing national norms for sexual and reproductive health. Other NGOs felt that successful practices in NGO-run services have indirectly influenced decision-making in the public sector. In many cases, however, NGOs reported that they have had little influence on public sector decision-making.

NGOs can play a very useful role in advocating for priority health needs that may be overlooked by health reforms in the public sector. *Profamilia*, for example, joined with many other organizations in advocating for the inclusion of family planning in the basic package of services that is covered under Colombia's decentralized health system.

NGO coordination

As pointed out before, the NGO sector consists of a large number of organizations that vary widely in their mission, motive, and capacity. Information about these NGOs and the services that they provide is often not readily available to the government. Public sector health reformers, even those with a genuine commitment to developing public/NGO partnerships, are thus faced with great difficulty in trying to determine which NGOs can become creditable partners to government.

NGO networks and umbrella NGOs can represent the views of the NGO sector in reform debates, and coordinate information exchange between NGOs themselves, and between the NGO and the public sectors. No consensus emerged in the Bolivia meeting of NGOs, however, about the value of such networks or umbrella organizations. The experience in the different countries of the region proved very variable. In some countries, NGO networks have served as a very valuable common voice for the NGO sector in its discussions with the public sector. They have also been useful avenues of mutual learning for the NGOs themselves. In other countries, however, these networks appear to have had a very corrupt history.

Insalud, a consortium of 62 NGOs, is serving a very useful purpose in the health sector of the Dominican Republic. The Dominican government recognizes Insalud as the organization representing the NGO sector in all decisions that involve NGOs. Insalud organized the election of NGO representatives to the Comisión Ejecutiva de Reforma del Sector Salud (CERSS) and to the Comisión Nacional de SIDA. It also participated in defining the strategies regarding the Ley General de Salud, as well as the development of relationships with the Cámaras Legíslativas.

Insalud is a member of the Comisión Nacional de Habilitación y Acreditación de ONG. It collaborates through this Commission with the Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS) in developing a process to ensure that service delivery NGOs comply with minimum standards and norms. Insalud is also working to change the terms under which SESPAS transfers public funds to NGOs.

CHALLENGES FACING NGOS

The public sector in any LAC country consists of a variety of organizational entities and management levels from the central Ministry of Health or Social Security System to municipal governments and local health offices. Each of these components of the public sector has its own organizational aims, resources, constraints, and level of trust – or suspicion – of the NGO sector. NGOs face numerous challenges in navigating the maze of such a complex public sector when they seek to form useful partnerships with it. Challenges arise especially as a result of unclear expectations by the public sector, new conflicts that decentralization creates, and resource constraints that NGOs experience.

Unclear or unrealistic expectations by the public sector

Changing the role of the public sector through health sector reform dictates that the role of the private sector, including that of NGOs, also changes. The potential contribution of NGOs as a partner to the public sector should thus be of great interest to health reform planners. The interviews revealed, however, that NGOs are only rarely included in the discussions in which the new power sharing arrangements under decentralization are determined. Over one half of the NGO representatives interviewed reported that they had no involvement at all in such discussions.

The exclusion of NGOs from contributing to the design phase of decentralization can jeopardize their later participation in the reform. First, government documents on planned reforms commonly do not contain sufficient detail about the expectations that the government has of the future role and contribution of NGOs. A vaguely defined NGO role may leave the public sector with quite erroneous assumptions about the role that the NGOs are willing to adopt. Second, the lack of input by NGOs to the sectoral reform may result in reformers setting unrealistic standards for government's potential new partners. It was reported, for example, that when the Colombian health sector was decentralized, public sector reformers set such high minimum standards for participation as a service provider that many NGOs were excluded from participating. Third, exclusion from the design phase may leave NGOs very poorly informed or suspicious about the goals of the reform, and struggling to define their own potential contribution to it.

New partners, new conflicts

Health sector reform is a highly political endeavor. As a result of decentralization, NGOs are faced with a new set of political stakeholders, such as municipal governments. Responsibility and authority for health planning and budgeting is no longer exclusively held by the central level. The new relationships challenge the accountability and transparency of NGOs. NGOs who have gained the trust of local authorities through their prior work at the local level have generally found it easier to manage the change and adapt to the new working environment. NGOs whose operations and management are perceived as lacking such transparency are likely to fare worse.

Disagreements commonly arise between the central government level and the new decentralized institutions and administrative levels, when power is being transferred. NGOs have at times found themselves caught in the middle in such political fights, as the 'ham in the sandwich.' The political skills of NGO managers are called on to navigate such conflicts.

Municipal governments are perhaps the most important new stakeholders in the decentralized countries of the LAC region. Management capacity at the municipal level is still very limited in most

LAC countries. NGOs are thus working not only with new partners, but also with partners whose capacity to manage the emerging public/NGO partnership may still need much improvement.

Resource constraints

NGOs often encounter much greater competition in a post-decentralization environment. The Colombian reforms, for example, increased the competition both between service delivery NGOs themselves, and between these NGOs and the public sector. The Bolivian reforms have similarly increased the competition between service providers.

To stay competitive, many NGOs have had to devote resources to improving their facilities and expanding the services they provide. The decreasing level of donor funding to the NGO sector, coupled with the increasing demands, raise questions about the sustainability of operations for those NGOs who are resource-poor.

NGO response to challenges

NGOs who have risen to the challenges of decentralization have done so by thinking proactively and taking steps to make themselves more competitive in the changing environment. In particular, NGOs have sought to improve their:

- services
- facilities
- staffing
- management systems, and
- organizational structure.

Successful service delivery NGOs in decentralized countries have broadened the array of services that their clinics offer. *Prosalud* in Bolivia, for example, added new specialties to its clinic services, opened an eye-care program, a workshop for orthopedic devices, and a physical therapy program.

In addition to widening their services, NGOs have improved the physical infrastructure of their clinics. They see such improvements as essential for their ability to continue to attract clients in the more competitive environment. Both *Profamilia* in Colombia and *Prosalud* in Bolivia sought extra outside resources to improve their clinics.

BEMFAM has improved its services, facilities, and management systems in order to respond to the new demands of the reform context. It established new specialties among its clinical services, and acquired new equipment. Maintaining the skills of its human resources is one of the continuing priorities of BEMFAM as it takes on the challenges of the Brazilian reform.

A common theme in the discussions with service delivery NGOs that operate in decentralized countries was their recognition that they had to become much more businesslike in the way they are managed. *Profamilia* in Colombia, for example, commented that they 'have had to become a health firm that runs like a private firm.' This has had a distinct impact both on the staffing of these NGOs and on

their internal staff training. Several NGOs observed that MBAs are increasingly taking the place of medical doctors as clinic managers. NGOs are providing more management training for their own staff. They are also seeking to ensure that their staff remains technically up-to-date, especially when the NGO has a role in providing technical advice to the public sector.

Financial management is another area that NGOs pay a lot of attention to, because improvements in this area can greatly assist them in adapting to their post-decentralization role. Sustainability under the new more competitive working environment, coupled with contract-based partnership arrangements, bring different demands than before for the way the NGOs manage their finances. NGOs need to be much more aware of the cost-benefit of their services, as well as have the ability to monitor and evaluate the accessibility, quality and efficiency of such services.

Management information that is up-to-date, reasonably accurate, and easily accessible is increasingly important for sound management decisions. NGOs have rightly sought to improve the collection, processing and analysis of such essential data. *Profamilia* commented that its management information system, in particular, has been difficult to modify following decentralization. As Profamilia changed it role to selling its services, the focus in financial management shifted. The previous requirement of the right kind of financial information to satisfy donors changed to Profamilia now needing appropriate information for managing its costs.

The concern for improved quality, together with the requirements for quality assurance that a decentralized public sector places on its partners, have led to various efforts to monitor and improve this area. *Mexfam* created a new department of medical quality. *Fusal* now has a department of 'systematization and evaluation of experience.' *Profamilia* organized quality committees (comites de calidad) in all 35 of its health centers. These health centers are regularly audited both by the Ministry of Health and by the Empresas Prestadoras de Salud.

Finally, NGOs that work at several levels of a health system have found it increasingly important to reassess the relationship of their own central office to their local branches. Local branches are closer to decision-makers at the decentralized level, and thus in a better position to market NGO services to those who now hold the purse strings at the local level. The managers of these local branches must be able to take quick decisions without constantly referring to the central office of the NGO. *Prosalud* in Bolivia, for example, has empowered its regional offices to develop good relations with munic ipal mayors. Prosalud's central level has strengthened its own capacity to support the regional offices, while the regional level has been given more leeway in decision-making.

6. CRITICAL CONSIDERATIONS

To succeed, health sector reform requires technically and organizationally competent partners. NGOs vary greatly in their current technical strength and organizational capacity. While stronger NGOs have already taken advantage of new openings, weaker NGOs have not benefited to the same degree. Some NGOs may, in fact, have suffered as a result of decentralization. The NGO leaders in the Bolivia meeting emphasized that prior to entering into a partnership with a public sector, an NGO must analyze its own technical and managerial strengths and weaknesses, and be genuinely committed to strengthening areas that need improvement.

But health sector reform is also a political issue. The NGO leaders recognized that they must improve their own understanding of the political environment in their country, as well as the health sector reform changes that are planned or already under way. In particular, they must examine critically the likely implications that these changes have for the work of the NGO that they lead.

STRENGTHENING MANAGEMENT SYSTEMS AND SKILLS

The participants in the Bolivia meeting stressed that before an NGO can become an effective partner to the public sector, it must put its own house in order. It must ensure that its own vision and mission are clear, and that it has a well-developed strategic plan. It must examine critically its internal management structures and systems, identify areas of weakness, and seek to improve them. If the NGO has been run in a very centralized manner, it may have to change its organizational structure to be in line with the new decentralized public sector context.

Improving management systems and processes is important, but it is not enough. The NGO leaders noted that an NGO must also ensure that its staff has the appropriate management skills to use these systems and processes. Adequate skills in planning, financial and human resource management, pharmaceutical and inventory management, management information, and monitoring and evaluation are all necessary for sound management.

Health sector reform brings with it a demand for a new set of skills. The NGO leaders pointed out that even well managed NGOs may currently lack adequate skills in advocacy, negotiation, marketing, and contracting. Advocacy skills of staff need to be sharpened, if NGOs are to represent the needs of their constituents in the most effective manner. Negotiation skills are essential for developing mutually beneficial partnerships with the public sector. Marketing skills need improving, if an NGO is to survive the increasing competition that decentralization is likely to bring. Skills for drawing up and managing contracts are essential for an effective and sustainable contractual partnership with the public sector.

DEVELOPING A SOUND FINANCIAL BASIS

The NGO leaders emphasized that NGOs must have a very clear picture of their sources of revenue, if they intend to partner with the public sector. They need to engage in long-range fiscal planning, and be willing to explore new sources of revenues. They must also know how much their resources vary from year to year.

POSITIONING IN THE HEALTH CARE MARKET

NGOs must begin to see themselves as actors in a health care market. The Bolivia meeting participants underscored the importance of examining whether the NGO already has a market lead in certain areas, and what it will take to remain competitive. NGOs must examine new opportunities, and decide which of these markets might be particularly suitable for them.

In order to position themselves in the health care market, NGOs must know their current target populations, and whether their service populations vary from year to year or remain stable. They may also have to improve their own infrastructure and equipment to remain competitive. If such improvements are essential, NGOs must examine, whether they can finance the new capital costs from their own revenues or whether they should approach suitable donors.

CULTIVATING LEADERSHIP

The NGO representatives repeatedly stressed the importance of leadership as a key ingredient for successful partnership. NGOs must identify and cultivate such leadership potential within their own ranks. They must seek opportunities for developing such leaders, and for exposing them to the wider health sector reform discussions in the region.

In addition to individual leadership, NGOs as organizations should also see themselves as leaders. They have a very important role to speak out for disadvantaged groups, such as ethnic minorities or women, whom they are serving. The Bolivia meeting participants emphasized that in order to exert this leadership role, NGOs must seek to develop a common vision of what the health system in their country should look like in the future, and what the appropriate role of NGOs should be. Such a leadership role requires that an NGO foster appropriate relationships with other like-minded NGOs, as well as with local and central governments.

Strengthening an NGO's own internal management capacity is important, but it is not enough. As stated before, the NGO leaders recognized that developing sound public/ NGO partnerships also requires that those responsible for managing NGOs develop a keen understanding of health sector reform processes that are planned or already under way in their own country. Without such an understanding, they can not shepherd their organization to take the best advantage of new openings that decentralization may bring. The participants acknowledged that these openings are not only for big NGOs. All kinds of NGOs can join hands with the public sector, but only if their managers fully understand the changes that health sector reform is bringing.

7. LESSONS LEARNED

The NGO leaders attending the Bolivia meeting identified five key lessons from their own experience in developing public/NGO partnerships:

BE PROACTIVE

An NGO must be proactive in approaching the public sector to seek mutually profitable partnerships. The NGO leaders emphasized that innovative and flexible NGOs, which actively look for new openings while maintaining their organizational mission and integrity, can be very valuable partners to the public sector.

EXAMINE PARTNERSHIP IMPLICATIONS TO NGO CAPACITY

An NGO must examine closely the nature of the partnership that the public sector offers in terms of its implications for the NGO's own capacity. Signing a contract with the public sector, for example, has very different ramifications for the management of the NGO than accepting a subsidy to focus on target services or populations.

CONSIDER IMPACT OF AGREEMENT LENGTH ON NGO OPERATIONS

An NGO should carefully consider how the length of the proposed agreement is likely to impact on its operations. The cost of proposal writing is not insignificant. A year by year contract with a decentralized public sector can consume a lot of NGO managers' time and resources. NGOs must thus decide whether entering into such a short contract is worth it for them. If the risk of short-term contracts appears to be too high, NGO managers should examine what leverage they have to push for longer-term partnerships that would be less risky.

UNDERSTAND OBLIGATIONS AND AUTHORITY

An NGO must appreciate what it is obligating itself to under a public/NGO partnership. In particular, it must understand clearly what authority it will have to make any changes, if such changes are needed during the course of the partnership.

WEIGH RISKS TO OTHER RELATIONSHIPS

Finally, a competition for contracts with the public sector can potentially jeopardize the existing relationships that an NGO already has with other NGOs. An NGO must carefully weigh the risk of damaging these relationships that may be important to its mission, against the benefits of winning a contract with the public sector.

8. CONCLUSION

This 'state of the practice' paper reflects early experience with health sector reform. In many LAC countries, the reform itself is only beginning to take shape. The nature of participation by NGOs is still evolving in response to these nascent reforms. Consequently, the emerging public/NGO partnerships represent a diversity of responses to the health reform initiatives in the Latin America and Caribbean region.

This document can only be suggestive, not prescriptive! Inevitably, the growing experience with public/NGO partnerships in the region will generate new options and alternatives that have not been considered in this brief. It is hoped that document provides a helpful first step in supporting this process of development.

9. LIST OF PARTICIPANTS

INTERCAMBIO TÉCNICO

EXPLORANDO LAS RELACIONES ENTRE LOS SECTORES ONG Y PÚBLICO:

DECENTRALIZACION Y CALIDAD

La Paz, Bolivia, April 12-14, 1999

Organization	***Participant Name***	***Contact Information***
BEMFAM	Rita Passoa	Av. Repubplica de Chile, No. 230-17 Centro Rio de Janeiro, RJ, CEP 20031-170 Brazil Tel: 55 21 210 2248 Fax: 55 21 220 4057
CARE/ Bolivia	Geraldo Romero	Edición Ignación de Loyola, 1er Piso Calle 12 esq. Hector Ormachea, Obrajes La Paz, Bolivia Tel: 591 2 787 471 Fax: 591 2 783 698
CARE/ Ecuador	Ivan Palacios	Av. Eloy Alfaro 333 y 9 de Octubre Edif. Plaza Doral, 1er piso Apartado 17-21-1901 Quito, Ecuador Tel: 593 2 528 689 Fax: 593 2 565 990
CARE/ Guatemala	Oscar Cordon	**Av. la Reforma 6-64, Zona 9** **Ciudad Guatemala, Guatemala** Tel: 502 339 1139 Fax: 502 339 1149
CEMOPLAF	Teresa de Vargas	Calle Cuero y Caicedo 258 y Ave. 10 de Agosto Casilla 17-01-3549 Quito, Ecuador Tel: 593 2 230 519 Fax: 593 2 233 713
CIES	Jack Antello	Calle Jacinto Benavente No. 219 Casilla 9935 La Paz, Bolivia Tel: 591 2 361 645 Fax: 591 2 361 614

Fundación San Gabriel	José Barragán	Nuñez del Prado, Esq. Pedro Villamil Casilla 4093 La Paz, Bolivia Tel: 591 2 230 646 Fax: 591 2 231 109
FUSAL	Celina de Choussy	Boulevard Orden de Malta Urbanización Santa Elena Sur Antiguo Cuscatlán, El Salvador Tel: 503 289 1100 Fax: 503 278 9432
INSALUD	Guillermo de la Rosa Berges	Luis F. TI omen No. 308 Apartado Postal 11184 Santo Domingo, DR Tel: 472-3613 Fax: 472-3967
IPPF/ Bolivia	Ivan Prudencio	Av. 20 de Octubre #2164, Sopacachi La Paz, Bolivia Tel: 591 2 416 054 Fax: 591 2 416 047
Organización Panamericana de la Salud	Yanuario García	Calle José Aguirre Achá #37 Casilla 2504 La Paz, Bolivia Tel: 591 2 263 646 Fax: 591 2 391 296
PROCOSI	Bertha Pooley	Av. 20 de Octubre No. 2164, Casilla 9432 La Paz, Bolivia Tel: 591 2 374 104 Fax: 591 2 314 188
Prosalud	Antonio Arrazola	Calle Jorge Sáenz #1382 Miraflores La Paz, Bolivia Tel: 591 2 222 663 Fax: 591 2 222 479
USAID/ Bolivia	Judith Timyan	Calle 9#104, Obrajes La Paz, Bolivia Tel: 591 2 786 544 Fax: 591 2 786 654

Publications of the Latin America and the Caribbean Regional Health Sector Reform Initiative

1- Methodology for Monitoring and Evaluation of Health Sector Reform in Latin America and the Caribbean (English/Spanish)

2- BASE LINE FOR MONITORING AND EVALUATION OF HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARIBBEAN (ENGLISH/SPANISH)

3- ANÁLISIS DEL SECTOR SALUD EN PARAGUAY *(PRELIMINARY VERSION)*

4- CLEARINGHOUSE ON HEALTH SECTOR REFORM (ENGLISH/SPANISH)

5- FINAL REPORT – REGIONAL FORUM ON PROVIDER PAYMENT MECHANISMS (LIMA, PERU, 16-17 NOVEMBER, 1998) (ENGLISH/SPANISH)

6- INDICADORES DE MEDICIÓN DEL DESEMPEÑO DEL SISTEMA DE SALUD

7- MECANISMOS DE PAGO A PRESTADORES EN EL SISTEMA DE SALUD: INCENTIVOS, RESULTADOS E IMPACTO ORGANIZACIONAL EN PAÍSES EN DESARROLLO

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13- CUENTAS NACIONALES DE SALUD: REPÚBLICA DOMINICANA *(PRELIMINARY VERSION)*

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