Growth of civil society in developing countries: implications for health

Pål Jareg, Dan C O Kaseje

Owing to changes in political systems, the number of non-governmental organisations worldwide has increased substantially since 1980. The influence of civil society on health and health care depends on the recognition of its role as a partner in primary health care, on its success in the scaling up of activities, on its cooperation with the State and business sector, and on networking. In the event of health-sector reforms, civil society should focus on substantially since 1980. The influence of civil society on health and health care depends on the recognition of its role as a partner in primary health care, on its success in the scaling up of activities, on its cooperation with the State and business sector, and on networking. In the event of health-sector reforms, civil society should focus on substantial gains.

During the growing disenchantment with the State over the past few decades and changes in political systems, attention has shifted towards allowing civil society a greater role in the health sector. Civil society is defined as “a sphere of social interaction between economy and State, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication.” Part of the rationale for this shift is to give consumers and organisations a greater say in health services, and to build and sustain democracy in parts of the world where civil society is weak. This paper focuses on those voluntary organisations, traditionally called non-governmental organisations (NGOs), which work with service delivery in the health sector.

Nyang’oro describes three forms of interaction between the State (or government) and non-governmental organisations within civil society. Some groups detach themselves from the State system and develop parallel health, political, and economic systems by means of the “exit option”—of which the emergence by means of the “exit option”—of which the emergence of the community-based health care movement in the 1970s and 1980s was an expression. Other groups organise themselves to engage the State in dialogue for the purpose of addressing inefficiencies, corruption, and bad policies, and to ensure that the State meets minimum obligations to its citizens—these measures are known as the “voice option”. The third form of interaction, “straddling”, describes those groups that oscillate between the “exit option” and the “voice option” according to the circumstances.

Civil society is sometimes referred to as the Third Sector. The State represents the First Sector, and business the Second Sector. In health terms, the First Sector represents the government’s public-health system, the Second the “private for profit” providers, and the Third the “private not for profit” health initiatives, such as NGOs and health facilities run by religious organisations. The Third Sector has grown rapidly in the past two decades. The number of development and relief organisations. The Third Sector has grown rapidly in the past two decades. The number of development and relief organisations. The Third Sector has grown rapidly in the past two decades.


Diakonhjemmets Internasjonale Senter, PO Box 23 Vinderen 0319 Oslo, Norway (P Jareg MD); and CISS International, Nairobi, Kenya (D C O Kaseje PhD)

Correspondence to: Pål Jareg (e-mail: jareg@diss.no)
Nepal, for example, rose from 220 in 1990 to 1210 in 1993.1

This paper examines the relation between the State and civil society, explores the shift of emphasis between them, and questions the tendency to idealise civil society as the magic cure for underdevelopment. We focus on Africa, though we also use examples from other parts of the world.

Civil society and primary health care
NGOs working in health have traditionally tried to reach the poorest sections of the community in order to improve access to health services in a given population. Many NGOs work within the concept of primary health care, by which they focus directly on disadvantaged families and communities. In many African countries, religious missions have provided health services in both primary health care and in hospitals, and in some countries such services are provided in partnership with government.

Primary health care was launched by WHO through the Alma Ata declaration in 1978,2 with the slogan, “Health for all by the year 2000”. It became clear, however, that the grand vision for primary health care could never be fulfilled by governments working on their own. NGOs, which were accustomed to working with communities, had to be the core part of the declaration and its implementation. The declaration required a transformation in the understanding of health and health care, and an overhaul of the service-delivery systems, incorporating all stakeholders in health into joint action. However, this lack of inclusiveness was the weak link in the implementation of primary health care; policy makers took more than a decade to recognise the role of civil society in providing an institutional base to facilitate the implementation of those elements of primary health care that the State could not cope with. The primary-health-care approach was embraced with enthusiasm by NGOs, since it promised to tackle the root causes of ill-health through partnership and by empowering people to increase their influence over events affecting their health and well-being. Unfortunately, however, this was seldom the way governments enacted the primary-health-care approach.

Instead, the Alma Ata declaration was often watered down to a few vertical quick-fixes related to the essential elements of health care, and some fear that the current WHO-led process of renewing the commitment to the health-for-all strategy may suffer the same fate as the declaration if it does not treat communities and NGOs as equal partners. What is critical is that the gulf between rhetoric and implementation is bridged.

Although NGOs may adopt exit, voice, or straddling options in relation to the State, they sometimes have to replace the State. Recent experience has shown that civil society has the capacity to take over the State’s functions in situations when the State machinery has collapsed. Examples of this are the Integrated Health Programme, managed by the Somalia Red Crescent Society with the support of the International Federation of the Red Cross, the Red Crescent Society, and the Northern National Societies; the Church’s health and development activities in the Democratic Republic of Congo; and the Integrated Health and Development Programme in Afghanistan, managed by the Afghan Red Crescent Society.

Health networks
Although NGOs often act alone, they are increasingly forming networks to advocate or campaign for particular health actions, or against actions that harm health directly or indirectly. One of the most publicised actions of global networks on health is related to The Milk War.3 The International Baby Food Action Network was founded in 1979 to support activists responsible for the campaign that resulted in the Code of Marketing of Breast-milk Substitutes by WHO and the United Nations Children’s Fund (UNICEF) to regulate the monitoring (among other things) of the sale of baby-formula foods.4 The code was adopted by the World Health Assembly in 1981 and represented an historic cooperation between the UN system, national governments (through the World Health Assembly), and civil society, against the Second Sector’s aggressive marketing of infant-milk formulas. NGOs continue to monitor the implementation of the code through such networks as the Interagency Group on Breast Feeding Monitoring, which includes many key NGOs, the British Medical Association, and the Church.5 Another health network, the International Campaign to Ban Landmines won the Nobel Peace Prize in 1997. There are more than 100 million anti-personnel mines worldwide; these mines maim and kill primarily civilian population many years after hostilities have ceased, and prevent the cultivation of valuable land in areas often affected by food shortages.6

The rapid advances in information technology have an important role in the expansion of many health networks. Some of these networks function through organised structures with an institutional base, such as the International Baby Food Action Network (IBFAN), whereas others represent a less tangible informal network of concerned people working towards a consensus view on different health issues.

Scaling up of development impact of NGOs
A major criticism of NGOs within civil society is that such organisations are fiercely independent and act autonomously, so that their projects tend to be limited to local settings with few examples of lessons learned successfully turned into sustainable national programmes. This apparent weakness must be put in context. Development of communities can be tackled most efficiently at local levels. Partnership can occur most effectively at the community, since resources can be pooled and the results of positive action and change are manifestly evident. If local structures of civil society are sustainable, they are best replicated rather than scaled up, which often leads to inefficiency and ineffectiveness. The structure of the Church and Red Cross provides a good framework for the networking of such local initiatives. The resulting network can be national and even international, but the individuality of each community group must be maintained.

A rough estimate in 1991 suggested that the work of 10 000 to 20 000 Southern NGOs covered a population of 100 million people in developing countries, most of them working to promote people’s health.7 Although such coverage is impressive, the NGOs will never be large enough to secure lasting improvements in the life and health of poor people worldwide through their own operational activities. In the past 5–10 years, different ways of “scaling up” their activities and experience have

820 THE LANCET • Vol 351 • March 14 1998
Therefore been discussed. Three distinctive approaches have been suggested: additive strategies, which advocate an increase in the size of the programme and organisation; multiplicative strategies, whereby impact is achieved through deliberate networking, policy influence, legal reforms, and training; and diffusive strategies, whereby spread is informal and spontaneous.10

Bangladesh Rural Advancement Committee provides an example of the additive strategy. The committee was established in 1972 after the liberation war with Pakistan. Through administrative growth in different sectors and geographical expansion, it is now one of the largest Southern NGOs. Since 1990 it has employed 4500 staff and has an annual operational budget close to US$23 million. Among its health activities, it runs programmes for child survival and women’s health. One study concluded that the committee’s growth took place without the quality of its operations being compromised.11

Such NGOs effectively compete with government ministries for impact.

An example of a multiplying strategy is the establishment of the Task Force Against Female Genital Mutilation in Egypt, where different NGOs in 1994 coalesced into a national movement and took the Health Minister to court for permitting female genital mutilation to be done in public hospitals. A religious leader, who declared that Muslim women should undergo genital mutilation, was also challenged legally. In July, 1996, a decree by the new Minister of Health for Egypt prohibited physicians from carrying out female genital mutilation in private or public health facilities, and official religious authorities have confirmed that female genital mutilation is not Islamic practice. The potential impact on reproductive health and reproductive rights of such a decision is clear in a country with a high frequency of female genital mutilation.12

An example of the diffusive strategy was the way the concept of primary health care was developed through the work of, among others, the Christian Medical Commission in the mid-1970s. The organisation had by then gained much experience in community health care. After entering into an informal dialogue on these issues with WHO, the commission’s ideas spread and the ground-breaking Alma Ata conference was organised in 1978.13

Growing political role of civil society

Civil society can provide an alternative voice when the political opposition parties are weak or absent. This voice often comes from the Church in many African countries, where the Church has been responsible for reviving much of the democratic process.

Models for community-based health care emerged in many parts of the world in response to severe and urgent needs. These models had a humanitarian rather than a political agenda. However, institutionalised exploitation of the poor and routine violation of their basic human rights contributed so clearly to ill-health that many of these community-based programmes evolved strong sociopolitical components:14 they also developed local, national, and international networks that linked health, social justice, and human rights, taking health action as an entry point for social action and holistic development.

In Nicaragua (under Somoza), the Philippines (under Marcos), and South Africa (under Apartheid), systematic violation of human rights and enormous social inequality contributed to the abysmal health status of the marginalised majority. The movement for community-based health care had a crucial role in sensitising communities, developing problem-based learning, organising action for health, and eventually organising political action for transformation.

Threats to integrity of civil society

Closer cooperation between the First and Third Sectors in health is important for improvement of efficiency, complementary functioning, and access within the health sphere. Concerns have been expressed that this relation is “too close for comfort”.15 Both Southern and Northern NGOs usually receive support directly or indirectly from their own governments and from external governments through donor funds. Some of these funds are also channelled through multilateral agencies, such as the UN system, development banks, and, in particular, the World Bank. Such contractual arrangements might easily lead to dependency and conditional demands—the agenda to be pursued being that of the funders.

Large inputs of resources channelled too rapidly into the community from outside can impair a community’s capacity for sustained development. The commodity needed most is time—time to overcome human apathy and despair after generations of poverty, oppression, and war.

“The New Policy Agenda”,16 which represents the combined theories of liberal economics and liberal democracy exposes clearly the built-in conflicts in government, donor, and NGO relations. Many western donors, including the United States Agency for International Development (USAID), see development of civil society as a precondition for greater markets. NGOs will subscribe to wider scope for democracy, but will be more critical of the strengthening of market forces as outlined in the World Bank’s conditions in economic structural-adjustment programmes. The effect, argue those running NGOs, will often have negative consequences on the health and nutrition of the poor in low-income countries if these people are not sufficiently protected during reforms.

Looking ahead

What will be the role of civil society in health in the new millennium? There are two important perspectives: challenges in the health sector, and how civil society may promote health more generally.

The aim of current health-sector reforms is to increase effectiveness, minimise cost, and reduce the public role in service provision. At the same time, equity cannot be achieved if governments withdraw from health as a public responsibility. Some suggest that the Church’s role (and that of NGOs) in such a climate is not to take over government responsibility, but to focus on equity, justice, and caring, by filling gaps in basic and essential care for those who remain under-served, and in ways that connect with community initiatives and ownership. Advocacy by NGOs for reorientation of services to ensure more equitable access is also needed.17

The current focus on sustainable health financing does not mean that income needs to be generated from fees for services, but that a dependable revenue base is built in the long term; this could be done through subsidies from
Further challenges are to promote health and to prevent disease. The causes of ill-health are related to gross social inequity and poverty, macroeconomic adjustments and extreme market orientation, corrupt and ineffective economies, armed conflicts and disproportionate public spending on arms, environmental degradation and pollution, and unhealthy lifestyles.

Three arguments exist for why the Third Sector may be a growing force in tackling these difficulties. First, the sense of a global environmental and impending social crisis—and the acknowledgment of a shared future—may fuel the quest for change at local, national, and global levels. Second, the international network of concerned individuals in civil society is becoming more influential in addressing the causes of ill health owing to better access to media and electronic communication. Third, the number of people of both sexes worldwide who are well-informed about health issues is growing as a result of better education. This paper has presented some examples of how such awareness among civil populations can lead to mass movements.

Members of the medical profession have a special responsibility to respond to the struggle for better health, since they can observe and document causes of ill-health and, as experts, they occupy a particularly influential position in society. Changes would come about more quickly if they joined forces with members of civil society as advocates in public-health matters. Such “scaling up” would be possible if public health and medical societies made greater efforts to take up health policy, public speaking, networking, advocacy, and lobbying for health promotion and disease prevention, thereby broadening the traditional ways of dealing with such matters.

A shift has taken place during the past few decades: health and health care is dominated less and less by a few large players (in some countries from the public sector only; in others, from both the public and private sectors).

In the new millennium, a much greater number of agents are likely to be involved in this work, for example, through partnerships and networks in which members of civil society will again have an important part to play in the health of populations.

We thank Gill Walt for her support and comments during the preparation of this paper.

References
17 Mogedal S. The call for sustainability: does it empower or constrain the Church’s action for health? Contact; December 1997–January 1998; 158: 3–6.