#4

Documento de Trabajo del IPES
Estudios comparados

"Against the State, With the State, Within the State: The Risks of Being an NGO in a Context of Health Reform in Santiago and Montevideo"

Javier Pereira

IPES

Universidad Católica
DAMASO A. LARRAÑAGA • URUGUAY

EMBAJADA DE ESPAÑA EN URUGUAY
COOPERACIÓN ESPAÑOLA

CDD 300
ISSN: 1510-5628

Serie Documentos de Trabajo del IPES / Colección Estudios Comparados Nº4
Las naciones presentan diferentes niveles de desarrollo social, diferentes estructuras de oportunidades así como diversos grados y tipos de pobreza y exclusión. A su vez enfrentan estos desafíos de manera diversa. Esta serie pretende ofrecer panoramas comparados de desarrollo social y extraer lecciones de dichas comparaciones que permitan a la comunidad académica y a los tomadores de decisión conocer mejor las realidades nacionales, sus niveles relativos de desarrollo y las causas detrás de logros y problemas del desarrollo humano.

Programa IPES
Facultad de Ciencias Humanas
Universidad Católica del Uruguay
Dep. Legal 326.861

ASA Paper

Against the State, With the State, Within the State: the Risks of Being an NGO in a Context of Health Reform in Santiago and Montevideo[1]

Javier Pereira

January 15th, 2005

[1] Paper submitted to the ASA 2005 annual conference. Please direct all comments to Javier Pereira at jpereira@mail.utexas.edu
Paper enviado a la conferencia anual 2005 de ASA. Por favor envie sus comentarios a Javier Pereira, jpereira@mail.utexas.edu

INTRODUCTION

The need of a systematic assessment of the impact of globalization forces upon the nature of governmental and non governmental structures has been the motivation for recent calls for further research among prominent political sociologists in different parts of the world. For the Latin American region in particular, the lack of research about the changing role of non governmental organizations (NGOs) has been particularly severe leading to a spread of stereotyped visions about the effectiveness and advantages of these structures relative to public agencies. The local manifestation of global processes of decentralization, economic liberalization and democratization has been transforming the landscape of Latin American NGOs and their linkages with governmental structures. Administrative and political decentralization has become a major trend as promoted by multilateral financial agencies such as the World Bank, the Inter-American Development Bank and the International Monetary Fund. After overturning authoritarian regimes in the 1980s and 1990s formal democracies have gained ground becoming current currency in most countries of the region. Also waves of free trade, reduction of tariffs and greater openness of local economies prevailed with the implementation of more than one decade of neoliberal policies.

At the national level these global forces resulted in the emergence of new institutional arrangements as part of governmental efforts to effectively address community needs and fulfill citizens' expectations in fields as diverse as education, security, employment and health. Under pressure to reduce the burden of public deficits, central and local governments have been patronizing the transfer of social service delivery to non governmental organizations and other institutional formations developed at the frontiers of the State, the market and civil society. However, evidence about the impact and effectiveness of these new institutional arrangements still remain uncertain, with their benefits and risks standing substantially unexplored (Edwards and Hulme 1996). Compared with other fields of social policy, this lack of research has been more acute and severe in the domain of health care services where the deterioration of the public network and the advancement of a new wave of reforms have called for an urgent examination of the new scenario and a revaluation of current forms of distribution of public goods.

Additionally, the changing political meaning of non governmental action in the sphere of health care services requires a new understanding of the identity politics that lies behind the increasing participation of this type of organizations (Dagnino 2004). The analysis of the identity politics of the NGO phenomenon unveils new meanings for the notions of citizenship, participation and democracy, challenging our current understanding of these organizations. In terms of citizenship we may inquire about the effects that the increasing participation of NGOs have on the entitlements and rights for individuals and groups. We may also examine what does the greater role of NGOs mean for the equal access to quality health care of poor and undeserved communities. Similarly, pertinent questions arise about whether or not NGOs are enhancing opportunities of genuine participation for their constituencies and citizenry in general. It is worth noticing that, though focusing on the same actors, there is a divorce between the literature on NGO performance and efficiency, and the one that examines their cultural and identity politics. Hence, our research relies on the assumption that both corpus of literature have

strengths and they need to be connected if we aspire to increase our understanding of the NGO phenomenon.

For the primary exploration of our field we have selected a comparative approach between two countries in the Southern Cone of Latin America: Chile and Uruguay. Beyond material reasons of accessibility and familiarity, theoretical and contextual arguments make the case for the relevance of this comparison as will be discussed in further detail below. Two fieldwork trips to Santiago and Montevideo in the summers of 2003 and 2004 provided rich ethnographic data and archival information for the analysis of the health related NGOs and their liaisons with governmental agencies. Besides this, one year of distance between the first and second visit to these capital cities permitted to observed changes across time accruing the temporal dimension in our analysis. In both countries, aspects related to health care reform and medical services were extremely salient during my stays, with outstanding visibility in the press and ranking high in public agendas of governmental officials and civil society organizations. In Chile, the approval and implementation of national health reform plan (called *Plan AUGE*[2]) constituted the major political theme under discussion in my two visits to Santiago. In Uruguay, current administration led by President Jorge Batlle has dismissed five health ministers in the last four years due to several crisis originated in inadequate responses to population health demands.

More generally, the information collected across countries in both instances reflect ongoing processes of substantial change among actors in the health arena and the apparition of new forms of articulation between them. While the States' agendas were pervaded by debates about health reforms to advance equal access to health care, intervening market institutions were also called for reforms as a result of their low levels of accountability, lack of public control or excess of profit orientation. Likewise, national and international organizations of civil society also become –direct or indirectly- involved in these transformations. In the wake of restructuring in the public health system, non governmental organizations have increased their role as linkages between the community and health services, especially among poor and underserved clients. Multilateral organizations and international banks also emerged as critical players with the role of providing the necessary funding and pressuring the States to introduce the reforms needed to rationalize the system.

In what follows we will first introduce the problem of NGOs as discussed in the literature in order to provide some theoretical background for our findings. Next we will turn to the analysis of the context variation across our selected countries and the methodology deployed in both summer fieldworks. The final sections present the main findings of our exploratory study, organized around the impact of decentralized policies in the opportunities for NGOs and the observed role that these organizations have in the domain of health. The conclusions presented in this report need to be taken as preliminary findings of a major research project which will constitute a doctoral thesis. Hence, the purpose of this research report was to assess the feasibility and potential of the addressed topic as a subject for a PhD dissertation and allow a first exploration of the world of health NGOs in the Southern Cone.

[2] Spanish accronym for "Acceso Universal con Garantias Explicitas", which stands for "Universal Access with Explicit Guarantees."

THE PROBLEM OF NGOS AS DISCUSSED IN THE LITERATURE

The assessment of benefits and advantages of NGO's participation in the delivery of public goods is far from being unanimous among scholars and policy analysts. The examination of particular cases and the specific evaluation of their achievements and drawbacks have been the subject of much recent scholarship in the field of sociology and related social sciences. However, the active role of civil society organizations in public policies and social programs shouldn't be seen as a new phenomenon. Third Word historians and scholars (Cruz and Barreiro 2000; Guerra 2001) have documented the importance that the Catholic Church and other religious institutions had since early colonial times in addressing the needs of vast sectors of the population in Latin America. In the Southern Cone countries like in other sub-regions Catholic congregations and fraternities took substantial part in providing for the educational and health needs of different collectivities and social groups. But if civil society involvement has been documented as a process rooted in the early consolidation of Latin American societies, then, what is be considered new or original in present times as to deserve so much attention? The answer is that despite this historical participation of civil society in addressing community needs, only recently has this been signaled as the preferred and recommended channel for providing services.

Multilateral agencies followed by national governments have contended in favor of delegating responsibilities to non governmental organizations based on arguments of cost effectiveness, accessibility to communities and organizational flexibility, all which are claimed to be relative advantages of these institutions vis a vis governmental structures. But after two decades of euphoric enthusiasm with NGO performance, the 1990s witnessed a moderation of these claims of success. Several development practitioners and advocates introduced some skepticism about the effective advantages of NGO participation, and called for further research before continuing to praise NGOs results. In any case, -as Edward and Hulme have stated- "the absence of a large body of reliable evidence on the impact and effectiveness of NGOs make it difficult to generalize about this subject" (Edwards and Hulme 1996: 4). As these authors have documented, reasons about their cost-effectiveness and greater access to poor communities than the states, may be derived from self-assessments more than systematic examination, constituting not sufficient evident to draw generalizable conclusions. It is clear then that beyond simplifying labels and generalizations, unevenness and diversity also need to be acknowledged as intrinsic characteristics of the NGO universe. (Bebbington and Riddle 1994; Carroll 1992).

An alternative approach to the analysis of NGOs' nature and role may be recognized in the work of cultural scholars who discuss the political implications embedded in their contested identity. (Dagnino 2004; Alvarez, Dagnino and Escobar 1999, Fisher 1997). Instead of comparing NGOs performance vis a vis pure public or private forms of services delivery, these authors concentrate on the analysis of the political meaning of NGOs' actions and recent transformations. Drawing upon cultural and political analysis of social change, their scholarship examines the identity politics of NGOs as social movements and discuss the role that these organizations play amidst hegemonic neoliberal forces. In this perspective the transference of responsibility to and greater involvement of NGOs in "governmental activity" is seen as part of a process of advancement of the economic and political neoliberal project. In Gramscian language,

these authors perceive these organizations in civil society as the battlefield where hegemonic and counter-hegemonic models of organizing the society confront and dispute. By using the NGOs structures to accomplish their goals, national states have succeeded in de-mobilizing their former bases of legitimacy and disarticulating their challenging power.

Furthermore, notions of citizenship and participation are being reshaped and deconstructed by means of increasing NGO-State partnerships. Consolidated as political expressions of resistance to military dictatorships in the 70s and 80s, NGOs in Chile and Uruguay acquired their legitimacy as representatives of social movements who were banned from public life. By prioritizing the professional and expertise dimension over their representative character, governments are emptying NGO action from its political content, rendering them as mere "technical" organizations. Consistently, the participation of NGOs in the implementation of target policies is conceived as another mechanism in this process of de-politicization by rendering targeted citizens – usually defined as poor or "in need"- as passive and mere receptors of public assistance. Pushing their analysis further, authors like Evelina Dagnino and Sonia Alvarez also examine the manner in which the notions of solidarity and social responsibility have been reshaped by ongoing process of *"NGOization"*[3] of politics. By channeling and promoting volunteerism and individual community service, these authors claim that NGOs emphasize the private dimensions of solidarity over more collective notions of rights, entitlements and social responsibility.

Thus far, we have presented two different approaches to NGO participation in public policy. Drawing upon different theoretical backgrounds, these perspectives are usually treated separately in the literature, privileging an "either-or" approach. For the analysis of the data discussed in this paper, we intend to overcome this division and bring these perspectives together building on their respective strengths and complementarities. As we will approach them, questions about the effectiveness of NGO performance are intrinsically associated with the potential of NGOs to promote sustainable development among poor communities. Consistent with this viewpoint some authors have claimed that lack of downward accountability and detachment from communities have become major problems of NGOs activities (Farrington and Bebbington 1993).

Similarly we may hypothesize that the transformation operating at the level of the political meaning of the NGO project substantially affects their results and policy outcomes. By aligning NGOs efforts to governmental objectives, states have lessened the capacity that NGOs have to hold them accountable. This has been aggravated by increasing processes of financial dependence on the State in the face of reduction of international cooperation with the organizations of civil society. As a result, NGOs may see their margins of autonomy reduced affecting their power to challenge governmental structures and to bring innovation to the policy agenda. In this respect, our research examines the implicit risks that are associated with the cooptation of health NGOs as a result of the advancement of neoliberal agendas by governments and multilateral

[3] The term usually refers to the process of increasing participation of professional NGOs in the formation of public policy. The process of "NGOization" implies a specific relation between the state and well-established non-governmental organizations who provide the necessary information to design and implement the policy. (Alvarez 1997).

organizations (Edwards and Hulme 1994) and their effective contribution to development.

A more specific justification for this study is found in the distinctive focus built around the particular nature of health related organizations. As one of the most relevant and sensitive areas in public policy, the field of health provides a unique instance of the role of NGOs in advancing community welfare. Additionally, health institutions operating at the national or municipal level can offer an interesting account of the impact of global forces on local settings. Maybe in no other field of public policy might we succeed in tracing so clearly the impacts that trends of decentralization, privatization and democratization have had on communities and municipalities.

Decentralization reforms have been pervading the political structures in Chile and Uruguay at a different pace, though the former has taken the lead with substantial reforms implemented under the Pinochet regime. The reforms implemented in both countries have targeted specifically the institutional arrangements for the provision on health services, by transferring direct responsibility to the municipalities in the case of Chile and increasing the role of the community in the management of public hospitals in Uruguay. Also the process of economic liberalization had significant impact in shaping the institutional landscape of health markets producing substantial changes in the provision of health care services. Despite national differences, the need to remove the burden from public health clinics and hospitals operated as an incentive for the consolidation of a market of health providers in both countries[4]. Furthermore, the consolidation of democratic regimes across the region has moved NGOs to the front of the scene as major players in the implementation of policy designs. As we have seen, these changes have recognized NGOs as the preferred channel for reaching the needs of poor communities. However, the effects that this recognition have in the specific domain of health services is still uncertain as is the extent to which the State has effectively diminished its role as has occurred in other policy areas. In any case, there is no doubt that the above mentioned changes have an impact on the role of non governmental organizations, though the direction and nature of these transformations remain to be analyzed.

A final dimension that accounts for the relevance of this study derives from the direct effects that transformations in the "health institutional landscape" have on the access to quality health care among disadvantaged and disenfranchised groups. Health reforms and the institutional redesigns that come along with them usually aim to address critical issues of equity and quality of the services provided. It is worth noticing that -compared with other major policy fields-, health care has been one of the most resistant areas to reformist efforts, as has been noticed by Chilean and Uruguayan scholars (Filgueira, 2003; Arteaga 2003). In the case of social security, for example, both countries have implemented rather successful reforms that permitted them to amend their traditional loss making system. In education, though results have been highly contested in both countries, current and past administrations have been advancing serious reformative plans aiming to close the inequity gap at all levels of the educational cycle. Not surprisingly, it has been in the field of health that reforms have been mostly delayed and

[4] The terms ISAPRES in Chile and MUTUALISTAS in Uruguay refer to private entities that operate within a regulated market to ensure the provision of health care services to formal workers through social security contributions and others privately insured.

the equity gap has been increasing. While the effects of social security and educational reform may be seen in economic stability or greater job opportunities, the consequences of delayed health reforms are dramatically evident in the loss of human lives. As a matter of fact, during our second visit to Santiago some interviewees referred to people who have died since our fist stay due to bureaucratic inefficiencies or interminable "waiting lists" in public hospitals.

It is, however, surprising that the health field has been underplayed in the literature when studying the role of NGOs in the region. A tentative explanation –one we brought to the field for further examination- may be articulated around the fact that the intervention of NGOs in health and medical services hasn't been as salient as in other policy fields. Another plausible explication relies on the predominance of a "two tiered" health system in Chile and Uruguay, which somewhat relegates the role of NGOs in health to a secondary or third level compare with purely public or private providers. Despite diverse attempts to reform the organization of their respective health systems, the organization of healthcare in Chile and Uruguay is still dominated by a strong tradition of public services which are deeply rooted in the collective imaginary of their populations. Finally, the fact that health services in the hands of NGO are usually embedded in a wider range of social responses to the community, may be another reason for preventing the independent conceptualization of these services as separate from other policy fields. Though all these factors may provide reasonable arguments, they finally confirm that examining the limitations and potentials of the role of NGOs in health care is an imperative in terms of the analysis of health outcomes and larger policy discussions.

CROSS NATIONAL VARIATIONS

The observed contextual differences between Chile and Uruguay provide an interesting ground for comparison and allow us to take advantage of the virtues of sociological comparative analysis. The observed natural variations in national political and economic structures suggest contrasting scenarios for the analysis of non governmental arrangements. From a methodological perspective the characteristics of the studied countries have the potential to enhance our understanding of the role, transformation and effectiveness of NGOs.

Uruguayan and Chilean healthcare systems are usually categorized as "two tiered" with public health networks and private providers (partially funded through social security contributions) covering most segments of the population. However, this classification veils some significant differences among countries that are particularly relevant for the purpose of our study. In Uruguay collective medicine constitutes a major actor in the national health system with half of the population being covered under this modality. (Veronelli, Nowinski, Roitman, and Haretche 1994).

Table 1.
Distribution of Uruguayan population according to health subsystem used
Source: National Census of 1996, cited in PAHO, 2002.

Subsystem	%
Public Health Ministry	33.7
IAMC-Collective Medicine	46.6
Armed forces health subsystem	4.2
Police health subsystem	1.2
Other	1.2
Lack of coverage	11.7
N/A	0.9
Total	100,0

The data in Table 1 reflects the importance of collective medicine institutions as the major providers in the country compared with other existing organizations. This is relevant because "IAMC" (Instituciones de Asistencia Medica Colectiva[5]) in Uruguay constitute a differentiated actor from the public network and the purely private system. These organizations are registered –in the vast majority- as non for profit organizations creating a debate about whether they might be considered NGOs or not. Though this may constitute the topic of a specific paper we chose to avoid aprioristic definitions and

[5] "Instituciones de Asistencia Medica Colectiva" refers to the technical name that these organizations are given by the law, which in English means "Collective Health Care Medical Institutions".

visited the field with broader and inclusive definitions. Additionally, the purely private insurance, though rapidly expanding, is still an extremely small category in the case of Uruguay.

In Chile, despite efforts to increase the coverage of the private sector, the public subsystem is still the largest provider of health care services in the country. Figures in Table 2 reflect the relative incidence of public and private subsystems in a comparative perspective for the year 2003. Unlike Uruguay, the category of "collective medicine institutions" is practically non-existent, being replaced by profit making institutions denominated ISAPRES[6]. As a group, these organizations constitute the second largest subsystem in the country and -though they are funded through workers and employers contributions to social security-, they operate as fully private and are guided by market oriented criteria. The reference to "other" providers in Table 2 alludes to other private insurance services, which are not included in the ISAPRES category. When examine in temporal perspective, it is worth noticing that the Chilean distribution among subsystems shows that the reforms of the 1980s resulted in segmentation of health care as has been pointed out by some analysts (Arteaga 2003).

Table 2.
Distribution of Chilean population according to health subsystem used (2003).Source: own elaboration based on data from the Ministerio de Salud de Chile (2004).

Subsystem	(thousands of persons)	%
Public	8.809	68,3
ISAPRES	1.927	17,6
Armed Forces	318	3,1
Other	1.550	11,07
Total	12.801	100,0

Also in the domain of decentralization policies Chile and Uruguay exhibit significantly differentiated paths in the administration and regulation of their public health services. In Chile, decentralization reforms implemented under the Pinochet regime sought to lower the burden on the public health budget. As a result, the administration of health care was divided into regions and primary health clinics were transferred to the orbit of municipalities. In Uruguay, the advance of decentralization policies was subtler, less incisive and somewhat resisted. The approval of a timid reformist law in 1987 promoted the decentralization of public hospitals through the creation of a public organism (ASSE[7]) in charge of administering these entities. Under recent administrations, uneven efforts have been timidly oriented towards the transformation of public hospitals into decentralized units with greater levels of financial and administrative autonomy. As of yet, the enduring centralized Uruguayan political structure and the pressure of interest groups have rendered decentralizing reforms substantially ineffective.

[6] ISAPRES refer to the Spanish acronym for "Instituciones de Salud Previsional" in Chile.
[7] ASSE refer to the Spanish accronym for "Asistencia de Servicios de Salud Externos" in Uruguay.

Beyond contrasts between the two countries, health reforms are unequivocally at the top of the agendas of Chilean and Uruguayan governments. In Chile, the current major reform of the national health system (Plan Auge) has become the main social program of President Lago's administration. The core of the transformations being currently implemented aim at a broader fulfillment of the principles of equity and universal guarantees for all Chilean citizens. The advanced reforms were a clear response to urgent claims for greater equity in the public health system and increasing accountability of public hospitals. Also central to the reformist objectives was the need to include more transparency in the management of private providers and clearer rules in terms of their costs and services.

In Uruguay, despite increasing demands from users, changes have been repeatedly postponed and delayed lessening the vitality of the health system. There has been a widespread resistance among the political establishment against affecting corporate interests, which has limited the necessary reforms. Across diverse fields of public policy, the Uruguayan mode has been defined by political analysts as more gradual and usually pursuing "middle way" reforms. However, in the case of healthcare policies the reforms have been postponed and the State has been forced to repeatedly rescue private providers in bankruptcy and solve the constant crises of a saturated public health network. Based on these reactions, a surprising lack of initiative and a tendency to protect the interests of collective medicine institutions, some scholars have labeled the Uruguayan health policy as a process of progressive "privatization by default" (Filgueira 2003). By avoiding substantial institutional reform and just rescuing bankrupt health providers, the Uruguayan State maintains of the inefficiencies of the private sector.

Table 3.
Contextual differences for comparative analysis across studied countries (Chile and Uruguay)
Source: own elaboration.

Characteristic	**Chile**	**Uruguay**
Health insurance	Two tiered system	Two tiered system with Collective medicine
Public health care	Universal	Universal
Decentralization	Municipalization of primary health care	Centralized
Health reform	Plan Auge	Gradualist
State reform	Advanced	Embryonic
Welfare reform	Market driven	Mixed
Cultural diversity	Some (8%)	Less
Macro-Economic Crisis	1970s	1980s / 2000s

Finally, the principal variations analyzed across countries are summarized in Table 3, including more specific aspects like ethnic diversity and period of major economic crisis. These contextual references serve as the political and social conditions that frame the transformation of the structures and roles of local NGOs. They constitute an important component of our methodological design allowing for differentiated settings in which to contextualize the observed outcomes.

METHODOLOGY

Our research used a comparison between Chile and Uruguay focusing attention on three crucial aspects: a) the evolution, role and potential of NGOs structures in the field of health services, b) the mode in which NGOs are affected by political and economic structures, and c) their interface zones with the governmental structures, other organizations of civil society and international institutions. Given the exploratory nature of our study, we restricted our fieldwork observations to the universe of non governmental health organizations operating within the boundaries of the capital cities of these countries. Thus, Santiago (Chile) and Montevideo (Uruguay) were the destiny of two summer fieldwork trips where I spent around two months in each city.

The initial challenge, anticipated in the preparation of our field activities, referred to the selection of the appropriate criteria to identify a "health NGO" and therefore, to construct an exhaustive list of organizations that could operate as a tentative universe or sampling framework for our contacts. Following a practical criterion based on the availability of accessible and updated information I identified the units of observation drawing upon lists provided by local directories, public programs, NGO associations and other secondary sources. In both countries exhaustive and partial attempts to build national and city wide directories of NGOs led to quite reliable sources daily used by clients and organizations seeking information about the resources available in the community. Though they do not provide in depth information about the organizations, they constitute a good source for identifying their names, contact information and main fields of intervention. There are also many social programs run by public agencies, municipalities or more hybrid arrangements that operate with NGOs as counterparts making ad hoc or permanent contract for the delivery of public services. The directors and officials of these programs constituted an invaluable source of information for the identification of and access to the existing NGOs in the domain of health. Additionally, active national associations of NGOs (two in Chile and one in Uruguay) have registries with some basic information on their members. It is worth noticing that in some instances these associations have conducted profile studies and in depth analysis of the changing characteristics among their affiliated organizations, serving as useful secondary sources for our research. Once organizations were identified and contacted the use of snowball sampling constituted an effective tool to assure that all significant organizations intervening in the health field were brought to our attention.

After grasping a fair idea of the universe of local organizations in each capital city, the NGOs identified were grouped according to their main field of intervention within domains of health topics. This procedure proved to be very helpful as our initial objective was to inquire about their concentration and density across sub-fields of action and the specific type of health services they provided. The grouping process yielded a set of

categories of services/areas described as one of our main findings in further sections of this paper. Additionally, purposive sampling was conducted inside each category to select particular NGOs for in depth examination and gain further understanding of their institutional strategies. These cases were selected from within each of the field categories based on the following three criteria: a) "typical" cases which may well be considered representative of the rest of the category, b) "innovative" cases which promote new approaches and strategies as responses to the problematic situations in each field of intervention, and c) "relevant" cases referring to those organizations with high coverage or impact in terms of the extension of their actions. In each city the assistance of local informants was crucial for the identification of the specified cases in each category and –therefore- completing the purposive sampling process. In this respect we relied heavily on the expertise of our counterparts in the field as a way to assure that the selected organization matched the three mentioned criteria. In this process, particularly important was the support provided by members of the program *"Ciudadania y Gestion Local"* in Santiago and faculty members of the *"Universidad Catolica"* in Montevideo.

To survey the selected organizations the researcher adopted a combination of techniques depending on the natural possibilities offered by the visited institutional settings. According to the situation encountered in each case one or more of the following methods were adopted within an ethnographic approach based on intense field and site observations. The principal techniques deployed by the researcher in the field refer to: a) in depth interviews with NGOs directors or project leaders, b) participant observation in some of the staff/board or participants meetings when this was offered, c) direct observation of the area and informal contacts with local informants, d) archival analysis of institutional documentation, such as mission statements, evaluation reports and regular publications of the organizations. Complementarily, a significant number of interviews were conducted with key informants from central government and municipal agencies involved in public health activities as well as staff members from local delegations of multilateral development organizations. Taking advantage of our previous knowledge of academic institutions we also contacted senior researchers and faculty members from national research centers and public/private universities. Beyond the information directly provided by the interviewees in these instances, valuable sources were accessed in the form of ongoing research reports and institutional publications.

MAIN FINDINGS

For the purpose of this research report, the results are organized in two main sections: one around the issue of decentralization and the other focusing on the role of health NGOs. In the first section we will discuss the impact that current processes of administrative and political decentralization have on the structure of opportunities for non governmental organizations. More specifically we will try to assess the consequences that municipalization and a shift towards more technical and managerial central states –as occurred in Chile and partially in Uruguay- entail for the development of different types of services and strategies across the NGO movement. At this stage, we will attempt to relate the advances in civil society participation and State reform, with their differentiated effects upon the NGO community and its relationships with public structures. In the second section the core of our analysis is devoted to the identification

of the main areas where we found NGO intervention and some plausible explanations for the observed commonalties across countries. Furthermore, we will examine the different approaches that NGOs adopt in their relation with the State and the implications that these differences may have for the future of policy making. We will then conclude with some final remarks on the principal findings across both sections and bridging these results with current policy challenges for governmental and non governmental structures.

THE IMPACT OF ADMINISTRATIVE AND POLITICAL DECENTRALIZATION IN THE ENHANCEMENT OF OPPORTUNITIES FOR NGOS

One of the most contrasting results of the comparative analysis between the two countries may be observed in the greater levels of mobilization and visibility that we found in Chilean civil society compared with its parallel structures in Montevideo. During our visit to the field we collected evidence about what some of our informants called the "new boom" of civil society mobilization in Chile. The proliferation of spaces for citizen participation and collective initiative has been recently documented by some Chilean scholars (De la Maza 2001). As we could observe in our visits to the municipal network of health centers in La Florida[8] (Santiago) the irruption of this new wave of community and citizen participation is significantly noticeable around primary clinics and public hospitals. Most of the experiences we encountered refer to associative spaces integrated by groups of neighbors and users of public services who organized themselves to collaborate with the local health centers in order to promote or achieve specific health objectives. These groups tend to have direct and fluid ties with the authorities and personnel of the municipal clinics with which they have a relation of dependency and resource asymmetry.

As documented in our fieldwork, these groups bring together citizens from different socio-economic backgrounds who feel affected by similar health conditions or community members who share common concerns about sensitive health issues. Though diverse and heterogeneous in nature, some of the most frequent types of associative expressions include patients with chronic diseases, groups of health promoters, elderly people who attend the same centers, women sharing a common health concern, relatives of juvenile drug abusers and groups of teenager mothers among others. Though being private spaces for citizen association and community initiative, most of the experiences were organized around a public service that operates as a structuring factor for the life of the groups. In some occasions the dependency upon the public facility may be expressed through the geographical proximity of the group to the services, or the fact that some meetings are explicitly held at the municipal clinic. At times, the convocation to create the groups was activated by the initiative of the director or staff members of the municipal clinics, in need of extended community support to achieve the health and preventive goals centrally defined by the health ministry. As the system works in Chile, municipal health centers are obliged to meet the health objectives established by central authorities and a part of the governmental funds is

[8] La Florida is a middle class *comuna* in metropolitan Santiago, mainly populated by working families, with scattered concentration of poor and low income residents.

transferred based on results and the goals accomplished. A significant example of this type of situation is epitomized in the valuable role –as told by its members- played by different groups of elder residents who collaborated with the national public campaign that prevented the spread of the cholera virus in specific areas of Santiago some years ago.

In the same spirit, the Uruguayan decentralization law of 1987 encouraged the presence of "supporting groups" (*grupos de apoyo*) to improve the management of public hospitals in the country. However, our visit to the field yielded scant evidence of the existence of these spaces, and when they were found, they were isolated exceptions[9]. Similarly, the mobilization of the community and citizens around the primary health clinics of the *Public Health Ministry*[10] hardly ever materialized in visible spaces for the organization or action. Nevertheless, some germinal experiences of citizen participation were documented around the primary health centers run by the municipality of Montevideo[11]. This network of *"policlínicas barriales"*[12] is outside the orbit of central government administration and constitutes a parallel structure of primary centers that tend to operate without coordination with their ministerial partners.

However, two features of these experiences are worth noting. In the first place, the local government of Montevideo –like any other in the rest of the country- is not constitutionally mandated to provide health services. As we have seen, the provision of all levels of public health assistance still remains in the hands of central government structures, leaving intervention in this field to the discretion of each municipal government. Secondly, as a response to the increasing demands for health services, the municipality of Montevideo is currently running a total of twenty clinics in a city that holds around half of the country's population[13]. Additionally, most of these clinics are located in low income areas of the city and were established to address the primary health care needs of underserved communities whose demands exceeded the existing services. Despite their limited character and their concentration in low resource areas, a higher number of participatory experiences were found around municipal health centers.

Promising as these experiences may be, it is clear that the municipal government doesn't have a systematized model to promote or encourage community participation, as was acknowledged by municipal officials in our interviews. The absence of a suggested path that could be taken as a reference for action –with the exception of general guidelines- contrasts with the Chilean case where a specific model to channel community participation has been implemented (with the corresponding economic stimuli to promote it). Among the experiences we found in Montevideo, we documented some groups of women administering *"banks of contraceptives"* in coordination with the municipal clinic as well as scattered groups of neighbors that supported preventive campaigns in the center's area of influence. In global perspective, these experiences

[9] Our observation on this issue coincides with the perception expressed in the final report of the "Taller de Consulta sobre las Prioridades de Investigación en Políticas Públicas de Participación Ciudadana en Salud en el Cono Sur", Buenos Aires, March 2004.
[10] Ministerio de Salud Publica, M.S.P.
[11] Local government of the capital city known as *Intendencia Municipal de Montevideo* or by its acronym *I.M.M.*
[12] This is the local name for the municipal centers usually allocated to serve the primary health needs of low income areas of the city.
[13] According to the last census conducted in 1996 Montevideo has a population of 1.344.839 inhabitants

may well by characterized by their unevenness across neighborhoods and their lack of a programmatic framework[14] making any generalization difficult.

In both countries, the participation of community organizations in areas related to municipal services creates the conditions for clientelism. The participation of these groups is usually managed or tutored by clinic authorities who tend to take advantage of it for their specific objectives. Thus, participation in this context is never seen as a right or as a demand, but as a natural and spontaneous interaction with scant impact on the quality of the services. Using a mechanism that reinforces dependency, municipal governments usually provide some funding to these community organizations through project competitions. Given their small size and reduced staff what they receive is hardly enough to sustain their needs for survival and basic operation. Municipal funding creates favorable conditions for clientelistic attitudes since it makes community organizations more vulnerable to the desires and strategies of local government.

Consequently, when seeking funds or financial assistance grass roots or community organizations usually turn to local/municipal sources due to several reasons. In first place, we have observed that these small organizations are usually excluded from competitions and funding sources at the level of central government which usually tends to assign resources to larger and more professional NGOs. Secondly, there is an implicit division of labor that operates between more structured, professional organizations and grass roots, community initiatives. An illustration of this type of situation is the institutional landscape of the municipality of "Lo Espejo" (Santiago) where a traditional NGO with great legitimacy in the area restrains from submitting projects to the local government to avoid interference with grass roots organizations. A final reason for reinforcing clientelism and dependency refers to the issue of accountability. Since local authorities are elected by constituencies living in the same jurisdiction, and every four years they are held accountable by voters, it is not surprising that municipal officials tend to be complacent with local organizations.

Following a similar –though symmetric- logic, we have observed that larger and formal NGOs turn to central governmental agencies and international organizations when they seek funding for their projects[15]. As in our previous analysis, the reasons for this association are diverse and need to be analyzed separately. When newly elected government officials in both countries took office as a result of democratic restoration, they required professional and policy making expertise to replace the authoritarian establishment. As a result, they drew upon professional members of NGOs in order to fulfill the need of technical staff for ministries and specialized units at central government. It is not difficult then, to see how these strong ties between current ministerial staff and their former employers constitutes a first reason that reinforces this alignment. Secondly, central government agencies also tend to require counterparts with high a level of professionalization in order to implement or advance projects that entail a certain level of complexity. The professional staff -and the implicit skills- that this type of projects requires are not common assets among small and community based organizations. In third place, as the division of labor of labor operates, this type of NGO

[14] This conclusion, though it may be contested, was extracted from the report provided by the director of Health Services of the Municipality of Montevideo on interview conducted in July 2004.
[15] In fact, thinking in "projects" as their temporal units of intervention is a classic feature of more formal NGOs.

usually operates as an intermediary between the public agencies and grass root organizations that need channels to central decision-making.

Transformations in the orbit of the State affect these dynamics. The move towards a more "managerial type State" has been another driving force of State reform, one that is usually coupled with decentralization trends. As a result, the process of decision making and policy formulation are now placed in the hands of specialized governmental units. Though they tend to be under ministerial supervision -or even reporting to higher levels in the hierarchy- these groups of professionals enjoy a significant degree of autonomy in their decisions. In Chile, for example, policy formulation about HIV/AIDS, mental health or elder care has been allocated to specialized units under the administration of health ministry but with an important degrees of technical autonomy. In Uruguay, a country where State reform is still a pending issue, technical and professional staffs are more subject to change or be dismissed when the political heads rotate.

Additionally, this model entails another facet of decentralization, which corresponds to the culture and attitudes towards NGOs – and civil society in general- that prevail among public officials. In Chile, efforts are in progress to build a culture of alliance and partnership between the State and NGOs. As part of these goals, Chilean government created a public agency with ministerial rank called *Division de Organismos Sociales.*[16] While strengthening the organizations of civil society, the goal of this office is also to promote citizen participation and prepare public officials for productive partnership relationships between the State and the NGOs[17]. In Uruguay, this "partnership culture" hasn't permeated the governmental structures sufficiently and has been observed only in confined enclaves within specific spheres of the State. When such a culture is embraced in Uruguay, there is usually excessive reliance on the personal preferences of public officials lacking sustainability across time. This volatile scenario has dramatic effects on the survival of NGOs that live in permanent uncertainty about their financial viability.

Summarizing, our analysis about the observed impact that decentralization of health services had on the structure of opportunities for NGOs, yielded conclusions at various levels. Above all, the process of municipalization of primary health clinics enhanced the availability of political and economic resources for local NGOs. This increase in the structure of opportunities is mediated by the transfer of health responsibilities to the local level, channeling more resources for activities that address issues of health promotion and health prevention at the community level. Also local authorities are willing to provide political support as long as the local organizations contribute to the attainment of municipal objectives.

However, a more indirect effect of decentralization refers to the segmentation of the NGOs universe according to their level of formality, structure and professional expertise. On the one hand, the group constituted by large, professional and traditional NGOs is characterized by greater access to funding opportunities at central level, with some of them receiving direct financing from international cooperation. As a natural consequence of their accumulated expertise, these organizations also exhibit larger incidence in the

[16] A subdivision of the *Ministerio Secretaría de Gobierno.*
[17] As part of our archival research in 2003 we had access to the manuals of the training courses that the agency was preparing for public officials.

process of policy formulation and policy evaluation. Being legitimated by their high levels of specialization and professionalization, these are seen as natural providers of services for specialized governmental structures in need of policy orientation. On the other hand, we encountered a multifaceted group composed by community and grass roots organizations which tend to lack a professional structure and are usually organized around the voluntary participation of people in the area. These organizations are more dependent on funding from local government and some of them rely upon alliances with the larger NGOs. Their role in this type of partnership is usually linked to the provision of local services for which they have a natural legitimacy given their ties to the community and their cumulative knowledge about their needs.

In third place, we have documented how decentralization has created greater spaces for citizen participation around municipal health clinics. However, the question still remains whether this participation has been capitalized primarily for the benefit of local authorities or whether these constitute effective spaces for local empowerment and the articulation of community demands. In any case, our exploratory analysis suggests that the prevailing political and structural conditions that surround these experiences nurture the ground for clientelistic practices and political alignments.

More broadly, as part of ongoing processes of State reforms, changes in the prevailing culture of public officials (at both levels, central and municipal) have been advancing a new vision of NGOs as occasional or permanent partner and collaborators with the public sector. As widespread as this perspective is becoming, it has a couple of limitations that are worth noting since not all public officials have welcomed this new perspective with the same enthusiasm. In both countries, the defense of particular corporate interests –frequently tied to public labor unions- may introduce some limits to the expansion of the new culture, which may be seen as a threaten to their position within the State structure. Similarly, some traditional visions of the State responsibility may distrust NGOs motivations and suspect their political intentions, preferring the concentration of responsibilities in the hands of public providers.

ADVANTAGES AND DISADVANTAGES OF NGOS IN THE PROVISION OF HEALTH SERVICES

Though it was one of our main objectives in the field, it was difficult to find pure “health NGOs” in our visits to Santiago and Montevideo. Instead, we found NGOs that provide health services, meaning that health related activities comprise just a part of larger and more ambitious institutional missions. It is common for these organizations to develop this type of activities as an attempt to articulate more integral responses to the community’s needs. The expansion in their activities as part of their efforts to reach out to their target population usually entails actions in the field of health prevention, health promotion and health education. However, institutional mission statements lack explicit references to the provision of health services, being usually defined in broader, social and promotional terms, meaning that they were not created to assist the community with specific medical issues. Nonetheless, several NGOs members asserted that their organizational mission statements perfectly fitted into broader and more integral definitions of health, ones that include bio-psycho-social dimensions of individual and collective wellbeing.

In relative terms, only a minority of the visited NGOs has explicit health statements in their missions and when this occurs, it usually corresponds to de-territorialized organizations, oriented towards particular health issues, more than to territorial based problems. Responses to problems derived from HIV /AIDS, mental health, or burns, are some of the examples that led to the emergence of this type of institution. When compared with organizations that exhibit a territorial scope of intervention, the latter tend to present a more diverse pattern of services while the former remain more specialized and focused.

Apart from statement definitions, in both countries we considered the fields where NGOs exhibited higher levels of intervention and involvement. Though a more precise operational measure will be required in the future, for the purpose of our exploratory study we focused on the type of health care domains that exhibited greater concentration of organizations, services and resources. In this respect, the presence or absence of NGOs in a specific field might be taken as an indicator of the potential strengths and advantages that these organizations have vis a vis State or profit oriented institutions. As a result, the majority of the organizations that were identified in both countries were grouped under one or more of the following categories: a) HIV/AIDS, b) Sexual and reproductive health, c) Drugs prevention/rehab and mental health, d) Elder care, e) Child maternal care. Also some less frequent residual categories were identified, to include a few organizations operating in the following domains : a) Intercultural health (basically organizations working with indigenous population in Chile), b) Users of public networks (promoting greater accountability of health services) and c) primary health clinics (transfer to NGOs administration though still under public system). Our analysis will now focus on the main findings surrounding the institutional NGO arrangements in these fields.

The field of HIV/AIDs may be considered one of the largest fields of work and activity for health related NGOs in both countries. This constitutes an interesting note if we take into consideration that neither Chile nor Uruguay are among the high risk countries in terms of the prevalence of the disease. A closer look at the institutional map of civil society in this field unveils a suggestive division among the organizations working on HIV issues. On the one hand, we encountered several groups of persons infected with HIV that tend to seek assistance and defend their rights through the coordination in larger structures that operate on a nation wide basis. Despite differences across countries, these spaces of articulation and coordination originated as responses to member's demands for quality services from the State, to promote changes in the realm of public opinion and to advance protective and anti-discriminatory legislation in the national legal systems. On the other hand, we found numerous organizations guided by solidarity principles that are trying to work on the prevention of the disease as well as to alleviate the consequences. Many of these spaces were inspired by religious congregations and –as an interviewee referred to them- they constitute the face of "civil society in HIV". Usually, these organizations are formed by professionals and volunteer personal who foster a more paternalistic approach compared with the "rights" perspective of the previous group. Not to be taken as absolute, this division line provides a useful insight to identify and portray existing differential patterns of relationship between civil society organizations and governmental structures. In this respect, the first group deploys a more political agenda and their goal is to advance the rights and demands of HIV patients. Contrastingly, the

second category of associations exhibited a more friendly approach to public services and is usually identified as less political, departing from the “rights” and “accountability” type of discourses.

The category of sexual and reproductive health organizations represents another major field of NGO concentration. This category, as heterogeneous and diverse as it is, integrates a vast group of organizations operating under the umbrella of sexual and reproductive health rights. This broad –and at times ambiguous- definition refers to organizations that work in the subfields of teenager pregnancy, domestic violence, abortion, sexual minorities and family planning. Also the HIV organizations as those described above can be allocated under this category since they focus on the advancement of a “sexual rights” agenda and –most of them- also offered services in some of these subfields. However, based on the salience of the HIV crisis and the large number of organizations working specifically on this area, we preferred to give these associations a separate treatment. As in the HIV/AIDs category, a similar division may be established in this case along the lines of those that are primarily service providers and those that focus on advocacy activities. Particularly among the latter, the “rights approach” has being gaining ground as a strategy to defend and promote the entitlements of disadvantaged groups –such as teenage mothers- in the face of public services and governmental agencies. As a result, these organizations have been increasingly confronting the State, monitoring the quality of service provision and mobilizing for the effectiveness of universal access. Coincidently with our perception, Molyneux and Lazar (2003) have documented a substantial increase in the number of organizations mobilized around gender issues in recent years for the Latin American region. The assertion holds true for both countries, though in Chile these organizations have achieved greater visibility as a result of their participation in public campaigns and significant involvement in high profile media debates.

Organizations working in drug rehabilitation, drug prevention and mental health treatments constituted a third major field of NGO involvement. The participation of civil society organizations in these areas has been extremely important in promoting new approaches and pushing ahead new models of intervention. Path breaking and highly professionalized organizations have been introducing new perspectives to prevent and cope with mental disorders and drug dependency. For the case of Santiago, our visit to the municipalities of La Florida and Lo Espejo permitted the identification of an array of local experiences that provided support to patients with mental disorders and drug consumers, in coordination with their families and the primary health centers. These organizations play a significant role inside their area of influence as they cooperate with the municipal clinics by acting as a bridge between the patients and the existing services. Additionally, they provide spaces for longer rehabilitation processes and act as supporting and coaching groups for the patients and their families. Similarly, we also contacted therapeutic communities in Santiago that worked in close and permanent relation with the health staff of municipal governments. Considered as key resources in their community, these spaces are usually funded by municipal transfers and run by a small group of specialized professionals that assume the work with great commitment. Some of these experiences succeed in the implementation of innovative models of intervention, though they are usually small-scale enterprises, limiting the possibilities for replication on a larger basis.

As they accumulate sufficient experience and knowledge, these organizations may engage in direct relations with units at central government level, opening new windows for the advancement of changes in the traditionally recommended approach to these specific problems. Based on the success of their concrete practices, these associations are quite effective in introducing new "issues" in the agenda and provide the government with new expertise, experience and renewed approaches to tackle health problems. More concretely, the field of mental health may be signaled as one of those under major transformation in present times with increasing questioning of the traditional models and growing participation of civil society. In Chile and Uruguay, we have encountered a significant number of therapeutic communities working to create opportunities for the social reinsertion of patients in local communities (such as one in Peñalolen, Santiago which created job opportunities in the municipal zoo) replacing former strategies based on isolation and institutionalization. A similar example can be drawn from the experiences that we found in the field of drug prevention and rehabilitation. Interestingly, some organizations (like Caleta Sur in Santiago) are focusing their preventive strategies on existing social networks as a means to reduce the exposure of kids and teenagers to toxic substances (such as "paste base[18]"). By embracing a communitarian approach to drug prevention, these organizations have gained attention from municipal and central government officials who see in their pilot experiences a challenge to more traditional strategies.

Services related to child and maternal health care represent another important field of non-governmental activity. As has been documented in our visit to Santiago, the primary level of attention may well be considered one of the strengths of the Chilean public health network. Despite problems with some specific areas of specialization, public clinics provide high standards of care for problems related to pediatric and obstetric visits, which constitute the most frequent reasons for consultation in poor communities. In Uruguay, the assessment of current standards of attention in the public network shows a contrasting situation. Unlike Chile -and despite their structural lack of funding-, Uruguayan public hospitals still manage to provide medical emergency responses to the uninsured population. Nonetheless, the bottleneck occurs at the primary level of attention where a saturated network of public clinics run by the Health Ministry is being permanently overwhelmed by an increasing demand on child and maternal care. A massive disaffiliation from the collective medicine system as a result of growing unemployment, has increased the need of resources and personnel, adding new pressures to an already exhausted system.

Consequently, this situation turns into a major challenge for community organizations committed to improve the living conditions in low income areas as they try to respond to these insufficiencies in health services. In Montevideo, national authorities have relied on a nationwide network of local associations, "juntas de vecinos" and "comisiones de fomento" to play a significant role in child and maternal health prevention. Originating as a public program to fund local associations that provide child care in poor areas, the initiative is now broadening its scope, taking advantage of local NGOs and neighborhood associations as health providers. Given their original condition of child care providers, these associations are ideally situated to assume roles of health promotion and health education among the participants to their programs. A recent loan

[18] Highly addictive and harmful drug obtained as a by product of the cocaine refinement process.

from the International Development Bank, allowed a substantial increase in the number of families that are being covered by the program. Additionally, the expansion in the range of services fostered a more integral approach to the community, one that complements their role as child care givers with the delivery of maternal and child medical care. Given the centrality of these associations in the life of their communities, current efforts are being made to connect them with public clinics and public hospitals through the training of their personnel. Overall, these organizations may be seen as part of the new type of arrangements that are emerging in health services delivery, based on more integral approaches to health, the community, and their mutual implications.

Another field for NGO participation was found in the provision of elder care services. In both countries this field constitutes a major area of intervention and activity for local associations and community organizations. Directories of local or municipal non-profit sectors are filled with large numbers of social, recreational and sporting institutions that provide opportunities of social integration for the elderly. However, only a few of them transcend the auxiliary and complementary level to provide effective medical care. In Santiago, the large majority of institutions providing healthcare to the elderly can be classified along the lines of purely public and private services, with only a scarce number of NGOs participating in this field. The requirements in infrastructure, access to technology and problems of scale make it difficult for NGOs to be effective participants in this field. However, a well known exception to this rule in Chile has been the popular "Hogar de Cristo", one of the most respected and trusted organizations in the country. Being founded by a Jesuit and operating under the umbrella of the Catholic Church, this organization has built a nationwide reputation based on years of visible work with the poor and the elderly. Among other unique features, the "Hogar de Cristo" has succeeded in incorporating managerial tools that allowed them to increase their share of private donations moving away from State dependency.

Though lacking the incidence of previous categories, the existence of associations of users of public health systems represents an interesting analytical case to examine in both countries. Organized to defend the interests of users and patients of public hospitals and clinics, these organizations operate as channels for making demands and to denounce the omissions and failures of the system. However, more often than not these organizations are co-opted by the corporate interests of medical doctors and unionized health workers who need to broaden their bases to resist change. As a result, the agenda of users' organizations tend to be aligned with the interests of medical corporations opposing what they see as the "dismantling of the old and egalitarian public health system". In contexts of health reform these organizations of clients and users may uphold some of the interests that are being challenged by reformers adopting confrontational strategies typical of the labor union culture.

Finally, we would like to mention the experience of primary health clinics that belong to the public network of assistance but are currently under the administration of non governmental organizations. We found embryonic experiences of this type in both countries[19], where NGOs have assumed direct responsibility over a small number of clinics that are still part of the public network. Like any other municipal or ministerial clinic, NGOs in charge are paid according to the same criteria that health ministries use

[19] The "Fundación Cristo Vive" in Santiago is an exception, since it has been in charge of a primary health clinic for many years. However, the rest of the experiences in both countries had a pilot and embryonic character.

for the allocation of resources in their own services. Though the observed experiences may not be sufficient to draw any conclusion, these initial experiences may be opening a new path for increasing the responsibility of NGOs in the direct provision of primary health services. In this perspective, these pilot experiences represent another token of the new type of possible arrangements between the State and Civil Society, and a promising area for increasing NGO intervention.

After concluding the analysis of the major fields of NGO participation, I will now attempt to connect these experiences within a broader perspective. As diverse as these fields may be, I concentrate on what do they have in common and why NGOs are primarily found in these domains of health and not in others, focusing both on the characteristics of the State and of the NGOs in these fields. On the one hand, we will attempt to explain the concentration of NGOs as a result of the limitations and constraints encountered by the State to participate and intervene in these spheres. On the other hand, the strengths and advantages of the non governmental sector in these domains provide the suitable complement that fits with the observed public conditions (or omissions).

Regarding the former, a comparative approach across these experiences reveals a higher presence of NGOs in situations where the State shows one or more of the following conditions: a) need to extend coverage and has limited resources to do so, b) has not been capable to articulate adequate responses (or needs to adopt new modes of intervention), c) is not legitimated to intervene in this area yet, d) has not enough trained personnel or lacks well prepared human resources. Concomitantly, the areas of higher involvement of NGOs reflect situations where they meet at least one of the following conditions: a) have professional staff and accumulated expertise in a field of specialization, b) have access to and knowledge about a specific group, which constitutes the target of a policy, program, or public agency, c) claim to represent or defend the interests on behalf of local community or targeted groups, d) anticipate and design new models of intervention, and e) encounter available resources to sustain their actions.
To illustrate the last points with an example, there is the case of a Uruguayan non governmental organization that was granted the necessary funds to conduct a health research project to study the risks of HIV infection through needle exchange in groups of intravenous drug consumers. The organization proved to have sufficient knowledge about the studied population, but more importantly, demonstrated that it was the only organization that could assure effective access to these target groups. Since the study implied the distribution of personal kits for self-administrating the drug among users (in order to avoid contagion by trespassing syringes) the State could not, legitimately, take any action in the project, without running the risk of being seen as promoting consumption. Therefore, a non governmental organization with experience, expertise and access to the field appeared as the most suitable counterpart for the project. Though in many cases NGOs claim representation for their target groups or participants in their projects, we need to distinguish between effectively doing so and the pretension to act on behalf of the participants' interests. As we have suggested in our analysis, this has been a common feature among NGOs working for disadvantaged communities, though many have questioned the truthfulness of this representative claim.

To summarize, the response to the question “Where are the health NGOs?”, rests in the following succinct reply: “Where the State needs them”. Though the agency of NGOs also needs to be taken into account, structural constraints expressed through the action of the State and the needs of the community reduce their margins for autonomy. Looking at the content of their activities in our study, it is clear that NGOs are allocated to the periphery of health services, in a subsidiary role with respect to the State. In Chile as in Uruguay, the strong tradition of public health systems relegates the role of civil society in health services to a secondary place. Medical treatments –especially for low income citizens- are provided by public health networks and there is only a few NGOs that are fully involved in this type of service. Instead we found them dealing with ancillary, auxiliary services that are inextricably related to an integral notion of health, but are not located in the core of the medical needs of the population. More commonly, NGOs’ activities tend to concentrate around issues of “community health”, deploying an array of actions in health promotion, health prevention and health education as instruments to increase community wellbeing.

To enrich this perspective, I now take a new approach on the particular roles that non governmental organizations have assumed in the face of State transformation. As an attempt to go deeper into our analysis, we will focus our attention on what I consider are the most important features of the State-NGO relationship. As I have argued so far, the role of NGOs in relation to the State can be classified according to the degree of alignment of the former with respect to the objectives of the latter. In other words, non governmental organizations may be seen as *partners* of the State or as their *challengers* depending on the attitude that dominates their approach to pubic structures. This dual categorization, though somewhat fictitious, has some value in explaining the political meaning of NGO action as well as its effectiveness. We refer to NGOs as *partners* when they function as collaborators of the State in achieving public (in the restricted sense) defined goals through the provision of services. In contrast, the role of NGOs as *challengers* refers to the situation of those organizations whose primary goals consist in holding the State accountable to its universal mandates, advancing the rights of disadvantaged groups, and promoting changes in the sphere of policy formulation (more than leaving this as the entire responsibility of the State). Despite the confrontational nature of the “challengers” it is worth noticing that both roles can be seen as “cooperating” with the State, depending on the ultimate goals that we defined for governmental action.

My research experience reveals that far from been exclusionary roles, they can be combined in the same organizational setting. Indeed, a particular organization may be uncertain about whether to position as a challenger or as a partner of the State or may even change roles in a short period of time depending on the circumstances. An interesting example of this type of situation was provided by the case of a NGO working on teenager pregnancy in the outskirts of Montevideo. The staff meeting was set up to debate and decide about the convenience of submitting a project to the consideration of the Uruguayan government to be funded with a loan from the International Development Bank (IDB). The discussion took on a profound ideological character as the participants debated the political meaning of their decision and what it meant to “work with” the State and “cooperate with” the IDB in terms of institutional political projects. As in this case, the division between *challengers* and *partners* is frequently reproduced inside the same

organization with some programs or departments clearly working for the State and others challenging the State's vision and advocating for the rights of a specific group.

In general terms, the organizations that function as *challengers* of the State tend to play a significant role in the process of agenda setting and policy formulation, making substantial contributions to the way in which issues under debate are being framed. These organizations embrace causes and approaches that may lead to changes in the policy outcomes and the adoption of new models of intervention to assure the enforcement of declared formal rights. In this sense, organizations working as *partners* of the State may benefit from the advancement of the novelties introduced by the *challengers*. As part of their advocacy activities, *challengers* also contribute to promote the rights of minorities and marginal groups by means of expanding awareness, mobilizing and holding the State accountable for its compromises. However, it is necessary to highlight the double nature of every NGO action, which is irreducible to just one category. When acting as *partners* of the State in municipal or governmental programs, NGOs encounter daily opportunities to question ongoing policies and political process. Similarly, when challenging a specific vision of the State, NGOs are becoming engaged in a dialogue that creates certain levels of responsibility among actors while shaping the possible outcomes of policy debates.

The role of NGOs as *partners* of the State also entails great potential since it allows for their participation in different spaces such as a) direct service delivery, b) capacity building at governmental level and c) demonstration projects. Regarding the involvement of NGOs in the direct delivery of public goods, our preliminary findings for the cases of Montevideo and Santiago suggest that partnerships at this level appear to be more plausible and effective with municipal governments, rather than central authorities. In the realm of training and capacity building, we need to acknowledge the potential that NGOs may have to assist the State in particular situations. My fieldwork offered very interesting cases where non governmental personnel supported and trained public officials in the wake of critical situations. The example of a Ministerial health clinic in Casavalle –one of the poorest urban ghettos in Montevideo- reflects the synergy that may be achieved when this type of partnership is pursued. As a result of the continuous aggressions and threats received from local people, the director of the clinic decided to request the support of a local NGO to work with the clinic staff as an ultimate strategy prior to removing the health center permanently from the area. As outsiders, (though profoundly knowledgeable of the actors and problems in the area), the participant NGO was able to provide the health team with new insights into the episodes of violence against the center and enable the team to reopen the service.

Finally, the possibility of implementing demonstration projects of pilot health delivery models has become a potential sphere for NGOs participation. Nonetheless, I didn't find a significant number of cases of this activity. Reviewing my field notes, I only encountered one organization, - located in Montevideo- that was implementing a demonstration project, and it belonged to the domain of HIV/AIDS prevention.

CONCLUSIONS AND IMPLICATIONS

In the realm of health care services in Chile and Uruguay the State still has the core responsibility despite the important role that NGOs are playing in ancillary and complementary services. This situation emerges as the partial result of financial constraints on the action of NGOs. At one level, the financial requirements of health care introduce some barriers to the full participation of NGOs as service providers in this field. In the same vein, the technological requirements of medical treatments and specialties constrain the range of services that NGOs can provide and favor the role of profitable (market oriented) and public (social oriented) medicine. But also budgetary constraints entail serious difficulties for employing medical doctors and highly trained health care personnel on a permanent basis.

Additionally, corporate interests expressed through professional associations and health related unions exert control over the opening of spaces for new providers. Alliances of users and workers of public health hospitals in Chile are among the principal forces opposing the reforms. Also, the higher valuation attached to secondary health services (hospitals) compared with primary health care (clinics) restricts the availability of qualified doctors at the community level. The strong tradition of and high expectations on the public health system in both countries impose some limits to the possibilities of widening the scope of actors involved in direct provision of services. In fact, when discussing the actors in the reform of the health system in the literature, NGOs are never or rarely mentioned as effective providers.

However, as we have already seen, this doesn't mean that NGOs are absent players in the field of health services. This study has documented that –not without contradictions - there are forces working in favor of the expansion of NGO participation in these areas . One of the most relevant is decentralization, which has enhanced opportunities for many organizations that operate at the community and local level. But also specialized units at the central level have promoted new spaces for more professional NGOs with accumulated expertise. Even among those organizations that were not established around formal health services, their strong commitments towards a specific community or territory push them into activities that include major components of health prevention, health promotion and health education. Besides, we have encountered more formal NGOs that operate as major actors in the agenda setting process, engaging in advocacy actions, holding the state accountable and pressing for rights advancements around specific health issues such as HIV treatment or contraceptive information.

An additional constraint for NGOs derives from the risk of increasing their closeness to the State (Gonzalez Meyer, 1999). There has been a traditional path of getting closer to the State that could be summarized in the following historical sequence: against the State, with the State, within the State. This path has been followed by most Chilean and Uruguayan NGOs that originated under authoritarian regimes in the 1970s and 1980s. In its origin, the name *NGO* represented the identity of those organizations that –despite their public objectives- were not part of governmental structures. The "non-governmental" character of these organizations was part of their signal of identity, as they emerged as political expressions against the military regimes. With the restoration of democracy, the oppositional role was usually transformed into a more collaborative

attitude towards the State. In the 1990s and to the present , NGOs followed the call of the State and operated as its extended arm in the various fields of public policy.

Despite the generalized expansion of these transformations in the NGO community, my research shows that the role of challenging hegemonic power and contesting governmental structures has still survived in some organizations and has motivated the emergence of new ones. In the place of the former traditional NGOs, there are now new groups of organizations that have assumed previous roles of contestation and counteraction. As we have observed, these NGOs want to participate in the "agenda setting process", intervening in what Evelina Dagnino (2004, 103) defines as the "decision powers" and the "strategic nucleus" of the State. Some NGOs adapt to this double role by diversifying their actions and programs. While they collaborate with the State in the execution of programs and of specific actions they also keep open spaces for political contestation and challenge. In this sense, second-level associations have proved to be a powerful instrument in both countries to articulate and coordinate the dispersed strategies of these heterogeneous organizations.

In health this double role of NGOs has been more contrasting and sharper than in any other field of social policy. As I hypothesized, this may be explained by the enduring incidence of the public health system in both countries. Unlike any other field, the prevalence of State action in health services has pushed NGOs to the margins, limiting their spaces for expansion and autonomy. Furthermore, the consolidation of a managerial type of State entailed a more technical leadership of public agencies forcing the NGOs to follow centrally defined policies and standards. However, as much as States need disciplined NGOs, they also need challenging and contentious ones. Many of the current innovations in social policy have been introduced through the cumulative experience gained through NGOs. Since democratic restoration the State has taken advantage of the accumulated expertise in the hands of NGOs in three basic ways: a) through cooptation of personnel formerly working for NGO structures, b) through cooptation of knowledge appropriated by means of direct service delivery, training of public personnel, consultancy services or similar, or c) through advocacy activities that put pressure from below, forcing the State to expand and enforce rights and entitlements.

In any case, as far as we have come, States need the participation of NGOs in order the get the job done, either because they have the people who know, the knowledge to intervene, or the access to the community. Full cooptation, as functional as it may sound for the purposes of public agencies, entails serious risks for the long term future of public policy. When dealing with NGOs, States need to be aware that a rebel organization might be as useful as a domesticated one. Keeping the NGOs as truly non governmental entities and overcoming the temptation to convert them into quasi governmental structures seems to be in the State's interest.

REFERENCES

Alvarez, Sonia. 1997. *Cultures of Politics/Politics of Cultures: Revisioning Latin American Social Movements*. Boulder, Colorado: Westview Press.

Alvarez, Sonia, Evelina Dagnino, and Arturo Escobar. 2000. *Cultura e Política nos Movimientos Sociais Latino-Americanos.* Belo Horizonte: Novas Leituras, Editora UFMG.

Arteaga, Ana María. 2003. "La lógica brutal de la privatización." In *Social Watch Report Chile 2003*. Montevideo: The Third World Institute.

Bebbington, Anthony and Roger Riddell. 1994. "New Agendas and Old Problems: issues, options and challenges in direct funding of southern NGOs." Presented at the workshop on NGO and Development: Performance and Accountability, June 27-9, University of Manchester.

Carroll, Thomas. 1992. *Intermediary NGOs: The Supporting Link in Grassroots Development.* West Hartford: Kumarian Press.

Cruz, Anabel and Fernando Barreiro. 2000. *Sociedad Civil en el Cono Sur de America Latina*. Montevideo: Instituto de Comunicacion y Desarrollo.

Dagnino, Evelina. 2004. "Sociedade civil, participacao e ciudadania: de que estamos falando?." Pp. 95-110 in *Políticas de Ciudadanía y Sociedad Civil en tiempos de globalización*, edited by D.Mato. Caracas: FaCES, Universidad Central de Venezueal.

De la Maza, Gonzalo. 2001. "Sociedad Civil y Construcción de Capital Social en América Latina: ¿Hacia dónde va la investigación?" *Revista Polis Académica Universidad Bolivariana*. Santiago.

Edwards, Michael and David Hulme. 1994. *NGOs and Development: Performance and Accountability in the New World Order*. London: Save the Children Fund and Manchester: Institute for Development Policy and Management.

------. 1996. *NGOs, Performance and Accountability: beyond the magic bullet.* London: Earthscan.

Farrington, John and Anthony Bebbington. 1993. *Reluctant Partners? Non Governmental Organizations, the State and Sustainable Agricultural Development.* London: Routledge.

Filgueira, Fernando. 2003. "La reforma del sector social: estatismo, desigualdad y privatización by default". In *Social Watch Report Uruguay 2003*. Montevideo: The Third World Institute.

Fisher, William. 1997. "Doing good?. The Politics and antipolitics of NGO practices." *Annual Review of Anthropology.* No. 26

Gonzalez Meyer, Raul. 1999. “Relaciones ONGs-Estado en Chile: Aportes para un balance de la decada del 90” In *Revista de Economia y Trabajo*, No. 9. Santiago: PET.

Guerra, Pablo. 2001. “Iglesia Católica y Tercer Sector en Uruguay: avances para una comprensión histórico- sociológica de su acción social.” Presented at the III Encuentro de la Red Latinoamericana y del Caribe de ISTR, Buenos Aires.

Molyneux, Maxine and Sian Lazar. 2003. *Doing the rights thing: rights-based development and Latin American NGOs”*. London: ITDG Publishing.

Veronnelli, Juan, Aron Nowinski, Benito Roitman and Alvaro Haretche. 1994. *La salud de los Uruguayos. Cambios y Perspectivas.* Montevideo: OPS/Editorial Nordan.