Series on Democracy and Health

Democracy and Health: An Overview of Issues Presented in Four Papers

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Introduction

The current global trend toward democratization provides an opportunity for health improvement in developing countries. Many countries are now experiencing an expansion of the competitive political market along with economic liberalization. These democratic trends alone, however, may not necessarily lead to better health for the population. It is therefore important to examine the relationship between democracy and health in developing countries. This analysis holds critical implications for USAID's role in promoting democratization, which constitutes one of the agency's main strategic pillars for assistance. The health sector within USAID, therefore, may benefit from an exploration of the key issues of democratization and their implications for health assistance policy.

This overview presents key questions and strategic options in the area of democracy and health, as an introduction to the material examined in more detail in the fourbackground papers (Figure 1). The first paper (by S.W.R. de A. Samarasinghe) summarizes conceptual issues about democracy and the processes of democratization. The second paper (by Ramesh Govindaraj and Ravi Rannan-Eliya) analyzes empirical evidence about the relationship between democracy and health. The third paper (by Charlotte N. Gardiner) presents policies that Ministries of Health can use to promote democracy and health. And the fourth

Figure 1

Four Papers on Democracy and Health Series Edited by Michael R. Reich

1. Democracy and Democratization in Developing Countries

   By S.W.R. de A. Samarasinghe

2. Democracy, Communism, and, Health Status: A Cross-National Study

   By Ramesh Govindaraj & Ravi Rannan-Eliya

3. Democratization and Health: Implications for Ministry of Health Policies

   By Charlotte N. Gardiner

4. PVOs and NGOs: Promotion of Democracy and Health

   By Adrienne Allison & James A. Macinko

paper (by Adrienne Allison and James A. Macinko) examines the role of non-governmental organizations in democracy and health. These four papers are intended to serve as background materials, to assist in exploring possible strategies for USAID action in this area. The objective is to identify options that are both academically sound and practically relevant, to stimulate new thinking about strategies in the area of democratization for health.

This overview briefly presents some of the main points of the four papers. The limited space necessarily results in some simplifications in the presentation, and readers are directed to the original papers for the full arguments. This review also provides some critical comments on the four papers, to indicate areas for future study. Finally, since the papers are still working drafts, the overview is intended to solicit comments and questions from readers. We welcome suggestions on each topic, on the overall presentation, on actions that the USAID Health Office could consider, and on the next steps for the project.

Conceptual Issues

The first paper, "Democracy and Democratization in Developing Countries" by S.W.R. de A. Samarasinghe, has two main objectives: to provide an overview of the main elements of democratization, and to explore the implications of democratization for health. This paper places the issues of democracy and health within a broader theoretical framework and within USAID's understanding of democratization.

Some elements of democratization are obvious and widely accepted: the emergence of competitive political parties, freedom of the press, freedom of association, strengthening of an independent judiciary, and the social control of corruption. But these elements have not emerged equally in all countries, nor have the consequences been the same. What kinds of patterns are emerging in different countries, and how have these trends affected health policies and health problems? In order to examine the conditions under which democratization strategies are likely to improve health, we need to have a clear conceptual and practical definition of democracy. This first paper provides that basis.

As Samarasinghe points out, the concept of democracy is straightforward and uncomplicated, in sharp contrast to the theories of democracy. Broadly speaking, the concept of democracy relies on the principles of equality and popular control of collective decision-making. Theories of democracy, however, disagree over how to achieve the basic principles, with major debates over the appropriate scope of democracy (political versus social and economic spheres), the relative emphasis on democratic process versus outcome, and whether a universal model of democracy exists. While these theoretical debates cannot be resolved within this project, they provide an important context for understanding the relationship between democracy and health and efforts to intervene therein.

Democratization, then, involves a process of political change that increases the degree of peaceful competitive political participation in the governmental system and that enhances political and civil liberties at the same time. The process of democratization, Samarasinghe notes, begins under various political and economic conditions, and does not necessarily follow a linear or universal path. A major theoretical debate here concerns whether certain cultural conditions must exist prior to democratization, or whether institutional capacities and mechanisms are more important than political culture in explaining successful cases of democratization. These two positions have quite divergent implications for

interventions to establish and sustain democratic processes. If the "can do" school is correct in its judgement that democracy can be taught and learned, then assistance in building institutional capacity and leadership can make a difference in promoting democracy. Moreover, political theorists do not agree on the consequences of democratization for economic development, pointing to successful cases of development under both democratic regimes (such as Sri Lanka and Costa Rica) and non-democratic regimes (such as China and Taiwan).

Samarasinghe next examines issues related to the measurement of democracy. He reviews four different indices that seek to quantify the degree of democracy within a country, to asses progress or regress over time and to provide a comparative global evaluation of democracy. The indices suggest some trends about the relationship between democracy and development, but Samarasinghe urges caution on the use of these quantitative measures. He concludes that the indices should supplement rather than substitute for "informed judgement" about changing patterns of democracy within a country or a group of countries. If democracy continues to become an important criterion for foreign assistance, or even develops into a form of aid conditionality, then these issues and cautions about measurement will become increasingly critical.

What does "democratization" mean within USAID? Unfortunately, no single, easy answer exists. Democratization covers various evolving programs, employing different perspectives. But some basic ideas or principles can be identified, based on several working documents. The document on "Building Democracy: USAID's Strategy," for example, provides these key ideas:[1]

> *Because of the menace generated by nondemocratic regimes and because democracy and respect for human rights coincide with fundamental American values, the Clinton Administration has identified democracypromotion as a primary objective of U.S. foreign policy. Foreign assistance is a natural vehicle for achieving this goal.*
>
> *In accordance with Administration policy and congressional mandate, USAID will decline to provide any form of assistance, except to meet humanitarian needs, to governments that engage in a consistent pattern of gross violations of internationally recognized human rights. Further, when allocating scarce development resources among countries, USAID will consider a government's human rights performance, including its willingness to permit the emergence of democratic institutions and independent political groups.*
>
> *Democratization is an essential part of sustainable development because it facilitates informed participation in the development process. USAID's success in the other core areas of sustainable*

1/ "Building Democracy: USAID's Strategy," Washington, DC: USAID, n.d.

> *development -- environmental protection, population planning and equitable economic growth -- depends on democratization. Repression, human rights abuses, disregard for the rule of law, corruption, and autocracy are antithetical to development. Therefore, USAID has attached a high priority to strengthening of democratic institutions and popular participation in decision making. Our programs will be developed and implemented accordingly.*
>
> *USAID's strategic objective is the transition to and consolidation of democratic regimes throughout the world -- as an end in itself and because it is a critical element in promoting sustainable development.*

Given these basic ideas about democratization, USAID's strategy would provide three types of countries with program assistance. First, are the "sustainable development countries," where USAID would provide an integrated package of assistance. Second, are those countries that have recently experienced a national crisis or natural disaster, where the timely provision of assistance is needed to reinforce institutions and national order. And third are those countries where USAID's presence is limited, but where aid to NGO sectors may facilitate the emergence of a civil society or help alleviate repression.

According to the same document on USAID's strategy, assistance programs would seek to address various problems that are considered "impediments to democracy":

- misperceptions about democracy and free-market capitalism
- the absence or weakness of intermediary organizations, such as labor unions, business organizations, and civic groups
- nonexistent or ineffectual political parties
- ethnic divisions and the reemergence of nationalist politics
- lack of experience with democratic institutions
- absence of national charter documents -- a constitution, a bill of rights, citizenship laws, land reform laws -- that meet international standards
- powerless or poorly defined democratic institutions, including politicized or corrupt judiciaries, overly-centralized government institutions, and rudimentary or unaccountable institutions of local government
- elected positions for which there is no meaningful contestation or competition
- unsettled civil-military relations
- abiding patterns of corruption
- tainted or desultory elections

These criterion from USAID documents illustrate, as Samarasinghe concludes, that "promoting democracy is the broadest and most inclusive sense of the word has become central to the entire foreign assistance program." USAID is moving away from direct support of the private sector and is emphasizing a more grassroots approach that embraces the socioeconomic as well as political sense of democracy. In his review of USAID's democracy promotion activities in each region (Latin America, Near East, Central and Eastern Europe, Africa and Asia), Samarasinghe notes that the efforts have produced "mixed results": some ambiguous as hard-to-qualify effects, along with important contributions in facilitating elections and in raising awarenessand priority about human rights in certain countries. He concludes that success on democratization for USAID will not come easily; experience to date shows "that there is no grand strategy available to USAID to foster democracy in a comprehensive manner." The agency will need a country-by-country strategy, which seeks a cooperation with other donors on politically sensitive issues, and requires a positive macroeconomic context and sectoral policies. In short, incorporating democracy objectives into the agency's traditional development work, in health as in other areas, represents a major strategic challenge.

Given USAID's basic principles of democratization and the impediments to democracy, what should the agency do in the health area? The agency has produced various lists of proposed activities, which are implicit in the principles and the impediments. One review of USAID's experiences in supporting democracy, prepared by Gary Hansen in 1991, provided thirteen categories of activities (Figure 2).[2] These categories were then operationalized in a "democracy objective tree," as an analytical framework for sustainable democracy, in September 1993, with eleven strategies divided into three program priority areas (Figure 3).[3] Remarkably, Hansen's report included no mention anywhere of health activities. This absence may reflect a lack of concerted attention within the agency to the interactions of democracy and health, as well as a lack of knowledge and information about these interactions. The disregard seems to affect officials concerned with political development as well as those concerned with public health. The four papers in this project seek to focus more attention on the interactions between democracy and health.

2/ Gary E. Hansen, "A.I.D. Support for Democracy: A Review of Experience," Interim Report, Center for Development Information and Evaluation, U.S. Agency for International Development, June 1991.

3/ "Sustainable Democracy," Draft PRISM/CDIE Analytical Framework, U.S. Agency for International Development, 4 September 1993.

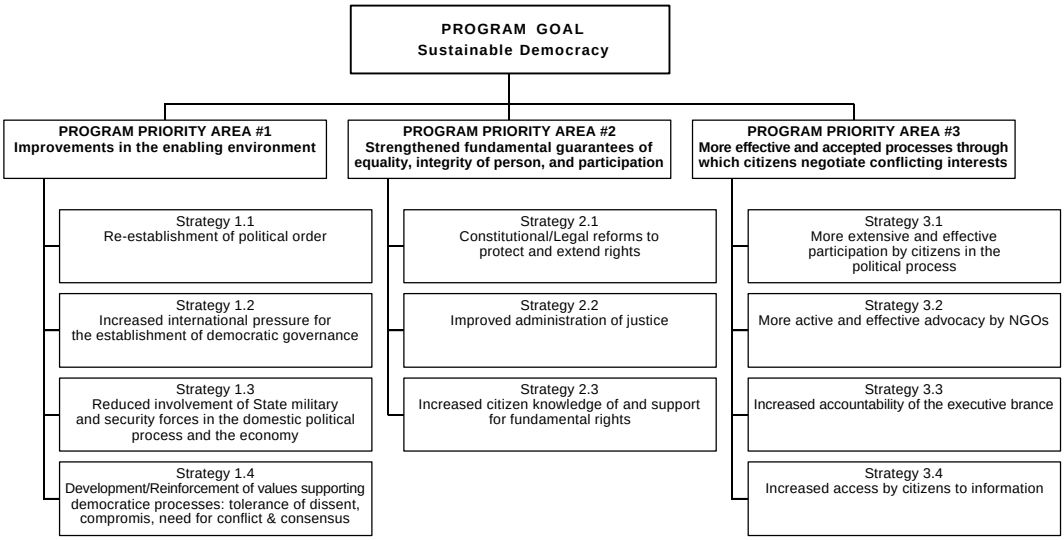
Figure 2

USAID Categories of Democratization

1. Constitutionalism
2. Human Rights
3. Administration of Justice
4. Decentralization
5. Legislative Development
6. Political Parties
7. Elections
8. Training in Political Leadership
9. Non-Governmental
10. Organizations
11. Labor Unions
12. Civil/Military Relations
13. Civil/Religious Relations
14. Civic Culture

Source: Hansen, 1991.

Figure 3
Democracy Objective Tree



Source: Sustainable Democracy: Draft PRISM/CDIE analytical framework 9/4

Empirical Evidence

The second paper, "Democracy, Communism, and Health Status: A Cross-National Study" by Ramesh Govindaraj and Ravi Rannan-Eliya, explores the political economy of health and development. The study provides empirical evidence about the impact of the political system on health status, using statistical analysis to show a significant association between democracy and health. The paper follows a series of previous studies on this topic, which have also shown the importance of democratic political systems. The previous studies, however, tended to underemphasize those results in their interpretations and conclusions, and to emphasize instead the positive association between health status and leftist/socialist regimes, which rarely included democratic states. The study by Govindaraj and Rannan-Eliya reevaluates these previous findings using new data and new methods. Their results are instructive, provocative, and potentially controversial.

The study by Govindaraj and Rannan-Eliya seeks to compare the association between political regime and health status across several dimensions: democracies versus non-democracies, communist regimes versus non-communist regimes, and democratic versus communist regimes. The study also seeks to test the validity of previous work using more recent and comprehensive data, and to identify potential areas of future research on the political determinants of health status. As shown in Figure 4, the authors propose to test whether non-communist democracies (Box I) have a better health status than non-democratic communist regimes (Box II) as well as all non-democratic regimes (Boxes II and III), and also to test whether non-democratic communist regimes (Box II) have a worse health status than all non-communist regimes (Boxes I and III).

In short, this study compares the health performance of democratic and communist regimes, based on several assumptions. First, the study proposes that a demand exists in democracies to be responsive to voters; second, that this demand creates incentives to perform better on health status (as well as other social indicators); and third, that those incentives do not exist in communist or non-democratic regimes. These assumptions are not tested in the study by Govindaraj and Rannan-Eliya, but could explain the mechanism for an association between democratic regime and health status.

The study depends heavily on clear (and acceptable) definitions of democracy and communism. For the purposes of this paper, democracy is defined operationally as two characteristics: 1) regular, competitive, multiparty elections for executive and

Figure 4

Comparison Categories of Political Systems

	Democracies	Non-Democracies
Communist	-----	II
Non-Communist	I	III

Hypotheses:
a) I > II
b) I > II + III
c) II not > I + III

Methods Used:
* Regression analysis
* Non-parametric testing - Two sample Wilcoxon Rank Sum Test

Source: Govindaraj and Rannan-Eliya, 1993

legislative office; and 2) real or potential opportunity for change in government through the electoral process. Similarly, communism is defined operationally as four characteristics: 1) government guided by Marxist/Leninist doctrine; 2) totalitarian system of government; 3) single authoritarian party controls the state-owned means of production; and 4) official discouragement of private economic activity. The study classified a country's political system according to consistency inregime for 90% of the 20 years prior to 1990. The classification of 166 countries (for which health data are available in 1990) produced shows 50 democracies, 26 established communist regimes, five recent communist regimes, and 85 other countries (Figure 5). The study used life expectancy and infant mortality as the dependent variables on health status.

The main results of this study are as follows. First, democratic regimes, on average, are more positively associated with health status than non-democracies (both communist and non-communist), controlling for income. The study found a remarkably high representation of democratic regimes among the best health-performing

countries, compared to the total number of democracies in the world. Second, communist regimes, on average, are not more positively associated with health status than non-communist regimes (both democratic and non-democratic). Third, communist regimes, on average, are more positively associated with health status than non-democratic, non-communist regimes, when controlling for democracy and income, although the coefficient for democracies, in this regression, is statistically significantly higher than for communist regimes, reinforcing the first conclusion about the importance of democracy. Fourth, China and Cuba stand out as two major exceptions of communist countries with good health status indicators, possibly suggesting that cultural factors may affect China's superior performance, along with Taiwan and Hong Kong; and that regional factors may also affect Cuba's performance. Finally, the paper proposes that the experiences of democratization in countries of Eastern Europe will provide a prospective study for examining these hypotheses about the relationship between political system and health status.

Figure 5

List of Countries

Democracies	***Established Communist Regimes***	***Recent Communist Regimes***	***Other Countries***
Antigua & Barbuda	Albania	Nicaragua	Algeria
Australia	Armenia	Ethiopia	Argentina
Austria	Azerbaijan	Laos	Bahrain
Barbados	Belarus	Mozambique	Bangladesh
Belgium	Bulgaria	Vietnam	Benin
Belize	China		Bhutan
Botswana	Cuba		Bolivia
British Virgin Islands	Czechoslovakia		Brazil
Canada	East Germany		Burkina Faso
Cayman Islands	Estonia		Burundi
Columbia	Georgia		Cameroon
Costa Rica	Hungary		Cape Verde
Cyprus	Kazakhstan		Central African Republic
Denmark	Kirghizstan		Chad
Dominica	Latvia		Chile
Finland	Lithuania		Comoros
France	Moldova		Congo
Greece	Mongolia		Cote d'Ivoire
Iceland	Poland		Dominican Republic
India	Romania		Ecuador
Ireland	Russia		Egypt
Israel	Tadzhikistan		El Savador
Italy	Turkmenistan		Equatorial Guinea
Jamaica	Ukraine		Fiji
Japan	Uzbekistan		Gabon
Luxembourg	Yugoslavia		Gambia
Malaysia			Guinea-Bissau
Malta			Ghana
Mauritius			Grenada
Netherlands			Guatemala
New Zealand			Guinea
Norway			Guyana
Papua New Guinea			Haiti
Portugal			Honduras
Singapore			Hong Kong
Solomon Islands			Indonesia
Spain			Iran
Sri Lanka			Jordan (E.Bank)
St. Kitts & Nevis			Kenya
St. Lucia			Kuwait
St. Vincent			Lesotho
Sweden			Liberia
Switzerland			Madagascar
Trinidad & Tobago			Mali
UK			Mexico
USA			Malawi
Vanuatu			Morocco
Venezuela			Mauritania
Western Samoa			Namibia
West Germany			Nepal
			Niger
			Nigeria
			Nigeria
			Oman
			Pakistan
			Panama
			Paraguay
			Peru
			Philippines
			Qatar
			Rwanda
			Sao Tome & Principe
			Saudi Arabia
			Senegal
			Seychelles
			Sierra Leone
			Somalia
			South Africa
			South Korea
			Sudan
			Suriname
			Swaziland
			Syria
			Taiwan
			Tanzania
			Thailand
			Togo
			Tonga
			Tunisia
			Turkey
			Uganda
			United Arab Emirates
			Uruguay
			Yemen
			Zaire
			Zambia
			Zimbabwe

Policies for Ministries of Health

The third paper, "Democratization and Health: Implications for Ministry of Health Policies" by Charlotte N. Gardiner, identifies a series of policies that a Ministry of Health could adopt to promote processes of democratization. How could the MOH be made democratic? What actions could the MOH take to make society more democratic? Would making the MOH more democratic also make society more healthy? This paper suggests mechanisms for USAID to consider in encouraging a Ministry of Health to adopt democracy-promoting policies. Gardiner examines incentives and disincentives associated with these policies, and suggests ways that USAID could influence the structure of those incentives.

The paper proposes seven types of policies that would strengthen democratization in the health sector (Figure 6): district health systems, integrated service delivery systems, community participation, human rights and reproductive rights, cost effectiveness, equity of access, and sustainability. These policies, while inspired by the principles of primary health care articulated in the Alma Ata declaration, are grounded in the world of the 1990s, in particular, the realities of economic liberalization and political democratization. The policies would be promoted by the political democratization processes now underway in many developing countries. In addition, as Gardiner suggests, the pressures of economic liberalization and the economic environment of structural adjustment

Figure 6

MOH Policies To Promote Democratization

1. District Health Systems
2. Integrated Service Delivery Systems
3. Community Participation
4. Human Rights & Reproductive Rights
5. Cost Effectiveness
6. Equity of Access
7. Sustainability

Source: Gardiner, 1994.

ironically may be effective in removing some critical obstacles that ministries of health previously could not overcome in their efforts to implement these policies under the banner of primary health care. The seven types of policies are briefly reviewed below.

District Health Systems represent a basic component of political decentralization, which is broadly agreed to be part of democratization. Many countries are enhancing the power of the district assembly and seeking to bring critical decisions closer to communities. This form of decentralization, which increases the power of district decision making bodies, also requires increased management capacity at the district level. Management training could be quite useful for district health management teams, for example, in helping these teams achieve the potential contribution of the district hospital and assure the effective operation of a district health referral system. Increased power at the district level, however, usually means decreased power at central level, which can become a major block to implementation.

Integrated Service Delivery Systems are often part of district health systems, reflecting a district preference for horizontal coordination of health services and a general perception of vertical programs as imposed from above and therefore undemocratic. To the extent that district health systems reflect popular preferences, however, these systems may give greater attention to curative services over preventive services and thereby undermine a comprehensive health approach. On the otherhand, an integrated service delivery system (including preventive and curative services) can help meet other democratic goals, such as equity in access and protection of human rights in health. These potential problems suggest that the seven principles may have some tensions and inconsistencies that must be resolved.

Community Participation is recognized as both an end in itself (increased democracy) and an instrument to other goals (increased health). Health workers, however, are rarely adequately prepared to engage in community dialogue in deciding goals and implementation strategies. Opportunities exist for training health workers in the processes of community participation, and also for creating innovative ways to inform and educate the public and designing community-specific approaches. In some cases, effective community participation may require the empowerment of certain groups in a community, which can upset the existing power structure in the community. Moreover, community participation does not necessarily result in health improvements and can produce a rejection of centrally decided (or even district-level) health policies.

Human Rights and Reproductive Rights represent an area that Ministries of Health must give increasing attention, since, for example, family planning policy raises basic questions about the human rights of women. Family planning is increasingly viewed as a means to improve the overall status of women and

alleviate poverty, not simply as a population control measure. The broader recognition of women's rights has implications throughout the health sector, with various ways for a MOH to enhance this democracy-promoting element of its policies. Examples include efforts to improve the quality of health care for women as a means to protect human dignity, and efforts to improve the logistics of contraceptive devices as means to protect the right to choice. Opportunities exist to make Ministries of Health more sensitive to the full implications of human rights issues in all areas of health policy.

Cost-Effectiveness is commonly viewed as an analytical tool to improve the efficiency of resource allocation and utilization, but it can also promote more democratic decision making processes. Cost-effectiveness analysis can contribute to enhanced accountability for government decisions and expenditures, and can also provide more information to people about policy options, as an input to decision-making. In some situations, cost-effectiveness analysis can help protect against the power of interest groups that may seek to distort priority-setting. Whether cost-effectiveness analysis contributes to democratic processes thus depends not only on the quality of analysis but how the information is disseminated and used.

Equity of Access, as a basic democratic principle of the health sector, can be assured through a minimum package of services available to all. Not all countries that consider themselves as democratic, however, currently provide such basic services. A Ministry of Health might be encouraged to find ways to target the poor with subsidized services and to avoid providing subsidized services to those who can afford to pay. Questions nonetheless remain about what to include in the basic package. Questions also arise about intra-family access to health care, especially for women. How might the democratization process be extended into the family?

Sustainability represents the seventh area of democracy-promoting policies for a Ministry of Health to consider. Here, ministries should seek to assure that the process of democratization in the health sector will be sustainable over time. Policies need to consider the following factors in assuring sustainability: 1) providing answers that respond to felt needs of real communities; 2) adopting measures that are culturally appropriate and accepted; 3) seeking to involve community members in policy implementation; 4) enhancing the individual and collective skills of communities in order to enhance the program's continuity. In sum, health policies should create the conditions for assuring autonomous, non-dependent continuation, including the possibility of cost-recovery.

These seven policy arenas may seem like a wish list of idealistic proposals, but they are being implemented to varying degrees by Ministries of Health around the globe. Five conditions seem to enhance the probability that democracy-promoting policies will be adopted. First, the policies must be perceived as

politically feasible, by the MOH and political leadership, by the relevant organized groups, and by the electorate. Second, the policies often require enhanced management capability, both at the central level and the district level, with a willingness to accept new roles and new powers (or loss of powers). Thirdis a revised organizational structure and processes within the MOH, to assure more democratic processes of decision-making. Fourth, donor support can be critical in allowing a Ministry to shift from vertical programs to district-level programs, and in tolerating inefficiencies that may result with increased democratic decision-making. Finally, economic growth can provide the broader context within which democratization can be promoted and can flourish.

Gardiner thus provides a broad array of health policies that could enhance democracy and health within developing countries. We still have more to learn, however, about how to select an appropriate set of policies within a specific context, in order to both promote democratic processes and improve health status. The seven policy areas discussed in this paper provide a good starting point for considering specific actions that could be undertaken by a Ministry of Health, and the potential interactions and consequences of the various policies. The paper also raises difficult questions about the relative priority of different democratic principles, especially when conflicts and trade-offs occur, and about the best sequencing of policies (where should a ministry start, and why?).

Policies for NGOs/PVOs

The fourth paper, "USAID, PVOs and NGOs: Partnerships for Democracy and Health," by Adrienne Allison and James A. Macinko, provides an overview of how USAID and other aid agencies can relate to nongovernmental organizations (NGOs) in ways that promote both democracy and health. The paper identifies sources of tension in the relationship between foreign aid agencies and domestic NGOs, due to conflicting social and political objectives, and shows how aid agencies seeking to assist NGOs can end up undermining the social effectiveness of those organizations. The authors examine past cases of USAID efforts to assist health NGOs, and identify determinants of success and failure. They conclude with an analysis of NGO assistance patterns adopted by other aid agencies, with the goal of suggesting possible strategies for USAID to follow in the health field.

The paper defines NGOs and private voluntary organizations (PVOs) as belonging to the "independent" or "third" sector (not public, and not private-for-profit). In addition, these organizations are value-driven, often committed to providing services, and serving as advocates for specific human needs. These organizations also provide important opportunities for individual participation in social decisions and social change. The authors consider three categories of NGOs/PVOs, as shown in Figure 7: international, intermediary, and grass roots.

They use the category of PVOs in a manner that follows USAID, which defines these groups as "US-based charitable organizations that operate programs overseas in developing and/or transitional societies," such as CARE. (These organizations might also be considered US-based NGOs focused on development.) NGOs based in other developed countries, such as OXFAM in the UK, are called "Northern NGOs." Intermediary NGOs include regional organizations, national organizations, and donor-organized and government-organized NGOs. Finally, there are grass roots NGOs, including community groups and popular movements. These three categories represent different sources of funding, levels of participation, and overall goals.

The authors argue that NGOs have various advantages over official government and multinational organizations. NGOs often can deliver social services to people at the community level efficiently and appropriately, and have a higher capacity to reach the poorer and more marginalized people among urban and rural populations. NGOs can work effectively to promote local participation in

Figure 7

Types of PVOs and NGOs

Classification	***Example***
I. International	
a. PVOs	- CARE
b. Northern NGOs	- OXFAM
II. Intermediary	
a. Regional	- Forum of African Voluntary Development Organizations
b. Southern	- Bangladesh Rural Advancement Committee
c. DONGOs & GONGOs	- Secretaria de Reconstruccion (El Salvador)
III. Grass Roots	
a. Community NGOs	- TASO (AIDS Support Organization, Uganda)
b. Primary Organizations	- Self-Employeed Women's Association (bombay)

DONGO = Donor Organized NGO

GONGO = Govt Organized NGO

Source: Allison and Macinko, 1994

both development and service delivery processes, and also can provide a rapid response to emergency situation. Because of their close ties to local populations, these group have a capacity to articulate the felt needs of communities, the potential to promote social change through advocacy and education in the community, and an ability to innovate and adapt new strategies, which can then be replicated in other areas. Some NGOs also operate at the national and international levels, affecting major policy decisions and their implementation, acting as advocates for particular positions and bringing new perspectives to policy questions.

The impact of NGOs in the Third World is difficult to document. The UN Development Program estimates that over 250 million people in the developing world are “touched” by NGO activities. The UNDP furthermore estimates that $7.2 billion,or about 13% of net disbursement of foreign aid, was passed through NGOs. Among various sectors, the health sector has one of the highest percentages of NGO funding, according to the *1993 World Development Report*, which estimated that about one-quarter of the total $4.7 billion transferred for health went through NGOs. In addition, there is a trend toward channeling increasing amounts of official aid through NGOs, out of concerns to increase both efficien-

cy and equity. The extent to which NGOs actually improve on the efficiency and equity of government or multilateral organizations, however, remains to be demonstrated in a clear and quantitative manner.

The paper's analysis suggests that for NGOs, some tension may arise between fulfilling health goals and promoting democracy goals. Village development committees, for example, may not be able to continue primary health care programs initiated by outside donors, as shown in a case involving Save the Children. The priorities of village development committees may not reflect those of donors, and, consequently, project outcomes may not meet donor expectations. This may result in donor unwillingness to fund community-identified development projects.

Donor agencies have developed different strategies for working with NGOs. The World Bank mainly considers NGOs as a mechanism to assist in project implementation, with little effort to encourage self-reliance, innovation, or open decision-making. The *1993 World Development Report*, for example gave scant attention to the role of NGOs in health improvement. PAHO, on the other hand, seeks to create a more transparent, accountable approach to NGOs, and considers NGOs as partners with governments in fostering development. PAHO therefore encourages governments to collaborate with NGOs doing similar work, and encourages NGOs to act in areas where governments are unable or unwilling to move. The Canadian International Development Assistance (CIDA) has given considerable attention to NGO development, including the establishment of a separate division to support all three categories of NGOs. CIDA has also focused on strengthening local NGOs in developing countries, as part of democratization . More than 10% of Canada's aid is channeled directly to developing country NGOs, and Canada claims to provide the largest percentage of official aid through NGOs. The Swedish International Development Agency (SIDA) has initiated an experiment to produce proposals through community-set development priorities, using local district health teams and intensive discussions at the local level. The project has achieved some success, but also a realization that more than four years will be required to reach program objectives.

The authors identified three main sources of tension between NGOs and aid agencies, in the area of health and democracy. First is a potential conflict between product versus process. While democratization is largely concerned with the processes of health development, aid agencies often are legally required to focus on the products of their activities. USAID, for example, is accountable to Congress for outcomes that are quantifiable. This raises the challenge of moving from product to process outcome measures. As SIDA encountered, aid agencies have specific organizational standards (in reporting, management and accounting), which tend to promote a bureaucratic relationship that constrains local NGOs. The product-orientation may also bias aid agencies toward service delivery NGOs rather than policy advocacy NGOs, and could foster dependency

rather than autonomy.

Tensions also can arise between US-based PVOs and local NGOs. The product orientation of PVOs can conflict with a more process orientation of local NGOs. Tensions can also result from competition over donor funding, and from the potential perception that the local NGO is simply an implementer for the US-based PVO. Tensions also arise between national governments and local NGOs. National governments can perceive NGOs as a political threat to the existing power structure, especially if the NGOs are concerned with promoting processes of democratization that may change the balance of power. Tensions can arise from better salaries and rewards provided for people who work for externally funded NGOs, in contrast to the salaries and working conditions for government officials. In addition, government officials can feel competition for scarce funds, especially as donors intentionally seek to bypass governments and support NGOs with aid that previously was channeled through government coffers.

The paper identified three main areas for potential USAID action to promote NGOs in health and democracy. First, USAID could identify programs that would be strengthened by or appropriate for NGO participation, and propose new indicators of success that include (or emphasize) process as well as product. Second, the agency could strengthen the capacity of NGOsto promote health by providing health interventions and increased civic participation and policy advocacy. Third, USAID could promote a positive enabling environment for NGOs in the health sector, at the national and international levels, in order to promote and protect open discussion of new policies that will improve the efficiency and equity of both government agencies and NGOs in health.

Next Steps

These four papers are intended to assist the Health Office, by reviewing the conceptual issues and relevant literature on health and democracy, as preparation for creating a strategy for this area. The strategy would include: 1) an application of the overall AID democracy strategies to the health field; 2) the development of democratization strategies specific to ministries of health; and 3) the development of strategies for USAID's engagement with all three categories of NGOs. As part of Data for Decision-Making's activities in this area, a draft strategy document could be prepared for these three areas.

A second possible follow-up activity would be to prepare case studies based on the findings in the four papers. The case studies could examine the successful implementation of democratization measures by a Ministry of Health, for example, in providing expanded access to public information or introducing mechanisms for district decision-making. A case study might also present a failed effort to implement democratization measures by a Ministry of Health, due, for example, to the opposition of a medical association that did not approve of the reduced professional privileges for physicians. Case studies could also be prepared on the dilemmas and difficulties of seeking to promote non-governmental organizations in the health field, and the need for different strategies according to the type of NGO.

Decisions about the next steps of the project on Democracy and Health will be taken after the papers have been discussed at an informal workshop and brainstorming session at USAID in Washington.