NGOs-STATE RELATIONS: A QUALITATIVE STUDY OF HEALTH CARE SERVICES IN NIGERIA

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Abstract
Provision of adequate health care has been challenging for government and private (profit and non-profit) providers. Despite this, relations between the government as primary provider and the non-governmental organisations (NGOs) as co-providers at the grassroots affect the latter's ability for effective health care delivery. This study analyses NGOs-state relations using Najam's Four Cs: confrontation, co-optation, cooperation and complementarity in health care. Eleven in-depth interviews with executive directors (EDs) of NGOs (7) and government officials (4) show a continuum form of relations, from confrontation, co-optation through cooperation and complementarity, shaped by the strategic institutional interests of actors. However, government tend to contrive confrontation or isolated existence through 'institutional engagement' of NGOs in satisfying donor agencies insistence on their participation in public health. Co-optation is prominent form of relation as the government control the public space, which significantly affects NGOs' capability for effective health service delivery.

Keywords: Health services, NGOs-state relations, four Cs, institutional interest, non-state actors

Introduction

The relations between government and NGOs influence the extent of the latter's ability to deliver effective health care services. The contribution of NGOs to health services cannot be overemphasized (Earle, 2007; Fidler, 2003; Sabri, Siddiqi, Ahmed, Kakar, and Perrot, 2007). NGOs improve general population's health in the face of decaying public infrastructure, and have the capability in resolving the asymmetric information (i.e. bridge information gap) between NGOs health providers and meeting health seekers needs based on voluntarism (Leonard, 2002; Lucas, 2002). Similarly, NGOs health care alleviate childhood killer diseases, strengthened and integrate community with government health system (Chowdhury 1990).

NGOs size, reach and closeness to local people, the willingness to confront the status quo, work in remote areas, innovation in pattern of provision and financing, coalition building and comparative advantage improves their ability to deliver health care (Gilson, Sen, Mohammed, and Mujinja, 1994; Micheal, 2002; Lankester, Rader, and Campbell 2002).

Partnership through sharing of expertise, skills and resources among various sectors in achieving greater health outcome has been stressed (Davies and Foley, 2007; FMoH, 2006, 2010; Gulzar, and Henry 2005; and NTBLCP 2010). Research shows collaboration between NGOs and MoH in health services improve Primary Health Care (PHC) systems (Pfeiffer, Johnson, Fort, Shakow, Hagopian, Gloyd, and Gimber-Sherr, 2008; Pfeiffer, Montoya, Baptista, Kargianis, Pugas, Micek, Johnson, Sherr, Gimbel, Baird, Lambdin and Gloyd, 2010; Pfeiffer, 2003). NGOs' demonstrate the capability to develop appropriate interventions for diverse communities to long-standing health challenges (Drake, Hutchings and Elias 2011; Ruhl, Stephen and Locke 2003:76-7). However, government antagonism, repression of NGOs and dependence on funders, difficulty in building NGOs network can inhibit NGOs capability in health care. The study analyses NGO-state relations using Najam's Four Cs, and how this continuum of relations affects NGOs health care.

Analytical Framework of NGO-State Relations

NGOs bridge the gap between state and society (Landim, 1997; White, 1999). The fulcrum of NGOs-state relations is the historical, legal, political, formal and informal organisations. Nature of the political regime type (its stability and inclusiveness), NGOs' financial autonomy, size and clout affects NGOs capability for policy influence (Batley 2011, Bratton 1989: ; Mcloughlin, 2011).

Najam's Four Cs framework for NGOs-state relations involves: cooperation, confrontation, complementarity and co-optation. Cooperation in the case of similar ends and similar means; confrontation in the case of dissimilar ends and dissimilar means; complementarity in the case of similar ends but dissimilar means, and co-optation in the case of dissimilar ends but similar means between NGOs and state goals (Najam, 2000). The nature of the relationship is best explained by the "strategic institutional interests" of actors rather than by discrete features of actors or society such as popular or authoritarian regimes, level of development or economic system (Najam, 2000). The relationship between the government and NGOs in Young's (2000; 2006) view is shaped by the economic gains in the outcome of the relationship for the NGOs and the government. Young taxonomy of the NGO-state relations shows a spectrum from complementary, through supplementary to adversarial relations. Supplementary model suggests that NGOs are fulfilling demand for public goods left

unsatisfied by government (Young 2006). Complementary perspective see NGOs as partners, helping to deliver public goods, largely financed by government. In adversarial relations, non-profits urge government to make policy changes and maintain accountability. Reciprocally, government attempts to influence the behaviour of non-profits by regulating their services and responding to advocacy initiatives.

Following Young line of economic reasoning, NGO-state relationship is mutually beneficial. NGOs are closer to the communities, understand their preferences and deliver services at lower transaction costs. Government profit from the relationship because NGOs reduced costs of managing contract (Young 2006).

Lorgen adds two models underpinned by patron-client relation resulting in NGO dependency. Adversarial relation encourages co-optation, force regulation or intimidation, and or collaboration. This model is a continuum of relationship from dependency through collaboration to antagonistic relation (Bratton 1989, Lorgen 1998). In adversarial relation the government narrows the political space and NGOs struggle for autonomous existence through low ebb of activism, selective collaboration (Bratton 1989). For government that expand the political space to encourage non-state actors are more likely to build cooperative and collaborative relationship (Brinkerhoff and Brinkerhoff 2002, Mcloughlin 2011). Bratton concludes that NGOs-state relations are more fruitful where the government enjoys political legitimacy and demonstrate capacity for social delivery. NGOs are better integrated into mainstream development programs. Government whose political authority is gravely eroded or when NGOs activate marginalised groups can engender oppressive relations. In such scenario, rather than regard NGOs as allies in development, leaders may distrust them as potential challengers in the realm of political leadership (Bratton1989). NGOs in developing country experience more governmental control, face challenges in contractual relationship and suffer threat to their identity and autonomy (Lorgen 1998). Nonetheless, studies finds that NGOs working closely with the government may influence policy, reversing the principal-agent role (Lorgen 1998:327, Batley 2011).

The pendulum of NGOs role swing between persuasive/activist advocacy in cooperative or confrontational relations (Batley 2011, Young 2006). An NGO potential for service delivery, advocacy, autonomy and influence, simultaneously, is a function of its financial strength, size and affiliations (Mcloughlin 2011: 248). NGOs dependence on funders may constrain it policy advocacy. Where NGOs-state collaboration in service delivery confines NGOs to the role of implementing rather than formulating policy, it is often seen essentially as a form of co-optation (Batley 2011, Bratton 1989).

The origin of NGO-state relations can influence the nature of the interactions between the two. When government initiate relations with NGOs, the interaction pattern is top-down and focus on NGOs' role as service providers. When NGOs are the initiators, interactions is bottom-up with an emphasis on policy advocacy and constituency empowerment (Brinkerhoff and Brinkerhoff 2002:11). However, this is not a fix pattern of interaction as relation can swing in opposite direction depending on the institutional and strategic interest of the actors (Brinkerhoff and Brinkerhoff 2011:11-12, Najam 2000). Resulting in a NGO-state relations fluctuation between Young's (2000, 2006) models. Where donor or government initiate the NGO-state relation, NGOs roles are defined beforehand as part of project design (Brinkerhoff and Brinkerhoff 2002). Donors' priorities shape NGOs role in a contractual relation (Batley 2011).

Method

Primary and secondary sources of data are used. Primary data from in-depth interviews (IDIs) of executive directors (EDs) of NGOs and government health officials at the local and state government (these include Medical Officer for Health (MOH), Deputy Director of Health at the Ministry of Health). Sampled NGOs are those registered under the Umbrella Association of Civil Society Working on Malaria, Immunization and Nutrition (ACOMIN), Lagos zone membership list. The final sample consists of 4 government officials and 7 NGOs Program Officers. The in-depth interviews were transcribed verbatim to provide a precise record of what was said during the interviews. A transcription and translation of data were provided to interviewees for validation. Key findings were aggregated and analysed to develop thematic areas.

Information gathered from the secondary sources are library sources. Interviews were triangulated to find agreements and dissonances on variety of issues and views around NGOs-state relations in health delivery.

The ethical approval was obtained for this study and an informed consent for participating in the study was sought from the respondents.

NGOs-State relations in health care: A Qualitative study

Confrontation

For the executive director of HMI, NGO-state relations is not necessarily antagonistic in any way, but Government generally in this country do not see NGOs as serious partners for meaningful development. They see us as a nuisance, an *unlicensed nuisance* in the

work they do. I personally do not think government has anything to offer us. They are busy trying to see how they can make money for themselves. Trying to get involved in activities that should involve NGOs is like you are intruding. They would rather form NGOs or support one or two NGOs that they know the people behind it. So they can get one or two things done and share money. Government involvement in NGOs activities is close to zero.

Institutional strategic interest of government can shape its relations with NGOs. Government will rather float NGOs or support NGOs they know the people behind it to siphon public wealth than engage with genuine NGOs for development. HMI stresses the role of government officials in frustrating their health services and tend to see NGOs as competitors. 'They see us as a kind of competitors. So they are always out to make sure that our services and efforts are stunted one way or the other. They will never allow us to progress or funds to work'. NGOs weakness and inability to play the role of a watchdog, influence policies, may account for why they are silenced through neglect and force to comply with state actions willy-nilly. For NGOs that remain obstinate, they are isolated from government programmes or co-opted to be relevant.

When funding agencies deal directly with NGOs, the government officials have suspicion and question NGOs credibility to render health care services in the community without government approval. In a case where Health-Guard Foundation (HGF) was implementing a donor-funded project, observed government officials reaction to forestall the project. '… probably they thought there is large sum of money coming in that was not allowed to pass through the government'. HGF stated, NGOs lack full government support. An example was the net distribution where NGOs roles are to create awareness, monitor, and improve knowledge on usage.

Another major obstacles to NGOs success is the bureaucratic delay in granting approval for NGOs health activities that are usually time bound. Government apathy results from over dependence on government as the funder of NGOs. Humanitarian services are not embraced by philanthropists. This severely limits their capability to support community health care. Most NGOs move into the community, understand the problems of the people, but they lack the financial wherewithal to influence positive change for improving the situation. ED of Life Link Organisation (LLO) explains this results from most NGOs being donor driven and donor dependent. NGOs should cover-up for services left unsatisfied by the public sector. In this part of the world, NGOs are over-demanding, over dependent on the government for social services delivery. This result in government apathy. Even though widespread corruption is the bane of the Nigerian state, humanitarian services are driven by philanthropist to support government.

Although, change in government attitude create greater synergy in project execution and improves communication. Thus, NGO-government suspicion is fading gradually. Nevertheless, NGOs are wary of government appropriating their ideas and brainwork without proper acknowledgement especially when proposals are submitted for government approval. Government unpredictability and lack of commitment to NGOs work lowers their achievement.

Also, proliferation of NGOs with high expectations adds to their frustration in health care. Occasionally, agencies like Lagos State AIDS Control Agency (LSACA) provides fund to government to support NGOs. But when such funds are not available, profit-oriented NGOs and others with high expectations and dashed hope were forced to quit. ED of LLO illustrates, 'As many NGOs are coming up today, they come up with the intention of making money. ... By the time they come in and there is no fund, they get frustrated. They get tired and just quit'.

LLO recognised that NGOs herald development in advanced societies. However, the motive for establishing NGOs in this part of the world is completely different. Nigeria NGOs lack mentorship and strength to withstand hard times. The humanitarian interests to serve is a push factor for NGOs in difficult times.

In summary, confrontation results from government belief that NGOs have total control over donors' fund, mutual distrust and denigration of NGOs as development partners. Similarly, high expectations and dashed hope of profit-oriented NGOs result in criticising government.

Co-optation:

The contraction of the political space thrives. NGOs are controlled to be associates or risk exclusion.

Apparently, donor agencies push NGOs-state interaction. Local NGOs are excluded as credible development partners except to satisfy donors demand. This limitation of NGOs-state relation in collaborative health delivery constraint NGOs achievement in health services provisioning. Until NGOs are seen as co-providers, supportive of government effort in health delivery, there may not be significant progress. CEPI adds that government is uninterested in NGOs health

care, but note that NGOs were summoned and discarded at will. 'NGOs are used and dumped by the government without necessarily being concerned about the wellbeing of the populace'. CEPI attributes this to the pervasive poor governance.

Under co-optation, CEPI observed, NGO-state relations necessitate collaboration for NGOs relevance, otherwise, they risk alienation. '… if you really want to be successful in the project you do, it is better you carry the government along. Often, government has nothing to offer… they can even make it difficult for you'. Co-optation becomes a strategy of relevance or recognition. A donor funded NGO proposal on community malaria laboratory test was abandoned for the purchase of utility vehicles used for drug delivery to government hospital. CEPI notes, 'The project has gutters and drainages for all densely populated areas. Free flow of water will prevent mosquito from breeding'. To deter project termination, CEPI was co-opted to do government requests. This result in the diversion of donor's funds to cover up for government basic function, and disrupted a project for combating a leading cause of mortality and morbidity in the locality.

Cooperation:

In the area of cooperation, NGOs help collate data on epidemiological trend in the local population used by government for planning and decision-making. State monitors evaluate NGOs' reports, strengthen and direct NGOs, and based on reports responds to health problems in the communities.

Cooperation between government and NGOs facilitate delivery of health care products to communities. Most health posts in the villages lack doctors and nurses to attend to people. The reports of opinion leaders, community volunteers, and Village Health Committees (VHCs) in collaboration with PHC from the locality to government enhance health care delivery. Cooperation between the VHCs and government is a way of ensuring functional health services through monitoring and feedback.

Similarly, government officials monitor the donor funds along with donor monitors who supervise NGOs activities. In reporting donor project involving the state, MPAFB highlights, 'If the state is giving us job through donors we report back to the donor through state'. A copy of the report is sent to the state as policymakers. In some cases, donors visit the NGOs community outreach centres to monitor their funding and NGOs retire directly to them. Regardless of how donors' funds are channelled to NGOs, state has full knowledge of external funding. Donors deal directly with NGOs to get feedback, monitoring and evaluation. To avoid conflict of interests between state interest and donors, one strategy adopted is state involvement in donor sponsored projects. HMI observes that some donors work through the state and insist on NGOs participation. NGOs that do not enjoy favourable relationship with the state are practically excluded from such arrangement. Also, state gather information and aid facility monitoring. Cooperation between NGOs and state are in few areas and are usually driven by eternal agencies that insist on CSG participation. Some NGOs rate government-NGOs collaboration as insignificant.

CEPI delineates, state support in capacity building and training, but little or no financial support. 'Lagos State AIDS Control Agency (LSACA) give out these test-kits for HIV and assist us in counselling. They train us so we can train our staff. I am a trained counsellor. They do support us but not in terms of money'. Also, government approve NGOs posters, flyers and letters for health interventions and mobilization. 'I write to them, they send me a message. When I have a work plan we acquaint them. That is collaboration'. The depth of the collaboration is shallow and insubstantial. It centres mostly around providing information to the state officials on NGOs annual work plan.

However, CEPI explains, the availability of funds from International Non-Governmental Organisations (INGOs) stimulates cooperation between local NGOs and the state. Neither the need to improve health outcomes nor push humanitarian objectives propels NGOs-state interaction. Donor funding can trigger one, resulting in a transient and inconsistent relationship.

Government officials give more recognition to INGOs than local NGOs in health care. INGOs identify health gap and incorporate local NGOs in executing health interventions, for example, distribution of Insecticide Treated Net (ITN), sensitization and community mobilization against malaria, HIV/AIDS, reproductive health and immunization campaign. Although, most local NGOs health services are sponsored by INGOs. Thus, government officials are more responsive to INGOs health programs, and may be disinterested or less supportive of local NGOs that lack financial capacity to support health care services.

Other areas of cooperation include coalition formation that offers platform for interaction and meetings between NGOs and the state. NGOs coalition and registration under different umbrella associations such as LSACA, ACOMIN encourages cooperation in health services delivery. Different coalitions meet regularly with government officials to discuss health problems and provide solutions. Donor sponsored HIV/AIDS project kick-off LSACA, which provides funding through the

state to local NGOs in offering HIV/AIDS testing and counselling services, drug supply and referral services to HIV/AIDS patients.

The state mainly coordinates NGOs activities through the network coalitions. Established standard and procedure that guides NGOs. AMCPH claimed on the framework for NGO-state cooperation '…you know what the guidelines of the state are because you must work within the standard of practice. There are standard operative procedures'. A Medical Officer for Health (MOH) claimed, the state provides a framework of engagement with non-state actors under the State Strategic Health Development Plan (SSHDP). The framework allows for the harmonization of resources and fosters partnership with NGOs, donors and government to improve health outcomes.

Under the SSHDP, government partner with donor funded project through counterpart funding. The SSHDP aims to exercise greater government control and scrutiny over foreign funds as well as monitoring and evaluation of what funding agencies bring into the country, foster cooperation and sustainability of donor project when funding dries up. The SSHDP is a new initiative whose implementation will be too early to assess. However, from the benefit of hindsight, it requires government commitment to qualitative health delivery in order to actualise the purpose of the scheme. Generally, NGO-state relation has been consistently temporal and less integrative of the third sector as development partners. NGOs-state cooperation are contrived to facilitate inflow of donors' funds that insist on NGOs participation. Apparently, no strategic inclusion of the NGOs in the development process except under the SSDHP yet to come into full-fledged operation at the time of the research.

Complementary:
State agencies collaborate with NGOs in complementary relation. According to MPAFB the 'Lagos State government introduced SuNMaP to us and we work with health institutions such as the general hospital, health care centres and so forth'. The deputy director of health at LSMoH, describes the NGOs-state collaboration in terms of state using NGOs in health service delivery. 'They cannot on their own go and render services without our inputs'. The government uses the NGOs to deliver health care functions. NGOs are used as health personnel in immunization campaigns, maternal health care and child week. Also, NGOs work as independent monitors for the state and disseminate information on appropriate health behaviour. MPAFB calls for more critical engagement with NGOs. 'State institutions and agencies must accelerate health delivery through complementary engagement to actualize the potentials of the third sector'. The salient point is that 'the state is not to lead from the front but need to remove any hindrance that it may constitute to the new harbingers of development: NGOs' (White 1999:308). This does not mean to undermine the role of the state as the primary driver of development but a strong acknowledgement of other actors involved in the act of governing (Sending and Neumann 2006).

NGOs are partners in progress and not competitors with state, but a symbiotic relationship. Complementary relations between NGOs and state has the potential to expand the scope of their operations, broaden their influence and participation in the formulation of the national development agenda (White 1999). Similarly, the state gains in a mutual interaction as primary provider of health care, control donors funds and deepens legitimacy through cost effective social service delivery (White 1999:309). Complementary relations facilitates government contracting of social services and funding of NGOs with capacity for social service delivery (Young 2006:62).

Government officials claimed, NGOs complement whatever the government is doing in health care. The deputy director of health at the Lagos State Ministry of Health (LSMoH) acknowledges that delivery of qualitative health is primary responsibility of government. But government needs the supportive services of NGOs to be able to deliver quality and affordable health to the people.

In terms of structure, the NGOs do not have much extensive structure as the government. But NGOs have the technical competence and reach to the communities'. Some of them are actually community based NGOs. It is easier for the government to get to the communities through the NGOs.

For the MOH of Alimosho, majority of the NGOs are working to support the government in strengthening the health system at the grassroots level, helping to fill the gap. Ministries coordinate the activities of NGOs in relation to the ministerial portfolio. State rules and regulation shape the conduct of NGOs affair in the best interests of the community. Nature of relation with the local government officials can strengthen support for NGOs health services at the grassroots. In some instances, HMI asserts, government officials will even demand for bribe or kickbacks on flimsy excuse that they need to fuel their car before they can attend NGO programme. Despite this manifestation, some NGOs enjoy government support when donor funding are

available. Government officials claimed that NGOs could access government financial support depending on the relevance of the project in terms of uniformity with government programmes and financial strength of the local government. Some NGOs admitted they get financial support from government to implement project. Usually no financial support is given to NGOs except when donor funds are available for health service delivery at the grassroots. Government supports NGOs programme when INGOs provide funding to boost health services by local NGOs. For example many NGOs work under the Lagos State AIDs Control Agency (LSACA). The LSACA fund and build capacity of NGOs. NGOs help in technical training of government workers, government in turns provide technical assistance to NGOs staff. NGOs provide materials, tools and equipment, and in some instances renovation of health facilities and drug supplies. Technical Assistance (TA) can be in form of time, expertise and cooperation of government in the community.

Najam's (2000) and Mcloughlin's (2011) contend that NGOs experience different relationship with government and different agencies of government. Similarly, Uphoff (1993) argues that there is no universal ground about the experience of NGO. There is no universal claim about the experience of NGO with different government agencies in the same administration. The nature of the relationship shift from one end of the conundrum to the other as actors shift interests. Different approaches also on the part of the donors emanating from experience necessitate greater involvement of the government officials could result in cooperation and collaboration. Confrontation between NGOs and state relations is the overriding nature of relations in health care services, even though silent or less observable. Co-optation becomes imperative to make NGOs yield to government request. Co-optation compel NGOs do government wish, even though it is less desirable. This become necessary for continued NGO relevance. Otherwise, NGOs that are irresponsive to government bid are disregarded, alienated and neglected in the health care delivery in the state regardless of such NGO contribution to improving health care services. More often than not, cooperation in NGOs-state relation is externally driven, inconsistent and devoid of any critical engagement of NGOs in health care delivery. Complementary relations thrive, in some cases but not in critical areas. This limits the contribution of NGOs to health care delivery and impact on the overall nation's health outcomes and achieving the goal of health for all.

Conclusion/Recommendations

This study explores the NGOs –state relation in health care services using Najam's four framework of confrontation, complementary, cooperation and co-optation. The finding shows that cooperation exists in selected areas but limited. The government use the NGOs in health care services delivery, facility monitoring and collection of health data utilised for health planning and policymaking. Cooperation between NGOs and government increase availability of data, report of infectious diseases from the communities and government response to address health challenges. Strengthening the health system under the new SSHDP will increase collaboration between NGOs and government if there is proper implementation. However, NGOs are of the view that government underutilizes the NGOs as partners in development. Government and NGOs cooperation are usually externally driven by funding agencies insisting on NGOs participation in health care services. Cooperation between NGOs and government are therefore inconsistent and transient. Government are compelled to integrate NGOs on donors' insistence, and they are neither involved in any strategic way nor carried along to a logical conclusion. Cooperation, in some cases, is a necessity for NGOs' recognition. Since the government provides the social space for NGOs existence, they are required *de facto* to comply with state demand.

Complementary relations between government and NGOs are mainly in the areas of capacity building and technical assistance. The government help build the capacity of NGOs in health services delivery and provide technical assistance to NGOs. While NGOs facilitates penetration of the communities and get to the hard to reach population. Similar goals between NGOs and government reinforce complementary services. The NGOs build capacity of government workers, support in health facility renovation and provide equipment to health centres and drug supplies. The complementary role of NGOs may be by government invitation or voluntarily by NGOs on humanitarian grounds. The fact that NGOs are involved in health care on humanitarian ground or similar goals between NGOs and government make complementarity more viable form of relationship than cooperation that is usually externally induced.

However, confrontation between government and NGOs results from government suspicion of NGOs control over donors' funds. This usually result when donors fund are not channelled through the government. The government officials may want to stifle NGOs work on the ground that such project lack government approval. In a particular instance, government move to stop a local NGO health services provoked resistance from members of the community, who are feed up with perennial absence of government in all critical areas of life. Autonomous NGOs are more likely to experience

adversarial relations with government officials. NGOs that refused to comply with corrupt officials dictate suffer neglect, exclusion and alienation. Nevertheless, NGOs inordinate demands and over dependence nature, profit driven motives, lack of philanthropism and altruism result in confrontation and breeds government apathy. Where government and NGOs have dissimilar goal but similar ends, co-optation become important for NGOs relevance. NGOs are conditioned to comply with government dictates to continue health services delivery or get silenced through administrative machineries.

NGOs cooperation serves to satisfy donors' requirement for local NGOs inclusion in grassroot health care. Government dumps the NGOs and sometimes health interventions are re-route through government. This results in lack of critical engagement of the NGOs in development with negative effects on effective and efficient health services delivery. 'Cooperation and autonomy' (Sanyal 1994) are not achievable in NGOs-state interaction in Nigeria. Cooperation is usually engendered to serve government interests and externally driven. Co-optation for NGOs relevance, and in a relation that is adversarial NGOs suffers neglect and alienation. Nevertheless complementary relations strive in some areas.

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