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State of the Practice:

Public-NGO Partnerships for Quality Assurance

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ACRONYMS

APOLO	Apoyo a Organizaciones Locales, Ecuador
BEMFAM	Sociedade Civil Bem-Estar Familiar no Brasil
CEMOPLAF	Centro Médico de Orientación y Planificación Familiar, Ecuador
CIES	Centro de Investigación Educación y Servicios, Bolivia
DDM	Data for Decision Making (Harvard School of Public Health)
FPMD	Family Planning Management Development
FUSAL	Fundación Salvadoreña para la Salud y Desarrollo Humano
HSR	Health sector reform
IEC	Information, education and communication
INSALUD	, Dominican Republic
LAC	Latin America and the Caribbean
MEXFAM	Fundación Mexicana para la Planificación Familiar
MSH	Management Sciences for Health
NGO	Non-governmental organization
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform (Abt Associates)
PROCOSI	Programa de Coordinación en Salud Integral, Bolivia
PROFAMILIA	Asociación Pro-Bienestar de la Familia Colombiana
PROSALUD	, Bolivia
QA	Quality Assurance
SESPAS	Secretaría de Estado de Salud Pública y Asistencia Social, Dominican Republic
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 (LAC HSR Initiative) 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 LAC HSR Initiative 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 LAC HSR Initiative 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 HSR INITIATIVE 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 HSR INITIATIVE.

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, one objective of the LAC HSR Initiative is to strengthen the ability of NGOs to contribute to effective health sector reform by working on both the demand and supply sides.

For the current activities, four aspects of public/NGO partnerships have been 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 is being developed for each area. Each draws on the experiences of a selected group of NGOs in the region. In collaboration with these and other organizations, the reviewdevelops a general overview of essential issues that need to be addressed if partnerships are to be developed where one of these four aspects is applicable.

It is recognized that, although NGOs in the LAC region have an extensive involvement in the health sector, the experience with explicit "partnerships" is just developing in many settings. The "State of the Practice" review is 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 are seeking to develop a guide to assure that these relationships are as effective as possible. At this stage, we are drawing 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.

2. OBJECTIVES AND METHODOLOGY

OBJECTIVES

The quality assurance review draws from the global experience with NGO roles in designing and implementing quality assurance activities and developing Public/NGO partnerships. It focuses on the evolving regional experience with such partnerships in the target countries of the LAC HSR Initiative. Its specific aims are to:

- Examine the possible impacts of HSR policies on quality assurance,
- Describe current NGO roles in quality assurance activities,
- Explore existing local experience with public/NGO partnerships to carry out quality assurance activities in the LAC region, and
- Identify critical themes that NGOs should consider prior to establishing such partnerships with the public sector.

The State of the Practice review will serve as an input to further LAC HSR Initiative activities, and be made available to NGO managers, as well as to interested reform planners in the public sector. of the methodology.)

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:CHALLENGES FOR QUALITY ASSURANCE

Health sector reform is a process that brings substantial changes in the way health services are managed. For the purposes of this policy brief, 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 pressures to respond to weaknesses in the health sector itself or from broader strategies of change targeted at the entire public sector. Sectoral reforms in response to both influences 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 in the midst of implementation.

All health sector reform involves changes in public sector roles and, therefore, in the roles of the private sector, nonprofit and commercial, as well. The shifts in public roles may take different forms and some or all of the following may be incorporated into a particular country's health sector reform.

- From central to regional/local levels
  - Decentralization of management
  - Decentralization of financing
  - Decentralization of political commitment
- From service provision to regulation
- From subsidy of supply through direct service provision to subsidy of demand through public and private insurance mechanisms

While each setting is unique, health sector reform in the LAC region displays some common general characteristics.

- increased reliance on financing as opposed to direct service provision in the public sector,
- increased roles for the private (commercial and NGO) sector,
- extension of ability-to-pay through expanded health insurance (both private and public),
- decentralization of public finance and budgetary operations, and
- increased reliance on incentives and market operations to allocate both public and private health resources.

Each of these changes has implications for quality assurance.

QUALITY ASSURANCE

While precise definitions will vary, satisfactory quality of care in the health sector generally implies that services are provided in a timely fashion, are individually tailored to the client, are respectful, are delivered in compliance with professionally accepted standards, norms and protocols and prioritize client satisfaction as a primary goal. Quality assurance (QA) refers to the mechanisms in the health system that support this outcome by assuring that health services are not only available, but also that they are technically and operationally appropriate. QA activities occur at the level of systems and, as well, at the level of individual organizations.

The activities of QA can be organized around key functions[1];

- Capacity building and training
- Development and application of standards and norms
- Quality monitoring
- Quality improvement
- Information sharing and documentation

Effective QA requires that each of these functions will occur in every system, regardless of the specific levels or organizational structure of the appropriate system. Because the emphasis here is on HSR, the interest is in how and where these functions are to take place in the "modified" service delivery system.

In the past, most emphasis on quality of service provision was placed on the skills of the provider as represented by initial training and subsequent experience. Strategically, this placed most of the burden of QA on training institutions and formal training/certification programs. Often, these elements are not specifically modified as part of HSR. More recently, it has been recognized that QA requires a broader base of continuous attention. The capabilities of providers need to be addressed as well through more effective support and supervision, training and skills upgrading, adequate resources, and appropriate priorities. Additionally, more attention needs to be given to the systems in which they work, the impacts on users and the community, the outcomes of care, and the perceptions and experiences of users and potential users. It is, in part, response to growing awareness of quality weaknesses, often viewed as solely the result of inadequate resources, that accelerates the extension of HSR in the region. Yet without direct attention, simply increasing resources will not automatically result in improved quality.

Perhaps the most critical element of QA is the emphasis on integrating both the assessment and the response into a single system.

[1] Developed from Nicholas, David. "Organizing for Quality: Options for Country Programs". QA Brief. Center for Human Services. January 1999

> *In essence, quality assurance is that set of activities that are carried out to set standards and to monitor and improve performance so that the care provided is as effective and as safe as possible.*[2]

Within an institution, QA is most effectively organized around the process of improvement rather than the process of monitoring and assessment. Participation by staff in the development of standards is also part of assuring the QA effort focuses on improving performance rather than simply on judging it.

HSR IMPACTS ON QA

Many of the characteristics of the service delivery systems in the region are being modified as part of the HSR process. Both the organization of services and the incentives that influence both users and providers are changing rapidly. Under health sector reform, assuring quality has become more difficult while at the same time becoming more important. Three characteristics typical of much HSR in the region account for these changes:

- Decentralization of public responsibility for the system
- Increased reliance on local markets for resource allocation and
- Expanded consumer choice and ability-to-pay

DECENTRALIZATION

In integrated systems, responsibility for many key QA activities, including the establishment, monitoring, evaluation, and enforcement of standard treatment protocols and norms for service responses, is held at the central level. While no guarantee of effective implementation of standards, such a system makes clear where responsibility for QA resides. Under health sector reform, many systems have decentralized virtually all functions related to the direct production of services.[3] In such settings, the procedures for consistent QA efforts throughout the system become considerably more complex. One potential result is the proliferation of multiple and diverse standards developed at the regional and local level or applied within specific provider institutions.

Decentralization also affects other elements of the system essential for effective QA. As an example, in integrated systems, supervision for quality has typically been conducted from the central office, often as a vertical program activity, and utilizing generally applicable performance standards. In the new decentralized environment, supervisory responsibilities have often been turned over to the local or regional level. Although often a more appropriate venue, staff must be trained and the supervisory system must be revised and integrated into operations before a supervision system that routinely supports QA can be implemented in a decentralized setting.

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[2] Brown, Lori et al. Quality Assurance of Health Care in Developing Countries. QAP

[3] for a more extensive discussion of decentralization issues, see 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

LOCAL MARKET ORIENTATION

The encouragement of competition among providers reinforces the reality that, regardless of organization, in almost every country the market for primary and secondary health care services is essentially a local market (although in the past, public providers have drawn on national pools of labor and suppliers.). Consumers and providers in each market will define quality against locally accepted standards limited to comparisons among local providers. This is not simply a result of decentralization. Rather, the emphasis on market allocation of resources means that local conditions will determine the availability of trained human resources in local labor markets, the relative costs of supplies and materials, and the alternatives available to users of services. The incentives for providers to "be competitive" (gain clients) will inevitably focus provider resources on the aspects of service most evident to users. Since many aspects of medical care are often well understood only by the provider, the potential for exploiting consumer ignorance is higher in these settings[4].

In most countries throughout the world, the elevation of local standards of care to regional and national norms has been an essential element of improving health care. One instrument for generating such changes has been improvements in information and infrastructure improvements (e.g. Roads and transportation) which made available a wider range of choices. This can be seen as broadening the size of the market for services. In national systems, the potential for application of national standards is higher even though there are wide regional differences in delivered quality in many such systems. The market focus of many health sector reform efforts creates individual (providers and users) incentives away from generally applicable norms which need to be specifically addressed as part of general QA activities.

INCREASED CONSUMER CHOICE AND ABILITY-TO-PAY

Although related to the localization of the markets for services, the increased dependence on consumer choices in allocation health care resources presents distinct challenges for the assurance of quality. The inability of users to assess many important aspects of health care quality has been widely noted in the literature.[5] While users are well able to judge elements of care related to adequacy of drugs and supplies, waiting times, and provider behaviors, they are less able to assess the technical dimensions of quality. Where clients' choices are critical and provider incentives emphasize meeting clients' priorities, the potential for inadequate attention to technical quality is raised.

Each of the above factors reinforces the need for addressing QA strategies directly in the process of designing and implementing HSR. The combination of local market focus, decentralization, and expanded consumer choice means that QA needs to reinforce national and global standards in ways that are compatible with local markets. Here

4 see Rice, Thomas. The Economics of Health Reconsidered. 1998

NGOs represent potentially critical resources for carrying out essential QA functions. The changes are already reflected in the expanding experience of NGOs in establishing partnerships to carry out QA activities. Some of these experiences are described below.

4. NGO/PUBLIC PARTNERSHIPS FOR QUALITY ASSURANCE

Although HSR presents new and expanded challenges for QA, the essential functions are important in all systems of service provision. Within the LAC region, many NGOs have been carrying out essential QA functions on behalf of publicly provided and supported health services. In some cases, these "partnerships" have preceded any changes in the system that might be considered HSR. In other settings, initial changes as part of national HSR initiatives, often related to decentralization, have created opportunities for NGOs to expand the QA responsibilities. In every case, the implementation of reform expands both the opportunities and the breadth of participation of NGOs in assuring the quality of services.

Two different general tendencies are evident, even in these relatively early stages. For NGOs with a specialized focus, most frequently those NGOs working in the areas of reproductive health and family planning, many opportunities have developed for expanded roles in developing norms and standards, training of providers, consumer education, and in some cases, serving as demonstration sites for direct service provision of quality specialty services. For other, more general NGOs, expanded opportunities for QA activities have been associated with collaborative standard setting exercises, peer reviews, monitoring programs, consumer advocacy, and actual responsibility for providing quality services to publicly served populations.

REGIONAL PUBLIC/NGO PARTNERSHIPS FOR QUALITY ASSURANCE ACTIVITIES

Training and capacity development

HSR has created new demands on local and central governments and, as well, often brings many new providers into the publicly supported health care system. As a result, both the need and the demand for quality assurance in health services have increased. Some dimensions of improved quality of care in has been forced to the forefront by the ensuing healthy competition among the many health care providers and the expanded choice of health care that users now have. In other cases, technical requirements for QA activities will be a condition of participation in public programs to avoid cost reducing strategies that can compromise care. Since funding for all providers under many new HSR schemes will depend on volume of covered users or the number of health services delivered, HSR creates the need for qualified and trained personnel in the public sector as well as in the private and NGO sectors. This training need provides an interesting opportunity for NGOs to sell these services, taking advantage of their capacity and experience. At the same time, it forces NGOs to be more vigilant with regard to their own QA activities.

BEMFAM in Brazil, MEXFAM in Mexico and CARE and CIES in Bolivia are all training public sector personnel in a variety of technical and operational areas. Areas of

training include adolescent and sexual health, training for trainers, reproductive health services, planning, monitoring and evaluation, supervision, and development of diagnostic skills.

Some NGOs in the region plan and implement academic training programs to support the public sector. In collaboration with Universidad Católica, CARE/Ecuador, using funding from the APOLO program, has developed an interesting specialist-training program for physicians in small population centers in Ecuador. FUSAL in El Salvador offers two diploma level courses, in health management and epidemiology, in an effort to support the growing demand for these skills generated by national HSR initiatives.

NGOs can also play an important role by offering demonstration sites and serving as training centers. NGOs' capacity to establish these demonstration centers is closely linked to the availability of resources. CARE/Ecuador has established different demonstration projects to support the implementation of the HSR in Ecuador. It has organized and implemented projects with three municipal governments and has also formed partnerships with other NGOs to support new initiatives.

Establishment of standards, norms, and protocols

The establishment of norms and standards to be applied across institutions and service delivery settings is of increasing importance as more private providers are supported through public and third-party funds and public providers operate at decentralized governmental levels. Many NGOs in the LAC region have collaborated in the development and promulgation of service delivery standards as part of national and regional efforts.

ASAPROSAR in El Salvador has actively participated in the determination of procedures, establishing within the organization a Quality Control Department. They have contracted with the Ministry of Health to establish quality of care requirements (norms, protocols and procedures) and assess compliance.

The norms, standards and protocols of BEMFAM-Brazil, utilized within their own system and in their training programs, were adopted by the Brazilian government as well as by many local NGOs. CIES and PROCOSI in Bolivia and MEXFAM in Mexico have participated in and supported the development of protocols, norms and procedures by their0 respective governments.

CEMOPLAF and other NGOs working in the area of sexual and reproductive health services in Ecuador participated in the elaboration of national reproductive health norms and procedures, which will remain operational as HSR policies develop.

INSALUD, an umbrella organization for more than 100 NGOs in the Dominican Republic, participates in the National Commission for NGO Qualification and Accreditation. As part of this Commission, INSALUD collaborates with the State Secretariat of Public Health and Social Welfare (SESPAS)] in the development of systems that seeks to ensure that services provided by NGOs receiving public funding, comply with minimum requirements, standards and norms. Although not limited to QA aspects of service provision, the INSALUD experience is an example of a broader Public/NGO Partnership stimulated by HSR. As NGO involvement in the service delivery responses to HSR escalates, this form of Public/NGO partnership will likely become more prevalent.

Setting standards through the provision of high quality services

There are many different forms of partnerships that can develop between NGOs and the public sector. A relationship with the public sector may be based on a formal contract between the two entities or on informal agreements.[6] Typically, however, these agreements or contracts anticipate compliance with a general set of norms, procedures and standards. Such relationships often serve to demonstrate the economic and operational feasibility of implementing the norms and standards in a more competitive environment.

BEMFAM in Brazil has clearly defined a strategy to complement the government sector, instead of competing against it. It offers sexual and reproductive health services, including AIDS/HIV care in twelve states, complementing the wider range of general medical services offered to the populations by public providers. They also have a long history of working directly with municipalities to support the delivery of high quality family planning services in municipal facilities. This support cosists of training of staff, application of appropriate service provision and counseling norms, and assurance of contraceptive supplies.

In El Salvador, where decentralization and HSR are in its initial stages, FUSAL has signed a three year contract with the Ministry of Health assuming full responsibility for primary health services in the municipality of San Julian, a difficult to reach, under served rural area. Their responsibilities include the management and provision of services for the Municipal Health Unit. FUSAL recently signed a new contract with the Ministry agreeing to provide additional services in other rural areas.

CARE in Guatemala has a project in partnership with the Ministry of Health and Social Welfare, through which it manages health services in 7 jurisdictions where health coverage was minimal and no formal service provision was operational.

CIES of Bolivia currently delivers reproductive health services and training at the municipal level. These services formerly were provided solely by the public sector.

[6] see Policy Brief on Contracting Out.

Research and documentation

In Brazil, BEMFAM is responsible for disseminating the results of National Demographic and Health Survey. This has been used as one of the most important tools available for the analysis of the impact of health reform and for the evaluation of the quality of services.

The Ministry of Public Health in Ecuador used many of the results of surveys developed by CEMOPLAF, incorporating these results into their norms (e.g. the results of CEMOPLAF's surveys on emergency contraception, Depo-Provera and Norplant all were incorporated).

Technical assistance and advocacy

Another area of quality assurance where NGOs have established partnerships with the public sector is the delivery of specialty consulting and advisory services. CARE in Guatemala carried out an evaluation of several health divisions. This process identified areas of weaknesses and advocated for programs aimed at the development of managerial skills, the elaboration of didactic materials for rural, `campesino´, indigenous and illiterate populations among others, to strengthen the delivery of services to an under served population.

5. CHALLENGES TO FUTURE DEVELOPMENT

The above experiences of NGOs in the region demonstrate the potential for productive Public/NGO Partnerships for quality assurance. However, the current scale of such activities involves a relatively small proportion of regional NGOs and many partnerships reflect local conditions not generated by HSR. The rapid changes in the organization and delivery of health services generated by HSR will expand the opportunities for such partnerships for a greater number of NGOs and public jurisdictions.

NGO INVOLVEMENT IN DESIGN OF HSR

Although potentially important collaborators, there are few signs that the views and experiences of NGOs have been drawn upon in the design of HSR in most countries.[7] Many of the respondents interviewed for the Bolivia workshop indicated that they had had little input into the design of the reforms with over half reporting no formal input at all. These views were reiterated at the workshop although the experiences varied considerably from country to country.

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 contributions to it.

CONFLICT WITH QA PRINCIPLES

A greater challenge comes from the nature of quality assurance itself. To be effective, the perspective of quality assurance must be integrated in the operational "culture" of the organization. Most organizationally based QA programs emphasize wide staff involvement and ongoing assessment, problem solving, and collective improvement. Much of the interest in quality stimulated by HSR has a more limited focus. In many cases it will relate primarily to providing external assurance that providers meet the requirements for participation in public programs and that basic consumer protections are incorporated into provider operations. This is a more limited orientation that may bring NGOs into roles that can conflict with their broader activities.

These risks are less consequential for collaborative activities like development of norms and standards or for training and capacity development. However, when NGOs take on responsibility for external review or program conformance monitoring, other collaborative relationships might be potentially compromised. The emphasis in this policy brief is on NGO partnerships for strengthening QA under HSR. The line between QA in this context and potential

[7] See Policy Brief on Participation etc.

regulatory or oversight functions can be quite unclear. To a large extent, these issues are better addressed in the design of the reforms rather than simply as part of ad hoc partnership arrangements. Nevertheless, the already mentioned lack of direct participation by NGOs in the HSR design process suggests a need for careful expansion of NGO activities in these areas.

FUNCTIONING IN A DECENTRALIZED ENVIRONMENT

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. They are thus in a better position to establish partnerships directly with the responsible public agencies. The managers of NGOs' local branches must be able to take quick decisions without constantly referring to the central level office of the NGO. *Prosalud* in Bolivia, for example, has empowered its regional offices to develop good relations with municipal 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 FOR NGOS

NGOs vary greatly in their current technical strength, organizational capacity, and scale of operations. While some NGOs have already taken advantage of new openings, many NGOs are just beginning to explore potential roles and opportunities. NGO leaders recognize that prior to entering into a partnership with a public sector, an NGO must first 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. NGO managers must improve their understanding of the political environment in their country, and 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 whose management they are responsible for.

NGO-SPECIFIC CONSIDERATIONS

Set a good example

Before an NGO can become an effective partner to the public sector, it must ensure that its own management and operations are strong and effective. It needs a clear vision and mission, a well-developed strategic plan, and effective operating systems. New partnerships with the public sector will create new demands on staff and organizational resources and, as well, subject the organization to greater public exposure. The organization must be certain that the new responsibilities will not compromise their ability to serve their existing priorities.

NGOs should also demonstrate an internal commitment to quality assurance in their own operations. For some organizations**,** this has been demonstrated by the development of more formal quality assurance programs within the NGOs. *Mexfam* created a new department of medical quality. *Fusal* now has a department of 'systematization and evaluation of experience.' *Profamilia* has organized '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. Even where such organizational changes are not appropriate, clear QA responsibilities and procedures need to be a visible part of organizational operations.

Consider the financial and operational implications

NGOs must have a very clear picture of the potential impact of a partnership on their resource requirements. For most organizations, every new activity will draw on already fully utilized resources or will require additional resources. While it is relatively easy for an organization to determine the direct costs associated with the activities, it is often more difficult to assess the implications for existing administrative and support staff. Formal partnerships may require considerably more time for proposal development before the partnership can initiate any activities. Partnerships with public organizations may require significantly more reporting and record-keeping than is typ;ical for the existing activities of the NGO. Organizations need to have

in place the financial management and costing systems that will support realistic assessments of the resource burden associated with a partnership.

Even where sufficient financial resources are available, new tasks inevitably make new demands on the time and attention of senior management as well as other organizational administrative and support staff. Developing realistic estimates of what will actually be required of the NGO is an essential first step in the process of initiating Public/NGO partnerships. Negotiating obligations and reporting requirements to assure the maximum applicability of existing systems is important. Nevertheless, taking on responsibilities on behalf of the public sector will usually require levels of reporting and accountability that require more resources than are typically available to all but the largest organizations. Preparatory assessment of current capacity in these areas is an important element in determining the organization's potential interest in partnerships and, as well, in identifying the types of activities which can be undertaken without creating undue resource management problems.

Explore the Implications for other collaborative relationships

NGOs will often have collaborative relationships with other organizations, both public and private. These collaborations may link the NGO to other organizations for many purposes including planning and/or service delivery, consumer focused IEC, training, advocacy, and outreach. It is important to consider possible impacts on these existing relationships that might be generated as a result of a new partnership with a public entity.

A new partnership might limit the ability of an NGO to provide independent leadership by requiring acceptance of particular strategies or position. A new role for the NGO can change the nature of its relationship to collaborating organizations, particularly if the new activities include monitoring and assessment of aspects of collaborator's performance.

PUBLIC / NGO PARTNERSHIP-SPECIFIC CONSIDERATIONS

Strengthening an NGO's own internal capacity is important, but developing sound public/ NGO partnerships requires that NGO managers also develop a keen understanding of the health sector reform processes that are planned or already under way in their country. Without such an understanding, they can not take advantage of the opportunities for improving and protecting quality implicit in HSR. These opportunities are not only for large NGOs. All kinds of NGOs can join hands with the public sector, but only if their managers understand fully the changes that health sector reform is bringing.

First, where appropriate, the NGO should be proactive in approaching the public sector to seek opportunities to support quality assurance activities. For organizations with leadership commitment to specific areas of service or advocacy, the emphasis needs to be on elevating the importance of quality issues, particularly when much of the reform emphasis is on financing and organizational changes. 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.

Second, 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. As noted earlier, some activities have the potential for compromising the independence and credibility of an NGO. In particular, the line between helping organizations maintain and improve quality and monitoring quality indicators to assure program compliance is a fine one. Many activities, such as accreditation and certification, take on new political and economic implications when they are linked to program participation. NGOs carrying out such QA activities need to be diligent in assessing possible impacts from partnership agreements that incorporate such activities.

Third, an NGO should carefully consider the specific obligations and commitments incorporated in the partnership agreement. 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. It should also consider the implications for its existing operating structure. This would include potential conflicts with board authority or the organization's articles of incorporation, required changes in current operating priorities, and obligations which, while not explicit in the partnership understanding, are implicit in carrying our public functions with or without public resources.

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.

7. CONCLUSION

This policy brief 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 this policy brief can provide a helpful first step in supporting this process of development.

8. LIST OF PARTICIPANTS

INTERCAMBIO TÉCNICO

EXPLORANDO LAS RELACIONES ENTRE LOS SECTORES ONG Y PÚBLICO:

DECENTRALIZACION Y CALIDAD

La Paz, Bolivia, April 12-14, 1999

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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

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