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**Public actors or private providers?: NGOs, Health Sector Reform and Community Based Health Care in Tanzania**

**PhD Thesis**

***Development Policy and Practice Discipline, Open University***

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# **Abstract**

The thesis poses two main questions: 'what are NGOs?' and 'where do NGOs fit in?'. Taking the World Development Report of 1993 as the articulation of an international Health Sector Reform (HSR) agenda, the thesis questions the depiction of NGOs as private health service providers. Identifying four themes as key to the conceptualisation, design and implementation of HSR, it reflects on how these themes have been treated in health and development policy and practice. The thesis proposes that the ethos, programmes and actions of NGOs in health shed light on the interpretation of 'private', 'health', 'decentralisation' and 'community' in ways that uncover important assumptions and contradictions inherent in the HSR agenda. It proposes that rather than taking NGOs to be private health service providers fitting neatly into increasingly market-based health systems, further exploration of the activist and advocacy role of NGOs is justified.

Investigating HSR in Tanzania, the thesis shows that the dominant view of NGOs is as private service providers, but that, despite recognition of this role, NGOs have been largely excluded from policy discussions. The thesis takes Community Based Health Care (CBHC) – identified in the HSR policy documents and referred to by NGOs – as a case through which to explore the notion that NGOs are 'community activists', with a significance beyond direct health service provision. Promotion of CBHC by NGOs shows how they work in and around the formal health sector, at national, local government, and community levels. It concludes that whether providing primary health services, supporting selective primary health interventions, or promoting comprehensive empowerment-oriented approaches to primary health care, NGOs are embedded in complex processes of defining and meeting 'public' need. This merits the reconceptualisation of NGOs as public actors constantly defining, maintaining and developing their role through engagement in networks of public action.



# Acknowledgements

*"All ages, since writing has been known in the world, have produced as does the present, and as doubtless will everyone to come, swarms of the ignorant and the designing to plague the world with mutilated fact and historical fiction. Few people apprehend how truth may be injured by the Melancholic, the Phlegmatic, the Choleric and the Sanguine tempers of the individual writers. Few have any notions of the wounds, the tarnishes and false beauties the truth may and does often receive from the reigning humour in the author. For my own part I think it does not little contribute to the discovery of truth in a history to know the temperament of the man who wrote it. It is not difficult to show that the constitution of a man frequently betrays him into a falsehood. And yet the curious thing is that were it not for this latitude allowed the author, this permissibility of falsehood in the individual, no apprehension of the truth may be imaginable at all. It is only by allowing the possibility of the lie that we can grope, as I am groping in this dark hole, towards what really happened, is happening, may yet happen."*

Andre Brink, *On the Contrary*

I would like to thank the Government of Tanzania for allowing me to conduct this research in Tanzania. I would also like to thank the Economic and Social Research Council and Health Projects Abroad for jointly funding the CASE Studentship that provided the resources for me to undertake this research.

However, this research project and the final thesis have also been the product of a series of encounters: most fleeting; some more enduring. Each one of those encounters has been rewarding in its own way, whatever my humour on that day, whatever the humour of those I had happened upon in my search for some 'truth'. Each of those encounters remains vivid in my mind, and I would like to thank all of those who have shared their time, experience and ideas with me. I hope you find at least some of what is true to you in this thesis.

In particular, I would like to thank David, Yamma, Rory and Caroline, and of course Fatma, for excellent food, many beds, and warm friendship. I would like to thank my supervisor, Alan Thomas, and also David Wield for all his support. In addition, I would like to thank the rest of my colleagues in Development Studies at the Open University, not least Tom Hewitt for encouraging me to place the last full-stop (and then type-setting it for me).

Finally, I would like to thank my colleagues in Tabora and Singida, some of whom, not least Sekasua and Mwiko, inspired this project years ago, and all of whom have been supportive in the final stages. *Shughuli ni watu na watu ndio sisi.*

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## List of acronyms

ADP	❖	Area Development Programme
AKF	❖	Aga Khan Foundation
AMREF	❖	African Medical Research and Foundation
CBHC	❖	Community Based Health Care
CBHCC	❖	Community Based Health Care Council
CCM	❖	Chama Cha Mapinduzi
CDT	❖	Community Development Technician
CEDHA	❖	Centre for Development of Health Administration
CEW	❖	Community Extension Worker
CHF	❖	Community Health Funds
CIH	❖	Community Involvement in Health
CMBT	❖	Christian Medical Board of Tanzania
CORPS	❖	Community Owned Resource Persons
CSO	❖	Civil Society Organisation
CSSC	❖	Christian Social Services Commission
CtC	❖	Child-to-Child
DED	❖	District Executive Director
DfID	❖	British Department for International Development
DHB	❖	District Health Board
DHMT	❖	District Health Management Team
DMO	❖	District Medical Officer
DPLO	❖	District Planning Officer
EASUN	❖	East and Southern African Support Unit for NGOs
ECM	❖	Extended Case Method
EDP	❖	Essential Drug Programme
ELCT	❖	Evangelical Lutheran Church of Tanzania
ERP	❖	Economic Recovery Programme
ESAP	❖	Economic and Social Action Programme
FUM	❖	Friends of Mwanhala and Urambo
FY	❖	Financial Year
GDP	❖	Gross Domestic Product
GoT	❖	Government of Tanzania
HFA	❖	Health For All
HMIS	❖	Health Management Information System
HPA	❖	Health Projects Abroad
HSR	❖	Health Sector Reform
IBPHC	❖	Institution Based Primary Health Care
ILO	❖	International Labour Organisation
IMR	❖	Infant Mortality Rate
KAP	❖	Knowledge, Attitudes and Practice
MCH	❖	Maternal and Child Health
MHSP	❖	Maasai Health Services Project
MoH	❖	Ministry of Health
NEC	❖	National Executive Committee
NGO	❖	Nongovernmental Organisation
NPA	❖	New Policy Agenda
NPO	❖	Nonprofit Organisation
ODA	❖	British Overseas Development Administration
OXFAM	❖	Oxford Committee on Famine Relief
PHC	❖	Primary Health Care

POW	❖	Programme of Work
PRA	❖	Participatory Rural Appraisal
RDD	❖	Regional Development Director
RHMT	❖	Regional Health Management Team
RMO	❖	Regional Medical Officer
RNO	❖	Regional Nursing Officer
RRA	❖	Rapid Rural Appraisal
RST	❖	Regional Steering Committee
SAP	❖	Structural Adjustment Programme
SCF	❖	The Save the Children Fund
SWAP	❖	Sector Wide Approaches
SWOT	❖	Strengths Weaknesses Opportunities Threats
TAHEA	❖	Tanzanian Home Economics Association
TANU	❖	Tanganyika African National Union
TB	❖	Tuberculosis
TBA	❖	Traditional Birth Attendant
TFNC	❖	Tanzania Food and Nutrition Centre
TH	❖	Traditional Healer
ToC	❖	Trainer of Communities
ToT	❖	Trainer of Trainer
TPHA	❖	Tanzania Public Health Association
UCBHCA	❖	Uganda Community Based Health Care Association
UMATI	❖	Family Planning Association of Tanzania
UNICEF	❖	United Nations Children's Fund
UWT	❖	Union for Tanzanian Women
VHW	❖	Village Health Worker
WAZAZI	❖	Tanzania Parents' Association
WDR	❖	World Development Report
WHO	❖	World Health Organisation
WVT	❖	World Vision Tanzania

# 1

## **Privatised, market-mediated, community-financed health care services: Some assumptions and contradictions**

“In most circumstances, however, the primary objective of public policy should be to promote competition among providers - including between the public and private sectors (when there are public providers), as well as among private providers, whether nonprofit or for-profit.” (World Bank, 1993, p58)

This statement implies that ‘public’ is ‘state’ and - in brackets - that such public service provision is not the norm. That market competition through ‘private’ providers should be the basic organising principle of service provision. And that non-profit organisations - or in the terms of this research, non-governmental organisations or NGOs - belong to the private sector. The statement locates NGOs squarely in the mainstream of private service provision in a world where private, not public, service provision is the norm.

This thesis poses a question. Are NGOs private providers or public actors? It poses this question for two reasons. Firstly, the question provides a rhetorical device through which to explore research, debates and programmed activities that grapple with a central social policy question: what is, should and could be the appropriate ‘split’ or relationship between public and private goods, provision, funding and organisations? Secondly, whilst many of those involved in these debates now take it for granted that NGOs are distinct and different from for-profit organisations, as will be discussed further in section 1.3 of this chapter, this appreciation is yet to be applied consistently by international, national and sub-national policy-makers.

The question derives from my first reading of the World Bank’s World Development Report (WDR) of 1993, ‘Investing in Health’. I was struck by the discussion of NGOs as private health service providers, with only the occasional reference to their role in promoting public health more broadly. As discussed in section 1.2 of this chapter, this contrasted sufficiently with my own perceptions of the role and activities of NGOs to whet my appetite for a research project that seeks to untease the notion that has underpinned international debate about reform of the social sectors in the 1990s. Namely, that NGOs are best understood as private service



providers working effectively and efficiently in predominantly private and privatising social service systems.

The WDR of 1993 sets out an agenda for the reform of health sectors based on the principles encapsulated by the extract quoted above. This thesis takes up this area of public policy, Health Sector Reform. It begins, in this first chapter, by discussing some of the assumptions and contradictions that I perceive to exist in that agenda. These contradictions lie in the gaps between what the reform agenda advocates *should* be happening, and what *has happened* or *is happening* in practice. In the next section of this chapter, I discuss the reasons why I have taken the WDR as the basis for discussing Health Sector Reform (HSR). In section 1.2 of this chapter, I go on to outline in more detail the research history and questions that informed this thesis. In sections 1.3 to 1.6 I explore in more detail four areas of the WDR that I have identified as problematic, relating these to discussions about the role of NGOs in health.

The purpose of this research, as I discuss in section 1.7, is to contribute to a growing body of work that informs policy-makers. The research seeks to contribute to a more sophisticated understanding of NGOs that can be applied to the development of health sector reform policies and programmes. It does this by attempting to gain insight into NGOs as organisations emerging, developing and maintaining themselves in a dynamic institutional context. The thesis addresses my research questions in the context of Tanzania's Health Sector Reform policy process, investigating the case of NGO involvement in Community Based Health Care.

## **1.1 Health Sector Reform: Policy package, agenda or process?**

“ Health sector reform, with its emphasis on change to policy and institutions as a means to achieving improved health status, has become a key investment strategy for donors. Yet reform challenges existing interests and practices: it is controversial and it is political.” (International Health Exchange, 1994, p2)

To pose the question of whether HSR is a policy package, an agenda or a process is to ask what HSR means, where it has come from, and what and who it involves. Is it, for example, a set of prescriptions to be followed? Or is it an organic (and political) process that develops according to context? This section argues that it is all of these, but in different ways to different protagonists.

The thesis takes HSR to be a policy package put forward by the World Bank. This finds its expression in a key World Bank document, the World Development Report (WDR) 'Investing in Health' (1993), which 'pulled together the various strands of World Bank health sector policy-making and outlined a comprehensive package' (Zwi & Mills, 1995, p313). It is a policy package that has been used to shape the health sector financing and support plans of a number of sub-Saharan African countries (Ugalde & Jackson, 1995; Green & Matthias, 1995a), and which, as the extract above indicates, has served to mobilise the support of donor agencies (SCF, 1993). It is for these reasons that this thesis uses the WDR as a central reference point when talking about HSR.

Of course, the key components of the World Bank's HSR package reflect a broader impetus towards, and emerging agenda of reform that had been 'in the air' for some time. This is not the first international attempt to mobilise commitment around reform of policy and institutions in the interest of improving health status. The World Health Organisation (WHO) led international health policy through the promotion of the primary health care agenda from the late 1970's. In the absence of continued clear leadership by the WHO, the policy vacuum has been filled by other agencies. As Zwi and Mills (1995) note, and as discussed in section 1.4 of this chapter, UNICEF has led the Bamako Initiative and Child Survival Programmes.

Taken in its broadest sense, HSR might be understood to mean any coherent initiative to strengthen the management of health services. From the early 1980's there has been a strong impetus to reform around the world in the wake of recession, debt crisis and structural adjustment programmes. All societies faced rapidly increasing health costs in the face of declining budgets (Goodman & Waddington, 1993). Most countries in sub-Saharan Africa had built their post-independence health systems around the principle of free health services for all (Zwi and Mills, 1995). But by the mid-1980's, the fragility of these systems was visible, in unused vehicles, low staff morale, and poorly maintained health facilities (Goodman & Waddington, 1993). Recurrent spending in particular suffered, with many governments unable to pay a living wage or to sustain the health system (LaFond, 1995). In many countries, for example, Tanzania, there have been a number of initiatives over the years that have sought to make changes within the health system. These might be referred to as incremental adjustments within health systems. Gilson and Mills (1995) note that many governments have responded to internal and external pressures affecting their health systems, often in a 'piecemeal fashion', although some have embarked on major reform to the whole health system. By the early 1990's, national and international discussions were becoming more focused on

the need for fundamental review of health policy. In these respects, HSR for most countries is about a process of defining changing needs and possibilities within an active policy framework.

Sandiford et al (1994) distinguish between change management approaches, such as information system development, management training, and use of planning and evaluation methodologies, and health sector reform, a comprehensive and wide-reaching set of changes to the system as a whole. This point about health sector reform is echoed by Cassels (1995), who suggests that reform implies fundamental not incremental nor evolutionary change. It should be sustained not one-off, and it should be purposive (Berman, 1995). In other words, the purpose of change is 'to promote the achievement of overall health policy objectives' (Cassels, 1995, p331). HSR then also becomes a matter of determining what those objectives should be:

“ The actual thrust of health sector reform tends to change over time. For many years it tended to focus, in many countries, on the principles of Primary Health Care... More recently, however, there has been a shift in focus... These developments amount to an approach to health sector reform known as managed competition.” (Collins et al, 1994, p20)

Many commentators do not place the World Bank's WDR at centre stage in their discussions. In many respects, they are quite right not to do so. As Collins et al (1994, p22) point out, the WDR should be recognised to be a 'watershed document in the emergence of new interpretations of international health sector reform'. Throughout the 1990's the proliferation of conferences, research projects and publications debating the public-private split, the need to separate purchaser and provider, the introduction of private sector management culture and techniques, and the search for new sources of health financing testify to this emerging consensus around the principles of HSR. The WDR could be understood to be capturing, not defining, a new orthodoxy, concerning the rationale for government intervention in the health sector (McPake, 1995).

The WDR has stimulated lively debate, however. As MCPake continues, whilst the rationales may not be much in dispute, their translation into 'prescription of specific roles' are the cause of much discussion. Whilst the WDR effectively questions the PHC commitment to the principle of universality in health provision, as Collins et al (1994) point out the prescriptions set out in that document lean towards a kind of universalism in applying HSR itself. But whilst HSR is a term that has come to have some shared meaning in industrialised countries, there is no consistently applied, universal packages of measure that constitutes HSR (Cassels, 1995). International

interest in HSR may have opened up what Cassels (1995) refers to as the 'somewhat sterile' debate about different approaches to primary health care, presenting a potential range of options for less developed countries, but there is no set of prescriptions. It is this aspect of the World Bank's involvement in international health that concerns me most, the potential for World Bank prescriptions to dominate national policymaking in less developed countries. This is the reason why I have based this thesis on the WDR. The relevance of doing so was only later borne out by my findings in Tanzania, as discussed in Chapter 5.

One of the key issues surrounding any reform process is who's values are driving the reform agenda (LaFond, 1994). Posing this question helps to remind that the HSR package put forward by the World Bank is not the only approach to changing policy and institutions in the health sector. However, as discussed above, the concern in this thesis is with the particular agenda that is shaping the policy framework. During the late 1980's, major health reforms in the United Kingdom and in New Zealand were evidence of a growing public policy force in the industrialised world which was to become known as the 'new public management' (Robinson, 1998). International health debate shifted from a concern with *access* in the late 1970's, to a focus on *management* in the 1990's (Sandiford et al, 1994). Of course management issues had been the subject of much earlier health policy debate. Discussions about promoting Primary Health Care in the 1980's were heavily concerned with establishing and developing effective district-level health management. What is different about the management debate in the 1990's is that it is based on a particular approach to reforming public sectors, to which Rhodes (1995) identifies two strands:

" The first strand is *managerialism*, which refers to hands-on, professional management based on private sector management experience which sets explicit standards and measures of performance and emphasises output controls. The second strand is based on the new institutional economics, also known as rational choice, which argues for the disaggregation of public bureaucracies; competition in the public sector (for example, contracting out, quasi-markets); and discipline and parsimony in public spending)." (Rhodes, 1995, p5)

What is a cause for concern for many of those contributing to the HSR reform agenda, is the way in which the World Bank took that agenda into its hands in the early 1990's. By this time, the World Bank had become the main source of international aid funding for health, surpassing the WHO and UNICEF (Buse, 1994). As Ugalde and Jackson (1995) write, this fact combined with the efforts

made in producing 'Investing in Health', indicate that the Bank had taken an interest in being a lead health actor. They propose that this amounted to a bid for 'global health policy leadership', the only reason for which could be an interest in promoting the Bank's own development ideology within the health sector. These writers express a concern that an international financial institution should be in the health arena at all, asking for a critical assessment of a venture that had not turned to specialised UN agencies or well-recognised NGOs for advice.

Whether or not particular commentators are more or less critical of the Bank and the WDR, this is the fundamental point. The perceived emphasis of the Bank on technical prescriptions and the neglect of policy processes:

" Though the ultimate aim of HSR – better health – is shared among different actors, the means of achieving it may differ. In general HSR advocates policy change, greater efficiency and better management to achieve it. In most cases, the impetus for reform is coming from donors. In emphasising these areas of health sector development, donors have extended their influence beyond technical questions. They explicitly involved themselves in formerly sovereign areas such as national priority setting and resource allocation." (LaFond, 1994, p10)

To the majority of the critics of HSR as presented in the WDR, whilst engagement in this arena takes donor agencies like the Bank into a political field, the political aspects that characterise any reform process have been severely underplayed. The package is presented as if identification of problem and solution were a mere technical matter. As Zwi and Mills (1995) point out 'the WDR approach' takes no account of a population's preferences, and:

" It can be seen as an attempt to make the values of epidemiology and economics dominate decisions on resource allocation." (Zwi and Mills, 1995, p316)

For the large number of academics, consultants and practitioners engaged in the debates surrounding the HSR agenda, the issues are agreed:

" Clear mechanisms now need to be established and continued among people, government, NGOs and the official aid community so that policy development is rooted in the real experience and not in ideology." (SCF, 1993, p11)

The emphasis of HSR programmes needs to be not simply on *content* but also on the *actors* and *processes* involved in policy reform (Walt & Gilson, 1994; Gilson & Mills, 1995). It must be understood that there can be no single strategy for HSR, as countries inherit different systems with their own advantages and constraints. This highlights the importance of research, and the fact that in the early 1990's the

empirical information base informing policymakers was weak, leading many researchers to call for policy development based on 'information rather than ideological assumption' (Bennett et al, 1997, p3). Zwi and Mills (1995) talk about the importance of evidence-based policymaking, and Gilson and Mills (1995) of the need to strengthen health policy analysis (Gilson & Mills, 1995). It is also important to recognise, that whilst HSR packages will vary from country to country, there are benefits to be had from a process of evaluating reforms and sharing experience (Battistella, 1993; Gilson & Mills, 1995).

Finally, whilst this thesis uses the WDR of 1993 as the reference point for defining HSR and for developing the research questions, my own belief is that HSR is in the broadest sense a policy process. It is a complex and political process, which, as Nabarro and Cassels (1994) point out can only be achieved through 'political commitment, and in practice, a great deal of courage'. It is for these reasons that it is important to embark on that process with a sense that it is a process, not with a set of prescriptions. It is also important to embark on that process with a sense of what policy processes involve and how they might be most effectively managed. It was my intention that this research would contribute to building such an understanding. As a reflection from the vantage point of the year 2000 - and as will become evident to the reader of Chapters 5 to 8 of this thesis - whilst the World Bank played a strong role in influencing the direction of HSR in Tanzania in the mid-1990's, a complex set of processes - many of them not directly connected to the HSR programme, and many of them set in motion long before HSR - have in fact given shape to the health sector and its development subsequently

## **1.2 Background to the research**

As discussed in the previous section, the World Development Report (WDR) of 1993, 'Investing in Health', sets out an agenda for the reform of health sectors.

Taking up this area of public policy, Health Sector Reform (HSR), this thesis begins by identifying certain assumptions and contradictions implicit in the outlined agenda. Such assumptions and contradictions lie in the gaps between what the reform agenda advocates should be happening, and what has happened or is happening in practice. The thesis explores these gaps from the perspective of the role of NGOs in health, posing two questions:

- What are NGOs?
- Where do NGOs fit in?

The thesis addresses these questions in the context of Tanzania's HSR policy and programmes, investigating the case of NGO involvement in Community Based Health Care (CBHC). The purpose of the research is to gain insight into NGOs as organisations emerging, developing and maintaining themselves and their activities in dynamic institutional contexts. The aim is to contribute to a more sophisticated understanding of NGOs that can be applied in health sector reform programmes. The higher level of concern of this research is with the paradigms, frameworks and mindsets that currently shape debates about public and private action for social sector development.

In this first chapter I outline the ideas and questions that have influenced the research. These have taken shape over time and strongly reflect my personal experience. My interest in NGOs, health and Tanzania began with a short period spent in Tanzania working as a volunteer with a British NGO, Health Projects Abroad (HPA). HPA began working - under the auspices of the Tanzanian Ministry of Health (MoH) - with villages and Regional and District governments in Tabora Region in 1991. When I was first involved in 1992, HPA's activities were largely in support of the building and rehabilitation of village-level dispensaries and associated infrastructure such as water tanks, latrines and incineration facilities. HPA's programme manager and certain regional government personnel were beginning to talk about the linkages between these activities, Primary Health Care (PHC) and community participation. Aware of these discussions, I was alerted to the emergence of an NGO-government relationship.

I took my interest in the historical, political and ideological issues surrounding NGO-government relationships further during an MSc course in Development Studies. The role of NGOs in general was receiving ever-greater attention in development debate as the scale and profile of NGO development activities increased. However, when I set about a dissertation entitled "The determinants of the development agenda: The interaction of international nongovernmental organisations and host states in Sub-Saharan Africa", there was less literature discussing NGO-government relations and NGO involvement in health than I had anticipated. It was only after completing this project that I read the 1993 WDR. Rather like the literature debating the 'public-private mix' in healthcare that I was starting to dip into, this did not cover certain issues to the extent, or in the way that, I had expected. In particular, as discussed in more detail in section 1.3 of this chapter, the description of NGOs as private health service providers did not correspond with my experience of HPA, which was supporting government health facilities and villages, not directly providing any health services itself. I also expected a more far-reaching

discussion of PHC and the 1978 Alma Ata Declaration. After all, in the literature covering NGOs and health, and through various informal discussions with people working with NGOs, I had come to the conclusion that the concept of PHC was an important motivating force for NGOs (Streefland & Chowdhury, 1990; LaFond, 1995; Klimmahorm, 1993).

During the next year, I became increasingly involved in the development of HPA's work in Tanzania. Writing funding applications to major donors I learnt more about the programme's emerging interest in working through a PHC-informed holistic and participatory approach with villages rather than focusing solely on the formal health facility project. Towards the end of 1994, my ad hoc involvement with HPA was formalised, when I became its Development Advisor. The relationship continued until 1998, partly through the co-sponsorship of this research project.

This relationship has influenced this research. It has provided practical support and at times has undoubtedly improved research access. It has also enabled me to adopt a more active approach to the project than might otherwise have been the case. By this I mean that some of my research activities have been in the form of designing, facilitating and participating in meetings, reviews and training workshops. In this way, I have been able to engage with a live policy process, both exploring some of the policy's implications, and beginning to share my ideas and findings, with NGO practitioners themselves.

My experience and reading prompted me to question the 1993 WDR on four fronts:

- What is meant by 'private'?
- What is meant by 'health'?
- What is meant by 'decentralization'?
- What is meant by 'community management'?

In this chapter, I discuss these questions using the relevant literature (from that debating the public-private mix in health, to PHC, to health management, to NGOs and health action, to community involvement in health) so as to highlight the concerns that underlie this research. The chapter concludes with the three researchable questions that have guided the fieldwork:

- Do, and if so, how do, NGOs seek to influence national and international health agendas for the continued promotion of PHC?
- In what ways do NGOs act as 'community activists' in promoting PHC at the community level?



- In what ways do NGOs work with local governments for the promotion of PHC?

In Chapter 2 I use the question ‘service providers or advocates?’ as a device for undertaking a more detailed discussion of what the literature about NGOs in general suggests about the role of NGOs. I take this forward into Chapter 3 where I describe the research strategy I adopted for this project and issues related to the state of NGO research and theory building. In Chapter 4 I reflect on the post-independence history of public policy in Tanzania, providing contextual detail and analysis that informs chapters 5-7 in which I discuss the research findings. Chapter 5 explores the involvement of NGOs in health policy in Tanzania, in particular their involvement in HSR. Chapter 6 turns to the work of NGOs in promoting CBHC, taken as a case of ‘community activism’. In Chapter 7, I reflect on what the practice of CBHC reveals about NGO relationships with local governments in the context of HSR. In Chapter 8 I draw the main conclusions of this research together, returning to the questions ‘what are NGOs?’ and ‘where do NGOs fit in?’.

### **1.3 What is meant by ‘private’?**

The early 1990’s international policy emphasis on reviewing the role of the state in development had not been accompanied by close examination of the consequences of this for the social sectors of developing countries. In particular, recommendations vis-à-vis the role of the private sector were often based on a weak information base (Bennett et al, 1997). During the past decade, numerous studies have explored the ‘private sector’ with reference to health sector reform. These examine the actual and potential role of private providers, and seek to further ‘policy development based upon information rather than ideological assumption’ (Bennett et al, 1997, p3)

As discussed above, my reading of the WDR of 1993 prompted me to pose the same question as many of these researchers. What is meant by ‘private’? My concern was with a depiction of NGOs as private health service providers working effectively and efficiently within predominantly private and privatising health care systems. This contrasted sufficiently with my own perceptions of NGOs and of NGO involvement in health to prompt the questions: ‘what are NGOs?’ and ‘where do NGOs fit in?’.

In providing answers to these two questions, I found both the NGO and health policy literatures of the early to mid 1990’s limited, which, as Green and Matthias (1995a) note amounts to a massive gap in understanding about how the NGO sector operates. In mainstream health policy debate I came across an emerging discussion about the private sector. Whilst it was becoming standard practice in statements

about this private sector to refer to its heterogeneity, extending this to include NGOs, I found references to what NGOs actually do to be limited, and very much confined to the role of NGOs as formal health service providers. This emphasis on NGOs as formal health service providers; has - for obvious reasons in debates very much driven by the actual and potential contribution of the private sector to health services - continued to be strong (see for example, Gilson et al, 1997). Alternatively, researchers have explored PHC activities within the context of an NGO providing a formal health service (see for example, Ramirez et al, 1997)

In the NGO literature related to health, I encountered a tendency to explore NGOs through studies of particular projects and programmes. These studies were often about interventions in the name of PHC, for example, a village-level health education project. Whilst providing interesting stories of innovation or of micro-level successes with familiar ideas, these studies tended not to be explicitly linked to the macro-level preoccupations of health sector policymakers. I developed a strong sense that between the oversights of health policy debate and the limited success of NGOs writers in articulating a stronger NGO position on health development, both PHC and NGOs were in danger of being treated as marginal oddities, and not as integral to the health systems of developing countries. I felt the significance of MacDonald's point that:

*"PHC is often understood in terms of campaigns or programmes within medical services or to mean health projects run by nongovernmental agencies on the periphery of the medical system."* (MacDonald, 1992, p58, emphasis added)

At the same time, through its fairly frequent reference to NGOs and the health sector, the WDR of 1993 actually implicates NGOs in a more integral than marginal role. It points out that NGO and Foundation spending on health in developing countries was \$0.8 billion in 1990 (WDR, 1993, p165) at a time when total aid flows to the health sector were \$4.8 billion. At that time, NGOs were accounting for 17% of the international aid contribution, compared to the UN agencies' contribution of 33%. The implications of ignoring the significance of NGOs are, as DeJong (1991) notes, that:

*"In an era of shrinking overall resources, governments' fragmentary knowledge about the activities of NGOs in the health sector is likely to impede their optimising the use of national resources for health - be they public, private or non-governmental - within the framework of government policies."* (DeJong, 1991, p1)

Whilst the WDR highlights the figures, it does not go on to systematically analyse the questions that arise. In other words, as what are NGOs important or integral? What do NGOs have to offer to the health sector and its reform? By the early 1990's a handful of researchers (DeJong, 1991; Gilson et al, 1994c; Green, 1987; Green and Matthias, 1995b) had turned their attention to the history of 'NGO' involvement in health, particularly in Sub-Saharan Africa. They identified an involvement that reaches back to colonial administrations, when mission-run facilities were the main or only modern health service providers outside most urban and administrative centres. These researchers indicate that since independence, most African governments have talked about, and with varying degrees of success, have achieved, fuller extension of state health systems to the national population. However, they also point out that NGOs have continued to provide a high volume of health services. DeJong (1991) cites a study by Ng'ethe et al that refers to a Kenyan Ministry of Health estimate that the NGO community was providing some 40% of the country's total health requirements, a figure similar to that given by Vogel for church missions operating in Cameroon.

In tune with prevailing health policy preoccupations, these researchers focused primarily on NGOs as health service providers. DeJong's overview of the role of NGOs in health takes up the popular idea that NGOs might possess some 'comparative advantage' over other types of health service provider (see also Gilson et al, 1997). She rightly notes that many of the comparative advantages claimed for NGOs – greater staff motivation; community-based structures; inter-sectoral scope; small-scale operations; a willingness to work in peripheral areas; and greater efficiency – require more careful study. There are also important potential downsides to NGOs as health service providers, such as dependence on external funding and foreign personnel working on short stints, and a tendency to fail to document and distribute information about their activities, thus making it difficult to evaluate or build on their experience (DeJong, 1991).

Whilst interrogation of the claims made for the comparative efficiency and effectiveness of NGOs vis-à-vis other forms of health service deliverer is vital to building informed policy, my own attention was drawn to those authors who pointed to roles for NGOs in health other than direct service provision. Green and Matthias (1995b) suggest that governments need to build a better understanding of NGOs in order to reduce conflict and capitalise on the strengths of NGOs. They also call on NGOs to view themselves as an integral part of health systems, both conforming to national policies and *engaging in policymaking*. In other words, they indicate that the comparative advantages of NGOs may not lie in forms of service provision

alone. Whilst policy advisors and makers might prefer to focus on issues such as cost, quality, and quantity of service provision - issues that seem to lend themselves to straightforward assessment of the pros and cons and from there to decisions about which organisations should provide what - there are more fundamental questions to be asked and answered about why NGOs are or should be working in the health arena at all.

In its critique of the WDR of 1993, The Save the Children Fund (SCF) points out that the 'private sector' referred to supposedly captures for-profits, NGOs and community groups (SCF, 1993). However, to lump these different forms of organisation and action into one category is to gloss over significant differences in norms, *raison d'être*, behaviours and activities. Such differences must surely have implications for the nature, scale, cost, acceptability and so on of the 'services' that each type of actor might offer. This in turn will have implications for the design of the support and regulatory mechanisms that will be required to enable each type of actor to be effective and efficient. For example, there is an assumption made by the WDR that NGOs (and indeed other types of 'private sector' organisation) are willing and able to operate as health service providers. But can NGOs meet this expectation or are they only able to provide a 'patch-work quilt' of service coverage (SCF, 1993)?

And if NGOs do not fit into the category 'private sector', where do they fit? SCF criticises the WDR because:

"The Report assumes that the role of NGOs is that of welfare-providers, which in some cases can be institutionalised into various forms of partnership with the government as legal and administrative changes are introduced in order to enable government-run health systems to be scaled back." (SCF, 1993, p8)

This supposed assumption of government functions by NGOs is often referred to as *gap-filling*. For many NGOs the term has negative connotations because it appears to correspond with government withdrawal from social services in the wake of economic crisis and structural adjustment programmes. However, to view NGOs as *gap-fillers* in retreating government systems is to oversimplify. As already indicated, NGO health service providers have been significant in the development of health systems in Sub-Saharan Africa over time. As Sivalon (1995) points out, for example, the history of relations between state and NGOs in Tanzania has not been one of replacement, conflict or *gap-filling*, so much as one of mutual interdependence in developing systems. Cannon (1996) concludes from her study of Oxfam's health activities in Uganda that the '*gap-filling paradigm*' has some

validity when you look at the increased tendency of donor agencies to use NGOs as contractors to implement programmes. However, when talking with government and NGO staff about whether they see NGOs as gap-fillers in health services, Cannon notes that the majority takes exception to the term. Instead, as one District Medical Officer indicates, NGOs, and in particular the missions, are seen as an integral part of the health sector:

“NGOs are partners in the services of health care, given the history, the church ecetera. They were the first people to start offering health services in this country. It wasn't gap-filling. They felt the service was needed and they continue to exist. It's not the gaps that continue, but the NGOs are established and continue in their own right” (Cannon, 1996, p9)

What emerges from such studies are indications that NGOs have not simply been filling gaps in government services that have gone into decline over the past 20 years, but that they often have a more fundamental role in defining and meeting needs. In other words, in identifying 'new' gaps. As Green and Matthias (1995b) point out, there is a tendency on the part of health policymakers to limit their sights to mission-run clinics. However, this overlooks a whole range of nongovernmental organisations and activities, from the training of village health workers to supporting mother and child health outreach programmes to working with women's groups to tackle poor nutrition amongst children. It is in these areas that it becomes clear that there may be something distinctive about NGOs that is neither captured by the idea of NGOs as private health service providers nor by the idea of NGOs as welfare-providers filling the gaps in government services. This possibility poses a challenge for policymakers, for:

“If NGOs are defined as organisations that contain the distinct characteristics whereby they pursue welfare-providing goals (potentially similar to that of a progressive government) in a manner free of public-sector bureaucracy, then it is important that governments recognise the distinction between this group of organisations and the private sector. Yet many governments have yet to recognise an NGO sector in the policy discussion, preferring instead to identify the private sector as a unity, or to divide NGOs into various sub-groups such as missions. NGOs also need to review their corporate identity and channels of communication.” (Green and Matthias, 1995b, p320)

In other words, government policymakers and NGOs need to be clearer about what NGOs actually do in health, what their distinctive contributions might be, and therefore how NGOs should and could be involved in health policy and

practice. Gilson et al (1994c) provide a useful starting point when they suggest that there are four overall health sector functions of which any NGO might perform more than one:

- **Service provision:** 'providing comprehensive services from health facilities or addressing a particular problem (e.g. tuberculosis, blindness or AIDS)';
- **Social welfare activities:** 'having particular concern for groups such as the disabled, children, youth and women';
- **Support activities:** for example, where NGOs train government staff or organise drug supply; and
- **Research and advocacy:** whereby NGOs act as 'community activists', a role which includes 'developing and promoting the primary health care concept, community health workers and community financing approaches' and is 'complemented by advocacy and lobbying at national and international levels and thus informing policy making' (Gilson et al, 1994c, p15-16)

The WDR says of itself that:

"This Report focuses primarily on the relation between policy choices, both inside and outside the health sector, and health outcomes, especially for the poor"(World Bank, 1993, p6)

In this section I have indicated that there are activities undertaken by NGOs that are not explored by the WDR, pointing to a gap in research and policy debate. These are activities that if better understood could contribute to more informed policy choices of the kind that produce better outcomes especially for the poor. I have identified one of the blockages to this exploration of NGOs as the depiction of NGOs as private sector actors. When Gilson et al (1994c) write about the 'community activist' role of NGOs or when SCF question where the 'social protest' role of NGOs has gone, concerned that the WDR seems to take 'the view that government should fill gaps in health services left by the private sector and not vice versa', they are articulating the concern that lies at the heart of this research. Namely, that NGOs are being presented on the one hand as positively different from the other sectors (state and market) but on the other as being part of the private sector in a two-sector world. In the former, NGOs are portrayed as being close and responsive to beneficiaries and more genuinely concerned with their needs given that their motives are not related to financial profit. In the latter, NGOs are effectively presented as the soft face of private provision. These two views of NGOs tend to be applied concurrently in 1990's social sector reform debate generally. However, the WDR leans more

towards the notion that NGOs are best understood in terms of being efficient and effective private health service providers. Two questions need to be addressed however. Firstly, are NGOs in fact efficient and effective health care providers? This is a question that has become the subject of a growing body of research as indicated in this section. The second question, of particular interest to this thesis, and as discussed in the next section, is the role of NGOs in health promotion that may take place outside or on the edges of formal health service provision.

#### **1.4 What is meant by 'health'?**

In my mind, the idea of NGOs working as 'community activists' (Gilson et al, 1994c) is intimately linked with the concept of PHC as an activist approach to health development. The question 'what is meant by 'health'?' derives from a concern with what is happening to PHC in the age of HSR. This is a concern shared by others, and aptly captured in a comment on the WDR of 1993 by Peter Poore, SCF's Health Policy Advisor:

"...I think everybody welcomed an economic appraisal of the sector but it fundamentally shifted away from our aspiration... it sort of said look, health for all is a nice idea but forget it, it's not possible so let's go for health for all those who can afford it..." (Poore, 1997, Interview)

The slogan 'Health for All' is associated with the Primary Health Care (PHC) movement, articulated as an international health policy agenda through the Alma Ata Declaration of 1978. As such, PHC has been strongly associated with the World Health Organisation (WHO) and with the United Nations Children's Fund (UNICEF). Governments around the world signed up to the principles of PHC, which implied new practices for health systems, in particular decentralised health services, intersectoral collaboration, community involvement in health, and comprehensive approaches to health that emphasised the promotive and preventive as well as the curative. As the last 'big idea' in international health before the World Development Report of 1993 provided a focus for consolidating debates about the public/private mix in health services (SCF, 1993; Buse, 1994; Zwi & Mills, 1995), it seems only pertinent to ask where PHC has got to, and indeed, how HSR relates to PHC, if at all?

The PHC concept and movement grew out of a strong critique of existing health systems. It went beyond the Basic Health Services approach - which viewed health as something to be 'delivered' - to uncover the political economy of health (Segall, 1983). It advocated a radical reorientation of existing systems:

“The 1978 Declaration at Alma-Ata (WHO, 1978) defined primary health care as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process. Primary health care addresses the main health problems in the community, providing promotive, curative and rehabilitative services accordingly” (Monekosso, 1992, p3)

The PHC brought key terms into mainstream international health debate; terms such as ‘universally accessible’, ‘community’ and ‘prevention’. Through the Alma Ata Declaration (unlike the country-by-country approach to HSR), governments collectively committed to an agenda to make better health a real possibility in countries that had inherited small, curative, urban-elite biased medical systems on independence.

However, as the result of an international conference, the Alma Ata Declaration is also open to criticism, not least for saying more about what should be done than about how to do it (MacDonald, 1992). The changes envisaged at Alma Ata require changes in society at large. The Declaration amounted to a potential revolution in health systems development, requiring a reframing of how health is understood, and of how better health is best ‘delivered’. There have been many disappointments for proponents of PHC, not least that:

“Some health practitioners are now familiar with the concepts and ideas of Alma Ata without realising the origins of that vocabulary: ‘health for all’ ..... is a slogan currently widely used in health campaigns.... ‘participation’ ....and ‘intersectoral collaboration’, key ideas of Alma Ata, are also used or (misused) frequently.” (MacDonald, 1992, p57)

Though often poorly understood, the concepts of PHC have indeed pervaded health policy debate. It is commonly understood that health is influenced not only by health care services, but also by other factors such as income, housing quality, educational status, water and sanitation and so on (Zwi & Mills, 1995; Bennett & Zwi, 1993). A



closer look at the WDR indicates that this understanding has also been internalised by the HSR agenda. Its opening statement is about global increases in life expectancy (World Bank, 1993, p1). Life expectancy serves as a proxy for articulating the improvements in health status that have been achieved for the bulk of the world's population over the past 40 years. However, the WDR goes on to note that 'enormous health problems remain'. The scale of these problems is especially stark when one compares the situation in developing countries with key health status statistics in high-income countries. In its exposition of the problems dogging health development, it is unsurprising to find the WDR clearly influenced by the principles underlying PHC. The WDR makes the link between health status and well-being; between improved health status and economic policies aimed at 'poverty-reducing growth', increased access to education especially for girls, and developments in people's living environments. It acknowledges that:

"Countries at all levels of income have achieved great advances in health. Although an unacceptably high proportion of children in the developing world - one in ten - die before reaching age 5, this number is less than half of that of 1960. Declines in poverty have allowed households to increase consumption of the food, clean water, and shelter necessary for good health. Rising education levels have meant that people are better able to apply new scientific knowledge to promote their own and their families' health. Health systems have met the demand for better health through an expanded supply of services that offer increasingly potent interventions." (World Bank, 1993, piii)

By making the connection between health status and access to clean water, primary education and other social and environmental factors, the WDR echoes the idea taken up by the PHC movement that 'health' is not simply absence of disease. This notion of health had been clearly stated in the WHO's constitution of 1948, which reads that health is 'a state of complete physical, mental and social well-being, not only the absence of disease and infirmity'.

The PHC movement provided an important critique of modern health systems as dominated by medical professionals working to a narrow, bio-medical focus. The implications of this critique were that the 'patient' should not simply be taken as afflicted by disease - a focus that can obscure the wider influences on an individual's health status - but as a social being located in a particular cultural, environmental and economic context. MacDonald (1992) cites Illich (1975) who suggested that 'national health systems' could be more appropriately referred to as 'national disease systems', and Morley (1983) who dubs hospitals 'disease palaces'. As

discussed in Chapter 6, similar language pervades CBHC in Tanzania, with practitioners commonly referring to dispensaries as 'disease recycling centres'. Such statements can easily be dismissed as representing radical extremes, but succinctly capture a basic point about health and health development. Namely that a single focus on identifying and curing a disease can overlook the causes of that disease and the circumstances in which it occurs. The idea of the 'disease recycling centre' is exemplified by the case of a child returning time and time again to a dispensary for treatment for diarrhoeal diseases, a child who is also returning time and time again to poor water and sanitation facilities at home.

In turning the principle that 'health is everything' into practice there have obviously been challenges. A pragmatic approach to PHC has been 'selective' as distinct from 'comprehensive' PHC. Selective PHC refers to targeted programmes and interventions, such as mass child vaccination campaigns. Harsher critics refer to this as PHC reduced to 'primary medical care' with add-ons, such as a water and sanitation programme (MacDonald, 1992). Examples of this approach include vertical, often donor-funded, programmes that are dropped into local health systems from a central ministry. These include programmes for malaria control, worm treatment, trachoma, essential drug provision and so on. Very often these programmes have their own dedicated managers and resources at all levels, all too often mitigating in practice against the building of intersectoral collaboration and more holistic approaches to health interventions. There are strong arguments for selective approaches to PHC, and it seems churlish to rail against apparent successes. However, there are those who suggest that agencies promoting selective PHC are driven by political and funding needs to opt for an approach that gives quick 'results' rather than tackling the more complex and time-consuming requirements of a comprehensive approach to PHC (MacDonald, 1992). Others challenge the justification of selective PHC on the grounds that comprehensive PHC is not affordable in poor countries, claiming that it is indeed viable, even where economic growth is slow (Segall, 1987).

Whilst the WDR clearly recognises the relationship between poverty and health status, on balance, the perspective of the bio-medical professional and the health economist prevails. This is clear in the description of the 'basic essential health care package' that is proposed, as 'a limited package of public health measures and essential clinical interventions'. These will require shifts in government spending towards: immunisation; school-based health services; selected services for family planning and nutrition; regulatory action, information and limited public investments to improve the household environment; and AIDS prevention. The WDR does not

make use of the term primary health care in describing this basic health care package. Nor does it refer to the debate and experience of implementing PHC and about selective PHC. Yet the proposed package is very much in line with the idea of selective PHC.

Similarly, in its identification of the problems with low-income country health systems, the WDR shares the same concerns as were raised in the 1970's. There is *misallocation* of public money towards health interventions of low cost-effectiveness (for example, a bias towards funding high technology interventions such as complex surgery). There is *inequity* in the allocation of public funds (again, biased towards services that are urban-based and tertiary-level). There is *inefficiency* in the management of resources (for example, purchasing of brand name rather than generic drugs). And finally, there is the problem of *exploding costs*, especially in middle-income countries.

This last concern, with exploding costs, is the lynch pin that connects all these issues around the central preoccupation of HSR – the financing of health services.

Sandiford et al (1994) make the point that health policy has shifted in emphasis since the 1970's from a primary concern with *access* to a focus on *management*. As the costs of making further gains in access to services has increased, as the burden of recurrent expenditure for existing services has grown, as the public revenues being made available to health sectors have shrunk in many countries, the issue of financing and management of resources for health sectors has come into sharper relief.

The WDR introduces the Disability Adjusted Life Year (DALY) as a tool for determining the comparative cost-effectiveness of health interventions and that will assist governments in making decisions about reallocating health expenditures. The DALY is 'a measure that combines healthy life years lost because of premature mortality with those lost as a result of disability' (World Bank, 1993, p1). It is an important tool for aiding design of the basic essential health package because:

“The health gain per dollar spent varies enormously across the range of interventions currently financed by governments. Redirecting resources from interventions that have high costs per DALY gained to those that cost little could dramatically reduce the burden of disease without increasing expenditures. A limited package of public health measures and essential clinical interventions is a top priority for government finance; some governments may wish, after covering that minimum for everyone, to define their national essential package more broadly.” (World Bank, 1993, p8)

As will be discussed in section 1.4 of this chapter, the World Bank is only one institution amongst many that have focused attention on the problem of resourcing health services. NGOs such as Oxfam (Goodman and Waddington, 1993), and in particular SCF through its study of PHC programmes that culminated in the book 'Sustaining Primary Health Care' (LaFond, 1995) have also looked closely at this issue. Yet the WDR of 1993 provoked a sense of disquiet in many quarters. Why? The WDR's proposed three-pronged approach appears sensible: a) foster an environment that enables households to improve health; b) improve government spending on health; and c) promote diversity and competition (World Bank, 1993, p6). In essence the WDR is proposing that:

- Governments should be reoriented from acting as funder, provider and policy-maker towards acting in a more regulatory capacity;
- The 'private sector' should be enabled to take on the provider role in health services;
- Systems other than government-based should be developed for health financing; and
- In the interest of public health and 'cost-effective' gains, governments should finance a basic essential health care package.

It proposes that:

"These recommendations will facilitate progress toward the goal contained in the declaration from the historic 1978 Alma-Ata Conference: 'the attainment of all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.'" (World Bank, 1993, p13)

But will these 'prescriptions' (SCF, 1993) meet the stated goals; goals that in themselves are laudable, welcome and shared by many? Save the Children states quite bluntly that it thinks not. It criticises the WDR's recommendations for lacking 'a real basis in evidence and experience', making the point that the basic conditions required for the success of the proposed policies cannot be readily met, especially in the poorest countries. In its critique of the WDR, SCF identifies at least five weaknesses in the recommendations:

- a) an under-estimation of the real costs of effective health systems and a failure to acknowledge the absolute lack of resources available in the poorest countries;
- b) an under-estimation of the time-scale required and difficulties in introducing radical change in poorly-resourced environments;

- c) an over-emphasis on cost-effectiveness as a methodology for allocating scarce resources which can be misleading and could undermine efforts towards integrated planning;
- d) a failure to grasp the lessons of experience from earlier World Bank policies, which demonstrate that prescriptions standardised across the world and imposed from above invariably fail to reach their goals because of lack of ownership and adaptation to circumstance; and
- e) unproven assumptions about the comparative advantage and impact of private-for-profit and NGO suppliers of health services on quality of care, access and coverage (The Save the Children Fund, 1993, p2).

SCF's critique picks up on the questions of feasibility, adaptability and ownership in the recommendations made by the WDR. I discuss these concerns further in sections 1.3 and 1.4 of this chapter. In this section I have briefly introduced the arena of international health policy. I have shown how, over time, the understanding that 'health' is about more than absence of disease, and that health status is influenced by many factors other than health services, has become commonplace. However, there are clearly many different views about how best to positively influence health. Whilst in its narrative, the WDR employs the language of an holistic understanding of health, its emphasis is ultimately on the formal health *sector* and the services and care provided by that sector. As Cassels (1995) points out, one dimension of HSR debate is whether reference is to reform of 'health care systems' or to 'health reform' in the general sense, tackling policies and institutions beyond the traditionally-defined health sector.

For many, the emphasis of the past 20 years of so has been on reconceptualising the 'sector' in terms of health action, in the understanding that:

“Many of the killer diseases are diseases of poverty: measles is only a killer epidemic in the context of material and social deprivation. Malnutrition and infectious diseases work together synergistically, especially in children.”

(MacDonald, 1992, p21)

This leads to a discourse of activism, based on the understanding that 'the organisation of health care involves decisions concerning resource allocation and this puts it squarely in the political domain' (MacDonald, 1992). It seems that in the WDR of 1993, the experience of those who have attempted to work with this understanding of health action has not been used as a resource; that comprehensive PHC has finally been pushed off the agenda; and that, as SCF points out, it is the

experience of the United States that most strongly influences the WDR, even at the same time as the WDR admits that US system shows a poor relationship between levels of health spending and health outcomes. However, as Cassels (1995) points out, it should also be recognised that the *process* of HSR affords an opportunity to redefine approaches to improving health status through a broader approach that encompasses the activities of other agencies. There may be opportunities and space within developing policy processes for the proponents of PHC to contribute to the redefinition of approaches. The question becomes, as discussed with reference to NGOs in section 1.3, the extent to which they are afforded that space, and the extent to which they perceive themselves to have a role or opportunity to engage.

## **1.5 What is meant by 'decentralisation'?**

My interest in what the WDR means by decentralisation was prompted by my interest in NGO-government relations, and how NGOs fit in to wider systems. I was particularly struck when I read the WDR by the huge management challenges implied by the reforms, particularly at the local level. The literature I have referred to points to a history of interaction between government and NGO health activities in many countries of Sub-Saharan Africa. Much of this interaction reveals itself as localised relationships formed around a particular set of operations such as the provision of a district hospital. At this level, project-by-project, unit-by-unit, NGO activities and relationships can take on a significance that has consistently defied description in central or national policy terms. The design and implementation of decentralisation packages will inevitably have an impact on how NGOs (and other agencies) are able to fit into these local systems. If NGOs are indeed significant local health actors, then their activities and relationships with governments will be affected by decentralisation, and likewise, there is much to be learnt for decentralisation programmes from the experience of NGO-government relationships.

In this section I make use of the literature about decentralisation in developing countries to explore three aspects of decentralisation that I believe are key to thinking about the role of NGOs in health action: a) the concept of decentralisation; b) the reasons for decentralisation; and c) the management of decentralisation.

**The concept of decentralisation:** The idea of 'decentralisation' as a 'good thing' has been popular throughout the history of development administration and public policy. However, experience shows that the underlying reasons for decentralisation are usually complex and decentralisation programmes are notorious for rhetoric that fails to become practice (Conyers, 1983; see also Chapter 4 on decentralisation in

Tanzania). A cursory browse through the rich decentralisation literature quickly uncovers good reasons to be cautious about the new wave of interest in decentralisation that has characterised reform programmes in the mid-1990's. This literature reflects on certain weaknesses in the design of decentralisation policies and programmes, most notably a persistent failure to clearly define decentralisation and to describe what a particular decentralisation programme seeks to achieve.

Decentralisation is about the relationship between some centre and some local. Commentators have identified different forms that relationship can take, analysing the implications of each form for the distribution of power and resources between the centre and the local. In development debate, decentralisation has most commonly been defined from an administrative perspective. In other words, referring to the transfer of responsibilities for planning, management and resource allocation from central government (although similar concepts apply to commercial companies) to various forms of local unit (Rondinelli, 1989). Mills (1994) describes three forms of administrative decentralisation:

- **Deconcentration:** involving the transfer of administrative responsibilities, but not political authority, to locally based offices of central government ministries;
- **Devolution:** creating or strengthening sub-national levels of government that have a clear legal status and statutory authority to raise revenue and make expenditure;
- **Delegation:** transferring managerial authority for defined functions outside the central government structure.

These administrative descriptions of decentralisation apply in the health sector as elsewhere. Mills (1994) refers to the growing significance of 'delegation', which has become popular for large referral hospitals in many countries. These hospitals are established in law with a board of management, and responsibilities are outlined that are similar to those of a nationalised company or parastatal. Decentralisation to the District or Provincial level has also been a key strategy for the implementation of PHC. As Monekosso (1994) of the WHO optimistically suggests, after two decades of PHC, a world consensus has been reached that it is only at the district level that the principles of PHC – community participation, intersectoral collaboration, affordable technologies, all set in the context of equity and social justice – can be simultaneously implemented. Indeed, it is only at the district level that a real partnership for health can be build between government and people.

These definitions provide a framework for thinking about what is meant by 'decentralisation'. For example, Monekosso's description looks for a 'partnership' between people and governments, and would imply some form of devolution or delegation for its realisation. These distinctions are both politically and technically important. Decentralisation to the District is very much part of the Health Sector Reform project. It has translated in many national programmes into stated intentions to create or strengthen District Health Management Teams (DHMT's). However, strengthening a DHMT may simply involve the deconcentration of certain management issues within the government system. It does not necessarily imply the devolution of wider powers.

Another notion of decentralisation that influences the Health Sector Reform agenda as outlined in the WDR is the contentious concept of '*decentralisation to the market*' (Mackintosh, 1997). This refers to the connection made between decentralisation and privatisation. Rondinelli (1989) describes this as a situation in which public goods and services are provided through the market mechanisms of demand and supply, occurring:

"In more advanced economies [where] people can select among local areas providing different combinations of services and facilities by moving to communities with the combination they desire." (Rondinelli et al, 1989, p59)

Collins and Green (1994) argue that in this case, decentralisation is simply being proposed as the next best things to privatisation and that:

"If privatisation is to be seriously considered a policy option for developing countries, its supporters should attempt to justify it on the basis of its own arguments and not those of decentralisation." (Collins and Green, 1994, p462)

This critique of 'decentralisation to the market' highlights a conflation of concepts and agendas, which on closer examination do not sit well together. For Collins and Green, decentralisation is about reallocation of authority, functions and resources within a system, the 'public' sector. This is completely different from privatisation, which is concerned with the reallocation of the same between systems, or in other words to the 'private' sector. They propose that governments should recognise the fact that the public sector faces political decisions about who gets what, when and how. In this case, decentralisation should not be seen as the route to privatisation but rather as *part of* a broader market surrogate strategy. Mills (1994) refers to privatisation as being 'the ultimate in decentralisation!', remarking however that government must still retain key responsibilities, in regulation, and in using incentives/ disincentives as a means to co-ordinating decentralised agencies.



**The reasons for decentralisation:** Whether arising from genuine over-ambition, lack of detailed consideration, or cynical manipulation of agendas, the conflation of concepts that has produced this mix bag called 'decentralisation' in the mid-1990s causes concern. Schuurman (1997) effectively formulates the question on the tip of many tongues when he asks:

"Is decentralisation (in the form of municipal democracy or local government) a progressive political project which emancipates the poor in the Third World, or is it merely a globalised neoliberal sham which disempowers the poor by giving free reign to global capitalism?" (Schuurman, 1997, p151)

Just as Poore (cited in section 1.2), proposes that the rationale behind Health Sector Reform may not be so much 'health for all' as 'health for all those who can afford it', one could ask whether decentralisation and reform in the 1990's is really about improved governance within 'public' systems or allocative efficiency within market-centred systems, and to what end. The World Development Report of 1993 captures both the great expectations of, and the contradictions inherent in, the current emphasis on decentralisation as a strategy for building more effective social services. For example, it states that:

"Decentralisation of government services is potentially the most important force for improving efficiency and responding to local conditions and demands. It will be successful only when local government health agencies and hospitals have a sound financial base, solid administrative capacity, and incentives for improving efficiency – when they are accountable to patients and local citizens." (World Bank, 1993, p163)

This statement alludes to the pre-conditions necessary for promoting decentralisation. It also talks about 'improving efficiency' and 'responding to local...demands' as the desired outcomes of decentralisation. But are these two outcomes compatible and feasible within the decentralisation project? For example, when the WDR refers to the potential contribution of decentralisation to making government health services more accountable to 'patients' and 'local citizens', is it referring to citizens or consumers, to decentralisation within government systems or decentralisation to the market? Is the accountability referred to economic, and expressed through purchasing of services, or political, and exercised through mechanisms such as voting?

It is easy to conflate the ideas of consumer choice and citizen accountability in a package that seems to offer all the good things – flexibility and responsiveness; popular mobilisation and involvement; improved service access and quality. But

these supposed outcomes of decentralisation, and the mechanisms designed for their achievement, will take on very different characteristics depending on whether decentralisation is seen as a project for improved governance or market development. If the preoccupation is with 'good governance' and with allocating a greater role for local organisations based on 'participatory' and 'democratic' principles (Davis et al, 1994) then space needs to be created for these organisations. In many countries, this will represent a significant departure from the development administration model employed in the past. Even the model of District Health Management for PHC promotion as developed in WHO circles can be criticised for overlooking the existence of other actors such as NGOs, although these have often been operating as an integral part of the district health system.

The 1990's are not the first time that the link has been made between improving government effectiveness and popular participation. Conyers (1983) points out that in the 1950/60's decentralisation was closely connected with the transition to independence in many countries. Very often the emphasis of the new government was on decentralisation as a means of tapping the potential for local governments to ease the burden of service delivery on central government, at the same time as demonstrating the new government's commitment to democracy and local needs in the wake of colonialism (Conyers, 1983). Decentralisation programmes were used as a means to harmonise national and local interests, or to achieve 'popular participation combined with national unity' (Conyers, 1983). In practice, this is a tricky balance to manage, especially where, as is often the case, the rhetoric of decentralisation is linked with the idea of promoting equity. PHC strategy is commonly developed around the notion that decentralisation combined with community participation will aid the reorientation of health policy formation to better meet the needs of disadvantaged groups. However, as Collins and Green (1994) point out, there is a contradiction inherent in relating decentralisation, which is 'enhancement of the different', to equity, which is 'promotion of equivalence'. These authors go on to note, reflecting on the World Bank's 1987 publication 'Financing Health Services in Developing Countries: An agenda for reform', that whilst it correctly identifies many of the deficiencies in health systems, such as an inequitable bias towards urban services, it 'prescribes solutions that may well exacerbate existing inequities' (Collins and Green, 1994).

In the current wave of interest in decentralisation, more clarity is needed as to whether the primary objective is 'efficiency' in economic terms, or equity considerations which have justified the PHC emphasis on district health management. If the primary concern is with efficiency, then a great deal of work will

have to be done at both local and central levels to enable this efficiency to emerge. In either case, as Rondinelli et al (1989) point out, it is because central government provision occurs only 'ineffectively and inefficiently', and provision by community organisations and private business 'only sporadically', that service provision tends to be limited outside capital cities. This has led to calls for decentralisation and privatisation of the financing, provision and management of services. However, the underlying reasons for this limited provision still need to be adequately understood if effective policies are to be designed.

**The management of decentralisation:** The WDR advocates the encouragement of private health provision, the reorientation of government towards a more regulatory than provider role, and the development of community financing (as discussed in section 1.4). However, it does not address the implications of these shifts for the management of decentralised health systems. There is an assumption that other actors will just fit into a pre-designed system. Reference is made to a place for NGOs as implementers at the district level, and to local governments being encouraged to 'work with' other actors, perhaps through district committees. However, the question of management capacities looms large over HSR as SCF (1993) comments:

“....the faith placed by the WDR in the power of *policies* to create an 'enabling' environment seems excessive. Throughout the Report 'policies' are given enormous importance as if they are a sufficient condition for effective implementation...*Capacity to implement policy* is just as important, and most poor countries have very limited capacity in this sense.” (Save the Children, 1993, p4)

Commentators such as Rondinelli et al (1989) and Collins and Green (1994) offer frameworks for analysing the decentralisation needs of specific contexts. These require research on a number of fronts such as the feasible options for service delivery, the nature of local goods/ services and their users, and the extent to which the decentralisation will require support for management strengthening. Similarly, Conyers notes that decentralisation requires a high level of organisational ability, which is not always readily available. This often leads to 'considerable opposition, frustration and confusion' (Conyers, 1983). Evaluating the implementation of PHC in Tanzania, Gilson et al (1994a) found that district health managers often felt powerless to address health care performance weaknesses despite the fact that the district was the unit to which key government health functions had been decentralised. The authors note very real obstacles to more effective local

management – resource constraints, conflicts between demands for central control and local discretion, limited institutional capacity, and political and cultural influences over the implementation of decentralisation, not least the widespread acceptance of paternalistic leadership. All too often, the preparatory support for decentralisation has been poor, as noted by Semboja and Therkildsen (1994) in the case of the reintroduction of local governments in Tanzania in 1983.

The literature clearly illustrates that decentralisation is a complex project in both technical and political terms. To simply advocate decentralisation is not enough. As Collins and Green (1994) warn, decentralisation can be used as a means to many different ends, but it should not be used as an end in itself. Decentralisation has an impact on relationships between units and organisations, on issues of control and accountability, on the articulation of need or demand and supply, and on financing and resource management. Where decentralisation involves a plurality of organisational types (in other words, it is not just about changing power relationships within an organisation), even greater thought will need to be given to questions of design and management; questions such as ‘management of what?’, ‘management by whom?’, and ‘how to manage?’ (Robinson, 1999). The history of NGO activities at the local level offers experience that could surely provide some answers to these questions.

## **1.6 What is meant by ‘community management’?**

My concern with the role of community in HSR derived from my interest in the ways in which NGOs operate at the micro-level. As emphasis is placed on decentralisation in health systems, the role of individuals, households, and ‘community’ receives increasing attention. The WDR does not make much mention of ‘community’ as such. It does however talk about households. It discusses the importance of the environment (referring more to economic than physical environment) in which households are located. It reflects on non-medical factors influencing health status, such as education and empowerment of women:

“What people do with their lives and those of their children affects their health far more than anything that governments do. But what they can do is determined, to a great extent, by their income and knowledge-factors that are not completely within their control. In every society, moreover, the capabilities, income and status of women exert a powerful influence on health.” (World Bank, 1993, p37)

The WDR points to the importance of government actions, such as ‘policies for improving the household environment’ (World Bank, 1993, p93); policies that

accelerate income growth, expand education (especially for girls), in addition to policies that ensure 'effective and accessible health services for all'. It proposes that combined, such policies 'create a virtuous cycle in which reduction of poverty and improvements in health reinforce each other' (World Bank, 1993, p38).

The WDR recites arguments that have become truisms in international health debate. My interest lies in how it proposes these areas are to be addressed, and how its proposals relate to a history of policies and programmes to involve households and communities in health. Most of the WDR is in fact concerned with the funding and provision of formal health services. It discusses four means of funding health services: a) out-of-pocket payments (private); b) voluntary insurance (private); c) compulsory insurance (public); and d) general government revenues (public) (World Bank, 1993, p108-9). The Report points out that private out-of-pocket payments account for over half of the per capita amount spent on health care in low-income countries each year. This fact justifies some increase in, and redeployment of, private and community contributions to health care – ranging from cost-recovery to private insurance to Community Health Funds (CHFs). This in turn becomes the argument that such schemes are not simply a practical necessity but a 'virtuous necessity'. They can 'help to improve the quality and reliability of services, in part by making health workers more accountable to their clientele' (World Bank, 1993, p159). This is an argument developed for the World Bank by Shaw and Griffin (1995) who write that:

“...as revenues accrue from cost sharing, all those who have a stake in improving health services, including households, private and public providers and donors, are questioning whether funds can be used more effectively to extend the quantity and quality of services. This is important because recent studies show that government expenditures on health can be allocated far more cost-effectively, with the prospect of extending basic services to larger numbers of low-income Africans.” (Shaw and Griffin, 1995, p1-2)

Segall (1983) notes that many international agencies and government are attracted by the idea that rural communities can be expected to raise their own resources for health care. However, this preoccupation can distract attention from the centrepiece of popular participation, namely people's involvement in planning and decision-making. Indeed, it is only in the final section, 'Agenda for Action', that the WDR comes out and states the importance of 'encouraging increased *community control* and financing of essential health care' as one of five policies for better health in low-income countries. The other four policies are: a) solid primary education, especially

for girls; b) investing more resources in highly cost-effective public health activities (for the poor); c) shifting curative spending from tertiary facilities to district health infrastructure capable of delivering essential clinical care; and d) reducing waste and inefficiency in government health programmes (World Bank, 1993, p158). By this point, the reader can be forgiven for being a little confused as to whether this 'community control' is about a consumer relationship with private providers in which the market relays signals about preferences which influence quality and quantity; or whether it is about political voice in which votes and lobbying relay signals to government; or whether it is about localised action in which communities fund and manage their own services.

The principles of participation and of partnerships that involve communities were elucidated at Alma Ata. In debating ways of translating these principles into practice in PHC, the movement for Community Involvement in Health (CIH) was born.

Oakley describes this as 'an imaginative new approach which seeks to bring together the formal, professional health structure and local people with their knowledge and resources (1989). Oakley's work is based on a review of CIH that took place at the WHO's Brioni meeting of 1985. He writes that CIH is central to WHO's HFA strategy, and that it should be used by all health professionals designing health promotion programmes.

The policy motivations, framework and practical mechanisms for promoting community involvement in health are various. Hildebrant (1994) articulates the classic PHC justification that:

"Using conventional ways of organising health care, the capacity and resources of developing and developed countries are already stressed to meet health needs. Over the past 100 years health was considered preserved or restored by professional care and health care systems were organized around illness, secondary care, technology and delivery of services. *Community Involvement in Health (CIH) is a participatory approach to health care that recognises the recipient rather than the provider as central to the process.*" (Hildebrant, 1994, p247, emphasis added).

However, as Chimere-Dan (1992) discusses in the case of post-apartheid South Africa, a careful distinction has to be made between community-oriented primary care and a programme of comprehensive primary health care according to the WHO definition. There is no generally accepted definition of 'community', but it is clear that there are different socio-economic, cultural and geographic groups, not all of which will be well served by comprehensive PHC package. In addition, whilst the

idea behind CIH, as a social action as distinct from a professional action approach to health, is radical (Chimere-Dan, 1992), it is susceptible to being reduced to simple forms of participation, such as community involvement in implementing services (Oakley, 1989). Finally, as Reidy and Kitching (1986) point out, the PHC discourse about involving 'communities', and changing the attitudes and behaviours of health workers, has come largely from the West. It might be time to question whose voice is conducting the questions.

In 1987 the WHO Regional Committee for Africa produced its own answers to the question of how to involve communities in health and PHC promotion when it launched the Bamako Initiative (BI). James Grant, then Executive Director of UNICEF said:

"... We are discovering that there is a key to making PHC centres work effectively, that there is only one element which, when available on a dependable and affordable basis, draws families to the centres... The component of PHC which may prove most capable of filling this catalytic role is the provision of essential drugs for all." (James Grant cited in Hanson and McPake, 1993, p267)

The BI was intended to revitalise PHC by promoting community participation in revolving drug funds at the level of their local health facility. In the BI Resolution of 1987, African Health Ministers agreed to:

- Encourage social mobilisation initiatives to promote community participation in policies on essential drugs and maternal and child health at district and local level;
- Ensure a regular supply of essential drugs of good quality and at lowest cost, to support the implementation of PHC;
- Define and implement a PHC self-funded mechanism at district level, especially by setting up a revolving fund for essential drugs (cited in Hanson and McPake, 1993, p267)

At the time, there were many concerns expressed about the BI. These included: the possible negative impacts on equity and access (as critics pointed out, willingness to pay for drugs is not the same thing as ability to pay); that the BI might not be integrated effectively into existing health systems but simply become another vertical programme; that the management and logistical difficulties implied might be insurmountable; that the BI might distort other initiatives, for example in attempting to improve prescribing practice; and that it did not address issues of sustainability in the larger health system (Hanson and McPake, 1993).

In many respects, the BI looks like a selective PHC initiative, focusing on the bio-medical system, drugs and cost, and not necessarily providing an opportunity for broader community involvement in health. However, Hanson and McPake conclude that in practice in many countries, the BI has gone beyond the 'narrowly defined revolving drug fund' and moved towards 'a strategy for the reinforcement of primary health care within an integrated framework'.

In the same year as the BI was launched, the World Bank 'recommended that the principle of cost recovery be incorporated into an agenda for financing publicly provided health services in developing countries' (Shaw and Griffin, 1995). It is interesting that the WDR of 1993 does not make much mention of the BI. It does note that the BI is promising but is yet to demonstrate sustainability on a large scale (World Bank, 1993, p159). This thesis is not concerned with the politics and relationship between the World Bank and the WHO. Goodman and Waddington (1993) suggest that it was the Bank's position that 'fuelled increasing interest in the idea of cost recovery in health care and clearly influenced the thinking behind the Bamako Initiative'. However, if a key plank of HSR is to increase the level of control and financing of essential healthcare at community level, it is a major opportunity lost not to look more closely at experience to date. Hanson and McPake (1993), for example, discovered whilst assessing the BI in Kenya, that discussion about the programme was missing from the national health financing debate that was taking place. The importance of improving understanding of micro-level action around community involvement, financing and management is not only highlighted by critics of the WDR such as SCF, which notes that the Report does not deal realistically with the issue of cost, financing, and people's capacities to contribute in poor countries, but by the WDR itself. The Report states that it is still not clear whether the BI's successes can be sustained on a large scale, and that, in addition:

"...efforts to encourage local private financing of health care by poor urban and rural households may allow governments to avoid tackling basic reforms of their health systems, especially the reallocation of public revenues from tertiary care hospitals to more basic services." (World Bank, 1993, p159)

The HSR agenda is crying out for ideas about how to make the connection between local-level financing and better services. Case studies available in the NGO literature indicate a potential wealth of experience in CIH and experimentation with Bamako-Initiative-style projects. This experience might help to shed light on how to move beyond community contributions to forms of cost-recovery programme to



effective community management that influences the quantity and quality of services available.

## **1.7 Conclusions**

As stated at the start of this chapter, the purpose of this thesis is to contribute to a growing body of research work that could inform policy-makers. In this chapter, I have identified a number of gaps, with reference to international policy understanding, about the existing and potential relationship between NGOs as health actors and HSR as a process of purposive and sustained change. Whilst this thesis makes a contribution to the literature in terms of an empirical discussion about certain aspects of NGO health activities that have not received a great deal of attention, its main contribution lies in the exploration of NGOs' institutional relationship with health sector reform processes.

Much of the discussion in this chapter, and indeed throughout the thesis, focuses on the description of NGOs as 'private service providers'. In Chapter 6, I explicitly counter this label by proposing that NGOs are better understood to be 'public actors'. My main concern, as discussed in Chapter 8, is not to say that NGOs are objectively one thing or the other. In my view, and the view of many others, NGOs are indeed public actors (see the discussion in Chapter 4 of this thesis). My concern is rather that the dominant public sector discourse, which in the case of HSR is captured by the WDR of 1993, labels and treats NGOs not as public actors but as private health service providers. As I have argued in this chapter, this labelling serves to obscure certain activities and organisations from the policymaker's view. Such obscurity is not new, but is becoming increasingly problematic in a global context in which purposive reform of the health sector is taking place at the same time as a rapid growth in NGO numbers and activities, both within the formal health sector and around health-related interventions.

Giusti et al (1997) refer to the 'current altercation' between the 'public' and 'private' health sectors, which they feel to be particularly strong in sub-Saharan Africa. They point to rigidity that colours the debate, in the absence of a coherent vocabulary and understanding. This conclusion reflects my own findings, as becomes apparent in the three fieldwork chapters of this thesis. Labelling still matters because it shapes perceptions. As Giusti et al conclude, the focus on the administrative or institutional identity of a health service tends to overlook the purpose and outputs of that service, which is surely where the question of 'public' or 'private' matters most. As I discuss in Chapters 2, 4 and 7, there is a need to

understand what NGOs are doing – their purpose and outputs - within the given institutional context. From this lessons could be learnt about the directions in which health sector policies, programmes and individual projects might usefully go.

Green and Matthias (1995a) argue for building better understanding of NGOs, or organisations that work for motives other than profit maximisation, because this will contribute to a clearer analysis of the role of NGOs. Governments and donors need to develop policy frameworks within which NGOs can work. In order to do so, they need to be clearer about what they understand about NGOs. Donors are clearly interested in the role of non-state sector organisations as service providers. However, it is not clear whether this is with reference to strong state-led policymaking with a tight framework of co-ordinated providers or a 'looser more competitive model' (Green & Matthias, 1995a, p568). Their attitude to the state is often not clear, which helps to explain either lack of clarity or over-simplicity in their attitude towards NGOs

This chapter has begun to illustrate why the WDR's representation of NGOs as private health service providers in predominantly private or increasingly privatised health sectors is unsatisfactory. It sets the scene for a research project that is described in the rest of this thesis. I have taken the terms 'private', 'health', 'decentralisation' and 'community' as key words in the HSR agenda. I have reflected on the meanings attributed to these by that agenda and from other perspectives.

There are gaps in the debates surrounding each of these terms that relate to the questions of what NGOs are and where they fit in. The term 'private sector' is inadequate in explaining NGOs and their behaviour in health. Those who point to other functions, such as 'research and advocacy' have not yet explored these functions in more depth. It is within those activist functions that there may be something to learn of relevance to an agenda that also emphasises decentralisation and community financing. This is because it is suggested that within these functions NGOs are experimenting, lobbying and building relationships that enable them to influence others.

By taking the terms 'private', 'health', 'decentralisation' and 'community' together, I am also challenging some of the premises of HSR. It is simplistic, but useful, to set HSR and PHC in a dichotomous relationship, because they appear to aspire to very different systems. On the one hand HSR emphasises the individual health consumer, being efficiently cured of disease when paying for a service from a private health service provider. On the other hand, PHC emphasises the individual within a

community setting, being able to access, and participate in, prevention, promotion and cure, through a mixture of basic, generally available health services and initiatives to promote awareness and knowledge. A great deal of the disquiet expressed about HSR undoubtedly derives from a gut instinct that somehow HSR is turning the international back on the concept and principles of PHC. At the same time, the WDR makes statements like 'strong public action is required to reduce HIV transmission' (World Bank, 1993, p9). This could, and should in my view, read 'strong public action is required to improve health and well-being'. Such statements would then require further discussion about what types of organisation or action have previously, currently or potentially best addressed the need for such public action? As Segall (1983) writes, PHC is basically concerned with distribution of resources. As such, questions of who owns and controls activities are key political issues for PHC implementation. It is the contention of this thesis that the activities of NGOs in health shed light on this, and provide relevant and informative answers to some of the questions raised by the HSR agenda.

Zwi and Mills (1995) cite Green who writes about how different perspectives on how 'health' should be viewed – as a right, a consumption good, or an investment – tend to influence how the roles of different actors are perceived. In Chapter 2 I explore the literature concerned with NGOs in development by posing the question 'Are NGOs service providers or advocates?'. This, like the dichotomous relationship between HSR and PHC that I suggest above, juxtaposes the 'private service provider' notion of NGOs with the idea that they are 'community activists' (Gilson et al, 1994c). It is from this juxtaposition - the search for answers to the question of what NGOs are and where they fit in - that I have developed the three researchable questions that I take up in Chapter 3. These are:

- Do, and if so, how do, NGOs seek to influence national and international health agendas for the continued promotion of PHC?
- In what ways do NGOs act as 'community activists' in promoting PHC at the community level?
- In what ways do NGOs work with local governments for the promotion of PHC?

As Green (1987) writes, nonprofit making organisations outside the state sector provide the majority of health care in many countries. It is my conclusion from a review of the relevant literature, that this fact has not been matched by explicit attempts to understand or engage NGOs in HSR processes. This heterogeneous collection of organisations makes for more complex policy analysis, but such

analysis is vital if governments are to develop explicit policies towards such organisations. In answering these three researchable questions, this thesis will provide some answers to the higher level questions about what NGOs are and where they fit in: whether they are integral actors or not; if so, integral as what; and integral within what kind of system. It is hoped that this will contribute to a clearer analysis of the actual and potential role of NGOs in health sector reform policy processes.

## 2

# What are NGOs: Service Providers or Advocates?

In Chapter 1, I posed the question: 'Are NGOs service providers or advocates?'. I use this question in this chapter as a device for exploring, through the NGO literature, the issues at stake in the representation of NGOs as private sector service providers simply fitting in to a state-defined or market-driven health system. The chapter starts with an overview of common representations of NGOs in development debate in section 2.1. In section 2.2 some of the key themes arising from this debate are discussed in more detail, before section 2.3 turns to NGO 'theory' and the question of how to study and make sense of NGOs. The chapter concludes, in section 2.4, with a reflection on what service provision and advocacy actually mean.

The chapter concludes that whilst the question 'what are NGOs?' is not new, it remains significant in the late 1990's. The rapid rise in donor interest and funding to NGOs from the late 1980's onwards, though initially rather ad hoc, has been increasingly tied to an apparently coherent development approach. This is an approach that has gained broad agreement across agencies and countries. This apparent consensus poses challenges as well as opportunities for NGOs, governments and donor agencies alike. Perhaps the greatest challenge to NGOs lies in maintaining or reformulating identities: identifying and articulating what it means to be an NGO. States, and in particular donor agencies, have in recent years been developing policies, and recruiting NGO 'specialists', in order to improve their interactions with NGOs (see for example, Nelson, 1995; World Bank, 1995; World Bank, 1996). However, a continuing challenge lies in defining where they stand vis-à-vis what NGOs say they are, and providing the relevant support and regulatory mechanisms.

In order to meet these challenges, more sophisticated analytical frameworks are required. The limitations encountered in development debate arise in no small part from the continued tendency to rely on 'stories' about NGOs (either good or bad) or on very specific case studies (Stewart, 1996, Comment). More work is needed that links the broad stories to the specific cases; that draws on good organisation and activity-focused field studies that are explicitly linked to building NGO 'theory'. The implications of this conclusion for researching NGOs are taken up in Chapter 3.

Finally, with reference to this chapter and the rest of the thesis, I have applied the term 'NGO' broadly. I take as its essence 'non-governmental' and 'non-profit making' organisations with a primary emphasis on social and economic development. I felt a loose definition to be appropriate to this research for a number of reasons, not least the lack of consensus about what term to use. For example, Padron (1987) refers to nongovernmental development organisations (NGDOs), international development co-operation institutions (IDCIs), and grassroots organisations (GROs). There is a more recent trend towards referring to NGOs as Civil Society Organisations (CSOs). As I indicate in Chapters 4 to 7, the understanding of the term NGO in Tanzania is loose, and only just beginning to take any shape at all. I only use the term NGO in this thesis, although where the use of a different term is significant, as in section 2.3 of this chapter where I discuss the American literature, which applies the term Non-profit Organisation (NPO), I discuss this.

## **2.1 Representation of NGOs**

As intimated in Chapter 1, there is continued debate about how to locate NGOs in organisational life. This section discusses three discourses about NGOs that have influenced development debate during the 1990s: a) NGOs as private service providers; b) NGOs as gap-fillers; and c) NGOs as civil society actors.

The allocation of NGOs to the private sector derives from two-sector models. These admit of only two possibilities, two organising principles, state and market.

However, this poses a conundrum, as captured by statements like:

“The World Bank has defined NGOs as "private organisations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment or undertake community development.” (Brown and Korten, 1989, p2, citing World Bank “Operational Manual Statement: Collaboration with Nongovernmental Organisations”, No5.30, 1988)

But, if NGOs are concerned with promoting the interests of the poor and so on, this surely means that they are very different from for-profit private organisations. This conundrum has given rise to the notion of the Third Sector in which:

The term 'third-sector' distinguishes these organisations from the 'private sector' and the 'public sector'. The ethos that unites all these organisations is that they are value-led. They are established and managed by people who believe that changes are needed, and they want to do something about it themselves...Unlike private-sector organisations they do not distribute profits to their owners, and

unlike public-sector organisations they are not subject to direct political control.”(Hudson, 1995, p12)

The idea that NGOs are ‘value-led’ (rather than profit-led) by people who believe in change highlights why a distinct category, a third way of thinking about NGOs might be required. A number of authors have argued the theoretical distinctions that justify such a third category. Uphoff (1993) for example, refers to a ‘collective action sector’ that consistently differs from the public and private sectors.

However, whilst the Third Sector notion captures both the non-governmental and non-profit aspects of NGOs, it only offers a description of what NGOs are not, neither one thing nor the other. It becomes a catchall category, encompassing everything that is neither state nor market. But a multiplicity of ways of organising around collective need and interests, such as households, kinship groups and community based organisation exist as well as formally registered and organised NGOs. These all share a kind of ‘otherness’, derived from ‘alternative’ characteristics such as voluntarism, in-kind transfers, trust and so on. Korten (1993) writes about a voluntary sector comprised of ‘governmental nongovernmental organisations (GONGOs), public service contractors, and voluntary organisations (VOs), he also proposes a fourth sector, of people’s organisations, or membership organisations. Vakil (1997) identifies ‘essential’ and ‘contingent’ descriptors, suggesting that this provides a system for classifying NGOs for research and practice purposes. What all of these commentators is looking for is a valid framework for understanding these different forms of organisation in order to better inform the design of projects, programmes and policies.

The development NGO literature is rich in its attempts to capture this diversity of ‘NGO’, with almost as many typologies as there are researchers. These typologies are important, because recognition of diversity challenges simplistic policy assumptions. In the same way that for-profit and government units could be broken down into groups of organisations with different functions and foci, so too NGOs. What complicates this further is that many organisations can be classified into more than one category. For example, Cherrett et al (1995) provide a typology for environmental NGOs in Africa. They suggest that in the first instance, these can be divided into grassroots and professional organisations. They then offer another approach, identifying from the 45 organisations studied the existence of:

- a) *governmental* NGOs (“reflecting current trends to transfer policy formulation from government to the private sector”);

- b) *entrepreneurial* NGOs (“development aid has always attracted more than its fair share of entrepreneurs, who see it as a ‘soft’ sector with weak management and gullible donors”);
- c) *networking* NGOs (both national and regional, these are often driven by donor funding);
- d) *conservationist* NGOs (initiated by private-sector funding, these follow a business-type operational model);
- e) *advocacy* NGOs (with a primary focus on influencing policy);
- f) *environmental* NGOs (involved in project implementation, with major donors being Northern NGOs); and
- g) *community-based* NGOs (local groups emerging from more traditional ‘welfare’ backgrounds or which form groups that are more explicitly transformative) (Cherrett et al, 1995, p29-30)

Such typologies might be useful for describing the organisational landscape of a specific situation. However, this specificity can reduce understanding of NGOs to being sets of organisations that can be plugged in to particular sectors or activities, hindering the development of a broader policy appreciation of the role of NGOs. As already indicated, Third Sector researchers and NGOs themselves have continued to debate terminology and meanings – throwing in new terms such as People’s Organisations (PO’s), Community Based Organisations (CBOs), and more recently, Civil Society Organisations (CSOs), or proposing, like Fowler (1991) that collectivities of these organisations, such as POs and NGOs together make up the ‘voluntary sector’. However, all too often economists, planners and other policymakers for whom this is not an area of specialised interest, tend to fall back on the more familiar two-sector description, providing their own answers to the question of what NGOs are. This answer is more often than not that NGOs are private service providers and/ or effective contractors to government. At the same time, however inconsistently, all parties continue to return to the idea that there is something ‘other’ about NGOs. Therefore while NGO projects have certainly moved from being treated as ‘at best, interesting oddities’ or as ‘largely irrelevant’ (Riddell and Robinson, 1996, p1) to occupying a more central position in the development arena, confusions and contradictions about NGOs have persisted. These contradictions are captured by the ‘New Policy Agenda’ (Edwards and Hulme, 1994).



The meteoric rise of NGO fortunes in development from the late 1980's, and particularly in Sub-Saharan Africa, has been explained in terms of the unresponsive and weak state. Paul and Israel (1991) point out that though legally required to channel its own funds through governments, the World Bank, has been encouraging recipient governments and other official donors to make greater use of NGOs on the continent because government institutions are 'relatively weak there'.

For each official donor the interest in NGOs will be driven by factors specific to their own political and institutional histories. However, there are general reasons for an international shift in favour of NGOs as development interveners. The strong re-emergence of neoliberal ideologies, new leaders and particular events fused during the 1980's to produce a strong challenge to the primacy of the state's role in development, whilst NGOs were edging into the limelight. The latter was greatly helped by a huge rise in private donations to international NGOs from populations in Canada, the USA and Europe, increasing from \$332 million in 1973 to about \$1.2 billion in 1983 (Thomas, 1992). This is mirrored to some extent by the fact that between 1980 and 1993, the number of development NGOs registered in the OECD countries grew from 1,600 to 2,970 (Edwards & Hulme, 1995). As for the former, a focus on privatisation in the North, prompted largely by analyses which highlighted 'government failure' as a greater evil than the older bogey of 'market failure' won the day in terms of forcing the rolling back of the 'developmental state'. At the same time, rolling back was aided by a financially enforced retreat of the state, as the combination of debt burden and poor economic growth got the better of much of sub-Saharan Africa.

Out of this arose the idea that NGOs might have a comparative advantage over states in certain areas. Official donors began basing their funding on 'pragmatic considerations' in which NGOs are seen as 'more efficient conduits for development inputs' (Masoni, 1985), leading to rapid increases in Official Development Assistance funds available to NGOs, particularly in the North. For example, in the early 1990's the Britain's Overseas Development Administration's Joint Funding Scheme (JFS) for NGOs was cited as one of the fastest growing components of the British aid programme. In 1992/3 it amounted to UK28 million, an increase of 22% over the previous financial year, and compared with UK2.5 million in 1981/2. In the same year, the scheme financed more than 1500 NGO projects run by over 100 British agencies (British Overseas Aid, 1992).

Edwards and Hulme (1994) propose that with the end of the Cold War and the demise of communism, the anticipated New World Order did not emerge. Instead, there has been a reconfiguration of powers, making space:

“...for the centres of economic and political power in the North to ‘market’ (no pun intended!) the tenets of western liberal democracy as the only development path they are willing to finance in the countries of the South.” (Edwards and Hulme, 1994, p3)

The New Policy Agenda (NPA) is an agenda based on economic and political liberalisation, generally associated with initiatives to reform public sectors, privatise social services, and promote ‘good governance’ and ‘democratisation’. Edwards and Hulme (1994) suggest that the NPA challenges NGOs in three ways:

- a) In its economic dimension the NPA identifies markets and the private sector as the most efficient mechanisms for achieving economic growth and for providing services: In this view: “ *NGOs are viewed as market-based actors which are more efficient and cost-effective than governments, and give better value-for-money.* ” (Edwards and Hulme, 1994, p3). Whilst this means that NGOs are finally acknowledged to be playing a major role in the provision of social welfare services in many contexts, both the effectiveness of markets in the social sectors, and the allocation of NGOs to the market, need to be questioned.
- b) The political dimension is concerned with ‘democratisation’ and the promotion of the active involvement of citizens in the processes of governance. Here, it is suggested, NGOs can play a key role as developers of civil society (see also Frantz, 1987), which provides a counterbalance to the story of the overbearing state. However, as Edwards and Hulme point out, there is no real discussion about how this role is to be operationalised, or whether the democratising of civil society and the provision of welfare services roles are compatible. Nor has the question of the acceptability of such a role to governments been adequately addressed (Bratton, 1989; Bratton, 1990; Allen, 1990)
- c) The financial dimension of the NPA is the willingness of donors to channel increasing amounts of funding to and through NGOs. This has created opportunities for NGOs, but has also raised many questions around the way in which that funding is offered and structured, and what this implies for NGO identities, operational roles and accountabilities.

Although emphases vary in practice, the NPA has emerged as a broad consensus that serves to mobilise donors around a common focus - economic and political

liberalisation processes in which the developmental role of the state is no longer central, but is picked up by forprofit and nonprofit actors. However, the agenda itself is riddled with conceptual and practical problems:

“In a subject in which ideology runs ahead of evidence,... empirical verification is essential. One of the problems here is that NGOs find themselves in the middle of a dynamic debate in which the relationships between theory and practice are often weak, and the relationships between actions and outcomes are uncertain.”  
(Edwards and Hulme, 1994, p6)

The logic of the NPA is that NGOs can be all things to all people, from service contractors to social democratisers. Biggs and Neame (1995) take issue with the formalisation of this type of labelling within the NPA, on the grounds that NGOs ‘become instruments for the delivery of services, democracy or innovation on the basis of clearly defined inputs, outputs and NGO interventions’ (Biggs & Neame, 1995, p39). This ‘projectises’ development, ignoring the complexity of processes and power structures that characterise the real world.

Since this research project began, one particular strand of the NPA has been gaining ground. This is the notion of NGOs as promoters of ‘good governance’, meaning their role as builders of ‘civil society’, an essential component in any modern-day project of political liberalisation. Statements about NGOs as private service providers run alongside statements about NGOs and civil society. The World Bank, for example, says that:

“NGOs comprise a sub-set of civil society – a broader term which encompasses all associational activity outside the orbits of government or the for-profit sector.” (‘The Bank’s relations with NGOs; Issues and Directions’, World Bank discussion paper February 1998)

The whole idea of ‘civil society’ is subject to vigorous debate. For example, Fine (1992) points out that ‘civil society’ can mean anything from all things that are not the state, to the democratic idea of people against the state, to the liberal concept of pluralism and tolerance against authoritarianism and enforced homogeneity.

However, the main reference is:

“...to the associational life of civic, professional, trade union and other voluntary organisations. Civil society theory is an attempt to define an alternative realm of the ‘public’ that is beyond the private concerns of individuals but not identical with the political realm of the state. It refers to the public realm of free

association which mediates between the state and the private individual: a 'third road' that is neither ..." (Fine, 1992, p71)

By defining NGOs as civil society actors, the existence of three sectors has been accepted in mainstream public policy debate. The concept of 'civil society' also recognises a variety of associational forms, not just formally constituted NGOs. However, whatever the rhetoric, all players in the policy arena continue to contradict themselves. During 1998, the British Department for International Development produced a paper on civil society inviting comment (DFID, 1998). This paper made references to NGOs as 'replacing', 'gap-filling' and 'privatising' even as it sought to understand a positive 'civil society' role for NGOs. In the next section I look at reasons why these contradictions persist. Taking up the service provider or advocate dichotomy, I juxtapose three pairs of terms that are in common usage in the debate about NGOs in development. These terms are not opposites, nor are they exhaustive, but they help to provide insight into the issues at stake.

## **2.2 Service providers or advocates?**

### **2.2.1 Privatisation or gap-filling?**

As discussed in Chapter 1, the idea of NGOs as gap-fillers has negative connotations. For those who maintain that 'the state' has certain social service obligations that it should meet on behalf of its citizens, there is concern that the increased donor interest in NGOs, and attendant growth in NGO numbers and activity-levels, has amounted to an NGO replacement of the state in certain areas. This idea of 'gap-filling' emerged in the context of retreating states - variously attributed to financial crisis and ensuing Structural Adjustment Programmes (SAPs). In many cases, NGOs have been vocal in criticising SAPs for having negative impacts on people at the grassroots. Therefore, NGOs themselves often share this concern that they are filling gaps as the state retreats, and that in doing so are effectively allowing the state (and donors) to renege on social responsibilities.

From a different perspective, the issue is not 'gap-filling' but *privatisation*. There has been general acceptance that governments cannot afford to both fund and directly provide comprehensive social services - especially where demand is constantly growing - on a sustainable basis. The pragmatic recognition of this problem has created space for the pro-market ideologues. A privatisation approach to social services has come to dominate internationally. This basically involves government reorienting itself to focus on policymaking and regulation, whilst the actual provision of services is met by 'private' organisations (for-profit and NGO)

which users pay for, with some provision of government subsidies and contracts.

*Gap-filling* and *privatisation* share a common conceptualisation of NGOs. Namely, that they are service providers that are willing and able to step in, probably as contractors to government, donor or user groups.

The debates about gap-filling and privatisation go to the heart of NGO perceptions of themselves. The literature suggests that this perception derives from a complex mix of claims. These include at least the following three components:

- That NGOs should not replace the state by either setting up parallel structure or substituting for state services, but they can act to fill certain kinds of 'gaps', working, for example, with groups 'ignored or by-passed by large state development schemes' (Oxfam, 1985);
- That NGOs are innovators in response to grassroots need and develop activities and approaches that government can then adopt and replicate;
- That whilst NGOs may be at times ambivalent about or sharply critical of particular governments, their rhetoric is generally in support of state provision. NGOs can advocate and lobby in the interest of improving these.

What is interesting about this debate is that development NGOs generally define themselves, and are defined, vis-à-vis the state not the market. Yet it is only with the rise of the privatisation approach to development that NGOs are being recognised as being part of the bigger picture. Few governments in Sub-Saharan Africa have acknowledged the significance of NGOs until very recently. Few NGOs would represent themselves as being long-term service providers in public service systems. Ironically, what pro-privatisation reforms have allowed for is a more systematic approach to dealing with non-state actors. Whilst in practice 'privatisation' is often ad hoc (which in part explains the perception of gap-filling) pro-privatisation reforms as encapsulated in the NPA are about making conscious policy choices and providing the appropriate institutional frameworks.

This in turn has implications for what is identified as a gap, and how and why this is. In a state-centred view of service provision, NGOs have argued for a role as advocates in ways that range from participatory problem identification to policy lobbying. This is effectively about ensuring that 'gaps' in 'public' systems are being identified and met. Rarely addressed in the gap-filling debate is this question about who's gap? For example, Cannon (1996) reflects on the case of NGO involvement in health in Uganda, and proposes that four types of gap exist: i) where there are no government services; ii) where there is a lack of medical personnel; iii) where there

are problems in the financial management of health programmes (from this I read limited capacities in managing the system); and iv) in the promotion of community based health care. This is useful but appears to suggest that these are the gaps because they are the activities in which NGOs engage. They are not necessarily 'gaps' that government planners and policymakers see. So gap identification and filling is not a matter of technical definitions of what should be happening. It is dynamic and context-specific. This is precisely why so many NGOs are engaged in activities that might be referred to as advocacy.

In a market-centred view, where the system of provision is based on diverse and multiple suppliers acting in response to consumer demand, then the system is mediated through market signals. Gaps are not identified through political mechanisms but through client interaction with providers. In this sense, policy advocacy becomes something of a non-issue. Taking the privatisation paradigm literally, there are no gaps because gap definition is through user demand and supplier response. In the real world however, problems of access, information, infrastructure and cost mean that many demands (gaps) will remain unmet by the market (and many potential demands will go uncreated!).

The gap-filling and privatisation debates have a powerful impact on how NGOs are perceived. Both the idea of gap-filling and of privatisation tend to draw attention to NGOs as service providers, neglecting their claims to act as advocates. But this advocacy function is important because these debates are also about broader concerns, captured by words like fragmentation, universality, equity and access. There is an urgent need to think through what NGOs can do and are doing *within* particular geographic and political contexts, because the state-centred and market-centred views of social service provision imply different things for the relationships and mechanisms through which NGOs might function. The debates surrounding gap-filling and privatisation have tended to gloss over this issue of interdependence by assuming that NGOs are simply service providers that just slot into some pre-determined system.

### **2.2.2 Scaling-up or innovation?**

One of the 'special' characteristics commonly attributed to NGOs is that of *innovation*. This is associated with other supposed qualities, such as small organisational size and close involvement at the 'grassroots'. While, as Clark (1991) points out, many NGOs may not be innovative with ideas but rather give preference to applying well-tested approaches to new constituencies, the assumption of a capacity to innovate is fundamental to the discourse justifying NGO action. It is

inextricably tied up with notions of 'small is beautiful', allowing for responsiveness and flexibility. However, as NGO profile and access to funding increased during the late 1980s, organisations began to face questions about the appropriateness and feasibility of expanding their work. In the NGO literature this became known as *scaling-up*.

Within the 'scaling-up: innovation' dichotomy lie two concerns, both of which derive from the depiction of NGOs as service providers. In the NPA, scaling-up is about expanding service provision. One concern is that such expansion will have a negative impact on the very qualities that supposedly enable NGOs to innovate (Edwards and Hulme, 1994), such as organisational flexibility. Indeed, in advocating expansion around service provision, the international agenda is contradictory. A thread running through it continues to be the comparative advantage of NGOs in being small and innovative. The other concern is whether NGOs have the capacity to scale-up service provision. This issue of capacity extends from the organisational level to the national, for as Save the Children Fund (1993) point out, the likelihood is that NGOs can only offer a 'patchwork quilt of coverage'.

Even where scaling-up means expansion within the same activity area, such as a move from running five clinics to ten, there are organisational issues to be addressed. But scaling-up in the NGO literature does not simply mean expanding service provision. There are different, but not mutually exclusive pathways to scaling-up. Clark (1991) writes about project replication, building grassroots movement and influencing policy reform. Klinmahorm and Ireland (1993) of scaling-up via working with government, via operational expansion, via lobbying and advocacy, and via supporting local level initiatives<sup>1</sup>. Wils (1995) writes in a similar vein, but distinguishes between 'scaling-up' – attempting to apply small-scale solutions to the larger-scale – and 'mainstreaming', which is concerned with converting such solutions from alternative, NGO strategies into officially accepted approaches.

The emergence of a particular strategy will depend not just upon an organisation's *raison d'être*, but a combination of factors, including the stage that an intervention has reached, and the context that other institutions create. For example, Clark

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<sup>1</sup> Authors such as Klinmahorm and Ireland (1993) imply another form of scaling-up when they refer to supporting local level institutions, or project replication both by government and other NGOs. This has been less thoroughly discussed, but comes under an increasingly popular strategy, which is working through partner organisations and building their capacity to implement development projects.

(1991) suggests that the path of project replication is more likely to be followed where the NGO has a plentiful resource; where government institutions are either weak but benign, or autocratic and offer no real prospect for influencing policy; where there is little evidence of popular perception of exploitation by local elites, or the poor are fearful of voicing their discontent; and where there is strong community leadership by members of the traditional elite. In such a context, the authorities are unlikely to be persuaded to take up the desired services or to facilitate the NGO in the task of providing these, which leaves only the option of project replication, rather than building grassroots movements or influencing policy.

Klinmahorm and Ireland (1993) add that the skills and strategies required for scaling-up change over time. They discuss the pilot project approach as a frequently used method for scaling-up, on the supposition that it will be replicated by government, and/ or other NGOs. This strategy takes place in stages: i) the pilot project to explore a new approach to service provision; ii) small-scale integration into existing government structures and budgets; and iii) assimilation, whereby the local example is adopted as a model, and systems, structures and budgets are accordingly adapted. The first two stages are important for demonstrating replicability (key to the pilot project approach to scaling-up), whilst it is not until the final stage that the approach has met the other key criterion, demonstrating sustainability. The move from ii) to iii) is not simply a matter of doing more of the same. Small-scale integration tends to depend heavily on individuals in government organisations who are willing and able to take initiatives and behave creatively. Assimilation goes beyond dependence on individuals, to a situation where an approach has been internalised through broader changes in policy and practice.

Once scaling-up is understood to cover a whole range of different strategies, not simply organisational or programme expansion across the same set of activities, then the fears about losing innovation begin to diminish. In fact, there may be synergy between innovation and scaling-up. The positive side of innovation is that being less restricted than official aid agencies and governments (outside scrutiny is slighter making for lesser consequences of failure, numbers involved in decision-making are smaller) and being imbued with the ethos of 'volunteerism', which encourages individuals to develop their own ideas, NGOs and their staff often have more flexibility to experiment (Clark, 1991). The other side of the coin is 'amateurism' the weaknesses of which are idiosyncrasy, lack of continuity, and poor learning (Clark, 1991)



There are also different ways of being innovative. Clark (1991) points to two: a) a 'seeding' role whereby the NGO demonstrates the efficacy of a new idea, then publicises it, and then encourages the widespread adoption by others and; b) more controversial innovations located at the radical end of the NGO spectrum, such as making use of legal systems to challenge injustices in the government system. This latter approach to innovation is usually tied to support for popular movement.

What does this debate about scaling-up and innovation say about NGOs as service providers or advocates? Once more, there are no definitive answers. The sheer diversity of organisation that is referred to as 'NGO' once more mitigates against simplistic categorisation of agencies as 'either...or'. It does indicate that service provision and advocacy may well be inextricably linked in many NGO strategies, especially where advocacy is explicitly the strategy for scaling-up impact. *It suggests that there can be innovation and scaling-up through service provision, and innovation and scaling-up through advocacy.* Scaling-up does not have to imply that innovation is lost.

The literature also indicates shifts as organisations and interventions change over time. Avina (1993) refers to the life cycle of NGOs, and the different organisational characteristics that are associated with different stages in their evolution. Korten (1987) describes three generations of NGO, as individual organisations move over time from welfare provision to acting as catalysts of 'sustainable systems development'. These types of shift have implications for focus, capacities and legitimacy. In reality, many NGOs do not have the capacity (or desire) to meet the extended demands to 'do' that are implicit in a view of scaling-up as being about increased service delivery. It cannot be assumed that NGOs will step forward and meet increased service needs. Many NNGOs are not operational in-country; many SNGOs do not have the experience and staff.

On the other hand, many SNGOs (and a number of the newer generation of NNGOs) are emerging as service deliverers. On a very simplistic level, this can often be assumed to be 'a bad thing' - an example of increased donor funding 'distorting' the NGO sector by providing funds for certain types of activity - which encourages opportunists to establish NGOs to take advantage of this. Whilst there are some important concerns in this view, there are also many problems with it. For a start, it supposes some sort of global view of what it means to be an NGO - a certain set of values. In particular, it fails to look on this situation from other perspectives. From the perspective of actual or potential beneficiaries, meeting service delivery needs and demands may be the most important aspect of an NGO's

operations, not any empowering mission the NGO may have. Far from being removed from 'real' grassroots needs by engaging in service delivery, the NGO may be more in line with beneficiary perceptions of need. From the perspective of ex-government employees or philanthropic groups that establish new NGOs, engaging in service delivery and accessing donor funds in order to do so, may be about promoting their values and social concerns through new channels, not just opportunistic, self-interest; and is certainly about establishing an organisation in situations in which it is often difficult to obtain donations locally.

Each of the different strategies for scaling-up has its own implications for working with other organisations. Management of a series of health clinics requires a capacity to relate with a larger health system - policy, training, employment of skilled staff, drug supply and so on. Community mobilisation and health education projects can be conducted on a more ad hoc and idiosyncratic basis.

Whether NGOs are scaling-up and/ or innovating, they are operating in multiorganisational contexts, and their strategies will affect existing relationships and needs for different kinds of relationships. A scaling-up of programme or organisation in a particular geographic area may be welcome where this is concerned with service delivery. However, it may be threatening to local government and power groups where the activity is innovative and appears to challenge existing norms and practices. This needs to be managed.

So scaling-up and innovation are conducted with reference to context and relationships with other agencies such as government (Clark, 1991). For example, the diffusive strategy (informal, spontaneous, for example replication) identified by Edwards and Hulme (1992) would require a context conducive to information-sharing, where organisations and programmes of activities were able to learn from each other<sup>2</sup>. Scaling-up and innovation are also about the organisation, and continuous interactions between values, pragmatism and experience, through which NGOs manage identities, and which result in different emphases in practice. This is captured by Fowler's depiction of NGOs' 'onion-skin approach' (1993) which consists of an 'outer layer of welfare-oriented activity that protects inner layers of material service delivery that act as nuclei for a core strategy dedicated to development.'. This suggests that at any one time, NGOs find a variety of ways in which to manage multiple agendas around service provision and advocacy.

Finally, there is another understanding of scaling-up that is innovative, and highlights the increasing importance of NGOs as advocates as well as service providers. Bebbington and Farrington (1993) refer to the main possibilities for NGO-government relationships, which include NGOs acting as the instruments of government programmes and NGOs as sources of lessons for wider programmes. But they add a further thought, which is moving beyond an instrumental view of NGOs to looking at the scope for power sharing and collaboration. Whilst the first two approaches are relatively feasible 'because they do not impinge too greatly on government control of decision-making or bring NGOs too closely to the mechanisms of government', they do not give NGOs any 'voting rights' over government programmes. The authors suggest that the creation of other structures, such as advisory councils, is beginning in some contexts to create space for broader based decision making and co-ordination of actions.

### **2.2.3 Operational accountability or legitimacy?**

The rising star of NGOs has prompted much critical discussion about their efficacy, accountability and legitimacy (Brett, 1993; Gordon Drabek, 1987). As NGOs have become more involved with official donors, questions of *operational accountability* have been of increasing interest. This type of accountability is about 'professionalism' and organisational effectiveness in terms of reporting to stakeholders at various levels. Clark (1991) suggests that this accountability is basically about the relationship between donors, the general public and the media - holding NGOs to account; shaping the flow of donations. One negative cut on this type of accountability is that it may curb NGO autonomy in defining roles and taking action (Van der Heijden, 1987). Another negative view on this type of accountability is that it focuses on whether the funds are going where they are supposed to, which simply assumes that the 'intended purpose is the right purpose' (Clark, 1991, p72). More recent debate has paid more attention to questions of demonstrable impact and effectiveness, moving beyond simply demonstrating financial probity towards demonstrating relevance and achievement (Taylor, 1997). However Clark's comments sound as if they are reserved for NGOs operating from the North within pluralist institutional frameworks which provide space and systems for holding agencies to some sort of account. This is not the same thing as having legitimacy in the South. Legitimacy is a far broader concept than accountability.

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<sup>2</sup> Edwards and Hulme (1992) talk about scaling-up strategies in terms of the additive strategy (organisational or programme growth), the multiplicative (networking, policy influence) and the diffusive (informal, spontaneous, such as replication).

Edwards and Hulme (1994) cite Bratton, who refers to legitimacy as being about who has the right to exercise power, to lead, to organise people and to allocate resources. Implicit in a discussion about whether NGOs are service providers or advocates are quite different understandings of accountability and legitimacy. From where does such legitimacy derive?

The question of legitimacy is about whole institutional contexts, not simply about NGOs as individual organisations. Fowler (1991) suggests that in many countries the implicit contract between governors and governed has been broken. In this case, the voluntary sector can offer an alternative by demonstrating the efficacy of a people-centred and democratic approach to development. This is a point echoed by many. Clark (1991) refers to NGOs as strengtheners of civil society, deriving legitimacy both from their social base and their potential through influence with government to become agents of change. In this view, NGOs have a legitimate role as advocates. But there are two major problems with this view. The first is to do with whether and how governments themselves see this role. Quite apart from those governments that view any form of non-governmental action as threatening, there is also plenty of scope to effectively ignore the role of NGOs as advocates. For example, Green and Matthias (1995) make the point that many Ministries of Health only 'see' mission-run health service facilities, but no other agencies. The second point is whether NGOs really do derive legitimacy from the grassroots, whether they are Northern or Southern. Many NGOs find themselves devoting increasing amounts of time and resource to being accountable to donors. Whilst there has been a move towards recognising multiple stakeholders, and many innovative efforts to be more accountable to the 'grassroots', this is not the same thing as legitimacy.

Accountability is relatively easily identified as being about links and mechanisms for relating to the stakeholders that can be identified with a particular intervention. Legitimacy is a broader concept that tends to be associated with voting, democracy and governments. The significance of this difference is highlighted but often not explicitly addressed in the NPA. The NPA effectively supposes that NGOs will scale-up service provision. In a very limited definition of service delivery this means that NGOs are accountable to donors and government through contracting and regulatory mechanisms, and to users as indicated through demand. This supposes a broader framework that accepts non-governmental service provision as legitimate. On the other hand, the NPA anticipates that NGOs are builders of civil society and democracy. But is this compatible with being strongly accountable to donors, and is it acceptable to governments which themselves may be in insecure positions vis-à-vis broader legitimacy?

Once more organisational imperatives (values, mission and capacities) and institutional context will act together in shaping answers to the question are NGOs service providers or advocates. In many cases, NGOs may shelter their advocacy concerns behind a service provision role (as indicated above by Fowler's 'onion-skin' approach). The legitimacy they claim for such advocacy will be very complex. Similarly, increased interest and funding for NGOs around service provision offers inducements to scale-up. But this has implications for the links through which NGOs claim their legitimacy, and as Klimmahorn and Ireland (1993) point out, NGOs should not attempt to scale-up until they have identified what roles are legitimate for them in different contexts.

There are many other terms which could be juxtaposed in an attempt to highlight the issues and tensions at play in the debate about what NGOs are. Others might include co-optation/ co-operation (to capture discussions about contracting and autonomy) or efficiency/empowerment (a whole debate about purpose and effectiveness). What has been illustrated is that the question 'service provider or advocates?' is about far more than categorising individual organisations. NGOs are located in dynamic institutional contexts, and perceptions of their legitimacy, location and capacities are contested. At the same time, ideas about what is happening in the world, and the language that is used, are also shifting. Clark (1991) talks about NGOs moving from being the carers of society to being the changers. This reflects a broader redefinition of 'development', moving away from the idea of state welfarism to other forms of action around social services.

## **2.3 Investigating NGOs**

What does all this mean for investigating NGOs? A useful starting point is to think about how NGOs are currently studied, and what this both offers and fails to offer in improved understanding. As noted by Lewis (1999) of an innovative initiative to put together researchers drawn from both the nonprofit sector world and the development NGO world, significant research challenges remain, not least in analysing the relationship between policy context and organisation.

### **2.3.1 Theoretical lenses**

"Theory is not value-neutral. It is inevitably appropriated, constructed, or appealed to, for purposes related to the configuration of institutional power and the interests of stakeholders." (Dobkin Hall, 1995, p5)

Some of the richest literature on the study and theory of NGOs is the American non-profit literature. This literature is of interest to this research project for a number of

reasons. Having grown up in a very different institutional context from, for example, the British development NGO or voluntary sector literatures, it reflects the preoccupations and history of a different society. It is a literature that has been largely driven by the type of question posed by Ben-Ner: 'Why do non-profit organisations exist in market economies?' (1986, cited in Ostrom and Davis, 1993). In other words, the starting point for thinking about how society's needs should be met is with reference to the market not the state. This helps to explain where the World Bank's depiction of NGOs as private providers comes from, given the Bank's strong roots in the United States. In addition, in answering the question of why non-profit organisations exist, the American literature provides rich debate to help inform a research strategy. Answers to the question are shaped by the 'discipline' or school of thought from which the researchers comes (Ostrom and Davis, 1993; Thayer Scott, 1995, Hammack and Young, 1993). In other words, what you see depends upon the lens through which you look. Hammack and Young (1993) provide a good summary of what this can mean, comparing economists' and policy analysts' explanations of non-profit organisations (NPOs).

*Economists and market failure:* Economists tend to think of NPOs in terms of market failure. What this means simplistically, is that for the economist, the profit-making business is the 'natural' form of organisation. NPOs come into existence only to overcome problems related to public goods, collective goods and asymmetry of information. Whilst governments are generally considered to be the organising form which provides public goods there are situations in which NPOs become involved. Hansmann (1987, cited by Hammack and Young, 1993) identifies four theories for this forwarded by economists. These are: i) the provision of public goods beyond governments, which tend to provide for the 'median voter'; ii) acting in situations of 'contract failure' whereby consumers feel unable to assess the quality and quantity of goods and therefore lack confidence in for-profits; iii) NPOs emerging where there are 'government subsidies'; iv) NPOs emerging where there is a desire for consumer control.

Hammack and Young (1993) suggest that ideas about median voters, contract failure and consumer control may indeed offer scope for exploring what might be the distinctive qualities which shape consumer preferences and decisions, and therefore explain the NPO phenomenon. However, some limitations on this include a tendency for economic analysis to imply that public goods are somehow 'homogenous in general categories', failing to acknowledge the variations in notions of what constitutes a public good.

*Policy analysts and government failure:* Hammack and Young (1993) suggest that policy analysts come from different first principles but often reach similar conclusions. For example, they cite Douglas (1987) as a proponent of the view that while the norm may be for-profit organisations, it is government that is the logical alternative. In this case, NPOs are explained with reference to 'government failure'. Governments are tied by the 'categorical constraint' that obliges them to provide services that are equitable, equal, uniform and universal. When this combines with the 'median voter' limitation, then government is unable to offer 'diverse, experimental, or flexibly nonbureaucratic services' (Hammack and Young, 1993).

*The voluntary sector and philanthropic failure:* A completely different perspective is provided by Salamon (1987) (Hammack and Young, 1993), who suggests that the NPO sector is in fact the 'normal' and 'preferred mechanism' for providing collective goods. His position is that 'Americans turn to government only in cases of voluntary failure or philanthropic failure' (Hammack and Young, 1993). Salamon identifies four categories of philanthropic failure: i) *insufficiency* - whereby the freerider problem cannot be solved through voluntary action; ii) *particularism* - where voluntary organisations are only serving a part of the public; iii) *paternalism* - where those providing the resources exercise excessive control; and iv) *amateurism* - whereby those paying for the service insist that it is provided by those selected on criteria other than professional excellence.

Salamon offers the beginning of an assessment of NPOs on their own terms, not simply with reference to government or market failures. It is a positive statements about the existence of the Third Sector, not one which implies that the third category is a rather awkward one, of secondary concern, which, if possible, should be ignored or kept behind closed doors in the analysis and design of service provision. Although Ben-Ner and Van Hoomissen (1991) do not claim that nonprofit provision of collective goods is the norm, they do reach a similar conclusion. Namely, that services, especially those characterised by non-excludability and asymmetry of information, are likely candidates for nonprofit provision in a market economy. They reach this conclusion in part by focusing attention not simply on demand but also on supply, or the formation of NPOs by groups of interested stakeholders that will only emerge if they have the ability to exercise control over the organisation.

Whilst it is important to note that the American literature bears all the marks of the context from which it is derived - taking for-profit organisation as the norm, assuming effective market mechanisms for communication signals and so on - it raises issues which are echoed in other literature. For example, Therkildsen and

Semboja (1995) writing about East Africa make effectively the same point as Salamon. That the state may not be the normal mechanism for providing collective goods.

### **2.3.2 Organisational analyses**

Organisational analyses would seem to be one of the best ways to come to grips with what 'NGO' means. Almost every researcher of NGOs prefaces their work by referring to heterogeneity amongst NGOs, and undoubtedly goes on to produce their own system of classification pertinent to their particular research focus. This type of work can have many uses, but is often simply descriptive. It is also highly dependent on the researcher's worldview. Thayer Scott (1995), attempting to move beyond what she found rather stagnant voluntary sector theory, entered the world of political theory. What she found was that within political theory, different perspectives provide different cuts on NPOs. Therefore from the perspective of pluralist theories of the state the important issues become the NPO's membership, constituency, and functional programme direction - an organisational focus. In a neoconservative view, the issues are control, marketing, efficiency and entrepreneurship - an economic focus. From the communitarian viewpoint, the NPO is understood in terms of governance (capacity for co-operation) and the values of its mission - the focus is community building.

If organisational analyses are driven by theoretical or disciplinary predisposition, how useful are they for understanding the phenomenon? Salamon and Anheier (1993) contribute to this question by proposing that distinctions need to be made between definitions of NPOs with reference to a context, which therefore cannot be consistent across cultural, legal and other systems, and broad definitions related to operational characteristics of NPOs, which they claim can be used to identify non-profit organisations cross-nationally:

“The structural-operational definition Salamon and I suggested includes organisations that are formal, private, nonbusiness, self-governing, and voluntary, and we group these under the heading non-profit sector.” (Anheier, 1995)

These are the generic definitions and statements, along the lines used by Hudson (1995) when writing about non-profit organisations in the UK

“Not-for-profit organisations exist everywhere because of a human quality that brings people together to provide services for themselves and to campaign against abuse of people and environment. People want health, welfare, educational,



humanitarian, environmental and cultural services to improve the world we live in. They expect the organisations that provide them to be 'not-for-profit' and also 'not-in-the-public sector'." (Hudson, 1995)

These kinds of definitions can be used to identify an NGO, or set of NGOs, or maybe an NGO 'sector' for study. Hudson (1995) suggests that the Third Sector includes organisations that exist primarily for a social purpose, are independent from the state, and which reinvest all their financial surpluses in their service or their organisation. Such studies can be used to generate organisational typologies, arranged perhaps by organisational objectives, or by age and function (Korten, 1987, Avina, 1993). But as already indicated in section 3, and as proposed by Anheier (1995), organisational and sectoral analyses may not be enough in themselves for understanding NGOs.

### **2.3.3 Institutional contexts**

NGOs are located in institutional contexts that are dynamic. Hudson (1995) points out that the boundaries between different sectors in the UK are constantly shifting. For example, building societies, which started as third sector organisations, would see themselves today as private sector organisations. He also points out that there has been a reversal in the trend for the state to take up voluntary sector activities.

Anheier (1995) proposes that the idea of the non-profit sector has not emerged as an 'island of meaning' in the same way that 'state' and 'market' have. He argues that given the institutional arrangements of 'modern societies' such a concept is needed because the terms market and state are increasingly insufficiently meaningful for use by researchers and policymakers. In earlier work with DiMaggio (1990), Anheier had proposed two sets of questions that might guide non-profit researchers in exploring the meaning of NGO in organisational and sectoral terms:

- a) Why do non-profits exist? What is the division of labour and responsibilities between organisational forms?;
- b) To what extent, and why, do non-profit organisations differ from other forms in terms of performance, efficiency, equity, clients, strategies, and outputs?

To this, Anheier (1995) adds a third:

- c) How does the non-profit sector relate to or interact with other sectors? How is it located in the overall institutional set-up or structure of society?

This is a question that begins to place organisations and sectors - their emergence, development and meanings - within contexts. The questions posed by Anheier (1995) provide a way of thinking about NGOs at different levels: a) as organisations in

themselves; b) as a 'sector'; and c) as actors embedded in, and shaped by, a wider institutional context:

“We need to be aware that we are not only defining reality through research on non-profit organisations; we are also creating reality by changing the cognitive map of social science research and policymaking.” (Anheier, 1995)

In Chapter 3 I discuss how I made use of this idea in my research strategy in designing the fieldwork I conducted in 1996 – in attempting to link the micro-story to the macro-policy framework.

## **2.4 Conclusions: What are service provision and advocacy?**

The literature discussed in this chapters shows that the question of what NGOs are is neither new nor specific to development debate. The chapter has also shown that references to NGOs as private service providers, or as gap-fillers to the state, or as civil society organisations, do not adequately or satisfactorily capture what NGOs are. This has been demonstrated through a discussion of the question, 'are NGOs service providers or advocates?'. The question has been used as a device to unpack debate and research. This has indicated that whilst there are plenty of studies of NGOs as organisations (individually and collectively), and studies that set out to make distinctions both between sectors, and within the NGO 'sector' itself, there are gaps in understanding about how NGOs are located in given institutional contexts. It is argued that without such understanding, it is difficult for researchers and policymakers to make sense of NGOs. To gain such understanding, it becomes vital to explore the relationships between the specific case and the broader context, between the micro and the macro.

The fact that NGOs have rarely been studied with reference to institutional context reflects both the complexities of the organisational arena and the constant political contest over meaning, representation and legitimacy. It appears relatively straightforward to take an individual organisation on its own terms, perhaps citing its stated mission and activities, and to define this organisation as an advocacy or service providing organisation in development. It is more complex, although possible, to take a collectivity or 'sector' of organisations, and to extract from their similarities and differences typologies or categorisations, for example, by ethos, activities or outputs. But how can NGOs be better understood with reference to a specific institutional context?

In the very difficulty of unpacking all this lies the importance of doing so - a recognition that the terms themselves, from 'service provision' to 'public', are constructs at a point in time in a particular context. As Edwards (1994) writes, changing notions of public and private responsibilities lie at the heart of the NPA. For example, as Semboja and Therkildsen (1995) point out, debates about service provision have become focused on privatisation. This strongly influences how service provision is thought about. The authors propose that in the case of East Africa, this perspective on service provision is highly restrictive since it neglects the fact that: a) provision of services depends on collective action by the state, NGOs and people's organisations; b) links between the voluntary sector and the state are becoming more not less important for service provision; and c) that there is growing dependence of service provision on foreign aid. What the authors are effectively saying is that it is this fundamental reality, not any paper definition of 'private' or 'service provision', which needs to be understood in order to develop appropriate policy.

Similarly, the meaning of 'advocacy' is contested. In many ways, debates around NGO advocacy have tended to define this away from service provision, rather than as connected to service provision. In practice, the term advocacy is often used to cover activities ranging from lobbying to campaigning to development education. What the British NGO literature provides is a debate about advocacy as work done in the 'North' which is about international or NNGOs engaging with donors and building international alliances:

"Generally speaking, advocacy is intended to alter the policies of governments or the aid system, or to monitor and obtain compliance with policies and conventions which already exist." (Fowler, 1997, p5)

In large part this is undoubtedly due to a perceived need for NNGOs to defend their *raison d'être*, and to review the strategies open to them (Twose, 1987). For example, INTRAC, a leading consultant to British NGOs, suggest that the justifications for the continued existence of NNGOs lie in their: a) being a net source of funds; b) being a source of specialised expertise, and/ or c) providing 'the link between developmental issues in the South to the public and opinion makers in the North and hence are engaged in educational and/ or advocacy work' (Ontrac, 1997).

In this debate about NNGOs, advocacy is defined as activities related to influencing Northern governments or the electorates which choose those governments, on the basis that many of the power imbalances believed to negatively influence development process in the South can only be addressed in the North. But this is

only one way to look at NGOs and advocacy. Nyamgasuria argues against the association of advocacy with NNGOs; against the idea that NNGOs should be abandoning their roles in the 'hardware' or operations of development to SNGOs, or that they should be monopolising access to Northern institutions. Rather than 'specialise' in different roles, NNGOs and SNGOs should revisit the meaning of partnership:

"A free unhindered flow, interaction and access to authentic voices in the South and to policy institutions in the North, is what one would call genuine partnership." (Nyamgasuria, 1997, p11)

These examples from the debate about service provision and advocacy reveal that the 'what' (and therefore the 'how') are not simply defined. NGO activities, NGOs as organisations, NGO 'sectors' are defined against other institutions (Diaz-Albertini, 1993). As the discussion about gap-filling and privatisation suggested, organisations are interdependent. For example, NGOs cannot simply be assumed to be cheaper, more effective, or more responsive than government providers, without some reference to what a change in the role of the state means for NGOs. This point about NGO-state interdependence is captured by an anecdote. Someone recently returned from Mogadishu in the mid 1990's was asked why, if Northern NGOs and other donors are supporting NGO capacity building, there are no local NGOs in the area today. The dry response was that there is no state there to create space for non-state actors. A Clark (1995) observes:

"A key determinant in the development contribution of nongovernment organisations (NGOs) is the relationship between NGOs and the state. NGOs may run parallel activities; they may play oppositional roles; or they may represent weaker members of society, organizing them to become more influential in decision making and resource allocation. This 'civil society' function entails moving from a 'supply side' approach concentrating on project delivery, to a 'demand side' emphasis, helping communities articulate their concerns and participate in the development process. Donors can use the policy dialogue to encourage governments to foster a more enabling environment." (Clark, 1995, p593)

The kind of space (and environment) provided will affect whether and how NGOs initiate and manage operational contacts with governments. Bebbington and Farrington (1993) point out that this implies the need for differentiated public policy, supporting research by some NGOs, but also offering contracts for service delivery to others. Over time, one might expect that different NGOs would find their

niche, some as innovators, others as implementers (Bebbington and Farrington, 1993).

This chapter has not proposed a definition for 'NGO' or laid out an answer to the question 'are NGOs service providers or advocates?'. What it has done is highlight what is important about this question in current debate, and proposed that in order to address the question effectively, research into NGOs needs to go beyond organisational studies to those that locate NGOs as organisations and 'sectors' in a given institutional context. This is because discussing the role of NGOs is also about discussing notions of public and private (goods, organisations, actions, spheres and so on). It is about how these are defined on paper and in practice. The fundamental questions being posed in debates over state, market and third sector are: who does what for whom? How and why do they do it?

The real life responses to these underlying questions produce ways of organising - organising and managing the expression and the satisfaction of needs, interests, concerns, power, values and so on. The sheer diversity - over time and context - of these ways of organising challenges those who would pretend that selection of the 'appropriate' organisational forms, for particular tasks, is a technical, apolitical matter.

## 3

# Research Strategy: What did I do and how did I study 'it'?

In this chapter I outline the development and application of my research strategy. In section 3.1 I begin with what I mean by research strategy, as made up of theory, methodology and technique. In section 3.2 I explore the role of theory and how I have used theory. In section 3.3 I talk about methodology, my use of case studies, and the process of identifying the research 'object'. In section 3.4 I present the techniques I have used, describing my fieldwork activities and reflecting on what I have learnt about doing research. Finally, I conclude with a short discussion about 'engagement', 'surprise' and 'blockage', terms that have been at the back of my mind throughout this research project.

### 3.1 What is a research strategy?: Linking theory, methodology and technique

I take 'research strategy' to refer to a complex process of continuous interactions. These are interactions between theory, methodology and technique; between researcher and research 'object'; and between the micro-level and macro-level dimensions of the research 'object'. I do not take it to be a linear arrangement of distinct phases dedicated to particular activities from problem-definition, to fieldwork, to analysis, to write-up. This does not mean that a research strategy is ad hoc and chaotic. I take it to be something that is explicit and can be explicated. However, in order to be able to effectively explain a research process, there is a need for space to 'admit' - to talk about some of the semi-conscious decisions, the pragmatic adjustments, and the forays down cul-de-sacs. It is these admissions that open the research strategy to scrutiny, and that reveal it as living and evolving.

My understanding of research strategy - as being about interactions, explication, and admission - derives both from my own experience and from an extensive literature that debates the role, purpose and practice of social science research. One of the most eloquent expressions of this notion of research strategy comes from Burawoy, who writes:

"In the social sciences, the lore of objectivity relies on the separation of the intellectual product from its process of production. The false paths, the endless labours, the turns now this way and now that, the theories abandoned, and the

data collected but never presented - all lie concealed behind the finished product. The article, the book, the text is evaluated on its own merits, independent of how it emerged. We are taught not to confound the process of discovery with the process of justification. The latter is true science, whereas the former is the realm of the intuitive, the tacit, the ineffable, in short, the 'sociological imagination'...I try to break open the black box of theory construction by regarding discovery and justification as part of a single process." (Burawoy, 1991a, p8)

### **3.1.1 Interactions: Research as engagement**

Morgan's description of research as engagement (1983, p19) has been one of the most influential ideas I have taken from the research methodology literature. Sayer (1992) writes of a research strategy being comprised of parts – method, object, and purpose – and rather like three corners of a triangle, those parts need to be considered in relation to each other. The nature of the relationship between the parts will depend upon the chosen form of engagement. So a research strategy is not simply about a choice between methodologies. It involves making choices about forms of engagement, or about the relationships that might exist between theory and method, concept and object, researcher and researched. The nature of the interactions between the parts of the research strategy needs to be explicitly and carefully considered.

### **3.1.2 Explication: The search for rigour**

Much of the debate surrounding social science research focuses on the similarities and differences between social sciences and natural sciences. Whilst this has interesting positive implications for practice on both 'sides', negative differences emerge around the notion of 'objectivity'. On the one hand, there is an idea of objectivity, which Sayer (1992) suggests derives from 'scientism', a highly restrictive view of science. This questions the rigour of social science research. On the other hand, some reactions to this 'scientism' have been to negate the relevance of objectivity completely. As Sayer continues, there is an equally restrictive view of social science, which reduces social science 'wholly to the interpretation of meaning'.

Clearly, like any other researcher, the social scientist has to manage the opportunities that exist to experiment with and develop research strategies that are most relevant to the research being undertaken. At the same time, they should not lose rigour. That rigour derives from the conscious development of a research strategy, which is used to guide questions and field-study, and which encourages an analytical, not simply descriptive, approach to the research. That rigour also derives

from charting and being able to explain decisions made about the research strategy over the life of the research project.

### **3.1.3 Admission: The interplay between theory and data**

The pursuit of rigour should not be equated with a linear approach to research strategy. There are very real difficulties in keeping the 'parts', such as methodology and problem, distinct (Naughton 1977; Burawoy, 1991a). This needs to be admitted and worked with. I think that one of the most important admissions is that explicit thinking about theory, methodology and technique does not always come before the event. In other words, these components are constructed during the life of the research, and in continuous reaction to events and experiences. The challenges (and opportunities) that this presents are nowhere clearer than in discussions about the interplay between theory and data. I am particularly interested in thinking about what theory 'does' to data and what data 'does' to theory.

Wuyts (1993) echoes Burawoy's point that 'we are taught not to confound the process of discovery with the process of justification' (1991a), when he talks about the tendency to impose theory on data. This tendency arises not so much from the 'technology' of the research tools, as approaches to methodology:

"Proper scientific practice (many economists argue) requires that data serve to test theory, not to develop hypotheses. This view is inspired by a dominant tradition in the philosophy of science...of first making a sharp distinction between the context of *conjecture* and the context of *testing* - and *then* proceeding by *ignoring* the context of discovery altogether, on the grounds that this is a subjectively psychological matter, and hence no business of the epistemologist. What matters in scientific practice, therefore, is the context of testing. In this view, empirical analysis is a *lonely encounter of a hypothesis with evidence...within a falsificationist strategy.*" (Wuyts, 1993, p4)

But if it is impossible, and undesirable, to pretend that the component parts of a research strategy can be separated and dealt with in isolation, what does this mean for the researcher? My view is that admission of 'the false paths, the endless labours' (Burawoy, 1991a) is key. It both helps to reveal the legitimate limitations of the work, and to clarify the nature of the contribution being made to the specific area of study and to social science method more generally.

In establishing a structured way of handling research as engagement, explication and admission, I am drawn to Morgan's idea of three levels of research strategy (1983). The first level is the researcher's *constitutive assumptions*, through which they make



explicit their view of the world. This enables the researcher to clarify why they have pursued certain data, and how they have used that data to form their conclusions.

The other two levels of research strategy are what Morgan refers to as *epistemological stance* or metaphors, being the images of social phenomena that are used to structure the enquiry. And the *favoured methodology* or puzzle solving, being 'the procedures and protocol used to operationalise the network of assumptions embodied in the paradigm and metaphor' (Morgan 1983). I use these three levels in the rest of this chapter, referring to them as theory, methodology and technique. I explain what has framed this research, how I have placed boundaries around the research, and how I conducted the research in practice.

## **3.2 The role of theory: Passive or active?**

### **3.2.1 Grand theory and 'islands of meaning'**

In my use of theory as a component of research strategy, I make a distinction between what I would call 'grand theory' and 'organising concepts'. This research is not directly concerned with grand theories about the world, into which category I would put Marxism for example. Of course, like all work both in the social and natural sciences, this research is infused with (at times in contradictory ways) the assumptions and principles that underlie many influential grand theories. Our ways of thinking are, usually unwittingly, shaped by such theories. What I am concerned with is the 'organising concepts', which are used to explain and analyse phenomena, and to justify interventions in the world. For me, an organising concept lies somewhere between Morgan's constitutive assumptions and epistemological stance. It is something akin to the 'islands of meaning' that Anheier (1995) refers to when he proposes that, unlike the notion of 'state' and 'market', the non-profit sector has yet to emerge as an island of meaning in research and public policy.

Often the organising concepts applied to explain the world, especially in the cut and thrust of policymaking, are 'chaotic'. In attempting to uncover this chaos, it may be appropriate to delve into some of the grander theory underpinning these concepts. It is certainly possible to think about whether these concepts need challenging, and to propose new formulations. In this way, theory, or organising concepts, are open to being built or re-built.

### **3.2.2 Characterising theory**

There are many different ways of thinking about theory and its role in a research strategy. In my mind, I have categorised these into at least four.

*Theory as a peg:* Theory can be treated as a passive component of a research strategy, perhaps by taking an existing theory that matches a set of data. This reinforces the validity of both the theory and the data. Whilst this can include innovative work, such as the application of a particular theory in a new context, there is also a danger of the theory being taken uncritically, and of it passing unmodified by the data. Wuyts refers to the dangers of 'theoretical over-determination' rather than the use of theory as 'guidance'. This is rather like a set of data being found a peg to hang on.

*Theory as explanation:* A more active approach to theory, is its use to make sense of data. Rather than simply attaching a set of data to the most relevant theory, different bodies of theory can be used to shed light on the data. Theories help to build abstractions from data, in a process of 'individuating objects and of characterising their attributes and relationship' (Sayer, 1992, p86).

*Theory as linkage:* Taking this use of theory one step further, theory can be used to challenge the conceptualisation of research 'objects', which as Sayer (1992) points out, tend to start life in a research project as superficial and chaotic. With constant reference to existing theoretical abstractions, these 'objects' will change in shape and form (perhaps with reference to a survey of literature). Theory is used to frame research questions, shape data collection, and guide analysis. At the same time, the research process and data may also be used to challenge existing abstractions.

Wuyts (1993) argues that this is essentially what happens in most research practice. Hypotheses emerge after examination of the data, from patterns seen in the data that combine with the researcher's subject-matter knowledge. Once research is understood as hypothesis creation, not simply as hypothesis testing, then it can become an active part of the research strategy. The role of theory within the research strategy is as a link between method and data, whereby the theory provides explanatory depth (Wuyts, 1993) to the data. Similarly it can help link the micro-level study to the macro-context, by enabling the researcher to abstract, from study of a phenomenon, an explanation with wider significance.

*Theory to be generated:* The idea of theory re-formulation is key to many social scientists, partly because:

"In any real situation there is usually a complex combination of these types of relation [within and between research objects]. The structure of a system can be discovered by asking simple questions about such relations: what does the existence of this object (in this form) presuppose?...What is it about the object that makes it do such and such? These question may seem simple to the point of

banality, but the answers are often complex and many errors of conceptualisation and abstraction stem from evasions of them.” (Sayer, 1992)

So the researcher may find plenty of reasons to challenge the ‘theory’ of others, not least because the territory on which most social science research takes place is characterised by ideological differences, constantly shifting policy debates, and changing jargon. If the battle to make sense of this with research and data is ongoing, then so too, the theoretical framework (or organising concepts) must be subjected to continual scrutiny.

One form of theory ‘reformulation’ is active theory generation, as for example, in grounded theory:

“A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore data collection, analysis, and theory stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge.” (Strauss and Corbin, 1990, p23)

Strauss and Corbin (1990) offer useful guidance for those interested in a more active development of theory. They indicate that the criteria for a study that seeks to generate theory are whether: a) it generates concepts; b) those concepts are systematically related; and c) the categories are well developed and linked to related concepts. As discussed in section 3.4, this project has been influenced by the theory generating approach to research.

### **3.2.3 Theoretical framework**

In Chapters 1 and 2, I have identified areas of theoretical concern relevant to this research. Firstly, I concluded that ‘theories’ about NGOs are somewhat chaotic and underdeveloped. Secondly, that as a result, representations of NGOs in policy debates are often inadequate and open to manipulation. Thirdly, that NGO ‘theory’ draws on a rather mixed bag of organising concepts, which is both problematic and creative. I began this research with my own constitutive assumptions about how to better understand and explain NGOs. These are captured by two concepts – public policy as process and public action.

#### ***Public action***

In international policy debate, the concepts of ‘public’ and ‘private’ have attained the status of being ‘islands of meaning’ (Anheier, 1995) in one important way. That

is that 'public' is commonly associated with 'state' and 'private' with other ways of organising. Of course, as indicated in Chapter 2, the notion of what constitutes public and private is dynamic. Hudson (1995) writes for example about the way that areas of social provision such as education have, over the years, moved backwards and forward over the private-public divide in British society. There is also a question mark hanging over the connection made between state and public to the exclusion of other forms of activity in the public interest. This has given rise to the concept of public action, meaning 'purposive collective action, whether for collective private ends or for public ends (however defined)' (Mackintosh, 1992, p5).

The arena of public action is the public sphere, encompassing action by parliaments, public demonstrations, media, trades unions and voluntary associations (Mackintosh, 1992, p5). Public action does not refer to the simple addition of forms of non-governmental action to state action (Wuyts, 1992, p282). It is an holistic concept, drawing attention to complex forms of interaction and their dynamics.

Public action does not take place in neat categories:

"Local public action...like state action, does not operate in a vacuum. It can be constrained, twisted or enhanced by state action and often by the actions of better funded, resource-rich NGOs from the industrialized countries." (Wuyts, 1992, p282)

From a public action perspective, it is a very small leap to recognising that the public sphere and public policy are social and political constructions. Ideas about what constitutes public and private emerge through processes that include (and exclude) forms of public action. These processes vary across time and place, helping to explain why:

"Seemingly similar policies, therefore, do not necessarily lead to similar outcomes." (Wuyts, 1992, p280)

### ***Public policy as process***

"We sat after lunch, five of us, arguing about the meaning of health policy. For the economist from the World Bank it was about the allocation of resources. For the Ugandan health planner it was about influencing the determinants of health in order to improve public health. For the British physician it was about government policy for the health service. The Brazilian smiled. 'In Portuguese the word 'politica' means both policy and politics', she said. For her, health policy was synonymous with health politics." (Walt, 1994, p1)

This extract from Walt (1994) is one of a handful of statements that have stuck in that back of my mind throughout this research. Walt is arguing that health policy needs to be understood as a process that involves the play of power. It is not simply a technical matter, concerned for example with making decisions about the 'best' method for developing health insurance systems. As Walt and Gilson (1994) point out, health policy tends to focus on the content of reform, at the expense of the actors and processes that are involved in designing and implementing change, and the context within which the policy is being developed. Other authors echo this point when they reflect on the importance of using good understanding of a particular context to design change, rather than relying on prescriptions (Gilson and Mills, 1995; Cassels, 1995). The rather technocratic over-confidence that I detected in the 1993 World Development Report, and the tendency in much of the early public-private split literature to ignore the politics of health policy, has consistently drawn my attention to the importance of understanding how public policy is constructed in particular arenas.

Walt (1994) identifies various disciplines that have contributed to policy analysis, and suggests that something can be taken from all of these to create an 'overarching framework' for investigating health policy. These disciplines include political science (with debates about pluralism and elitism); policy modelling (with ideas about policy as rational and policy as incremental); and public choice theory (which identifies the state not simply as a disinterested manager of the public good, but as an actor in its own right). Walt touches on work from these disciplines when outlining questions that provide a framework for understanding the relationship between political systems, health policy, and people's participation in policy. This framework involves:

- identifying the nature of the particular political system;
- exploring what determines participation in public policy-making (for example, the leverage available to international donors, and their insistence (or not) on the participation of certain groups in national policy processes);
- investigating what public policy is and how it is made (for example, certain actors might be involved in different stages of the policy process from issue identification to implementation to review and termination or continuation);
- researching how the public policy agenda is set (for example, what it takes for policy alternatives to be taken up by governments).

In this research project, I have understood policy to mean both policy and politics as captured by the Portuguese commentator in Walt's extract above. I have taken public policy as something that emerges through a process of interactions between interests and actors over time. And as Wright and Shore (1995) propose, I have attempted to take this process as data in itself:

“An anthropological approach to policy studies would treat the models of decision-makers as ethnographic data rather than as frameworks for analysis. Instead of assisting in this vain attempt to present ‘policy processes’ in terms of systematic and tidy ideal-types, anthropological approaches would explore the characteristic cultural complexity and messiness of that process.” (Wright and Shore, 1995)

The two concepts - public policy as process and public action - are the basic assumptions that I make about the world. They help explain why I questioned the representation of NGOs in major policy agendas such as Health Sector Reform. They also encouraged me to think harder about: a) the explanatory values of different bodies of theory; and b) building alternative hypotheses and frameworks. In section 3.5 I look at the question of research ‘object’ or the unit of study. My thoughts about theory have been important in determining this, and at times the boundaries around my research ‘object’ have become blurred. Yet, as discussed in Chapter 2, I felt that answers to ‘what are NGOs?’ must surely lie in understanding that NGOs are located in complex institutional contexts. This makes it important to look at how NGOs are involved in processes, in interactions and in public action.

### **3.3 The role of methodology: Case studies**

In this section I look more closely at the role of methodology in a research strategy, exploring the use of case studies. It is useful to remember Burawoy's comment that methodology is neither the ‘science of technique’ nor ‘a branch of theory’, but a link between technique and theory, for:

“If technique is concerned with the instruments and strategies of data collection, then methodology is concerned with the reciprocal relationship between data and theory.” (Burawoy, 1991b, p271)

The qualitative nature of my research interests indicated that a case study approach would be appropriate. But what is a case study? Why do a case study? What type of case study? How does a case study methodology relate to theory in practice? These are questions that I think through in this section. Another important question: ‘how do you boundary a case study?’ also arises, which I address in section 3.5.

### **3.3.1 What is a case study?**

Yin (1994) points out that case studies have often not been thought of as formal research strategies in their own right, being treated merely as the exploratory phase of some other research strategy. He suggests that a case study is not simply a data collection tactic, however, but a research strategy in itself, which enables the researcher to:

- i) engage in an empirical inquiry that investigates a contemporary phenomenon within its real-life context and especially when the boundaries between the phenomenon and context are not clear; and
- ii) which is a research strategy that copes with situations where there are many more variables of interest than data points. It therefore relies on multiple sources of evidence with data needing to converge in a triangulating fashion and benefits from prior development of theoretical propositions to guide data collection and analysis.

In all these senses, a case study approach is appropriate to my research.

### **3.3.2 Why do a case study?**

Yin (1994) notes that case studies tend to be defined by the topic they address, for example, 'institutions' or 'processes'. This is a significant clue as to why they are an important research strategy. The study of processes would be less appropriately tackled purely by a survey approach, which is concerned with 'who, what, where?', than by an historical or a case study approach, which are more concerned with 'how and why?' questions. Yin suggests that the type of question asked will determine the research strategy. The experimental, historical and case study approaches all share the same questions, 'how and why?'. The distinction between them lies in the fact that a case study does not require control over behavioural events, unlike experimental work, and focuses on contemporary events, unlike an historical approach.

Langrish (1993) also justifies case studies on the basis that there are different tools for different jobs. Highlighting two main research traditions, he justifies case studies on the basis of the biological approach to research:

“The physics approach looks for underlying principles,....the biological approach glorifies diversity. The physics approach looks for mathematical equations; the biological approach seeks out taxonomies – simplification versus classification.” (p2)

and:

“If case studies can be compared to biological studies, then the purpose of case studies becomes clear, namely to assign the different examples into ‘classes’ and to observe the different ways in which the different classes ‘survive’ in either the same or different environments.”(p3)

This is Yin’s ‘how and why?’ as distinct from (but not excluding) the ‘what and how many?’

Langrish proposes that case studies meet four general aims of research:

- developing ‘labels’ or taxonomy, citing Mintzberg and Quinn (1991) who talk about theories as ‘cataloguing systems’ or useful shortcuts to data;
- seeking out the principles that underlie the taxonomy;
- understanding movement through time, a key aspect of which is the extent of control over what is happening. Langrish proposes that the biological approach does not assume a greater degree of freedom for phenomena than may exist in reality. Instead, it looks at ‘how things survive in a hostile environment and how they adapt to changes in their environment’.
- unravelling causation

On the question of the use of case studies as a means of unravelling causation, Langrish suggests that the biological approach does not simply think in terms of cause and effect, but also allows that ends cause beginnings and that things are not organised simply because of desired ends. Langrish writes about this understanding of causality as being useful in two ways. Firstly, when applied to human organisation it challenges the idea that cause (for example, policy change) simply leads to effect (planned outputs). Secondly, that within the biological idea of causality lies the ‘principle of stoppage’, in other words, the factors that limit activity or by being withdrawn, enable activity to proceed.

Given that this research is concerned with challenging and reforming existing ‘labels’ applied to NGOs, the case study approach as an approach that encourages the researcher to explore the underlying principles, and the nature of continuity and change over time, is appropriate as a methodology.

### **3.3.3 What type of case study?**

The question ‘what type of case study?’ reveals a diversity of case study. Even though the case study approach might seem appropriate to the research, there is still more to be thought through.

Langrish (1993) provides a typology of case studies suggesting that there are:



- a) *comparative*: deriving from agricultural research and based on the use of controlled variables;
- b) *representative*: based on 'vague notions of a statistically valid sample';
- c) *best practice*: the aim of which is to seek out examples of best practice;
- d) *'the one next door'*: on the basis that perhaps honesty is best when outlining selection of case studies!;
- e) *'cor look at that'*: picking unusual examples; and
- f) *taxonomic case studies*: cases may be different parts of a taxonomy developed from the research.

Although none of these matches closely with my research needs, this typology has been useful for clarifying what I am not trying to do. For example, Langrish refers to PhD projects generally undertaking 5-7 case studies. I think that this choice of number of case studies is directly related to the purpose of the case study. It is tempting to collect together a set of case studies because there appears to be something 'scientific' about setting out to compare a set of examples. But the case study approach to methodology should stand up to scrutiny in its own right because it is the appropriate methodology for the research concern.

Yin (1994) addresses this issue by describing the possibility of multi- and single-case studies. There is a rationale for a single case study where that is the critical case 'in testing a well-formulated theory'. The single case might also be important for study because it is a unique or extreme case or revelatory case. These justifications for a single case are similar to Langrish's unusual example and best practice cases. However, for the purposes of this research, the question of what type of case study is about the relationship between methodology and theory – not just or even testing theory but generating theory. I am therefore drawn to Burawoy's exposition of the extended case method (ECM)

In the ECM as I understand it, the search is not for a series of cases of, for example, a set of organisations which reveal similarities and differences. It is for a single case, for example, NGOs and the promotion of Primary Health Care. The concern is not with representativeness (which implies that other cases have been explored and a single case identified for further study) and comparison. Rather, it is with exploring the interplay between the micro-level and the macro-level characteristics of a phenomenon.

### 3.3.4 Extended case methodology

Burawoy's exposition (1991b) of the extended case method identifies an approach that explicitly sets out to identify and understand the macro-micro, and indeed, the theory-practice interactions I am interested in.

Burawoy explains how the ECM has emerged as one response to common criticisms of participant observation, the methodology ordinarily associated with the single case study. These criticisms are concerned with significance and level of analysis. Critics suggest that whilst interesting results may emerge, the single case is not generalizable. In addition, the face-to-face situation is deemed to be inherently micro and a-historical.

Burawoy explores the use of the extended case study in dealing with these criticisms. He compares the ECM to other approaches – ethno-methodology, interpretive case method, and grounded theory. Burawoy suggest that ethno-methodology denies the relevance of the critique by viewing the macro world as a construction of the participants<sup>1</sup>. The interpretive case study similarly 'collapses' the macro and micro, but by taking the micro as an expression of the macro<sup>2</sup>. Both grounded theory and the extended case method accept the micro and the macro as discrete and causally related levels of reality. They posit that generalizations can in fact be derived from the comparison of particular social situations. The key difference between them is that:

“On the one hand, the extended case method, by explicating the link between micro and macro, constitutes the social situation in terms of the *particular* external forces that shape it. It faces the problem of generalization. On the other hand, grounded theory, by pursuing generalizations across social situations, obscures the specific contextual determinations of the social situation. It faces the problem of the link between micro and macro.” (Burawoy, 1991b, p274)

There are a number of reasons why the ECM approach to case studies seemed appropriate to my research. Partly because, unlike grounded theory, the ECM does not set out to build theory, but to reconstruct it, deriving generalisations by setting the research situation against an existing 'body of generalisations' and then

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<sup>1</sup> “In the view of ethnomethodology the macro world is not a real world but a construction of participants enabling them to negotiate and uphold face-to-face interaction.” (Burawoy, 1991b)

<sup>2</sup> “The interpretive case method denies the premises of the conventional criticisms by claiming that, properly understood, the micro and particular are simultaneously macro and general.” (Burawoy, 1991b)

reconstructing this (Burawoy, 1991b). This research derived from problems I was beginning to identify in existing generalisations about NGOs.

In addition, because the ECM is about using the single case to explicate the link between micro and macro, not about comparisons across a series of cases. This research is not concerned with producing typologies or generalisations that are comparable. It is about developing frameworks for thinking about NGOs that recognise that NGOs are located in institutional contexts with which they engage and which shape them. As Burawoy states, the ECM does not build significance in terms of the statistical, but the societal, such that:

“...the importance of the single case lies in what it tells us about society as a whole rather than about the population of similar cases” (Burawoy, 1991b, p281)

The ECM is concerned with a single case, not because what is happening there is specific only to that case, but because general laws are being revealed there. I have applied this idea of the case study to this research because the project is not concerned with finding one-off examples, or with ‘better’ definitions of NGOs as organisations. Rather, it is about better appreciating the role of NGOs in the public action process.

### **3.3.5 The research ‘object’**

This section looks at how I have defined the research ‘object’. The process of constant interaction between parts of a research strategy has been particularly clear as I have searched for a research ‘object’, ‘unit’ or ‘phenomenon’. This search is a continual process, not due to any indecisiveness or lack of clarity, but because whilst you are reading, talking, interviewing and observing, the insights you are gaining keep reshaping the boundaries. This process has taken me into several bodies of literature that I have not used directly in this thesis, but which have contributed to my thinking, such as organisational sociology and the New Institutional Economics.

#### ***The parameters of the project: Soft systems methodology***

One of the literatures I turned to when thinking about defining the research ‘object’ was systems thinking, and in particular, soft systems methodology (SSM). As its name implies, SSM is a methodology - it is intended to provide a framework for problem solving. However, in terms of the distinctions I have made earlier, it could also be seen as a technique, or ‘tool for appreciation’ (Engel, 1995). I became interested in SSM for two reasons. Firstly, given my interest in the process of public policy and the existence of a plurality of actors in the public domain, I am

investigating an arena characterised by complexity. As such, I was interested in research approaches that would help me to make connections between organisations and events explicit, without reducing these to single lines of causality. Secondly, some of the techniques of SSM, such as drawing rich pictures, developing 'images', seemed appropriate to the process of reaching my unit of enquiry or drawing boundaries, because:

"Soft systems thinkers do not take the world to be systemic nor do they assume their systemic images can be developed into representations of (parts of) wholes in the 'real' world. Systemic images can be used in order to build instruments of inquiry... 'Systems' do not have to have a purpose they are *given* one.

Consequently, for soft systems thinkers, systemic images are 'windows' upon the world rather than representations of the world. Each of them implies a way of looking at the world and can be constructed to reflect different worldviews or perspectives." (Engel, 1995, p29)

The appeal of SSM lies in its concern with developing systemic images to construct windows to study the world, with the focus of those systemic images being social actors, activities, perceptions and relationships.

SSM as developed by Checkland, offers more specific guidelines about practice than some other methodologies. The process involves analysis of the problem area, the development of a root definition of relevant systems, and the derivation of conceptual models. Being a problem solving method, SSM also moves into design and implementation, which would be of interest were this truly an action research project. However, to stay with the early stages of SSM, it encourages a throwing open of the problem area, not having preconceptions about its characteristics, but developing a rich picture to capture its components as they are. The development of the root definition is about capturing the basic nature of the system(s) thought to be relevant to the problem situation. Checkland gives examples of root definitions that might be formulated for a church, which could be seen as a social welfare system or as a ritual-organising system. Conceptualisation then begins to move you into the area of acting on the problem, since:

"Conceptualisation starts from the root definition and asks: What would the activities have to be in a human activity system which meets the requirements of this definition?" (Naughton, 1977, p27, citing Checkland)

SSM is concerned with holism, in the sense that the systemic images developed encompass a whole 'human activity system'. It also offers useful ways of thinking

about boundaries. Boundaries need to be drawn which enable the researcher to establish a level of analysis that reduces the complexity to manageable proportions:

“To study something as if it were a ‘system’, according to Kramer and De Smit (1987: 19), the following questions have to be answered:

- 1) What entities are part of this ‘something’?
- 2) Which entities do not form part of it, but influence it?
- 3) How do the entities within this ‘something’ relate to each other?
- 4) How do the entities within this ‘something’ relate to those outside?” (Engel, 1995, p33)

### ***The unit of analysis***

These are the kinds of questions I have been thinking about during this research. They have been important in considering what is inside and outside the system I am concerned with, and what the relationships are between these. I have used them in thinking about whether I am concerned with NGOs as organisations, with the health system, with the health policy process, with the arena of public action. At different times and in different ways, the research has been about all of these. As discussed in section 3.6, the field-study has taken place in three blocks, partly for practical, but also for methodological, reasons. In the first block I was interested in NGOs and their perceived location in the health policy process. In the second block, I was interested in a couple of regions and the location of NGOs as actors in CBHC in those contexts. In the final block of fieldwork, I was interested in the single case of an NGO CBHC programme, and what could be learnt from this about NGO relationships with other actors, definitions of health, and community involvement. I have essentially moved from study of policy to organisations to networks as different ways of thinking about the location of NGOs in the political economy of organisation and supply.

As I explained in Chapter 2, I have not defined tightly what I mean by NGO, or confined myself to defining a particular subset of organisations, such as local NGOs or international NGOs or mission health facilities. I have allowed myself to follow other people’s meanings, and some of this comes through in the data discussed later. Given that I never believed that my unit of analysis was ‘NGO’ as an organisation, but ‘NGO’ in a given institutional context, I feel that this was appropriate.

I have however battled over other issues to do with boundaries. For the final stage of fieldwork, I struggled for some time over whether I should focus on an organisation, programme, set of organisations, or maybe even an administrative district? I had

been trying to avoid focusing on HPA's experience of implementing a CBHC programme, given my close working relationship with the programme. However, this became the best option for two reasons. The physical and social logistics of moving around rural districts and regions are complex, unless you work in certain areas that are already overrun with social science researchers and PhD students. Through HPA I knew that I would get easier access to people outside the organisation, and indeed better access to people within the organisation than if I had had to start to build deeper relationships with another NGO. I had already interviewed in several NGOs and begun to appreciate how much time is involved in building trust and improving research access. I also knew from this earlier fieldwork that many of the issues being dealt with by HPA were similar to those of NGO programmes in other parts of the country. In that sense, I see the case of CBHC as the single case study through which I am exploring the role of NGOs in health in Tanzania. The organisations, programmes, objectives and relationships that I uncover in Chapters 5-7 are aspects of that case study.

My tacit knowledge of the HPA programme also placed me in a position to engage in forms of participant observation. Whilst at times I have had to check myself not to impose too much on the data based on any predisposition towards the work being done, I have to 'admit' to the active nature of this research project. I was always predisposed to a study that both drew on direct experience and that could be used to directly inform the work of others. This relationship has existed between myself, this project, and the HPA programme and its staff. My link with HPA offered me a way of entering the tangled web of what is happening in practice, and to emerge from there with abstractions that could usefully reflect on the role of NGOs in health action.

### **3.4 The role of technique: Charting my research activities**

The purpose of this project has been to explore the role of NGOs in HSR and PHC promotion in Tanzania. In this section I discuss this exploration in terms of my approach to literature, and then how I conducted three pieces of fieldwork, each of which was designed to cast a slightly different light on the research phenomenon. These three pieces of fieldwork basically correspond to chapters 5,6 and 7 of this thesis. In this section I outline each piece of fieldwork in terms of:

- What I did
- Why I did it

- Who it involved
- How I did it
- Reflections: What I learnt about doing research

I conclude the section with a brief retrospective on the research.

### **3.4.1 A literature strategy**

There are two forms of written material that have been important to this research project: secondary and primary documents. By secondary documents, I am referring to books, papers, articles and grey literature such as reports, that I have read to build background knowledge, familiarise myself with debate, and understand the work of other researchers in the areas of relevance to this project. By primary documents, I mean those reports, proposals and brochures I have collected from the organisations in which I have interviewed, and which I treat as data.

There are two considerations that have influenced my approach to the secondary literature. The first is the explosion of materials concerned with development, not least those focused on NGOs, since the late 1980's. This has necessitated a pragmatic approach to literature that helps to reduce the problems of information overload. The second consideration has been the interdisciplinary nature of this project. Rather than staying within the boundaries of one discipline or body of literature, I have selected aspects of many literatures to dip in to. This has enabled me to: a) make use of ideas from diverse literatures, lending a particular shape to this project; and b) to observe (a point I cite in Chapter 2 by Thayer-Scott) the extent to which different disciplines, often unwittingly, pursue very similar trends of thought. A weakness of this approach is that I have not spent a lot of time on a few pieces from one area, and have had to quickly grasp concepts from different areas. However, this in itself leads to new skills, not least in being able to sift and sort fast from a vast number of options, and from there to develop an overview understanding.

In practice, I have come to this project through two literatures. The first has been the development and NGO literature, in particular those parts that deal with NGOs and health, NGO-state relationships, and the *raison d'être* for NGO action. The second has been through health literature, in particular where this has intersected with key words such as NGO, PHC, decentralisation, community and HSR. A few days spent surrounded by the titles of books and articles soon orients you to the main thrusts of debate to be followed up. I have also made use of other bodies of literature to varying degrees. Chapter 4 is the product of extensive reading on Tanzania, using

many materials that I was only able to find in bookshops in Dar es Salaam. This chapter also draws on background understanding and interpretation derived from reading English language newspapers. During my visits to Tanzania in 1995 and 1996 I was able to record key issues arising in the press on a daily basis, although by 1996 the explosion media services was beginning to make this impossible. This chapter itself is largely the product of reading around social science research methodology. In my attempts to identify the unit of analysis of this research, and to link this to concepts, I have dipped into many areas of social science debate, such as organisational theory, New Institutional Economics, and Public Choice Theory.

I have also been prompted to follow other lines of enquiry, such as the American NPO literature. As I explain in Chapter 2 I was quite simply intrigued by the fact that development debate tends to refer to non-governmental organisations, whilst in the America literature the term non-profit organisations is applied. This foray proved rewarding. I have also pursued work by certain 'big names' in key fields – for example, Rondinelli on decentralisation – in the knowledge that such authors should provide comprehensive discussions to complement other pieces I was using that might be over-specific or one-sided. A similar logic applied in my use of Walt's book on health policy, which, being a distillation of a number of other literatures, a major project in itself, I felt would provide a useful and comprehensive overview sufficient to my needs.

Finally, I have collected a wide range of primary materials from people I have interviewed. Some of this material, in particular Ministry of Health documentation, was initially very difficult to obtain due to resource constraints in the Ministry. Key documents that are used extensively in Chapter 5 had to be actively pursued over a series of visits to Dar es Salaam.

### **3.4.2 Fieldwork 1995**

In September to October 1995 I undertook six weeks of preliminary research that was aimed at finding out what was being said about, and by, NGOs in the context of Health Sector Reform. I did this through two sets of activities:

- Identifying and interviewing key donor, ministry and NGO actors involved in health and health policy in Dar es Salaam;
- Organising and facilitating a workshop for NGO and government staff concerned with community health and development in Tabora Region.

My objectives were to:



- Answer the first of my research questions: Do, and if so, how do, NGOs seek to influence national and international health agendas for the continued promotion of PHC approaches?
- To build background knowledge and a set of contacts that would assist me in deciding how to study the other two research questions concerned with NGOs and local government relationships, and NGOs as 'community activists' in promoting PHC.

In the case of the research conducted in Dar es Salaam, I interviewed 14 members of donor agency staff in 11 bi-lateral and multi-lateral donor organisations; 10 members of NGO staff from 10 NGOs; 5 members of MoH staff, and 2 people from organisations in the research and consultancy sector. The method I used was to identify agencies and names of key people by literally walking around Dar es Salaam (there were no telephone directories and in any case, addresses are given by post office box number not geographical location). I would talk with receptionists about who would be the appropriate person to interview. I also asked all those I interviewed to suggest others they thought I should meet.

I was able to arrange interviews with the majority of people I identified as key. These interviews were open-ended. I started in all cases with a short and general introduction to my interests, namely HSR, the role of NGOs with particular reference to PHC, and District Health Management. I then left the interviewee to speak, only intervening when I wanted more detail or clarification, or when I felt an issue of interest was not being raised or even avoided. I recorded most of these interviews through hand-written notes made during the discussion (although initially I was nervous of taking notes because I felt it might unsettle people, I became more confident later). Reflective notes written after the interview complemented these notes. These notes and the notes made during the later periods of fieldwork are in the form of fieldwork diaries.

The detailed analysis and conclusions arising from this piece of fieldwork are the subject of Chapter 5. However, it is worth making the following points in this chapter:

- I did not encounter any positive reaction to the idea of linking HSR, NGOs and PHC. Many people, both in Dar es Salaam and Tabora, just did not see the significance in relating NGOs to HSR. In addition, I was asked by a large number of people why I was researching policy and not some other 'useful' area such as client usage of health services or epidemiological issues. Perhaps the most extreme version of this position was reported to me in 1998, when I was

told informally that the reason one particular person was reluctant to schedule an interview with me was his feeling that it was too early to start talking about the implementation of HSR policy. I treat these responses as data in themselves because they reflect predominant perceptions;

- The Tabora workshop was designed to open up discussion about NGO-government and NGO-NGO links. I wanted to develop a better understanding of what relationships existed in Tabora Region and to shed light on advocacy and service provision activities by NGOs. I found that no participant, whether government or NGO, knew what HSR was. This made it somewhat difficult to talk about the possibility that NGOs might be actors in health policy processes! Whilst all participants talked about their micro-level work in areas such as water improvement, agriculture/ livestock, dispensary construction, health education and so on, and whilst they explained these activities in relation to a concept of health that went beyond the medical service facility, they did not articulate links between their work and the active development of government policy;
- At least half of the NGO 'staff' I met at the workshop were either secondees or liaison officers from the Regional and District governments of Tabora Region, revealing an important NGO-government form of interdependence. However, the participants themselves noted with surprise that they had not met previously in such a way to discuss the issues that were the focus of the workshop. In fact, the main conclusion of the workshop was the need to approach the Regional Government with a proposal for an NGO-government forum. This was acted upon in the following months;
- I had hoped that the Tabora workshop would help me to identify a group of NGOs working around health issues in one location where I would be able to focus my fieldwork. Given the limited response to my research, the lack of knowledge about changing health policy, and the small number and nascent nature of the NGOs working in the region, I concluded that this would not be the best way forward. However, my work in Dar es Salaam and Tabora had confirmed that the implementation of CBHC by NGOs offered a relevant and feasible area for further investigation of all three research questions.
- Chapter 5 draws primarily on public documents available in the MoH. Not all the documents were mentioned to me, or available, when I was first in Dar es Salaam. For example, I did not come across the HSR Proposals (1994a) until 1996. In addition, most of my learning about HSR has come about through

doing this research in Tanzania. As a result, I have been more dependent upon what interviewees in Tanzania have told me about wider trends in HSR since 1995, than on keeping abreast of the HSR literature.

- I had originally seen the fieldwork of 1995 as being about information gathering and building a background understanding than as 'research'. However, I realised during analysis that what I had was data in itself. This was largely brought home to me when I dipped into some of the literature about development discourse (for example, Gasper and Apthorpe, 1996; Apthorpe, 1986). I began to realise at this stage just how important the things that people were saying, or not saying, were to my understanding the location of NGOs in health action and HSR. In the next two phases of research, I began to place more emphasis on thinking about what people were telling me and why, rather than treating this simply as 'information' to be recorded.

### **3.4.3 Fieldstudy 1996**

Between August and November 1996 I undertook 10 weeks of fieldwork. The aim of the fieldwork was to find out what was happening in CBHC in Tanzania in terms of history, policy and practice. I had determined that my exploration of CBHC would be through what NGOs had to say about their mission, objectives and activities, not through the eyes of communities, since this research project is concerned with the political economy of the supply of health action, not the impact or effectiveness of interventions such as CBHC.

My main fieldwork activities were:

- Visiting the regional towns of Mbeya, Arusha, Tabora, Singida, Moshi and Dar es Salaam, and identifying and interviewing NGO staff and other actors involved in PHC/ CBHC policy and practice;
- Following up individuals and documents I had been unable to access in 1995.

My objectives were:

- To establish the extent and relevance of CBHC-oriented activities in Tanzania;
- To answer all three research questions but with the emphasis on: In what ways do NGOs work with local government for the promotion of PHC?; and In what ways do NGOs act as 'community activists' in promoting PHC at community level?;

- To assess whether a single, detailed study of one CBHC programme or NGO would be appropriate and feasible, and in that case, to identify such a programme or organisation.

During this period I interviewed 23 NGO staff from 14 NGOs; 5 donor staff from 4 agencies; 8 government staff from Regional and District administrations.

I had decided to visit a number of areas in order to build an understanding of the scope of CBHC nationally. The rationale I used in identifying the areas I visited was as follows:

- *Arusha and Moshi:* Arusha and Kilimanjaro Regions both have a long history of mission and NGO involvement in social development activities, including health. The towns of Arusha and Moshi are home to a number of NGO head-quarters, as well as advocacy and consultancy-oriented NGOs. I knew that both places would offer a concentration of NGOs;
- *Tabora and Singida:* The two regions are the location of CBHC programmes developed by HPA. They are both regions with comparatively limited NGO activity and in addition to the research access facilitated by my link with HPA, would also provide some balance to the examples of Arusha and Moshi;
- *Mbeya:* I had been offered the opportunity to visit two British ODA-funded health programmes in Mbeya, on the basis that both programmes were concerned with PHC and with promoting capacities and linkages for PHC activities between health actors;
- *Dar es Salaam:* As the de facto administrative centre of Tanzania, home to ministries, donor agencies and a number of NGO headquarters, I felt it appropriate to return to Dar to build on the research I had conducted in 1995.

The method I used was semi-structured interviews based on a written questionnaire I had devised (see Appendix 1). This had been developed with the first two levels of question proposed by Anheier and DiMaggio (Anheier, 1995) in mind. Namely: a) Why do NGOs exist? What is the division of labour and responsibilities between organisational forms? And b) To what extent and why do NGOs differ from other forms in terms of performance, efficiency, equity, clients, strategies and outputs? I recorded these interviews through hand-written notes in my fieldwork diary. During this fieldwork, some of the interviews were more effectively conducted in Swahili than in English. I did not work with a translator, and had to rely on my own language skills and to ask for clarification from the interviewee where necessary.

The analysis and conclusions arising from this fieldwork are discussed in Chapter 6.

However, there are some reflections on what I learnt about doing research:

- The questionnaire and attached summary of my research proved useful in obtaining interviews (especially when I had to go through a receptionist rather than a face-to-face introduction). However, it was not adhered to in the interviews. None of the interviewees completed the questionnaire prior to interview, and after my first few experiences of this, I resorted to using the questionnaire as a guide for discussion. I also found that the level and type of information that the questionnaire was looking for was problematic. It supposes that organisations carry such information in accessible forms, which is not always the case. It supposes that individuals are able and willing to access that information for you. It soon became clear to me that obtaining the information required to systematically assess the division of labour and responsibilities, or the comparative performance and outputs, of different organisational types, would involve meticulous study over time. In an environment in which many NGOs are young, organisations are constantly moving from one project or programme to another project or programme with limited assessment and recording of information, and relationships with other types of provider are complex and changing, it is difficult to provide answers to such questions in anything more than qualitative terms. In essence, what you think you can get information about when you start research, and what is actually available to you, are two very different things;
- Interviewing people is an art, and it takes time to build your own confidence as an interviewer. It also takes skill to put the interviewee at ease. In my experience, attempting to adhere to an interview format too strictly can upset what is quite a delicate relationship. Such a relationship is better developed by allowing people to speak freely with some prompting. It is in the flow of conversation that some of the most interesting data emerges;
- At the end of this fieldwork I was able to start to map out the practice of CBHC in Tanzania. However, I did not feel that I had yet grasped how NGO promotion of CBHC fitted into the institutional whole. With hindsight, I realise that I already had a great deal of the data I needed, but that I was not confident enough to value this as data. Over the life of this project I have learnt not to dismiss valid data by simply thinking of it as background information for a later piece of fieldwork.

### **3.4.4 Fieldstudy 1998**

Between March and August 1998 I spent 14 weeks working on my final piece of fieldwork. The aim of this fieldwork was to look more closely at how CBHC is being promoted by an NGO with reference to the wider institutional context. The focus was HPA's CBHC programme in Tabora Region. My main activities during this time included:

- Facilitating a review workshop of HPA staff from the Tabora and Singida programmes, part of which involved working with a CBHC facilitator from AMREF;
- Identifying and interviewing key district and regional government staff, NGO staff and HPA staff;
- Working with two HPA Tabora staff on the design and delivery of a training workshop with rural councillors in Urambo District;
- Interviews in Dar es Salaam following up on developments in Health Sector Reform policy and plans, and in CBHC.

During this fieldwork I interviewed 11 members of district government staff from Tabora Municipality, Urambo District and Tabora Rural District; 4 members of Tabora regional government; the five core development staff of HPA Tabora; and 3 members of staff from 3 NGOs in Tabora Region. In Dar es Salaam I interviewed 2 NGO staff, both retired from AMREF, and 1 person from one other NGO; 2 members of donor staff from 2 donor agencies, and one person from the Ministry of Health. I was also involved in two meetings, one concerning the planning of a workshop on NGOs and HSR in East Africa, and the other concerning the establishment of an NGO Health Forum in Tanzania.

The fieldwork conducted in Tabora was based on interviews using the questions outlined in Appendix 2. The design of these questions was informed partly by the third question posed by Anheier (1995), which is concerned with how the nonprofit sector relates to or interacts with other sectors, and what this suggests about how the nonprofit sector is located in the overall institutional setup of society. Applying a two-level understanding of institutions as: a) organisations; and b) norms, values and practices (Chataway et al, 1998), I sought to 'map' the institutional environment in which this CBHC programme was located. As I explain in Chapter 7, I found the organisational field more sketchy than I had anticipated. However, people's perceptions as articulated in their answers to my questions, enabled me to develop a

stronger sense of how this NGO CBHC programme is located in the institutional context.

The questions were framed using my detailed background knowledge of HPA's programme and history in Tabora. In the case of two members of the HPA team, I turned an initial interview into a basic cognitive map. I then met with both people together to discuss the map. This meeting provided some new and modified data, but largely reinforced the first interview. I took this approach purposely in order to confirm that what I was hearing from individuals during an interview was consistent across more than one interview. The interviews I conducted in Dar es Salaam were largely follow-up interviews with people I had already met, or had wanted to meet, and along the lines of those I conducted in 1995 and 1996. During this period of fieldwork I recorded all the interviews on audiocassette. About half of the interviews were conducted in Swahili. I had these transcribed for me, and I have worked through the transcripts with a Swahili speaker to ensure that my translation and interpretation is correct.

The analysis and conclusions arising from this fieldwork are discussed in Chapter 7. However, there are some reflections arising about doing research:

- Some of the interviews I conducted involved groups of people. In addition, in the case of the cognitive map, I brought two people together to talk about the maps I had drawn for each of them. I found this approach useful as it helped to open up discussions of the kind that are not always forthcoming in a one-to-one interview.

### **3.4.5 Analysing the data**

The methods I used for analysing my data involved the identification and organisation of information around themes, and the comparison of similar pieces of information from different sources for the purposes of triangulating or confirming the validity of that piece of information. My ability to analyse interview and documentary data was heightened as the project progressed and I built up a greater tacit knowledge of the arena and organisations I was working with. It is important to reflect too on the fact that analysis – reflection, organisation and reframing – takes place as you are involved in your fieldwork. This means that as you move between interviews, new or differently phrased questions come into your interview schedule. This reflects a process of triangulation, or the need to confirm a piece of 'data' by viewing it from other perspectives or other sources.

As already discussed, I had originally viewed my fieldwork of 1995 as fact-finding and building and appreciation of the background to HSR and health policy in Tanzania. As I read through my diaries over a year later, I began to see the relevance of how people had been talking, and of relating this to the health policy documents I had now begun to acquire. For example, the fact that most of those I interviewed did not see the relevance in connecting HSR, PHC and NGOs was clearly data relevant to my project. I then returned to my diaries and to the policy documents and went through them colour coding relevant statements according to the four themes that interested me. In other words, picking up on what the interviews and documents said about public/ private, health, decentralisation and community management. I then organised the key statements under each heading, and reviewed these for predominant agreements and any striking differences. It was using these agreements and differences that enabled me to structure the argument I present in Chapter 5. As an interesting aside, it should be noted that my capacity to utilise this analysis in designing and undertaking the fieldwork in 1996 was limited by the fact that I had not done the analysis! Whilst I had internalised much of what had come from the interview data in 1995, it was not until I had the health policy documents (which for early HSR documents was not until late in 1996, and in some cases, 1997) that I went through the process of analysis I describe here.

I used a similar method to analyse the fieldwork of 1998. This was based on taped interviews and transcripts, many of which were in Swahili. Again, I colour coded transcripts of these interviews around the same four themes, seeking out the prevailing similarities and any differences. As I discuss above, I also attempted both a physical map of organisations and their activities, and some mapping of the extended interviews I conducted with two people. These methods may prove useful with more practice and reflection. They would be particularly so in a research process that was based on active participant involvement. For the purposes of this project, I found the process of colour coding, transferring linked groups of statements to another paper, and attempting to triangulate related pieces of data, a more useful exercise.

As discussed above, I had developed a questionnaire to form the basis of the interviews that I conducted in 1996. In the event, I did not make use of this formally. Being realistic about what it was possible for me to find out, I used it to guide interviews, and where possible obtained written sources that would augment what someone had said or provide more background to the organisation. This fieldwork was recorded in the form of my notes, written up after each interview. My analysis of these notes was on the basis of grouping what different people had said about



HSR, their agency's relationships with the government, the purpose and achievements of their work, and their description of the CBHC approach. I have indicated that, like the fieldwork conducted in 1995, I thought about this piece of fieldwork as another step in finding out in order to do the 'proper' fieldwork. With hindsight, it might have benefited from being tape recorded to enable me to analyse the interviews in more depth. Having said that, such a process is extremely time-consuming (from interview to transcript to interpretation), and much of what people were telling me was very simple and direct. Again, I took the approach of grouping together similar statements (and marking out any distinctive comments). This enables me, for example, to present an overview of CBHC that most practitioners would accept.

### **3.4.6 Retrospective on the fieldwork**

It is important to note that this research took place over time. Three years may not see significant change in some areas, but rapid shifts in others, with turnover of individuals, documents, and interventions. In the period since the research began, Tanzania has held its first multi-party elections, introduced cost-recovery to tertiary health services, and implemented a civil service reform programme linked to local government reform. It has effectively turned its back on socialism in the field of economic development, freed up the media which has led to an explosion of written and other forms of communication, undertaken a process that will lead to a new body of legislation on NGOs, and begun a process of adopting more participatory approaches to development. These are only the shifts that I have noted because they touch on my research. These are reflected on in more detail in Chapter 4.

Given the changing institutional context within which this research has been conducted, and the fact that over the life of this project I have been going backwards and forwards to Tanzania, I have often been prompted to question my relationship with the research. I have been left wondering to what extent what I see in my data reflects changes in the context over time, or changes in my perceptions arising from growing familiarity with the context. The answer is inevitably that both types of change influence the way that the data is interpreted. However, I have experienced a tendency for data to be reinforced rather than contradicted.

Issues of access and logistics have loomed large in this project. When I began the research in 1995, I spent my time in Dar es Salaam walking from office to office. Telephones did not work well, there were few places from which I could telephone, and telephone directories were not available for tracing numbers I did not have. This made arranging appointments difficult, and I depended upon being able to find an

office, find the relevant person in their office, and arranging a time to meet from there. On many occasions, this process involved long conversations with administrative staff to both identify relevant people and then ask them for an interview. The same was true of accessing key documents, as already noted. My experience of fieldstudy in 1998 was far easier, partly because communication infrastructure had greatly improved, and partly because I was able to ask for interviews on the basis of an introduction or HPA's name.

Interviews themselves can be enjoyable and useful but extremely challenging. In some cases, I found interviewees surprisingly comfortable and open, but in most cases, somewhat guarded. To some extent I think that caution derives from the fact that many of those I interviewed have not been involved in such an activity before. In other cases, whilst people were open, it was clear that they did not want to be quoted because they felt their comments to be sensitive. This is no doubt a challenge inherent in doing research in an area of current and unfolding policy. I have dealt with this sensitivity in this thesis by not using names as references to interviews. I have coded interviewees into groups: a) donor or D; b) NGO or N; c) Government or G; and d) Other or O. I have allocated individuals within each of these categories a number, which is followed by the year in which I interviewed them. An example reads D1/95, which would denote an interview with a staff member of a donor agency, the first on my list of interviewees, and interviewed during my fieldwork in 1995.

If discussions are sensitive, it is not always in the ways that you anticipate. On one level, there is the (very useful) discovery that the people you are interviewing often do not see the relevance of the issues you are pursuing, and of the connections you are making. I embarked on my research interested in Health Sector Reform, District Health Management and NGOs, and particularly with the place of PHC in relation to these. I have encountered very few people who both see the logic in investigating these things together, and have a good knowledge of all of the issues. At times this arises from a lack of familiarity with the particular subject (for example, NGOs) or limited information (for example, of health sector reform plans). At other times, it clearly arises from differences in perspective. Broadly speaking, I have found that donor and Ministry of Health staff do not talk about PHC unless prompted, and that when they do, it is in the narrow sense of particular vertical programmes. On the other hand, where I have interviewed in NGOs, I have found health and development discussed in more holistic terms, but that there is limited (at times, no) knowledge of health sector reform plans. These factors explain why so few (until more recently) see the significance of linking HSR, NGOs and PHC.

This research project has made use of a number of different approaches to data gathering. As in the case of Chapter 5, which looks at health policy and NGOs in Tanzania, some of the work has been based on the study of policy documents. Interviews have however formed the bulk of the research activity, with some observation and participant observation (where I have facilitated and participated in meetings and workshops). This approach to data gathering has been partly by design, as I have sought to 'triangulate', or converge on a conclusion through a number of sources of data. It has also been partly pragmatic, in the sense that I have had to turn to what it is possible for me to obtain or pursue in the absence of access to, or availability of, what I had expected.

Finally, my research questions reflect on NGOs and health action at three levels – community, local government and national levels. As I also explain in Chapter 2, this research has been driven by a desire to link specific stories to broader frameworks; to understand NGOs within a given institutional context; to link the micro and the macro. One approach to this in practice, is to explore the research 'object' from a 'multi-level perspective' (Der Geest, Speckland and Streefland, 1990), which is largely what I have done in this research project. However, I still feel, as noted for example by Booth (1995), that whilst case studies are useful in highlighting issues arising from national policy measures, there is still some way to go in making this type of work acceptable, accessible and meaningful to policymakers.

### **3.5 Conclusions: engagement, surprise and blockage**

As already indicated in several places, there are certain ideas about developing a research strategy and 'doing' research that have captured my imagination, and which I have tried to build in to my research process.

One of these is the idea of research as engagement. Looking back on my research project at this stage, I can think of many forms of engagement (and disengagement) that have been significant. An important aspect has been engagement with people: at times strained; at other times about building relationships that have run through the project. Another aspect has been engagement with different perspectives in an arena that is live and political. Finally, my engagement has often been personal, with individuals' working lives. Disengagement, for me, has been about stopping, and standing back. About being able to appreciate that what I have is data, and being able to step back from that live policy arena, even as it continues to unfold.

Another important idea has been that of surprise. Wuyts (1993) writes about research as a dialogue between researcher and theory, and how theory is not something which fits all the facts, but which gives surprising insights into how things relate in the face of combined evidence (Wuyts, 1993). This of the Tanzanian expression 'ahaa kumbe!' which denotes awakening or realisation. There are times I have come away from an interview literally in discussion with myself, either intrigued or thrown by something somebody has said which was wholly unexpected. It is those moments of surprise which have often been more revealing (if initially more challenging at first) than coming across the expected.

Finally, the idea of blockage. Langrish writes about the principle of stoppage when discussing case studies. He uses a biological metaphor to explain this as follows:

"If any plant or animal suddenly increases its overall population, the likely cause is that whatever had been stopping it has stopped stopping it." (Langrish, 1993, p6)

My use of this idea has been in thinking about what is stopping those things I expected to find from happening. And when I am surprised by something, wondering what blockages have been removed, or do not exist, that have enabled the 'unexpected' to happen.

This chapter has outlined my view on research process as a tangled web of experience, reading, challenging assumptions, and thinking. The following chapters illustrate how, using my ideas about research strategy, I have untangled that web in different ways, to reveal both the expected and unexpected.

## 4

# Tanzania: An overview of development policy and practice

**“We are determined to build a country in which all citizens are equal - where there is no division into rulers and ruled, rich and poor, educated and illiterate, those in distress and comfort.” (Nyerere’s inaugural speech to Parliament in December 1962, Jonsson, 1986, p745)**

This chapter explores the policies and practices through which this objective has been pursued in Tanzania – from the independence of Tanganyika in 1961 to the first multi-party elections to be held in Tanzania in over 30 years, in 1995. It traces key themes in economic, political and social history, outlining the institutional context that has shaped government and NGO health action over the years.

The chapter begins in section 4.1 with an overview of five ‘periods’, which correspond with major political and economic milestones: Independence, The Arusha Declaration, Decentralisation, Structural Adjustment, and Liberalisation. In section 4.2 it goes on to explore the meanings attributed in policy and practice to the notion of ‘private’, following with a similar discussion about ‘health’ in section 4.3, about ‘decentralisation’ in section 4.4, and about ‘community’ in section 4.5. It concludes in section 4.6 with some reflections on the years 1995-8, the period over which this research was conducted.

There are two points to be made about this chapter and which apply to the whole thesis. Firstly, whilst Tanganyika and Zanzibar were unified as the United Republic of Tanzania in 1964, they maintain separate administrations for domestic affairs such as health and education. This thesis is concerned with the Tanzanian mainland (not including Zanzibar), and uses the word Tanzania to denote this unless otherwise stated. Secondly, the quality of available data is often poor and sources can be contradictory on everything from population size to the extent of non-governmental provision of services. For example, until recently there have been few initiatives on the part of government, donors and NGOs themselves, to collect, analyse and disseminate information about the NGO ‘sector’ and its activities.

## **4.1 Politics, economics and society 1961-1995**

### **4.1.1 Independence: 1961-67**

The achievement of independence in 1961, and the Arusha Declaration of 1967, boundary a period in which the government had no stated 'development ideology' (Munishi, 1995), proceeding with a strategy which was largely a colonial inheritance (Green, 1995). The first Three-Year Development Plan (1961-3) was based on a World Bank report requested by the colonial administration shortly before independence (Jonsson, 1986; Green, 1995). This was deemed consistent with the desire to advance Tanzanian ownership and control of economic activities, and to promote economic welfare (Green, 1995).

At the same time, significant changes were instituted. Legislation put an end to racially segregated education. With the drive towards 'Africanisation' some 60% of government posts were filled by Tanzanian nationals in 1967 compared with one-third in 1962 (Jonsson, 1986). New administrative districts and regions were created. Key *national* bodies such as the National Development Corporation, the Tanzania Central Bank, and the Tanganyika Housing Association, were established. However, Nyerere, leader of the Tanganyika African National Union party (TANU) and elected national President had, in his inaugural speech to Parliament in 1962, declared war on poverty, ignorance and disease<sup>1</sup>. It became clear during this period that there were limits to what results could be expected on these fronts from a state gently guiding private business. Inflows of international capital and the application of local capital proved disappointing (Svendsen, 1995). As the strategy seemed increasingly unlikely to deliver equitable development, even at a time of economic growth, Nyerere initiated a critical review (Jonsson, 1995).

By this time, international politicking in the wake of revolution in Zanzibar had led to the union with Tanganyika. Discussions about the desirability of a one-party state were gaining momentum. In 1967 TANU and the Afro-Shirazi Party (ASP) of Zanzibar endorsed a one-party constitution. These parties were to merge in 1977 to form the Chama Cha Mapinduzi (CCM), or Party of the Revolution.

### **4.1.2 The Arusha Declaration: 1967-72**

"The policy of TANU is to build a socialist state" (Nyerere, 1968a, p13)

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<sup>1</sup> It is important to note that the constitution of TANU committed members to support socialism. In 1967 Nyerere had produced 'Ujamaa - The Basis of African Socialism' which discussed socialism as being about an attitude of mind and a matter of how you used wealth (McHenry, 1994)

In the Arusha Declaration of February 1967 - and in Nyerere's pamphlets on 'Education for Self-reliance' of March 1967, and 'Socialism and Rural Development' of September 1967 - the single party governing Tanzania set out a development ideology based on the principles of equity, self-reliance and rural development.

There were three key components to this ideology. The first was the *policy of socialism*, the aim being a society based on the absence of exploitation, peasant and worker control of production and exchange<sup>2</sup>, the existence of democracy, and socialism as a belief<sup>3</sup>. The Declaration discusses this policy with reference to TANU members, leaders and the government. It states that in enrolling party members, more emphasis should be placed on acceptance of the beliefs of the Party, and on teaching of the Party's ideology. This concern was later translated into a stipulated three-month period of ideological training for members (McHenry, 1994). The Declaration lays out the Leadership Code. This states that every TANU and government leader (including ministers, MPs, high and middle-ranking civil servants, councillors, and elected or appointed TANU officers) should be a worker or a peasant. These people should not be associated with capitalist practices such as holding shares, directorships, receiving more than one salary, and owning houses for rental. It calls on the Government and other key institutions such as the UWT (Union of Tanzanian Women) and the co-operatives, to implement the policy of socialism and self-reliance.

The second key component, *the policy of self-reliance*, states that Tanzania should not rely on money (either tax or external aid) as the major instrument of development, or place excessive emphasis on industry<sup>4</sup>. It should seek to be independent, whereby 'Independence means self-reliance' (Nyerere, 1968a, p23). In the wake of the Arusha Declaration banks were nationalised and the National Bank of Commerce created. A Price Commission was set up to regulate prices. Large

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<sup>2</sup> "To build and maintain socialism it is essential that all the major means of production and exchange in the nation are controlled and owned by the peasants through the machinery of Government and their co-operatives. Further, it is essential that the ruling Party should be a Party of peasants and workers." (Nyerere, 1968a, p16)

<sup>3</sup> "Socialism is a way of life, and a socialist society cannot simply come into existence. A socialist society can only be built by those who believe in, and who themselves practice, the principles of socialism." (Nyerere, 1968a, p17)

<sup>4</sup> "The policy of inviting a chain of capitalists to come and establish industries in our country might succeed in giving us all the industries we need, but it would also succeed in preventing the establishment of socialism unless we believe that without first building capitalism, we cannot build socialism." (Nyerere, 1968a, p26)

commercial buildings were nationalised. Public sector/ parastatal companies such as the Tanzania Milling Corporation and the Tanzania Tea Authority were established.

Building this form of independence and self-reliance also meant paying more attention to the peasant, which linked to the third key component of the development ideology - *ujamaa* or the principle of African Socialism. Ujamaa is explored in Nyerere's 'Socialism and Rural Development' (1968b). This describes ujamaa as a development approach based on the idea of the traditional African family: living and working together and sharing the outcomes; working to the principles of affection (respect), shared property, and the obligation of everyone to work. The pamphlet reflects on the growing problem of rural capitalism, and advocates that agricultural organisation in a socialist Tanzania should be based on co-operative living and working:

"This means that most of our farming would be done by groups of people who live and work as a community. They would live together in a village; they would farm together; market together; and undertake the provision of local services and small local requirements as a community." (Nyerere, 1968b, p124).

Such communities would need organising, with a 'manager', 'treasurer' and governing committee. These committees would also need to be brought into being. Nyerere advocates 'persuasion not force' in bringing people to live in single villages. Government personnel and local government would also have a role to play, with the nation as a whole having to cooperate in areas such as health and education:

"The job of Government would therefore be to help these self-reliant communities and to organise their co-operation with others." (Nyerere, 1968b, p129)

The aim of ujamaa was twofold: to move from a situation of independent peasant producers adopting capitalist approaches, to a nation of ujamaa villages based on co-operation; and to use the village as a location for providing basic services. In the event, a villagisation programme, based initially on voluntary action, became two 'operations'. These led later to a massive national campaign in 1974, which became known as 'forced' ujamaa.

The Second Five-Year Plan (1969-74) was shaped by these three components of the development ideology. It was driven by the idea that emerging from poverty required a strategy. Such a strategy needed to be based not just on economic growth, but on ujamaa and social development guided by an active leadership (Svensen, 1995). This saw an emphasis in the 1970's on basic needs approaches to development. As



Nyerere says in the Arusha Declaration, the pre-requisites for development are people, land, good policies and good leadership, combining hard work with intelligence:

“The development of a country is brought about by the people, not by money.”  
(Nyerere, 1968a, p28).

#### **4.1.3 Decentralisation: 1972-82**

The early 1970's saw an intensity of efforts aimed at promoting the vision and objectives of the development ideology outline in 1967. For example, 1970 was pronounced the Year of Adult Education. In 1971 the TANU NEC directed the government to give priority to health, water, and education investments and set out specific national goals for these areas (Kleemeier, 1984). As a result, the issue of relationships between centre and local came into sharper focus. There were growing concerns that district development activities along socialist lines were not taking off. In his Republic Day speech of 1968, Nyerere had complained of the ineffectiveness of the local authorities (Liviga, 1992).

Whilst the importance of local action was recognised in the development strategy, the idea of 'decentralisation' was to be riven with tensions. One apparent tension is akin to that discussed in Chapter 1, which Collins and Green (1994) identify as the tension between equity - the 'promotion of equivalence' - considerations and decentralization - the 'enhancement of the different' - considerations. This potential tension is captured by Nyerere's statement in 'Socialism and Rural Development':

“...there must be an efficient and democratic system of local government, so that our people make their own decisions on the things which affect them directly, and so that they are able to recognise their own control over community decisions and their responsibility for carrying them out. Yet this local control has to be organised in such a manner that the nation is united and working together for common needs and for the maximum development of our whole society.”

(Nyerere, 1968b, p119)

Another tension lies in the selected mode of 'decentralisation'; a tension between decentralisation and recentralisation. Institutional reform at the local level seemed necessary on the basis that 'efficiency' and 'democracy' were not strongly apparent in the existing structure. Liviga (1992) points out however that some of the perceived ineffectiveness of the existing local government system in fact resulted from a gradual erosion of local powers, not least financial, during the 1960's.

A committee set up to look at decentralisation proposed a greater devolution to provincial councils. This would effectively act as a check on TANU power (Kleemeier, 1984), and was clearly deemed unacceptable. The task of making recommendations for the achievement of the Arusha Declaration statements on rural development had been passed to the consultancy firm McKinsey and Company. In the wake of these recommendations, the elected rural and urban councils were actually abolished in 1969 and 1972 respectively<sup>5</sup>. These were replaced with Regional and District Development Committees, working alongside the other central government agencies that were being established such as the Housing Corporation, Urban Water Authority and District Development Corporations:

“Known popularly as decentralisation, these administrative reorganisations placed responsibility for provision of services and the task of initiating, implementing and monitoring local development programmes under the District Development Director, Regional Development Director and the Prime Minister’s Office.” (Liviga, 1992, p213)

In the event, what took place during this period was effectively a form of ‘recentralization’ - a shift from devolution to deconcentration (see the discussion of decentralization in Chapter 1). The process saw the concomitant increase in the number of civil servants posted to the regions from 75, 000 to 175, 000 between 1972-83. At the same time the figure for central government staff remained stable at about 123, 000 (Semboja & Therkildsen, 1994).

This period saw the radicalisation of strategies to promote socialism, as what McHenry (1994) refers to as the ‘ideological’ socialists (as distinct from the ‘pragmatic’ socialists) gained influence. The TANU NEC issued the 1971 ‘TANU Guidelines’ or Mwongozo after the overthrow of Obote in Uganda. These called for a people’s party and people’s army. In 1981, the NEC of the now CCM issued another set of guidelines. These called for an extension of communal agriculture, and essentially a reaffirmation of the Arusha Declaration in a strained economic context (McHenry, 1994).

During the 1970’s the extension of the Party and the subsuming of areas of social, economic and political life under the state-party apparatus continued. In 1976 the co-operative unions were dissolved (although reinstated in 1982) and replaced with

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<sup>5</sup> “A number of other central government decisions put local government on the road to bankruptcy and collapse. Following the Arusha Declaration in 1967, the country’s policies of socialism and self-reliance strengthened central government rather than local authorities.” (Liviga, 1992, p213)

state marketing organisations. The logic of a one-party system was that various interests should be represented through the party (McHenry, 1994)<sup>6</sup>. Five mass movements were recognised: the Union of Tanzania Workers; the Co-operative Union of Tanzania; the Tanzania Youth Organisation; the Tanzania Parents Association; and the Union of Tanzania Women. Increasingly, individual civil rights were abrogated, with, for example, the Newspaper Act and the Tanzania News Agency Act of 1976 (McHenry, 1994) which restricted the flow of information. With the formation of villages through the compulsory villagisation initiative came the creation of an organised political system which reached to the village, and appointments of village-based party officials (Svendsen, 1995). The democratically elected individual was gradually losing power to appointed officials (Coulson, 1982).

In 1982 five pieces of legislation re-instating local authorities were processed. The literature is not clear on the reasons for the re-establishment of local authorities in 1982. Gilson et al (1994b) write that the system was adapted when it was clear that the special needs of urban areas were being neglected. In 1978 fully elected urban councils were in fact re-established and given powers to raise their own revenues. Liviga (1992) writes that under pressure from the World Bank and IMF on a number of fronts the government was unable to continue with the decentralisation scheme instituted in the early 1970's.

#### **4.1.4 Structural Adjustment: 1982-91**

“The State was not only developmentalist, it was also in a hurry: Julius Nyerere was quoted as saying ‘we must run while others walk’. In this period he was generally in favour of the more positive interpretations of the signs of economic strain. In his view it was not the task of a political leaders to be ‘gloomy’, that is to dwell on constraints.” (Svendsen, 1995, p110)

Financial shocks and strains underpinned the 1970's. The oil shock of 1973 coincided with drought and food shortage; another balance of payments crisis struck in 1974-5. Despite some boosts such as the coffee boom of 1976-7, the main theme of the 1980's was to be major economic hardship. External debt arrears increased from US\$4 million in 1980 to US\$183 million in 1985. At the same time external aid declined from US\$470 million in 1981 to US\$300 million in 1985 (Wratten,

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<sup>6</sup> “...the organisational autonomy of existing interests was replaced by a kind of corporatist arrangement linking them with the party.” (McHenry, 1994, p52)

1993). Inflation doubled between 1978-80 to 30% and remained at this level during the 1980's (Wratten, 1993).

As GDP growth fell to -2.3% in 1982/3 (Wratten, 1993), there were still the huge financial implications of the basic needs strategy - which had prompted rapid expansion of government-provided basic services (Kleemeier, 1984) - to be managed. The break-up of the East African Community in 1977 implied a major increase in infrastructure-related imports (Gibbon, 1995), and in 1982 the sale of certain commodities such as building materials was restricted. The war with Uganda in 1978-9 led to a doubling of defence expenditure (Gibbon, 1995).

McHenry (1994) divides the 1980's into two parts; each characterised by different government approaches to the problem. In the first instance Tanzania rejected the terms of a World Bank/ IMF structural adjustment package in 1981. Instead it developed the National Economic Survival Programme (NESP) which proved unworkable (Gibbon, 1995). This was followed by a Tanzanian-designed Structural Adjustment Programme in 1982-3, but the decline in external assistance meant that the government had to make more concessions to the requirements of the international financial institutions. In the 1983-4 budget, social services spending was reduced (Gibbon, 1995). After the resignation of Nyerere as President in 1985, the new President, Mwinyi, proceeded with negotiations. The Economic Recovery Programme (ERP) was agreed with the IMF in 1986. Donor assistance increased to US\$850 million in 1989 (Wratten, 1993). The Economic and Social Action Programme (ESAP) started in 1989 which added to the ERP the objectives of improving the quality and quantity of social services, and the privatisation of the parastatals (Wratten, 1993). This was coupled with the Priority Social Action Programme (PSAP) to ameliorate some of the worst impacts of structural adjustment.

As in the case of other countries in Sub-Saharan Africa, the impact of such programmes, not least the possible negative repercussions for social sectors, has been the source of much heated debate. The World Bank estimated that real GDP growth between 1986 and 1990 averaged about 4% a year (Wratten, 1993), attributing this to the reforms and to favourable external factors. At the same time, however, there was a major increase in donor aid, which by 1991 provided 95% of the government's development budget and 45% of the recurrent budget (Wratten, 1993).

This period also saw significant political changes. Whilst in 1987 the CCM's national conference had adopted the Fifteen-Year Party Programme, which pushed

further in the direction of the 'ideological' socialists (McHenry, 1994), in 1990 Nyerere proposed that the single party system needed reviewing, and a commission was set up under Judge Nyalali. His commission was to report in 1992 that, though only a minority of respondents favoured a multiparty system, a majority wished to see changes which might be promoted most easily through multipartyism (Gibbon, 1995). In 1990 the CCM overturned the Fifteen-Year Party Programme as the basis of its election manifesto. At the 1991 CCM NEC meeting the Zanzibar Declaration was produced. This limited the scope of the Leadership Code, by now known as the Code of Ethics and applied to all party members. As a result of this declaration, party members were allowed to engage in private capitalist activities, and 'ideological training' was scrapped. Whilst retaining the word 'socialist' in its constitution, the CCM was letting go of the 'trappings of a socialist party' (Gibbon, 1995).

#### **4.1.5 Liberalisation: 1991-95**

McHenry (1994) characterises the twenty years from Arusha as a period in which the Party was increasingly dominated by 'ideological' socialists, whilst the Government became increasingly pragmatic. The political changes being introduced in the early 1990's show which group won out.

In 1992 the multi-party political system was re-established, implying wider reforms to separate party from state functions (Gibbon, 1995). Civil Service Reform was agreed in 1993, with a commitment to reduce staff by 50, 000 by 1995, and to liquidate parastatals, although little progress had been made on both fronts by 1994. (Gibbon, 1995). Other reform programmes, effectively reviewing the role of the state, began to be designed, including Health Sector Reform and Social Sector Reform. Political parties, non-governmental organisations, and private media all began to spring up. In November 1995, Tanzania held multi-party elections, which returned the CCM to power with a new president, Benjamin Mkapa. The commitments of this government included efforts to stamp out corruption, an apparently growing problem in an age of liberalisation:

“...the process of economic liberalisation in Tanzania has been characterised less by real economic and social progress than by an upsurge of what has elsewhere...been called 'wild capitalism'. By this is meant the reappearance, in free market guises, and on a larger and less controlled scale, of many of the much condemned pre-adjustment forms of 'rent-seeking behaviour'.” (Gibbon, 1995, p16)

## 4.1.6 Conclusions

### *Personality, ideology and pragmatism*

Reflections on what made Tanzanian socialism tick are various. The Arusha Declaration did not emerge from national or even Party debate, but was presented to the TANU NEC by one man, Mwalimu (or Teacher, the term commonly used to refer to Nyerere). In this sense, Tanzania was managed through a centralised system based on personal (albeit, respected) rule. However, the contributions of Nyerere need to be balanced against the limitations. Green (1995) describes Nyerere as both practical politician and statesman, pragmatic negotiator and principled prophet. He also makes the point that Nyerere's willingness to delegate without adequate systems for reporting back was a weakness<sup>7</sup>, such that policy outcomes were insufficiently subjected to scrutiny.

At the same time, there were other important individuals and groups with influence. And, as Green (1995) indicates, at times Nyerere's positions irritated these interests. For example, his position that private property did not all have to be state owned, but could be held through rural co-operatives, annoyed orthodox Marxists as much as orthodox capitalists (Green, 1995). As already noted, McHenry (1994) describes these kinds of divisions as the ideological versus the pragmatic. Commentators are at pains to distinguish the role of Nyerere, the individual, in shaping vision and policy, vis-à-vis various interest groups. What is clear however, as Svendsen (1995) writes, is that Tanzania's was a 'strategy-driven development effort', and one which attracted much external attention. The drive behind this was a belief in the role of strategy and of an active leadership in guiding the country out of poverty.

### *The failures (and successes) of Tanzanian socialism*

"Tanzania is seen as a failed experiment and no longer elicits the kind of enthusiasm or sympathy it did in the 1960's and 1970's when Tanzania's brand of socialism attracted the attention of states, donors, international organisations, movements and individuals. The Tanzanian emphasis on equality, people's participation in decision-making, self-reliance and providing basic needs captured the imagination of these early well-wishers. Indeed, Tanzania was a leader in creating a public health programme geared to Primary Health Care even before

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<sup>7</sup> "It does, however, illustrate Mwalimu's willingness to delegate large areas of socio-economic policy articulation with, arguably, too infrequent critical examination of results. In general President Nyerere was very wise in delegating with little interference but, arguably, less so in not institutionalising reporting back for monitoring and review." (Green, 1995, p82)

the World Health Organisation had identified Primary Health Care as an international strategy..." (Tripp and Swantz, 1996, p1)

Whoever or whatever lay behind many of the gains proclaimed in Tanzania, it is clear that by the late 1970's, many had started to unravel. It is also clear that declines in these gains have been barely halted, and in some cases, have worsened during the period since the late 1980's. Gibbon (1995) cites the case of primary school enrolments, falling from 93% of the relevant age group in 1980 to 72% in 1985, and then again to 63% by 1991.

In many circles, the period of attempting national development through a socialist strategy has been dubbed a failure. Depending on the leanings of the commentator, this failure is variously attributed to external factors, such as international economic trends or relationships with the international financial institutions, or to a one-party state system which discouraged private capital and centralised policy (Tripp and Swantz, 1996).

There are however, different ways of looking at this idea of failure. Tripp and Swantz (1996) propose that instead of looking at what went wrong, it might be more useful to focus on what went right. They propose that 'self-reliance' became more of an 'ideological catchword', taking on new meaning as people themselves redefined the ways they met their needs. People became self-reliant *in spite of* the official self-reliance efforts rather than because of them. The authors suggest that what is needed now are changes in government policies to meet the challenges posed by this self-reliance from below - creative and flexible policies which reflect the actual conditions of Tanzania.

This focus on 'the people', and not simply on key personalities or on international institutions as an explanation for what has happened in Tanzania, is an unsurprising form of revisionism given the emphasis on 'civil society' and 'participation' in international development discourse in the 1990's. What it highlights is the importance of making sense of development processes in more holistic ways. Svendsen (1995) proposes that it is premature to attribute crisis either to external factors, to the implementation of the strategy, or to the strategy itself. However, it is important to relate the strategy, and the idea of active leadership in its promotion, to important socio-economic changes beyond the control of the state. The rest of this chapter looks more closely at key policy initiatives and their implementation with a view to better understanding the space for, and forms of, public action, which have emerged.

## 4.2 The 'private' and the 'public' in Tanzania

This section looks at understandings of 'public' and 'private' in Tanzania since independence. It considers these from the perspective of public and private 'goods', organisations and interests. This provides some insight into how NGOs (and indeed community organizations and local governments) have been defined and understood to fit in to the definition and provision of development and social services.

### 4.2.1 Private and public 'goods'

"The Arusha Declaration itself gave the government a mandate to undertake all sorts of nationalisation in order to ensure regional and social equality in the distribution of social services. Moreover it stated that the government had to commit itself to fight against three national ills or enemies, namely disease, poverty, and ignorance (including illiteracy)." (Munishi, 1995, p145)

The Arusha Declaration identified 'disease, poverty, and ignorance' as national (or public) issues, and justified state (public) action in ensuring access and equity as guiding principles in the provision of the basic services which might help to address these 'national ills'<sup>8</sup>.

This was a shift away from the inherited colonial system, which had provided limited social services with an urban, racial, and class bias<sup>9</sup>. It was part of a wider move on the part of many newly independent states in Africa to extend free social services in a bid to meet the expectations raised by nationalist movements. The extension of government provision of services was seen as a means to establish the legitimacy of new governments and to draw people together as a nation (Semboja and Therkildsen, 1995; Munishi, 1995).

Having identified access and equity as principles to guide public concern, and education, health, and water/ sanitation as public 'goods', the Tanzanian state set about increasing its role in the provision of these. However, this was not simply a question of extending state-provided services. There were also moves to curb, or incorporate within the state and party structure, other forms of action<sup>10</sup>. For

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<sup>8</sup> In the Arusha Declaration, one of the principal aims and objectives of TANU is cited as being: "To see that the Government mobilises all the resources of this country towards the elimination of poverty, ignorance and disease." (Nyerere, 1968a, p14)

<sup>9</sup> Although Semboja and Therkildsen note that the rising force of nationalism had prompted the colonial administration to extend services further, leaving the newly independent government with a reasonable infrastructure (Semboja and Therkildsen, 1995).

<sup>10</sup> "One by one the commanding heights of organisations in civil society (labour unions, co-operatives, development associations) were brought under state and party control...Even collective action at the grassroots levels outside party auspices was suppressed. Church and



example, in 1977 (implemented from 1981), a law was passed stating that social services could not be treated like other commodities, and private health practice was proscribed with the exception of authorised bodies such as the armed forces, parastatals and religious organisations<sup>11</sup>. Similarly, self-help initiatives around service provision were increasingly drawn under the auspices of the state and party (Munishi, 1995, Semboja and Therkildsen, 1995), and people were promised better services if they moved into designated villages under the programme of villagisation.

#### **4.2.2 Private and public organisations**

Implicit in these initiatives to extend and nationalise services lies some notion about what constitutes public (and private) organisation. The new state was not only deemed public; it was also moving into areas of life that then become part of that public. However, if the lines between public and private can be redrawn over time, they are also commonly blurred at any point in time. For example, Mujinja et al (1993) note that many private health practitioners continued to work under the umbrella of religious/ voluntary agencies after the 1977 ban on private practice was introduced. In practice, the problems of registration have often made it difficult for the government to control private practice for-profit (Munishi, 1995). Interestingly, during the period of this research, by which time private health services had been re-legalised, I have noted that many private clinics refer to themselves as 'charitable', an apparent throwback to the period of restriction.

Whilst the banning of for-profit action appeared to remove one form of private organisation, voluntary or non-governmental organisations have been in a more ambiguous situation. Implicitly deemed to perform some public function (hence religious organisations are counted as 'authorised bodies' in the provision of 'private' health services), in practice NGOs have been referred to as private organisations<sup>12</sup>.

Some of this ambiguity is reflected in the frameworks governing NGOs. There is no legal or policy definition or understanding of the term 'NGO' in Tanzania.

Currently, many NGOs are registered as societies under the Societies Ordinance

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NGO-run services in health and education were nationalised." (Semboja and Therkildsen, 1995, p22)

<sup>11</sup> This legislation was further reinforced in 1986 when 'authorised' was specified as registered trustees who were non-profit oriented (Munishi, 1995)

<sup>12</sup> Indeed, when I submitted my application for a research permit, it was suggested that I might have difficulties presenting the idea of NGOs as public actors because 'we' (in Tanzania) understand NGOs to be private organisations.

(1954). This applies to any club, company, partnership or association of 10 or more persons, whatever its nature or objects, and which is not specifically excluded. Those organisations that are excluded are covered under separate legislation for limited companies, trades unions, co-operative organisations, sports clubs and political parties. Some organisations that might be described as an NGO are indeed registered under these other pieces of legislation. Therefore, when in 1995 the President's Office announced that there were 813 registered NGOs in Tanzania (up from 200 in 1992) including local, national and international, this was a severe undercount of NGOs existing in practice<sup>13</sup>.

Tax law refers to societies as 'public':

"...subject to Section 29 of this Act the income of any institution, body of persons or irrevocable trust, of any *public* character established solely for the purposes of the relief of the poverty or distress of the public, or for the advancement of religion or education..." (Income Tax Act No.33 of 1973 Revised, emphasis added).

Other parts of the Societies Ordinance (1954) indicate that whilst societies cannot engage in political activities, they can lobby and pressurise on legislative and policy reforms, and can agitate for political reforms if they are non-partisan. So in the Tanzanian legal system and policy context, an NGO is a society, which is a private organisation, with a public character, which is free to lobby on legislative and policy matters.

But more important perhaps than policy and legal definitions of what constitutes a public and private organisation are the ways in which NGOs have been treated, and that NGOs have behaved, in the given institutional context. The indications are that the space allowed NGOs in Tanzania has constrained them to certain types of approach:

"... two major factors in the Tanzanian society that have affected the NGOs are: the predominantly rural structure of the Tanzanian society combined with thirty years of a centralised socialist type of state. As in other countries with such a system of state governance, Tanzania did not favour independent organisation of

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<sup>13</sup> There are many problems with the system of registration, and the whole policy and legal framework for NGOs is under review, the aim being to pass an NGO act in 1999. Finding any form of reasonably accurate data is hugely problematic. For example, the Daily News (17/7/97) reported that the Minister of State in the Vice-President's Office announced that there were 8,360 non-governmental organisations countrywide. It is not clear where this figure came from, but it is far in excess of those registered.

popular initiatives. The NGOs therefore took refuge in a 'welfare' approach to community development, a model which is conducive to the cooptation of NGOs, as they would not operate without the state consent." (Kisare, 1995, piii)

However, it could be argued that the key role of NGOs in the provision of basic services has also seen them working in the interests of promoting equitable access to services defined as desirable for the public good. Indeed, these activities have seen non-governmental organisations effectively defining basic services through their provision. For example, in 1958, 81% of primary health service facilities, many of which were in rural areas, were provided by non-governmental organisations, whilst the 19% owned by the government were urban-based (Munishi, 1995). In addition, whilst EASUN warns about government co-optation and limitations on NGO action, relationships between state and NGOs reveal significant interdependence in the provision of public services subsequent to independence, the case of district-designated hospitals being a case in point.

#### **4.2.3 Private and public interest**

One of the major concerns underlying Tanzania's development ideology from the late 1960's onwards was the need to prevent the exploitative dominance of particular groups or classes. As in other countries in the region, there have been moments of tension around the role of Asian Tanzanians within the development strategy. Similarly, in the bid to build a nation and to work towards universality of access to basic services, less attention may have been paid to diversity of interests based on ethnicity, culture, and 'community'. But what was really at issue in 1968 when the Leadership Code was laid down, was a desire to control capitalist and individualistic tendencies among leaders in the interest of normalizing them around collective and public interests.

However, Svendsen (1995) suggests that the state-oriented development policy of the 1970's, with the increasing number of wage earners in the public sector, led to the emergence of a very powerful interest group. In the wake of economic crisis, these state employees were unable to protect the real value of their incomes, which had negative effects on morale and stimulated both legal and illegal activities outside and within the public sector. Doriye (1992) writes about a breakdown of the 'public interest' attitude and practice, which had lent cohesiveness to the administration of social services and policing. By the late 1980's, he suggests that 'private interest' use of public office had become a form of survival strategy for state employees.

As will be discussed in Chapters 6 and 7, this interest group - public sector employees - has had a powerful impact on the development of NGOs. During the

1980's and early 1990's, NGOs like bi-lateral and multi-lateral donor agencies, appear to have relied heavily on various types of staffing arrangement with government. These arrangements have enabled them to access government staff for the implementation of activities. Government employees have in turn benefited from the per diems and other perks associated with undertaking this type of work. Since the mid 1990's, as government has retrenched workers and reformed the civil service, many of these government workers have opted for employment within NGOs, or have established NGOs of their own.

This phenomenon is of particular interest to this research project in the sense that it is concerned with the forces that influence the definition of public and private. Those forces might include donor agencies, as well as central government policymakers. They also include groups that are more fundamentally embedded in Tanzanian society. As Sivalon (1995) writes, for example, the relationship between the Catholic Church and the state around development activities has over the years been more collaborative than conflictive. He proposes that this relationship has been possible in large part because of the ties that exist between state employees and the church organisations. These ties have been built through shared education at mission-run schools in the 1950's and 1960's and through continued interactions around religious and social events in people's daily lives. Sivalon's conclusion is that the increasing involvement of Catholic organisations in service provision over the years is not in fact a sign of the weakening of the state and its bureaucratic class, but a strengthening of it. As I indicate above, this interest group or class may be strengthening its position to define and meet public and private need in society, albeit increasingly working with NGOs rather than within government.

## **4.3 Health in Tanzania**

This section looks at the different understandings of health that have influenced health policy in Tanzania, and the role of various actors in defining and meeting health needs.

### **4.3.1 The provision of health services**

The health system inherited by the new independent government was largely urban-based, serving 'Grade A' patients (including expatriates and senior civil servants) and providing a reasonable standard of curative medical service (Coulson, 1982). In 1958 these government hospitals accounted for 58% of beds (Munishi, 1995). Non-governmental organisations, predominantly religious agencies, provided 81% of dispensaries in 1958 (Munishi, 1995).

In the existing national development plan, the health sector was only allocated 4% of the national budget (Mujinja et al 1993). However, in 1964 the Titmuss Commission reported on a study begun in 1961. It recommended that there be closer integration of the services provided by government local authorities and voluntary agencies. It also proposed the separate but co-ordinated provision of curative and preventive services - the former by central government and the latter mainly by local authorities, with voluntary agencies concentrating on the provision of curative hospital care with some preventive activities (Gilson et al, 1994b). The ideas of the Titmuss Commission fed into the 1969-74 national development plan, influenced by the Arusha Declaration emphasis on equity and access to basic services.

During the 1970's the government was to increase its commitments to the health system, both by expanding the numbers of facilities and staff available, and by bringing other institutions into the realm of state provision. In 1970, two major church hospitals, Buganda Medical Centre and Kilimanjaro Christian Medical Centre, were nationalised to become government zonal referral hospitals. A number of church-owned hospitals became 'district-designated' government units. In 1977, private medical practice by individuals was banned, and restricted to approved organisations such as missions and the armed forces.

By 1980 the government's basic needs target of ensuring one dispensary per 10,000 people had been met - although this did not keep pace with subsequent population growth (Munishi, 1995). In 1978, the 86% of the Tanzanian population who were rural-based were accounting for 70% of all in-patient days, 75% of all outpatient visits, and benefiting from 65% of all health expenditures (Jonsson, 1986). The government had built up a system that ran from 4 national referral hospitals, to district hospitals, to health centres, to dispensaries to rural health posts, of which it could be said:

"The pyramid structure of public health services in Tanzania came to be based therefore, on an apparently strong foundation of primary-level facilities located in rural areas." (Gilson et al, 1994b, p456)

The government had also been extending its role as policymaker. In 1972 the Ministry of Health took over all national projects and responsibility for providing policy direction for overall sectoral co-ordination. The planning and implementation of local health programmes was defined as the responsibility of lower levels of government (Kahama, 1995). The Private Hospitals Act of 1977 laid out government powers in areas such as review, price setting and salary scales. The Ministry of Health has also had the function of issuing guidelines and circulars to

non-governmental providers. These govern issues such as location of health facility, catchment population and personnel (Mujinja et al, 1993), and rules have been developed for professional bodies, such as the Medical Practitioners Rules of 1968. By the time Mujinja et al were writing in 1993, government agencies were responsible to the Ministry of Health and Regional and District administrations for health activities. Through this system, the government was supporting 96% of the mainly rural health centres, and 75% of dispensaries.

Alongside this expansion of the government health system, 'private, not-for-profit' organisations have continued to be major players, owning 56% of hospitals (Mujinja et al, 1993). Even at the peak of government financial support to health care in 1976, these account for between 37% and 43% of total health expenditure (Mujinja et al, 1993). As Munishi (1995), amongst others, points out, data concerning health service provision through NGOs is limited. However, it is clear that church organisations have been the dominant non-governmental providers, owning 40% of the national hospitals, which include the 17 'district-designated' NGO facilities primarily operating in rural areas (Mujinja et al, 1993). Implicitly, the government's policy has been not to locate new health units in areas already well served by NGO health facilities (Munishi, 1995).

The early 1990's saw reconsideration of the role of the state in health service provision. In 1991, private practice was re-legalised. There has been overt recognition of the role of mission facilities (Mujinja et al, 1993). In the Government's Health Sector Reform proposals this recognition is quantified:

The private sector owns 40% of all service delivery points (8-10% for-profit and 30% not-for-profit). The remaining 60 per cent of facilities belong to the public sector, Government or Parastatal." (Government of Tanzania (GoT), 1994a, p33)<sup>14</sup>

#### **4.3.2 The focus of health services**

Increased government involvement in health service provision after independence has been accompanied by active debate about the focus of those services. The Titmuss Report highlighted the importance of prevention to improving health status.

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<sup>14</sup> The Health Sector Reform Proposals (GoT, 1994) show the ownership of health facilities on the mainland as follows:

Hospitals	77 (government); 85 (voluntary); 9 (parastatal); 4 (other)
Health Centres	265 (government); 8 (voluntary); 2 (parastatals); 1 (other)
Dispensaries	2, 218 (government); 485 (voluntary); 175 (parastatal); 36 (other)

Where I assume 'other' means private, for-profit.

Attention began turning to the possibility that it might be more cost-effective to prioritise prevention than to focus limited resources simply on cure (Coulson, 1982). Curative services provided through hospitals were consuming 87% of the Ministry of Health's recurrent expenditure, with Muhimbili Hospital in Dar es Salaam alone receiving 41% of government funds allocated to drugs and equipment in Financial Year 1970/1 (Coulson, 1982). At the TANU Conference of 1973 Nyerere said that Tanzania must resist offers from donors of new hospitals with their high running costs, at least until all citizens had basic medical services (Kahama, 1995).

The First Five-Year Development Plan (1964-9) had taken up the recommendations of the Titmuss Committee, calling for more attention to preventive services, more co-operation between government and voluntary agencies, and the building of more dispensaries and health centres to provide a rural health system (Gilson et al, 1994b; Kahama, 1995). With the Arusha Declaration emphasis on basic needs, the health sector reached a turning point. The Second Five-Year Plan of 1969-74 saw a dramatic increase in resources allocated to health (Kahama, 1995)

The 1971 TANU Conference emphasised health, water and education. In the same year, the Mother and Child Health Committee was set up within the Ministry of Health. This was the starting point for developing a nation-wide programme aimed at providing mothers and children with immunization, nutrition education, ante- and post-natal care, and growth monitoring, all through the same visit to the MCH clinic (Jonsson, 1986).

A health plan for 1972-80 had the objective of limiting the expansion of hospitals to the rate of population growth and pushing ahead with the construction and staffing of dispensaries (Jonsson, 1986). The Third Five Year Plan of 1976-81 set out three aims related to health:

- a) to extend services so that they would be available to more people;
- b) to strengthen preventive services; and
- c) to develop training programmes for health workers, especially for rural areas (Jonsson, 1986; Kahama, 1995).

The target was one dispensary per village. However, an evaluation of the health sector in 1979 concluded that it was not feasible to construct dispensaries in every village. Instead it proposed that dispensaries should be considered to be ward-level institutions, serving 4-5 villages (Jonsson, 1986). As a 20-year plan for development (1981-2000) was worked out, the goal for health shifted from being a 'dispensary

for every village' to 'primary health care in every village'. By the time of the Alma Ata Declaration, Tanzania was already prioritising PHC.

From 1980 the Ministry of Health began using a Strategy for Primary Health Care. PHC Guidelines were issued in 1983, and a PHC Coordinating Unit was established in the Division of Preventive Health. This was supposed to coordinate a national PHC programme, which included a strategy for training Village Health Workers, and Traditional Birth Attendants (Jonsson, 1986).

The shift in health policy emphasis from a health system based on limited service provision, to extending basic medical services, and ultimately towards a more holistic PHC strategy did not simply occur within the government system. As Sivalon (1995) writes of the Catholic Church during the 1970's, although it remained significant in formal health and education service provision, the emphasis of activities moved towards socio-economic development, rural health and non-formal education projects.

At the same time, the government has struggled to keep a hold on gains in basic medical services. The health budget of FY 1982/3 was only 57% in real terms of what it had been in FY 1977/8 (Kahama, 1995). In the wake of economic crisis, key inputs, such as the provision of free drugs, became increasingly difficult to manage. A review recommended changes such as the development of a list of essential drugs. In 1983 the Essential Drugs Programme (EDP) was established with donors to provide regular basic drug kits to health facilities. This revolving system was intended to generate enough funds to enable the Central Medical Stores to take on the packaging and distribution role initially placed with UNICEF. But only 50% of funds are reported to have been recovered by the CMS from the District Executive Directors (Kahama, 1995). The Tanzanian government's health initiatives, whether preventive or curative, have been confronted with major financial obstacles for most of the period since the 1970's.

### **4.3.3 Financing health**

Central government expenditure on health had increased both in real terms and as a percentage share of the total government budget in the early 1970's. There were further real increases in health expenditures again in 1976-8 (Jonsson, 1986). However, economic crisis, inflation, structural adjustment and population growth continued to have a negative impact on government health infrastructure gains made in the 1970's. Between Financial Years 1978/9 and 1988/9, real per capita government expenditure in health declined by 46% (Mujinja, 1993). By the early 1990's it was clear what some of the impacts were:



“The symptom of under funding of the Health Sector is vivid: dilapidated health facilities, lack of essential working equipment, medical supplies and logistics, and the unmotivated health workers.” (GoT, 1996a, pv)

The stated policy of free health services for all was beginning to look unsustainable.

Health financing is about both the sources of finance, and the application of funds. The Health Sector Reform Proposals of 1994 look at the absolute allocation of funds to the health sector and note a decline in the government budget allocation from 9.4% in the early 1970's to about 5% in FY 1990/1 (GoT, 1994a, p4). The proposals recommend that the government allocate not less than 14% of the national budget to health.

Also important are trends in allocation within government health spending. Whilst between 1975-88 the growth rate of hospitals was 0.3% compared to a growth rate in health centres of 5.4% (Munishi, 1995), success in shifting the emphasis from urban to rural, from tertiary to primary, has not been consistent<sup>15</sup>. This is a fact recognised in the 1994 Health Sector Reform Proposals:

“Between 1989 and 1993, about 89% of the Government's health recurrent budget was spent on curative health services and only 4% on preventive services. The remaining 7% went on training and administration... While 90% of the Tanzanian population are served in rural health facilities, there has been a preference of resource allocation to urban-based health services.” (GoT, 1994a, p4)

Also important, however, are sources of finance and their allocation external to government. These have not been subject to detailed scrutiny until recently. Studies in the early 1990's (Mujinja et al, 1993; Abel-Smith and Rawal, 1992) explore willingness and ability to pay amongst health service users. They generally conclude that people are willing and able to pay where service quality is high and drug availability reliable. Such studies reveal that people are familiar with paying (whether in-kind or cash) for health services. Those services might be obtained from NGO health facilities, traditional health providers (for example Traditional Birth Attendants are estimated by Mujinja et al (1993) to be responsible for 40% of

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<sup>15</sup> Kahama (1995) writes that from 1970-80 the percentage of the budget spent on urban hospitals fell from 74% to 69% whilst spending on rural health care rose from 12% to 18.5%. This is a shift, but far from an equitable re-distribution of resources. Mujinja et al (1993) note that the division of health spending in 1987/9 was 43% to the Ministry of Health for referral and special hospitals, 31% to the Ministry of Local Government for rural health services, and 26% to the Prime Minister's Office for district and regional hospitals (Mujinja et al, 1993).

deliveries in rural areas), and indeed, informal payment for receiving better quality service within the government health sector. By the early 1990's, policy attention was turning to the introduction of user fees and health insurance schemes (discussed further in Chapter 5) as a means of tackling the problem of financial sustainability in government health services:

"The Government's per capita expenditure on health is approximately US\$3.46. The household expenditure is estimated to be only 1.9%. In the wake of high population growth, complexity of disease treatment, and growing recurrent cost, the Policy of Universal Free Health Care for all Tanzanian is no longer sustainable." (GoT, 1996a, pv)<sup>16</sup>

Other potential sources of health financing are the district and urban councils, which have a capacity to raise local revenues. Mujinja et al (1993) note however that these sources are very limited, and rarely applied to health services. Far more significant are NGOs and donors. It is not clear what the total spending of NGOs on health is, but they receive funding in the form of service fees, overseas grants, and in some cases government support through staff grants and bed grants<sup>17</sup>. By 1980/1 these grants represented 17.1% of total Ministry of Health spending (Mujinja et al, 1993).

In the case of multi- and bi-lateral donors the Ministry of Health notes that:

"Donors contribute 90% of the Development Expenditure on health services. Of all donor contributions, 40% is on preventive services (including immunization program) and 57% on curative services, i.e. health centres and dispensaries." (GoT, 1996, p6)

It is also noted in the same document that donor support to health provides nearly 81% of the total amount budgeted for preventive services, mostly targeted for Primary Health Care.

#### **4.3.4 Key issues in the health sector**

The enthusiasm with which Tanzania's initiatives in health and development were greeted in the early 1980s were undoubtedly deserved. For example, life expectancy

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<sup>16</sup> User fees have been subject to much debate. As Gilson et al point out user fees aimed at raising revenue but which do not deter use of services require management capacities to collect and use those fees, and their retention at the local level:

"The link between user fees, decentralisation, institutional capacity and resource mobilisation is therefore a conundrum, a circular 'chicken and egg' relationship..." (Gilson et al, 1994b, p473)

<sup>17</sup> Sivalon (1995) points out that given the customs and sales tax exemptions allowed non-government agencies, they were able to make purchases outside Tanzania that became very difficult to government agencies. In the wake of growing and immediate demands in the 1980's, this led to an increased dependence of the Catholic church on external support.

increased from 37 years in 1967 to 51 years in 1978 (Jonsson, 1986<sup>18</sup>). But these achievements have not been maintained, leading to more sober assessments in recent years. On the one hand, that there were 466, 700 people per health centre in 1961 and 98, 190 in 1994 (Munishi, 1995) suggests significant achievement. On the other hand, another figure shows one doctor per 24, 724 people in 1961 and one per 23, 898 people in 1994 (Munishi, 1995). This is less much less impressive, but at least indicates some holding of position against population growth.

Chapter 5 looks more closely at the diagnosis of the problems of health systems and development in Tanzania from the perspective of the Ministry of Health and other key actors. It is clear that financing health services is a major issue for the Tanzanian government. This helps explain the emphasis on cost-recovery and health insurance in the Health Sector Reform Proposals. However, there are other important issues to be addressed in health financing. Paramount amongst these is the real and growing dependence on donors for health funding. This has implications for the setting of health policy; a fact not lost on Nyerere when he said to the TANU Conference of 1973:

“...we must determine to maintain this national policy and not again be tempted by offers of a big new hospital, with all the high running costs involved – at least not until everyone of our citizens has basic medical services readily available to him.” (quoted in Kahama, 1995, p179).

There are also persistent problems in the structuring and management of the health system. From Jonsson writing in 1986, to Mujinja et al in 1993 and Gilson et al in 1994b there is clear identification of problems related to capacities, management skills, and support systems. Jonsson (1986) refers to an infrastructure which is insufficiently effective and efficient - with isolated health workers who rarely make home visits, vertical donor-supported programmes with their own systems, vehicles and training which the new PHC unit does not have the capacity to coordinate, and a poorly functioning referral system. Gilson et al (1994b) point to issues of central control versus local discretion in decision-making; to political and cultural influences which shape systems of authority around paternalistic leadership; and to a weak institutional capacity to make informed decisions, adapt to and influence change, manage resources to meet objectives. Mujinja et al (1993) note similar

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<sup>18</sup> For example, Jonsson cites an ILO/ JASPA statement of 1982:

“Tanzania’s experience demonstrates that some of the features of poverty can be eradicated at quite low income levels within a short period of time, by appropriate selective Government policies, in a peaceful manner, and in conditions of political stability.” (Jonsson, 1986, p746)

problems of management skills and the need for training to improve capacities to set priorities and develop strategies. The focus of their work being non-governmental providers, the authors also make important points about the need for review of existing legislation and regulation, improved co-ordination<sup>19</sup>, and more research into the performance, quality and roles of the 'private sector' in health services provision.

Finally, health policy in Tanzania has also been concerned with the allocation of resources, for example to primary health care and preventive activities. Whatever the stated commitments made from the late 1960's, the Tanzanian government has been unable to significantly reallocate its funding in this direction. It has already been noted that donors play a key role in primary health care, and that potentially, with many rural based services and programmes, so do NGOs. This begs the question of who has actually driven basic medical care provision and the extension of PHC at different times. As attention is increasingly paid to the individual consumer's willingness and ability to pay for services, and to the consumer's quality demands of that service, has Tanzania lost its commitment to social good and equity in health?

The Tanzanian literature exploring health and the roles of government and NGOs, says remarkably little about PHC in any broad sense outside of debating provision in a primary service system. There are references to past policy, but few reiterations of the kind of recommendations put forward by Sembajwe in 1983 and cited by Kahama:

"The study concluded that while Tanzania strives to provide health care for all, an integrated approach to rural development should be adopted as the well-being of the population is affected by a wide variety of factors." (Kahama, 1995, p178)

It is worth turning back to Jonsson's review of PHC in Tanzania, in which he writes:

"The analysis here clearly shows that many of the causes of ill health are outside and beyond the MoH's conventional area of responsibilities. This is fully recognised in the new PHC-strategy, but the mechanisms for a PHC strategy are

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<sup>19</sup> "Although the Ministry of Health does work quite closely with the non-government organisations in the health sector, co-ordination is variable and not always effective. At district level the functioning of the health system can require co-ordination, especially where NGO hospitals are 'district designated', but at the national level communication is hampered by weak coordinating mechanisms between individual NGOs and between NGOs and government. The capacity of the MoH to monitor the activities of the private sector is even more limited." (Mujinja et al, 1993, p223)

not established. Perhaps one of the most important strategic issues is to emphasise not only health for all but health *by* all.” (Jonsson, 1986, p752)

Such statements beg the question of what become of the PHC strategy and the recommendations put forward by people like Jonsson<sup>20</sup>. It leaves one wondering whether PHC continues to have any place in the conceptualisation of health systems and health in Tanzania, and if so, in what form.

#### **4.4 Decentralisation in Tanzania**

As intimated earlier, the policy and practice of ‘decentralisation’ – from the inherited colonial system of elected local authorities, to the abolition of local governments in favour of local administrations in 1972, to the re-instatement of elected local governments after 1982 – has been fraught with the tensions and contradictions which have typified decentralisation programmes around the world.

This section reflects on this history, providing more insight into the Tanzanian institutional context. This is a context within which attention has yet again been turned to decentralisation as reform programmes for the 1990’s have been initiated in the social sectors, in the civil service and in local government. It begins with a discussion about power distribution and the intended outcomes of decentralisation, and concludes with the issue of management capacities for effective decentralisation.

##### **4.4.1 Participation or control?**

“The general point should be clear as one looks through these elaborate pieces of legislation. The reality is that they were passed by a state-party machinery not intent on democratisation, but on furthering its control while lessening its financial burden. These pieces of legislation were passed at a time when the Party was undertaking measures to further consolidate itself and its stranglehold on government and society.” (Mukandala, 1995, p22)<sup>21</sup>.

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<sup>20</sup> Jonsson suggests that in the 5-10 years from the mid-1990’s, the health sector, within the framework of PHC, will have to: a) increased the effectiveness and efficiency of delivery systems; b) advocate that Health for All becomes a national political priority which involves all relevant ministries and the Party; and c) contribute to the creation of effective popular demand for preventive services. He goes on to discuss health as a responsibility of the community - the need to strengthen village and ward level planning, to enable people themselves to take on activities of village health workers such as growth monitoring, and to support MCH services to move outwards from health facilities into villages.

<sup>21</sup> Mukandala notes that in the 1977 Constitution of the United Republic of Tanzania, Article 145 concerns the establishment of government authorities in each ‘region, district, urban area and village’. And Article 146 states that the prime objective of local government is ‘consolidating and giving more power to the people’, and that ‘local government shall be entitled and

Mukandala (1995) concludes that the 1982 re-establishment of local authorities was more about control than participation. Liviga similarly proposes that whilst the preamble to the 1982 Acts states that:

“Local governments are established to cater as institutions geared and devoted to the pursuance of the meaningful involvement of and participation by the people in the making of decisions on matters affecting or connected to their livelihood and well-being at all levels.” (Liviga, 1992, p215)

There was no intention in this reconstruction of local governments of allowing independent local government service delivery without supervision and control from the centre. In addition to noting a trend towards Party supremacy<sup>22</sup>, Liviga proposes that whilst the new acts implied a critical role for local governments in the development process, the pattern of central-local relationships in the past was unlikely to support this.

When Mukandala writes of increasing control whilst lessening the financial burden, he goes right to the heart of the matter. Extension of social services and popular participation in decision-making may not always be compatible. For example, few of those who write of the ‘decentralisation’ of 1972 would accept it as anything other than a deconcentration of central government (Semboja and Therkildsen, 1994). Yet in the 1970’s, the Tanzanian government was embarking on a process of nation building and rapid service extension in the name of access and equity. This was deemed to require a hugely expanded government system to deliver (hence the rapid increase in the numbers of government employees outside central government). Maro (1990) focuses on what he sees as the outcomes, not just the structures, of this decentralisation. He argues that it increased popular participation and reduced spatial inequalities.

Semboja and Therkildsen (1994) take issue with this statement, suggesting that the 1972 reforms were ‘the final blow to a devolved local government system inherited from the colonial regime’. They suggest that village participation had been possible through the village development committees that were abolished in 1969. The system inherited on independence was one of elaborate arrangements for planning and implementation through committees at all levels, comprised of directly elected

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competent to participate, and to involve the people in the planning and implementation of development’ (Mukandala, 1995, p21)

<sup>22</sup> Liviga (1992) also notes changes in the Constitution, which in 1965 mentioned that other bodies were under the ‘auspices’ of the Party, in 1977 spoke of the ‘guidance’ provided by the Party, and in 1984 of the ‘final authority’ of the Party.

members, with local governments able to raise their own revenues and receiving matching funds from central government<sup>23</sup>. Other writers clearly state there were also more 'sinister' overtones to decentralisation, to do with the extension of state and party into people's lives (Kleemeier, 1984; Munishi, 1995)<sup>24</sup>.

Perhaps the shift to a deconcentrated central government is no more than should have been expected from a consultancy project (completed by McKinsey and Co) that based its recommendations on the management structures in vogue in business corporations (Kleemeier, 1984). However, the fact that it was a deconcentration and not a devolutionary approach to decentralisation should not detract from the fact that there were strong reasons for this - the pursuit of equity goals. At the same time, this also facilitated a strengthening of the hold of the Party, or of political control of local administrations. The decision that the heads of the regional and district committees, and later re-established councils, should be those already chairing the corresponding Party branch indicated that '*politics rather than technical competence took command in running local government*' (Liviga, 1992). This system whereby some officials wore the 'kofia mbili', or two hats of government and Party, meant, for example, that technical officials working under ministries were brought under the control of the Regional Commissioners (in the 1972 reforms), who also led the Party's regional organisations (Gilson et al, 1994b). The same system was replicated at village and ward level:

"This parallel bureaucracy increased the party's influence over development at all levels, as for example, its officials played the crucial roles of approving village, ward, district and regional development projects and plans before submitting them to the Prime Minister's Office." (Gilson et al, 1994b)

#### **4.4.2 Managing decentralisation**

Gilson et al (1994b) also offer insight into what decentralisation looks like from the perspective of government managers in the health system. They refer to what came

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<sup>23</sup> "A number of other central government decisions put local government on the road to bankruptcy and collapse. Following the Arusha Declaration in 1967, the country's policies of socialism and self-reliance strengthened central government rather than the local authorities. Central government grants, capital investment monies, and trading receipts were segregated compulsorily in separate bank accounts so that they could not be misallocated. Moreover, a Public Accounts Committee recommended in 1967 that a much closer control of central government on local government should be effected. Then the President in a speech on Republic Day in 1968 complained of the ineffectiveness of the local authorities but came short of declaring their abolition." (Liviga, 1992, p213)

<sup>24</sup> "The populist ideology of the Arusha Declaration emphasised rural development, indeed marrying well with the desire of the political elites for national mobilisation and integration." (Munishi, 1995, p146)

into being after 1982 as a 'hybrid' system in which the regional administration remained unchanged but the district level was strengthened<sup>25</sup>. This led to a lack of clarity about lines of authority and accountability (Gilson et al, 1994b), which local government and sector-based reforms are seeking to address in the 1990's. Indeed, these reforms appear to be aimed at further increasing the powers of districts, and reformulating the role of the regional administration.

Their research found that district health management teams (DHMTs), despite their theoretical responsibilities, had little authority to implement management actions to tackle resource use, quality of care, and community dissatisfaction with health services. They similarly had little control over finances and resource allocation (Gilson et al, 1994b). Writers such as Kleemeier (1984) and Liviga (1992) chart similar constraints back to the colonial period. Kleemeier describes District Commissioners (DCs) as 'jacks-of-all-trades' who were able to take substantial decision on their own initiative, and worked in a structure that did not evolve effectively, with the rapid increase of technical specialists beneath the DCs. Over the years, heads of department have tended to hand out only small tasks to subordinates (Gilson et al, 1994b, write about a culture of paternalistic management). Kleemeier also writes about the pressure of the 'we-must-run-while-others-walk' style of policymaking, which tended to emphasise once-and-for-all solutions to chronic problems.

Access to resources is also key. Kleemeier (1984) proposes that one of the issues in the 1972 'decentralisation' was that the regions received only 14% of the government budget on average, whilst McKinsey and Co had assumed them handling 40%. This obviously hindered the development of implementation capacity, improved co-ordination, and better management. Mukandala (1995) writes of the reforms in the 1980s that whilst financial provision is made under the acts, even if the councils could harness the potential revenue sources, 'which is a big assumption', this would still make little inroad into the list of functions which fall under local authorities. In addition:

"The amount of cash from the central government to a particular local council certainly depends on the ability of its leaders to lobby the central government and

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<sup>25</sup> Rural district councils were given particular responsibility for primary education, primary health care, roads and water supplies in the district, for which they received finances from central government to cover the bulk of the salary costs of these services. In addition, they were given responsibility for running some fourteen other activities - including forestry and fisheries - the costs of which were to be met from the council's revenues generated through taxes (Gilson et al, 1994b)



particularly the two ministers. But the ability of government is structurally strained given the financial strain under which it operates.” (Mukandala, 1995, p22)

Finally, there are other actors involved in local development activities. Semboja and Therkildsen (1994) criticise Maro’s study for not taking account of the long history of donor-supported district programmes, and their impact on participation and equity outcomes. Similarly, whilst district health managers have had the authority to supervise and coordinate with voluntary agencies, and to shape the delivery strategy of vertical health programmes, evidence suggests that this has not been acted upon. DHMTs simply run vertical programmes rather than develop them, the role of health centres is determined by national planners, and about half of Tanzania’s health services (those provided by NGOs) remain effectively outside the sphere of influence of the DHMTs (Gilson et al, 1994b).

#### **4.5 Community involvement in Tanzania**

This section reflects on the different ways in which the term ‘community’ has been used in public policy during the period. The idea of co-operative involvement or participation was key to promoting rural economic growth and meeting basic needs as expressed in 1967. So too was democracy - not necessarily of the liberal, multi-party kind - but of the kind where leadership responds to the masses (McHenry, 1994):

“In theory, the party represented the collective interests of the people and made policy in accordance with popular will.” (McHenry, 1994, p49)

The idea of the ujamaa village was of production in communal units and a locus for the provision of basic services for social development. But what was the relationship of ‘communities’ to all this? In reality, there has been a constant tension between development action based on spontaneous self-help, and that based on state interventions through planning.

To begin with, much of the villagisation process was ‘compulsory’, to which donors, impressed by the emphasis on rural development and basic needs, largely turned a blind eye (Svendson, 1995). Secondly, the focus of service provision was provided by state and planning machinery, through a ‘campaign type’ process (Svendson, 1995) calling for nationalisation, decentralisation, universal primary education and so on. One of the issues for the government was nation building from the diversity of tribal and other groups:

“Means and ways had to be found to mobilise and integrate such peoples into a new and wider conception of a modern nation-state. The development and distribution of social services was one of the strategies to penetrate such societies.” (Munishi, 1995, p144)

The imperatives for such nation building did not necessarily sit comfortably with systems for democratic participation. Positions along the lines of Maro’s conclusion (1990) that the 1972 decentralisation increased popular participation, and Jonsson’s statement that decentralisation and villagisation:

“Created a unique infrastructure for participation in decision-making. Villagisation also made it easier to reach a larger proportion of the rural population with social services.” (Jonsson, 1986, p746)

have already been shown to meet with disagreement. Semboja and Therkildsen (1994) challenge the notion that decentralisation and villagisation were in themselves responsible for increased access to social services and the reduction of spatial inequalities. They agree that such inequalities decreased in the 1970’s but due to other factors such as a growth in social service coverage that outstripped rural population growth. They indicate that it is difficult to see how much leverage local involvement could have when regional administrations only controlled 14% of recorded government investment in this period. Further, donor involvement is poorly documented, but may have had an impact.

There are rather more commentators of the opinion that the decentralisation of 1972 did not increase people’s participation, and that even the re-instatement of local governments did not address this situation. Mukandala (1995) proposes that the legislation of 1982 was not about a ‘state-party machinery’ bent on democratisation, but rather on ‘furthering its control while lessening its financial burden’. Concerns of this kind had been expressed in other quarters. In a Pastoral Letter from the Catholic Bishops of Tanzania in 1972 called ‘Peace and Mutual Understanding’, there is discussion about the relationship of the individual to the community, and a warning to the political leadership against the party and its organisations monopolising all responsibility rather than leaving space for personal initiative and responsibility (Sivalon, 1995).

Whilst the main thrust of practice appears to have been increased control over autonomous action on the part of party and state, it is also the case that the rapid growth of services in the 1960’s and 1970’s relied upon action initiated by self-help groups and then adopted by the government (Munishi, 1995):

“However, within the context of the Arusha Declaration, self-help becomes a highly dubious and contradictory concept. Without self-help, resources for service provision would be totally inadequate. On the other hand, the popular and NGO initiatives were regarded as supplemental and transient, as the state was presumed to be the benevolent provider of the essential social services.”

(Munishi, 1995, p145)

‘Self-help’ is a contradictory concept. Kleemeier (1984) suggests that people’s participation in government and donor projects was limited to: “... *‘self-help contributions’ which were more often a form of labour tax*”. There is a thread running through the story of participation in Tanzania which points to more coercive than empowering forms of participation, for example in Iringa where villagers are often excluded from active participation by the village leadership.

The other side of the coin is what people expect of the government. Another thread running through development interventions in Tanzania is the expectation that government will deliver:

“Furthermore, villagers tended to look upon social services as something promised and owed to them by the government, and therefore the latter’s responsibility to maintain. The result was that villagers themselves did little to maintain the projects, nor were they given the skills to do so.” (Kleemeier, 1984, p194)

This issue of responsibility for maintenance becomes a key issue when it is recognised that whilst the government had made decisions in the 1970’s to increase basic services, it did not increase maintenance expenditures in proportion to development investments (Kleemeier, 1984).

A system built on the idea of participation through planning was riven with contradictions and with expectations on all sides that could not be met. With ‘liberalisation’, the notions of individual payment for services, and of individual rights in civil society have gained ground as the basis for participation. On the one hand, people are consumers. Studies such as Mujinja’s research into 42 non-governmental health facilities in 1989 (Mujinja et al 1993) indicate that people were having to make payments at government facilities although services were officially free of charge, and that they often preferred NGO facilities on the basis of available drugs and quality of service. In the study, over 80% of respondents said they were willing to pay for health services which delivered on drugs and quality.

Mmuya (1995) in his commentary on strategies for poverty alleviation, reveals the shifting emphasis from state to individual:

“As a general recommendation it is proposed that civil society as individual citizens and in its organisation has to rise to the awareness that the primary force in bringing about better conditions of life rests on their own potentialities. The government also must recognise this fact and understand that its apparent strength is derived and can only be sustained through acceptance by civil society...The point is that government should be ready to accept sharing of responsibility with society.” (Mmuya, 1995, p32)

#### **4.6 Conclusions: Some reflections on 1995-8**

This chapter has charted the post-independence history of Tanzania, focusing on areas of interest to this research. This history reveals the evolution of the concepts of ‘community’, ‘health’, ‘decentralisation’ and ‘private’ and their power in shaping public policy discourse in Tanzania. The points raised are key to understanding the discussions that take place in Chapters 5 to 7. I reflect on some of the main points here, with reference to the period during which this research project took place.

As Tanzania has moved from organisational pluralism, to state and party extension into organisational life, to ‘privatisation’ and a return to accepted organisational pluralism, the definitions of what constitutes ‘public’ and ‘private’ have also been shifting. This has far-reaching implications for the organisation of business, social services and associational life.

As a result of these changing, and contested, definitions, the relationships between government and other actors have never been straightforward. As Nyerere said in 1961:

“... ‘Does the government help the voluntary agencies or do the voluntary agencies help the government? Sixty-six per cent of our children who are now in school are at the schools run by the voluntary agencies. They are teaching the children at half the cost which they would have required had they gone to a government school. I would have expected, Sir, that most of the speeches here referring to the voluntary agencies would be of gratitude and not of criticism.’”  
(Nyerere to Parliament in 1961, cited in Sivalon, 1995, p182).

Even during the period of ‘self-reliance’ many non-state agencies played, often unacknowledged, an important role in social development. As Munishi (1995) notes, ‘popular and NGO initiatives were regarded as supplemental and transient’, yet

without self-help activities, the resources required for service provision would have been wholly inadequate. Throughout the period however, the rhetoric has been one of the state as 'benevolent' provider of basic services.

During the period 1995-8, debates about the role of non-state agencies, in particular NGOs, have gathered momentum as the sector itself rapidly increases in size and presence. These debates are riven with contradictions, as different actors do not know what to say about NGOs or where to place them in a changing public-private interface. The prevailing 'public' discourse is of NGOs fitting in to a government-framed system. In one parliamentary debate in 1997, a minister is reported as saying that NGOs help by providing farming inputs, repairing classrooms and hospitals, building dispensaries and shallow wells, environmental awareness and distribution of medicines. When questioned about NGO support to under-supported regions, 'the minister said NGOs would be directed to operate in regions they have not yet considered...however, the NGOs would only be encouraged to invest where districts have already prepared 'profiles' and shown development initiatives.' (Daily News, 17/7/97). However, there is still a great deal of thinking to be done about just how the government will frame systems. As Mujinja et al (1993) comment on the Minister of Health's statement of 1993 that NGOs should be 'partners', the modalities of partnership, from roles, activities to accountability mechanisms still need to be defined. These are challenges that manifest themselves from local to national level. Tanzania has moved to recognising pluralism and the principle of organisational autonomy, away from the corporatist organisational arrangement under the single-party (McHenry, 1994). However, many NGOs and other bodies emerging outside government are heavily dominated by ex-government staff, steeped in the culture of government service in a single-party system. NGOs themselves, on the scale that they now exist, are very young (although some particular organisations have long histories). And as yet unfruitful attempts during this period to develop an adequate NGO policy and legislation continue to oscillate between an instinct towards government control and advice that frameworks should be more regulatory and supportive than directive.

Since Independence Tanzania's approach to 'health' has moved away from an urban-based biomedical service available to the few, to a system built on the principle of access by all to basic medical services, to a broader conceptualisation of health systems as being about primary health care not just primary services. Since the late 1980's there have been indications of a shift away from this latter position, reflecting in many ways the shift in focus of international health policy from *access* to *management* (Sandiford et al 1994). In the Tanzanian context, this raises the

question of where the government's stated commitment to PHC, equity and access in health has gone.

It is interesting to reflect on these questions in the light of comments made by President Mkapa during an interview after his election in 1995. In talking about the issues that people had raised with him during the election campaign, he turned to health costs. People were complaining about the introduction of cost-sharing, but seemed to be more concerned about drug availability than the fact of payment itself (Martin, 1995). When asked about Tanzania's commitment to preventive health approaches, Mkapa continues:

"No, that was not raised. What I can say is that the health problem was perceived more in terms of facilities for cure, for health, for the curing of illness, not prevention." (Martin, 1995, p2)

As public policy for health in Tanzania changes, there are many questions to ask, as taken up in the coming chapters of this thesis. It does not appear that PHC in the sense of need for access to basic health facilities, has become any less relevant. The Titmuss report proposed that NGOs should provide curative services and government focus on prevention. It is not clear from the literature how this division has worked out over the years. This issue will be discussed in the next chapter, but it is interesting to note here that HSR effectively advocates the same split.

Tanzania's decentralisation programmes reveal a running tension between attempts to de-centralise and *de facto* re-centralisation, long dominated by strong political forces attempting to regain central control<sup>26</sup>. This will clearly remain an important issue in more recent decentralisation initiatives. Liviga (1992) suggests that central government has not lost its 'big brother' approach to local government, and that as a result there is a mismatch between assignment of functions and allocation of revenue raising powers.

Current design and implementation of decentralisation policy and practice need to take account of history, observing warnings of the kind put forward by Gilson et al;

"Tanzania's past experience of decentralisation suggests that future reform of the organisational structure of government health services must be developed cautiously. It must, in particular, recognise the critical importance of institutional capacity to success and ensure that the process of policy reform mobilises

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<sup>26</sup> Semboja and Therkildsen (1994) write of this effort at central control: "It typically involves central ministries and is often backed by donors with specific sector interests."

political and economic support for the health system.” (Gilson et al, 1994b, p474)

During the period 1995-8, decentralisation reforms have begun to be implemented. As will be discussed in Chapter 7, greater emphasis has been placed on the role of the District Councils as the appropriate location for decisions about local development, where elected councillors and district government staff interact. The regional governments have been designed to be regional secretariats ostensibly acting as advisors not controllers of districts. And the old Regional Development Committees have become Regional Consultative Committees, inviting the participation of key agencies outside government to their discussions. However, in many areas these reforms have yet to be completed (for example, regional employees who are being re-located to districts are waiting on resource transfers to effect the move), and it is not yet apparent whether these changes are to be accompanied with real changes in resource allocation. Districts are not unfamiliar with the failure of central government to disburse their development budgets on time or at all.

Individuals and communities in Tanzania have been through free association to forced villagisation to centralised control through state and party and back to free association again. This history has inevitably had an impact on the way in which communities have been involved in, or participated in, development activities. There is no doubt that during the period, a ‘unique’ and powerful infrastructure for mobilising communities was developed. This ran from household (through the ten-cell system) to village to local government level. As the literature discussed in this chapter shows, the form that this participation has taken has often been self-help through linking with government initiatives, although as Tripp and Swantz (1996) highlight, much of this self-help could be thought on in terms of what people did for themselves in spite of the government’s notion of ‘self-reliance’.

In the period since 1995, the language of development with reference to ‘community’ appears to have made more active use of terms such as ‘participants’, ‘users’ and ‘citizens’. There has been a growing emphasis on community financing and management in all areas from water to education to income generation. Government policies in these areas emphasise the community role, and in some case, villages and groups are themselves seeking their own ‘private’ options, such as recruiting teachers for the village primary school, to meet collectively defined needs. The idea of participation has been increasingly influenced by the methodology of Participatory Rural Appraisal (PRA), and has led to national level discussions about how to promote this approach.

Whilst 'communities' appear to be being given more space to prioritise, decide, and plan, however, the other side of the coin are concerns about quality, access and cost of social services. According to many of the government and NGO development workers I have interviewed during this period, communities are having to leave behind their 'dependency mentality' and learn that government will not provide these services. It is not clear what this means for the vision expressed by Nyerere as cited at the start of this chapter; or whether that vision still holds:

"We are determined to build a country in which all citizens are equal - where there is no division into rulers and ruled, rich and poor, educated and illiterate, those in distress and comfort." (Nyerere's inaugural speech to Parliament in December 1962, Jonsson, 1986, p745)



# 5

## NGOs and Health Sector Reform in Tanzania

The purpose of this chapter is to explore what is being said about NGOs – their role in health development, health systems and health sector reform – by the Ministry of Health (MoH), donor agencies, and NGOs themselves. The chapter primarily addresses the fieldwork question:

- Do, and if so, how do, NGOs seek to influence national and international agendas for the continued promotion of PHC approaches?'

The chapter describes the HSR policy context. It also explains why I selected the case of Community Based Health Care as a means of investigating the two other fieldwork questions, which are the subject of Chapters 6 and 7.

As described in Chapter 3, the data used for this chapter derive from: a) MoH documentation; b) interviews with MoH, donor agency and NGO staff; c) my own participation in meetings and other fora; and d) my following of the English language print media.

The chapter is divided into four sections. In section 5.1 I discuss the HSR policy process from the perspective of government, donors and NGOs. In section 5.2 I look more closely at policy content with reference to the four themes: public/private; health; decentralisation; and community. In section 5.3 I reflect on the implementation of the HSR policy with reference to a joint MoH/ donor review conducted in 1998. Finally, in section 5.4, I conclude with a discussion about the nature of the policy process, and the connection between NGOs, HSR and PHC/ CBHC.

### 5.1 A policy process

#### 5.1.1 Government ownership of policy

MoH documentation indicates that the government is sensitive on the issue of policy ownership, in the sense of government ownership of policy. For example, the 1994 Proposals for Health Sector Reform (GoT, 1994a) point out that the idea for HSR started with the Health Strategy Note of 1993, which was based on a 'need to re-examine the present health services delivery system'. HSR is firmly located within

the Tanzanian government's management of its own ongoing history of reform in statements such as:

"The current initiative for reform by the Ministry of Health preceded the World Bank initiative to invest in health as evidenced by the World Development Report 1993..." (GoT, 1994a)

In the May 1996 version of the Health Sector Reform Plan of Action this process of reform is charted back to the 1960's and the Arusha Declaration. It points out that two significant changes to the health sector were introduced before the WDR of 1993, namely the unbanning of for-profit medical practice in 1991/2 and the introduction of cost-sharing in 1993 (GoT, 1996a)

However, some government staff contradict this story of policy ownership with statements like:

"These policies have been imposed, not locally generated. This is World Bank policy. People are not given the time to discuss it. You are given a package, including a timetable... There are no proposals now coming out on how to modify cost-sharing so it works. We need to be more systematic...review...not cosmetic changes...Cost-sharing is not bringing in money. Our experience is not different from other developing countries...Just massaging the donors..." (G2/96)

Others talk about being excluded by a small group within the MoH itself. A staff member of one bilateral donor agency (D1/95) pointed out that a HSR Conference had been scheduled to take place in October 1995, directly clashing with the Annual General Meeting of the Tanzanian Public Health Association (TPHA). He felt that the TPHA might be expected to have a significant and legitimate say in the emerging policy. In the event, this conference led to the production of the Action Plan for HSR (1996-1999) (GoT, 1996a, p1). An MoH employee and member of the TPHA also made the same point, and indicated that his knowledge of the proposals for HSR came through a personal friendship, not through the MoH or the TPHA, which to his knowledge had not been informed about HSR:

"Noone knows what is going on. Muhimbili [Dar es Salaam-based referral and teaching hospital] accounts for half of the Ministry of Health's budget and noone here knows about Health Sector Reform....It is all a one-person game played with the World Bank...it is not real." (G2/95)

The documents acknowledge that HSR is an undertaking of great magnitude that will affect all aspects of the health sector, from administration to clinical facilities to preventive services to health training institutions (GoT, 1996a, p11). This fact

would seem to merit the involvement of actors other than the MoH. At times, the importance of this is picked up in statements like:

**“The strategy for Health Sector Reform will be holistic. The Central Government, Local Government, donors, the NGOs, communities, and private practitioners will all be involved. The district leadership is especially expected to play a key role during implementation. The ordinary Tanzanian will be involved with the reform through acceptance of policy changes.” (GoT, 1996a, p11)**

However, it is not clear whether the proposed role for these actors is in policy formulation, design or implementation. In practice, as this research shows, the scope for involvement in agenda-setting, formulation and design has been extremely limited. For example, the HSR Proposals indicate that the Health Strategy Note was followed by a meeting in November 1993, and then a national workshop ‘involving a wider cross-section of multisectoral stakeholders that took place at Kunduchi’ in April 1994, although it does not list who was involved<sup>1</sup>. In making this point in this chapter, I do not seek to make simplistic political statements about who should have been included. Rather, I seek to better understand the power balances, individual idiosyncrasies, organisational capacities and histories, and very real resource<sup>2</sup> and infrastructural constraints that shape inclusion and exclusion from policy development.

### **5.1.2 Donor involvement in policy**

MoH and donor staff all state that the donors are there when the MoH seeks advice. The Minister of Health stated firmly that all donor programmes have to fit in with the HSR plans, and those who did not want to subscribe to this could take their funds elsewhere (G1/1996). However, as might be expected, this glosses over a complex reality, with MoH and donor agency staff variously asserting themselves and their own perspectives.

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<sup>1</sup> The 1994 HSR Proposals thank certain donors for their support, and also thank the members of the Health Sector Reform Working Group, listing these. The members are all government staff (mostly from the central MoH office) with the possible exception of the chair, who came from the Christian Social Services Commission (CSSC), an organisation established by church organisations to work with government on issues of health and education.

<sup>2</sup> For example, in 1995 I found it impossible to obtain any of the key policy documents. This was not because they were restricted, but because most people I met with did not even have their own copy to give me for photocopying, and the MoH library did not house them. This being a problem right at the core, in the MoH in Dar es Salaam, it is unsurprising that in other parts of the country people were unfamiliar with the policy proposals and plans. By 1998, such documents were more readily available, but with limited external distribution, as attested to by the small number of people I have encountered in regions and districts who have received any.

There are a number of threads running through this. One is the process through which donors have increasingly mobilised around the HSR agenda. I had earlier been told of 'semi-secret' health meetings held in donor staff houses (D1/92; O1/94). Some of the minutes I have seen concerning meetings of the Population, Health and Nutrition group, do indeed reveal its organisation and publicity to have been rather ad hoc and limited. Donor views about the nature of policy ownership and process vary, but tend to revolve around the role of the World Bank. One person expressed indignation that the World Bank had not been participatory in the early stages of HSR but was beginning to do better now that it had started to involve other donors (D4/95). Another person maintained that HSR, unlike the Social Sector Review, was an MoH project that had been going on for years. This person also reflected that the World Bank had become more co-operative recently, allowing for good dialogue between bilateral donors and the government (D5/95). An interesting point was made by another person, who suggested that the value of the World Bank's involvement does not lie so much in the detail it proposes as in its provision of an agenda around which donors can mobilise (D8/95). This point was echoed by others, one of whom said that the donors (and NGOs) were now looking together at the future and in terms of sector investment approaches rather than projects (D2/95). Another noted that during the previous year, the donors had tended to be critical of the Bank, but that the Bank had begun to move towards their views on health. Apparently many donors had been questioning the Bank's piloting of cost-recovery and community insurance schemes in health and education, taking a stand against 'doing experiments' on the basis that these can be unreliable in terms of outcomes and problematic in terms of sustainability (D6/95).

Another thread therefore, is that of disagreement, especially between donor agencies. A handful of people expressed serious reservations about the HSR agenda. Some question how they can be expected to rally around initiatives they would not endorse in their own country. For them, HSR is directly associated with the World Bank:

"The World Bank has hijacked the Ministry of Health which won't argue because it is a donor, but this is even worse because the money is lent. In theory it [the World Bank] responds to the needs of the recipient, but what is the practice? The donors have taken time to realise what the World Bank is doing."  
(D7/95)

It is difficult to determine whether these differences are about policy process or content. What is clear is that clashes of both ideology and institutional culture are not uncommon. Evidently individuals and their agencies see things in very different

ways. Interviewing one donor staff member, responsible for health support in the East Africa Region, I introduced my research interest as being the connections between HSR, PHC, district health management and NGOs. His immediate response was that there was no connection between the 'grandiose, pompous confusion of Health Sector Reform', the preserve of a range of consultants and 'few people with any insight', and the various efforts (including donor-funded District Rural Development Programmes) to improve district management in all its aspects (D1/95). The strength of this person's criticism derives from a perception that what is being promoted is 'aggressive neo-liberalism', the proponents of which are out of touch with the reality of the country:

"These people [donors and their consultants] have never been outside Dar es Salaam. They call up-country 'the bush'." (D1/95)

Another thread running through the story of donor involvement with HSR policy is concern about the capacities of the MoH. Having been one of the major health donors in Tanzania, SIDA stopped funding in 1994 on the grounds that the much of the annual allocation was going unspent (D9/1995). I have heard rumours on several occasions about World Bank tranches allocated for HSR also going unspent. Others talk about the MoH's lack of political will, as well as limited capacity to implement, never mind, make policy (D1/95; D4/95). Another side of this story was presented to me by one MoH employee who said that donors themselves do not handle things well, and involve the wrong people:

"For example, Muhimbili teaches public health. It should be involved. Instead, donors are giving this thing to administrators, not the deliverers. Not even the RMO's [Regional Medical Officers] are informed..." (G2/95)

This statement implies that donor agencies do wield enough influence to shape a policy process; that they are far more than advisors waiting to be sought out. The level of dependency on donor funds reinforces this possibility. Whilst none of the donor staff I interviewed talked about the level of their resource input and any leverage that may come as a result of that, it is clearly an important issue for the MoH. For example, about 81% of budgeted spending on preventive services comes from donor funding (GoT, 1994a, p29-30). As it recognises, this places the MoH in a challenging position. For example:

"There is inclination by donor agencies to invest in areas of their interest. In most cases, they choose to have vertical control over manpower, funds and materials associated with their programmes in order to ease their accounting systems. As a

result, there is no integration of the different programmes which eventually creates problems in the sustainability of the programme.” (GoT, 1994a, p25)

Looking back from the vantage point of 1998 however, there appears to be a much more open and active process of dialogue between the MoH and donors, rather than the ad hoc and individualised relationships that seem to have characterised the past. This has no doubt been built through sheer experience of interaction around the HSR process. It demonstrates some commitment to genuine MoH-led policy-making rather than just focusing on programme implementation and donor-to-donor co-ordination. Indeed, the 1998 Joint MoH/donor review of HSR notes that although relationships are not always harmonious, and donors often fail to comply to government arrangements, there is a commitment to ‘partnership’, and an implementation strategy for managing this relationship is spelled out (GoT, 1998). On the other hand, for recent arrivals into this context, the situation can still seem rather ad hoc and the process slow (D1/98), while some feel that certain donor staff members are pushing the MoH too far too fast (G1/98).

### **5.1.3 NGOs and Health Sector Reform**

The HSR Proposals recognise that NGOs are involved in health service provision. However, as this section will show, the MoH, donors and NGOs themselves are not very clear about what this means in the context of HSR. Few of the people I have interviewed have picked up possible connections between NGOs, HSR and PHC. I found that government and donor agency staff tended not to mention NGOs until further prompted. Even then most were not in a position to say very much. Within NGOs I encountered a very limited knowledge of government policy beyond the broadest brush strokes, and rarely any sense of an explicit relationship existing between government policy and the NGO’s activities, other than in the sense of government policy providing the framework within which NGOs have to work. Both of these factors help to explain (and reflect) the very limited involvement of NGOs in the HSR policy process.

The MoH refers to ‘substantial support from NGOs, particularly religious organisations’ (GoT, 1994a, p18). However, it completes the statement with a reminder that the remaining 60% of services are provided by the government, as if this justifies the limited attention then paid to NGOs. This still leaves the ‘private’ sector with the not insignificant ownership of 40% of service delivery points – 8-10% for-profit owned and 30% owned by non-for-profit organisations (GoT, 1994a, p33). Yet the recognition of NGO involvement is limited to statements like:

“Private Health Care Providers (both for profit and not-for-profit) are now PARTNERS rather than opponents or competitors for the demise of each other.”  
(GoT, 1994a, p8)

The indication that not only are NGOs are health service providers, but that relationships have not been amicable in the past, would seem to provide a persuasive argument for devising mechanisms for more effective interaction. It would also seem, that in order to do this, NGOs need to be better understood.

Some donor agency staff expressed an openness to involving NGOs in dialogue. However, it is clear that for many this interest goes no further than recognition. I was told that NGOs ‘can participate’ in the Population, Health and Nutrition Group (D2/95) and the Health Sector Reform committee. I was also told that whilst MoH staff tended not to attend the Population, Health and Nutrition Group meetings, AMREF and the Christian Social Services Commission (CSSC) regularly did (D8/95). Although another person (D5/95) said that NGOs were not involved, and that AMREF did not attend these meetings. If NGO involvement in policy discussions is limited, none of those I interviewed connected this to their own actions, such as failure to communicate with NGOs. One person told me that AMREF had been invited to represent NGOs in the HSR process. But he acknowledged that other agencies (he named some international NGOs based in Dar es Salaam) had been angered by the decision on the basis that they had not been consulted about NGO representation (G1/95). This same person, whilst speaking keenly of NGOs, in fact knew the names of very few, attributing this to the fact that NGOs generally failed to keep him informed (G1/95). As my own experience of being closely involved with an NGO based in comparatively remote regions has shown, until around 1997 poor telecommunications, infrastructure and resourcing within government and NGO alike, mitigated strongly against engagement with policymakers.

In general, the ways in which the MoH writes about other actors in health suggests that their role is not in policy but implementation. This appears to be the understanding of donor staff too. One donor suggested that the district-focused nature of the proposed reforms was conducive to NGO involvement as NGOs tend to have an advantage in local-level implementation (D2/95). Another person suggested that from his experience, NGOs generally lack the capacity to influence or to prompt change, but that where any district programmes is doing well up-country, it is usually for a special reason, such as the existence of a strong NGO in the area (D8/95). Someone else told me that although supportive of NGO work, NGOs had

to fit into the district government programmes his agency was supporting, and would not get funding for activities developed outside of these (D1/95). The Minister of Health also talked about close working relationships with NGOs (for example, mission-run hospitals that are district-designated health facilities, and in which government pays salaries), and of the importance of the MoH being informed about what NGOs are doing in order to avoid duplication (G1/96). She stated that the need to facilitate liaison was one of the reasons for the creation of the district health boards. However, in the HSR documents, some confusion about what NGOs are indicates that there might be problems in defining adequate modalities for co-operation. For example, in statements such as:

**“All NGOs/ Managers of vertical programmes will integrate their planning process and execute programmes together to allow cross-fertilization of ideas and efficient utilization of resources.” (GoT, 1996a)**

there is a suggestion that NGOs are like vertical programmes, not horizontal actors that already exist and interact at the local level.

But how does this look from the perspective of NGOs themselves? In general, NGOs articulate their relationship with the government as being supportive, complementary and advisory (for example, N1/95). However, many were clearly not aware of the HSR process itself. For those agencies that have direct contact with the MoH, it seems to be limited to particular units or individuals, so that their advice is related to specific areas, not wider policy change. For example, UMATI, the Family Planning Association, operates under the ‘umbrella’ of the MoH and works to its guidelines. It liaises directly with the Family Planning Unit in the MoH (N1/95).

I found a handful of NGOs were aware of the detail of HSR, and were debating issues raised by the policy itself. As one interviewee said, whilst on the one hand NGOs are not good at networking between themselves, and can be quite weak, on the other they are concerned with influencing policy, which includes policies of donors (N1/96). A major problem is that donors do not know what NGOs are doing. So for example, he noted that the World Bank had failed to recognise the fact that about 50% of health and education services are church-run. His NGO had initiated a meeting with the World Bank in 1996 to discuss the ways in which it had been marginalising NGOs (N1/96). Another problem for NGO involvement in policy is identified as being the MoH :

**“We have a lousy Ministry of Health. The government system not wanting us to join in...there has been no decentralisation, no liberalisation...government doesn’t**



recognise other actors. It is a mistake to nationalise these NGO hospitals...”

(N1/96)

At the same time, the same person notes that on balance the relationship with the government is one of partnership. Generally, NGOs adapt to government policy. However, if they feel the policy is not fully appropriate, they will take on an advocacy role. This has to be based on research. He cites the example of attempts over the previous couple of years to solicit partnership among the church-based organisations, encouraging the churches to talk one language, making informed decisions, and influencing the government through dialogue. This initiative came to fruition with the formation of the CSSC. An example of NGO policy work is provided by way in which the CSSC took up the HSR idea of developing District Health Plans by piloting programmes with certain DHMTs around the process of planning, supervision, management, equipment, drug supply and infrastructure (N1/96).

A few NGO staff express a sense of unease about the thrust of reforms. For example:

“...we [Tanzania] are in the wilderness...there is a mushrooming of private services and there are issues of quality...we are trying to come up with regulatory systems...but don't have the capacity and finance, in the midst of an ignorant community...things have come to the nation suddenly, the country is very poor...politicians have a tendency to abdicate responsibility in health and education...NGOs, churches are working in Primary Health Care where the private sector doesn't emerge, and they are being pressured by government on the training of staff...and what about the peripheral areas ? People have no income...” (N2/96)

This research indicates that NGOs have had limited involvement in the HSR policy process. Like the MoH and donor agencies, NGOs are constrained in terms of time, communications, location and capacity. Engagement with policy processes that goes beyond particular agencies talking on the basis of individual relationships, obviously requires some mutual knowledge, understanding and constituency building among NGOs themselves.

## **5.2 Policy content**

“The Government of Tanzania professed, through its Health Policy, to provide health services to all Tanzanians, especially the most vulnerable; to reduce morbidity and mortality, and to raise life expectancy. However, compared to

other Sub-Sahara African Countries, Tanzania's health indicators are lagging behind..... this is an indication that the policies and/ or strategies being applied in the health delivery system are not effective enough. The problems facing the Health Sector are both economic and managerial..." (GoT, 1996a, p10)

The HSR Proposals state that the overall objective of Tanzania's health policy is to improve the health and well-being of all Tanzanians - focusing on those most at risk - and to encourage the health system to be more responsive to the needs of the people (GoT, 1994a, p7). The Proposals set out specific objectives, such as reduction of infant and maternal mortality and morbidity and ensuring availability and accessibility to health services. Of particular note, given the emphasis of this research, are the objectives of sensitising the community about common preventable health problems, promoting awareness amongst government and the community at large that health problems can only be adequately solved through multi-sectoral co-operation, and creating awareness that the responsibility for health rests with the individual as 'an integral part of the family'. The Proposals explicitly place PHC at the heart of health strategy, stating that:

"These objectives must be achieved through Primary Health Care (PHC) which is the central element of health promotion aiming at co-ordinated action by all concerned: health and health related sector, local authorities, industry, non-governmental and voluntary agencies, the media and the community at large." (GoT, 1994a, p7)

The Proposals recognise that the existing health system has been built on the principles of equity and self-reliance. An MOH study of 1978 is cited to verify the fact that 93% of the population lives within 10kms of a health facility. However, very real problems are acknowledged, such as the lack of an effective information system, unreliable transport, poor communication, shortage of medical equipment, poor health staff motivation and lack of co-ordination between programmes (GoT, 1994a, p25).

These weaknesses, and the proposed reforms, are categorised as ideological, organisational, managerial and financial. Each of these touches in important ways on the way in which the idea of public/ private, health, decentralisation and community are being described and re-formulated in the policy arena.

### **5.2.1 Public/ private**

HSR in Tanzania is about fundamental ideological changes that aim to reorient the role of the 'public' sector and increase the level of 'private' action. It is anticipated that as a result:

"Once the Government has determined its role in the provision of equitable health services and has liberated private practice, the public will have access to a health service mix that it can afford, and can then make a choice between public and private services depending on the quality, affordability and consumer satisfaction of such services." (GoT, 1994a, p6)

The HSR Proposals state that the reforms will involve:

- every Tanzanian taking an active part in disease prevention and health promotion;
- an end to free health services;
- a reorientation of the government to be more of a facilitator than a provider; and
- the encouragement of a more active role for the private, for-profit sector (GoT, 1994a, p66).

They add that this ideological shift preceded the 1994 Proposals. Although the 1990 National Health Policy re-stated the commitment to free health services (Universal Free Medical Services for all Tanzanians had been declared in 1977), in 1993, 'cost-sharing' was begun through the introduction of user charges for hospital services. In 1991 the Private Practice (Regulation) Act formally reversed the 1977 banning of private medical services for profit.

The reorientation of the role of the government has a number of components. Firstly, the government has to respond to a crisis in health financing. This is attributed to the economic crisis of the late 1970's, which was then exacerbated in the late 1980's by the rate of inflation and 'the Structural Adjustment Programme which was adopted by the government as one of the IMF/ World Bank conditionalities'. These factors contributed to a downward trend in public recurrent expenditure to health from 1985 onwards, resulting in a decline in per capita spending in both nominal and real terms. Further strain was placed on the government budget by a rapid expansion of government health services. As a result, the health sector is characterised by 'dilapidated health facilities, lack of essential working equipment, medical supplies and logistics, and unmotivated health workers' (GoT, 1996a, pv). It is proposed that

the allocation of government resources to health be increased to 14% of the government's budget<sup>3</sup>.

Secondly, a re-allocation of government health finances is proposed. The HSR Proposals note that between 1989 and 1993, 89% of the government's recurrent health budget was spent on curative health services, with only 4% being allocated to preventive services, and a preference in government resource allocation towards urban-based health services. The Proposals state that the government intends to:

“Re-allocate resources to cost-effective service that would have a greater impact on the health status of communities. Basic indicators like composition of the population, age structure, disease pattern, income distribution and utilisation of health services should be used to allocate resources to specific areas.” (GoT, 1994a, p31)

Thirdly, it is proposed that the government will be a facilitator, creating an enabling environment for other actors. This will partly require some changes within the government system itself. For example, the role of the MoH will be more focused on policy management and quality assurance, whilst organisational changes will allow the districts a greater role in health service management. It will also involve some changes in the way that the government relates to the 'private' sector, and statements are made about the need to shift towards being 'partners' rather than 'opponents' (GoT, 1994a, p8).

The 'private' sector is defined very broadly in these documents:

“The term 'private sector' is used here to signify all those organisations and individuals working outside the direct control of the Government - both for-profit and not-for-profit services.” (GoT, 1994a p33)

The Proposals note that a comparison of the strengths and weaknesses of both public and private sectors would help to build an appreciation of the need for reform along the lines of a public/ private mix (GoT, 1994a, p33). However, the documents do not contain evidence that such comparisons have been conducted. The Proposals also recognise that privatisation will not ease the health management burden of the government, which will still need to provide 'strong regulatory authority', especially in order to ensure that private services are 'provided in accordance with the overall health needs of a locality' (GoT, 1994a, p32). Again, there is no evidence that work

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<sup>3</sup> The HSR Proposals (1994a) indicate that the government's allocation to the health sector was 9.4% of the budget in the early 1970's, declining to about 5% in 1990/91.

has been done to build understanding of existing and emerging 'private' services in different localities.

Instead, the indications are that the MoH believes that changes in its role will simply lead to 'adequate tapping of the private sector' (GoT, 1994a, pvi). It is assumed that the private sector 'has the advantage of complementing the Government in the provision of health services' (GoT, 1994a, p33), although it is recognised that the government may have to remain the main provider of public services 'while the private sector is organising and consolidating itself' (GoT, 1994a, pix).

But what will the 'private' sector be organising and consolidating itself to do? As indicated already, NGOs make up the major proportion of the 'private' sector as described. The documents emphasise the role of NGOs as health service providers. There are some references to the role of NGOs working with the MoH and donors to implement preventative health programmes such as: Malaria control, Maternal and Child Health, Essential Drugs Programme; National Aids Control Programme; Expanded Programme on Immunisation; National TB and Leprosy Programme; Control of Diarrhoea diseases; Family Planning; Health Education; Oral Health; School Health; Control of Blindness; Mental Health; Village Health Workers; Control of Plague (GoT, 1996a, p8-9). However, there is no analysis of the extent and distribution of such contributions.

The HSR Proposals conclude that the introduction of user-charges are important to improving the health financing situation, and that the government is developing a National Health Insurance Scheme for those working in the formal sector. But they also recommend the need to increase private financing through earmarked taxes, lotteries, private payments, insurance schemes and community financing. However, in the absence of more information about what those actors outside government currently contribute, it is not clear whether the MoH has the capacity to, or can develop the appropriate mechanisms with which to influence an increase/ re-allocation of, financial resources for health. The Action Plan (GoT, 1996) identifies donors, NGOs, and voluntary and private practitioners as sources of finance. In the case of donors, it is able to present some quite staggering figures. Some 90% of health service development expenditure (as distinct from recurrent expenditure) comes from donors. Of the resources contributed by donors, 40% is allocated to preventive services (including the immunisation programme) and 57% to curative services. It is noted that the level of donor involvement requires better integration of vertical programmes at district level in order to improve the efficiency of its use (GoT, 1996a, p6). The Action Plan also contains some, albeit brief, discussion

about household expenditure on health. We are told that this accounts for only about 1.9%, although it is not clear whether this refers to 1.9% of an average household's expenditure, or 1.9% of spending on health nationally! We are also told that about 58% of household expenditure on health is for traditional birth attendants and traditional healers. However, there is no informed discussion about how 'private' providers such as for-profits and NGOs actually generate and allocate resources.

There are huge expectations about the potential of the 'private' sector to act as financier and service provider. But in a reform process which, according to the Action Plan, is expected to cost US\$ 608 million between 1996-1999 (whilst the recurrent budget for the health sector in 1996/7 was estimated at US\$ 83 million), there are few attempts made to explore this potential. The Proposals and Action Plan do not make clear just how the government has, and will, set about determining its role in the provision of equitable health services, nor how it will expand its efforts in 'preventive and promotive health care vis-à-vis curative care' (GoT, 1994a, p8).

Nor do they reveal on what basis it has been concluded that the liberation of private practice will improve accessibility, affordability, quality and satisfaction. Indeed, the evidence suggests that a large proportion of the 'private' sector (NGOs), and donors, dominate the arena of PHC, providing the very services and programmes that are most relevant to the 'poor and marginalised'. This begs the question of whether it is appropriate for the government to re-orient itself away from service provision. These documents feel their way round complex aspirations and assumptions concerning 'public' and 'private' split. In the process they make statements that cry out for much more considered exploration.

### **5.2.2 Health**

"The outstanding weakness is in implementing the policy. The policy was supposed to be implemented through the Primary Health Care Strategy.

Unfortunately, PHC was misconceived at all levels. There was inadequate co-operation between ministries, technicians and other stakeholders. Some donors shifted from comprehensive PHC to selective PHC strategies. The result was an ineffective seeding of the concept of comprehensive PHC to the community."

(GoT, 1994a, p9)

The Proposals and Action Plan maintain the government's commitment to PHC as the strategy for building a health care system that will be 'cost-effective, efficient and sustainable' (GoT, 1994a, p9). These documents point to the continued relevance of PHC to national health strategy given the country's health profile, with malaria responsible for 16.67% of deaths, AIDS/ HIV for 5.89%, diarrhoeal

diseases for 4.76%, prenatal/ maternal for 14.4% and so on (GoT, 1996a, p7). There have been successes attributable to PHC, as indicated by increases in the number of staff and facilities and improvements in life expectancy and infant mortality. These reveal a health system that has indeed been built on the principles of equity and self-reliance.

What is at issue is the way in which PHC has been resourced and implemented. Unfortunately, the government's spending has not reflected the importance of PHC (GoT, 1996a). For a start, it spends only US\$3.46 per capita on health, compared with the World Development Report's recommended US\$12. And, as already noted, the 'skewness of budgetary allocation' indicates an emphasis on 'disease rather than cause'. Given that many of the diseases in Tanzania are preventable, this justifies budgetary reform (GoT, 1996a, p5-6).

However, the documents are neither coherent on what lessons have been learnt from experience, nor on how these can be applied to moving forward with PHC-informed health sector development. Under 'Analysis of the Existing Situation', the HSR Proposals discuss the PHC Guidelines that were developed by the MoH in 1983 (revised in 1992). These guidelines are criticised for emphasising training of Village Health Workers (VHWs), raising 'misconceptions by some implementers who diluted the whole idea of PHC to mean only the training of Village Health Workers' (GoT, 1994a, p59). As I discuss in Chapter 4, by the early 1980's the government was shifting its key health service target from being one dispensary per village to establishing a village health post manned by a VHW. The HSR Proposals claim that about 10,000 VHWs were trained, but that there has been a high drop-out rate. In the copy of the Proposals that I have, the sentence concerned with how the situation is to be rectified is incomplete, perhaps due to a printing error.

There is also a tension running through these documents about whether to work with comprehensive or selective approaches to PHC. The Proposals state that whilst Tanzania adopted a comprehensive approach to PHC, the success stories have mainly been in selective PHC programmes 'with donors being at the forefront'. On the one hand, this has resulted in a number of vertical programmes that are poorly integrated into the health care delivery system, 'a situation which makes sustainability questionable' (GoT, 1994a, p61). But on the other, there are references to the importance of preventive services 'which are made up of multiple vertical programmes such as EPI, AIDS and TB/Leprosy (though the latter have some curative elements)' (GoT, 1994a, p29).

In the section of the HSR Proposals that discusses PHC, recommendations are made that included the need to:

- To make links between the PHC strategy and expected outputs and national targets;
- To conduct PHC training from the grassroots to District managers and higher;
- To develop PHC activities based on a multi-sectoral approach in order 'to eliminate the misconception of equating health to 'disease/treatment'';
- To 'continue to identify and train traditional birth attendants/ practitioners to foster entry points to community based health care';
- To 'adopt comprehensive PHC implementation while retaining positive elements of the selective PHC approach'<sup>4</sup>;
- To establish a plan of operations for PHC committees (which run from village-level upwards) with built-in monitoring and evaluation mechanisms; and
- To review the National PHC Strategy activities and expected outcomes/ outputs on a yearly level.

The section notes that more actors than the MoH should be involved in PHC implementation if it is to be sustainable (GoT, 1994a, p64).

However, as already discussed in the previous section, the activities of other actors do not receive a great deal of attention in these documents. It is clear that donor agencies are the main players when it comes to financing PHC programmes. The HSR Proposals refer to NGOs that collaborate closely with the government around family planning, citing the case of UMATI (the Family Planning Association), WAZAZI (Tanzania Parent's Association), UWT (Union of Tanzanian Women) and the Red Cross Society<sup>5</sup>. There is also some discussion of nutrition, as an issue taken up by Nyerere when he talked about fighting the three enemies of the people, disease, ignorance and poverty. Attention is paid to research conducted by the Tanzania Food and Nutrition Centre (TFNC), and the development of future nutrition goals. However, there is little said about other forms of action to tackle malnutrition around the country. Nothing is said, for example, about organisations such as the Tanzania Home Economics Association (TAHEA) which started life as

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<sup>4</sup> It is noted that: "Selective PHC can be useful as an entry point into the community for eventual development into comprehensive PHC at all levels." (GoT, 1994a, p64)

<sup>5</sup> At this point UMATI, WAZAZI and the UWT were associations still falling under the auspices of single-party state.



a government initiative, and which has as a top priority the improvement of nutrition.

The discussion about Community Based Health Care (CBHC), cited in the Proposals as one of the tools for implementing the policy commitment to PHC, is interesting because it does make a direct reference to an NGO. In 1993, AMREF was requested to conduct a study into the implementation of CBHC. It is recognised that previous government efforts have concentrated on improving health institutions for health service provision, leaving out communities and other sectors, and 'not changing the health status of the people of Tanzania' (GoT, 1994a). As a result of this study, AMREF proposed that the government provide more support to CBHC activities as a means to benefit the majority of the population and as a strategy representing the 'actual implementation of Primary Health Care'. It advocates that the existing regional, district, ward, village structure should be maintained because:

*"The structure provides an effective decentralisation and coordination of community involvement in the health sector in conformity with other sectors. The potential of linking Government and health administrative structures is further amplified by the results of the Community Based Health Care study. The study recommends approaches that will empower communities to organize their health and health services within well defined Government administrative structures. It is recommended that the Government provides more support to CBHC activities since they benefit the majority of the population and represent the actual implementation of Primary Health Care."* (GoT, 1994a, p66-7, emphasis added)

However, CBHC is not mentioned in the main body of the Action Plan. It does appear in the tables that form the Plan of Operation, appearing as Section 7.1 on 'Community Initiative for the improvement of health services promoted and strengthened'. This proposes activities such as helping communities to organise PHC social services (allocated US\$97,000 p.a. for each of the three years of the Action Plan); assisting communities to assess their health needs; incorporating community health needs into District Health Plans; making basic health care materials such as mosquito nets available at the nearest facility; training VHWs to foster CBHC (100 from each district at a cost of US\$456,000 p.a.); and involving communities in monitoring and evaluating health services/ facilities.

In conclusion, whilst PHC is declared by the MoH to be the national health strategy, whilst there are many references to the link between PHC and equitable health services, and whilst the Proposals advocate that deliberate efforts should be made to shift government resources towards preventive services, there is very limited

attention paid to why and how this should be done. The documents declare the strategy and then jump straight to some recommendations about the types of programmes and activities that could be adopted. No connections are made between PHC - either as providing a strategic framework or as a collection of programmes - and other recommendations about cost-sharing and other forms of health financing. There is no critical discussion about how the introduction of such forms of financing might affect affordability and access. As an example, although the documents refer to the need to support certain groups such as the 'indigent', they do not identify who the vulnerable groups might be and how the proposed policy changes might affect them.

### **5.2.3 Decentralisation**

"Devolution of authority to regional, district, and local authorities can increase the health system's responsiveness to local conditions and needs. Ideally, decentralisation promotes the development of health services by taking advantage of the locally available resources and placing more emphasis on the needs of the community. In Tanzania, the administrative structure has been decentralised to the village level hence bringing the decision making process closer to the people." (GoT, 1994a, p20-1)

The HSR Proposals make the connection between PHC and decentralisation as does PHC debate more generally. They refer to attempts in the 1980's to tackle growing problems in the health sector by adopting the PHC strategy and decentralisation policy (referring to the 're-introduction of local government'). The Proposals also refer to the problem posed by the fact that the concepts of decentralisation and PHC have not been well understood by policymakers, implementers and community members (GoT, 1994a, pvii). However, regardless of whether or not PHC provides the framework for the health sector in an age of reform, decentralisation is clearly a key organisational and managerial issue in the HSR proposals and plans.

To begin with, a number of problems are identified within the existing government service delivery system. One of these is the system of dual accountability. Health care management structures have followed existing government administrative structures, with different roles allocated to national, regional and district government. Therefore, whilst responsible for all other services, the District Medical Officer (DMO) is not the main officer responsible for health service delivery because the district hospital comes under the auspices of the regional administration (GoT, 1994a, pvii). The HSR Proposal notes that this has made it possible for the regions and districts to develop independent health sector plans and budgets, the

result being fragmentation, making national co-ordination difficult. The two existing co-ordination mechanisms are the PHC Committees at Regional, District and Village level, and the Regional and District Management Committees. However, the former do not meet often, and the latter 'are undermined by vertical programmes whose operations by-pass regional and district administrative structures' (GoT, 1994a, p24).

This lack of co-ordination leads in turn to: lack of comprehensive health sector plans, so that many activities are duplicated and donors by-pass the MoH; a failure to set or adhere to performance standards; and capacity building that focuses on 'individual rather than team building, and emphasises on knowledge rather than skills development' (GoT, 1994a, pvii). Factors which have rendered the decentralised health system less effective include the fact that the central level retains most of the authority, with, for example, vertical programmes being planned at central level with little or no participation on the part of the ultimate implementers. In addition, the concept of decentralisation is poorly understood. This leads to the by-passing of relevant authorities, and a 'tug-of-war' between regional and district authorities, not least over financial matters (GoT, 1994a, p21)

Whilst the Proposals veer between arguments for greater district responsibility and statements that pose freedom of district planning as a problem, decentralisation is ultimately put forward as a way of rationalising the current situation in the health sector. It is proposed that the DMOs be given the mandate to be responsible for all health service delivery. District Health Management Teams (DHMTs) should be given the appropriate support to improve their management, including their supervisory role. The District Health Planning Guidelines should be used to develop a health sector plan for implementing health activities at district level and co-ordinating donor inputs. In essence, all health services at district level should be under local government, DMOs, and answerable to the district council (GoT, 1994a, p22).

At various points in these discussions, references are made to the role of other actors. When outlining the problems experienced with the PHC committees and the Regional and District Management Committees, the HSR Proposals refer to the need to co-ordinate various actors. Those actors are listed as being: The MoH, the Prime Minister's Office, Local Government, NGOs, Traditional Healers and private practitioners. However, while the recommendations cover issues related to decentralisation within the government system, and whilst they state that capacity-building at all levels 'is mandatory in order to interpret and implement health and

health relates policies' (GoT, 1994a, pvii), they do not deal with the question of how other actors are to be involved in planning, or how relationships are to be managed at the local level. This is somewhat surprising given the acknowledgement that limited understanding of the concept of decentralisation and lack of the requisite management skills is recognised to have hampered previous decentralisation attempts. It might be expected that the question of how to engage with other actors would be addressed in the District Health Management Guidelines. However, quite apart from their complexity and density, the guidelines are rather technically-oriented, and based on the assumption that managers are organised in a clear hierarchical line within the government system. Whilst the language of policy is decentralised power, promotion of private services, and the importance of collaboration, in the Management Guidelines, reference to working with other actors is limited to statements like:

“In areas where there are ‘special’ programs financed partly or in total by external donors or NGOs, these *might* be represented in the District Health Planning Team.” (GoT, 1995, p25, emphasis added)

On balance, as in the international health debate discussed in Chapter 1, decentralisation is proposed to be a ‘good thing’, that will strengthen PHC facilities, bring people closer to the decision-making process and help to expand choice, but the HSR documents have yet to explain why this is desirable and appropriate, and how it is to be carried forward in a policy context that had already failed to deliver on such expectations in the past.

#### **5.2.4 Community involvement and management**

The term ‘community’ is mentioned with some frequency in the HSR documents. As might be expected, it is often discussed in relation to health financing. The HSR Proposals suggest that forms of community financing should be considered. By the 1996 Action Plan, this idea has become more definite with statements like:

“Cost-sharing will be extended to the health center and dispensary levels, and communities are expected to take full responsibility for financing their health services through formal and informal risk pooling mechanism, e.g. Community Health Fund.” (GoT, 1996a, pv)

The same document claims that part of the vision of HSR is that cost-sharing should be fully operational at the level of health centre and dispensary, with communities taking full responsibility for financing their health services (GoT, 1996a, p2). However, what is not discussed in either of these key documents is the question of

willingness and ability to pay, although a piece of consultancy on this very question was commissioned by donors, and available in 1994 (Abel-Smith and Rawal, 1992). What is lacking, therefore, is a proper analysis of what 'community' means, and what capacities exist for communities to take action on statements such as 'community input in the management of services delivery units should be encouraged' (GoT, 1994a, p27). For example, the HSR Proposals recommend, under organisational issues, that more PHC units (meaning facilities such as dispensaries) should be built according to need. However, there is no analysis here of whether that is feasible, or, as discussed in Chapters 6 and 7, of the long-existing involvement of communities in providing core health services infrastructure such as dispensaries and staff houses.

As already indicated, there is mention in some places of CBHC, the guidelines for which are cited as one of the key documents of the current health policy in the HSR Proposals. However, CBHC is not discussed coherently in those proposals, and it is not clear what, if any relationship it has with HSR. There are statements like:

"The health services delivery system at all levels should be integrated. A multi-sectoral approach should be adopted in the implementation of a Community-based Health Care (CBHC) system." (GoT, 1994a, p22).

Thus, whilst the HSR Proposals refer to the need to 'improve the capabilities at all levels of society to assess, analyse problems and to design appropriate action through genuine community involvement', and whilst the Action Plan identifies some activities and allocates some funds towards this type of improvement, one is left with the distinct impression that the existing and potential role of 'community' is yet to be further explored. In the meantime, the prevailing view of policymakers of the role of the community seems to be aptly captured by one statement:

"The ordinary Tanzanian will be involved with the reform through acceptance of policy changes." (GoT, 1996a, p11)

### **5.3 Policy implementation**

A statement in the early days of reform was that HSR would be holistic, involving central government, local government, NGOs, communities and private practitioners (GoT, 1996a). The interviews I conducted in 1995 and subsequently, do not suggest that such holism has been achieved. It is worth reflecting on what has actually been happening. I do that in this section using two documents that were produced from a joint MoH/ donor review process conducted in late 1997 and early 1998.

One of the most striking things about the documentation that comes out of this 'technical' review (conducted by a team of 11 external consultants and 8 national consultants), is the significant change in language and tone from the HSR Proposals and 1996 Action Plan. HSR is now something started in 1994, not with the long history claimed for it in the earlier documents ! The presentation is glossier and reflects the involvement of consultants. A glance down the contents pages of the Review (GoT, 1998) reveals terms like: 'SWOT' (Strengths, Weaknesses, Opportunities, Threats), 'The Reform Dream', 'POW' (Programme of Work), 'The resource envelope' and SWAPs (Sector Wide Approaches). Other terms, most noticeably PHC, are now missing.

The terms of reference (ToR) for the review request the consultants to 'review HSR as relates to strategy, devolution to districts, integration of vertical programmes, basic package, HMIS [Health Management Information System], institutional and financing issues' (GoT, 1998, p14). In a section referring to strategies for HSR, the two key themes are identified as being the development of more rational use of resources and addressing the organisation and management of health services. There is no mention of PHC as an overarching strategy or even as an aim. In Chapter 1 of this thesis, I talk about the ways in which health debate refers variously to health sectors, health systems and health action, each of which implies setting different boundaries. The Tanzanian HSR Proposals and Action Plan talk in terms of a continued commitment to PHC as providing the framework for reforms. However, the review document of 1998 sets very different boundaries, focusing, as this statement shows, on health services not on wider health issues:

*"The main killer disease is Malaria (29% of all deaths of children of under 5 years). Further problems of public health importance are communicable diseases.....Although improving those problems require solutions that cross sectoral lines, in this document, we will analyze only the health services."*  
(GoT, 1998, p11, emphasis added).

Such a statement runs counter to a comprehensive PHC perspective of health systems. Yet, the reader is told a couple of pages later about the Health Sector POW or Programme of Work for the years 1998-2001 (it is not clear what happened to the Action Plan of 1996-99). This is ostensibly building on the earlier HSR proposals and plans, and should be seen not as something new, but as a framework that helps to broaden the scope of the earlier plans within a SWAP (Sector Wide Approach). So it seems that the boundaries being set for HSR now are the formal health service

delivery sector itself, and that the scope of work within those boundaries is being broadened. But how?

In terms of HSR as a policy process, the SWOT analysis reveals 'consensus on the conceptualisation of HSR'. One assumes this means in the terms already discussed, and as captured by the objectives described under the vision of HSR. These refer to organisation and management changes, in particular devolution of authority and the role of the MoH as regulator providing an enabling environment; to building effective health services (equitably distributed, manned by qualified staff, with integrated vertical programmes); sustainable health care financing; adequate drugs, medical supplies and logistics; and human resources development.

However, important weaknesses include the failure to involve key stakeholders (the example of CSSC is cited) in the preparation process. The review document notes that opportunities and threats include the willingness of not-for-profit organisations to participate, although there have also been fears expressed by both not-for-profit and for-profit organisations. And, an interesting point in terms of inclusion in, and exclusion from, policy development, the lack of a 'champion' for reform.

Although these documents refer to NGOs, as might be expected, the implicit understanding of NGOs is that they are private health service providers. The documents are not much clearer than their predecessors about what is meant by 'private' or about what these 'private' agencies actually do. However, there are a couple of comments that intriguingly coincide with the few references made to PHC, promotion and prevention. The Theme Report prepared for the Review refers to MoH collaboration with donors, Voluntary Agencies and NGOs providing preventive and promotive health services (GoT, 1997b). In the 1998 Review, there is a discussion about improving service coverage through partnership with the private sector, which comments:

"The private sector is the major provider of health services in Tanzania. While there is no reliable information on for-profit providers, it is commonly recognised that voluntary agencies are providing about 50 per cent of hospital services and 24 per cent of PHC services throughout the country." (GoT, 1998, p56)

Talking to one donor about where NGOs fit in to the reforms, I was told that this is 'conceptually as an equal player' (D1/98). The reference made was to the idea of the District Health Plan as representing not just the government's health plan, but all the health needs of the district. This requires all stakeholders to be involved, bringing 'the NGOs up as a full partner'. This donor continued that NGOs should work at the district level, make themselves credible in the district, get in touch with the district

health boards making their presence and opinions known, 'and there should be no barrier whatsoever to their being involved in the planning process' (D1/98). As I will discuss in Chapters 6 and 7, not only do barriers exist to NGO involvement in planning, but those barriers are not so easily overcome. This has been evident from the start of the reform process. As this same donor admitted, echoing others, NGOs are difficult to work with in the sense that '...we have a job finding out who is actually who in this country. I mean we are not Tanzanian, we are here for a maximum of four years' (D1/98). This leads to a preference for dealing with one group or even one particular NGO as a 'representative'.

On the question of health financing, the ToRs for the Review note that some practical problems have been experienced, such as weather conditions and the late arrival of consultants<sup>6</sup>, making it difficult to follow some issues through:

"An example of this was the inability of the team to visit Igunga district to study the community health fund experiences... {prohibiting} the team to perform the in-depth review of the Community Health Fund." (GoT, 1998, p15)

This refers to the piloting of Community Health Funds (CHF) that was begun in earnest in 1996 in pilot districts, including Igunga and Nzega Districts in Tabora Region

In terms of cost-sharing, although the Action Plan of 1996 referred to the introduction of user charges to referral, regional and district hospitals, and to a success that has led to plans to continue to extend this to health centres and dispensaries, a stop was put to this after a debate in the National Assembly in 1996.

The 1998 Review reflects on the role of the District Health Boards (DHBs), citing their strength as lying in their autonomy, whilst being responsible to the District Councils which 'means community control over management of health services is recognised'. In addition, District Health Plans provide a basis for a contract between the MoH and the Health Boards (GoT, 1998, p27). However, there have been tensions in implementation, with delays in improving boards, leading to a demoralisation of DHMTs, a lack of clarity on the roles and responsibilities of the DHBs, and the MoH's failure to meet obligations by not delivering resources.

The Review document discusses elsewhere the role of the DHMT and other actors:

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<sup>6</sup> Although more than one person has commented on the tendency for people on donor missions to be reluctant to travel outside Dar es Salaam (see, for example, G1/95).



“At the district level, the DHMT is responsible for overall sector planning (the district plans), in co-ordination with all stakeholders. This *implies* that the other stakeholders have a representation on the District Health Boards for setting the overall policies (no taxation without representation). Furthermore, the district health board could contract with the private sector for certain service (laboratory, maintenance, cleaning...) or for covering a specific population (Designated Hospitals or dispensaries).” (GoT, 1998, p57)

But who are these stakeholders referred to in the rather cryptic statement, ‘no taxation without representation’? The roles of, and connections between, various actors is still not clear. Whilst ‘community involvement in management’ is recognised as a strength, it is not clear how this is being built in practice. It is recognised that the lack of village and ward health committees means that the DHMT is effectively making the district health plans, which it is noted, amounts to top-down planning. In a somewhat surprising reference given the overall lack of discussion about PHC, it is remarked that ‘experiences from PHC activities are not used in plan design’ (GoT, 1998, p27). It is stated that until the roles and responsibilities of the various actors, such as village committees, are decided, it is not possible to identify the capacity needs of each group (GoT, 1998, p59).

In this document, and in some follow-up interviews I conducted with donors in 1998, it is evident that all parties have become more philosophical about what is feasible, and more cognisant of the ‘stickiness’ of change. One donor talked about the time it has taken to address the legal changes that have been needed in order to empower district health boards. This was ultimately conducted not through one national law, but by a series of bylaws (D1/98). However, as I discuss in Chapter 1, there does seem to be a persistent assumption that if you just decentralise then the district remains the point at which things will simply happen.

The ‘community as consumers’ aspect of the community involvement in health debate seems to have gained ground by 1998, with most of the discussion of community (limited in any case) being about health needs, and ability and willingness to pay. The link between community action and preventable diseases is not made in the 1998 Review, which does not mention CBHC either. It does, however, note that:

“The technical vision of health services post reform must be put in a social context.” (GoT, 1998, p20)

In other words, as the document goes on to explain, the health system comprises three elements – the community, the health service delivery system, and the

environment in which these two are located. This environment (meant in the broadest sense to include demography, socio-cultural factors and so on) exerts a major influence on the nature, volume and quality of health service available. The extent to which the community is involved with health care influences health problems, needs and the nature and quality of the health service delivery system. Health planners must take these factors into account (GoT, 1998, p20). The document also notes general trends, such as the move towards greater popular participation in the social sectors:

“The reform process that is ongoing in the health sector in Tanzania is a sector specific actualisation of the overall political democratisation process. The overall direction is one of involvement of all actors beginning with the community. The ultimate end-point is to devolve power fully to the districts which will enable area specific priority setting.” (GoT, 1998, p20)

Finally, we are told, under ‘The Reform Dream’, that ‘The reform at its maturity will be substantiated by how much motivation for health action is achieved at the individual and family levels’ (GoT, 1998, p21). However, the documents do not indicate that ‘health action’ at either of these levels has yet been addressed under HSR. Indeed, as one donor admitted, PHC in any form has not yet received any attention, as HSR has focused on formal health services (D2/98). It is not clear whether there are any plans to go further.

As I discuss in both Chapters 1 and 4, the term ‘community’ trips easily off the tongue, but its various meanings and the complexities involved in working with communities, tend to be left to one side. The HSR documents of 1994 and 1996, rely on the notion of community involvement as projected since independence. The 1998 Review document goes little further beyond this, apart from mentioning the word ‘democratisation’. In addition, it implies that the process of community involvement in health and development activities is comparatively new. It refers to the need to develop strategies for rewarding community members who devote substantial time to health service management, and to improve the transparency in handling of community funds and so on, without referring to the practical experience of programmes and organisations already working in these areas in Tanzania. One leading donor I interviewed in 1998 had this to say of my question about what had happened to PHC:

“...you can have a number of policy declarations that primary health care is the way...Having said that, I don’t think that primary health care should be an aim in itself because we can’t say that we are going for an holistic, sector-wide

approach in order to get the best use of resources, if you define in advance what the priority areas are.” (D1/98)

This donor went on to make the point that different areas need different mixes of services, and that the nature of that mix should be up to the local community in the first instance – their health problems, their health profile. It seems that there is a persistent tension between attempts to sharpen boundaries around what HSR is about in terms of formal service provision, and how to make sense of the concepts of PHC, community and decentralisation, that involve casting the net more widely.

## **5.4 Conclusions**

This chapter set out to explore what is being said about NGOs with reference to health development, health systems and HSR. It addresses the fieldwork question ‘do, and if so, how do, NGOs seek to influence national and international agendas for the continued promotion of PHC approaches?. Finally, as I explain in this conclusion, it illustrates why I selected the case of CBHC as a means of investigating my other two fieldwork questions.

There are general and specific conclusions to be drawn from the data discussed. The specific conclusions pertain to NGO practice in health in the Tanzanian context. The indications, from these interviews and from the HSR documentation produced between 1994 and 1996, are that neither Ministry of Health, nor donor agencies, nor NGOs themselves, have thought systematically about the role of NGOs in either the health sector or health development more generally.

*NGOs as private health service providers:* Where NGOs are referred to it is generally as ‘private, not-for-profit organisations’, although the MoH documentation uses this terminology interchangeably with terms such as ‘religious organisations’ or ‘voluntary organisations’.

Three points should be made about this. The first is that the ad hoc application of different terms suggests an absence of thorough research into NGO activities, and of discussion about where NGOs fit in to HSR. In fact, the HSR documents are rather more anecdotal than analytical on this subject. The second point is that the emphasis is on NGOs as providers of formal health services, such as dispensaries and hospitals including the district-designated hospitals. As the HSR documents themselves indicate, the level of this service provision shows that NGOs are significant actors in the health system. This is a fact that merits further study, as for example, being undertaken by the CSSC, which since 1996 has been conducting research to chart, assess and compare church-supported health services. Finally,

whilst some people refer to the desirability of NGO involvement in health policy discussions, the prevailing idea of NGO involvement is around their work as implementers at the district level, not as potential partners at the policy table.

*NGOs as policymakers:* However, there are indications from this fieldwork that NGOs are - or potentially are - organisations with justifiable contributions to make to policy. Yet, even from those donor and ministry staff who indicated that NGOs should be involved in policy discussions, little thought had been given as to how NGOs could be included - or, in other words, to the barriers to inclusion.

These barriers are significant, and apply not just to NGOs, but also to local governments. Some of those I have interviewed, both in NGOs and other agencies, point to the *limited capacity* of the vast majority of NGOs to influence or prompt change at a central level. Most NGOs do not have the capacity to support staff dedicated to policy-related matters. Larger agencies such as the ELCT, or the CSSC, do perform such functions, and in these cases have staff who are familiar with key policy issues, and who are conducting relevant research. However, most of the NGO staff I have interviewed have been fieldworkers not researchers or policy analysts. Their knowledge of relevant areas of government policy has consistently revealed itself to be no more than what can be gleaned from newspapers, radio, and informal discussions with colleagues. Or else from their own experience as health service users who are dealing directly with some of the implications of the changes in the health sectors. As interviews conducted in 1996 and 1998 show, these are not people who see themselves as either having a need to make thorough reference to government policy documents, or as having a place in contributing to such policy. For most, it is not evident how the detail of policy debates and processes relate directly to their work.

So barriers to policy action include *access to information and communication facilities, perceptions about who should have a say, the will to engage, the capacity to do so, and limited research and knowledge concerning NGO locations, policies and activities*. On the other side, donors and government have limited contact with organisations and programmes around the country, unless they fall within the remit of their own geographical or sectoral interests. However, it is worth noting that by 1998, a number of national consultation processes on a variety of policy issues were being initiated, and being conducted outside Dar es Salaam. In addition, I know, for example, that in 1996, the British Overseas Development Administration (ODA) invited NGOs to present their activities at a review of ODA's support to health in Tanzania. In 1998, the Aga Khan Foundation (AKF), taking the lead from a similar

meeting hosted by the AKF in the United States in 1997, prepared a workshop on the role of NGOs in Health Sector Reform in East Africa. In 1998 I found myself at the second meeting of a proposed NGO health forum, on that occasion being hosted by the WHO. It seems that the birth of the forum lay in an initiative of the World Bank, which had organised a meeting of some of the NGOs ('put us together' was how one of those present described it). Apparently about a week later, the WHO came up with a similar idea in the wake of the WHO conference in Dakar in September 1997, the subject of which had been partnerships in health. From what I could gather, the purpose of the proposed forum will be to develop a new Memorandum of Understanding between the MoH and NGOs working in health. From what I have seen of such activities however, the emphasis is still on NGOs in their capacity as health service providers. Those engaged in broader forms of health action are less likely to be noticed. As a footnote, HPA, which supports the CBHC programme I discuss in Chapter 7, was signed up with the Ministry of Health in its first technical agreement. When it came to renew this agreement in 1998, it was advised that it should now sign its technical agreement with the Prime Minister's Office, now the office that is responsible for developing the emerging NGO policy. However, from the research conducted in 1995 and 1996, it was evident that there are a handful NGOs that adopt a systematic approach to research, lobbying and advocating around national health policy. The example that most interested me was the reference to AMREF's study of CBHC, largely due to the fact that CBHC appeared in the HSR Proposals as a strategy for implementing PHC.

*NGOs and PHC* : The chapter indicates that the HSR proposals are a mixed bag of references to curative health services, to health promotion, and to the role of community. This suggests that various understandings of 'health', and of how to improve health, coexist within them. Many of the indications are that NGOs are important in the promotion of activities on the edges of the formal health sector. For example, there are references to the involvement of NGOs in projects that fall under the National AIDS Control Programme. There are references to the role of AMREF in assisting the Ministry of Health in evaluating the national PHC strategy and in advocating the CBHC approach to promoting community involvement in health. Many of these initiatives are not concerned with primary health service delivery, but often involve activities outside the formal health system. For example, many of the NGOs involved in the National AIDS Control Programme are promoting community based condom distribution and education. Yet whilst these projects are deemed to fall under the aegis of the MoH, the HSR documentation does

not explore them in detail. It does not address any links between HSR and NGOs working to promote PHC.

Similarly, neither the MoH documents nor the interviews with MoH, donor agency or many NGO staff indicate any notion that NGOs act as 'community activists'. Those who mentioned NGO involvement in the National AIDS Control Programme spoke of them as 'contractors', participating on an advisory committee, with individual NGOs taking on specific tasks. Otherwise, there are only some general references to NGOs working in preventive and promotive health services, and calls to NGOs, as well as donor agencies, to implement the PHC and other advocated guidelines (which include Guidelines on Information, Education and Communication, CBHC, Village Health Workers and so on).

There are also clear indications of the government's extremely limited capacity to undertake PHC activities. And indeed, some NGOs see their role as being in support of health services, systems and management, which includes at times providing technical support to the MoH in the interest of promoting PHC systems (N8/98). Whilst in the HSR Proposals and Action Plans the indications are that the government intends to reorient itself in favour of such activities, it is clear, particularly in the 1998 Review documents that the key actors in this area are donors, and NGOs. As noted in Chapter 4, the Titmuss Report of the 1960's also advocated that government take responsibility for primary health and prevention and that missions/ NGOs focus on health care services. Certainly, the Tanzanian government has made huge inroads in terms of its role in providing the primary services that are the cornerstone of PHC, but in the 1990's it is still striving to be the lead actor in PHC. However, the documents and interviews cited in this chapter do not explain why. It would seem appropriate, if NGOs are important in PHC activities, to look in more detail at why they are, what they do, and how this relates to the government's reforms.

The more general conclusions arising from this chapter concern the policy process itself. There are a host of reasons - ranging from the need, in democratic systems, to ensure that reform programmes are valid and acceptable, to accountability for decisions that involve committing to more external loans and grants, to the practicalities of implementing a programme of reform in which few have any stake or sense of ownership, to making sure that the reforms have been designed to fit with the actual context - for developing a consultative policy process. However, whether expressed as indignation against donors, or against the MoH, it is clear that many of

those I interviewed have been excluded from something in which they feel they should have a role:

“Health Sector Reform is the game of the World Bank, giving Tanzania debt for no fruit. It requires the starting of new institutions. For example, the insurance mechanisms requires organisations in the villages. But they [the World Bank or MoH?] don’t know if these organisations exist, and in any case, most people are in the informal sector. When people, for example, from Muhimbili, raise objections, the Ministry of Health says: ‘you guys have academic arrogance.’”

(G2/96)

I stated in Chapter 3 that I understand policy to be a process. That is to say that the arrival of an issue on the policy agenda, the development of plans to address that issue, and the implementation of those plans, is a process that takes place over time, and which involves many actors along the way. For that reason, I am interested in who is included and excluded, and why. This point is important in this chapter for a number of reasons. Firstly, I set out to establish whether NGOs are involved in national policy processes, and have indicated that some agencies are in a limited way. Secondly, my discussion of the HSR policy process contributes to a better understanding of where NGOs fit in to the institutional context. Thirdly, it highlights the point that what constitutes the ‘problem’ and what the ‘solution’, is strongly dependent upon who has been involved in the policy process, and indeed, who is deemed to have a legitimate role. In Chapter 1 I discuss the WDR of 1993 presenting my concerns about certain oversights, not least regarding PHC. In this chapter I have looked at early Tanzanian HSR documents that are framed in terms of PHC, the philosophy which has guided health policy in Tanzania since the 1970’s. However, in the 1998 Review document it would appear that the perspective of the WDR has won the day. For many of those I interviewed in 1995, the possibility that such a thing might happen was a cause for concern. For some of those who feel excluded, the challenge has been thrown down:

“Public policy makes a difference. Can we influence it? We have a path which is money-led. In other words, get to stage two and we will give you the next block. For a long time we have not been providing proposals from within. There are many paths. Challenge ourselves to influence...Reform also means reviving what has broken down...we talk about reform as if it is finance. We forget the preconditions, for example, the public-private interface.” (O1/96)

It is evident that those who have been excluded do not always stake their claims to a policy role. For example, the CBHC Training Guide produced in 1996 does not refer

to HSR as such, or to the way in which practitioners of CBHC can link their activities to the reforms. I have found that many NGOs are no more sophisticated or nuanced in their articulation of their role in health than donors or the MoH. Although some NGOs have undertaken research initiatives, or hosted discussions about the role of NGOs, I am not aware of efforts to take these discussions much beyond service provision in the formal health system. One might simply leave it there, on the basis that if actors such as NGOs are not being thoroughly explored and are not being involved in policy design this simply arises from their lack of significance in the health sector. However, throughout this chapter it has been clear that: a) NGOs are major providers of health services; b) that they play a role in PHC promotion in a context in which the government admits it should do more; and c) some NGOs do engage in policy discussions. Having prior knowledge of CBHC as an approach to village-level health programmes, and one usually mentioned with reference to NGOs, I was struck by the identification, in the HSR Proposals, of CBHC as a national strategy for implementing PHC. This provided confirmation that CBHC would be an appropriate case through which to further explore the role of NGOs in promoting PHC at community through to national level. This is the subject of the following two chapters.



## 6

# Implementing PHC: The case of Community Based Health Care

The purpose of this chapter is to identify '*what is going on?*' in terms of NGO promotion of CBHC. The chapter primarily addresses the fieldwork question:

- In what ways do NGOs act as 'community activists' in promoting PHC at the community level?

This chapter links the previous chapter, which explores national health policy making, and Chapter 7, which looks at health sector reform and CBHC promotion from the perspective of local level actors (Regional, District and NGO health and development workers). It does this in two ways.

Firstly, the chapter discusses why NGOs are involved in CBHC promotion, and what they are trying to achieve. I do this in sections 6.1-6.3. This enables me to discuss - in section 6.4 of this chapter - answers to the two questions that I used when designing this research (see Chapter 5, section 3.4.3.):

- Why do NGOs exist? What is the division of labour and responsibilities between organisational forms? and;
- To what extent and why do NGOs differ from other forms in terms of performance, efficiency, equity, clients, strategies and outputs? (Anheier, 1995)

Secondly, in doing this, the chapter provides some of the institutional context to Chapter 7. It reflects, in the concluding section, 6.5, both on the extent to which NGOs are committed to the values of PHC and the promotion of CBHC, and on the nature of the links, and the lack of links, between NGOs and government.

The chapter concludes that CBHC, as proposed in the conclusion of Chapter 5, is indeed a relevant and feasible case through which to explore the role of NGOs in promoting PHC and their potential for informing HSR. From this case, this chapter then concludes that NGOs might be best understood by policymakers reforming the health sector to be public actors engaged in networks of public action. This notion is taken up in Chapter 7, which explores how this form of public action manifests itself in a local context.

As described in Chapter 3, the data that forms the basis for this chapter was largely derived from interviews with NGO staff in Dar es Salaam, Arusha, Moshi, Mbeya, Tabora and Singida Regions. The discussion in the chapter also makes extensive use of brochures, leaflets and programme documents where I was able to obtain these from the NGO. There are two reasons for this. Firstly, I felt that this level of detail would be necessary for those who are neither familiar with the work of NGOs nor CBHC promotion. This is of value because, as I discuss in Chapter 3, just locating, finding out about and scoping NGOs and their activities continues to require time-consuming research in the absence of comprehensive studies, directories and NGO networks in Tanzania. Secondly, organisational literature produced for public consumption, and interviews with individuals, provide very different types of information. Organisational literature amounts to a formal statement of intent at a point in time, and has the benefit of presenting a certain type of structured thinking. It helps to define the proposed shape of an organisation and the scope of its activities. An individual, on the other hand, will often present a differently structured or apparently partial picture. This is partly because they may not be familiar with all components of an organisation or programme. It is also partly because their working reality is inevitably more complex and dynamic than organisational literature can convey. For these reasons, I felt that it was important to make use of relevant documentation, particularly in section 4.2 of this chapter, which looks at the objectives, modes of implementation, and outcomes and evolution of CBHC promotion by NGOs. However, I attempt to use this documentation reflectively, making use of interview data in the discussion.

## **6.1 CBHC: The approach**

Originally developed by AMREF in Kenya, CBHC is the complement to the more familiar Institution Based Health Care (IBPHC) approach to Primary Health Care (N1/98; N2/98). It is now widely used in Tanzania and Uganda. CBHC is concerned with individuals and households, as they are located within the wider community setting. In other words, looking beyond the health service delivery unit itself. It focuses on the basic PHC problematic: that the majority of cases<sup>1</sup> presented at village health posts and dispensaries are 'home-preventable'. They tell the tale of poverty - in income, environment (sanitation, water sources, housing quality), education, power and organisation. The CBHC approach recognises that these are

issues that no health service facility can address alone, even if the facility is well-resourced and has the capacity to deliver quality health education. Indeed, as I indicate in Chapter 4, for the CBHC practitioner, unless peoples' knowledge, attitudes and practices (KAPs) are tackled, dispensaries and health centres are in danger of being no more than 'disease recycling centres'. Therefore, CBHC seeks to develop health awareness and healthful practice within a framework of empowerment. It focuses on community, on local needs and understanding, on local organisation and resource, and on managing linkages.

The community focus is about collective action. This is very simply expressed by the notion that a recurrently sick child is a burden on a mother's time, which is in turn an issue for the household (in terms of maintenance of livelihoods). Recurrent and unresolved problems for a household are an issue for the community, and ultimately, what cannot be dealt with by the community is a concern for the nation (N3/96). CBHC therefore makes a direct link between individual health problems and collective action. Individuals are important, not simply as individual users of health services, but as actors who take on broad communal responsibilities, and who are in turn supported by a national system.

Within CBHC, working with local needs and understanding is about recognition of diversity between and within communities. The provision of standardised packages in health service and education is not appropriate to all, justifying a place for community-oriented approaches to health. Health education messages delivered from health facilities are deemed by many CBHC practitioners to have a limited impact on the practices they are attempting to change. This is because they are usually externally derived and not based in local realities and institutions. Using a learner-centred approach to introducing PHC concepts (including disease cause and prevention), CBHC seeks to develop understanding within the community, and local agreement about appropriate changes that can be made in practice.

CBHC is also concerned with local organisation and action, and focuses on building management skills at community level (N3/98). Through a process of facilitated dialogue, research, analysis and planning, community groups identify locally feasible action priorities. A classic example of the use of CBHC dialogue is in communities organising for the rehabilitation or building of a dispensary, which is how many agencies have made original contact with villages. Questions and

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<sup>1</sup> The profile of cases seen at this level includes malaria, diarrhoea, respiratory diseases, worms, and malnutrition. The impact of these health problems is most tellingly apparent in high levels of infant and maternal morbidity and mortality.

discussion about whether the dispensary is the real, only or most immediate solution to the key health issues of the community, can lead to the identification of particularly prevalent health problems, such as diarrhoea. The causes of these health problems are discussed, as are the possible forms of prevention. Such dialogue commonly concludes with the question 'what will the community do now?' (N3/96). Through this process actions or activities other than rehabilitating or building a dispensary can be identified and acted upon. In the case of diarrhoea, these might include house-to-house visits by community members to share information about disease cause and prevention such as the importance of boiling water or how to prepare oral rehydration solution. It might lead to decisions to tackle the water supply situation, or even take the discussion into areas such as the quality of village leadership or the non-existence or composition of the village health committee.

This process is a key element in supporting local organisational capacities, because it tackles issues such as who is involved in decision-making, and how limited local resources are both mobilised and used. As such, CBHC touches on community financing activities, the emphasis being on minimising community dependence on external support. It is concerned with the development, maintenance and management of resources, and may promote activities that include start-up support for income generating activities, payment in-kind arrangements for community health workers and health services, and Bamako Initiative-style schemes for managing community-based payment and distribution of drugs.

CBHC practitioners I have interviewed in Tanzania tend to talk about the importance of the CBHC approach in terms of the perceived failures of earlier PHC initiatives. The national promotion of PHC in the 1980's followed the existing government administrative system, seeking to establish PHC committees at all levels, right down to the village government. The composition and roles of these committees was stipulated centrally. The stated aim of many CBHC practitioners is that organising forms and structures should not be predetermined, but developed by each community. This is in part a reaction against the rather formal and bureaucratised approach previously taken to PHC implementation, which, as noted in Chapter 5, did not in fact lead to active PHC committees. For CBHC practitioners, the problem in the past has been that PHC promotion in villages has been top-down and health facility-led rather than community-led (N5/96), an approach that leads to 'committee-based' rather than community-based health care (N3/96).

Finally, although the main focus of CBHC is at the community-level, the approach recognises that linkages between communities and other actors in the social service system are important, and must be promoted and made more effective. It is multiactor and intersectoral, encouraging CBHC trained Community Own Resource Persons (CORPS), Village Health Workers, Traditional Birth Attendants, religious and political leaders and government extension staff to work together at the village level. In order to move beyond duplication of work, or single, vertical programmes, CBHC also attempts to build intersectoral and multiactor awareness and committees at other levels from ward to district to region, drawing together communities, local government and NGOs.

## **6.2 CBHC: The practice**

This section looks at the work of 5 NGOs that explicitly refer to CBHC in their programmes or activities. These organisations are AMREF, World Vision Tanzania (WVT), Health Projects Abroad (HPA), the Evangelical Lutheran Church of Tanzania (ELCT), and the Community Based Health Care Council (CBHCC). The material discussed here is drawn from brochures, reports, and in most cases, interviews with staff. In all cases, there is a vast amount of rich information and detail that could be discussed at length. I have attempted to capture the essence of the practice of CBHC by reflecting on three aspects. These are: a) the objectives that prompt the project or organisation to promote CBHC; b) the nature of CBHC implementation itself; and c) the outcomes of CBHC, and its evolution within the project or organisation.

### **6.2.1 The objectives of CBHC promotion**

The mission statements and objectives of these NGOs and their programmes clearly reveal that they are motivated by an holistic understanding of health, and by a desire to 'transform', 'enable' and 'conscientise' people in communities. In the brochures and other documents I obtained, this type of language is used to a greater or lesser degree. For example, an evaluation by AMREF of its Rukwa CBHC programme is couched more in terms of health statistics than the language of empowerment. However, in interviews with the CBHC practitioners associated with any of these programmes, such language is strong.

The Community Based Health Care Council, founded in 1992, 'believes that development originates from a conscientized community being aware of the problems around them' (CBHCC, undated, p2). The aim is to empower people to initiate, plan and implement health and socio-economic activities. This intention is

shared by Health Projects Abroad, a British NGO established in 1990, which, according to its ethos, seeks to work 'in partnership with community-based groups to develop innovative, appropriate and sustainable approaches for the maintenance and improvement of primary-level health and education' (HPA, 1996). HPA's intention is to build on the principles of 'inclusion, ownership by the primary users and democratic consultation' in supporting community health-related infrastructure projects (dispensaries, water/ sanitation, primary school buildings), community management capacity building, and health education activities.

In the case of the CBHC Council, promotion of CBHC provides a rationale for taking a broad and empowerment-oriented approach to tackling health issues and status. Organisations such as World Vision Tanzania come to CBHC promotion through the logic of their established empowerment-oriented approach to community development. WVT has been working in the field of community development in Tanzania since 1981, and is part of an international, inter-denominational Christian partnership. In the mid-1990's it was the largest NGO in Tanzania with an income/expenditure of US\$4,286,959 in Financial Year 1995 (WVT, 1995a). With headquarters in Arusha, WVT was operating over five zones in 1996 (referred to as Arusha, Northern, Kagera, Central and Lake Zones). In addition, WVT has been involved in running special programmes, which in 1996 included a programme in Kahama aimed at reducing child and maternal mortality rates. It also included management of part of the British Overseas Development Administration's programme (N12/96), which fell under the national HIV/AIDS programme. WVT does not have an organisational goal or objective for CBHC promotion as such, but uses CBHC as an approach within its Area Development Programmes (ADPs) discussed in section 6.2.2. The WVT vision, as expressed by one staff member, is to enable communities to promote health using minimal external assistance, where training is the backbone of self-reliant health (N3/96). The CBHC approach is in line with WVT's commitment, as expressed in its corporate mission statement and key objectives to promote 'transformational development that is community-based and sustainable, focused especially on the needs of children' (WVT, 1995a). WVT is also concerned with the 'promotion of justice that seeks to change unjust structures affecting the poor among whom we work'.

Similarly, AMREF's *raison d'être* is not CBHC promotion as such, but its mission, and the interpretation of that mission in practice, have led to the development and adoption of this approach in much of AMREF's work, guided no doubt by the fact that for AMREF:

“ The primary health care strategy is the basis for most of the activities, with special emphasis given to community participation and gender equity.” (AMREF, undated)

Operating from headquarters in Nairobi, AMREF has four country offices, in Kenya, Uganda, Tanzania and South Africa. In 1996, AMREF was promoting its concerns through five programme areas: sexual and reproductive health; child and adolescent health and development; environmental health; health policy and systems reform; and clinical services and emergency response.

AMREF has a long history in Tanzania, being involved in a range of health activities, including the running of a Flying Doctor service, epidemiological research and, like WVT, managing part of the national HIV/AIDS programme. AMREF has been involved in a number of CBHC projects and programmes, designed and managed by the members of its CBHC unit. Projects include the Safe Motherhood Initiative Community Education project in the Temeke and Kilosa districts of Dar es Salaam (which was initiated by a consortium of UNICEF, UMATI, the MoH, the Ministry of Community Development, the Christian Medical Board, and UWT) (N1/96), and AMREF's work as a sub-contractor for two years to SwissAid on their Kilombero District Health Support project. The most prominent however, is the region-wide Rukwa programme that AMREF co-ordinated between 1988 and 1996. The programme was implemented in two phases with different objectives. In Phase 1, the objective was to:

“Improve the health and nutritional status of children between 0-5 years through a community-based health care approach.” (AMREF, 1996)

In Phase 2 this became:

“AMREF aims to contribute to health and development in Rukwa region by improving and sustaining childhood immunization coverage as well as tetanus toxoid through strengthening of Primary health Care/ Community Based Health Care.” (AMREF, 1996)

The specific objectives of Phase 1 included: halving the infant mortality rate; involving at least 75% of the 338 villages in the region in community-based activities and motivating them to undertake disease prevention and health promotion activities; achieving 80% childhood immunisation coverage in the region; and an 80% reduction in death caused by diarrhoeal diseases.

In Phase 2, the focus for objectives became: promotion of safe motherhood including AIDS education; community-base nutritional surveillance; community-based

distribution of contraceptives; promotion of environmental health through improved sanitary practices including use of pit latrines; increased accessibility of safe water; and promotion of tree planting.

Like AMREF, the ELCT is involved in a range of health-oriented activities. Primary amongst these is provision of formal health services. Operating across 20 dioceses, the ELCT was running 20 hospitals in 1996. In addition, the ELCT supports a network of development offices, with a policy unit based in Arusha. This policy unit follows and responds to, amongst other things, national health policy. The ELCT has also established CBHC projects. The example I refer to here is the Maasai Health Services Project (MHSP), which is run from the ELCT's Selian Lutheran Hospital, a facility based in a semi-rural area outside Arusha town. I did not manage to obtain written information about the goals or objectives of the MHSP itself, which is in fact a programme of the ELCT Diocese, not the hospital as such. However, the Selian Hospital also supports CBHC projects in four surrounding villages. These are described as 'those activities of the Selian team which concentrate upon enabling communities and families to assume greater responsibility in defining their own health and community problems and then seeking appropriate solutions to those problems at the village level'. This type of involvement with villages is framed by a particular understanding of health:

"The vision of Selian Lutheran Hospital is to serve, treat and minister to the whole person: in body, mind, and spirit. Selian Lutheran Hospital strives to attain this vision by providing competent, compassionate medical care, by promoting health development through community health projects, and by proclaiming the gospel of Jesus Christ." (ELCT, 1995)

What these organisational and programme level objectives vis-à-vis CBHC promotion suggest is that NGOs are committed to the PHC principles and the promotion of PHC both through comprehensive and selective, targeted initiatives. For example, the CBHC Council seeks to 'promote and prioritise preventive health care' (CBHCC, undated). Commitment to the types of objectives discussed here may be important in distinguishing NGOs from other organisational forms (Anheier, 1995). This distinction lies in their commitment to equity, and to working directly with 'clients' using strategies that focus on participation in analysis and action. However, given that in the Tanzanian health policy context, these are commitments also shared by the government, this may only help to distinguish NGOs from for-profit health service providers, operating under the logic of profit-making.



## **6.2.2 The 'project': Modes of implementation**

There are differences between each organisation and programme in terms of how they implement - organise and manage - CBHC promotion. However, the similarities are more striking than the differences, even amongst those not aware of, or not directly using the government's CBHC Guidelines (1996b). Such similarity is found in the emphasis on self-formed rather than pre-determined committee and group structures at community level. Another common factor is the focus on the use of dialogue as a means of building understanding. I found it not unusual for CBHC and other NGO practitioners to refer to the 'dependency mentality' of rural Tanzanians (N9/96). In some cases, Health Sector Reform - understood primarily to be about removing subsidies in health services - was not necessarily seen to be a bad thing in the light of a commonly experienced expectation that in villages you 'are there to alleviate their problems. They expect much.' (N7/96). This links to another common theme, concern with a process of community involvement, from research through to defining action priorities through to implementation and then reflection. This is the process designed to work through the 'dependency mentality'.

In addition, there are many NGOs working in the area of health promotion that do not refer to CBHC at all, but that work in very similar ways. These include, for example, the peer health education projects of the development offices of the Anglican Church. Of course, such similarities are not surprising, given that NGOs in Tanzania predominantly work through participatory and learner-centred approaches, and given that those who have attempted to build community involvement in PHC over the years have had similar experiences, learning similar lessons. It is important to note this similarity because it highlights the significance of CBHC/ PHC promotion by NGOs; a significance that might not be appreciated if the focus were only on individual projects or organisations. Finally, it is interesting to note that whilst none of the programmes I was introduced to have been designed in response to HSR as such, in some cases NGO staff do anticipate a greater expressed need for health education to result from the introduction of cost-recovery in health services (N10/96).

The story of each organisation or of its CBHC programmes, is one of organisational realities and interests interacting with experience and learning over time, all taking place in a changing institutional context. Each stands as an example of this in its own right.

The CBHCC grew out of a PHC Coordinating Committee that Oxfam helped to initiate in the early 1980's. Most of the membership of this council was drawn from

the Ministry of Health, hospital staff, and Oxfam, though with some community involvement. Over time, the membership of this committee began to feel the need for a locally registered NGO, which was completed in 1992 (N4/96; N3/98). At the same time, the CBHCC inherited all the health activities previously supported by Oxfam. In other words, with regards to health, Oxfam took on funding as its primary role, with the Council as its implementer.

The CBHCC brochure lists the activities/ functions of the CBHCC as: organising training for beneficiaries; influencing curriculum development to incorporate CBHC into education; facilitating the exchange of information about CBHC; and liaising with government to build a network and co-ordination of efforts between government and non-government sectors. In its early work, the Council covered 9 regions (Dodoma, Arusha, Kilimanjaro, Mara, Mwanza, Shinyanga, Singida, Tabora, Kigoma). At this time, it was working through the hospital system, identifying and training key people within NGO and government regional hospitals. However, 1993 was a crisis year financially - Oxfam's funding to the Council suffered due to an overall reduction in funding from the UK and from the diversion of funds to the Rwandan refugee crisis. The former co-ordinator and secretary of the Council were moved to manage Oxfam's refugee programme, which left the Council without active staff for some time. Support to the hospitals almost stopped, though most were dependent on the Council programmes for vehicles, and in some cases, for staff salaries (N4/96).

In early 1995, the Council was re-staffed, and its previous approach reviewed. It was decided to scale down, since the initial geographic coverage had been extensive. In each area the number of communities getting involved in CBHC was growing, such that it was difficult for the CBHCC to directly supervise and monitor the use of funds. Given an even worse financial position in 1996, it was decided to proceed by concentrating on Arusha Region, and attempting to demonstrate what could be achieved in one place (N4/96). This decision resulted in the CBHCC's involvement in the design and management of Oxfam's Arumeru water project.

Although set up to network and promote CBHC, and although it was certainly successful in doing this through training within government in its first few years, the implications of the CBHCC's funding position are that in practice it is concentrating on supporting the health component of Oxfam projects, rather like a sub-contractor. Indeed, Oxfam staff told me to talk to the Council if I wanted to talk about health, as they no longer cover this. Thus, in 1996, the CBHCC appeared to have failed to draw together and maintain an active membership for promoting the CBHC

approach. The CBHCC did not seem to be aware of a number of the CBHC promoting programmes and organisations I mentioned. Many of the people I was interviewing in other organisations had not heard of the Council either. Where they had it was because they were amongst those who had been involved in the early round of training. They were wondering what had happened to the CBHCC since.

By 1996, the component parts of HPA's development programme in Tabora could be identified as Child-to-Child (CtC) activities, participatory research and project management development, and village-level construction projects. All of these components were being linked by the concept of CBHC. HPA's programme and its emphasis on CBHC has evolved through phases than can be roughly described as:

- **Phase 1 (1991-4):** When HPA began working in Tabora Region, it provided a limited programme of support to villages and district governments. This support was for the rehabilitation of government health facility infrastructure. After some work on a hospital building, the programme began to focus on dispensaries - village-level health facilities - responding to requests from villages that were coming through the district planning system.
- **Phase 2 (1994-6):** During this period, HPA began to develop more intense relationships with key regional government staff. The infrastructure project began to be talked about as providing 'entry points' for engaging in relationships in villages that could focus more on participation, health awareness and empowerment. CBHC was beginning to provide the conceptual framework for this, and nested within this were activities such as developing the use of RRA (Rapid Rural Appraisal) for project identification into more participatory approaches, and the piloting of Child-to-Child (CtC) - a learner-centred approach to health education - in primary schools. At this point, there was emphasis on building capacity in district governments by training teams of ToTs in PRA, CBHC and CtC.
- **Phase 3 (1996-8):** During 1996, HPA began to make more firm arrangements with 'staff' and as such began to develop a capacity to develop its CBHC activities further with villages themselves. A strategic planning meeting in October 1996 provide a point for consolidating discussions and to take stock of activities, producing the ethos and principles referred to above.

As will be discussed in more detail in Chapter 7, the shift towards promoting the CBHC approach was accompanied by a move away from working with single villages located anywhere in the region, to working with clusters of villages (four clusters in total). The idea behind this was that a single village might provide a focal

point from which to unfold the approach, extending CBHC ideas and activities outwards to neighbouring villages. A Cluster Extension Worker (CEW) was elected in each of the four clusters, and has since been active in liaising with neighbouring villages concerning their priorities, plans and capacities to act on these. This type of work is supported by the core HPA team. This team facilitates workshops about CBHC in villages, training leaders, teachers and CORPs in the concept and skills of CBHC, and facilitating dialogue in villages to enable people to define their key priorities and identify the resources they can tap in order to take action on these.

AMREF's Rukwa project was managed by AMREF's CBHC unit, which worked through various levels of local government building capacities to understand, manage and facilitate CBHC in multi-sectoral teams. (AMREF, 1996; N6/96).

AMREF began by working with a broad selection of district leaders (religious and social as well as government) to raise awareness about CBHC. This was seen as a key first step, given the influence such leaders wield, whether positive or negative, vis-à-vis a programme. In addition, it was also understood that government needed to be involved, not least because once communities initiate projects, particularly infrastructure, local government ensures that protocols, such as building design, are followed. The next step was to conduct similar activities at the Ward level, where Trainers of Communities (ToCs) were identified and trained. It was intended that these trainers would then work within communities to discuss their priorities. It was expected that through this interaction, communities would decide to establish CBHC committees, and that the ToCs would help to identify and train Community Owned Resource Persons (CORPs) drawn from the community itself.

The Rukwa project followed a typical CBHC approach in attempting to build capacities and relationships between various parts and levels of government, and between government and community organisations. However, multi-sectoral co-ordination is identified as being persistently weak (G3/96), and, as discussed below, the Rukwa Evaluation Report (AMREF, 1996) also shows that this area of programme work has been less successful than others.

In a strategic direction document for 1995-99 (World Vision Tanzania, 1995b), WVT announces that its focus will now be on Area Development Programmes (ADPs), and no longer on small, single projects (although specialised programmes, such as the Kahama programme, with a specific focus and covering up to 300,000 people will continue). It is proposed that each ADP will cover populations of between 20,000 and 100,000, the purpose of an ADP being 'to help the people to help themselves in improving their quality of life'. This shift towards ADP's is seen

to be more genuinely 'community-based' than the earlier approach (N13/96). CBHC is used as the approach informing health education within the ADP. The primary target group is children aged 0-5, on the understanding that the health of other groups will be promoted through this emphasis. This helps to define secondary target groups, these being young people of 15 years and over and women of reproductive age. CBHC programmes also target men of 25-45 as the primary holders of financial resources and household decision-makers, and finally, key village leaders (N3/96)

Each ADP is an integrated programme, which has a focus, depending on the community's priorities, on one or more of the following: health; agriculture; primary education; enterprise development; environmental protection; disaster mitigation and promotion of justice (with an emphasis on women and children). The ADP model is based on a collection of conterminous villages (not separated by non-participating villages), with the government's administrative unit of the Division taken as the normal maximum size. Each ADP is established with a project office, located centrally within the area. All ADP villages should be within a 15 km radius, and around 10-25 villages might be involved. The organisation within the ADP consists of a project committee that operates around the ADP centre, but links with specialist advisors in the zonal office. Each zone has a dedicated health co-ordinator (N11/96). This project committee is supported by the core staff of the ADP, but is itself elected from the participating villages. In turn, it liaises with elected village committees and sub-committees. The project committee facilitates the village committees in setting targets and activities related to their different project goals. This committee is responsible for decision-making about allocation of funds to village and sub-village projects.

The CBHC approach is promoted within the ADP's, not as a project with a single goal, but on the understanding that it is part of broader programmes. The project committees' development of active CBHC might be through the revival of an old PHC committee structure. However, the emphasis of the ADP is on working with structures that the community sees as relevant and trustworthy, not on pushing for the (re) creation of structures determined by bureaucratic procedures (N3/96). Of relevance to the promotion of CBHC is the fact that the ADP's also work to a set of guidelines concerning the balance between structures and community-based education. These state that:

**“The emphasis will be on encouraging and training of the people in the communities, NOT on building structures that will primarily benefit some institution.” (WVT, 1990)**

These guidelines suggest that 20% of effort be placed on construction of buildings, with the other 80% on Community Based Education. In addition, only one structure will be worked on at any one time in an ADP, and it should be a multi-purpose structure, such as classrooms or a dispensary (where agreed with the MoH).

Finally, WVT does not simply promote health by developing CBHC within integrated projects in ADP's. Like many other NGOs, it is also involved in other health-related activities, including support of vertical health programmes. This work involves liaising closely with government health services; perhaps conducting information dissemination prior to vaccination campaigns or providing transport for these.

The MHSP began operation in one pilot area in 1982. Its emphasis was on developing health education within villages, working with Traditional Births Attendants (TBAs) and training VHWs. When the project was assessed, it was found - in line with many other projects, and as reflected in the national evaluation of PHC in 1988 - that VHWs tended to be used by communities for largely curative purposes, as 'small' doctors. It was felt that the VHWs were becoming too much part of the government health system rather than being seen to be part of the community. The MHSP team also felt that the gap between health staff in formal health facilities, and actual community health issues, had continued to be great. It was for these reasons that the project decided to focus more on a community-based approach (N5/96).

The MHSP central project team consists of 7 staff. The project works with 75 villages (including the 35 it started with in 1982). It also works with the 21 dispensaries in the diocese that fall under the Selian Lutheran Hospital. Each dispensary's mganga (medical aide) and MCH (Mother and Child Health) nurse is part of the project, working as the site coordinator. The project also works with government dispensaries in the same way. Where there is no dispensary in a village, then the project works with the village committee. In some villages, school teachers also work closely with the dispensary staff (site co-ordinators). At this level, the MHSP team provides support in the form of twice yearly workshops developing skills for facilitating CBHC, and through follow-up visits.

Within villages, the project works with the village health committee, community health workers (CHWs), and other key health actors such as TBAs. These groups

come together to develop the community health profile, which involves visits with individual households to discuss their problems, as well as time spent around the community to assess whether the problems being identified are the real concerns, or whether there are other issues. These groups then develop action priorities. The project team visits every 3-4 months to follow-up. In addition, it holds one workshop a year for CHWs and village health committees. Over the years, the project team has linked individual villages with other agencies, such as Oxfam, where external resources have been required. Increasingly, they feel that these links have been developing more directly, so that the MHSP team no longer has to act as a conduit for project funding.

Many of the issues encountered by the MHSP team are similar to those raised by other agencies. These include the problem of relying on government guidelines, which, for example, stipulate the number of VHWs per village. This is not the approach the MHSP takes to CBHC. The MHSP team believe that as soon as an agency determines issues like the number of VHWs needed in a village, the village attitude becomes one of 'the VHWs are yours not ours'. In addition, they feel the government guidelines are unrealistic in suggesting too few community workers, thus imposing too much work on individuals. Related to this is the problem of payment. The more people come to VHWs for treatment and not prevention advice, it seems the more the VHWs want to be paid. The CBHC approach has certainly been developed with these problems in mind. The MHSP team recognises a need to prepare villages carefully, which involves people coming to decisions themselves, discussing how CBHC might help, and planning strategies having thought through their resources. In practice, however, because CBHC is a slow process, old problems resurface. Villagers tend to view those trained to facilitate action as 'experts', and still often look to external solutions and sources of support before analysing their own capacities. One member of the MHSP team mentioned that people tend not to trust their own resources, seeing new and imported things as constituting development. Finally, it is evident that relationships with other organisations, in particular local government staff and structures, are important to the project, and that these relationships between the project, government health facilities and communities have been developing satisfactorily.

This section shows that the implementation of CBHC varies across projects and organisations. For some, CBHC promotion provides the *raison d'être* for the organisation's work; for others it is just one approach that informs interventions. In some cases, project staff directly train and work with community members, referred to as CORPs or animators. In others, project staff work with intermediaries, either

training teams of ToTs within the local government system, or training health facility staff in both government and non-government health facilities. Some projects will provide inputs to support community-initiated projects such as health-related infrastructure; others do not go beyond facilitation and training. Some projects have grown out of direct health service provision activities; others promote CBHC within integrated development programmes. Some CBHC initiatives are explicitly linked to stated health status indicators; others place emphasis on changes observed in social behaviour.

However, it is also apparent from this section that all these NGO programmes are working with close reference to government. At times, this finds expression in the organisational or programme objectives, as in the case of AMREF's statement that its mission is:

“ In partnership with communities, governments and donors, AMREF aims to improve health among the under-served in Africa through service delivery, training and research.” (AMREF, undated)

These organisations seek to promote multi-sectoral 'health care programmes' (CBHCC, undated; HPA, 1996). In practice this means that these CBHC programmes have all been undertaken through some form of 'partnership' with the Ministry of Health – at local or national level - and District Councils.

HPA's pilot work in Tabora Region, for example, had arisen from initial requests from the District Medical Officers of Igunga and Nzega Districts. From the start, HPA's work was focused on supporting rural communities and district governments in their efforts to upgrade and rehabilitate the physical infrastructure related to health services, namely dispensary and health centre buildings. Whilst, as discussed above, HPA's approach to its work has developed through a number of phases, close co-operation with district councils has always been a key component of the organisation's strategy.

What is particularly interesting about these forms of interaction between these NGOs and government is the extent to which they are taken for granted. The effect of this seems to be that these interactions may not be explicitly discussed by the actors involved unless directly asked. This in turn may mean that such interactions fail to be sufficiently visible to merit analysis by policymakers.

### **6.2.3 The outcomes and evolution of the 'project'**

For its proponents, the appeal of CBHC clearly lies in the answers that it supposedly provides to problems experienced in the implementation of PHC during the 1980's.



For example, many practitioners are looking for something that goes beyond VHWs acting as 'small doctors'. Each of the projects and organisations discussed here show signs of evolution, usually in response to experience and learning on the part of practitioners. Each of the projects also has a system of planning, monitoring and reporting. For example, WVT's ADP's are required to conduct a baseline survey within the first six months, an evaluation every two years, and the ADP's project staff are in place in order to assist villages develop their project planning from needs identification right through to reporting and evaluation. Individual CBHC practitioners are able to talk convincingly about the processes of change with which they have been involved, providing anecdotes. However, I was not made aware of the existence of systematic attempts to assess the outcomes, effects and impacts of CBHC promotion over and above regular project monitoring activities. That is, apart from a formal evaluation of the AMREF Rukwa programme (AMREF, 1996), the only documented exercise I have come across in Tanzania, to assess the efficacy of CBHC as an intervention. It is full of inconsistencies and anomalies, deriving largely from zealous attempts to quantify the qualitative, and a tendency to link effects to CBHC interventions without placing these within the wider context. However, in its conclusions, the report touches on all the main constraints and questions that other CBHC practitioners discussed with me.

The general conclusion of the report is captured by the statement that:

"Nowadays communities in Rukwa Region have realised that the habit of depending on government to identify and solve problems confronting them will not bring development to them. Through the spirit of CBHC communities have built bridges, roads, schools, health facilities, wells and staff houses." (AMREF, 1996)

The aim of the evaluation was to assess both of the project's phases in terms of:

- a) *Process indicators*: For example, these show that 93% of villages in the region were covered, and that some 612 ToCs were trained of which 14.4% were women.
- b) *Change in attitudes and habits*: The report notes that there had been no baseline survey conducted, but that focus group discussions indicated that people had realised that development of the community depends upon people themselves working with the CBHC approach. The evaluation suggests that people have become more self-reliant and that their health-seeking behaviour has improved, citing as an example, early attendance at antenatal clinics.

- c) *Health, nutrition, and overall development*: For example, it is claimed that the Infant Mortality Rate had been reduced by 23% between 1988 and 1995, whilst immunisation levels increased to over 80% in all districts. Malnutrition had declined from 50.8% at baseline in 1990 to 29.2% in 1991/2.
- d) *Technical and managerial design*: The evaluation praised technical staff for their good community relations and commitment, but reflected that there were problems in turning objectives into tangible activities. This is attributed to lack of research and information management skills.
- e) *Community involvement and gender equity*: Community involvement is claimed to have increased after awareness-raising activities, but men have dominated leadership positions, and the issue of gender equity and access still needs to be addressed.
- f) *Integration of CBHC initiatives in the overall strategy for social and economic development*: Problems of co-ordination and integration of CBHC activities within the various health sector programmes, and between other related sectors such as water and education, remains a problem.
- g) *Relevance of the project to local community problems and aspirations*: The CBHC approach is deemed to be relevant to local community problems.
- h) *Sustainability*: The evaluation indicates progress on meeting health targets, and is positive on issues such as community spirit. This leads to conclusions like:  
 “Sustainability of the CBHC project in Rukwa is assured. Already communities are responsible for the general management of CBHC activities under various committees at regional, district, ward and village level...it was expressed that there are plans to include some of the CBHC activities into the regional budget estimates this year...Whether the allocated amounts would be adequate or not would depend on regional and local priorities, share of development funds available as well as stability and commitment of the local leadership.” (AMREF, 1996)

The report is useful in illustrating the type of activities and concerns that inform CBHC programmes. It is also useful in illustrating some of the constraints to implementing CBHC. It seems that management between various groups is still a problem, with hints that there are mismatches in priorities between community committees, regional budget allocations, and local leadership. Some of the management problems are defined as ‘technical’, but without admitting it openly, the evaluation has come across the major political issues which influence health and

development, and which the whole notion of community-based and intersectoral action was set up to tackle. Therefore, whilst it notes that political and government leaders, and extension workers, have built an understanding of CBHC and are better able to work with communities and 'to articulate their management capacities better' (AMREF, 1996), frequent changes of leadership have also limited the efficacy of sensitisation and advocacy activities. For example, over the life of the project, there has been a 20% dropout of ToCs. The evaluators feel that the role and responsibilities of the various donor-supported projects in the region have not been properly conceptualised and thought through by local government and leaders (which could be taken as a negative assessment of efforts to promote intersectoral, interagency collaboration). Other obstacles to effective relationships include limited access to transport, which affects the continuation of supervision and support. This may be why the evaluation notes that coverage of CBHC activities has been wide at the expense of concentration over time.

The Rukwa evaluation suggests that communities can be empowered to recognise their own problems, analyse them and prioritise, but low educational/ literacy standards are cited as a reason why it can take a long time for communities to reach clear understanding about CBHC. It was not until 1992 that the Rukwa project began to see tangible outcomes, in terms of classroom building, construction of protected shallow wells, the raising of immunisation coverage and so on. Low income levels limit the capacity of communities to undertake activities, and are thought to contribute to the failure of some projects. Another issue common across all projects, is that although villages might mobilise around one project, for example, dispensary rehabilitation, they do not always continue with CBHC activities thereafter. Yet the principle behind CBHC is that it sets up an ongoing process of problem identification, prioritisation and action, which becomes self-sustaining within the village. One of the people involved in the Rukwa project explained that in the evaluation of the project, they had graded villages to capture the differences (G3/96). Class 1 villages were those that had followed through their initial priorities, moving from one activity to another. Class 2 villages were those that had started an activity and then moved on to other lower down their list, perhaps because the first was taking so long. After these came 'moderate' villages, where there is evidence of awareness about CBHC but no activity, and 'poor' villages where there is no evidence of awareness, which he attributed to the ToCs not being very active.

This evaluation report reinforced interviews that indicate that the promotion of CBHC is a long and resource intensive process. For example, the Rukwa evaluation report notes that:

“The findings were that the CBHC project took three years before its impact on attitudes and habits of the people, as well as the overall health and development status began to be felt.” (AMREF, 1996)

Similarly, multi-actor, intersectoral action, seen to be key to effective CBHC, can flounder. For these reasons, it is clear that ongoing interaction between villages, CBHC teams and other actors is important, requiring various types of technical support and resourcing. The success of CBHC is largely dependent on the commitment of trainers and project officers, and of leaders at all levels. This requires close supervision and support, as well as community acceptance of trainers. However, there is a conflict between the amount of time it takes to establish a CBHC ‘mentality’ at all levels, and the desire of many donors to see projects completed with ‘results’ in a few years (G3/96). AMREF staff express concern about this, but clearly state from their experience that no immediate results can be expected. This is the point of a real community-based approach, in which the emphasis is on using the community’s own resources. For example, AMREF did not provide direct resourcing for the community projects in Rukwa, but relied on the community’s capacities to analyse and solve their own problems, to channel their plans through existing structures, interacting with government rather than working with new structures set up temporarily by another agency, and to mobilise their own and government resources for their activities (N6/96). Similarly, in working on the Swiss-funded Kilombero project, AMREF’s CBHC staff have worked to move the project from an emphasis on institution-based activities to community-based approaches. As a result, communities have begun to change their priorities and project plans, moving away from the usual request for a dispensary, towards other types of intervention to improve health.

The main conclusion that I draw from this is that there is a constant tension between macro policies and micro initiatives along the lines of CBHC promotion. For example, there is a history of villages tending to come to local government requesting support for a standard list of infrastructure projects, such as a dispensary or a school. That is, their ‘priority’ is strongly influenced by policy and directives from central government. CBHC practitioners tend to be energetic and enthusiastic about their success in working with communities to get at the real issues and the actions that are within the reach of the community in terms of changing their situation. However, these practitioners tend to work more to the premise of ‘you have to see it to believe it’. Until they are able to articulate the macro significance of the work that they do, their micro experiences will remain a series of projects in the eyes of many health professionals and policymakers.

### **6.3 CBHC: The policy**

As I was leaving a group of interviewees in 1996, one person said to me, 'ask him where the salt is', referring to another CBHC practitioner she knew I would be seeing (N5/96). She was reflecting on the lack of interaction, during the previous few years, amongst those who had shared CBHC training in the late 1980's. What she meant was, that in the same way that salt is used to draw out the flavour in food, the CBHC practitioner should be both acting as a catalyst in communities, and drawing out the flavour of CBHC for wider appreciation. As indicated in Chapter 5, the HSR Proposals (1994a) refer to CBHC as a strategy for promoting PHC in Tanzania, and to the CBHC Guidelines as providing a framework for this. During my fieldwork, I have untangled some threads that explain how CBHC came to be being discussed in the MoH at all, and how some people and organisations have attempted to act as the salt.

By asking how people learnt about CBHC, I became aware that many of the CBHC practitioners I was meeting knew each other from previous encounters. Collectively, they begin to tell a story about policy, which though dependent upon people's memories and perceptions, takes shape along the following lines. It seems that a number of CBHC practitioners came to know each other through involvement in the PHC Council that preceded the CBHC Council, and/ or they were also involved in the same PHC/ CBHC training initiatives conducted in the late 1980's. Most of these individuals were employed in district, regional or central government at that time, and in a number of cases, still are.

Two examples are the Tabora Region PHC Co-ordinator (who works in conjunction with HPA), and AMREF's ex-CBHC Co-ordinator. The Tabora PHC Co-ordinator was introduced to what was called PHC/ CBHC training provided first by CEDHA and then Oxfam (through CMBT) in the late 1980's. Apparently CMBT were targeting mission hospitals for training at that time, but he was able to join the initiative. He was involved in the MoH's evaluation of PHC in 1988, and shares in the criticism of that strategy for effectively reducing PHC promotion to training VHWs. Taken with the concept of CBHC, and finding few people in the PHC Unit of the MoH responsive to it, he decided to start a pilot in one village in Tabora Region in order to explore the potential of CBHC in practice. Similarly, AMREF's ex-CBHC Co-ordinator, was also involved in the PHC evaluation. She is critical of the narrow focus on VHWs, and of training that was based on lecturing, a technique that VHWs have simply reproduced in the village context. A nurse, who was working within the MoH, it appears as the VHW Co-ordinator, she subsequently attended AMREF's CBHC training in Nairobi. It was on returning from this trip

that she began to draft guidelines for CBHC, taking as the basis for these the need to involve communities from the start, and the idea of training village animators or CORPs. Around this time, UNICEF, as the main donor to the VHW programme in the MoH, ended the funding. She remarks that there was no money left to extend CBHC from the MoH, and so she left to work with AMREF in 1992. By that time, the MoH had trained zonal co-ordinators and regional co-ordinators in the government system in CBHC<sup>2</sup>. As VHW/CBHC Co-ordinator, she had also begun work in Kibaha, taking one district as a unit in which to pilot CBHC. It seems that this work did not continue out of the MoH after her departure.

As AMREF's CBHC Co-ordinator, she was able to continue to lobby the MoH on the need for CBHC Guidelines. This was an idea that the CBHC Unit (now 3 people) in the MoH eventually accepted. Apparently it took some time for the MoH to then approve the proposed guidelines. Once they were accepted, AMREF used them to train 'top bosses' in the MoH. These people appear to have found the training interesting, but she comments that no one subsequently took the idea further. Her memory is of about 72 people having been trained during this period, mostly from the MoH, with some from the CMBT.

Both the HSR Proposals, and individuals within the MoH refer to the hiring of an AMREF consultant in 1993, who was to determine whether and how CBHC could be implemented (G2/98; GoT, 1994a)<sup>3</sup>. However, over the life of my research, it has been difficult to determine the place of CBHC within the MoH. For example, AMREF's Rukwa project was ostensibly undertaken on the request of the MoH, referred to by some as 'an MoH initiative' (N6/96; N2/98). However, the MoH's CBHC Co-ordinator did not mention this to me, and I have not seen any of the programme documentation that might refer to the MoH's role. Similarly, one person I interviewed was at pains to point out that whilst the government might have adopted CBHC as a strategy, it is an approach that came from NGOs (N1/96). Others have indicated that it is not part of the government's health strategy at all (G3/98); a possibility that is borne out by the lack of mention of CBHC by the time of the 1998 Joint MoH/ donor HSR Review. In fact, it seems that the place of CBHC within the MoH is tenuous:

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<sup>2</sup> The Tabora Regional PHC Co-ordinator refers to MoH CBHC workshops taking place in Morogoro. He attended one with the Tabora MCH Co-ordinator and another regional health worker.

<sup>3</sup> Indeed, it seems that AMREF has a long history of interaction with the government around health policy, having been involved in the preparation of the Titmuss Report in the early 1960's.

“In the Ministry of Health it [CBHC] is dying now. They have even taken it out of the Ministry compound. They have sent it to the Health Education Unit....They are using the same guidelines that AMREF made. I don't know why they have put it in the health education unit, but to me, I just feel that we need stronger people in that unit to fight for it.... We need somebody really dynamic to do it.” (N2/98)

This same person refers to the lack of strategic planning, with members of the CBHC Unit trained to be trainers not strategic managers. There is still a PHC Secretariat in the MoH but, according to some, ‘they don't have community involvement’ (N2/98). She talks about the example of Namibia, where she has heard that the PHC Secretariat is located not in the MoH but in the President's Office, from where the ideas of PHC/ CBHC can be used to influence all ministries.

From all directions there are sorry shakes of the head when it comes to talking about CBHC and national promotion. One NGO CBHC practitioner mentions that she does not know what others are doing around the country. She sees a need for practitioners to be co-ordinated and says that she has proposed that the CBHC Unit in the MoH call a meeting of a small group of people, enabling them to plan together how to take CBHC forward. She says that she has never had any response, and concludes that ‘maybe they do not even know where they [CBHC practitioners] are and what they are doing’ (N1/98). To hear the story from the point of view of the CBHC Unit<sup>4</sup> itself does not encourage hope. It seems that in the wake of the AMREF study of CBHC in 1993/4<sup>5</sup>, it was concluded that a strategy should be developed for a unified approach to training the DHMT's, to enable them to integrate CBHC into their plans. This strategy has not yet been implemented due to financial constraints (G2/98). In addition, lack of knowledge about CBHC projects and organisations working in CBHC is attributed to the fact that few organisations send reports. References are made to the potential of CBHC in improving people knowledge, attitudes and practice (KAP), enabling people to become more self-reliant and to prevent disease, and thus relieving the government of its burden. But the arguments are not made forcefully, and as this person admitted, whilst the MoH might be interested in CBHC, it is a low priority:

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<sup>4</sup> The person I interviewed noted that the CBHC Unit is a sub-unit within the Reproductive and Child Health Unit. It is comprised of a medical officer, and environmental health officer, and 2 public health nursing officers (G2/98)

<sup>5</sup> One interviewee remarked of this study: ‘...I wasn't very happy with the appraisal, because it didn't bring things like case studies...that we could study’ (N2/98)

“Maybe no-one is aggressive enough....I don't know if that is a fact. Having everything written in the plans we expect some resources are allocated...something went wrong somewhere. And maybe they are not adequately informed what are the benefits of the CBHC approach ....maybe we need to sensitise them more?” (G2/98)

There are a number of issues that emerge from this story of CBHC and policy. Firstly, as is further demonstrated in the next chapter, a number of government staff have been trained in the use of CBHC. Secondly, a handful of these have attempted to pilot and promote CBHC within the government system, and in some cases have either been supported by NGOs, or have left to work within NGOs, in order to be able to this. Thirdly, there are important issues of power and perception that explain what and how certain things get on to the agenda. Evidently, the fact that CBHC has not been located in the PHC Secretariat has allowed it to be sidelined as an approach to health education rather than as the partner to IBPHC, as discussed at the start of this chapter. For some people, this comes down to professional power:

“For example, me, in the Ministry of Health, as a nurse I have no voice. You go to meetings, to talk about it, yes, it is a good thing but, I am just a nurse....The doctors say no, let us try to find out what else we can do about it..... because with the big shots they don't want to do this because it deals with the community.....our people don't even know the importance of washing hands after going to the toilet. Just a small thing like that they don't know.” (N2/98)

The CBHC Unit itself admits that it needs to be located in the PHC Secretariat if it is to have any voice. Without that position, it is unlikely to be able to make the kind of contributions to HSR that were intended, such as building the skills of the DHMTs to involve communities in health planning. Whilst in 1998 the CBHC Unit appeared to be in the process of working on proposals, plans and budgets for donors, its primary emphasis was on training ToTs, not tackling issues of higher priority in HSR, such as Community Health Funds (CHF). In fact, there has been no apparent interaction between the CHF pilot run from the MoH and the CBHC Unit, other than the fact that individuals know each other. At the same time, none of the CBHC practitioners I have talked to over the years have demonstrated any detailed knowledge of what is on the HSR agenda, or indicated that CBHC has anything direct to offer to implementing HSR in practice. Whilst there are interesting glimpses of CBHC in the MoH, and whilst there is plenty of evidence of CBHC in practice, it seems that the salt that will draw out the flavour of CBHC, giving it macro-level significance to policymakers, is missing.



## **6.4 The case of CBHC: Why do NGOs exist?**

As I explain in Chapter 3, the research that underpins this chapter was informed by the questions posed by Anheier and DiMaggio (Anheier, 1995). In this section, I reflect on what the data I obtained around the promotion of CBHC by NGOs suggests in answer to these questions.

The first two of those questions are concerned with: a) why NGOs exist, or what the division of labour is between organisational forms; and b) how NGOs are different to other organisational forms in terms of performance, clients, efficiency, equity, outputs and strategies. As I explain in Chapter 3, and as indicated by the data discussed in this chapter, it was not feasible for me to answer these questions comprehensively. There is limited quantitative information available concerning the activities of different organisations in health. The for-profit health sector is still very young. In addition, the scope for obtaining information from individual organisations is limited by people's caution, and indeed knowledge of the details. However, these questions provide a useful tool for scrutinising data, from which broad conclusions can be reached.

In terms of the division of labour and responsibilities, the case of CBHC indicates that in the 1990's, the key players in community-based approaches towards PHC are NGOs. Whilst government staff are involved, there are signs that they are unable to mobilise the resources within the government system that would enable them to develop CBHC. As a result, some work closely with NGOs. In this sense, NGOs have taken on the 'responsibility' for piloting, implementing and promoting CBHC with communities and with government. However, this division of labour is neither clear-cut, nor is it fixed. In the late 1980's, the strategy for promoting CBHC appeared to be through the formal health system, which meant government and mission-owned health facilities. Whilst MoH HSR documents may not talk consistently about PHC, they do talk about the importance of the government shifting its emphasis towards PHC, and about the role of community in health. At one point it looked as if the MoH had adopted CBHC as a nation-wide strategy. It might still elect to follow that path, in which case the role of NGOs in CBHC could change. However, to date the division of labour has been one in which some NGOs have initiated CBHC through piloting and training. Other NGOs and local government staff have taken the approach up. Central government has loosely taken responsibility for CBHC, by issuing guidelines for example. But its promotion of CBHC continues to rely on donor support for NGO projects. People I have spoken with do not explicitly talk about the division of labour and responsibilities between NGOs and government. However, comments are framed in terms of government

being the lead actor vis-à-vis NGOs, and NGOs acting in support of a government system that will take up the kind of activities they are promoting. Perhaps more honestly however, whilst one NGO staff member working in CBHC referred to the Regional Nursing Officer (RNO) as her 'boss' (N3/ 96), she also made it clear that without people like herself, working with NGOs, CBHC was unlikely to be promoted.

In terms of performance, clients, efficiency, equity, strategy and outputs, NGOs appear to be different from the emerging for-profit sector in the sense that they promote CBHC at all. For-profit health services are still limited and urban-based, and emphasise curative services. Although some private practitioners refer to their clinics as 'charitable' – no doubt a hangover from the days when for-profit practice was banned – it is difficult to find anything in the philosophy and practice of CBHC that provides incentives for for-profit action. Again, what are really at issue are the differences between NGOs and government when it comes to CBHC promotion.

Since NGOs are the active proponents of CBHC in Tanzania, they are by default the better performers. The interview data suggests a number of reasons why government has been less successful in taking up CBHC. High turnover of government staff - as people are retrenched or redeployed - disrupts the continuity, commitment and flow of skills to any initiative. Individuals and even groups of people in government might be trained in CBHC but be unable subsequently to mobilise the transport, fuel and other resources that they need to be able to work closely with villages and village-based health workers. Some NGO CBHC practitioners would, however, dismiss government staff claims that they are unable to promote CBHC because they do not have a car:

"That is what they say, but there are villages surrounding the hospital....a lot of problems that could be solved. You know, once you solve this problem in a village, it's like fire, it will go to another village." (N2/98)

In many respects, NGOs have a certain 'comparative advantage' over government in this area in that they are evidently able to mobilise funding for CBHC projects, and to build and maintain a certain body of experience about CBHC implementation within their staff. They are also able to access government staff time through the system of attachments and secondments. Yet, another area of comparative advantage that begins to emerge from comments of this nature is the apparent commitment of NGO 'staff' to the promotion of CBHC, a commitment that undoubtedly goes hand-in-hand with access to resources. However, what still needs to be demonstrated is

whether PHC is 'better' promoted through CBHC by NGOs, or through the existing government system.

In terms of clients and issues of equity, NGOs are ostensibly targeting the same client groups as government, namely, the general public at large, that general public being predominantly rural-based and low-income. Of course, NGOs work in particular geographical areas, whilst government aims to provide national coverage of PHC services. And most NGOs define target client groups within their CBHC programme, such as children under 5, or women. However, NGO CBHC initiatives are all aimed in some way at building capacities within government, which implies that NGOs recognise their limitations in terms of reach. This emphasis on building government capacity indicates that NGOs attempt to contribute to the 'public good' by implementing projects that aim to become self-replicating and embedded within the government system. In practice too, as admitted by the HSR Proposals (1994a) and Action Plan (1996a), the government health system has consistently stated its concern with equity, but needs to tackle its effectiveness in redirecting resources towards the rural areas and poorer groups.

Finally, in terms of efficiency, strategy and output, the focus of the nascent private for-profit sector is on direct health service provision, not in community based health education and development. The strategy and output is different from CBHC, and therefore there is very little basis on which it is possible to assess comparative efficiency. Compared with government, as already noted, NGOs appear to have the efficiency advantage when it comes to promoting CBHC, in the sense that they undertake CBHC, and have some experience from which lessons have been learnt and projects and organisations have developed. However, such comparative efficiency is by no means static. The government system has potential advantages in the sense that it has built a health extension network that positions trained health workers within a reasonable distance of most villagers. Most of the NGO projects discussed in this chapter do not have staff based within villages. Those that do, such as WVT, see this as a medium-term strategy for building capacities within villages. Others work through the existing health system to train health workers in CBHC. The strategy for promoting CBHC is learner-centred, facilitative rather than directive, and holistic. As such, it is time consuming in the initial stages. NGOs are effectively different from government in undertaking, and in being able, to support such a strategy in the areas in which they work. One NGO practitioner admitted that promoting CBHC is 'expensive' because of the level of resources required to provide the necessary facilitation, training and support (N2/ 98). Yet the same person went on to suggest that taking CBHC-oriented action at village level (as

distinct from training people to use the CBHC approach) does not require a lot of resources, if villages start working on small problems that lie within their resource capacity. In terms of output, referring back to the discussion about evaluation of CBHC, many of the results of CBHC are described anecdotally and in terms of people's perception of change in behaviour and attitude. In fact, the very definition of these changes as outputs indicates that NGOs working in CBHC are adopting a different understanding of health and strategies to improve health from the bio-medical definition that informs the work of health service delivery units. Where attempts are made to quantify outputs in terms of direct health gains, these only refer to particular villages or projects. It is not clear what the gains might be across larger areas, or as a result of the integration of CBHC into standard health worker practice.

## **6.5 Conclusions: CBHC and NGO 'activism'**

The purpose of this chapter was to identify what is going on in terms of NGO promotion of CBHC, addressing the fieldwork question: In what ways do NGOs act as 'community activists' in promoting PHC at the community level?. As I discuss in Chapter 3, I have explored this through what NGOs themselves say – in organisational literature and from NGO staff - about their *raison d'être* for undertaking CBHC, and how they implement it.

As discussed in Chapter 1, I took the notion of 'community activism' from Gilson et al (1994c). In that article, the authors identify community activism as being about research and advocacy. This might include activities such as promoting the PHC concept within villages, training community health workers, and developing forms of community health financing. It might also include advocacy and lobbying at national government level. This research shows that in the case of CBHC, NGOs are indeed acting as community activists in these different ways.

The NGO CBHC initiatives discussed in this chapter reveal that NGOs are able to go beyond statements about the desirability of community based approaches to health, to action. People do not talk in terms of activism as such, but these projects and organisations clearly share a philosophy of activism. Firstly, this is expressed through their concern with promoting change – change in health-related behaviour, change in power relations, change in resource and management capacities to address key problems, and ultimately, change in health status. Secondly, these projects and organisations are generally driven by a mission and/ or objectives that relate to building and supporting forms of collective action in the name of 'public' health

outcomes; not just individual health gains. CBHC is an approach that promises to deliver on this, and that is also currently fundable. Thirdly, in all cases, these projects and organisations work closely with existing government structures from village to regional level, attempting to change the mind-set of government health workers and to build their capacities to support CBHC within those structures.

This research has indicated that the CBHC 'project' remains an NGO preserve in its promotion and implementation. One NGO manager went so far as to suggest that NGOs are the only primary health actors in Tanzania, many of them being the missions (N12/96). Arguably, this should be cause for concern in national health policy debates, in which, as indicated in Chapter 5, the government states its intention to lead PHC promotion. At the very least, this fact might be expected to attract more attention than it has done. There are two conclusions to draw from the data presented in this chapter, both of which are relevant to current health policy debates in Tanzania. The first relates to the nature of NGO 'community activism' and what this reveals about the commitment of NGOs to PHC values. The second relates to the nature of links between government and NGOs in this field.

### **6.5.1 NGO commitment to the values of PHC**

NGO 'community activism' can be characterised as taking different forms. I characterise them here as 'evangelical activism', 'managerial activism', 'advisory activism' and 'policy activism'. I do this in order to capture the key strands running through the why, how and what of NGO CBHC promotion. The analysis of these forms of activism reveals a high level of NGO commitment to PHC principles and practice.

The most important form of activism in evidence in the practice of CBHC is at the community level and might be described as *evangelical activism*. The use of the term 'evangelical' is not intended to be taken in its religious sense, but as a reference to the overwhelming energy and optimism with which proponents of CBHC take forward their 'mission'. The CBHC practitioner is an agent of change, saying of themselves:

"I am a facilitator. A facilitator is one who helps others to identify, realise, to go forward....when you are a facilitator you just create a tendency of people sharing, presenting their views..." (N3/98) and:

"How do we do our work? We are few in an enormous region....we set the idea to people." (N3/96)

There is a mission to overcome the often referred to 'dependency mentality' which is deemed to have rooted itself in the being of Tanzanians (at village and local government levels alike). It is a mission to enable and empower people to understand their circumstances, and to change their knowledge, attitudes and practices (KAP) in ways that will improve their health and well-being. It is a mission carried forward through the tools of learner-centred information sharing and dialogue. This evangelism professes to tackle poverty and diversity of need, exhorting people as individuals to take on their collective responsibilities as a means of doing so. At the same time, this evangelical activism implies a commitment on the part of the practitioner to learning, to overcoming their own tendency to behave as the 'expert', and to bridging the gap between themselves and the community (N5/96).

The 'you have to see it to believe it' enthusiasm of the evangelical activist does not necessarily sit comfortably with economists, planners and macro-level policymakers. However, it does speak eloquently about the needs, priorities and experiences of people at village-level. It draws out stories, for example, about villages that have identified heavy drinking as a community health problem, and have started a football club to provide another social focus (N2/98). However, such stories should not be dismissed as the simple preoccupations of the evangelist. CBHC has its more radical edge too. For example, because CBHC activities are not driven by the normal 'professionalism' of the health service, practitioners are able to develop innovative ways to tackle issues. I was told of one case where a CBHC programme took community members on study tours to Uganda to find out about the impact of HIV/AIDS in communities, and about the type of activities that were being developed to tackle the problem. This was felt to be necessary in communities that to date had had little exposure to HIV/AIDS and that were not receptive to initial health education initiatives. The study tours were found to be highly successful in mobilising commitment to action (N3/96).

There is another important form of activism running alongside this evangelical activism, which could be described as *managerial activism*. This activism refers to the whole structured process of facilitated dialogue through which NGOs support 'communities' to research, analyse, prioritise and act upon 'problems'. This is a process that makes use of internationally accepted participatory techniques. During the process of interacting with villages, many of the NGOs discussed become aware of the need for support and training in order to build particular 'management' skills. These might include skills for the mobilisation and management of resources, or for planning and leading a community infrastructure project. Another level of managerial activism is where the NGO works with village and government leaders to

improve their management skills. For example, as explained in the next chapter, HPA has been placing increasing emphasis on training for village leaders and elected rural councillors. This type of activism could provide an important example for the design of Community Health Funds (CHF). As one CBHC practitioner said to me, the World Bank's idea of cost-sharing is also community-based. The problem is that programmes being developed with the World Bank's support did not seem to share the same type of concern as the NGO's community management activities. Namely a concern to invest in a process of building an 'honest' management system at village level (N1/96).

A step beyond managerial activism is what might be referred to as *advisory activism*. This involves activities such as information sharing with district government departments concerning CBHC, inviting district government staff (and indeed other NGOs) to take part in CBHC activities, and the type of work undertaken by staff at AMREF as they set about discussing, researching and training for CBHC in the Ministry of Health.

Finally, what is less in evidence, but a growing phenomenon, is *policy activism*. This refers not to involvement in partisan or party-political activities - an activity from which NGOs and societies are barred through registration - but to engagement with the politics of identifying and acting upon public need. At times, NGO do get caught in the crossfire of party politics. As one person said of the introduction of multi-partyism:

“Some parties, what they said is CBHC is for CCM. And then we sat down and posed the problem to the community....they said we should ignore the parties because the development of our village is for ourselves.” (N2/98)

However, what I am referring to here are the oft cited examples of villages that have analysed their situation in areas affecting community health, and have either used this to lobby with district government for support, or indeed mobilised themselves and taken matters into their own hands. On the other hand, CBHC as a philosophy and practice has not yet been used as a platform from which to debate national health policies or to advocate particular approaches to building more effective public health services. At the national level, in the type of work completed by AMREF's CBHC Unit, it has simply been advocated as an effective approach to community involvement in health. To state what is no doubt obvious, there generally is a gap between the evangelical activist and the policy activist, in the sense that NGO researchers and policy activists are more preoccupied with the agendas currently at centre stage, in essence, the cost, quality and quantity of health services.

It is important to note that these forms of activism are in no way unique to NGOs working in CBHC. There are many NGOs working in community development or integrated rural development, which could be described in the same ways. They too share the language of 'transformation', 'sensitisation', 'sustainable, self-reliant health', 'trust', 'moral support' and 'dependency-mentality'. In fact, such terms are deeply reminiscent of a government development speak that has rapidly fallen out of vogue since this research project began. As one practitioner reflected:

"I really wanted to take Nyerere.....because this is what he was preaching, but he never had people who could do it, so I wanted to show him that it has been done here, ...if we could have his voice again...." (N2/98)

Finally, whilst many people indicated that they thought CBHC was part of government health policy, or that it should be, history has taught caution:

"...we try to wake up government, and we get told not to be critical of our government." (N1/96)

In a context in which comment can be construed as negative criticism, the main opportunity for NGO activism really lies in creating and managing spaces at the local level – being evangelical, managerial and advisory activists. This involves working with communities in simultaneously defining and meeting health action needs, albeit within the parameters set by government policy and directives. Indeed as the government's philosophy has increasingly shifted towards communities taking direct responsibility for common facilities such as water supply, NGOs have an ever growing role to play in the area of managerial activism for promoting better health.

### **6.5.2 NGO and government links around health promotion**

As indicated in section 6.3, this research reveals forms of government-NGO interaction that appear not to be highly visible but that are fundamental to enabling a whole range of PHC activities and programmes to take place. From the data presented here it is evident that these interactions include the following:

- i) District Council involvement in approving community infrastructure projects, and providing necessary technical expertise alongside the NGO (N3/96);
- ii) NGO material assistance for activities such as immunization programmes or to tackle an epidemic (N3/96);
- iii) NGO delivery of specific interventions such as HIV/AIDS education initiatives;



- iv) NGO support to MCH and safe motherhood activities at dispensary level;
- v) NGO support to school health programmes;
- vi) NGO provision of training, learning and networking opportunities for government health and development staff;
- vii) Government extension of invitations to certain NGOs to attend ministry meetings concerning specific health issues.

Whilst these interactions are key to the PHC activities taking place – not least given the number of NGO ‘staff’ who are actually seconded government employees – there are limits to the extent of the links. One NGO practitioner (N7/96) observed wryly that the closest his agency had come to policy discussions was being invited to the (then known as) Regional Development Committee whenever it wanted to ‘capture’ the NGO commitment (for which read funding). Whilst NGOs are clear that they are working with reference to government policies, and whilst they commonly seek to draw key government staff into their activities in communities, they are keenly conscious of persistent problems. Government staff often don’t take up NGO invitations to take part in community projects. Agreements made with District Governments may not always materialise (N13/96). Government Guidelines may not always be accepted as realistic (N5/96) by NGOs. Government may have the policies, but it often does not have money (N8/96). From this research it is evident that in the mid 1990’s, links between individuals and around certain initiatives were indeed important to these PHC/CBHC initiatives. However, in many cases, these are characterised by a degree of informality that obscures them from the policymaker’s eye. From my personal working experience I would say that Local Government Reform as being implemented from the late 1990’s is likely to set in motion processes that help to formalise these interactions. This is not least because District Councillors are being encouraged to more carefully scrutinise the work and relationships of the District Councils. This changing context may enable more NGOs to engage with policy issues, and to achieve the type of ‘scaling-up’ and institutionalisation of their work that was discussed in Chapter 2.

In the next chapter I investigate in more detail the ways in which NGOs work with local governments for the promotion of PHC. I am particularly interested in what this reveals about how NGOs are located in the Tanzanian institutional set-up. It is my conclusion, in light of the data discussed in this chapter, that NGOs promoting CBHC look more like public actors, advocates and activists embedded in wider patterns of public action, than private providers simply supplying a particular health service. This is not the understanding of NGOs that comes through from the national

policy documents and protagonists, as discussed in Chapter 5. The embeddness of NGO activities seems to take shape as network relationships between individuals, organisations and programmes. Looking in detail at one NGO CBHC programme and its location within a local government context, I reflect on the significance of network relationships for local public action, exploring the ways in which relationships between local government and NGOs emerge, survive and fail.

## 7

# NGOs, CBHC and public action networks

This chapter looks more closely at how CBHC is being promoted within the 'local' context. Taking up the case of HPA's CBHC programme in Tabora Region, it reflects primarily on my third fieldwork question:

- In what ways do NGOs work with local government for the promotion of PHC?

The chapter discusses further the notion that NGOs might be better understood to be public actors engaged in networks of public action, than as private health service providers.

As described in Chapter 3, the data that underpins this chapter was derived from interviews conducted in Tabora Region in 1998. These interviews were conducted with staff of HPA, of other NGOs, of three District governments and the Regional government. In addition, I have been directly involved in facilitating and participating in the preparation of programme documents, meetings and workshops on behalf of HPA.

The chapter is divided into six sections. In section 7.1 I describe the CBHC programme and its position in the region in more detail. In section 7.2 I discuss the ways in which roles and responsibilities for health are defined. In 7.3 I reflect on how health is being promoted within the region, and in section 7.4 on the nature of interaction, interdependence and isolation amongst different actors. In section 7.5 I talk about the nature of community involvement as discussed by the interviewees, and in section 7.6 I conclude with a discussion about how the different actors, programmes and approaches fit together.

## 7.1 CBHC in a 'local' context

### 7.1.1 The CBHC Programme

In chapter 6 I outlined the purpose of HPA's development programme in Tabora Region. This was defined during a strategy meeting in 1996, at which the following goals were also outlined:

- To improve the organisational and management capacity of individuals and community-based groups;

- To enhance the knowledge and understanding of primary health and education issues;
- To continue to support the development of health and education infrastructure in the community;
- To continue to develop HPA as a learning organisation;
- To encourage the sharing of experience between development actors;
- To develop a locally-based, sustainable NGO which responds to the needs of people.

The philosophy underpinning these goals is that the promotion of primary health care depends upon a multi-sectoral approach that tackles knowledge and understanding (hence an emphasis on community and school health education), community infrastructure (dispensaries, schools, water and sanitation), and community organisation and management skills (HPA, 1996).

The programme is made up of components that can be identified as Child-to-Child, participatory research and project development, and support for construction of village-based infrastructure, all linked by the concept of CBHC. Finally, I indicated in Chapter 6 that the programme had evolved through a number of stages.

Situated in the mid-West of Tanzania, the main access to Tabora town is by rail, a journey that takes over 24 hours from Dar es Salaam. Travel within the region is difficult, with few all-weather roads, and it is not unusual for a number of villages to be cut off from Tabora town during the rainy season. Since I began this research project in 1995, water, electricity and communications-supply-have-improved tremendously, as in other parts of Tanzania. However, the negative impact of problems with these services on development activities and on awareness of changes in policy and practice should not be underestimated:

“There are several things [stopping people from being more dynamic]....One of them is, as remote as Tabora is, information. There are no workshops run in Tabora several times...you get a paper, the Daily News, three days after it is out. There is no television. There are all sorts of set-backs in Tabora.” (N4/98)

When HPA first started working in Tabora Region in 1991, the programme was run by a programme manager working alone and from home. In 1995, the organisation was offered a room in the Regional Block, home of the regional administration. HPA moved to its own office base in late 1996. Walking into the compound on a normal day in 1998, you are greeted by the sight of three or four vehicles, at least one positioned over a sump pit, where a full-time mechanic and his assistant are busy. There is a store for construction materials, where the Construction Co-

ordinator and his assistant are often hovering, when they are not at their desk poring over designs, or out delivering materials and technical advice to villages. Inside, the office manager is responsible for accounts, salaries, and paying for supplies. She works closely with the Programme Manager, an expatriate recruited in the United Kingdom, who is mainly based in town. The core development staff of HPA include the Cluster Extension Worker (CEW) Co-ordinator, the Research Co-ordinator and the CBHC Co-ordinator, who are either to be found discussing plans, writing reports or else simply as a name on the board announcing a trip to one of the villages currently being worked with. Most trips involve at least one night out of town.

The Construction Co-ordinator is a Community Development Technician (CDT) with Tabora Rural District, and has been attached full-time to HPA since 1995<sup>1</sup>. The CEW Co-ordinator joined the programme in 1997, having previously worked as an accountant. She is a full-time HPA staff member, and also a councillor for Tabora Rural District and women's representative for the District on the National Women's Committee. The Research Co-ordinator was a planning officer primarily responsible for health in Tabora regional government for six years. He spent the last three and half years whilst in post liaising with HPA, eventually on a formal attachment. When Civil Service and Local Government Reforms began to impact on government employment decisions in 1996, he opted to leave government service and join HPA as a full-time staff member. The CBHC Co-ordinator trained as a clinical officer, working in this capacity at the regional hospital and in a rural health centre. He was appointed the Regional Primary Health Care Co-ordinator in 1985, responsible for PHC activities in the region. Subsequent to meeting with HPA's Programme Manager in 1992, it was agreed that HPA would provide support to the village of Itonjanda in which he had been piloting CBHC. Increasing interaction grew into a more full-time arrangement in 1997, although he remains the Regional PHC Co-ordinator. Referred to as HPA's CBHC Co-ordinator, he has been responsible for the incorporation of CBHC as the concept informing HPA's programme, and also for piloting and developing another important component, CtC, a learner-centred approach to health education applied to primary schools. In addition, he continues his routine work as Regional PHC Co-ordinator, supporting VHWs, in particular those that are active around the mission hospital of Nkinga. He is responsible to the RMO, and for reporting to the MoH on the state of PHC in the region.

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<sup>1</sup> In 1998 a total of 3 of the District's CDTs were working with HPA. One as the Construction Co-ordinator as mentioned, and 2 others on village construction projects being supported by HPA.

### **7.1.2 Other organisations and programmes**

Tabora Region is currently divided into five district administrations and the municipal council. The districts are Igunga, Nzega, Urambo, Tabora Rural and the more recently created, Sikonge. The district interviews conducted for this research were done in Urambo, Tabora Rural and Manispaa (the municipal council), as these are the areas in which HPA has worked. However, Nzega and Igunga have been home to part of the World Bank funded Health and Nutrition Project which covered 10 districts in Tanzania, and more recently, to the World Bank funded Community Health Fund Pilot.

The Regional Hospital is Kitete, from where the regional health staff work operate. This is within walking distance of the offices of both the Manispaa and the Tabora Rural District Council.

NGO health service providers include the three mission hospitals of Nkinga, Ndala and Sikonge. Other NGOs are the church-based development agencies, such as CARITAS, the development offices of the Moravian and the Anglican Churches, and a number of small initiatives, including activities by the Pentecostal Church, and American evangelical organisations. Non-religious NGOs include WaterAid (which started work in Tabora in 1995), and HPA, and Tanzanian NGOs such as TAHEA (Tanzanian Association of Home Economics). In 1998, additional NGOs were active in the region. These included Save the Children Fund, which was on contract to the World Food Programme to conduct research into the food situation, AFRICARE, and Pride Tanzania, which provides credit and training to micro-entrepreneurs. Finally, there are a number of private dispensaries and pharmacies that have emerged in Tabora Town, and in the district towns. There are also growing number of international companies in the region, most notably concerned with tobacco and mining.

### **7.1.3 Working with local governments**

HPA's first port of call when visiting Tanzania and then Tabora in 1990, was government departments. It was through meetings with government staff that the 'problem' of building and maintaining the physical infrastructure of local health services was identified. When HPA began its programme in Tabora Region, like the majority of NGO programmes that were providing support for village-level infrastructure – dispensaries, schools, water and sanitation – its relationship with district administrations was based on the idea of working with the existing government system of project identification and implementation. Through this system, village governments would submit requests for support with village infrastructure projects to the district, which would then assess the proposed project in the light of national and district priorities and budget. Where a project was

accepted, the district would then ostensibly provide support in the form of particular inputs. These inputs would include a CDT to supervise the construction work, a district truck and fuel to transport materials, and provision of any materials not available in the village locality, such as corrugated iron and timber. The village would be expected to contribute to the project in terms of funds to pay for local craftspeople such as carpenters, voluntary labour for the site, and mobilisation of locally available materials that might include sand and rocks for making bricks.

However, in practice, district governments were unable to keep up with requests, the result being a growing backlog of need to build and rehabilitate dispensaries and other infrastructure. In common with other NGOs and donors, HPA attached itself to this district government to village government system on the basis that there was an expressed need for additional external inputs. This meant that the districts would pass on requests from villages to HPA, which would then assess the extent to which each village demonstrated the project to be a 'felt need', and prioritise villages for support. This basic assessment work was done with the help of regional and district government staff. The supposed result was a tri-partite understanding between government, village and NGO, in which HPA would most commonly provide the additional construction materials, in addition to other forms of support such as facilitation of management issues.

As HPA began a gradual shift away from a single focus on village infrastructure towards CBHC, it went through a number of stages in its thinking about this tri-partite relationship. By late 1993 it was recognised that the process of assessing village requests coming through district administrations needed developing. The existing system supposed that requests being put forward by village governments expressed a felt-need. However, it was clear from HPA's experience that in reality projects might not mobilise village support once started because they had not been proposed through a process of wider discussion in the village. In the throes of a transition from the single-party centre-to-village 'government' system, this approach to 'project identification' did not work satisfactorily for an organisation that was itself maturing into an awareness of the importance of 'participation'. The first step taken by HPA was to train Trainers of Trainers (ToTs) from the districts in Rapid Rural Appraisal techniques, and for the regional planner now attached to HPA to work with these ToTs in assessing the needs and motivations of villages whose requests had been passed on to HPA.

The tripartite understanding around project set-up and management continued. Yet by 1996 consistent difficulties being faced by districts in meeting their obligations were provoking discussion about programme support in HPA. For a period, district administrations had not received their development budgets from central

government. Previously, due to the late arrival of central government funds, HPA had been helping districts by paying the CDTs' out-of-station allowances in order to enable them to continue to work on project sites, the idea being that districts would refund HPA later. As funds were not coming from central government, the districts began to run up a debt to HPA. By the time repayments were eventually made, HPA had decided to work in slightly different ways.

Once again, these decisions reflected not just the operational reality in the region, but the maturing and growth of the organisation, which had also been expanding its capacities through increased government staff involvement through formal attachments. Since late 1994 there had been discussions about developing CBHC as a programme approach, and about the strategies through which HPA could extend CBHC in order to make its support to village health infrastructure more effective and meaningful. Once again, it was recognised that the system of ToTs conducting RRA in villages was insufficient. On a practical level it was not working effectively, since HPA could not always be sure that the ToTs would be available for activities with HPA in villages. It is a commonly cited phenomenon that NGOs and donor-funded programmes depend upon the same district resource, and at times effectively out-compete their rivals in terms of the per diems they are prepared to pay to have government staff attend training or undertake activities on their programmes. HPA began to discuss the desirability of working in clusters or groups of villages, rather than across a series of 'stand-alone' projects. It was felt that this would allow HPA to make more rational use of resources, reducing the demands imposed on staff time and on transport when responding to individual projects anywhere in the region. The justification for working in clusters of villages was developed further in the debate about programme objectives in 1996. The idea was that the CBHC principles of participation, dialogue and village-based action would spiral outwards to neighbouring villages from a core village. This would be actively promoted by HPA, especially through the recruitment of 4 Cluster Extension Workers (CEWs). These CEWs are women who have been elected by their villages to this role, and by 1998 were being supported by a full-time Cluster Coordinator based in HPA's Tabora office.

By 1998 HPA's project agreements in Tabora were two-way and formalised on paper. Signed with village building committees, these formalised agreements do not involve district administrations directly. HPA now pays for the CDTs' out-of-station allowances, calculated into its project budget as an HPA cost. Where villages need support that they expect from districts in the project implementation system, such as access to a district truck, they negotiate this for themselves with the



district and either raise the money for fuel themselves or request help for this from HPA.

The current system effectively reduces HPA's operational reliance on districts. A growing emphasis since 1996 on building the management and organisational skills of communities in prioritising, planning and managing community-level projects reflects the realities of the context in terms of who is expected to do what for community projects. It also represents a shift away from direct efforts to build or develop certain capacities in government, to doing this in villages. In line with this shift, by the end of 1998, in some villages HPA had piloted the idea of a village project management team that signs to its obligations for the project, rather than the more fluid arrangement of the building committee formed from village government members. Although such a building committee ostensibly report to the village council, it has proved difficult to pin down accountability to the project, because its composition appears to keep changing. The project management team consists of named individuals elected to the role by the village, who receive training and support from HPA staff, and who can be held more directly accountable for issues related to project management.

In this section, I have begun to uncover the way in which HPA's programme is located in Tabora Region. It is the only programme that refers to CBHC, although there are other NGO programmes in existence that are concerned with health, and with community development. The relationships that exist between HPA, regional and district governments, and communities, are not dissimilar to those that exist between other NGOs and the same parties working on community development initiatives in general. In the following sections I look at how NGO and government staff talk about each other and their work to promote PHC and improved health.

## **7.2 Defining roles and responsibilities for health action**

All development actors in this context share the same broad notion of who is responsible for what. Central government designs policy, and local government implements policy. Local government monitors and supervises NGOs and for-profit service providers, and these NGOs and for-profit service providers should be aware of whether or not their activities are in line with government policies (N4/98; G4/98). This system is managed through more or less adequate tools and mechanisms, many of which, in an age of reform, are being redesigned. For example, private health facilities cannot open without government permission, and may be restricted in certain activities - such as provision of vaccination services -

until they can meet the required standards (G8/98). However, the comments of NGO and government employees point to a more complex working out of roles and responsibilities.

To begin with, few people are aware of the actual content of government policies, such as HSR, beyond the broadest brush-strokes. One member of HPA's staff who, as a government planner previously, had been responsible for co-ordinating agencies concerned with health in the region, says:

"I must be frank. At that time I didn't know much about the policy itself... I knew that health was free, but... I hadn't read a policy document on health. Maybe, through my own initiative I read some papers on community based health care... But I am not sure whether I, people, talked much at the regional level... about the policy, how it is affecting people, how it is being implemented..." (N4/98)

He did begin to hear about HSR in 1994, when others began attending workshops in Dar es Salaam. These workshops were concerned with the World Bank-funded Health and Nutrition programmes in Nzega and Igunga Districts in Tabora Region, which were to become two of the pilot districts for the Community Health Fund (CHF). Those people who are conversant with policy details are those who have been targeted through workshops specific to their particular job. For example, in 1997, key health staff in the region were involved in a workshop with people from the MoH (G5/98). It seems that this was aimed at describing how to implement the activities associated with the policy rather than inviting comment or advice from the local level.

Similarly, most people only gave a vague sense of who is who in the region. After some reflection on the part of the interviewee, I might be told that there are about 23 private dispensaries in Tabora Manispaa (compared to 14 government dispensaries) and possibly around 15 dispensaries owned by religious organisations (G8/98). Or that there is one Roman Catholic and one Moravian health centre, and some private dispensaries in Urambo District, which are supervised by the DMO/DHMT according to MoH standards (G6/98). Some government staff reflect that Tabora lacks donor support, unlike regions such as Arusha. If pressed further they will begin a short list of who this includes, such as CARITAS, the mission hospitals of Ndala and Nkinga, HPA, possibly Oxfam, the World Bank programme in support of dispensary building, and possibly the Child Survival and Protection Programme (CSPD) under UNICEF (G5/98). Such sketchy responses do not suggest the existence of close relationships between programmes and organisations. In some cases this might be because the initiative in question is being implemented as a vertical programme, and is only being handled by one

person on a regional or district team. In other cases, as with the example of HPA and other NGOs such as FUM, the lack of knowledge on the part of certain government health staff is attributed to the fact that these organisations work direct with villages (G6/98). Finally, an organisation's interests and geographical coverage can limit the scope for co-operation between parties (G5/ 98). Interestingly, I was given almost as much information about specific activities - such as the rehabilitation of the regional hospital maternity ward - sponsored by for-profit health service providers or tobacco companies working in the region, as I was about what NGO health actors are doing. For most government staff, who consistently refer to the lack of resources such as funding, transport and staff (G8/98) in the government system, all these organisations, whether NGO, multi-lateral development agency, or for-profit business, are donors, to which the term 'NGO' is generically applied.

The question of access to requisite resources and capacity drives right at the heart of the definition of roles and responsibilities in practice. No-one I interviewed spoke in terms of public and private, but people articulate the differences between government and other agencies, and between central, regional and district government. Civil Service Reform and Local Government Reform have together been responsible for a number of significant changes in the definition of roles and responsibilities within the government system. Within the regional administration, the shift has been away from departments with heads supervising a corresponding department at district level, and responsible to a parent ministry. Instead, regional governments have been re-formed as secretariats, responding to central government, and co-ordinating district governments. This idea of a secretariat encourages team-based rather than department-oriented work (N4/98). It also helps to reduce the duplication of work that used to exist between regional and district level. Now the implementers are ostensibly all in the districts, although delays in receiving funding have disrupted the re-deployment of staff (G4/ 98).

"The intention is that most of the technicians should be allocated into districts because they are the ones who are closer to the people. And only a few to be [at the regional level], for advising the Regional Commissioners and Government, and the implementers should be at the district level." (G4/ 98)

Government staff also see NGOs as implementers, a role that attached or ex-government staff employed with NGOs such as HPA are happy to take on:

"You know, when you work with government...you cannot concentrate completely. Sometimes I was co-ordinating UNICEF activities, World Bank activities, you have to rush to workshops, where you have to do this. I mean you don't concentrate and you don't have time to design interventions." (N4/98)

People who work within the sphere of an NGO programme commonly express a sense of frustration about working within government. They refer to the lack of resources, the resultant lack of work to do, the lack of reward for initiative, and low pay. Working with an NGO can enable people to actually do the job that they were trained for by the government (N6/98).

However, the definition of what constitutes the role of NGOs in implementation is interesting. Their role is seen in part as being to provide the additional resources that villages need for projects. Indeed, for some, the role of NGOs is to fill gaps where others are unable to meet their responsibilities:

“...first you must understand that the work we are doing, we are doing it for somebody else... for the government and for the villages... the work that somebody else was supposed to have done. If the villagers had done it we wouldn't have done it. If the government had done it, we wouldn't have done it. Now as an NGO I think we are bridging the gap.” (N4/ 98)

But it is not clear whether these activities are simply in gap-filling for what 'should' have been done, or in the name of a partnership that both identifies and meets needs. There is a word of warning about making simple assumptions about the roles and responsibilities of other actors:

“... the main objective for these [for-profit health service providers] was to augment or to help the government meet the needs of the people.... Something which is happening differently is that now these private people are just interested in getting money.” (N3/98)

The role of government is described as being to co-ordinate, and to provide government officers 'as required by... NGOs, to strengthen their planning capacity, to strengthen their work in villages, to smoothen their operations' (N4/98).

However, the work being done by NGOs is not simply about filling gaps as government resources retreat. It is also about taking forward types of work that government has not (yet) built the capacity for. As one government employee told me, the government is interested in people being involved in development through participation. The government expects NGOs to take on the role of creating awareness within communities so that they can identify their problems and implement them, because government 'is somehow not so capable for implementing these projects involving communities' (G4/98).

### **7.3 Promoting health**

Through this fieldwork I wanted to find out about how NGO and government staff understand HSR and PHC, and whether and how they work together for PHC/

CBHC. The links are often weak, but reveal some interesting, and indeed, surprising connections.

The first point of interest is the way in which HSR has been experienced and understood. One person described HSR as starting in 1997, and as being about instituting a regular supervisory and monitoring system, based on the Management Information System (MIS). For her this means that reports cannot simply be written, sent upwards and filed, but require some action and response. The regional health team should visit districts twice a month, whilst previously there was no time or opportunity to do so (G5/98). So HSR is experienced as a tidying up of health service management. For most, HSR is also about people paying for health services in hospitals (G5/98; G6/98). It is about dispensaries ordering the drugs they actually need rather than receiving standard basic drug kits every month (G6/98). Very few people referred to CHF's without prompting. No-one was able to talk in detail about the design or outcome of the introduction of these funds. One person did make the point that, if these CHF's are currently being matched with 50% funding from the World Bank, he is concerned about what will happen when the donors withdraw this contribution. The one person I thought might be able to tell me more declined an interview on the basis that it was too early to talk about the progress of HSR.

The second point of interest, and probably the most surprising thing I have encountered during this research project, is the way in which people were connecting HSR and PHC. I had expected to encounter health practitioners at the local level who are both wedded to the PHC philosophy and its history in Tanzania, and concerned that HSR, with for example its introduction of user fees, might run counter to the aims of PHC. What I came across were plenty of statements about how PHC, as implemented, has not worked well. These were not surprising in themselves, as they have been well rehearsed around me over the past few years. What is significant is that it is precisely the problems that have been experienced with PHC implementation that make HSR all the more acceptable to government health staff. Although one person did refer to a functioning PHC committee system from regional to village level (G6/98) others were quite open about the fact that what was once active is now dormant (G5/98), and that:

“... there was a committee at the regional level, HAM [PHC]... what it was doing was to discuss some reports from the district primary health care committees. It wasn't very active... The RMO has a certain role there. Now if he doesn't actually call a meeting, then it doesn't meet. There was no pressure.”  
(N4/ 98)

It seems that the lack of activity amongst PHC committees preceded the reforms of the mid-1990's, although to some extent, their weakness is explained by disruptions due to recent changes. The introduction of multi-partyism has altered the way in which various village-level committees are formed and operate, the implication being that such committees are more a matter of choice than directive (G5/98). Significant restructuring within government has seen the movement of staff, and a resultant lack of continuity in some areas of work (G5/98).

In fact, HSR is also experienced as a change in the composition of committees and working groups. Its emphasis is on the Regional and District Health Management Teams. One person suggested that this is a good thing, because 'team' sounds better than 'committee'. However, he also expressed concern that these DHMTs only comprise health staff (N4/98). For example, the RHMT has been reduced in size. Staff who might have taken part in meetings previously, such as the VHW Co-ordinator, have been allocated to districts, which is where, after all, the 'community' is (G5/98). In this respect, although nobody said it, there is potential to strengthen the PHC system as 'experts' are moved to district level. However, it should also be recognised that the DHMT or RHMT that are the focus of the current wave of HSR, are fundamentally different from the PHC Committees. One interviewee talked of a district PHC plan, prepared by the district PHC committee, which is chaired by the District Commissioner (DC) and has the DMO as its secretary. This committee works across all sectors, including education, water and community development. In principle, it is providing an integrated and holistic approach to health development, provided, of course, that it is active. It is this committee that then supervises the PHC committees-at-village level (G6/98).

Although on balance, people indicated that the PHC committee structure is not active, and that the DHMTs are functioning, they did not see this as the death of PHC and the rise of HSR. Instead, PHC and HSR are perceived to be the same thing, albeit working through different systems. For one person, PHC was simply about going on supervision visits and discussing issues. On the other hand, with HSR, you visit, you discuss issues, you identify solutions, you get feedback about the implementation of the solutions, and you follow-up. In other words, you actually do some work beyond discussing the problem. This prompts her to describe HSR, unlike PHC, as 'down-up' (G5/98). Under PHC you could devise strategies but not make any decisions, but with the DHMT, monthly decisions are being taken that enable staff to work towards their goal (G8/98):

“... they are not two different things. It is one thing. PHC is to ensure that primary health care reaches the people, and [health sector] reforms are simply

changes in order to improve such service to be able to reach the client.” (G8/98, translated from Swahili)

On reflection, what people are talking about is a more conducive working system for the implementation of HSR than was experienced latterly under the PHC strategy. However, implicit in the comments made about PHC implementation are plenty of warnings concerning the sustainability of current reform. The most commonly cited problem with PHC is lack of resource. This lack of resource might be described as a lack of funds for committees to meet, as it was once intended would happen on a three-monthly basis at zonal level (G5/98). More commonly however, the resource issue comes back to transport, and the capacity to visit districts or villages. Lack of transport does not simply refer to the lack of vehicles as such, but also to lack of resource to ensure maintenance and to buy fuel. For those who remember the heyday of PHC implementation, activity was possible due to the provision of vehicles for support and supervision. This fell apart once resources were withdrawn:

“The plan was to support ... the Ministry of Health to conduct primary health care in a sustainable way, but they didn't prepare the regions... so it was something which was superficial... the idea that UNICEF was to supply transport, but after three years the transport is permanently for the region. But most of the leaders were [not] aware of that, so once the vehicle gets broken... it may get repaired, but it may now start being used by several other people within the hospital management.” (N3/98)

For the time being however, those DHMTs that have direct access to a vehicle under HSR, express confidence that it will not end up on the blocks - a not uncommon sight in most government compounds until a few years ago. This vehicle is for dedicated not general use, and they feel secure that it will be maintained (G8/98).

As for CBHC, I found some people who had been trained, either through the CBHC training provided to regional government staff in the early 1990's, or in one case, whilst in post in Rukwa Region (G10/98; G5/98). However, most other people I interviewed had only heard of CBHC in the vaguest sense, as something that is part of PHC (G6/98). Another group of people knew about CBHC from the pilot work done in the village of Itonjanda, but had not followed its progress (G8/98). Someone else said he had heard about it during a PHC course as part of his postgraduate diploma in rural planning (N4/98). For one person who had been trained in CBHC, and who claimed to use the approach in her work, there is no difference between CBHC and HSR. CBHC is about communities being able to identify their own problems, and being able to resolve them without relying on

others. HSR also wants the community to work for itself. She describes CBHC as something that has come as a stirrer of the community, to make them think about how to be more self-reliant. HSR has followed as the outcome, addressing the issue of how the government should implement health services in order for the community to be able to do things itself:

“And that is the reason for HSR to be included [as a policy from the MoH]... for the people to realise that the government has no capacity to contribute or to provide everything... It is implementation only. HSR is about implementing what came from cobasheca (CBHC).” (G5/98)

At another point in this interview, she talks about the problem of poor communities and people's inability to afford user charges. She refers to the CHF scheme in Igunga in positive terms, because it enables people to pay one small amount, and then to be entitled to health services as they need them. However, for others, there are causes for concern in HSR, mostly related to why and how it is being implemented. If the DHMTs are facilitating rather than lecturing then this will represent positive change, after all, they are working to the same PHC package of prevention, promotion and curative services (N3/98). Similarly, if CHFs are being established:

“... to make sure they are capable of running their health facilities, then this community health fund is a nice thing. But if it is just creating a market... or asking people to contribute their money and then the health does not improve, then it is wasted... If they come by a place where this CBHC training has been done, I think that is where they will get a challenge. And if they get a challenge from there they can learn what is happening. Because I am sure if communities realise... what they need, they may even say, no, this is not appropriate...”  
(N3/98)

This kind of statement captures the scope for tension I discuss in Chapter 1; tension between reforms aimed at empowering communities and reforms that treat communities simply as the recipient of change.

No-one I interviewed made a significant distinction between preventive and curative services, which I take to mean that they really do see PHC as being about combining prevention and cure at the primary service level. In this sense, NGOs and government staff share similar concerns, and even common activities. An NGO such as WaterAid will refer to the problem that ‘most of the diseases that affect people in the villages could be prevented’, and hence make a link between water and sanitation facilities (N8/98). Similarly, government health workers see themselves working with communities to tackle the same issues. This might



include working with ward leaders and committees to ensure that health education is being conducted in the area. The ward health committees can also use bylaws to apply pressure, for example to ensure that households build latrines. This work might also include training Community Based Distributors (CBDs), often used to spread information about the importance of vaccination (G8/98; G5/98).

However, for those concerned with community-based as distinct from institution-based health services, there is a worry that CBHC will be treated as a project, implemented out of the MoH as another vertical programme like the VHW scheme:

“I said, ‘the CBHC Guidelines say they are going to teach community owned resource persons’. Now I tricked her. I said ‘are you going to teach people to become community owned resource persons, or are you going to teach community owned resource persons to become what?’ .... What I know of CBHC, I am sorry, if it is to be implemented from the Ministry to the grassroots, there must be so many changes. But if the resource persons...existing already in the system, do something in their places... these will become focal points for others to learn, and through that CBHC may be something...” (N3/98)

For the CBHC activist, there is a need to go further, for CBHC to become institutionalised. HPA’s Co-ordinator talks about how he would never have been able to take CBHC beyond a pilot village and CBHC training at the mission hospitals had it not been for his relationship with HPA. Through this he has been able to access the resources, the support and the opportunity to build his own confidence in CBHC through experience. In his capacity as Regional PHC Co-ordinator he has no CBHC budget, and neither does the RHMT. He has to lobby with NGOs and local governments (which have their own sources of funds that can be lobbied for).

#### **7.4 Interaction, Interdependence and Isolation**

By 1998, Local Government Reform had begun to have a significant impact on the working environment within which other reform packages such as HSR are being implemented. Local governments (meaning the districts) have their heads of department as in the past, but are no longer arranged directly under corresponding heads of department in the regional government. The districts previously received directives from the Prime Minister’s Office, and indications as to how much money and how many projects they could undertake:

“There was this man McKinsey, he misdirected us, so we changed, and that is the reason they brought back town committees. These committees should have

their own powers to decide in their areas and the affairs they see as important and beneficial to them and the local people. Not someone from Dar es Salaam... you haven't even sent him to the interior of the villages, where you drive for six hours in order to get there...." (G9/98, translated from Swahili).

The district council works with the elected district councillors, Indeed, in recognition of the real shifts in power that are implied within these reforms, HPA has begun to train and work with rural councillors, now a key link between villages and district decision-making. At the same time, there were plans afoot within the regional and district governments of Tabora to train district staff in PRA (G4/98). As one district government planner noted, villages are bursting with projects. The problem is helping villages to plan these projects more strategically, in manageable phases There is also the very real resource constraint at district level. It is worth noting that a district's development budget (as funds available over and above funds for meeting recurrent costs) is not very different from the amount of money being spent annually on development projects by an NGO of the size of HPA.

The corresponding change in the role of regional administrations has been a substantial downsizing, as they have moved from being comprised of departments mirroring those at the district level, to forming secretariats. The idea of the Regional Secretariat is that it acts as a team, a team that co-ordinates and advises the Regional Commissioner and the Districts (G4/98). The development budgets have been shifted directly to District Councils, leaving the Regional Secretariat with the role of co-ordinating between Districts, Ministry of Finance and the Planning Commission.

Of course, whilst many of those working within the government system talk positively about the changes and the potential they have for making a difference to the way that they work, there are still many problems, not least with resources. For example, the DMO might be responsible for all district health services now, but given a common lack of transport for supervision trips to health centres and dispensaries, is often unable to follow up on village based services. This problem is compounded by the fact that with staff shortages, the level of work required of the DMO in the district hospital itself, leaves little time for outreach work (G6/98). Talking of decentralisation as an aim of HSR, one person suggested that districts still do not have the power to do the work intended, and rely on the region for support for planning (G5/98). There are also limitations to the extent to which each layer really internalises the idea of decentralising. For example, one district staff member reflected that HSR was a policy that had been designed by central government and sent down for implementation, indicating that this is as it should be. The districts are then the translators of the policy for local people. Each

ministry has its own policy that descends (with its targets), and the district has to set out to achieve it. It is the districts' role then to explain it to people, and educate them to see the priority (G9/98).

Within this context, relationships between HPA and district governments are described as being good. HPA staff refer to 'respect' for HPA's work, and the fact that HPA and district governments are working in partnership on the basis of agreements about respective roles (N4/98). However, there are can also be misunderstandings, and at times pressure can be placed on the organisation to direct resources in particular ways. The nature of the 'agreement' has also changed, in admission of reality. HPA began to pay for CDT's allowances in order to keep them on village sites, and the cost of a CDT's out-station allowance has simply been taken up as part of the total cost of projects to HPA. The districts still provide trucks, but at times it can seem that this is not worth the effort required to organise, fuel (although ostensibly the districts provide this) and, often, maintain them (N6/98). In many respects, the interface between an NGO such as HPA, and district governments, has grown around practical needs. And as these change, or as the capacity to meet them shifts, the need for this interaction might begin to fade. However, in this changing context, NGOs themselves also redefine their reasons and mechanisms for interaction with government. One example of this is provided by WaterAid, which aims in its programme in Tabora to build the interest and capacity of local NGOs to get involved in water and sanitation. In recognition of the practical need of such NGOs to access experienced water staff, who are still largely only available in government<sup>2</sup>, WaterAid proposed a forum where NGOs could come together with government and discuss access to the human resources they need for projects. Around the same time, a meeting of NGOs in the region recommended that the regional administration be approached concerning the establishment of a committee where NGOs and government could discuss development issues. In the event, WaterAid took the initiative with the Regional Development Director (RDD), and the Regional Steering Committee was formed in 1996:

"It has powers because it is being chaired by the regional administrative committee so we can give directives and.. the NGOs and the departments of the government have to adhere to it." (G4/98)

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<sup>2</sup> "the government is the partner, the only fact is we don't fund the government... we fund the NGOs, and the NGOs are using the government staff... I must admit that if we did not have the human resources available within the government departments it wouldn't be feasible for NGOs to..." (N8/98)

Such initiatives from NGOs highlight the nature of interdependence between government and NGOs in some areas. However, the case of the Regional Steering Committee (RST) shows that things do not always run smoothly. Some NGOs have not participated, on the grounds that it has been reduced to being a water committee, not a development forum. Others suggest that people simply go there to meet because they receive a sitting allowance for doing so. Still others complain that some NGOs do not want to share information about their work or funding levels, hindering the preparation of a development plan that incorporates all actors (N8/98). During the period of Local Government reforms, rather like the PHC committees, the Regional Steering Committee has not been meeting regularly (N7/98). Indeed, in light of these reforms, it appears that District Steering Committees might be a more appropriate level, because it is from there that more direct co-ordination and administrative support can be offered to wards and villages than by the Regional Steering Committee (N8/98).

However, what does seem important about initiatives such as the RST, is that it came from an NGO proposal to government, and does offer an opportunity for building mutual understanding. It becomes possible for government staff to say:

“I think the relationship is improving. There is no conflict of interest between the government and NGOs...NGOs should ... do their work, assist the community in accordance to the government policy, so we advise them to go along the policy.” (G4/98)

It provides an opportunity for NGOs, still a very new phenomenon in Tanzania to overcome:

“... the impression a good number of people have of NGOs ... as some funny malingerers. Nobody knows what is an NGO.” (N8/98)

## **7.5 From the bottom-up?**

As I discuss in Chapter 4, the notion of involving ‘community’ has a long history in Tanzania’s public policy discourse. Regardless of whether the people I have interviewed work in an NGO or in government, they express a similar idea about the need to enable communities to move beyond their ‘dependency mentality’ - whereby they expect government to come and provide services - to become more self-reliant. In neither NGO nor government have I encountered people who attempt to define or disaggregate the ‘community’ they are referring to. Where this does happen, it is largely in terms of categories, such as ‘youth’ or specific target groups, such as the under-5’s. Alternatively, different ethnic or geographical communities are referred to, as in, the people of Arusha who simply have to be

mobilised and they will fundraise to solve a problem, whereas communities in Tabora have too low an income (G7/98). However, the notion of community itself remains powerful, and is constantly alluded to in the public policy arena.

In the microcosm I was looking at, where CBHC begins to meet HSR, where decentralisation begins to meet villages, it is evident that wider reforms within government have had an impact on the talk surrounding community involvement. For those in districts talking about decentralisation, there are the changing roles. Districts are now there to give power to the local people, building their capacity to think for themselves, and witnessing their waking up to self-reliance. The District is simply there to help give people direction (G9/98). On the other hand, participating in a workshop introducing rural councillors to participatory approaches to development, I heard a lot of comments about how the councillors feel pushed by government directives (in 1998, the issue was building primary school classrooms) rather than being able to take forward community needs. There is clearly a persistent tension between calls for community involvement and a de facto centralised policymaking process. Whilst even those in NGOs do not see that the role of policymaking should be open to villages (N3/98; N4/98), they do seek to enable communities to make their own kind of decisions in certain areas.

A classic example of this tension is the issue of who owns village infrastructure such as dispensaries, an issue caught between policy directives from the centre, the rhetoric of community participation, and the de facto lack of capacity on the part of districts to provide the requisite resources for such infrastructure. References are commonly made to the fact that such infrastructure is owned by the village. At the same time, on more than one occasion, HPA has been asked by government staff about whether or not the dispensary building projects it is supporting meet the standard government design. Whilst standard designs have obviously served a purpose over the years, in the sense of providing a basic model against which to measure appropriate size and cost (N6/98), there is another aspect to this question of design:

“I think the challenge that there is now is how to... discuss with the communities who owns the institutions which are in their areas. Is it really entirely government property? Who is caring for them, who is maintaining it, and from that point, they can realise it is their own... even in the designing they can say ‘we want it to be like this’.” (N3/ 98)

This is about the closest I have come to a statement that links community participation to the politics of provision rather than simply to the need to mobilise communities for development activities. This same person spoke along similar lines when talking about CHF's and the importance of people understanding them

properly so as to be able to give their ideas about them. However, the bulk of NGO and government talk about community involvement is about people accepting change not influencing it:

“I think in this period of reforms the people who are required to have more responsibility in the health changes are the local people.... We [health workers] are just the doers, trying to implement the changes.... And if the local people refuse to do them... we will not succeed. Therefore the society ought to be educated to realise why we ought to make changes...” (G8/98)

For those who have not been immersed in the Tanzanian discourse of community participation, there is some scepticism about approaches such as CBHC, a sense that it is simply reduced to being a training course or a committee, and:

“Although we do train people and there are CBHC committee, I am not sure how sustainable or how effective they are...I mean, I think there is just a tendency in Tanzania to have a committee for everything, and part of our job is to question that kind of thing.”(N5/98)

## **7.6 Conclusions: How does it all fit together?**

This chapter set out to look more closely at how CBHC is being promoted in the local government context. It addresses the fieldwork question: In what ways do NGOs work with local governments for the promotion of PHC?, taking up the idea put forward in Chapter 6 that NGOs might be best understood to be public actors engaged in networks of public action. As I explain in Chapter 3, the design of the research that underpins this chapter was informed by Anheier's third question: How does the nonprofit sector relate to or interact with other sectors? How is it located in the overall institutional setup or structure of society? (Anheier, 1995).

I embarked on this piece of research with the intention of exploring the institutional location of NGOs through the case of one NGO CBHC programme. I took, as my understanding of institutions, a two-level definition. Firstly, of institutions as organisations. Secondly, of institutions as norms, values and practices (Chataway et al, 1998, pp8-9). It was my intention to 'map' the institutional environment within which this CBHC programme is located. I sought to map out the organisational field, or the various organisations that came with the orbit of the programme, and to map the linkages between these. I also intended to develop a map of people's perceptions of the programme and of relationships around health action.

In the event, I found the organisational field, and the scope for uncovering links between organisations, sketchier than I had anticipated. I had expected to be able to

identify networks of relationships, and to be able to look at how these work, with reference to how they emerge, what they do, and how they are mediated (for example, through trust or through contract). In the event, as I discuss below, over the whole of this research project, I have uncovered some important network relationships that fall between assumed organisational and sectoral boundaries. However, my attempt to chart the institutional setup through people's talk - which begins to uncover their levels of knowledge and their perceptions - was far more rewarding than my attempt to map out the organisational field. It has enabled me to draw a firmer outline around the shadows that reveal how organisations, programmes and approaches fit together. This is a conclusion for this research in itself. In other words, the apparent manifestations of phenomena in terms of projects, programmes or organisations, may not be as solid, satisfactory, nor revealing, as people's expressions of what they think is happening in their environment. Indeed, there are many activities and relationships occurring in that environment that are nascent, transient or quite simply hidden. This can make them hard to identify and to chart.

As for what this research reveals about the ways in which NGOs work with local government for the promotion of PHC, there clearly are important forms of interaction and even interdependence. These alter as individuals, organisations and institutional context change. However, although these forms of interaction are quite deeply embedded (for example, the district-NGO-community relationship around infrastructure projects) they are more operational than strategic. By this I mean that the individuals, organisations and indeed institutional context has not encouraged the emergence of forms of interdependence that go beyond simply meeting the practical needs of the parties involved. An organisation such as HPA is not aware of the details of government policy to the extent of relating its support of community health development to HSR. Likewise, government staff at local level do not demonstrate a good knowledge of the various agencies operating in the area. Or rather, they can talk at length about the most recent project, programme or initiative to have walked through the door, suggesting that their working life is often more directed by opportunities that arrive rather than by opportunities to develop their own initiatives.

That is not to say that organisations are not acting strategically. HPA's shift away from training district ToTs towards working with CEWs is in effect a strategic decision in a world in which local government is not able to provide all the practical parts anticipated, and in which 'civil society' and forms of action outside formal government structures are increasingly emphasised. The organisations that are part of this story are still finding their way towards more strategic interactions.

Very often, for example, initiatives that bring organisations together, are short-lived, and/ or more individual than institutional. As one person says 'the informal network here is good and these guys use it well' (N5/98). At the same time, for those government staff attached or seconded to NGOs, their place in the government network can also suffer from tensions arising because others think they are earning much more (N3/98; N6/98) and because they effectively have two bosses. As NGOs shift more and more to direct employment of staff rather than government secondments, the scope for people to use these networks may be much reduced. This will have a significant impact on how CBHC is promoted. During this research, I have been most struck by the relationships that exist between government and NGO staff. Indeed, it is through these relationships that CBHC has developed and maintained a life of its own. Most NGO staff I have interviewed are ex-government employees, or people who have been attached or seconded to an NGO. When looking at a small group of people facilitating a CBHC programme, it can be difficult to separate out what is 'government' from what is 'NGO'.

However, although their nature might change, these government-NGO staff relationships have persisted around a common interest in community based and promotive health activities, and can be described as networks of action. The case of CBHC promotion reveals two types of network, implementation network and policy network. Implementation networks are primarily concerned with processes and activities at the regional level and below, and aimed largely at the operationalisation of CBHC programmes. Policy networks are formed around direct efforts to influence national level thinking through relationships at the centre of national government.

As I indicate in Chapter 6, the implementation network is the most common form of government-NGO relationship, largely because this is where NGOs operate and where there is space for regular interaction. These networks are generally built around the existing principles and history of supposed relationships as conceived of under a one-party system. Under this system, the region was seen as connected to the district, connected to the ward, connected to the division, and ultimately to village-level committees as representing the lowest echelon of government. As discussed in Chapter 4, the principle of this system has been that all levels are involved in development initiatives, each with certain responsibilities. Thus village committees are responsible for mobilising local funds, labour and materials, district for providing extension workers, staff allowances for technicians working on site, and transport for materials. Over time, given severe resource constraints and changes in policy, this system has often not worked clearly and effectively. It is not uncommon to encounter contested and confused understandings about who is



responsible for what. NGOs have often slotted into this context in ways revealed by the case of CBHC – providing additional resource, linking village to district council, and lobbying local government for resources.

The example of AMREF highlights a connection between implementation and policy networks. Like other CBHC actors, AMREF set out to promote the adoption of CBHC within the regional and district government system in Rukwa. However, its CBHC unit also targeted the national level through the MoH, attempting to train MoH staff and to generate appreciation of the approach. There is also evidence of other policy networks in the health arena. The CSSC emerged from a history of collaboration between the churches in Tanzania. It was preceded by the Christian Medical Board of Tanzania (CMBT) that developed in the 1970's. By the late 1980's, economic crisis and its impact increased the level of dialogue between the churches, and saw their discussion broaden out from health to concern with social services more generally. In 1992 the CSSC was formed to explicitly contribute both the expansion of social services and to facilitate policies related to social services (N2/96). As HSR has gained momentum, this body has set about undertaking research at district level that will enable it to contribute to policy discussions, and to chart the quantity and quality of church-based support to health services. In this sense, the CSSC is evidently engaged in public action. It is attempting to co-ordinate its members activities in the interest of increasing their effectiveness and to influence the government around the identification and allocation of public responsibilities and resources.

Whilst there are signs of network relationships that enable individuals and organisations to promote PHC in different ways within the public domain, the indications are that these are nascent and often fragile. Many simply depend upon individuals. In addition, there seem to be few cases such as that of the CSSC where NGOs themselves have come together and developed a shared identity and set of concerns. There is still limited awareness of NGOs as a sector, working together for the purposes of mutual learning from practice or research and policy lobbying. My observation of practice around CBHC is that other NGOs do not necessarily make the most natural allies or collaborators of an NGO. Most CBHC programmes are focused on linking with communities and with government, not with other NGOs. Whilst, as indicated, some individuals know each other from PHC/ CBHC training activities, but I have been surprised by the number of NGO CBHC practitioners I have encountered who are not aware of the CBHC Council, or who are not aware of AMREF's work, for example. There are many possible explanations. One, as mentioned in Chapter 5, is the very real problem of information-flow, communication and travel around Tanzania. By the same token,

it is possible for two agencies located in the same street not to be familiar with each others work, so other explanations have to be found. However, the significance of this lack of communication about CBHC between NGOs is that it limits the scope for learning from practice and sharing that learning. Limited opportunities for interaction in turn limit the extent of collective action that might be taken. This in turn limits the possibility that experience and learning could be formulated as a means of lobbying government at the local and national level.

Much can also be learnt from cases of 'isolation', or examples of interaction that do not develop into something more. What I am talking about are the opportunities lost. NGOs undertaking work of the nature described in Chapters 6 and 7, are attempting to promote PHC by working with local governments through activities from training government health staff, to supporting specific government PHC activities, to initiating forms of discussion and lobbying within local government. In many cases, these NGOs talk holistically, about the fact that a dispensary building project is an entry point to improving the preventive care that health workers provide or to developing the capacities of villagers to organise preventive action and so on. However, they often do not have the leverage to influence all of these parts at any one time. In practice, making all of the links can simply be too much. The case of CHF's provides a good example. The pilot of the CHF's is being conducted in the two districts in which HPA does not currently work. At the same time, in the areas where HPA (and indeed other NGOs) do work, various forms of community contribution for health and development activities are an accepted norm. This experience could be built on to promote initiatives along the lines of the CHF, and using the CBHC approach as the basis for introducing and developing them. However, macro policy initiative and micro programme action seem destined not to meet. That is unless the CHF initiative really does go national, in which case NGOs like HPA will probably begin working to help communities to adapt to these.

Whilst the CBHC programme I have discussed in this chapter is in itself limited; whilst it is not tidily described through a policy document and plans; whilst it is not making direct links with certain government policies, this does not mean it is insignificant. Located in a changing institutional context, the programme develops organically. Much of its development is driven by a loosely articulated but significant interest in going beyond 'implementing' CBHC in villages, to building it in government circles:

"I am lobbying for the government to implement CBHC in the region... we have got area, we have got communities, whereby even if someone comes from

outside you can tell him or her to go there and learn something about CBHC.”(N3/98)

There are many factors that mitigate against the institutionalisation of CBHC within government systems, as already hinted at. These include lack of understanding and lack of dedicated budget lines:

“They [region] know there is such a thing like CBHC, but they are waiting for somebody from top to bring... some funds for its facilitation in the region. It’s the dependency syndrome, everywhere. Not only in the villages but also the leaders.” (N3/98)

However, what both this chapter and Chapter 6 show is that NGOs really are more than private health service providers running individual health service units. They are also more than philanthropists responding to government requests for paint and maternity beds. They are actively engaged in forms of public action, both attempting to promote PHC *within* local government and *through* local government. Whilst NGO engagement in public action is primarily apparent in the work they support in villages, a great deal of it is happening at the government-NGO interface, where all parties are using the relationships, knowledge and mechanisms at their disposal to promote their public ‘interests’.

## 8

# What are NGOs and where do they fit in?

In Chapter 1 I explained that this research is concerned with two main questions: 'what are NGOs?' and 'where do NGOs fit in?'. Taking the World Development Report of 1993 as the articulation of an international Health Sector Reform (HSR) agenda, I challenged the depiction of NGOs as private health service providers that will fit neatly into market-based health systems.

In Chapters 1 and 2, I make use of the relevant literature to discuss what other researchers have indicated about the roles undertaken by NGOs in the health arena. I identify a continuing gap in research and policy debate concerning the activities of NGOs as 'community activists' and advocates, as exemplified by the involvement of NGOs in promoting PHC. That this gap in knowledge persists in policy practice is also evident from the fieldwork I discuss in Chapter 5. In Chapter 3 I discuss my research strategy, and the use of case study methodology to explore the role of NGOs in promoting PHC through the case of CBHC. I show that this methodology is suited to this research for two reasons. Firstly, because the research seeks to understand *how* and *why* NGOs are involved in promoting PHC. Secondly, because the research is concerned with understanding the relationship between micro-level activity, programme and organisation, and macro-level policy and institutional set-up. In Chapter 1, I propose that there are four key themes in the HSR agenda—private, health, decentralisation and community—that when explored from the perspective of NGO action in health, point to the inadequacy of the description of NGOs as private health service providers. In Chapter 4, I describe the meanings that have been given to these themes in post-independence policy Tanzania. This provides an analysis of the institutional set-up that I apply to the interpretation of NGO health action in Tanzania in the 1990s.

In this concluding chapter, I review the main conclusions arising from the empirical questions addressed in this thesis, as discussed in Chapters 5 to 7. I use this review to answer the questions 'what are NGOs?' and 'where do NGOs fit in?'. The purpose of this is to reflect on what these answers tell us about the relationship between NGOs and HSR, or the actual and potential role of NGOs in health policy and health action.

I organise this discussion into three sections, beginning in section 8.1 with what my conclusions suggest about NGOs as organisations. In section 8.2 I move on to what the conclusions suggest about NGOs as a 'sector' and, in section 8.3, as actors

located in an institutional set-up. In section 8.3 I review the importance of investigating NGOs in their institutional context, and how this might lead to the reshaping of our understanding of NGOs for policy purposes. In section 8.4 I reflect on the key empirical findings of the thesis, discussing some of the policy and practice implications for HSR processes of understanding NGOs to be public actors engaged in networks of public action.

## **8.1 Making sense of NGOs at an organisational level**

This research has confirmed in Chapters 6 and 7, that NGOs are constituted to work on behalf of groups that are identified as marginalised or in need of support, in the interest of collective outcomes. From their mission statements, activities and modes of operation, it can be seen that the NGOs discussed in this thesis seek to enable groups of people to improve their health through collective action. Unlike government, individual NGOs cannot begin to pretend to tackle universality and equity of coverage either through direct provision, or by attempting to encourage direct support to emerge by providing an 'enabling' policy environment. However, they can show a concern for the principles of universality and equity in the name of the public interest through their actions, whether through project activities, research, or lobbying. To date, NGO engagement with health policymakers in Tanzania has obviously been limited. However, one's eye should not simply be drawn to initiatives to promote CBHC as part of the national health strategy. Attempts to promote CBHC at the District level are a clear indication of the 'public' concern of these NGOs. They are looking beyond their own direct provision of CBHC to its adoption and institutionalisation. These are the strategies available to individual NGOs concerned with promoting public health.

This is the essential point when it comes to making sense of NGOs as organisations involved in health action. In Tanzania, NGOs are engaged in a number of activities that can be described as promoting PHC. These range from providing primary health services, to the design and provision of selective primary health interventions, to the promotion of comprehensive, empowerment-oriented approaches to PHC as encapsulated by CBHC. This research has concentrated on the latter. HSR policy discussion refers primarily to the former, and partially to the involvement of NGOs in delivery of selective primary health interventions. It is my contention that this focus tells us more about the understanding of NGOs (and of health) that has informed reform debate, than about what NGOs actually do. This is an understanding that is constantly being reinforced, not challenged, through the reform discourse.

As I conclude in Chapter 5, NGOs are acknowledged to be part of the Tanzanian health sector as health service providers. They play a significant role, which merits the further research that has been undertaken since the early 1990s. NGOs are also acknowledged, in the HSR Proposals (1994a) and fleetingly in the Joint MoH/ Donor Review (1998), to be involved in PHC activities, such as vertical health programmes. There is some awareness that NGOs might have contributions to make to national policy discussions, but on balance, their input is seen to be primarily at the district level, and within formal health service provision. Finally, there is no evidence of appreciation that NGOs are working as 'community activists' or advocates, by promoting various approaches to PHC outside vertical health programmes. However, through the research conducted for Chapter 5, I identified some NGO involvement in certain areas of health 'policy', in particular in CBHC. I also identified the existence of a number of NGOs working with the CBHC approach, and concluded that this would be a useful case through which to further explore the role of NGOs as 'community activists'.

I did not embark on this research with the intention of concluding with a simple statement along the lines that 'NGOs are x or y'. I pose the question 'what are NGOs?' because I believe it challenges policymakers, researchers and observers to take think again about their understanding of NGOs. I am interested in the meanings attached to the term 'NGO', and how this influences perceptions of their roles when it comes to shaping health policy and practice. As I noted in Chapters 2 and 4, to refer to NGOs as private organisations is to mean something specific. In other words, that NGOs are private organisations in strictly legal and organisational terms. This description reflects the fact that NGOs are not directly accountable to the general public through mechanisms such as national elections that give governments public mandate.

The description of NGOs as 'private service providers' has a resonance that goes beyond the legal-organisational definition of NGOs as private organisations. It is imbued with particular meanings about what NGOs are perceived to do, how they do it, and with whom they do it. It constructs NGOs as a particular kind of agency in public policy debate. It shapes NGOs as the necessary object to suit the desired form of intervention, in this case, health service provision. This process of constructing organisations, institutions and programmes in order to justify the desired actions is eloquently described by Ferguson (1994), taking the case of development interventions in Lesotho. One of the reasons why this research focused on the role of NGOs in national and international health policy was that I wanted to uncover the process through which various actors are included and

excluded from policy formation. To explore the politics of whom gets a say in defining 'problem' and 'solution'.

This research has demonstrated that NGOs are not tightly bounded entities. Like the government agencies that they relate with, their programme and organisational boundaries are permeable. They are not 'black boxes' that can simply be picked up and plugged in to a private service provider/ contractor slot, any more than they should be taken at face value as advocates for the poor and marginalised. I did not embark on this research project to come up with a set of criteria that would enable me to point to an NGO and say 'this is a service provider' or 'this is an advocate'. As I point out in Chapter 2, typologies of NGOs can serve certain purposes. Of course it is possible to make broad distinctions between NGOs. In the case of the NGOs I have researched for this thesis, some have developed CBHC from direct health service provision and look more like service providers; others have developed CBHC through community development programmes, and as a result look more like advocates. However, these descriptions can limit one's appreciation of NGOs as organisations situated within particular institutional contexts (as I discuss below). The intention of this research is to remind policymakers and researchers who inform public policymaking in health, that this is so. The description of NGOs as private health service providers limits the observer's attention to formal health units. As a consequence, the observer can be forgiven for overlooking the activist-oriented projects and programmes of NGO service deliverers. And it is entirely understandable that the programmes of activist-oriented organisations - for which the goal is not delivery of health services, but delivery of healthy knowledge, attitudes and practices, and in some cases, 'delivery' of transformation - is entirely obscured.

In conclusion, NGOs do behave as community activists - a factor that helps to distinguish them from for-profit organisations - and they are able to undertake programmes to prove it - a factor that partially distinguishes their community activism from government health agencies in the current context. Such community activism is a quality that transcends institutional context, rather like a basic legal-organisational definition, capturing something essential about NGO-ness. I propose that this community activism is best described in terms of public action. Public action to inform and mobilise the 'public', and public action to influence the public policy process, whether at the level of design or implementation. And to say that NGOs are community activists in these ways, is effectively to say that NGOs are public actors. As I discuss in the next two sections, the specific forms that public action takes will, however, be determined by the particular institutional set-up.

## **8.2 Making sense of NGOs as a 'sector'**

I take Anheier and DiMaggio's (Anheier, 1995) questions about how NGOs differ from other organisational forms, as being about identifying the shape of an NGO 'sector', or the existence of a sense of NGO-ness that helps to distinguish NGOs from other organisational forms. As I have indicated, there is a significant difference between a legal-organisational definition of NGO, and uncovering NGO-ness. As I explain in Chapter 4, there is no policy or legal definition of NGO in Tanzania that is adequate to the current situation. As a result the mixed bag of legislation that governs societies and other forms of non-state organisation, is under review. And it is not just that a legal-organisational definition is lacking. As I indicate in Chapter 7, even in day-to-day practice there is not a strong or shared sense of what an NGO is in terms of Tanzania's organisational and institutional set-up. Indeed, it is not uncommon for any socially-oriented project or programme that is not strictly a government programme - whether it is run by an NGO, initiated by a donor, or even funded by a for-profit organisation - to be referred to as an 'NGO'. Having participated in a number of meetings about NGOs and NGO policy in Tanzania, I have become aware that NGOs themselves are only just beginning the process of identifying a corporate identity.

There are two points that the case of CBHC highlights about this corporate identity in the NGO 'sector'. Firstly, whilst a number of NGOs are involved in CBHC promotion, their awareness of each other and their proven ability to work together is limited. In Chapter 7 I identify nascent policy networks concerned with health policy, proposing that these are limited due to the relative newness of large-scale NGO action in Tanzania, and due to the limited capacities on the part of most NGOs to engage in research and policy lobbying. I also identify the existence of 'isolation' as the counterpart to interdependence. This refers to the lack of interaction between NGOs, or between NGOs and government, as in the example of the apparent lack of NGO involvement in design and implementation of the CHF's in Tabora. I would compare this with the Uganda Community Based Health Care Association (UCBHCA), which produces a regular newsletter (UCBHCA, 1996), and which CBHC practitioners in Tanzania (N2/98; N3/98) claim is strong. However, the UCBHCA was motivated and strongly supported by UNICEF (Cannon, 1996), and it would seem, as in the case of the NGO Health Forum that I mention in Chapter 5, that these groups are highly dependent upon initiatives taken by donors agencies. Thus far, the only successful exception to this that I am aware of in the health arena is the CSSC, built on the corporate identity of Christian churches working in the social sectors, and established with its own staff and organisation.



Secondly, although NGOs promoting CBHC in Tanzania do not seem to make the most obvious operational or strategic partners for each other, they do work in very similar ways. In this sense, there is a form of underlying corporate identity. For example, the very fact that NGOs promote CBHC - or similar community based PHC initiatives - at all, highlights the similarities of ethos, mission and objectives. As I conclude in Chapter 6, these similarities are evidenced by common forms of community activism – from evangelical to managerial to advisory activism. NGOs in different parts of the country, working with different ‘communities’ have identified a place for themselves in the existing health and development system, and are managing that space in similar ways. They are providing similar human, financial and other resources in order to promote CBHC. At the same time, these NGOs are working in similar ways at the district level, enabling them both to utilise District resources and structures, as well as to influence the practice of government staff.

As I conclude in Chapter 7, NGO engagement in networks as a means to influence policy is strongest around the implementation of activities at District (and Regional) level. Promoting CBHC at this level is about influencing government policy in the sense of local government practice. These networks are a sign of interdependence, crossing organisational and sectoral boundaries, or certainly arising from the continued intermingling as government and nongovernment begin to extricate themselves from the legacy of one-party statism.

It is through engagement at this level that NGOs develop their activities, responding to change as it manifests itself in their operational context, more than responding to change as indicated in national policy documents. It is at this level, that NGOs are involved in simultaneously defining and meeting ‘public’ need. It is not a matter of suggesting that government should have a longer list of services that it acts upon. The nature of interdependence is far more complex than that.

Although some of the quotes I use in Chapter 7 indicate that people do have strong ideas about what should be done by government and by community, in practice, these ‘obligations’ are constantly being redefined. NGOs respond to this through their interactions with villages, and through their interactions with government. It is not the case that NGOs in CBHC are innovating, piloting and integrating activities or approaches into government systems. As Clark (1991) writes, the strength of NGOs does not necessarily lie in innovation as much as in taking forward existing ideas and promoting these with new constituencies. In fact, the evidence to suggest that government staff have internalised and use CBHC because they have been involved in NGO CBHC programmes is not strong. Many claim to be too constrained by lack of resource, but other structural and cultural factors

within the government health system might offer more compelling explanations. Indeed, if HSR does alter the working environment of government health staff as suggested in Chapter 7, this may well enable those already familiar with CBHC to make greater use of it in practice.

Finally, to talk about NGOs as organisations that are involved in simultaneously defining and meeting needs is not to suggest that they start with a blank sheet of paper. NGOs are distinctive in the sense that they use approaches such as CBHC in order to facilitate a dialogue at village level about root problems and causes, and to keep the discussion about potential solutions as open as possible. Some programmes indicate a level of success in the sense that the identified 'projects' have been concerned with promoting knowledge or information, or with activities that promote more healthful behaviour. However, many of the 'projects' that come out of CBHC dialogue are predictable. They involve the building of wells, classrooms, and dispensaries. This no doubt reflects perceived need at village level, but it also reflects a history in which these are the projects that villages have been expected to undertake with District governments, and it reflects the power of government directives in influencing village-level decisions. As I indicate in Chapter 3, citing Mackintosh (1992), public action is not about single activities, or simply adding to a government activity. It is a process of identifying and working upon 'public' matters that takes place through complex relationships. In this sense, NGOs promoting CBHC are indeed aptly described as public actors engaging in network relationships that mediate between slightly different definitions of what should constitute public action.

### **8.3 Making sense of NGOs in an institutional set-up**

In Chapter 1 I refer to the calls from health policy researchers for 'evidence-based policymaking' (Zwi & Mills, 1995) and policymaking based on information 'rather than ideological assumption' (Bennett et al, 1997, p3). Mills et al (1997) conclude the book '*Private health providers in developing countries: Serving the public interest?*' (Bennett et al, 1997) with the same point. There has been too much assuming about the private sector in health (which they take to include for-profit organisations and NGOs), but there is much research still to be done. They propose a research agenda that focuses on:

- i) exploring the influences and determinants of the behaviour of different parts of the private sector, to learn what arrangements should be encouraged, and to think about what policy tools might be of value; and
- ii) evaluating policies that involve the public sector making greater use of the private sector.

The authors recognise that the book has focused on the 'ownership' of the entity. Each chapter shows, however, how unclear the dividing lines between public and private organisations, and how likely they are to become even more blurred over time. They propose that more research is needed to 'enhance our understanding of the key influences on provider behaviour' (Bennett et al, 1997, p305). Finally, they suggest that this understanding also needs to be based on consideration of the internal factors that shape an organisation – structure, objectives, remuneration patterns and so on – that tend to receive only passing attention.

It can be seen that this thesis goes some way towards doing this in the case of a variety of NGOs involved in health action in Tanzania. However, it goes one stage further. It asks what we need to do in order to go beyond looking at the 'entity' and its 'ownership', or to capture and make sense of the blurring of the lines between public and private? It is for this reason that my attention has been focused not only on NGOs as organisations or as comprising a sector of organisations, but also on making sense of NGOs in their institutional location. As I discuss in Chapters 3 and 7, this research has been concerned with how NGOs are located in an 'institutional set-up' (Anheier, 1995). This is on the basis (as explored in Chapters 1 and 2) that it is not possible to discuss what NGOs are without reference to where NGOs fit in.

But what does it mean, theoretically and empirically, to investigate and make sense of NGOs in an institutional set-up? The research that informs Chapter 7 was designed to capture two aspects of the location of NGOs in the Tanzanian institutional set-up. The first aspect is the location of NGOs vis-à-vis other organisations and programmes. In this section, I think of this in terms of what the ethos, mission and activities of NGOs tell us about the institutional set-up and nature of health action. The second aspect is the location of NGOs vis-à-vis norms, values and practices. In this section I think of this in terms of what the institutional set-up tells us about NGOs and their involvement in health action.

As I have already discussed, NGOs promoting CBHC are embedded in an institutional set-up. They work within existing organisational structures. To a large extent, their ethos, mission and activities reflect the prevailing norms, values and practices of that institutional set-up. For example, as I conclude in Chapter 6, the language that NGOs use to articulate their 'community activism' is not dissimilar from the activist language that used to pervade the CCM government. From the single case (CBHC) it is possible to observe the external forces that shape the situation, the relationship between the macro and the micro. Whilst the example of HSR reveals that NGOs (and other actors) have not been involved in central policymaking, the ways in which NGOs promote CBHC suggests that they have

internalised the norms, values and practices that have shaped government health policy in the past. I am not suggesting that NGOs simply adopt all aspects of policy that come from centre to local level, but that they have absorbed the main thrusts of these 'public' initiatives into their work.

In terms of what the institutional set-up tells us about NGOs and their involvement in health action, there are two factors that have strongly shaped NGOs. The first is the fact that so many NGO 'staff' have come from the government system. To an extent, it can be difficult to distinguish whether CBHC, in its philosophy and origins, is a government or NGO project. Indeed, this government-NGO relationship has been so strong that during this period of government retrenchment, not only are government employees joining NGOs, but they are involved in establishing NGOs or turning programmes of 'international' NGOs into 'local' NGOs. By and large, the model of organisation that is used to design these NGOs strongly reflects people's experience in the government system. It often produces what I refer to as the 'mini' district – an organisation designed along the lines of departments, and delivering the kinds of services that had been the preserve of District governments.

The second point, however, is that as the institutional set-up changes, there is a growing debate about what NGOs are and how they fit in. Whilst, as the following comment shows, NGOs have tended in the past to define themselves within state parameters, they are beginning to come to terms with what the notion of a 'civil society' role means for describing their activities:

"In the first decades following Tanzania's independence, there was no difference between development and politics. All development followed the party line....Life was easy, politically, if you developed your projects following the rules....As agents of development, NGOs in Tanzania must be aware of the fine line separating development and politics. Our NGOs are a very mixed bag, with varying sources of funding and objectives. But they are not political organisations. They are groups of development people working to build the country..... NGOs can consider themselves apolitical and can be so in most cases. But they must consider the political side of all development issues... When an NGO's development policy forces it to diverge from and even act against the political status quo, then it will need strong support... It must stress the development issues at stake whilst playing down the political side it is clashing with." (Ricardo, 1994)

As I note in Chapter 4, open discussion about NGOs in their operations as actors autonomous of the state is relatively recent. Tanzania's single-party structure and poor communications infrastructure have mitigated against such discussion and

involvement in policy debate, applying almost equally to NGO, District government and village committee alike. An explosion in the written media in recent years has increased the level of debate about policy issues. However, I have found the comments concerning health and HSR in the English-language press to be limited to articles reporting changes to health services - such as the introduction of CHF's - or reporting approval of a new donor grant for a particular health service. These articles do not debate the *raison d'être* or design of HSR. Nor do they critically discuss PHC. Where holistic approaches to health are reflected upon, these usually take the form of articles downloaded from international media services, reporting on the latest UNICEF or WHO initiative. Similarly, the English-language press is a rich source of articles about NGOs and their programmes, but these tend to concentrate in the 'service' aspect of the organisation's work, not activism, lobbying or advocacy.

At the same time, there are NGOs that are explicitly concerned with such activities, and that make good use of the media to convey their research and concerns. Most notable amongst these are TAMWA (Tanzania Media Women's Association), JET (Journalists for the Environment in Tanzania) and TGNP (Tanzania Gender Networking Programme). Increasingly, as the space and opportunity for debate widens, other NGOs are being more obviously activist in the name of 'civil society'. As yet, this policy activism is still young, and as the de-registration of some organisations reveals, it can arouse sensitivities. However, the extent of lobbying activities at District level appears to be increasing, and in fact by 2000, with the slowly unfolding Local Government reform programme, changes in the institutional set-up not directly related to HSR itself, seem to be providing new opportunities and spaces. These other public reform initiatives are providing a stronger rationale for government-NGO interaction - and different types of interaction - at the local level.

These are just some of the things that could be said about NGOs and their location in the institutional set-up that shapes HSR and health action more generally. In Chapter 3 I discussed the reasons why I had pursued not just a case study approach, but in particular, had been influenced by Burawoy's Extended Case Methodology (ECM). As I discuss in that chapter, the case study methodology can be used as a method to explore the relationship between the macro and micro dimensions of a phenomenon, as discrete but related arenas. The ECM is not concerned about generalising (in other words, building theory) across a set of examples - a statistical approach (Burawoy, 1991b). It seeks to reconstruct theory with reference to an existing body of generalisations. The emphasis is on what a case tells us about society as a whole, or what it reveals about the general laws of that society

(Burawoy, 1991b). My research has not been about building statistical significance as such, or deriving generalisations from the comparison of organisations, although to an extent some of the generalisations I have made about NGO promotion of CBHC have come about through a process of comparison.

Instead, my concern has been with deriving generalisations from the single case – the promotion of CBHC in Tanzania. These are generalisations with societal significance. In other words, they reveal general laws about NGOs, HSR, and health action and policy. What this thesis has revealed is a story of institutional continuity and change. That continuity is reflected in the continued commitment of government-trained health personnel to the values of PHC, although in a number of cases that commitment has been taken into the NGO sector where the environment is more conducive to PHC promotion. It is also reflected in the maintenance, and in a positive sense, the development of NGO-government relationships around PHC promotion at the local level. This continuity persists in a society undergoing wider institutional change, not just triggered by HSR. It serves to remind that change is not something that occurs at one time, in one place, but is a process that filters through, and that is interpreted through people's existing norms, values and practices. This thesis did not encounter powerful examples of resistance to change, nor of perceptions that the direction of change was negative. However, it is a conclusion of this thesis that it would be interesting to continue to chart the case of CBHC with reference to HSR in Tanzania. It would be useful to explore the extent to which the government is able to take up the primary and promotional health challenge it has set itself. It would be useful to investigate the extent to which it does this by building on the type of existing relationships and shared norms that I have uncovered in this research.

I have concluded that for the purposes of health policy and practice for HSR the understanding of NGOs as public actors engaged in networks of public action provides a more adequate explanation, or generalisation, about NGOs than the description of NGOs as private health service providers.

To reconceptualise NGOs as public actors – not as private providers, nor as gap-fillers – is to appreciate the fact that they have a more coherent and embedded role within society. Particular descriptions of that embeddedness may not be institutionalised – for example, descriptions of NGOs as 'civil society' organisations – but that does not mean that NGOs themselves are not already embedded in particular ways. This reconceptualisation of NGOs is useful because it goes beyond a restrictive organisational typology, to a conceptual framework for researching, analysing and talking about NGOs.

This reconceptualisation of NGOs has implications at the level of policy and practice. Amongst these, it implies the need for a different kind of policy process that seeks to establish what different actors have to offer rather than presupposing what that offering might be. It points to the need for better assessments of specific institutional contexts - their particular characteristics, histories, and problems - not least because these factors will be powerful in shaping the outcomes of any programme of change. It suggests a need to place more emphasis on building capacities for managing interdependence amongst different actors. Finally, beyond reconceptualising NGOs, it implies a need to reconceptualise the 'public sector' itself.

#### **8.4 Public action mediated pluralism: Policy and practice implications**

Definitions of 'public' and 'private' have provided the substance for debate across disciplines and policy discussions for years. However, one of the most relevant discussions I have come across - in the light of this research project - is Vickers' description of the task of public management being one of regulation. Regulation refers to the task of maintaining complex patterns of relations within limits that have come to be accepted as governing relations. It is the task of both maintaining activities within those governing relations, and modifying those governing relations. Ultimately:

“... the goals we seek are changes in our relations or in our opportunities for relating: but the bulk of our activity consists in the “relating” itself.” (Vickers, 1968, cited in Rhodes, 1995)

The WDR (1993) attempts to discuss the importance of multi-actor and multi-sectoral action in the name of better health. But, its philosophy is market-oriented not relationship-oriented. Ultimately, this means that the WDR reduces public action to state action, and HSR reform to dealing narrowly with formal health service provision. Those other activities that are mentioned as important for health improvement - such as access to primary education, health education, or initiatives to improve water supply - are presented rather anecdotally. They are not subjected to systematic analysis of how they are currently undertaken in low-income countries and how they can be further promoted. Indeed to respond to the actual health profile of a country such as Tanzania with a health policy that largely addresses the formal health service sector, and to suggest that the adoption of the WDR's recommendations will enable low-income countries to join a global movement through which:

“Millions of lives and billions of dollars could be saved” (World Bank, 1993, p13)

is trite to say the least.

What this research reveals is a government that has over the years proposed that it should shift its emphasis more towards public health activities, such as prevention and promotion. Under HSR, the government reconfirms the need to reorient itself towards public health. At the same time, other actors, not least donors and NGOs are major players in this public health arena. They are directly engaged in the process through which public institutions are created to ensure the distribution of public goods (Wuyts, 1992). NGOs are simultaneously identifying and meeting need, at the same time as they are attempting to create appreciation of that need within government. Yet, as the case of CBHC shows, NGOs are also looking to government to create the necessary framework for the promotion of CBHC. In 1998, AMREF's CBHC Unit effectively closed. At the same time, it seems that the CBHCC was being revived. These two examples reveal the vulnerability of initiatives when left primarily to NGOs. To some extent the government began to provide the lead that NGOs are looking for, preparing the Curriculum for CBHC Facilitators (GoT, undated/ a), for CBHC Trainers (GoT, undated/ b), the CBHC Training Guide (1996b) and the Guidelines on CBHC activities in Tanzania (GoT, 1994a). However, there is still some way to go if community-based approaches to PHC are to be institutionalised. I would use the case of CBHC to challenge the statement from the WDR (1993) that I cite at the start of this thesis. In this statement it is proposed that the role of 'public' policy is to promote competition among providers. From the perspective of NGO promotion of CBHC I would argue that the role of government is to provide a framework for enabling public action.

From the perspective of the research discussed in this thesis, what might some of the policy implications of seeking to provide a framework for enabling public action be for those engaged in HSR processes?

Firstly, and with particular reference to the findings of Chapter 5, policymakers need to adopt a more systematic approach to understanding the activities and contributions of NGOs, both to the formal health sector and to health development more generally. There is still a great deal to know, that is not captured by the surveys that I came across that stop at listing NGOs and their activity types. Taking a more systematic approach would also encourage policymakers to develop a more consistent vocabulary that captured both the limitations and the real possibilities of what NGOs have to offer. This should not be sidelined to 'those in the Ministry who deal with NGOs'!



In part this scoping of the contributions of NGOs should demonstrate, as in the earlier chapters of this thesis, that there is much already in existence that can be learnt for the purposes of developing policy. Taking the case of CBHC as an example, there is a shared mission among the NGOs discussed here, which is to promote health development in ways that contribute to building a good government and public health system. There are many cases of CBHC activities that have been supported in many villages, in different parts of the country, and in some cases, over a number of years. This could provide data for the purposes of learning about building community-responsive and needs-oriented health interventions.

Secondly, taking a more systematic approach to understanding NGOs would ideally go hand-in-hand with an appreciation that policymaking – from agenda-setting to evaluation – is a process. Policymakers at the central level need to challenge themselves to engage with other organisations and practitioners. In the process of understanding NGOs, they may come to appreciate that the agenda itself needs to be redefined or broadened.

Thirdly, central level policymakers need to appreciate that often the onus will be on them to initiate a process of dialogue, and to manage the relations referred to by Vickers. Organisations and practitioners working outside a central ministry may not feel able to contribute to discussions taking place at that level. Similarly, those NGOs that are serious about engaging with policy need to invest in building relationships with other NGOs that may share a similar interest. Until NGOs do this, they are also missing opportunities to be more strategic, to ‘scale-up’ their impact. It is also important that policymakers ensure that dialogue is a process, not just a series of one-off consultations about specific issues, for example, HIV/AIDS. Those consultations have their place, but it is also important to build relationships, and the mutual understanding, consistency and quality of input over time that those imply.

All of these conclusions would also apply to the involvement of other actors in the policy process. It is an important finding of this thesis that government staff at the Regional and District levels both felt excluded from the reform process and exhibited extremely limited knowledge about the vision and content of HSR. This will have implications for the rate of progress and the level of achievement seen from the HSR programme. It is also important to recognise that as reform programmes are moved out into the Districts, District Medical Officers and their staff become the ‘policymakers’ that NGOs have to deal with. All the problems of exclusion from dialogue that are identified at the central level are in danger of being repeated again. This amounts to more opportunities to take strategic and effective local action in the interest of improving health being lost. It is therefore

important that HSR programmes are designed with more emphasis on building the understanding of *all* local-level health actors of the aims and content of the programme. It is also important to encourage the formation of formal networks or groups with wide membership, and possibly with guidance as to the tasks such networks might engage in (for example, monitoring change or presenting locally developed research to the ministry). In the interest of taking a broader approach to health, it might be of value to ensure that such groups are not led and controlled by the District Medical Officers. Instead, care should be taken to ensure that they fall under more than one department and that leadership is open to election by the members, and not automatically conferred to specific postholders. This is not to bring into question the internal decentralisation process within the government health system that is managed through the DMO and the District Health Management team (DHMT). However, I have not yet encountered an example of a non-formal health service providing NGO being invited to attend a DHMT meeting. It must be recognised that more than one forum may be necessary to address all health-related discussions and involve all the health actors at the local level. The Local Government Reform process now in place provides an opportunity for defining other groups that can be formed across District departments, and for the purposes of sharing experience and advice. However, it is equally important that a committee formed to deal with water and hygiene issues, for example, does not become sidelined by District health teams. Otherwise it runs the risk of becoming either limited in its actions or defunct as seems to be the case with many of the PHC committees formed in the past (see Chapter 7).

Fourthly, and perhaps a more difficult recommendation to integrate in policymaking, is recognition that what people *say* may be more telling than what you *see*. As I discuss in Chapter 7, for example, mapping of organisations and their activities in Tabora Region did not reveal much interdependence. However, interviews with a range of people from different organisations did. It is not until you arrive at the level of listening to what people are saying that you begin to appreciate the continuities and the type of change that are characterising the reform process. This implies that policymakers need new skills and tools to enable them to analyse the path that a reform process is taking, as experienced by those living that process.

Which links to my final point that the commitment of NGOs and many government health workers to PHC is already strong, as are many of the relationships between people and organisations around promotion of PHC. Policymakers need to be mindful of this, and to review their proposals in the light of what is likely to reinforce what is strong and effective, and what is likely to undermine what has

taken time, often years, to build: Appreciating that such qualities and relationships exist is the first step, but much analysis is still required to understand what this means for public policy action. This idea of building and reinforcing virtuous cycles of behaviour in the public sphere has taken shape in recent years in debates about 'synergy' and 'social capital' (see Evans, 1996). Strongly influenced by earlier discussions about the role of institutions in development, this debate is concerned with the ways in which 'active governments' and 'mobilised citizens' (Evans, 1996) can enhance each other's development efforts. I came to this literature late in this research project, and indeed, have only begun to make sense of much of the literature around institutions having completed this particular project. However, I would like to use it in framing a new body of research. Of particular interest to me would be a study of the acceptability, effectiveness and impact of CBHC for 'communities', questioning whether the promotion of CBHC actually represents a more effective strategy for developing comprehensive PHC than the VHW scheme. Such a study would relate CBHC experience to experience of the outcomes of HSR at community level, with particular reference to the impact of the CHF's on community health-seeking behaviour and access to decision-making at the District level. In particular, it would be interesting to examine the role of NGOs, as 'community activists' in CHF and similar schemes.

## **8.5 Endnote**

My emphasis on the 'public' aspect of health (or more broadly, social) sector development is value-based. For me social sector development refers to the identification, provision and maintenance of the infrastructure that supports the social and economic well-being of societies, not just individuals. Whilst the notion of the state-coordinated welfare model was taken apart during the 1980s by reforms based on the principle of market-driven individualism, the race has been on to articulate alternatives. As the emphasis in 'public' sectors has shifted from equity and access considerations to financing and management concerns, a growing army of commentators have been disturbed about the potential impact of this in terms of excluding poorer groups and poorer countries from services and opportunities that have come to be considered basic. It is clear that the immense challenges faced in terms of financing, providing and regulating social sectors cannot be addressed by attempts at all-inclusive state welfarism – pragmatic socialists are as aware of that as pro-market liberals. Indeed, as many researchers have pointed out, social sector development in practice has always depended upon forms of non-state action, whatever the rhetoric of particular governments (see for example Semboja and Therkildsen, 1995, and Swantz and Tripp, 1996). One of the most powerful responses to the problem that state welfarism is too ambitious and costly, and that

market-based provision can be inequitable, has been an articulation of a role for 'civil society', for forms of communal action as distinct from state/ public action. The reconceptualisation of NGOs that I propose here goes beyond the 'neither state nor for-profit' and the 'communitarian' description of NGOs, both of which I believe allow policymakers to manipulate the idea of NGO to fit either the grass-roots action or pro-market version of multi-actor systems, according to ideological predisposition. These two models of pluralistic organisation continue to view the 'public' as equivalent to 'state'. They produce a tendency to focus on the idea of 'public-private partnership' as a form of contractual relationship between state and NGO. I propose that there are a whole range of relationships that are embedded within the institutional set-up that are far more complex than the idea of public-private partnership allows. It is for this reason that I suggest that NGOs are actors in public action mediated pluralism, and that by looking at them through this lens, policymakers would be in a better position to assess how to promote more effective public action in the name of better health.

# **Appendix 1**

## **Proposal and Questionnaire used in field study 1996**

### **Summary**

In current reforms of social sector provision across developing countries, in which the emphasis is on moving from state (public) to 'private' service systems, it is important to have a clear understanding of the different organisations involved in the system, and of the ways in which they interact to form an identifiable system. Understanding what different organisations have undertaken in the past and what they now do, is key to predicting provision and developing policy for the future.

Such understanding is urgently required in the case of NGOs. Policymakers often have contradictory ideas about the nature of non-governmental organisations and of their activities, which can lead to poor understanding, with unsubstantiated claims for the pros and cons of NGO work, and so inadequate policy and programme design. Such contradiction is apparent in the tendency by some policy organisations to group NGOs on the one hand, as part of a sector of 'private organisations' (World Bank, 'Operational Manual Statement: Collaboration with Nongovernmental Organisations', 1988), almost contractual service providers, but on the other, as value-led organisations, positively distinct from for-profit organisations, with a capacity to advocate on behalf of the poor and needy and to help build a vibrant civil society.

This research seeks to explore the role of NGOs as pro-privatisation reforms take hold, referring to their work - its possibilities and limitations - in a real context. As such, it will provide data which upholds or challenges the current predominant view of major international development actors - that NGOs are simply private providers in social service systems - and possibly help develop a more sophisticated understanding of the value-led, 'public' functions of NGOs.

### **Research Questions**

The research will use a modification of the questions developed by Anheier and DiMaggio (1990) and Anheier (1995). These seek to disentangle some of the problems which researchers and policymakers are grappling with when thinking about nongovernmental organisations:

- 1) Why do nongovernmental organisations exist? What is the division of labour and responsibilities between organisational forms?
- 2) To what extent, and why, do nongovernmental organisations differ from other forms of organisation in terms of performance, efficiency, equity, clients, strategies and outputs?
- 3) How does the nongovernmental sector relate to or interact with other sectors? How is it located in the overall institutional set-up or structure of society?

Using these questions it is possible to build a picture of NGOs as:

- individual organisations (their philosophy, activities, characteristics);
- forming part of a sector. By beginning to understand their similarities and differences vis-à-vis other forms of organisation, and therefore delineating the 'NGO sector'- the collection of organisations and activities which it encompasses - you can investigate its collective characteristics (which will differ from society to society). This sector will also interact with other sectors and organisational types. Indeed service provisioning is often de-facto a multi-sector activity, and the nature of relations has implications for provision (access, quality, consistency and so on). As such relations of conflict, control and co-operation need to be explored, in order to understand where NGOs and the NGO sector fit;
- a network of actors located in a dynamic context in which their roles are constantly developing and being redefined.

## **Research Areas**

This research will initially explore each of these three questions in three regions in Tanzania. The three regions have been selected as being potential cases of three different modes of organisation around health provision. These are:

- 1) Tabora region. A region with limited NGO activity, and as such comparatively important state role in health. NGOs and local government are developing links in the interest of coordinating health provision and meeting shared training needs. Most NGOs in the region work closely with local government.
- 2) Mbeya region. An example of a donor programme in the health sector, which provides a focus for relations and co-ordination between different health agencies.

# Questionnaire - NGOs in the Tanzanian health system

## Summary

This questionnaire is concerned with your organisation and its activities. It will be used for background data to a research project, as outlined in the attached letter. All information given will be treated with sensitivity, meaning that it will not be discussed or given out to other agencies without your consent. However, some information may appear in the final research thesis. Most of the questions are open, and will require some description.

Please indicate whether your organisation would be interested in receiving a copy of the research report:

Yes \_\_\_\_\_ No \_\_\_\_\_

Thank you for taking the time to complete this questionnaire.

## Section 1: About your organisation

Name of organisation

Name of person

Position in organisation (Job Title)

1) When was your organisation registered?

2) What geographic areas does it operate in?

a) In Tanzania

b) Other countries

3) What activities is it involved in (for example, building schools/ clinics, supporting health education, training, lobbying government....)?

**4) When did the organisation begin working in this region?**

**5) What type of health-related activities has it undertaken in this region since it began?**

**6) In which areas/ districts/ villages of the region does it operate health-related activities?**

**7) How many health-related projects has the organisation supported since it began operating in the region?**

**8) How much does the organisation spend on health-related activities in the region per year (the aim of this question is to get a sense of the size of organisations' contributions to the local health system)?**

**9) A) How many staff are there in the organisation?**

**b) How many work on health-related activities?**

**10) Please describe the structure of the organisation (for example, trustees, members, fieldworkers).**



## **Section 2: Other organisations in the region and beyond the region**

1) What other organisations do you know of which work in the same geographic areas as your organisation?

2) What other organisations do you know of which work in the same sectors as your organisation (for example, health, education, community development)?

3) Does your organisation work with other organisations in the region?

Yes \_\_\_ No \_\_\_

If the answer is yes, which other organisations are these (for example, village health committees, district government, other NGOs, donor agencies)?

4) What type of activity does shared work involve? (Please tick those applicable)

Joint meetings \_\_\_

Joint decision-making \_\_\_

Joint projects \_\_\_

Joint funding \_\_\_

Joint training \_\_\_

Other (please indicate what this is) \_\_\_

5) Is your organisation a member of other organisations?

Yes \_\_\_ No \_\_\_

If the answer is yes, which organisations are these?

What activities are you involved in as a member (for example, receiving newsletters, seminars)?

### **Section 3 : Other information**

If there is any information which has not been covered and you feel is important, please add it here.

# Appendix 2

## Proposal and Questions used in fieldstudy 1998

### District/Municipality

District level is local government. It is important for two reasons. First, it is where the national and local meet. Second, it is the focus of attention both in PHC and in HSR.

The aim in these interviews is to gather: a) Information/ fact; b) Knowledge/ perceptions; c) Opinion/ attitude. This in order to map: a) Activities/ organisations/ projects in the district; b) Relationship of district to policy positions, information/ training, and other organisations; and c) Feelings about what is going on and their role.

In my research, these interviews have the following function: a) enhancing the activity maps I derive from HPA; b) confirming my ideas about the policy process - poor consultation, information dissemination, understanding; c) seeing all this from a local government perspective - practice of multi-organisational contexts, and the problems of expecting regulation/ co-ordination to occur at this level.

*Purpose* To build a picture of health and development in the districts in terms of fact, knowledge/ perception of district staff, and their opinion/ attitudes.

*Objectives* To obtain 'information' vis-à-vis:

- a) Health-related services, programmes, projects, organisation, policy, issues; and
- b) The roles, responsibilities, and relationships of NGOs and other actors.

### Activities

Through interviews, relevant documents such as district plans, observation, cross-reference (interviews with other agencies). To interview District Planning Officer, District Medical Officer, District Nursing Officer and perhaps the District Health Team, Primary Health Care Co-ordinator, and District Executive Director.

## **Outputs**

1. 'Map' of health-related services, organisations, programmes, projects, activities
2. 'Map' of relationships between the above (who does what with whom?)
3. 'Map' of perceptions of roles, responsibilities, relationships, raison d'être

## **Guiding Questions - District**

### **A - Job**

What is your job?; What are your responsibilities/ activities? ; What are the main issues/ problems you have to deal with ?

### **B - Services**

What are the main health services in the district?; What do they do?; Coverage/ expenditure/ reports?; District Health Management Team - does it exist? What does it do?; PHC Committee - does it exist?; What does it do?

### **C - Programmes**

What are the health programmes in the district?; How are they organised? Who is responsible?; How do they operate?

### **D - Organisations**

Which organisations are involved in health?; What do they do? Where ? Does the district work with them? [Why not? What stops you?]; How?

### **E - Relationships**

What is the relationship with the region given changing structures?; How do you work with communities?; How do you work with other organisations? [steering, contracts, gap-filling]; [what do you think is the role of other organisations?]

### **F - Issues**

What are the main changes to the system within current health policy?; What is health sector reform?; What is PHC?; What is CBHC - what do you know about it?; Who do you think is responsible for health development?; What are their roles?; What are their relationships?; Where do NGOs fit in ?; Where do binafsi (private health facilities) fit in ? Why?

### **G - Miscellaneous**

What reports/ studies exist in the district/ region about health, communities, NGOs etc?; About expenditure, coverage etc?

## **Region**

Regional government is the lower arm of central government, meeting local government and other agencies at this point. It is responsible for delivering and supervising many of the central government's policies. It is where policies on decentralisation, health, 'private' organisations and community become practice. Their implementation shapes activities and relationships in the area. It is important for this research to improve my understanding of what is supposed to be happening, and what is actually happening. How regional government performs its tasks, and what this means for it in relation to districts and other agencies.

The 'practical' purpose of this is: a) to get a government perspective; b) to add depth (what is the health system in Tabora that HPA is located within, what exists and what doesn't?); c) to be able to look critically at what HPA staff tell me.

The aim in these interviews is to gather: a) Information/ fact; b) Knowledge/ perceptions; c) Opinion/ attitude. This in order to map: a) Activities/ organisations/ projects in the district; b) Relationship of region to policy positions, information/ training, and other organisations; and c) Feelings about what is going on and their role.

In my research, these interviews have the following function: a) enhancing the activity maps I derive from HPA; b) confirming my suspicions about the policy process - poor consultation, information dissemination, understanding; c) seeing all this from a local government perspective - practice of multi-organisational contexts, and the problems of expecting regulation/ co-ordination to occur at this level.

**Purpose** To build a picture of health and development activities in the region from fact, knowledge/ attitudes, and perception of key regional staff.

**Objectives** : To obtain information vis-à-vis:

a) Health-related services, programmes, projects, organisation, policy, issues etc; and

b) The roles, responsibilities, and relationships 'allocated' and how these are managed?

## **Activities**

This will be done through interviews, relevant documents such as regional plans and guidelines, observation, cross-reference (interviews with other agencies).

Interviews with Acting Regional Medical Officer, Regional Nursing Officer, Regional Health Officer, Regional Economist (NGO liaison)

## **Outputs**

1. Map of health-related services, organisations, programmes, projects, activities
2. Map of relationships between the above (who does what with whom?)
3. Map of perceptions of roles, responsibilities, relationships, raison d'être.

## **Guiding Questions**

### **A - Job?**

What is your job?; What responsibilities and activities does it involve?; What are the main issues and problems that you have to deal with?

### **B - Services/ Programmes**

What are the main health services and programmes in the Region?; How are they organised?; Who is responsible for them?; What does the RHMT do?

### **C - Organisations**

Which organisations are involved in health?; What do they do? Where?; Do you work with them? How?

### **D - PHC etc**

How does PHC influence your work? [how is PHC organised?]; What do you know about CBHC ?; How do you work with communities in the region ?; How are CBHC and current reform in the health sector related ?; What are the main changes which have been introduced in the past few years ?

### **E - Relationships**

How do you see the roles and responsibilities of different organisations in health development?; How do NGOs fit in?; How does the region fit in?; How does the private sector fit in?

## **NGOs - Tabora**

The focus is on HPA and CBHC. Other NGOs are not involved in CBHC as such, but they are important as 'public actors'. I am looking at NGOs in order to confirm information about relationships, and the way NGOs do and do not work with government.

As with the other groups, I am looking for a) information/ fact; b) knowledge/ perception; c) opinion/ attitude. This is in order to map: a) activities/ organisations/ projects; b) relationships vis-à-vis policy, implementation and so on in the region; c) feelings about what is happening and different roles.

**Purpose** To build a picture of NGO activities in the region and of relationships between NGOs and government. This is complementary work from which to discuss issues like decentralisation and regulation.

**Objectives** To obtain information and build a picture about:

- a) NGO activities/ project/ concerns
- b) NGO relationships with other NGOs, government and other groups

## **Activities**

This will be conducted through interviews, relevant documents, observation, cross-reference (interviews with other agencies)

## **Outputs**

1. Map of NGOs services, projects, programmes, activities
2. Map of relationships between the above (who does what with whom?)
3. Map of perceptions of roles, responsibilities, relationships, raison d'être etc

## **Guiding Questions**

### **A - Organisation**

What is your organisation? What is its history in Tanzania/ the region? What does it do? [Types - operational; grant-making; missions; CBOs; policy/ lobbying etc]; What are the main issues/ problems you come across in your work?

## **B - Activities/ Projects/ Programmes**

What are the main activities/ projects you have in the region (type, location, history)?; What are your organisation's aims/ activities/ achievements?; What kind of support does it get/ where from?

## **C – Relationships**

Which other organisations do you work with? Why?; How do you work with communities?; How do you work with NGOs?; How do you work with government (steering, contracts, gap-filling)?; What are the issues/ problems/ achievements in practice?; What do you think is the attitude/ understanding of the general public towards NGOs?; What is the attitude of government?; What is the attitude of business?; What is the attitude of donors ?

## **D - Issues**

Who do you think is responsible for development?; What are their roles and responsibilities?; How do these work in practice?; Where do NGOs fit in?; What is the role of other organisations?; How do you think this is changing over time?

## **E - Miscellaneous**

What reports/ exist of the region which are relevant to your work?; Do you work with individuals or departments?; How does what you do here relate to your organisation's structures and policies?



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