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The Role of Civic Organizations in the Provision of Social Services

Towards Synergy

Mark Robinson and Gordon White

UNU World Institute for
Development Economics Research
(UNU/WIDER)

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FOREWORD

The role of civil society in the provision of social services in developing countries is not well understood despite the widespread belief that civic organizations should assume important responsibilities in the provision and financing of these services. The paper critically assesses the relative strengths and limitations of civic organizations in this regard, and concludes that they should not be the primary providers of social services in low-income countries. Instead, the paper develops and recommends an approach in which multiplicity of service providers, the civil society included, is a key feature. The critical role of the state in this new approach is to create an enabling environment for complementarity among providers, particularly among the various civic organizations, as well as between them and the private providers.

The mechanisms for organizing synergy by the state include enforced provision, service co-determination, co-production and co-financing. However, as the authors note, organizing synergy requires political, administrative and managerial skills, some of which may be lacking in developing countries. It is a slow process of learning-by-doing, which is simultaneously technical, institutional and political. Nonetheless, the process can be facilitated by domestic policies that improve public institutions and enhance credibility of the state authority; by flexible interventions of external agencies, and by building bridges of trust across the state/society divide.

This highly original paper by Dr Mark Robinson and Professor Gordon White – both of the Institute of Development Studies, University of Sussex – should be of interest to researchers and policy-makers who are searching for better ways of organizing social service provision in developing societies.

Giovanni Andrea Cornia
Director, UNU/WIDER
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Mark Robinson and Gordon White
Sussex, June 1997

ABSTRACT

In recent years churches, NGOs and community associations, commonly referred to as civic organizations, have been playing an increasing role in the provision of social services in response to fiscal stress, state inefficiency and an ideological environment favouring non-state action. In this paper, we identify the organizational realm of civil society with greater precision by clarifying the diversity and ambiguity underlying this term and focusing on those particular types of organizations commonly involved in service provision. The distinctive capacity and role of the voluntary sector in service provisioning is analysed in the light of actual experience. The paper examines the types of organizations involved in this activity, the forms of provisioning that characterize various sectors (health, education, water and sanitation, and services for vulnerable groups – children, the elderly, and the disabled), and variations in provisioning across countries and regions. From the empirical literature it highlights the advantages and disadvantages of state as well as non-state provisioning and identifies the conditions underlying success and failure. Drawing on the concept of 'synergy' and on the literature, the paper rejects the view that the non-state sector should assume prime responsibility for the provision of social services. Instead it develops an approach in which the central role of the state is to create an enabling environment for effective civic action, with a focus on potential synergy in various sectors of service provision.

I INTRODUCTION

Over the past few decades there has been a rapid growth of associational activity across the globe, reflected in a growing number of private voluntary organizations outside the realm of the state pursuing public objectives on a non-profit basis. This expansion of 'civil society', which is characteristic of both developed and developing countries, has taken place in response to three sets of pressures. One is simply the spontaneous efforts of organized citizens to create an independent space outside the control of the state, as a means of escaping political oppression or improving their own living conditions. A second factor is external assistance provided by international church organizations, private voluntary organizations and official aid donors, which has boosted the resources available to indigenous non-profit organizations. Third, governments have fostered the growth of the voluntary sector by contracting out public services and by increasing the involvement of churches and non-governmental organizations in official development programmes (Salamon 1994).

Organizations of this nature, commonly referred to collectively as civil society, have also been playing an increasing role in the provision of social services and this trend has received growing attention and encouragement from government and aid donors for a number of reasons – theoretical, ideological, political and economic. The theoretical rationale for the role of civil society organizations as service providers emanates from an analysis of the developmental potential of collective action by groups and individuals within civil society. Individuals choose to cooperate when it is believed that collective outcomes are more beneficial than those produced by individual actors pursuing their narrow self-interests. Moreover, it is argued that distinctive qualities such as adherence to group norms, the ability to draw on existing stocks of social capital and the existence of distinctive forms of collective action facilitate the mobilization of new resources and reduce the transaction costs involved in development action.[1]

Ideologically, a concern with the developmental potential of the voluntary sector emanates from the currently dominant neo-liberal perception that state organizations are predatory and inefficient, with rent seeking as the primary motive for the behaviour of public officials. Prescriptions for tackling the perceived malaise of state organizations range from outright privatization of public sector undertakings and downsizing the civil service, through to contracting out service provisioning to the private sector, or simply reducing or eliminating the involvement of the state in the provision of various types of public goods in the expectation that wealthier individuals are willing to pay for health, education, and other services, and that private non-profit organizations will protect and offer services to the most needy and vulnerable groups in society. Hence voluntary organizations represent an alternative form of private service provision for

[1] For a discussion of some of these theoretical issues, see Bardhan (1993), Brett (1993) and Nugent (1993).

disadvantaged social groups which the commercial sector would find both unattractive and unprofitable to work with.

A politico-economic rationale also underpins this shift in focus towards the developmental potential of the voluntary sector. At a time when many developing countries are undergoing fiscal stress caused by an excessive imbalance between revenues and expenditures, shifting the burden of responsibility from the state to the voluntary sector for the financing and provision of public goods and welfare services presents an attractive means of reducing official outlays. Second, there is a perception that developing country states do not have the capacity to finance and deliver services of a cost and quality that are adequate to the needs of consumers, and that state provisioning is characterized by high levels of inefficiency and sub-standard services. As noted by Karger (1996), the pressure on states to provide an environment conducive to the emergence of a competitive market economy conflicts with expectations that the state will advance the larger social good by providing services to the poor, who may be adversely affected by economic reforms.

In this paper, we seek first to identify the organizational realm of 'civil society' with greater precision by clarifying the diversity and ambiguity underlying this term and focusing on those particular types of organizations commonly involved in service provision. The next section examines and assesses the distinctive capacity and role of the voluntary sector in service provisioning in the light of actual experience. It examines the types of organizations involved in this activity, the forms of provisioning that characterize various sectors (health, education, water and sanitation, and services for vulnerable groups – children, the elderly, and the disabled), and regional variations in provisioning. From the empirical literature it highlights the advantages and disadvantages of non-state provisioning and identifies the conditions underlying success and failure. The third section focuses on the relationship between the civic sector and the state, not only in terms of the latter's role in providing an enabling environment for effective civic action, but also with a view to the potential synergy which can be achieved by coordinated and collaborative action between the two sectors.

II THE EMERGENCE OF THE 'THIRD SECTOR'

The civil society argument for the distinctive role of civic organizations in the provision of welfare services is a central element of current development thinking and is one part of wider debates about the relative developmental contribution of three societal agencies – states, markets and social organizations. It reflects an extraordinary area of consensus among otherwise widely disparate political and ethical creeds – including populism, communitarianism, socialism and neo-liberalism. The central thesis is that elements of civil society – commonly understood as the realm of formal and informal associations notionally intermediate between state and individual – can and should function as key elements in social provision within a wider context of 'welfare pluralism' which also involves state and market provision. The case for civil society is buttressed by both negative and positive arguments: in negative terms, states and markets have certain widely rehearsed defects as agencies of social provision which require institutional alternatives; in positive terms, the organizations of civil society often display desirable characteristics, such as altruism, civic virtue, democracy and popular accountability, which give them an institutional edge in providing certain kinds of social services, in particular but not exclusively services to impoverished and vulnerable groups.

Unfortunately, the use of the term 'civil society' in development discourse tends to be confused and confusing, reflecting both the ambiguous theoretical heritage of the term itself and the competing uses to which its motley adherents try to put it. Actual civil societies are complex associational universes involving a vast array of specific organizational forms and a wide diversity of institutional motivations. They contain repression as well as democracy, conflict as well as cooperation, vice as well as virtue; they can be motivated by sectional greed as much as social interest. Thus any attempt to compress the idea of civil society into a homogeneous and virtuous stereotype is doomed to fail. It is also intellectually harmful not only because it misrepresents the reality of civil societies, but also because it distorts development discourse more broadly by encouraging similarly simplified but overwhelmingly negative conceptions of other societal agencies, whether state or market. For the purposes of this paper, therefore, we have decided to narrow our focus to that particular sub-sector of organizations which is the conventional focus of development discourse about the service-delivery role of civil society. This includes those organizations, commonly called NGOs, voluntary associations or membership organizations, which are involved in developmental and service-delivery work independently or in collaboration with international agencies and domestic states. We shall refer to these collectively as civic organizations.[2]

Arguments in favour of an expanded role for civic organizations in service provisioning generally centre on state and market failures. Civic provision can be seen as a response

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[2] There is a good deal of discussion about the differences between types of organizations within this particular sector of civic organizations; for a useful discussion, see Uphoff (1993).

to market failure in that commercial organizations are primarily driven by the search for profit and are not interested in forms of provision that do not offer a guaranteed return. It follows that groups who lack the resources to pay for services, and remote areas where the costs of provision are high, will be poorly served by the market. Equally, state organizations have proved to be inefficient, offering a poor quality of service and unresponsive to customer needs. However, in such conceptions voluntary provision is treated as secondary and derivative, performing a gap-filling role where state and market have failed to provide adequate coverage.[3] Salamon's theory of voluntary failure inverts this approach, arguing that public action is a response to a series of failings in the voluntary sector – inadequate resources, particularism, paternalism and amateurism – such that the state becomes a supplement to rather than a substitute for voluntary action, which is perhaps a more accurate depiction of the situation in a number of developing countries (Salamon 1987).

In contrast to the state, the voluntary sector is perceived to be imbued with a series of attributes conducive to better quality service provision and developmental outcomes. The assumption is that voluntary organizations are smaller, more participatory, less bureaucratic, more flexible, more cost-effective, with an ability to reach poor and disadvantaged people, all of which appear to justify an enhanced role in service provisioning. The practical experience of developed countries like the US and the UK, which have moved in the direction of expanded voluntary sector provision of public goods and services through various forms of contractual arrangements and withdrawal of state provisioning, has been a major influence on the policy prescriptions offered by aid donors.

It is commonly argued that voluntary non-profit organizations collectively constitute a 'third sector' located between the state and the market, and that organizations in the three sectors can be distinguished by the incentives used to secure cooperation or compliance (Van Til 1987; Salamon and Anheier 1996). Organizations grouped within the third sector are bound together by an appeal to voluntarism, whereas the integrity of the state depends on the rule of law, and the market on commercial pressure (Schuppert 1991). According to Uphoff (1993:610) these three categories of organization are also distinguished by the incentives used to secure compliance. In the case of the state, hierarchical control mechanisms are used to ensure compliance with government decisions. The private sector, which is founded on dispersed competition, uses market mechanisms to promote desired behaviour. The third sector, characterized by what Schuppert (ibid:127) refers to as 'spontaneous solidarity', relies on voluntaristic mechanisms to ensure compliance, involving processes of bargaining, discussion, accommodation and persuasion.

According to the proponents of this approach, third sector organizations share a distinctive set of characteristics: they possess an internal organizational structure and some institutional reality (which may have formal legal recognition); they are

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[3] Philanthropic provision of welfare services in 19th century Europe and North America emerged in a context characterized by state and market failure, a situation comparable to that of a number of developing countries in the present day (Salamon 1987).

structurally separate from government; they do not generate profits which are distributed to members, nor are they primarily motivated by commercial considerations; they are self-governing in that they control their own activities through internal governance procedures and enjoy a significant degree of autonomy; and rely on a significant element of voluntary participation. It is recognized that the third sector is heterogeneous, comprising organizations that do not share these five sets of characteristics to the same extent. There are obvious differences in terms of size, age, field of activity, type of activity, and internal structure. In this respect, it is possible to differentiate non-profit organizations by sub-sector i.e. whether their principal activity is health, education, environment, leisure, etc. (Salamon and Anheier 1996:3-4). But as noted by Uphoff (1993), such heterogeneity ends up placing self-help membership associations in the same category as large-scale philanthropic organizations.

While such distinctions are useful for taxonomic purposes, organizations that form part of this sector also exhibit other variations, which have led some commentators to question the existence of a distinctive third sector. At one level, there is marked distinction between organizations which act to express or satisfy the interests of their members in relation to themselves – i.e. they have no public service function outside the immediate sphere of their members' interests – and those which seek to achieve a condition or change in a limited segment of society. The former, which have been termed 'expressive' groups, include recreational and sports associations, social clubs, and scientific societies, and the latter 'social influence' groups, which include pressure groups as well as groups established to perform a public service (Schuppert 1991).[4] There is also the notion of a spectrum of organizations within the third sector, depending on their degree of organizational coherence and single-minded pursuit of well-defined organizational objectives. These range from self-help organizations on the one hand, through to rigid organized interests on the other, which might include business associations and trade unions engaged in formal corporatist relationships with the state.

Uphoff (1993) questions the theoretical foundations of a threefold categorization where organizations are located within a single category by virtue of a set of distinct organizational characteristics, arguing in favour of a sectoral continuum where the third sector (the collective action sector in his terms) is located between the market and state sectors. In other words, local organizations may be found at different points on an organizational continuum, where local government institutions form part of the state sector, membership organizations and cooperatives are constituent elements of the collective action sector, and non-profits and business enterprises fall within the purview of the private sector. The notion of an organizational continuum suggests a blurring of the boundaries between the private and the public, and the existence of organizations which share attributes of state organizations and private companies. Despite the obvious

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[4] Although 'expressive' groups are a very important component of civil society in that they exhibit important associational characteristics, they are excluded from the parameters of this study which is concerned those organizations which are involved in the provisioning of public services. In India, for instance, film clubs are a major associational phenomenon which are far more numerous than NGOs, but have no explicit public service function.

analytical attractions of a neat three-fold distinction with a specific locus for a category of organizations collectively referred to as the third sector, the types of organizations involved in service provisioning are sufficiently varied to warrant critical use of the term.

The idea of a civil society sector is increasingly used by adherents of a distinctive third sector, thereby introducing a further level of terminological confusion. According to Salamon and Anheier, this is the realm of 'private, nonprofit, and nongovernmental organizations ... through which citizens can exercise individual initiative in the private pursuit of public purposes' (1997:60).[5] There are two main problems associated with the use of such a term. One is that it conflates a multitude of organizations founded on very different premises and pursuing a wide range of objectives within the ambit of 'public purposes'. The second is a misconceived and partial notion of civil society, which is treated as the repository of civic virtue exercised in the altruistic pursuit of public goals. In reality, groups which have public service functions represent a narrow cross-section of civil society, and exhibit characteristics redolent of both state and private sector organizations, rather than a distinct set of organizational attributes associated with a putative third sector.[6]

Any analysis of non-state provisioning should begin with an assessment of the various types of civic organizations engaged in such functions. A distinction is made between formal and informal organizations, in which the former adhere to codified rules and regulations governing organizational behaviour, and gain legal recognition as a legitimate actor from state authorities, whereas the latter refers to groups of individuals who cooperate in the financing and provisioning of goods and services for the benefit of their own communities, through reciprocal exchange. The former includes intermediary service providers in the form of non-governmental and non-profit organizations (NGOs), churches and membership organizations such as labour unions, farmers' organizations, and business and professional associations for whom service provisioning is an ancillary activity. Informal civil society groupings include user groups of various sorts organized for collective action, focused on irrigation, thrift and credit and natural resource management, as well as parent-teacher committees, which have a more explicit service function. Forms of cooperation can be episodic or long term and inter-generational, framed by norms of exchange and reciprocity, mediated by rules and institutions which may not assume concrete organizational forms.[7] Seen in this light reciprocal service agreements between neighbours, kinship groups, landlords and

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[5] The concepts of the third sector and the civil society sector are treated as virtually synonymous (compare, for example, Salamon and Anheier 1997, and Salamon and Anheier 1996, where the same arguments are employed using different terms).

[6] A good example of hybrid organizations exhibiting traits of both state and private sector organizations are private service contractors, which are formally constituted on a non-profit basis but compete for contracts from governments and aid donors for the delivery of public services and the implementation of development projects (Robinson 1997).

[7] The concept of 'mediating institutions' is a useful way of conceiving the role of these organizations, which link 'individuals to larger institutional structures by groups and associations, the mediating structures that facilitate both individual influence upward and the downward transmission of institutional response' (Van Til 1987:53).

tenants, all constitute informal mechanisms of service provisioning that form part of civil society. Community or grassroots organizations in their various forms span the formal/informal divide. For the purpose of this analysis the focus is on formal, intermediary forms of voluntary provisioning, though examples will be drawn from informal mechanisms where appropriate to illustrate variations in cooperative behaviour in response to state and market failure.

III CIVIC ORGANIZATIONS AND SERVICE PROVISION

3.1 The nature and scope of non-state provision: health, education and social services

The involvement of civic organizations in the financing and provisioning of health and education services is an increasingly important feature of service provisioning in sub-Saharan Africa and parts of South Asia. In India and much of Latin America the non-state sector is not a major actor in direct provision but tends to play more of an advocacy role, mobilizing communities to demand services from the state.[8] Non-state actors also provide social services to vulnerable groups such as children, the disabled and the elderly, which often have health and education components. This section examines the types of organizations involved in providing these services in developing countries, drawing attention to regional variations in the spread of their activities.

There are considerable variations in the nature and scope of service provisioning by civic organizations in the health sector. The main types of civic organizations involved in non-state health care provision are NGOs (southern and northern), religious organizations, self-help groups, trade unions, business and professional associations and non-profit health maintenance organizations (Green 1987). Civic organizations have four broad health sector functions: providing comprehensive services (health facilities and disease prevention); social welfare activities (care for vulnerable groups such as children, women, the disabled, and the elderly); support activities (such as training and the procurement of drugs); and research and advocacy (developing and promoting new approaches, such as primary health care and community financing, promoting health awareness and mobilizing demand for health services) (Gilson et al. 1994). The extent of health provisioning by the non-state sector is also a function of the type of health intervention, i.e. whether it is preventive or curative, and whether the service is for routine consultations or acute cases.

There are significant regional differences in the form and extent of health provisioning by non-state actors. Non-state provisioning of health services appears to be most prevalent in sub-Saharan Africa where churches, NGOs and self-help groups have all made a significant contribution. In Latin America trade unions, business and professional organizations are prominent non-state actors in health care provision, in a context where state and private for-profit provision are dominant (Zuckerman and de

[8] Venezuela is something of an exception in this regard, since community organizations and private foundations have substantially increased their involvement in the direct provision of health services following the recession of the mid-1980s (Cartaya 1997).

Kadt 1997). NGOs and medical foundations are more common in Asia, in a context where the level of private provision is relatively high, especially in curative services.[9]

In the educational field, civic organizations are engaged in direct service provision by funding the construction and maintenance of primary and secondary schools, paying the salaries of teachers and covering the costs of training. Direct involvement in the formal sector is characteristic of NGOs and religious organizations in sub-Saharan Africa, which also has many examples of self-help educational initiatives (Semboja and Therkildsen 1995). In Asia and Latin America, the role of NGOs and intermediary organizations tends to be focused more on non-formal education and adult literacy work, rather than on direct provision though religious institutions in India and Bangladesh also run schools.[10] As in the health sector, NGOs in South Asia also mobilize poor people to demand better quality educational provision from the state, rather than providing services directly. Latin American NGOs have tended to favour a more radical conscientization approach where functional literacy and adult education are designed to promote the empowerment of the popular sectors (landless peasants, workers and slumdwellers) (Picon 1991; Zuckerman and de Kadt 1997). This approach has also proved influential among NGOs in India and the Philippines with community organization focused on awareness creation and functional literacy form an intrinsic element of social action among poor communities.

3.2 Church and NGO provision of health and education services in sub-Saharan Africa

In sub-Saharan Africa the non-state sector has played a significant role in the provision of health and education services since the colonial period. In no other region has the direct involvement of civic organizations in service provision achieved such prominence and for this reason merits detailed consideration. The form and extent of non-state provisioning in Africa has fluctuated over time in response to four sets of factors. First, the nature and depth of health problems or educational requirements determine the demand for services and the respective roles of state and non-state actors in responding to perceived needs. Second, government attitudes towards voluntary organizations and state policies in the health and education sectors have varied with political fashion and regime characteristics. Third, economic factors play a key role in determining the amount of resources available to the state sector for service provision and the scope for voluntary provisioning. A fourth factor is the involvement of foreign aid donors and northern NGOs in providing resources and shaping domestic social policy, which has become increasingly important in the context of economic crisis and structural adjustment from the 1980s.

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[9] A large proportion of the hospitals and health facilities are in the hands of the private sector in Asia and Latin America, though preventive measures (for example vaccinations) are largely the responsibility of the public sector (Aljunid 1995; Berman and Rose 1996).

[10] In India, Hindu and Christian schools have historically played an important role in primary and secondary education, though the state sector is now dominant. *Madrasas*, or Muslim schools, in Bangladesh primarily impart Islamic education in a supplementary capacity to state institutions.

In the colonial period church missions were the dominant source of health care provision in many African countries, primarily catering to the health needs of the indigenous population, especially in rural areas.[11] The church believed it had a distinctive role to play in service provisioning as an extension of its evangelical work (Sivalon 1995; Green and Matthias 1995). Colonial authorities adopted a fairly relaxed attitude towards church-based organizations in the absence of concerted efforts to develop health facilities for Africans. It was only in the later stages of colonial rule that state investments were made in health facilities, for the most part hospitals in urban areas for the benefit of civil servants, traditional elites and Europeans, partly as a means of securing political legitimation in response to the growing popularity of emerging nationalist movements (Semboja and Therkildsen 1995:20). Despite these initiatives, the non-state remained dominant in health provisioning. For example, on the eve of independence in Tanzania, religious organizations owned 42 per cent of all hospital beds and were responsible for 81 per cent of the primary health care facilities in the country (Munishi 1995:143).

The churches also played an important role in education provision during the colonial period, especially in East Africa. Education was an integral part of the proselytization work of Christian missionaries, such that it was even to be perceived to be a divine right for the church to be involved in educational work in some quarters. Such was the influence of the church that many of the post-independence political elite had their schooling in mission schools. For example, in 1945 mission primary schools in Tanzania outnumbered those run by government or native authorities by a 4:1 ratio (Sivalon 1995). Christian missionaries also established and ran schools in many parts of Kenya and Uganda. However, mission schools concentrated on a few selected areas of the country where Christianity was dominant, and prioritized the children of the wealthy elite and local chieftains. Parents supported these schools with contributions of land and labour, and in some cases paid fees (Passi 1995).

After independence, nationalist regimes opposed to the elitist approach of the former colonial authorities came to power in many African countries, which were committed to providing comprehensive services to the largely rural African majority. Most favoured comprehensive state provision of health services on the equity grounds and from a deep suspicion of private practice, which in East Africa was dominated by Asians. Initially the voluntary sector provided an important source of health provision which the state could not match and was tolerated, and in some cases, actively promoted through tax exemptions, grants and subsidies. However some governments sought to introduce universal state provision of health and education services, through a process of nationalization and curbs on voluntary sector provision. Priority was given to the tertiary sector in education, with a generous share of government budgetary resources allocated to the universities. In the late 1960s and early 1970s the Tanzanian government sought to nationalize all social services as part of the *ujamaa* (self-reliance) philosophy. The state assumed responsibility for maintaining all private trust-funded and missions

[11] In addition to the network of Christian mission facilities, small health clinics were established by Ismaili communities in Tanzania and other East African countries during the colonial period but these did not admit Africans until after independence (Kaiser 1996).

schools in 1971 with disastrous consequences; there were insufficient resources to maintain schools, teachers became demoralized and the voluntary sector withdrew its services, which had predictable results (Ishumi 1995; Munishi 1995). Although voluntary agencies were allowed to operate freely in the initial years of independence the Milton Obote government in Uganda pursued a similar path in the late 1960s through its attempt to centralize the provision of social services, viewing the voluntary sector as a transitional phenomenon which would be absorbed into the state. An impressive expansion took place in the initial years of centralization with a rapid expansion in the number of educational establishments, which was made possible by economic growth and revenues from coffee exports. This was sustained until the mid-1970s when growth faltered under the Amin regime followed by a decade of civil war which engendered the collapse of state services (Nabaguzi 1995). The gap created by the withdrawal of the voluntary sector and the destruction of state facilities was filled in large measure by self-help initiatives from within civil society (see below).

In the 1980s and 1990s a series of economic and political factors induced major changes in the role of government in health service provision which gave an impetus to the expansion of the voluntary sector. Despite a commitment to universal health provision a number of governments have found themselves enmeshed in economic difficulties which have limited their capacity to maintain a good quality system of state-provided services free of cost. Short-sighted economic policies, combined with falls in the world price of commodities on which their economies depended, led a number of African governments to adopt structural adjustment policies advocated by the IMF and the World Bank. As governments have sought to curb budget deficits public expenditure on social services has been drastically reduced. Governments have found themselves unable to maintain health facilities and purchase drugs and equipment, and a high proportion of recurrent health expenditure goes on salaries and emoluments.[12] In many countries the quality of government health facilities is often very poor, coverage is limited, technical capacity is inadequate, decision making is over-centralized, and service provision is plagued by inefficiencies and petty corruption which results in withdrawal by potential users (Mburu 1994). There are also increasing demands placed on an already over-stretched system with the appearance of new diseases such as AIDS and chloroquine-resistant strains of malaria and deteriorating health indicators. A major resource gap has appeared which, it is argued, can only be filled by the non-profit sector, and private providers of health services (World Bank 1993). The education sector is also plagued by poor educational standards, low enrolments (especially of girl children), and high drop-out rates.

The parlous state of health and education services forced a number of governments to reconsider their attitude towards NGOs and church organizations. In some countries democratically elected regimes have come to power which are better disposed towards

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[12] In Cameroon, the health budget dropped by 70 per cent between 1985 and 1992; 85 per cent of the recurrent budget goes on salaries, and drugs are no longer funded from the budget (Sauerborn et al. 1995:1731). In Tanzania salary costs absorb 40-50 per cent of all central government expenditure for health, and drugs account for 82 per cent of the non-salary budget allocation leaving few resources available for distribution to district health centres (Mogedal et al. 1995:356).

the voluntary sector and perceive it to be a valuable partner in development. Controls on voluntary provisioning have been abolished and official encouragement is now given to churches and NGOs to gear up their involvement in the provision of health and educational services.

The change in government attitudes towards the non-state sector has been influenced to a significant degree by external considerations. Bilateral and multilateral aid agencies have come to play an increasingly important role in recent years, in influencing health policy and financing the provision of health services.[13] This has entailed a concerted emphasis on the privatization of government health facilities, and the simultaneous relaxation of controls and the creation of incentives to encourage private provision. With this shift of emphasis the influence of foreign NGOs has increased their presence, either in the form of direct involvement or by means of increased funding for their domestic counterparts which have rapidly increased in number in recent years.[14] As a result NGOs now constitute a major source of health provisioning in Africa, in many cases with the active support of official donors (Green and Matthias 1995).

In some African countries church organizations have remained the dominant provider of health services to the present day, despite the imposition of controls on the voluntary sector by some governments.[15] The extent of non-state provisioning in selected African countries in the early 1990s is evident from Table 1, though these figures underestimate the significance of non-state provision in rural areas and the role of the voluntary sector in offering specific types of services where government is weak. For example, in Zimbabwe church missions provide 68 per cent of all beds in rural areas (Green and Matthias 1995:314). In Zambia the voluntary sector, consisting mainly of mission health care, was estimated to have been responsible for providing 40 per cent of rural health services (Mogedal et al. 1995:359). While Ghanaian NGOs provide 25 per cent of all hospital beds in the country, they provide 46 per cent of beds in the six less-developed northern regions (DeJong 1991). NGOs in Kenya provide an estimated 40-50 per cent of family planning services; in two divisions of the country, with a total population of 240,000, one NGO alone has provided over 80 per cent of health and education services since the mid-1980s (Kanyinga 1995:78).

There is a similar pattern in the education sector. The rapid increase in donor financing for the voluntary sector and a change in the domestic policy environment have resulted in

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[13] For example, it is claimed that 'Tanzania demonstrates a situation where further reform efforts are now being rushed, to a large extent driven by the World Bank, as the severe under-financing of the system makes compliance with donors an overriding concern' (Mogedal et al. 1995:353). Despite the increased prominence of official aid agencies in health and education policy, the social sectors account for less than 10 per cent of global aid flows.

[14] The World Bank (1993:166) estimates that resource flows from northern NGOs and foundations for investments in health services amounted to $1.16 billion in 1990, equivalent to a quarter of all external assistance for the health sector.

[15] NGO health provision in Asia is more limited. In India and Indonesia NGOs supply 10 per cent of clinical services, while in Nepal the church runs 19 per cent of all hospitals in the country (World Bank 1993:127; Gilson et al. 1994:15).

TABLE 1
EXTENT OF NON-STATE PROVISIONING OF HEALTH SERVICES IN AFRICA

Country (organization)	Percentage of total no. hospitals/hospital beds	Percentage of total services/contacts
Cameroon	40% (facilities)	
Ghana (church)	25% (beds)	40% (population) 50% (outpatient care)
Kenya (NGOs)		35% (services)
Lesotho (non-profit)	50% (hospitals) 60% (clinics)	
Malawi (church)		40% (services)
Tanzania (church)	40% (hospitals)	
Uganda (church)	42% (hospitals)	
(NGOs)	14% (facilities)	31% (services)
Zambia (church)		35% (services)
Zimbabwe (church)	68% (beds/rural areas)	40% (contacts)

Sources: DeJong (1991); Gilson et al. (1994); Nabaguzi (1995).

a rapid growth in the number of schools run by NGOs and church organizations. In Tanzania there are now 1.6 as many NGO as government schools offering secondary education and NGO schools have 1.3 times the number of secondary school children enrolled in state institutions (Ishumi 1995). In 1965 NGOs accounted for 28 per cent of secondary school admissions; the figure in 1990 had more than doubled to 58 per cent (Munishi 1995). In Uganda, twelve districts were prioritized for community rehabilitation of primary schools as part of the Programme for the Alleviation of Poverty and the Social Costs of Adjustment with the help of foreign NGOs which have been assigned a lead role in each district (Passi 1995).[16] In other countries, such as Kenya, the state sector remains the dominant provider of education services, with a heavy reliance on voluntary contributions of labour and materials. Voluntary provisioning through self-help initiatives is an important manifestation of civic activity at the grassroots, and distinct from service provision through intermediary organizations such as NGOs and church-based organizations. From the perspective of the developmental potential of civic action, the significance of self-help initiatives by people's organizations merits particular attention.

3.3 Self-help initiatives: civic action and service provisioning from below

NGOs and churches are the dominant types of civic organizations engaged in direct service provisioning. The construction, maintenance and financing of health, education and minor infrastructural facilities depend to a large extent on the mobilization of resources from local communities and special groups are often formed for this purpose. These include parent-teacher associations, community health groups, water user groups, and a range of other local organizations variously referred to as people's organizations,

[16] Although the government owns or assists 90 per cent of the country's 9,000 primary schools, most are strapped for resources and rely heavily on parental contributions. The quality of education is poor, buildings are in a poor state of repair and drop-out rates are high (Passi 1995).

grassroots or community-based organizations. Some emerge autonomously in response to local economic and political circumstances as a vehicle for collective action, while others are formed at the instigation of political leaders and intermediary organizations. Such groups also play an important role in mobilizing demand for services and pressing for micro-policy reforms, and for ensuring accountability on the part of intermediary service providers.

Self-help initiatives have been important in the production of health infrastructures in Kenya, and to a lesser extent in Tanzania and Uganda. Under the political patronage of the KANU regime, Jomo Kenyatta instigated the *harambee* self-help movement which drew on voluntary contributions of labour, money and materials for the construction of health and educational facilities in rural Kenya. These self-help initiatives helped in the creation of a wide network of health facilities and schools which are primarily under the control of the public sector, though grassroots involvement in the construction of such facilities has declined under President Moi (Oyugi 1995).[17] In Tanzania, people were encouraged to undertake self-help initiatives with the villagization campaign in the 1970s but an underlying element of coercion limited the scope and impact of such efforts.

Collective self-help initiatives are important when government authorities are unable or unwilling to provide services, due to civil unrest, resource constraints or conscious policy choice. The economic chaos and civil war which followed Idi Amin's military coup in Uganda resulted in the collapse of state services and the withdrawal of voluntary agencies, leaving people to finance locally based health and education initiatives with the support of the church (Nabaguzi 1995). Grassroots organizations assumed responsibility for running schools and paying teachers' salaries, with most educational facilities remaining under the nominal control of the state (Passi 1995). In Latin America, there are numerous examples of community self-help initiatives springing up in response to state inefficiency or cutbacks in public spending on social services (Zuckerman and de Kadt 1997). For example, in the Peruvian squatter settlement of Villa el Salvador in Lima, community organizations set up health care committees and arranged loans for the provision of water and other amenities during the initial stage of illegal occupancy when the government desisted from providing services (Asthana 1994). In Venezuela, community associations have taken a lead role in setting up and maintaining local health services in various parts of the country (Cartaya 1997). In the east coast of Nicaragua, church-based community groups ended up designing and implementing health projects without outside coordination, on the grounds that government bureaucracy was difficult to deal with and wanted to exercise centralized control of health programmes (Barrett 1996). These experiences suggest that social capital has been an important source of community initiative in the provisioning of health services, and has sustained voluntary provision during times of political turbulence and government inaction. It should also be noted that local community groups (such as village health committees) can play an important role in mobilizing

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[17] According to Zamberia (1996:52), community efforts through *harambee* were mainly directed towards building secondary schools which have resulted in a rapid growth of education provision up to the mid-1980s.

people to engage in mass campaigns, demand better services, and monitor actual provision (Picon 1991; Sundar 1994). For example, the Total Literacy Campaign in India and mass literacy drives in other countries such as Nicaragua and Ethiopia have relied on the mobilization of grassroots initiative by local organizations as a means of achieving their objectives.

There are few documented examples of health care provision by trade unions, cooperatives or business associations.[18] This may reflect the fact that such organizations do not tend to engage directly in service provisioning, either because they lack the capacity and resources to do so, or do not consider health provision to be part of their remit.[19] One illuminating example of health provisioning by a trade union comes from South Africa, where the Food and Canning Workers Association in rural Western Cape established a Medical Benefit Fund in 1951 to provide members with limited access to services provided by private practitioners. The Fund, which is self-financing and administered by a joint management-worker committee, was reasonably successful in providing a basic level of health care, but with relatively high administrative costs in relation to expenditure on benefits. Over time private practitioners were reluctant to accept the level of remuneration offered by the Fund, which forced it to look into the possibility of direct provision. As a result, the Fund established an independent clinic in 1981 which offers direct services to its members and to disadvantaged members of the community. Costs are lower than comparative services in the private sector and the quality and range of services are superior, reflected in shorter waiting times, improved treatment of chronic illnesses, intervention in work-related diseases and initiation of alternative health programmes (London 1993). While the scheme is a novel innovation in direct health provision by a civic organization, its potential for replication in other African countries is limited by weaker trade union structures and smaller memberships. Nevertheless, it does open up the possibility for a much wider range of non-state forms of health provision which may prove to be cheaper and potentially more sustainable than services provided by non-profit intermediaries.[20]

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[18] In Brazil a principal function of trade unions, until quite recently, was the provision of health and other social services to their members (Emmanuel de Kadt, personal communication).

[19] Members of business and professional associations are likely to have private medical insurance and direct provision by such groups would generally not be favoured. Cooperatives have acted as an entry point for literacy work and adult education in numerous countries in the past but such endeavours have disappeared with the decline of cooperatives as development institutions (see, for example, Fiagbey 1992).

[20] In Israel, the large-scale provision of health services by the General Federation of Labour (Histradut) conflicted with its organizational role in defending the interest of workers, and the quality of provision suffered from its attempt to provide comprehensive services to all its members, regardless of their existing health status and level of contributions (Yanay 1990).

3.4 Strengths and limitations of non-state provisioning

3.4.1 Health and education

Proponents of an increased role for NGOs and civic organizations in the financing and provision of health services base their prescriptions on a series of assumptions about their ability to deliver high quality services at low cost to the poorest and most disadvantaged people (World Bank 1993:127-8). Sauerborn et al. (1995) suggest three main criteria for assessing the relative competence of various organizational actors engaged in health care provision: operational efficiency, equity of access to health care, and quality of care.[21] However, it is difficult to arrive at well-founded conclusions, since much of the available evidence is in the form of detailed studies of particular organizations or is of an anecdotal nature. Comprehensive assessments of the effectiveness, efficiency, relevance and sustainability of state versus non-state provisioning of health and education services are virtually non-existent.[22] Insights from various studies must therefore be treated with a high degree of caution.

3.4.2 The quality of non-state health provision

As noted by Gilson et al. (1994:18), a major justification for the promotion of NGO health services is that they are of higher quality than either government or private sector providers, but that 'available evidence is limited and variable'. Numerous studies have drawn attention to the deficiencies of state provision and indicate a higher level of preference for private health care, though there are few assessments of the quality of care in the non-profit sector (Aljunid 1995). There is some evidence from Tanzania which suggests that the perceived quality of NGO providers is often better than government, reflected in consumer preferences. A number of studies have found that a key reason for the positive assessment of NGO health services is the regular availability of good drugs. Yet other studies from Zambia question the common assumption that NGO provisioning is of better quality than state services (Gilson et al. 1994:18; Mogedal et al. 1995:359; Kaiser 1995:191).

Although one or two studies have found that NGO health staff have stronger technical skills as compared to their government counterparts, it is difficult to generalize. A number of NGO health projects depend heavily on expatriate staff, who may have the requisite skills but find it difficult to exert influence on and to integrate with local government health services. Intensive programmes where an NGO concentrates its effort on a small area, with a high level of expatriate involvement and external resources, cannot be easily replicated or sustained by local health authorities (Walley et al. 1991).

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[21] These criteria were used to determine the appropriate institutional framework for cost recovery policy in health provision in Cameroon but can also be applied in the broader sense proposed here.

[22] Berman and Rose (1996) examine the comparative costs of government and NGO health services in India, but in the absence of data on quality and impact, are unable to arrive at firm judgements of cost-effectiveness. See Zuckerman and de Kadt (1997) for a discussion of this issue in the Latin American context.

The quality of non-state provision is often claimed to be a direct function of the participatory character of voluntary organizations. In contrast to the state and the private sector, service provision by civic organizations is often characterized by participatory or consultative style of decision-making where the intended beneficiaries are closely involved in decisions about the nature and mode of provisioning, sources of financing and targeting. As a result, projects and programmes supported by civic organizations have more of a tailor-made character, in contrast to the blueprint approach which is characteristic of the state sector. However, not all interventions supported by the voluntary sector are consultative and tailor-made as various studies have shown, and nor do NGO approaches have to be participatory to be effective (Brown and Ashman 1996). For example, a review in Zambia found that health sector activities supported by the voluntary sector were 'mainly oriented to curative services, without particular strengths in terms of community participation of activities' (Mogedal et al. 1995:359).

There are few studies of the quality of educational provision by the non-state sector. Mission schools in Africa and Asia have acquired a reputation for high educational standards, reflected in their popularity and continued expansion. Religious schools in India continue to recruit students from families disillusioned with the quality of provision in the state sector, especially in rural areas, who are willing to pay for better quality education. But heavy reliance on parental contributions can have an adverse impact on the quality of teaching in a context where salaries are low, training is poor and incentives are weak. For example, in Uganda, where parental contributions account for between 65-90 per cent of the costs of primary education, the quality of education is low, especially in the more remote rural districts (Passi 1995; Archer 1994).

Local level initiatives centred on non-formal education provision reveal a mixed picture of success. For example, NGO literacy programmes in Namentenga province of Burkina Faso were found to be of questionable long-term benefit for poor rural communities in that literacy skills were rarely practised and pedagogic methods were inappropriate to local needs (Maclure 1995). A more successful initiative is the non-formal primary education programme pioneered by BRAC in rural Bangladesh, which is targeted at drop-outs or children who have never attended school. By 1995 it was running an estimated 50,000 centres for 1.5 million children, with a drop-out rate of just 2 per cent (compared to a drop-out rate of 45 per cent in state primary schools), with 90 per cent of children entering formal primary schools (Archer 1994). However, as in the health sector, the absence of comparative studies of state and non-state education provision makes it difficult to derive firm conclusions on the educational standards of the non-state sector.

3.4.3 Operational efficiency

There is little data available on the operational efficiency of non-state health facilities. According to the World Bank (1993:127), 'recent data from Africa suggests that NGOs are often more efficient than the public sector'. To this end it is claimed that 'in Uganda physicians in church mission hospitals treated an average of five times as many patients in as physicians in government facilities, and NGO nurses treated twice as many patients as their government counterparts' (ibid). Missions in Ghana were found to have a lower

cost per visit than government facilities and were more efficient in procuring pharmaceuticals (DeJong 1991:9). Other studies indicate a higher level of usage and treatment in non-state facilities, but comparisons of cost have to take into account variations in staff salaries, the range of services offered, and the availability of drugs and equipment, before any conclusive assessment can be made.

One of the few available comparisons of the costs of NGO and government health services from India reveals that NGO hospital services were found to be operating at a level comparable to the lower end of the range reported for government facilities, on a similar level to the private for-profit sector (Berman and Rose 1996). Their estimates also suggest that per capita health expenditures for NGOs are within the range of current government spending on primary health care. For curative care and immunization, costs are comparable, that is 'there is no evidence of systematic differences in efficiency between the government and the voluntary sector' (ibid:47). In other words, the costs of health services provided by the two sectors are comparable, and not significantly lower for NGOs.

Several studies have highlighted a series of operational problems in NGO health provisioning, though it is difficult to make generalizations. One detailed study from Tanzania identified a number of inefficiencies in NGO provisioning which included the following: few outreach facilities; greater cold storage failures compared to government facilities; poor performance of health workers; low technical efficiency; and employment of untrained or inadequately trained staff (Gilson et al. 1994).

Management systems in NGO health facilities are often very weak. For example a review of non-state health care in Zambia found that 'dependence upon external financing and expatriate leadership, poor continuity in staffing, and weak management systems' threatened financial and organizational sustainability (Mogedal et al. 1995:359). Many NGOs have to maintain links to external funding agencies, parent organizations, local government bodies, and local communities, which can undermine accountability in the absence of viable organizational structures (Gilson et al. 1994; Edwards and Hulme 1995). This is reflected in weak and unstable organizational structures characterized by personality-based leadership, little formal accountability and limited participation by client groups, and confirms similar findings from assessments of NGO poverty alleviation programmes in Africa and Asia (Riddell and Robinson 1995). On the other hand, some health NGOs have developed innovative management techniques to monitor and improve efficiency. One NGO in India treats individual clinics as separate cost centres which are required to produce detailed monthly performance indicators, while another has introduced a village-level register system to track the preventive health needs of individual households (Berman and Dave 1996:48).

Operational efficiency is also affected by the source of financing. External donor support is often project specific and is generally only available for limited periods. Financial dependence combined with a tendency to rely on expatriate staff, means that many NGO health projects have poor prospects for long-term sustainability (DeJong

1991).[23] This a major drawback for projects which depend heavily on external sources of finance or expatriate personnel, and is a particular problem for many NGO health initiatives in Africa where there is limited scope for local cost recovery or securing additional resources from government. In India this is less of a problem since health NGOs raise the bulk of their funds from domestic sources, either from user fees or government grants, and staff are largely nationals (Berman and Rose 1996).

Effective coordination between non-state providers and between non-state providers and government health organizations is a *sine qua non* of an efficient national health system, but there are problems in this area. These include duplication of services, heterogeneous (and sometimes incompatible) approaches, and competition for resources. In some countries national umbrella organizations have been formed to overcome such problems and have been found to work effectively in promoting exchanges and dialogue; these include the Voluntary Health Association of India, the Private Health Association of Malawi and the Christian Hospital Association in Ghana. Such umbrella organizations can facilitate cooperation between NGOs by providing technical support to members, promoting information sharing, encouraging cost-effective practices and facilitating participation in national policy making (Gilson et al. 1994).

Studies of five NGOs involved in health provisioning in Bangladesh highlight the difficulty of recruiting and retaining trained medical staff, especially at the field level, who were lured away by higher salaries in other organizations or the security of government employment. Difficult working conditions and minimal allowances also acted as disincentives. Drug supplies from the government were erratic, leading to frequent shortages. As a result clinical services faced disruption and a lack of continuity (VHSS 1990). Similar problems of staff retention and rapid turnover were also found to be characteristic of the NGO health sector in India (Pachauri 1994).

3.4.4 Equity of access

The inability of private for-profit sector to produce equity in health care provision through universal access to services is a well-established example of market failure in both developed and developing countries (Bennett and Tangcharoensathien 1994). Even though universal access might be a stated policy objective, government services are uneven in their coverage and there is a tendency for resources to be concentrated in urban areas. The non-state sector, by virtue of philanthropic, political or religious motivations, is assumed to have innate advantages in delivering health services to low-income or socially disadvantaged people. Such commitment may instil trust in the clients of NGOs services which may be lacking among clients of private health services where profit is the dominant motive, or self-interest in the case of state provision (DeJong 1991; Green and Matthias 1995).

Numerous studies support the contention that non-state health facilities primarily cater to poor and disadvantaged sections of the population in rural areas. In Africa the

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[23] For instance in the church facilities linked through the Private Health Association of Malawi, only 30 per cent of the senior staff are Malawi nationals (DeJong 1991:11).

proclivity of church missions to locate health facilities in remote rural areas is frequently cited as a comparative advantage and in a number of countries non-state organizations fill gaps in the spatial coverage of state health facilities. NGOs in India tend to work mainly with poor and disadvantaged communities living in urban slums or remote rural areas poorly served by government facilities (Pachauri 1994).

Many NGO health projects rely on user fees as a means of recovering costs and it is commonly assumed that charges are levied in accordance with ability to pay so that no-one is excluded. User fees are the single most important source of funding for NGO hospitals in India, though in most cases there is a progressive fee structure and the poorest are usually exempted from charges (Berman and Rose 1996). However, the Indian case may not be typical. A study in Tanzania found that out of 42 NGO health facilities, only 9 per cent did not use an exemption mechanism (Gilson et al. 1994). There is evidence from a health project in Uganda which suggests that user fees can act as a disincentive for poor people to use health facilities (De Coninck 1992). Moreover, it has been observed that a downturn in financing has forced some NGOs to raise their fees to meet a potential funding shortfall. According to Gilson et al. (1994:18): 'Such actions may not only have negative consequences for equity but may initiate NGOs into the vicious cycle of falling resources, rising prices, lower quality, lower utilization, falling resources.'

In the education sector NGOs concentrate on providing services to poor and disadvantaged communities, though mission schools in Africa and Asia also cater to the educational needs of the elite. As in the health sector, there is also a close relationship between ability to pay and equity of access to educational facilities. In Kenya, the high degree of reliance on voluntary contributions of labour and materials for the construction of schools through *harambee* has resulted in regional disparities in education provision, reflecting existing level of socio-economic inequality. There are more and better endowed schools in wealthier regions where self-help initiatives command a higher level of contributions from local people. Such schools can attract the best teachers and erect better buildings, a situation that affects the quality of education provision (Zamberia 1996). The high costs of education in Uganda acts as a disincentive for poorer parents who are unable to afford fees, and there is evidence that schools discriminate in favour of richer parents.[24] As a result, drop-out rates remain high. The ability of schools in wealthier districts to charge higher fees reinforces educational inequalities as these schools can attract better teachers lured by higher salaries. NGOs are now involved directly in education provision in a major way, especially in sub-Saharan Africa and parts of South Asia, which highlights the need for effective coordination between various providers to ensure proper coverage and enforce basic educational standards (Archer 1994; Nabaguzi 1995).

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[24] Many schools in Uganda are a public-private hybrid where the state provides the infrastructure, but with parents bearing the costs of maintenance, teachers' salaries and educational materials through a fee structure determined by local parent-teacher associations (Nabaguzi 1995; Passi 1995).

3.4.5 Other considerations

Not all attributes of non-state provisioning are captured by quality, equity and efficiency criteria. Indeed, one important positive attribute of NGO approaches to health provision is their capacity for innovation and disseminating good practice, either to other NGOs or to the state sector. Primary health care is perhaps the best example of an approach that was initially pioneered by NGOs and then taken up by government agencies (Cumper 1986). Integrating traditional health practitioners into the formal system of health provision is another example of innovation. Examples may be found of NGOs drawing on the services of traditional midwives in India and Bangladesh, and of using traditional health practitioners to dispense drugs and certain types of contraceptives in remote parts of western Kenya (Pachauri 1994; VHSS 1990; World Bank 1993:129). Another type of innovation is the emphasis that a number of NGOs give to mobilizing people to demand better services from the state system, and treating health as an integral component of socio-economic development, rather than in isolation (Sundar 1994). Similarly, an important role for NGOs in the education field is to support and facilitate initiatives undertaken by community-based organizations to seek better quality provision and coverage from the state sector (Picon 1991).

From their review of NGO health sector provisioning, Gilson et al. (1994:22) conclude that NGOs should only be promoted where: they have a long-term and sustained comparative advantage in provision (better performance relative to standards) and financing (long-term resources not available to government); they can meet a need not otherwise met and make a positive contribution to the health system (e.g. by improving coverage and enhancing managerial efficiency); and use an untapped potential (health resource mobilization or community service mobilization). A similar rationale holds true for NGOs involved in education provision.

3.5 Water, housing and urban services

Many of the problems that arise in the provision of small-scale infrastructure investments by state agencies are common to health, education and social services – poor quality, inadequate supply, weak institutional capacity, lack of accountability and responsiveness – whereas others are germane to the provision of water supply, housing and urban services. Since the quality and reliability of these services depend to a greater degree on costly investments in buildings, materials and equipment, the source of financing for capital and maintenance costs is of central importance.

Inadequate domestic water supplies and sanitation facilities are a major problem in large swathes of the Indian sub-continent, dryland areas in sub-Saharan Africa and urban agglomerations in Latin America. Providing reliable supplies of safe drinking water and sanitary facilities to poor communities living in urban slums and densely-populated rural areas is beyond the financial resources of most governments. Specialized NGOs play an important role in filling gaps in state provision and in developing low-cost alternatives in poor communities, often with the involvement of local civic organizations. There is an expectation that communities will be willing to pay for such services, either to offset

the cost of the initial investment, or more commonly to cover the operating and maintenance costs (Davis, Garvey and Wood 1993; World Bank 1994).

The perceived advantages of NGOs provisioning of water supplies are their ability to work with poor communities through participatory methods and to develop innovative and low-cost approaches which are sustainable over the longer term. Experience suggests that projects which have been top-down and implemented without community participation experience maintenance problems and are unsustainable in the absence of a continued flow of external resources. For example, in a big piped water scheme in rural Kenya, fifteen communal water points were installed by the Ministry of Water Development to serve communities who could not afford their own private connection. After one year, only two water points were still working. There had been no consultation with the local communities in decisions about the siting of the water points, with the result that they were located in places where they were not required, or on private land. The taps were eventually disconnected due to non-payment of water. However, it should be noted that such problems are not confined to the state sector.

A couple of examples drawn from Bangladesh and Kenya provide some insight into NGO and self-help initiatives in the water sector, though most of the available documentation is descriptive and produced by the NGOs themselves, and there is a lack of analytical or comparative assessments of purported NGO capacities in this area of provisioning.

Bangladesh is a good example of a country where NGOs have been active in community water supply and sanitation (WSS) and illustrates the advantages of NGO provisioning. Despite the abundant availability of surface water, the majority of the population does not have access to safe drinking water and sanitation facilities. The NGO Forum for Drinking Water Supply and Sanitation is an autonomous resource and service group for NGOs working in this sector. In the late 1980s, more than 200 Bangladeshi NGOs took part in a water supply programme funded by the German NGO Misereor. The objective of the programme was to provide low-cost technology for water and sanitation in the form of tubewells and pit latrines for 100,000 unserved or underserved poor households in rural Bangladesh.[25] Misereor funded the purchase of equipment and materials for the construction of the latrines and tubewells, and the training of fieldworkers from local NGOs involved in the programme. The NGO Forum ensured effective coordination between the participating NGOs and that tubewell installation was not duplicated by other groups. Although the programme succeeded in installing more than 1,500 tubewells and 8,000 sanitary latrines, decisions on site selection were largely confined to male members of the community. Maintenance also proved to be a problem as the caretakers (who were largely women) lacked the tools to carry out the requisite tasks and found it difficult to collect dues to cover maintenance costs, in part because guidelines on community cost sharing were absent. In this respect the project shared some of the

[25] This low-cost technology had been successfully promoted by UNICEF in conjunction with the government of Bangladesh over the previous 15 years, and there was an interest on the part of both organizations in involving NGOs to deliver WSS services (Hoque and Hoque 1994).

problems experienced in state provision: limited consultation, and problems with cost recovery and community maintenance (Hoque and Hoque 1994).

Experience suggests that such problems can be rectified by involving community organizations at every stage as a means of ensuring sustainability and institutional continuity. The Murugi-Mugomango Water Society was formed to manage and operate a community water supply in Meru District of Kenya. The government of Kenya's Water Department and a Kenyan NGO provided managerial and technical assistance, while funds for the development and maintenance of the supply were covered by a water tariff set at an affordable level. An elected management committee was accountable to members of the society, which employed staff to run the project on their behalf. Factors in the success of the scheme, which have wider implications for self-help initiatives involving local civic organizations, included an existing spirit of self-help, contributions of money and labour which created a strong sense of ownership, and water points owned and managed by individual households rather than by the community (Davis and Garvey 1993).[26]

Water supply and sanitation systems can be managed by government agencies, NGOs and local communities, either separately or in conjunction. Since government water supply programmes are often inefficient, strapped for resources, and face staffing problems, there are benefits to be gained from involving NGOs in implementing state water supply programmes, especially in cases where community organization is an integral component. Governments can assist NGO and community-based organizations with grants and subsidies, equipment, and training. In some cases governments contract NGOs to perform certain types of services, though such a practice is still not yet very widespread (Robinson 1997). For example, the Bolivian government decided to contract out all the community-level work on the water and sanitation components of a child and community health project out to local NGOs on the grounds that private for-profit organizations lacked knowledge and concern about the social development aspects of the programme. An evaluation of the programme found that the speed and effectiveness of implementation was much enhanced as a result. As noted by Karp (1992), for such an approach to be effective, the contracting procedures should not be onerous, and the government may have a continued role in setting priorities and selecting communities, as well as monitoring the work of the NGOs, to ensure adequate coverage and quality. The scope for replicating this approach will depend on the skills and availability of local NGOs, and the ability of the government to design and monitor comparable programmes, which might prove problematic in African and Asian countries where state capacity is weaker.

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[26] Watson (1995) found similar factors at work in the development of condominial water supplies in the slums of Sao Paolo, which indicates that community self-help initiatives can be effective, whether it is government or an NGO which acts as the intermediary.

IV ORGANIZING SYNERGY

4.1 The idea

The preceding discussion suggests that, while civic organizations can play an important role in certain areas of service provision in poor societies, indeed in developmental processes as a whole, they have certain characteristic defects as well as advantages. These include problems of funding, uneven or unequal coverage, accountability, quality maintenance, internal organizational inadequacies, duplication, divisiveness or exclusion, and sustainability. Any assessment of the service-provision role of civic organizations must consider ways in which these problems can be ameliorated. However, the performance of civic organizations and efforts to improve it in turn depend on a large number of conditioning factors of a structural nature in their social, cultural, economic and political environment. A detailed discussion of these conditions is beyond us here; rather we intend to focus on the specific issues surrounding relationships between the state and civic organizations.

The state is a crucial environmental factor which can influence civil welfare provision for good or ill, either directly through the effect of state institutions on particular civic organizations, or indirectly through the impact of state policies and regulations on other structural factors such as the operation of internal and external markets or distributional patterns. The centrality of this relationship, for example, is stressed by Semboja and Therkildsen (1995:28-9) in their review of the recent experience of service provision in East Africa. The state is also the sole agency capable of providing welfare services on an across-the-board, universalist basis founded on some principle of citizens' rights. Given that the social goods provided by specific civic organizations may be mutually exclusive or conflicting and may reflect a variety of motives apart from altruism, the state offers a potential integrating framework to both reinforce, regularize and rationalize civic provision, reflecting some broader notion of *public* welfare which transcends specific embodiments of *social* welfare.

Since there is a strong argument to the effect that both state and civil forms of provision have intrinsic, albeit different, strengths and weaknesses, the question arises as to the extent to which some kind of complementarity can be organized in the provision of services between state agencies on the one side and civic organizations of various kinds on the other. This dyadic relationship is one element in conventional thinking about *pluralist* welfare systems which also include the market and the family. There is a growing body of literature on issues of *synergy*, *partnership* and *co-production* which originally developed in discussions of welfare reform in industrialized societies, but has more recently been extended to apply to developing societies.

The call for cooperation between the public and civic sectors is not new, either in regard to industrialized or developing societies. It has been an element of development discourse since at least the mid-1970s, but it has been given increasing impetus by

welfare reforms in the industrialized countries, notably the US and UK, over the past two decades and the dual movement in many developing societies in the direction of declining state intervention and growing NGO influence in the development process. Given movement towards the pluralization of provision, it is not surprising that increasing attention has been devoted to exploring the complex issues of inter-institutional coordination to which new systems of provision give rise.

While the notions of cooperation and complementarity would appear to be sound good sense almost by definition, there are good reasons for stressing notions of synergy at present. First, there is a tendency for advocates of developmental solutions based on civic and state institutions respectively to be organized in separate and often warring camps, often sharing derogatory images of each other and the sector each represents. This fosters a zero-sum approach to public and civic action, the former being castigated as elitist, bureaucratic and top-down and the latter as naive, anarchic and peripheral. Second, this intellectual and ideological divide has been paralleled in a variety of ways by the tensions and hostilities which have characterized relationships between government and civic organizations in many real-world situations where the two sectors have gone their separate and often conflicting ways in providing public goods and services.[27]

Complementarity seen in terms of the state providing an enabling environment is a common feature of current thinking about inter-institutional relations in the development field, operating not only through regulation, but also subsidies and various forms of contracting. However, all these forms of complementarity involve 'at-a-distance' relationships, whereas current thinking about co-production, partnership or synergy goes beyond this to consider closer, more intense and enduring forms of inter-institutional collaboration. In the context of the US, the notion of co-production expanded from an earlier stress on the voluntary participation of individual citizens in the production of public goods by local governments to an increasingly broad conception involving a greater range of actors (including civic organizations and private-sector firms) and a wider range of collaboration, including common decision-making and funding (Weschler and Mushkatel 1987; Warren 1987).[28] The UK literature on public-civic cooperation in the provision of social services has not used the concept of co-production explicitly and has focused heavily on the institutional and managerial consequences of the 'mixed economy of care' in the personal social services, particularly since the NHS and Community Care Act in 1993, involving a 'managerial mode of coordination' in a multi-provider system regulated by contractual arrangements (Charlesworth, Clarke and Cochrane 1996).[29]

In contrast, Peter Evans' notion of synergy goes beyond mere complementary interaction to include 'embeddedness'. Thus synergy, defined as 'mutually reinforcing relations

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[27] Riker (1995) discusses these tensions in the context of Asia and Clark 1992 more generally.

[28] Definitions of co-production vary in the US literature from more to less inclusive: for example, Brudney (1985:244) uses a restrictive definition in terms of 'the involvement of service consumers in the actual delivery of services (rather than in policy formulation and legitimation activities) normally in concert with public agencies'.

[29] For a broad and critical analysis of this new form of managerialism, see Clarke (1996).

between governments and groups of engaged citizens', rests on the following relational basis:

> [An] intimate interconnection and intermingling among public and private actors is combined with a well-defined complementary division of labor between the bureaucracy and local citizens, mutually recognized and accepted by both sides (Evans 1996:1119).

Consequently, Evans' notion of social capital, which is an essential underpinning of successful synergy, crosses the state-society divide:

> Social capital inheres, not just in civil society, but in an enduring set of relationships that spans the public-private divide

Conceptions of partnership also include the possibility that public and civic agencies and individuals may be tightly linked together in intermediary institutions, for example Mitchell-Weaver and Manning's (1991-92) conception of an 'elite committee model' of partnership working through 'boards' or 'conferences' involving representatives from different institutional sectors, arrangements which are characteristic aspects of various forms of formal and informal corporatist regimes in Western Europe, Latin America and East Asia, or the kinds of 'government organized NGOs' or 'GONGOs' to be found, for example, in East Asian societies including China, whereby elements of state control and social participation co-exist in various degrees of tension within putatively 'independent' social organizations (White, Howell and Shang 1996).

To clarify matters, it is perhaps useful to identify three basic processes which underlie various versions of synergy or partnership in the provision of social goods and services, namely determination, financing and production, as depicted in Table 2. These could involve the relationship between state agencies on the one side and either individual citizens or civic organizations on the other.

TABLE 2
FORMS OF CO-PROVISION BETWEEN STATE AND COMMUNITY ORGANIZATIONS (COs)

State \ COs	Determination (1)	Financing (2)	Production (3)
Determination (1)	Co-determination	Enforced provision	Delegation
Financing (2)	Devolution	Co-financing	Contracting/Granting
Production (3)	Pressured provision	Fee for service	Co-production

Source: Authors' compilation.

The key elements of co-provision usually identified in the literature run diagonally across the Table in cells (1,1), (2,2) and (3,3), each cell identified by row and column. Co-determination (1,1) involves processes whereby both parties jointly determine what social service is to be produced and how. This collaborative process can be

systematically organized, as in the case of various forms of corporatism which bring together both sides in institutionalized forums to decide on issues of common concern; it can also be more ad hoc and one-off, as in the case of meetings organized to discuss and decide on the use of resources in a given project or locality. Co-financing (2,2) involves both parties in paying for the cost of supplying the service in cash or kind. For example, local communities may raise extra resources for a clinic or local school in addition to resources provided by the state. Co-production (3,3) involves both parties in actually supplying the service, involving a commitment of resources and labour time. For example, this could involve NGOs or community organizations and state agencies in providing services to vulnerable groups, such as women, people with disabilities and the elderly.

While most descriptions of co-provision refer to these three collaborative functions, there are other forms of state-community organization interaction identified in the Table's other cells. Devolution (2,1) refers to an arrangement whereby the state provides financing for a given activity, but the community organization (CO) determines how the money is to be spent and the services to be provided. This could happen in cases where particular areas of service are highly complex, particular or sensitive and decisions about what should be provided and how are best made by a CO rather than a government department. Aid to certain types of vulnerable groups could fall into this category. Pressured provision (3,1) is a less common phenomenon, referring as it does to cases where a community organization determines what service needs to be provided and the state has to provide it, *nolens volens*. It is likely that this arrangement can usually only be enforced by advocacy efforts on the part of powerful groups in civil society, such as business and professional associations, but it is also conceivable that less advantaged groups could achieve it through actual or threatened direct action. Enforced provision (1,2), by contrast, implies that the state determines that a given service should be supplied and obliges COs to pay for it, by political pressure or legal sanction. An example would be in cases where community organizations are required by law to contribute financially to the construction and upkeep of local welfare infrastructure. Fee for service (3,2) is a collective form of user fees whereby the state requires fees for providing a social service but these are paid by community organizations as well as individuals. This arrangement could exist, for example, in the case of primary health-care services, particularly where there are community arrangements in place to supplement or subsidize individual payments. Delegation (1,3) refers to cases where the state determines what service is to be provided but delegates the entire responsibility of providing it to community organizations. This could involve, for example, the creation and maintenance of small-scale infrastructure for sanitation purposes. Contracting/granting (2,3) is a more familiar process whereby the state provides financing for a given service and COs are engaged to run it. These types of arrangements have become increasingly common in the United Kingdom, for example, where personal services have been contracted out to community organizations on a competitive tendering basis.

Each of the processes identified in the nine cells are ideal-types and specific instances of interaction between state and COs in the provision of social services may involve a mélange of various elements. The literature on co-provision tends to focus on co-

determination, co-financing and co-production, but it is of course easy to think of forms of co-provision in which there is no co-determination (the state decides what is to be done and how), or no co-financing (the state pays for everything), or no co-production (civic organizations take on the entire responsibility for production). However, much of the thinking about co-production in the US context tends to assume that state agencies and civic organizations/citizens share the responsibility for production. By contrast, when Ostrom (1996) comments favourably on the role of co-production in service provision in developing societies, she has in mind all three forms of cooperation. In her case-study of co-production of sewerage infrastructures in Brazil, the process involves co-determination in the sense of 'the activation of local citizens to participate from the very start in the planning of their own condominial systems' (1996:1074); co-financing in that citizens bear part of the costs of provision; and co-provision in that local residents were responsible for digging and maintaining feeder lines for water and sanitation.

Each of the three elements of co-provision promises benefits both for the parties involved and the clients they serve. Co-determination can enhance a feeling of ownership and participation on the part of social groups, influence policy to reflect specific needs and situations, thereby improving policy and programme design, and exert pressures for performance and accountability on public officials. Co-financing can mobilize extra resources and create incentives for care and economy on the part of both officials and clients. Co-production can mobilize extra inputs with low direct and opportunity costs and bring efficiency gains through a carefully specified division of labour and choice of appropriate technologies.

Ostrom's study of schools and health clinics in Nigeria illustrates some of the costs and lost opportunities involved in situations in which the involvement of citizens and groups is discouraged. Even though informal associations of villagers were very active in other community projects, such as road maintenance and the repair or construction of community facilities, this was not the case for primary schools. Local government educational officials operated in isolation from the villages, teachers felt under-valued or excluded, and local collective resources potentially available through the agency of parent-teacher associations were not mobilized. This and other experiences lead Ostrom to conclude:

> [Co-production] of many goods and services normally considered to be public goods by government agencies and citizens organized into polycentric systems is crucial for achieving higher levels of welfare in developing countries, particularly for those who are poor (ibid:1083).

This leads her to call for a bridging of the intellectual and practical gulf between analysts and advocates of civic and state solutions to developmental problems.

There is no shortage of similar calls for greater cooperation between the public and civic sectors. Drèze and Sen enter this territory when they define 'public action' as including 'not merely what is done *for* the public by the State, but also what is done *by* the public for itself' and argue that 'the problem of integration of governmental and non-

governmental activities is an important one in a programme of public action for social security' (1991:28-9). However, while they stress the need for a 'plurality of levers and a heterogeneous set of mechanisms' (ibid:29), they do not focus precisely on the specific problems of inter-institutional coordination involved. John Clark (1992 and 1995) makes a similar plea for 'a more strategic relationship between NGOs and governments'.[30]

All of these conceptions of complementarity or synergy imply some degree of collaboration between institutions in the public and civic sectors (and often the market sector) in pursuit of some common set of social objectives. But it is also possible to conceive of synergy in purely political terms as a consequence of political interaction between state institutions and institutions of civil society more broadly (including civic organizations such as business associations and trade unions) – which does not centrally involve institutional collaboration, rather a process whereby the pressures exerted by strong social organizations and movements stimulate government action to provide public goods and enforce government accountability to popular demands for them. Gita Sen uses this approach in her study of the history of social provision in Kerala, noting that social services are better there than in the rest of India in large part because of 'the willingness of people to join together to demand accountability from the systems and their employees' (1992:275). This phenomenon could be called political synergy and is a crucial background condition for the success of otherwise of efforts at inter-institutional cooperation. This distinction coincides with the familiar distinction between the supply-side approach to civic organizations, whereby they are seen mainly in terms of their capacity to provide services or run projects and the demand-side approach whereby, in Clark's words (1995:593), 'communities articulate their preferences and concerns so as to become active participants in the development process' through empowerment. Although we shall be concentrating on the former in this paper, the latter should be kept in mind since successful synergy depends upon a virtuous interplay between institutional and political factors. We shall return to this question in our concluding remarks.

4.2 The experience of government-civic collaboration: common problems

There is also no shortage of successful cases of public-civic cooperation adduced to buttress general arguments for public-civic collaboration in development efforts. For example, Taal (1993) cites ten case-studies from Asia, Africa and Latin America of which he regards eight as relatively successful examples of collaboration in the provision of social services. Clark (1995) goes further in his thirteen case-studies by seeking to distinguish degrees of success (clear, mixed and questionable) and linking these with levels and types of involvement by civic organizations. Certain cases, such as the Philippine National Irrigation Administration's Communal Irrigation Programme recur in the literature as models of successful collaboration (for example, in Korten 1980:492-4).

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[30] For arguments along similar lines, see Riker (1995), Taal (1993), and MacPherson (1989).

Even in countries where the non-state sector accounts for a significant share of health facilities and services, it is uncommon for non-state health services to be insulated from national policy priorities or state provisioning. This is evident from the common practice of state financing of non-state health services in a number of countries in Asia and Africa. The Indian government, for example, supports NGOs with grants for treatment of indigents, covering the costs of postpartum beds under the national family planning programme, and subsidies for primary health care services (Berman and Dave 1996:36). In several African countries, the state has financed health services provided by missions, through grants, subsidies and tax exemptions. For example, the Zimbabwe government provides funds to enable mission hospitals to expand and to purchase ambulances. In Botswana, the government covers most of the recurrent costs of NGO health facilities (World Bank 1993:128). The Tanzanian government has designated certain voluntary agency hospitals as district hospitals, with a contractual relationship for providing some public services in exchange for grants and personnel. The Zambian government supports mission health facilities in rural areas through bed grants and staff secondment (Mogedal et al. 1995). In Ghana and Uganda the government pays the salaries of all health staff, and in Uganda government staff are seconded to church health facilities. Church organizations in Malawi can purchase drugs at subsidized rates and in Ghana missions are exempted from paying import duties on drugs, dressings and equipment. In these various ways state funding accounts for 33-45 per cent of NGO health care financing in Ghana, Malawi and Tanzania. However, government financial support is not without problems: there are delays and uncertainties in the disbursement of funds, grants do not cover costs of provision, there is a lack of flexibility in the use of funds, or unacceptable conditions attached (DeJong 1991; Gilson et al. 1994; Berman and Rose 1996). Some African governments have designated mission hospitals as primary referral centres and receive grants and subsidies in return. For example, in Malawi mission hospitals will become responsible for all services within their areas, whether owned by government or members of the Church Association of Malawi, following the creation of special health delivery areas (Gilson et al. 1994:20).

Governments and non-state health service providers also collaborate in other ways. A good example is in the supply of drugs and medicines. In Cameroon the Ministry of Health has created the legal framework enabling non-profit associations to hold funds and purchase drugs from a non-profit bulk supplier or on the international market (Sauerborn et al. 1995). Church organizations in Malawi can purchase drugs from the central medical stores at subsidized rates (Gilson et al. 1994). But the roles of NGOs and government are not always well demarcated which can lead to inefficiencies in health provision. In Sierra Leone and Uganda, there was a tendency for NGOs to provide the funds and materials for constructing health buildings but without making provision for repairs and maintenance, which was assumed to be the responsibility of government which did not have adequate resources. Consequently the buildings fell into disrepair and became unusable (Mitchell 1995).

Problems of coordination, duplication and lack of integration between state and non-state services underline the need for an effective working arrangement as a basis for a more comprehensive and integrated system of health provisioning at the national and district levels. From their review of health sector reform in Zambia and Tanzania,

Mogedal et al. (1995:359) argue that for effective implementation of a broader provider mix at the district level, 'basic managerial capacity needs to be available for appropriate coordination of the different providers, for support and interaction between the providers, and for establishing functioning mechanisms of accountability.' Walley et al. (1991) discuss the virtues of a health systems approach in the Wollo region of Ethiopia where NGOs and the regional health department devised a common approach for the implementation of integrated maternal and child health (MCH) services, which was put into effect through bi-monthly meetings to ensure effective coordination of activities. The result was increased attendance rates and utilization of services, with an overall improvement in MCH indicators (Walley et al. 1991).

However, while the listing of 'successful' cases is instructive in showing some of the factors affecting collaborative performance, it can also be confusing. When it comes to explaining success, moreover, the criteria for and evidence of success are often not specified clearly. The cases cited often cover a bewildering range of activities and contexts and the impact of certain key conditioning factors is inadequately specified. Success also seems to be regionally specific, with Latin America of late providing the outstanding examples and Africa with a mixed record (see, for example, Farrington and Bebbington 1995). The proportion of 'successful' cases of public-civic cooperation is probably a very small proportion of the potentially available universe of cases. This is hardly surprising given the difficulties involved and catalogues of successful experiences need to be supplemented by a sober assessment of the difficulties involved in efforts to organize synergy.

Though each specific example of attempted collaboration may involve a wide range of contingent elements, some of the difficulties involved are structural, reflecting basic contradictions in the process: between types of institutions which operate in characteristically different ways; between social groups with different resource endowments and perspectives; and between political forces with different interests and values.

These tensions cause commonly observed problems, such as the following:

- The problem of *politicization*, involving conflict between civic organizations and the state, among civic organizations themselves and between them and other elements of the population; links between specific state agencies and civic organizations on the one hand and wider patterns of local and national politics on the other; and distributional issues surrounding uneven or unequal service provision.

- Dangers of *corruption and cronyism* which may attend more intensive and long-term inter-institutional relationships.

- Organizational problems arising from the complexities of *inter-institutional coordination*, particularly given the divergent organizational cultures and socio-political identities of the two sides. This is an issue which has been a primary concern of the Western literature on co-production. In addition to problems of

coordination between state and civic agencies, moreover, there is one of coordination between different types of civic organizations, notably national and international NGOs and between them and grassroots organizations (Brown and Ashman 1996; Howes forthcoming).

- Organizational problems involved in *adapting state institutions* and operatives to the requirements of external collaboration.

- The potential for conflict on the grounds of ideology and differences in approach; a well-known example is the refusal of Catholic church missions to provide contraceptives in family health clinics in several African countries despite a national policy commitment to population control.

- Organizational problems concerning the *transformation of civic organizations* from one-off, coping or emergency providers of social services to more routinized agencies capable of maintaining high standards of service and accountability. Since this may involve them becoming more businesslike and professionalized, issues arise concerning the potential loss of their distinctively 'voluntary' characteristics. To the extent that they are increasingly drawn into contracting arrangements, moreover, they may gradually begin to act like commercial companies competing for market share or brand reputation. This is the organizational Catch 22 identified in studies of the voluntary sector in the industrialized countries, viz. as the sector becomes more institutionalized, it loses much of its distinctive character and becomes closer – and possibly more vulnerable – to the other sectors to which it is supposed to be an organizational alternative, i.e. more bureaucratized and/or more commercialized.

- The problem of *dependence* is a potential feature of any inter-institutional relationship which is asymmetrical in terms of power and resources and a particularly severe problem in poor, dislocated societies where both states and civic organizations are financially dependent on different segments of the external donor system.

One should also realise that potential complementarity may be only a narrow sliver of the range of actual relationships between states and civic organizations, particularly in those developing societies ravaged by intense social hostilities, political instability and collapse, widespread official corruption, repressive states, fiscal indigence and international dependence. The following types of public-civic relationship are common:

- An *adversarial* relationship in which mutual hostility reigns and civic organizations exist at least in part to protect their clientele from state repression or interference and provide benefits which the state is unwilling to provide or finds positively threatening (for example, community organizations in authoritarian situations such as Pinochet's Chile or South Korea under military rule).

- A *displacing* relationship whereby states act to displace or replace the service role of civic organizations (as we have seen, the origins of Western states are often analysed in terms of inter-institutional displacement whereby state-sponsored

programmes replace previous agencies of provision such as self-help associations, churches and charities).[31] On the other side, civic organizations may displace ailing states by establishing 'independent kingdoms', areas of autonomy in which basic services are provided in lieu of state agencies (as in guerrilla bases). They may also replace state provision in societies where states are very weak or non-existent (for example, sectors of Mogadishu controlled by religious organizations). In such cases, if civic organizations do not provide services, they will simply not exist.

- A *competitive* relationship in which civic organizations and state agencies compete to provide services. While this is a common feature of relationships between state agencies and profit-oriented private entities (for example, in areas such as pensions and personal service provision), it may also occur in non-profit organizations in cases, for example, where religious organizations may seek to establish their own educational institutions in competition with state secularism.

- A *substitutive* or *subsidiary* relationship based on a mutually acceptable division of labour in service provision whereby civic organizations take over responsibility for the provision of certain services which the state cannot or does not want to provide and there is agreement that civic organizations have a comparative advantage in the area. In the case of agreed subsidiarity, we are entering the realm of potential inter-institutional complementarity, since it is likely that the state would play some kind of enabling role by providing a favourable policy or regulatory environment to institutionalize and encourage the agreed division of labour.

4.3 Conditions for failure and success

In diagnosing problems of failure and success and attempting to deal with the inherent problems of complementarity, there is a current tendency to rely on rather abstract concepts such as 'social capital' or 'trust'. But these can take protean forms and themselves have to be explained in the first place. The analytical difficulty is finding ways to steer between the Scylla of contingent complexity and the Charybdis of broad abstraction by breaking down the experience of public-civic collaboration into 'middle-range' categories which may be useful in providing practical benchmarks for assessing potential performance. Certain headway can be made by specifying certain central variables which influence the nature and efficacy of collaboration between public and civic institutions.

The first of these involves variations in *socio-political structural conditions* between and within individual societies which affect the feasibility of effective collaboration. The key structural variables here would appear to be the following:

- A society's degree of social cohesion which depends on the amount of structural inequality and the intensity of social conflicts, both horizontal and vertical. Where

[31] For a critique of this 'displacement' view of the welfare state in the US context, see Salamon (1987).

gaps between social groups are wide and political power is consequently highly skewed, and where social relationships are fragmented and conflictual, systematic efforts at organizing the kinds of complementarity which can produce public goods and distribute them throughout the population are likely to be difficult.[32] The same is likely to apply to societies which are highly 'disarticulated' in the sense of glaring gaps between state and society, urban and rural populations, and 'modern' and 'traditional' sectors.

- The nature of the political regime and, in particular, the legal framework governing the activities of the voluntary sector, respect for civil and political rights, and the overall transparency and accountability of governmental and political institutions. Authoritarian regimes are more likely either to discourage the activity of civic organizations or to seek to control or manipulate them. By contrast, democratization – even of a relatively superficial procedural kind – can not only open up more space for civic organizations but may stimulate their growth by providing more channels for organized interests to influence the policy process and attract the attention of officials. In this perspective, the prospects for synergy in the nineties are far better than those in the seventies and eighties.

A second set of enabling or constraining conditions lies in the *institutional character and capacity* of a particular society. The institutional requirements of successful complementarity are formidable since they cover three terrains: the civic, the public and the interactions between the two. So far, efforts to identify the conditions for complementarity have stressed the civic realm, in particular applying the notion of *social capital* to this sector of society. In his analysis of thirteen cases of public-civic cooperation, for example, Clark (1995) concludes that social capital, in the sense of 'relationships that are grounded in structures of voluntary association, norms of reciprocity and cooperation and attitudes of social trust and respect, is associated with the success of cooperative programmes. Specifically, three of his five clear successes, two of his five mixed successes and none of his three questionable successes' involved strong grassroots organizations or networks. However, the relationship was not a clear one – as Clark observes (1995:1471), '[there] were cases of clear and mixed success characterized by medium or even low levels of social capital as indicated in dense networks of effective local organization'.[33]

The weakness of this relationship reflects the protean and ambiguous character of specific civic embodiments of the social capital ideal-type. Unless social capital is defined in terms which make it 'a good thing' by definition and therefore analytically unhelpful – and some uses of Putnam's concept tend in this direction – it can be a force for anti-social conspiracy as much as socially-oriented cooperation; it can exclude as well as include and intensify and as well as ameliorate conflict; it can operate

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[32] Controlled experiments by Aquino et al. (1992) on the relationship between inequality and support for public goods suggests that, because of the differential impact of the free-rider and sucker effects, 'inequality in the distribution of resources leads to less cooperation and reduced support for a public good'.

[33] Similarly, Brown and Ashman (1996) argue that dense networks of social capital are not the only ingredients of success, and that organizational capacity is critical to effective performance.

hierarchically as well as horizontally. In particular, it may impede as well as facilitate cooperation among civic groups and coordination between them and public agencies. In spite of these qualifications, however, one could accept a more limited proposition, to the effect that the existence of a 'stock' of organizational capacity and relations of mutual solidarity, reciprocity and trust in the civic realm can often be a facilitating condition for organizing complementarity.

Two problems follow from this: first, what can be done if these stocks of social capital do not exist; and, second, to the extent that they do exist, how to mobilize them in the pursuit of synergy, a task which requires us to look at two more institutional realms, the public and the public-civic intersection. The first of these questions relates to what might be called the 'Putnam paradox'. Since stocks of social capital accumulate over centuries and cannot be built up overnight, if you haven't got it you aren't likely to get it. Moreover, since the amount of social capital is associated with actual and potential developmental performance, the localities which are the most needy in developmental terms are also likely to be the least endowed with social capital. Lack of social capital then operates like a kind of 'social debt', the burden of which debilitates groups and communities and intensifies the gaps between them and their counterparts with greater social assets. It might be said, however, that neither of these relationships hold decisively: for example, there are many examples of effective community and group organizations forming speedily in response to emergency or dire need; moreover, poor and excluded communities in the most need may also have substantial organizational reserves to draw on.

But what can be done if stocks of social capital are weak and/or dwindling? It is clear from many studies of both industrialized and developing societies not only that stocks of social capital vary considerably between dissimilar types of communities and among similar types, but also that the kinds of structural problems that one would like community organizations to address – such as cutbacks in government funding or economic disruptions – may weaken existing associational ties.[34] Moser's study of four poor urban communities under stress (1996:65) documents the extent to which 'economic crisis has ... eroded trust and cooperation in a number of important respects', notably by increasing crime and insecurity and reducing the time available for women to collaborate in community activities. Government cutbacks also contribute to this decline, for example in the case of a withdrawal of support for community childcare centres which reduced employment opportunities for women because of the increased burden of childcare and reduced the time available for other activities, including community participation. At a deeper level, it led to a loss of trust between local people and the government, 'the rupture of a social contract carefully negotiated over the years' (ibid:64).

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[34] Sundeen (1985) has investigated the relationships between co-production and community in the context of the US, concluding that communities vary greatly in the extent and character of their capacity for organized group action and that this has important implications both for the forms of co-production which are feasible in different contexts and the different roles required of local administrators. The US has numerous cases of functioning communities which are decimated by a particular marker occurrence, such as the sudden withdrawal of a large employer which leads to a downward escalator of fiscal decline and community disintegration.

This case not only demonstrates the fragility of trust as an aspect of relations between government and community, but also highlights the fundamental difficulties facing attempts at organizing complementarity in times of fiscal distress and economic crisis. It is in circumstances such as these, where both governments and communities are under stress, that the role of NGOs with external links is important. In effect, they can act in a substitutive capacity to restore local associational capacities when these would otherwise be weak or under stress. In relation to the possibilities for complementarity, this finding has two significant implications: first, as stressed in earlier sections, community or grassroots organizations (GROs) and NGOs are different types of organizations (even though they may often overlap) and must not be conflated when we are seeking to estimate the associational capacity and resilience of a particular locality; and, second, the process of organizing synergy is triadic (government, NGO, GRO) rather than dyadic and in many cases involves four or five parties when international NGOs and foreign donor agencies are involved. The distinctive roles of NGOs and GROs have been emphasized and analysed, amongst others, by Uphoff who argues:

> Both GROs and NGOs bring different advantages to our quest for poverty alleviation and multifaceted development. GROs offer closeness to the people, knowledge of local conditions, responsiveness to local needs. NGOs represent different principles of motivation – both for creating goods and services and for receiving them – from those that animate state or market institutions (1993:619).

While this distinction provides a useful caution against any tendency to homogenize the putative organizational character of the civic sector, the task of identifying the institutional underpinnings of government-civic complementarity could be extended in ways suggested by Evans (1996), Ostrom (1996) and Tendler (1995) to cover two institutional terrains additional to that of civil society and 'civic virtue': within the state and between state and citizenry/civil society. The first would refer to the creation of efficient and accountable public institutions populated by people motivated at least partly by considerations of public service (for the importance of the latter, see Tendler and Freedheim 1994), as a realm of 'public virtue'. The second would refer to relations of mutual trust, respect and cooperation across the state/society divide which are the fundamental underpinnings of any effort to organize synergy.

While the importance of the efficiency and effectiveness of public institutions would seem self-evident, current thinking about the role of the state in the process of organizing complementarity is inadequate in several ways. There is good deal of normative discussion about the need for the state to 'establish an enabling environment' for civic action, but there is insufficient attention to the problems faced by current state machines, particularly ones facing economic crises or grappling with structural adjustment programmes. Indeed, the currently dominant intellectual paradigm for state behaviour – the 'new political economy' and the theories of 'public choice' and 'rational choice' – tend to disparage the state as a realm of self-interest and rent-seeking, which makes thinking about issues such as 'public service', 'professional commitment' and 'public virtue' difficult if not impossible. In the realm of practice, it can lead to an

overwhelming negativity about the character of, and possibilities for, state action which not only destroy areas of effective state action but also undermine the motivation and effectiveness of state officials and employees, thereby producing a self-fulfilling prophecy. Drawing on their study of a public health programme in Brazil, for example, Tendler and Freedheim conclude that members of a state institution can be motivated by public service, that notions of self-interest and 'public calling' can be combined and these motives can be created and reinforced by a judicious combination of measures and pressures from 'above' and 'below'. To put it crudely, there are some 'good' governments which can be made better and there are some 'bad' governments which can be made 'good'. Thus our inquiry into the feasibility of complementarity and synergy would need to delve systematically into the theory and practice of 'good governance'.[35]

The realm of government-civic and government-citizen interaction is yet another area of institutional inquiry of central importance for understanding synergy. On the basis of a study of sixteen countries in Asia, for example, Uphoff (1993:613) concludes that 'countries which had the best linkage between central government and rural communities through a network of local institutions had the best performance in agriculture and in social indicators'. The problem with this kind of finding, as Evans (1996) points out in his discussion of prospects for synergy, is that, as in the case of Putnam's dilemma for the civic sector, these institutional linkages are to be found in long and well-established institutional systems and depend upon basic structural factors such as the capacity and coherence of the state machine, the degree of cohesion of local communities and the advantage of a relatively egalitarian social structure. The key problem for synergy in less well-endowed contexts is one of building institutional bridges in situations where the relationship between state institutions and society has been distant or antagonistic. While a problem for specific policy areas and projects, this need for bridge-building is often symptomatic of a broader, society-wide process of integrating or re-integrating state and society as well as establishing relations of trust between citizens and officials.

4.4 Avenues to 'constructability'

Discussions of the above sort, which emphasize the complexity of the problem and the structural constraints which operate to obstruct positive action, and imply a long-term perspective for potential solutions, are frustrating. Poverty needs to be tackled in the here and now, and life-sustaining and enhancing welfare services and public goods need to be delivered soon, not in some distant future. If complementarity is a potentially powerful way of tackling the problem – and in many situations it may not be, at least in the short term – then we need to confront the problem of what Evans (1996:1129) calls 'constructability'. What are the areas of potentially positive action which are feasible in the short term? Let us begin by defining certain areas of action.

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[35] For a useful discussion of the 'good government' agenda, see the special issue of the IDS Bulletin edited by Mick Moore (1993).

4.4.1 Creating an enabling policy environment

This is a familiar theme in discussions of complementarity (see, for example, Clark 1995) and we need not spend too much time on it here. The basic message, assuming some minimal level of state capacity, is that a balance should be struck between non-intervention, promotion and regulation. In situations in which governments have in the past imposed overly restrictive controls over the role of civic organizations (as for example, in Tanzania), both in general and in relation to the provision of welfare services, these should be relaxed, particularly in contexts where relaxation can reasonably be expected to result in a net increment of social provision, either complementary to or substitutive for state provision. For example, in the context of the health sector in Africa, most observers are agreed that strict control is likely to prove counterproductive and that the role of government is to provide the broad strategic and policy framework and a clear operating environment for NGOs to fit in (DeJong 1991; Green and Matthias 1995). To the extent feasible, moreover, governments should actively encourage civic organizations by helping to open up opportunities for civic action in the welfare field and providing incentives for civic organizations to become involved; these might include tax concessions, simplified administrative procedures, additional sources of funding in the form of contracts or grants, and opportunities for closer consultation with government in determining national policy objectives. At the same time as these enabling actions are being intensified, however, here is a concomitant need for regulatory action to institutionalize the status of civic organizations, screen them to prevent malpractice and establish socially beneficial standards of performance, in the light of deficiencies of non-state provisioning.[36] Overall, this approach implies a combination of measures to provide space for civic organizations, consolidate and defend their social position, provide positive incentives for socially productive action and enforce certain standards of accountability.

4.4.2 Institutional innovations in the public sphere

To the extent feasible, governments can take steps to encourage the involvement of civic organizations in one or more of the three elements of co-provision indicated earlier: for example, by setting up various kinds of intermediary institutions such as consultative bodies to solicit the views of social groups and involve them in defining priorities and operational objectives; or by actively seeking collaborative arrangements for co-financing and co-production. To the extent that localities are the natural context for such efforts, the balance between central control and local responsibility needs to be re-assessed with a view to encouraging the kind of organic 'embedded' type of relationship which many analysts and practitioners regard as an essential element of successful public-civic provision, but maintaining the controls necessary to maintain standards and enforce accountability. Achieving a desirable balance between centralization and decentralization, whether administrative, financial or political, varies between policy sectors and the process involves an incremental process of institutional 'tâtonnement' to

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[36] From their review of NGO health provisioning in Africa Gilson et al. (1994) conclude that 'Ensuring effective use of all health care resources requires the government to consider ways of regulating and supervising NGOs, given concern about their ability to sustain revenue generation, their efficiency and quality of care, and their coordination with government (ibid:21).'

achieve synergy. Any reform plan of the 'blueprint' variety would be wrong by definition, even if it was pointing in the right direction (Korten 1980). Such reforms would also involve efforts to provide new incentive systems and forms of training for public employees to equip them for the new roles which these arrangements would entail. This is particularly important in view of the fact that one of the major constraints on government-civic collaboration is the attitudes of government officials and professional employees: the former because the kind of action necessary to create and sustain collaboration is outside their professional ken, carries no career incentives with it and is perceived as a troublesome and time-wasting; the latter because interaction with citizens and civic organizations and sharing sectoral activities with them offends their sense of professional identity and threatens to dilute certain standards which they consider inviolate. This is a common reaction on the part of professional groups involved in providing social services, such as doctors, teachers and social workers.

4.4.3 The 'soft technologies' of organizational design

This is Evans' term (1996) to describe the potential benefits of certain organizational features of complementarity exercises, most explicitly drawn out in Tendler and Freedheim's study of a municipality based preventive health programme in Ceara, Northeast Brazil. Particularly important was the careful combination of centralization and decentralization in the administration of the programme, whereby the higher authority – the state government – kept firm control over the recruiting and payment of local health agents who worked for nurse-supervisors at the local level and helped to neutralize the potential opposition of local mayors to a programme which they could not use for patronage purposes. The local citizens who failed to be recruited into the programme were turned into 'informed public monitors of the programme' (Tendler and Freedheim 1994:1778) which enforced efficiency and accountability among the new health agents. Effective soft technology such as this is very context-specific and in the Ceara case depended on the successive arrival in power of two reformist state governors from the Brazilian Social Democratic Party which sought to break away from the corrupt pattern of clientelist politics that had bedevilled the area in the past. But this, and other successful cases of synergy, such as the urban infrastructure projects in Brazil described by Ostrom (1996), show specific (and varying) organizational responses to a common set of potential problems involved in organizing complementarity: for example, administrative responsibilities arranged in such a way as to avoid corruption and neutralize political opposition; the search for procedures to involve community groups of citizens in the design and implementation of the project; the discovery of ways to involve low-skilled community workers in projects while minimizing the resistance of professional staff; and intensive efforts to boost the morale of the public servants involved and give them a sense of 'mission'. The central message of successful cases is the need for a virtuous combination of multi-directional pressures – from above (higher levels of government), from the side (from local politicians and interest groups), from below (from organized community interests or 'activated' individuals and groups), and in some cases from outside (international agencies and other donors).

4.4.4 Particular areas of intervention

There are cases of both successful and unsuccessful relationships between government and civic organizations in the areas of social provision discussed in this paper, namely health, education, urban infrastructure, housing and assistance to vulnerable groups. There are different problems involved in areas in which provision by community organizations or NGOs could be described as 'additive' and 'integral'. The former – 'additive' – implies an area of provision, often of a very focused kind, which can be tacked onto ongoing government activities with minimal institutional interaction required, such as small-scale, low technology community-organized facilities such as crèches, youth centres, victim support centres, family planning centres, women's refuges and the like which can be disaggregated and linked only loosely with broader government programmes and institutions. The latter – 'integral' – involves areas of provision in which provision by GROs and NGOs is part of a broader, more integrated and hierarchical system of societal provision organized by government, with the following characteristics: highly stratified levels of technical knowledge and professional expertise, as in the areas of urban water services, health and education; large and complex physical infrastructures such as hospitals and urban water systems; organizational complexity in that coordination across sectoral institutional systems or geographical areas is required, as in the case of urban sanitation which involves a variety of local government agencies; and involving a commitment to maintaining standardized levels of provision, for example through school curricula or public health regulations. In such systemic contexts, governments play a crucial role in marshalling and maintaining expertise, in designing and constructing infrastructure, in coordinating across institutional sectors and localities and in defining and enforcing standards. The role of civic organizations will vary within these integrated systems, depending on the particular character of the organization and the activity. In the case of community involvement, one might expect that it would be locally specific, involved in relatively low-technology and low expertise activities, participating less in the construction of infrastructure and more in its operation and maintenance and in non-standardized, non-formalized forms of provision, such as informal education and self-help groups for care of children, aged and disabled people. The case of NGOs is often different since, particularly in the case of larger ones with international connections, they can deliver higher levels of expertise, coordinate across institutional sectors and localities, and manage more complex physical and institutional concentrations; for example, the cases of religious institutions running hospitals and secondary/higher educational institutions, and specialized NGOs handling areas of public health, such as disease eradication programmes.

The key element of synergy in these 'integral' systems of provision would seem to lie in the ability of the implementing agents to design ways in which these different levels and sectors within a given system of provision can be assigned to different agents according to their institutional comparative advantage. This involves two parallel, and hopefully mutually reinforcing, processes of design and coordination – the technical and the political. In the case of the urban sewerage system described by Watson (1995), for example, on the technical side, the urban water supply system was designed to be 'decomposible' into two physical systems, the second of which – a network of small

'condominial' feeder-lines running urban residential blocks – could be constructed and maintained by local residents. On the political side, local citizens were involved from the outset by means of neighbourhood meetings to discuss its technical and financial aspects and planners were induced to incorporate certain design features which might not otherwise have entered into their calculations. Complementary provision in other areas of the social services provision, such as health and education, involve similar processes of technical 'decomposition' on the one hand and corresponding institutional responsibilities arrived at through micro-political processes of consultation, bargaining and mutual accommodation on the other.

4.4.5 Facilitating factors

As in the case of many other accounts of efforts to achieve synergy, the above analysis shows, frustratingly, how complex, contingent and difficult the process is. Given this evident reality, it is perhaps rational to expect most efforts to end in failure or at least only partial success. But there are certain facilitating factors, some of which are susceptible to design and some of which are beyond the control of the architects of individual programmes and projects. The *political context* is very important. The nature of the political regime is crucial, as remarked earlier, in that it opens up space for both political pressures from civic organizations to improve performance and accountability and increases the room for institutional manoeuvre. The quality of political leadership and of the political process more generally at regional and local levels is a key element of success – if local politicians or the leaders of civic organizations turn against a project or are divided on the issue – the endeavour is imperilled from the outset.

Given the demanding range of micro-political skills necessary to broker complementarity, *the quality of individual leaders* – whether administrative, professional, political or civic – is a potentially decisive factor in smoothing the path towards synergy. On the public side, the adaptive capacity of public officials is a crucial factor, as Sundeen (1985) has demonstrated in the US context, identifying three roles for local administrators which are key determinants of success in organizing government-community relationships for the co-provision of social services – broker, facilitator and community developer. On the civic side, the drive and skills of community and NGO leaders provide another positive impetus and some analysts of the civic sector, particularly in the industrialized countries, are heralding the emergence of a new social stratum – the social entrepreneurs – who can combine the entrepreneurial flair of the commercial sector with the socially minded commitment of the voluntary sector.[37]

While these forces can provide both impetus and discipline in organizing synergy, external pressures can provide additional stimulus, given the knowledge and flexibility of NGO leaders. The operational performance of the donor community is itself a variable, however, and can produce or intensify some of the problems found in the host country. External interventions to assist synergy can be very helpful in concentrating the

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[37] In the UK, for example, the country's most noted 'social entrepreneur', Michael Young, plans to establish a School for Social Entrepreneurs, to open in January 1998, a 'businesslike non-business school' designed to train managers for the growing non-profit sector (*The Guardian*, 12 March 1997).

minds of local actors through a combination of carrot, stick and persuasion, but these interventions need to be informed by an increasing grasp of international best practice – political and institutional as well as technical – and endowed with the capacity to use this knowledge flexibly.

All these factors, as well as the contextual variables mentioned earlier, influence specific processes of attempted complementarity in complex ways which make each particular instance highly 'path dependent'. While we have suggested that certain maps and signposts do exist, their accuracy sometimes approaches that of their medieval equivalents. It is not surprising, therefore, that long-term observers and participants have emphasized the organic nature of the complementarity process. Watson, for example, in her study of urban sanitation projects in Brazil, concludes as follows:

> The lesson is that there is no 'right' way to approach projects, but that each project's design, implementation strategy, and management arrangements evolve during the course of give-and-take negotiations between the project team and residents (1995:23).

Similarly, Korten stresses the need for a 'learning process approach' when assessing the reasons for successful cases of both community and collaborative development in Asia:

> These five programs were not designed and implemented – rather they emerged out of a learning process in which villagers and program personnel shared their knowledge and resources to create a program which achieved a fit between needs and capacities of the beneficiaries and those of the outsiders who were providing the assistance. Leadership and teamwork, rather than blueprints, were the key elements (Korten 1980:497).

There is in effect a three-dimensional process of 'tâtonnement', simultaneously technical, institutional and political. While technical information available for service provision projects and programmes is more likely to be forthcoming and there are huge amounts of skilled personnel available and eager to provide it, knowledge of similar quality in relation to institutions and to micro-politics is in far less ample supply. Understanding the second and third dimensions of all forms of service provision – whether involving collaboration or not – requires the strengthening of applied organizational analysis (formerly confined largely to the public sector in the form of the much-maligned field of public administration) and of political, in particular micro-political, analysis.

V CONCLUDING COMMENTS

This review of the role of the civic organizations in the provisioning of public services offers a number of insights in terms of regional variations and conditions for success. Civic organizations in Africa play a major role in the financing and production of welfare services, accounting for a significant share of overall health and education provision in many countries. Pressure for increased non-state provision has principally come from aid donors, though fiscal stress has been a major contributory factor which has persuaded governments to accept an expanded role for churches and NGOs. Self-help initiatives through grassroots organizations are an important source of voluntary provisioning in a number of African countries where the state has not been able to provide a basic level of services. In Asia and Latin America, where non-state provision is less extensive, the contribution of civic organizations is more in the form of mobilizing demand for services, building awareness of community needs and experimenting with innovatory approaches which can be replicated by the state sector.

Evidence suggests that civic organizations play an important role in the provision of health and educational services where state provision is limited and the private sector caters for better-off sections of the population. Voluntary organizations also have a comparative advantage in facilitating community management of small-scale investments in water supply and sanitation, housing and urban services where the target group is relatively small and well-defined. The comparative strength of civic organizations in the direct provision of public services lies in their ability to work with the poorest and most disadvantaged people. Studies of welfare provision and small-scale infrastructure investments by civic organizations appear to confirm this. Unlike state organizations, which tend to aspire to universal provision, civic organizations concentrate scarce resources on the most needy and underprivileged sections of the population through targeted provision. They also work in poor and remote regions where government services are limited and where needs are often greatest.

While the literature highlights a number of positive aspects of non-state provision, the scope and coverage of the voluntary sector is deficient in a number of respects. Resources are inadequate to ensure comprehensive coverage and there is fragmentation of effort since a multitude of organizations are engaged in welfare provision using different approaches and operating procedures. Despite the ability of some organizations to work in remote areas, some regions and groups of people are poorly served or are beyond the reach of civic organizations, due to resource constraints and a tendency towards concentration in core areas and to working with more accessible and vocal groups. Although civic organizations focus their energies on poorer groups, equity considerations also arise with voluntary sector provisioning, which have gender, class and ethnic dimensions. By their very nature civic organizations have a tendency to work selectively with sub-groups of a given population, especially when their mission and

resource base derives from a particular ethnic or religious group.[38] Gaps in coverage are a problem, and certain groups of poor people can be excluded by virtue of physical location and the apparent intractability of their situation.

Evidence suggests that the quality of services provided through civic organizations is extremely variable, partly because they attempt to spread resources too thinly, but also because of technical complexities inherent in certain forms of service provision which non-specialist organizations are not well-equipped to handle. While there are examples of high-quality provision by NGO and church organizations, it is not possible to conclude that services provided by civic organizations are uniformly of a higher standard than those offered by government. Allied with this are problems of amateurism in that generalist organizations sometimes lack professionally trained staff to deliver services of an adequate quality and standard. There are also problems of high staff turnover stemming from competition within the voluntary sector and a lack of job security. Civic organizations also lack effective internal management systems to plan and oversee a complex array of projects and programmes in different parts of a country. Such problems are magnified when there is no overarching body or mechanism to ensure quality control and to monitor services provided through a multiplicity of organizations. A related issue is the cost-effectiveness of services provided by civic organizations. Although there is a lack of hard evidence, the assumption concerning the low cost of voluntary provision is open to question. While some services provided by civic organizations are comparable to or cheaper than state or private providers, in some cases the cost of voluntary provision is greater because the quality of inputs is better and staff salaries are higher. Moreover, providing services to poorer people living in remote and inaccessible regions can place heavier demands on scarce resources.

A further problem arises when a multitude of organizations are involved in providing an array of goods and services within a defined geographical area. There is considerable scope for duplication when several organizations (state and non-state) are working in the same set of villages or urban settlements, in some cases with the same set of individuals, in the absence of effective coordinating mechanisms.[39] This not only results in overlapping provision, but also in services being provided on the basis of different principles, for example, in terms of the expected financial contribution on the part of clients in the form of user fees, criteria for the selection of the intended beneficiaries, and the precise mix of services on offer.

Perhaps the most problematic aspect of service provisioning by civic organizations is that of sustainability, especially when they are heavily dependent on external assistance. A number of studies have highlighted problems of sustaining services with high staff costs (especially when expatriates are heavily involved) in terms of technical, administrative and supervisory inputs and heavy recurrent expenditure on educational equipment, medicines, and infrastructure maintenance. The introduction of user fees and

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[38] This problem is a key aspect of what Salamon (1987) calls 'voluntary failure', in contrast to bureaucratic or market failure.

[39] Anecdotal evidence to this effect, drawing on NGO water projects in Zambia, is provided by Mwansa (1995).

community management has partly allayed this problem, but it raises problems of access and equity. As examples of self-help provision in East Africa have demonstrated, the poorest and most disadvantaged groups lack the money and organizational capacity to sustain long-term provision in the absence of on-going external inputs. The assumption that poor communities have the capacity to manage and ensure a high quality of service provision is a questionable premise, yet it continues to inform much contemporary thinking about the desirability and sustainability of non-state provision.

While civic organizations have undoubtedly made an important contribution to service provision, whether in the form of direct health and education provision on a large scale in many parts of Africa, or by developing innovative community-based approaches and mobilizing demand for services in India and Latin America, their contribution should not be over-stated.[40] There are numerous examples of voluntary failure and a determined bid to replace state by voluntary provision raises problems of ensuring quality control, limited prospects for sustainability, pervasive amateurism, and inadequate coordination. For these reasons the state has to ensure that services are of high quality and delivered efficiently, but in view of manifest problems of bureaucratic failure and resource constraints, potential solutions lie in the creation of *collaborative, synergistic partnerships* between state and non-state providers. Such partnerships are premised on a scenario where the state has overall responsibility for ensuring a coherent policy framework and the bulk of financing, while civic organizations perform an essentially catalytic role, fostering innovation and community initiative, while avoiding a wholesale transfer of responsibility for the financing and provisioning of resources to the voluntary sector.

At the same time, there is something truistic and 'motherhood-and-apple pie'-like about abstract notions of the alleged benefits of *synergy* or *collaboration*, as in similar paeans to the alleged virtues of *community*, *participation* and *civil society*. As we have seen, not only is the potential complementarity between state and civic organizations dependent on a complex array of enabling conditions, but even where these are present the process of organizing synergy is delicate and often tortuous.

Given these problems, if one regards efforts at organizing synergy to be a strategic, long-term priority for improving service provision in developing societies, how can developmental thought and action be re-oriented to facilitate the task? First, it would suggest an intellectual approach which recognizes the separate importance of both public and civic institutional sectors. This would contrast with dualistic paradigms which disparage the state or belittle civic action. Over the long term the state is likely to be of crucial importance in organizing and financing of social services. Moreover, no comprehensive system of social provision, whether civic or commercial, is likely to work satisfactorily without properly constituted state authority and institutions. Second, this new paradigm would also extend to include systematic consideration of the institutional character and effectiveness of external agencies engaged in development

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[40] The view that civic organizations are inherently or invariably superior to state or market alternatives is referred to by Uphoff (1993) as a 'populist fallacy', but retains great force among NGOs and official aid donors.

interventions. Since external agencies – whether civic, public or international – are often central actors in efforts to organize synergy, there is a need for greater 'reflexivity' on their part, a willingness to apply the same rigorous forms of analysis to themselves that they apply to their domestic collaborators and clients.

Third, as we argued earlier, a more balanced and inclusive institutional perspective would require a rethinking of some of the concepts currently influential in the field. Notably, the notion of social capital could be extended beyond civil society to cover the public realm and the public-civic interface. Relationships of 'trust' and 'reciprocity' are not qualities confined to the civic realm. Concern with the public realm would relate to the creation of efficient and accountable public institutions populated by people whose motivations extend beyond crude self-interest or rent-seeking. Concern with the interface would seek to identify relations of mutual trust, respect and cooperation across the state/society divide which are the fundamental underpinnings of any effort to organize synergy.

At the practical level, the detailed experience of action to organize various forms of synergy, co-production and partnership can be drawn together in the search for potential lessons and best practice and new models of project/programme design which can be successful in achieving effective complementarity between state and voluntary agencies. The results of this kind of work would be valuable in bringing about a cumulatively clearer specification of the precise factors – both favourable and unfavourable – which condition the success of efforts to organize synergy, the precise measures which may prove effective in remedying the inherent difficulties involved, the alternative ways in which inter-institutional collaboration can be organized and the specific areas of service-provision where this collaboration may be particularly appropriate.

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