

NPO Performance in Reproductive Health Sector of Low and Middle Income Countries: What is the Influence of the Wider Policy Context?

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Non-Profit Organizations (NPOs) are increasingly being promoted as preferred providers to replace weak government services in Low and Middle Income Countries (LMIC) but results on ground show mixed performance. The variation in national policy contexts is one explanation for uneven NPO performance but has been under-explored in reproductive health literature. This paper collates gray and published literature providing an overview of how policy context impacts on NPO performance in reproductive health. Socio-political context, state policies and donor dependency indirectly influence NPO working by shaping operational space, autonomy, networking and mandate. These influences need to be recognized and modified so as to enable NPOs to better achieve their attributed characteristics of client responsive and quality services aimed at marginalized populations. Policy measures are needed to build better policy space and regulatory frameworks for NPOs, state-NPO collaboration forums, and greater reliance on internal funding.

Keywords: non profit organization, reproductive health, policy context, performance

Introduction

The last few decades have seen an upsurge in non-profit organizations with varying mandates. NPOs have been especially prolific in low and middle income countries (LMICs) with UNDP estimate of more than 50,000 NPOs working in developing countries with some 250 million beneficiaries by 2000 (Besley & Ghatak, 1999). The International Conferences on Population Development (ICPD), Cairo (1994) and the Fourth World Conference on Women (FWCW), Beijing (1995) set out a cornerstone role for NPOs for innovative and client oriented reproductive health services and positioning at marginalized groups (Sai, 1997). There has also been a growing trend, driven by multilateral and bilateral agencies, to replace weak government services through contracting out to NPOs (Perot, 2006; Spar, 2002). Globally, this preference for NPOs has manifested through increasing flow of aid directly to the NPO sector.

Despite international policy hype, NPO performance in maternal health, family planning and HIV services tends to vary widely across countries (Loevinsohn & Harding, 2005). While research has typically focused on measurement of NPO performance, the drivers of NPO performance have received little attention.

Presence of an enabling or constraining policy context is particularly relevant to working of NPOs as they are commonly credited with access to the disadvantaged, innovative flexible interventions, client orientated and transparent services, and these very attributes are particularly likely to make NPOs susceptible to external contextual influences (Edwards & Hulme, 1996; Zoeteman, 2012).

This paper collates existing published and gray literature to provide an informed commentary on how drivers within the larger policy context influence NPO performance in reproductive health in LMICs. The emphasis of this paper is not on quantitative gains of NPOs that have been better researched but on qualitative aspects of NPO growth, autonomy and workspace as influenced by the external context. We take up three policy parameters mentioned by development literature as being important for NPO growth - the socio-political context within which NPOs evolve, the state's regulation and support to NPOs, and extent of donor support and dependency (Tuckman, 1998; Michael, et al., 1999; Lecy, et al., 2010; Clark, 1995), and explore how these have shaped reproductive health work of NPOs. An exploratory discourse is provided on influence of these three drivers, the pathways through which policy influence has been manifested, followed by a discussion emphasizing need for investment in supportive policy measures rather than mere focus on contracting NPOs for service delivery.

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A broad search of both peer reviewed and 'gray' literature was attempted. Sources included online databases such as Web of Science, ScieVerse Science Direct, ELDIS and PubMed using the search terms of 'NPO performance', 'NPO effectiveness', 'NPOs in LMICs' 'NPO in health sector' 'reproductive health' 'women's health' 'women's development' and 'case studies'. Case studies that reported on any of the three aspects of the local policy context and resulting effect on NPOs were reviewed. Bibliographical citations from selected studies were also looked up. Effect on NPOs was broadly interpreted in terms of influences on growth and development of the NPO sector or nature of their working. The yield of peer reviewed articles was few and comprised a heterogeneous set that varied widely from being essentially descriptive to being more analytical.

What Are NPOs?

Common organizational features associated with NPOs, include a non-governmental background, an organized structure, a development focus, a non-profit orientation and involving voluntarism in some respect (Green & Mathias, 1997; Salamon & Anheier, 1992). These organizational attributes of NPOs have implications for capacity to deliver required services in line with NPOs' expected attributes of a grounded agenda and responsive approaches (Padaki, 2000). While in theory these are essential features expected of NPOs, in practice the NPO sector varies from country to country in terms of level of organizational development, governance and ideology. NPOs may be local, national or international in scope, be governed by a participatory or individual centered decision making, and have an advocacy or service delivery focus.

A common categorization of NPOs is that of grass-root organization, charity based NPOs and professional NPOs (Cherrett, et al., 1995; Ambegaokar, 2001; Hadenius & Ugglä, 1996). Grass-root organizations are distinguished by in-depth area specific linkages and a distinct ideology linked to the local context from which they have evolved but they can be hampered by weak experience and resources for programming and management. In contrast, professional NPOs are usually well resourced with staff, infrastructure and training but may have an outsider's exposure to disadvantaged settings. In between the two extremes, are the charity based NPOs which have a commitment to a philanthropic mission and usually have a trust based structure (Sen, 1992; Doh & Teegen, 2003). Majority of NPOs may well fall in between, borrowing features from more distinct

categories. This wide variation in organizational attributes of the NPO sector suggests that larger contextual factors may be relevant in shaping the NPO sector and its work.

NPO Performance: How Much Do We Know?

The scholarly consensus about NPOs is that while they perform better than government in reaching disadvantaged groups, they usually perform less well than credited (Edwards & Hulme, 1996). There is thin literature in this area, with few systematic reviews and most evidence confined to case studies having varying methodologies and little in the way of independent evaluation. Systematic reviews on contracting of NPOs generally show an increase in primary health care service utilization at the facility level (Liu, et al., 2007; Loevinsohn & Harding, 2005) however, there is inconclusive evidence on household level utilization and ability to reach the most disadvantaged (Zaidi, et al., 2012). NPOs have been successful in quick roll out of primary health care services in fragile states as seen in Afghanistan, Cambodia and Haiti (Bhushan, et al., 2002; Eichler, et al., 2001). They have also penetrated low income, low access areas in more stable countries often meeting service targets ahead of government counterpart, as seen by increase in institutional deliveries in Bolivia (Lavadenz, 2001) and postnatal care in Guatemala (LaForgia, et al., 2005). However NPOs have been reported to cluster in easier regions failing to reach the most vulnerable.

In Thailand, most NPOs tended to target brothel based female sex workers (FSWs) rather than the more hardened street based FSWS and Injection Drug Users (IDUs) (Ainsworth, et al., 2003). Similarly in Afghanistan there has been a rapid roll out of services by NPOs in the post-conflict period with remote provinces remaining uncovered (Sabri, et al., 2007). In Pakistan, there was thin response to tenders for HIV prevention service in rural areas as compared to major urban centers (Zaidi, et al., 2011).

NPOs have been known to perform better on certain structural aspects of quality of health care such as cleanliness and maintenance of health care facilities as seen in Pakistan where management of government's Basic Health Units was contracted to a NPO (Loevinsohn, et al., 2006). Improved availability of medicines and supplies has been established in Cambodia and Afghanistan where NPOs are responsible for running district and provincial health care systems services (Bhushan, et al., 2002; Peters, et al., 2007). NPOs are also commonly reported to have friendlier attitudes and lower waiting times than government programs as seen in Guatemala, Uganda

and Bangladesh. However, the technical quality of service delivery has not been consistently superior amongst NPOs. Even though some of the larger NPOs in LMICs have been partners in developing capacity on reproductive health for national governments, several NPOs still lack access to treatment protocols and have little exposure to national training programs.

NPO attributes in terms of both their performance and organizational attributes are highly context specific. This merits further probing of the external environment in terms of how it enables the development of a robust NPO sector and facilitates its optimal working. We take a closer look at the policy environment in which NPOs work in terms of i) the socio-political context; ii) the state policy; and iii) donor dependency.

The Socio-Political Context

In developed countries, the growth of NPOs has taken place in a background of relatively even footed power distribution. A high level of societal voluntarism and state support has provided space for organizational growth of NPOs, development of independent positioning from that of state and involvement in defining of national and international health agendas (Hadenius & Ugla, 1996). In contrast, NPOs in developing countries usually face tougher challenges in terms of a patronage based power structure, frequent societal divisions, weak democracies and low financing capital (Cherrett, et al., 1995).

In South America, because of a politically conscious culture and populist struggles against repressive regimes, NPOs have traditionally enjoyed a larger operational space. NPOs have addressed public health issues such as safe abortion and adolescent reproductive health that are politically and ideologically too sensitive for other providers to take on (Langer, et al., 2000). In LMICs with a vibrant culture of activism such as Nepal, there has been a conscious effort by NPOs to preserve an 'independent' image (Mayhew & Ambegaokar, 2002). In Zimbabwe, decentralization of health programs provided space to grassroots NPOs for more participatory RH programming (Petchesky, 2000). In contrast, in the backdrop of a weak societal context in Ghana, the push by aid agencies to boost the NPO sector led to instances of local NPOs creating their own fiefdoms in client villages (Mohan, 2002).

Quite often there is a 'mixed effects' effect on the NPO sector as a result of transition in socio-political contexts. In Bangladesh, the struggle for

independence provided a high level of political space to NPOs in the initial years, but recent governments, wary of the activist role of NPOs, encouraged a shift from activism to service delivery (Rahman, 2006). In Chile, although NPOs working on women's rights developed into a promising activist group during the Pinochet dictatorship, the nature of activities changed with the end of dictatorship. As several NPO leaders were co-opted into government, they diverted their energies to gather support for parties in government and secure government contracts, thus becoming distanced from the issues of the rank and file of activist women (Petras, 1997). In India a combination of both negative and positive features were seen in the socio-political environment. A politically democratic tradition sustained over the years despite traditional societal divisions provided a mixed environment for NPO expression. NPOs found issues such as family planning and HIV/AIDS to be government preferred safer areas for NPO advocacy with lesser space provided for more contentious areas such as land or caste conflict that challenged traditional power structures (Kilby, 2006).

Presence or absence of social safety nets has been seen to stimulate formation of NPOs working on RH and women's development. For example, the post-conflict period in Lebanon period saw the emergence of a number of charitable organizations in response to a weakened state structure while in South Asia there is a well-established tradition of philanthropic health services (Lyons & Hassan, 2002).

State Policies towards NPOs

Explicit state policies have included related acts and legislations defining the sphere of NPO functioning, fiscal and monitoring controls by government and organizational support to NPOs. Legislation on NPO establishment and approval of activities can be either supportive or restrictive. A multi country case study of RH NPOs in Asia showed that organizational development and level of activism amongst NPOs had clear links with the legislative environment (Mayhew, 2005). Vietnam had a strong socialist government with tight control over the NPO sector providing little space for NPO growth. Reproductive health (RH) NPOs were frequently headed by pro-establishment figures, faced extensive bureaucracy for receipt of funds and were vulnerable to be arbitrarily shut down by the state (Mayhew & Ambegaokar, 2002).

State indifference on NPO role, manifested through too little policy, was also found to have a negative impact on health NPOs as seen in Cambodia

where a lack of formal policies towards the NPO sector contributed towards an uncoordinated NPO sector and insufficient fiscal accountability (Mayhew & Ambegaokar, 2002). Similarly, in Pakistan, weak checks on NPO registration and poor accountability of performance and funds has led to mushrooming of NPOs in the HIV area but many suffered from gaps in terms of skills and weak orientation of confidentiality issues and client rights (Arjumand & Associates, 2004). In Nepal, where the legislative framework for NPOs grew out of the movement for rights and empowerment, the NPO sector has been very active.

The relationship between legislative context and the working of NPOs is by no means linear and in some instances, the activity of the NPO sector has also shaped legislation. In Bangladesh, the evolution of a NPO sector almost paralleling the state has led to government regarding NPOs as a competitor for foreign funds. This has resulted in restrictions on the flow of international donor aid to NPOs (White, 2002). Similarly, in Peru, despite a relatively large NPO sector, there are government concerns regarding the amount of funds NPOs receive independent of the Ministry of Health (Langer, et al., 2000).

Provision of training and support to NPOs is another area within the larger regulatory sphere of state which much too often is overlooked in favor of formal controls. This is pertinent given that several NPOs while being registered bodies have little capacity for internal documentation and organizational management (Herman & Renz, 1998). However, while opening up state supported avenues for funds and training, caution needs to be exerted to guard against government co-option of NPOs that may undermine their independent grounded role, as seen in India where opening up of government funds for NPOs led to funded agencies operating as a shadow state with little resistance to state policies (Sen, 1992). Structural processes related to government support may also influence effectiveness of support given to NPOs. Government funding support to reproductive health NPOs was initiated in Pakistan through the National Trust for Population Welfare but lack of autonomy slowed disbursements to the NPO sector (Zaidi, 2008).

Formal and informal steps towards Public Private Partnerships by government are also a manifestation of space provided by state for NPOs. Despite a highly favorable global environment for government engagement of NPOs, government stance on NPO engagement through public private partnership often tends to be vague (DFIF, 2002) and even confrontational at times. Formal channels for NPO participation in the policy process are usually non-existent, thereby excluding NPOs from priority

setting and shaping the process of service delivery. Provision of space for inclusion of NPOs in policy debate has often been circumstantial as seen during populist movements in post-apartheid South Africa (Schneider, 2002) and post-independence setting in Bangladesh (Rahman, 2006). At the service delivery level, government and NPOs usually have had isolated spheres of working with hesitations for closer working on both sides. Even in instances where visible state funded programs are in place to contract NPOs to supplement health care provision, poor ownership especially within the lower tiers of government and fears to relinquish budget and administrative powers to contracted NPOs has been experienced as a hurdle in more than one country (LaForgia, et al., 2005; Soeters & Griffiths, 2003).

Donor Dependency

The share of external aid to NPOs has dramatically risen in the last quarter of the 20th century, comprising 1.5 percent of NPO funding in the 1970s to a range of 15 to 20 percent in the 1990s (Greensmith, 2001; Buse & Walt, 1997). By 2006, over \$2 billion of official aid from developed-countries was channelled through NPOs, an increase of approximately 123 per cent from 2002 (OECD, 2008; Epstein & Gang, 2006). Many local NPOs are almost entirely dependent on donor aid for carrying out activities and internal revenue forms a proportionately small source of NPO funds (Fowler, 2002). In Afghanistan and Cambodia, re-building of the health care system extensively relies on NPO provided services funded by international donor agencies (Bhushan, et al, 2002; Ridde, 2005). In other countries NPOs are supported by international donors to provide HIV prevention, reproductive health and nutrition services, supplementing weak government services (England, 2004; Murthy, 2001).

Donor aid through its larger influence on the macro-economic environment has indirectly influenced the nature of NPO work on health. In several countries, neo-liberalist economic reforms promoted by international donors have reduced health care spending by government and increased expenditures borne by the poor with particular repercussions for women. In Zimbabwe, the introduction of user fee for antenatal care and removal of subsidies from medications and supplies led to a noticeable decline in antenatal attendance while cuts in public spending led to hospital closures in Peru (Petchesky, 2000). NPOs have filled the gaps in government service provision through donor funding but at the same time adopted the role of passive, apolitical service providers rather than

investing energies and mobilizing funds for organizing the poor to challenge market forces.

More specifically donor aid has also been seen to make NPOs vulnerable to donor funding priorities. In Pakistan, the NPO sector involved with HIV prevention was organizationally weak and evolving. With a sudden influx of donor aid for HIV prevention projects, the NPO sector grew but also began to identify with quantifiable health service targets linked to financial payments with less attention given to more process oriented activities such as empowerment, care and support amongst HIV high risk groups (Zaidi, et al., 2012). Moreover, there were turf fights over donor funding (Zaidi, et al., 2012). Even in contexts having a well-developed NPO sector, donor dependency can limit NPO responses. In Latin America NPOs were co-opted into excluding abortion services to conform to donor preferences (Langer, et al., 2000), and tight targets left less time for iterative learning and development of sustained linkages with clientele (Standing, 2000).

Donor dependency has been seen to have an impact on NPO networking. Networks amongst NPOs are valuable in cross-fertilization of experiences, making the most of their influence, as well as helping them survive times of crisis. NPO survival is frequently dependent on securing short-term donor projects and the haste to secure and implement projects often leaves less time for experience sharing. In Uganda, Tanzania and Zimbabwe, NPOs spearheaded much of the work on social and economic empowerment of women affected by HIV/AIDS. However, up scaling and experience sharing with other NPOs was restricted by lack of time and resources amongst NPOs due to the sporadic short-term nature of the projects (White & Morton, 2005). In Bangladesh, NPOs have had less time and fewer resources for NPO networking which has been connected with their passive role as service providers supported by international aid while in Ghana external donor funding encouraged factionalism and infighting amongst NPOs to secure donor contracts (Mohan, 2002; Rahman, 2006).

Discussion

NPOs have been advocated to play a critical role in bridging Reproductive Health service gaps in developing countries through more responsive, transparent and accessible interventions. At the same

time, NPOs have variable performance and a better understanding is needed of what the policy drivers affecting NPO performance for RH in LMICs are. Development literature emphasizes the role of larger contexts, however, these have been less well recognized within the health sector. Role of the socio-political context has been less well stated in conceptual frameworks. Fowler (1996) identifies donor assistance, stakeholders and, rather broad external influences as key determinants, while Edwards (1999) identifies upstream linkages with political structures at higher levels and NPO autonomy as determinants of NPO performance.

NPOs in LMICs face tougher policy challenges as compared to their counterparts in the developed world. These can be contextually categorized into three areas. First, evidence indicates that the socio-political context as manifested through populist struggles, devolution or identification of governments with traditional power structures, exerts influence on the mandate and activism of NPOs. Unfavorable political contexts can shape NPOs as passive service providers undermining their advocacy role and direct NPOs towards safer versus continuous agendas. Conversely, gaps in provision of social safety nets in LMICs trigger NPO growth, as seen by proliferation of philanthropies in post conflict periods. Second, state policies towards NPOs influence size and capacities of NPO sector as well as extent of space provided for policy and services. State policies may be explicit such as legislative frameworks for NPOs or more implicit as in terms of supportive training grants and presence of public private partnership forums. Tight controls over the NPO sector can limit NPO autonomy, restrict flow of funds and limit training opportunities while too little control leads to an uncoordinated and unaccountable NPO sector. Third, NPOs in LMICs are heavily dependent on foreign aid to carry out activities and remain solvent. This donor dependency makes NPOs vulnerable to donor funding priorities, location choices and vertical accountability on outcomes creating tension with their on-the-ground character. Moreover, emphasis on targets leads to too little time for learning and networking for NPO survival.

State policies, donor dependency, and the local socio-political context emerge as important drivers of NPO performance in the health sector directly influencing NPO operational space, autonomy, networking and mandate (Figure 1).

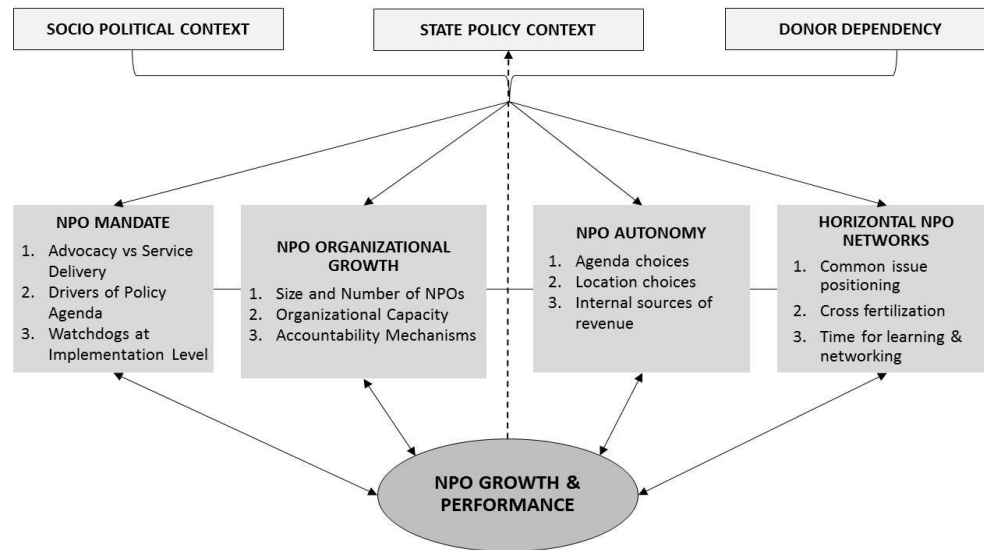


Figure 1. Determinants of NPO growth and performance in RH sector of LMICs.

NPO performance in developing countries needs new modalities of support to optimize NPO working. Traditional support measures of inflow of external aid to NPOs as well as more recently initiated market based NPO contracting for health service delivery are insufficient, will continue to result in uneven performance and even at times detract NPOs from their client focused attributes unless there is simultaneous investment in policy measures. Such measures can learn from successes of more developed countries in furthering civil society engagement at both policy and implementation level (Padgett, et al., 2004). Investment needs to be channeled towards macro policy measures aimed at enhancing citizenship, establishing democratic structures at local level, and moving away from punitive frameworks for NPO regulation to those based on incentives and self-regulation. These need to be backed with measures at the meso-level, aimed at space and funds for NPO networking, NPO-government engagement forums at policy and service delivery levels, training opportunities, enhancement in internal funding, and funding cycles that allow for iterative learning.

Conclusion

The variation in NPO performance in Reproductive Health can be explained by the national policy contexts within which NPOs work. Non-conducive socio-political contexts, inadequate legislative frameworks and dependence on external aid make NPOs underperform by undermining NPO operational space, autonomy, networking and mandate. Recent upsurge in contracting NPOs for service delivery is

insufficient unless supported by policy measures aimed to build better policy space and regulatory frameworks for NPOs, state-NPO collaboration forums, and greater reliance on internal funding for civil society.

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