

*NGOs in a Context of Health Reform:
Five Hypotheses for Santiago and Montevideo*

Summer Research Report

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Introduction

This document presents the first round of analysis of the materials and data collected during a two months fieldwork trip in Santiago (Chile) and Montevideo (Uruguay) to examine the role of non governmental organizations (NGOs) in the health sector. The justification for this study arises from the serious lack of research on these organizations and their changing roles as a result of decentralization, re-democratization and economic liberalization process in the region. Between mid May and mid July 2004 I interviewed NGOs leaders and staff, government officials at central and municipal level, community leaders, recipients of public and private projects, academics, and other key informants. In this period I collected a vast amount of useful information and developed new insights about the potential and constraints affecting the third sector in health related services in the two countries.

Due to the richness and diverse nature of the collected information, making sense of it and reducing the data was the principal goal in this first phase of the analysis. To achieve this objective our study combined the observed context variation in the studied countries with the political and institutional outcomes in the realm of NGOs. To organize the evidence, I used five hypotheses that were developed in the context of a larger research proposal aimed to survey the role of non governmental organizations and the distribution of health care services in the developing world. As a member of the research team, I took

the chance to refine and work out some of the propositions, advancing them for future instances of the project.

The present study has made extremely clear that we need to pursue a more complete understanding of the relations and new forms of articulations between the State, the market, international organizations and non governmental organizations. As a secondary product the project also provided an opportunity to check the feasibility and potential that a topic like the one approached here has for a doctoral thesis.

The report began with a summary of the problem, followed by the objectives and hypotheses that were examined in the study. Then we discussed the methodological design as well as the research techniques deployed in the field. Given the importance of the contextual variation we devote some pages to discuss the divergent path followed by the two countries. We conclude with a discussion of the five hypotheses and the main findings that confirm, refute or qualify them.

Finally, I would like to express my sincere thanks to the support provided by The Center for Latin American Social Policy (CLASPO) and the Summer Research Mellon Grants in the names of professors Bryan Roberts and Peter Ward.

The Problem

The debate about the role of NGOs in Latin America has moved in a more cautious direction as the 1990s and the new millennium has progressed. While many development experts, agencies and even academics in the 1980s viewed NGOs as the most promising solution to community level problems (Korten, 1987; Clark, 1991), during the 1990s observers began to rethink the appropriate role of the State and specific competence of NGOs in addressing the problems of civil society. The diversity among NGOs and the unevenness of their capacity for carrying out specific tasks has been recognized in past years (Bebbington and Riddle, 1994; Carroll 1992). More recent empirical research has tempered the initial enthusiasm and revealed that NGOs must also deal with hard questions concerning accountability, legitimacy and effectiveness (Fox and Brown, 1998; Edwards and Hulme, 1997, 1996). Additionally, analysts as well as those with direct experience have raised serious doubts about the initial promise of the NGO phenomenon. These include doubts about the potential of NGOs to foster sustainable patterns of community development (Pierce, 2000); dangers of co-optation by the neoliberal agendas of governments and multilateral organizations (Edwards and Hulme 1994); and the supposed relative superiority of NGOs over the State or the market as mechanisms for overcoming poverty and social exclusion.

Though the non governmental sector in its role apart from the state and the market has provided welfare services in Latin America since the early colonial period (Cruz, 2000), it is only recently that this organizational form has been seen as the preferred channel for

providing services and a deliberate substitution of the state. Despite some country variations, the so called “New Policy Agenda” for Latin America (Robinson, 1993) has fostered the role of NGOs in delivering public goods to those communities and individuals left behind by the market (Fowler, 2000). The arguments in favor of this approach are based on the supposed cost-effectiveness, accessibility to the communities, organizational flexibility and a commitment towards developmental objectives of NGOs. Edwards and Hulme (1996) caution, though, that “the absence of a large body of reliable evidence on the impact and effectiveness of NGOs makes it difficult to generalize about this subject”, despite their claims on successful performance.

Despite the evolution of an “impact assessment” and “results oriented” culture within the NGO movement that has been the consequence of the accountability requirements of multilateral and public funding agencies, evaluations of particular programs or institutions are rarely released and what is typically made public appears to be more propaganda than rigorous assessment. Additionally, internal/external evaluations that are implemented to measure specific organizational and program achievements often remain distant and peripheral to the actual economic, political, and social processes that might actually foster community development. In fact, there is increasing evidence that NGOs do not perform as effectively as had been assumed in terms of the actual alleviation of poverty, cost-effectiveness, sustainability of programmatic efforts, popular participation, gender equity, flexibility, and innovation (Fowler, 2000; Pierce, 1993; Eade 1993; Carroll 1992; Tandler, 1989).

Drawing upon our previous research in urban ghettos in the Southern Cone, this research focuses on the actual performance and effectiveness of NGOs working in extremely and homogeneously poor urban areas in Santiago and Montevideo. In these particular contexts, the “ghetto effect” or “culture of segregation”, as it has been studied by Sabatini (2001) in Chilean cities, places practical barriers to success in the NGOs path. The nature of poor communities reduces the ability of any NGO to foster collective strategies through community mobilization for addressing local problems. Criticism of NGOs’ performance and effectiveness in these contexts focus on (a) the frequent failure of NGOs to reach the poorest households (though they may reach a larger segment of the residents than governmental agencies, as has been pointed out by Farrington and Bebbington, 1993); (b) the lack of sustainable strategies at the community level which make the need for NGOs a “self perpetuate reality” and, perhaps most importantly; (c) serious problems with “downward” accountability which means concern with the benefits to beneficiaries and participants in specific projects.

In urban ecological units characterized by extreme poverty, the tension experienced by NGOs between service provision and effective performance as agents of democratization is crucial. While the former requires standardized delivery mechanisms, organizational capabilities to handle large amounts of funding, and making quick decisions, the latter relies on greater levels of autonomy, closeness to the poor and more representative organizational structures. Efforts to reconcile these trends within unique institutional frameworks make it very difficult for NGOs to engage in service delivery while maintaining their focus in strengthening community capabilities. Additionally, the

increasing involvement of NGOs in large-scale service delivery (what has been called the “scaling up” process) is hypothesized to be associated with reductions in the organizational ability to innovate and develop new responses and with low achievements in local institutional development (Uphoff, 1996).

Specific objectives of the study and hypotheses

Among the universe of non governmental organizations this study concentrates its focus upon those which provide health related services. The proposed objective of the study is to examine the nature and the extent of NGO involvement in health care activities in two capital cities of Latin America, Santiago and Montevideo. Additionally, the project seeks to assess the impact that these new organizational forms have for the quality and distribution of health services. In the face of insufficient public and private medical care, we want to explore the strengths and weaknesses exhibited by the NGO sector to meet the needs of all citizens, particularly those living in underserved communities. From this perspective, finding the main domains of intervention of health NGOs may reveal new institutional arrangements and more efficient strategies derived from transformed balances between the State, the Market and the Civil Society.

To provide a useful structure for organizing the collected evidence we will discuss our findings in terms of 5 major hypothesis that were built in the context of our larger project as a result of a collective effort between professors and graduates students interested in the study of the NGO phenomenon. The following statements connect the larger process

of decentralization, economic liberalization and State reform with their manifest and latent impacts upon the environment where these organizations perform and their multiple institutional dimensions.

Hypothesis 1: “The extent and nature of NGO activity in the health sector varies according to the degree of devolution of responsibility for health care to localities. As a consequence of the combination of neoliberal economic policies and political democratization, most governments have decentralized health care administration to some extent; however, nations differ in the extent to which they have actually devolved responsibility and decision-making to the municipal or local level. The degree of decentralization and devolution will define the domain of opportunity for NGO activities”. (Angel, 2004).

Hypothesis 2: “Health care NGOs have a competitive advantage relative to the State and appear more successful when they (a) focus their efforts on the bounded needs of specific sub-populations; (b) respond to short term crises; and (c) when they provide ancillary instrumental assistance in situations in which the core problem is dealt with by the State.” (Angel, 2004).

Hypothesis 3.: The reduction in funding from the international cooperation and a shift towards public resources creates more competitive scenarios for NGOs. The cooperative pattern of relationships coined under dictatorships was substituted by competitive relations that limit their impact and prevent from sharing accumulated experience and

articulating strategies. The turn to the State as a major financier for NGOs posed additional risks to the autonomy of these organizations. (This hypothesis has been transformed by the author, seeking more context specificity).

Hypothesis 4: “In the competitive environments in which they operate NGOs face economic hardship and upward accountability requirements that impel them to develop in ways that lead them to resemble either the bureaucratic government agencies they sometimes replace, or the private sector businesses to which they are meant to offer an alternative”. (Angel, 2004)

Hypothesis 5: “Access to basic health care for poor community residents will be enhanced or impeded by the extent to which local NGO health providers are able to combine the need to professionalize their operations and secure funding while retaining a community-based orientation”. (Angel), 2004.

The methodology

In order to map the domains of intervention of health NGOs in the two cities, the project distinguished two phases in its methodological design. The first step was the identification of organizations providing health related services on a city or nationwide basis disregarding their specific geographical area of intervention. At this phase we (1) identified most of the health non governmental associations, (2) obtained some basic information in terms of several key variables; (3) accessed existing data related to

previous NGOs directories for public use, databases of NGOs registered as service providers in public programs as well as organizations enlisted in the national NGOs associations.

Based on these sources and after constructing the main fields of intervention a purposive sample was conducted inside each category in order to select organizations that matches the following criteria: (a) “typical” cases which may well be considered representative of the rest of the category, (b) “innovative” cases inside each field of intervention, and (c) “relevant” cases, referring to those organizations with high coverage or impact in terms of service delivery.

As it resulted from our preliminary work, the main areas of intervention were: HIV/AIDS, health and reproductive rights, drug prevention and rehabilitation, mental health, primary health care, elder care, and clients’ organizations (also multicultural health for the case of Chile). The assistance of local informants was decisive in each city for selecting our units of observation. We relied heavily on the expertise of our counterparts in the field in order to identify the organization that best matches the mentioned criteria. Particularly important were 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 one or more of the following approaches was adopted by the researcher: (1) conducted in depth interviews with NGOs directors or

project leaders, (2) participated in some of the staff/board meetings when this was offered, (3) observed directly the area and established informal contacts with local informants, (4) requested documentation and reports related to the organization nature and performance, (5) conducted an archival and documentary search of previous and in progress research through academic centers, universities and representations of multilateral development organizations. Additionally, a significant number of interviews were conducted with central government and municipal agents involved in health service delivery in the area.

A second level of analysis consisted in a closer examination of two different areas in each city in order to get a deeper approach to the phenomena. At this level, the researcher drew upon the interviews that had been contacted among NGOs during previous fieldwork in the summer of 2003 and completed them with additional cases when was necessary. At that time, two neighborhoods were identified based on the following criteria: (a) a relatively homogenous level of extreme poverty; (b) a significant presence of non governmental organizations within its limits; and (c) previous experience of the researcher in the area which assure an efficient use of the time in the field. Following these criteria the selected areas were 'El Cerro' and 'Casavalle' in Montevideo, 'Lo Espejo' and 'La Florida' in Santiago.

Similarities and Differences in the Selected Countries

Given their trajectories, Chile and Uruguay provide fertile ground for comparative analysis. The natural variation of their political and economic structures shed light into our analysis of the evolution and changing role of health NGOs. The following chart summarizes some of the contrasting characteristics, developed in further detail below.

Table 1. Selected characteristics in the studied countries

Characteristic	Chile	Uruguay
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	Mid way reform
Health insurance	Two tiered system	Two tiered system with Collective medicine
Cultural diversity	Higher	Minimum
Macro-Economic Crisis	1970s	1980s / 2000s

Chile and Uruguay exhibited different trajectories in the recent evolution of their welfare services and in the paths followed for processing the required reforms in social policies.

Though we should be cautious in labeling these paths as opposites or completely divergent, we need to acknowledge the differentiated routes that marked their evolution and the prevailing inspirational principles behind each case. Also the use of the word

“model” as an articulated pattern informing and conducting each one of the reforms needs to be handled with care if we want to account for the specificities that qualified the reforms in particular sectors within the same country.

Major structural reforms in the Chilean case were processed under the military regime of Augusto Pinochet (1973-1989) introducing substantial transformations in the health, educational and social security systems. Reforms in these fields were articulated around the principles of privatization and decentralization, seeking to achieve higher levels of efficiency, reduction in the burden of social expenditure and promotion of economic growth. The new set of policies implied a significant break with the universal tradition of the Chilean welfare state that had prevailed in the country since the 1920s. The implemented reforms promoted the incorporation of the market as a provider of social services reducing the intervention of the State only to attend structural deficits of target groups with insufficient capacities. Private enterprises and market oriented actors substituted the State in areas such as health, education, social security and housing, while “targeting” of social expenditure became the preferred instrument for public intervention.

In Uruguay, the landscape of reforms appears less monolithic with mixed trends across sectors and variations along the reforming process. The universal objectives of an ambitious educational reform and the negotiated transformation of the social security system, unveils the continuing presence of the State in the social sectors. After two reformist attempts (1989, 1995) the unbalanced and loss making traditional social security system was replaced by a mixed regime that opened the space for private

enterprises as administrators of personal pensions funds, though assuring a solid presence of the State in the new market¹. Despite the inclusion of a capitalization component, by keeping a solidarity contribution for all segments of incomes the modified regime still assured the administrative monopoly of the State over a significant part of funds. Additionally, the new system implied the privatization of pensions and disability subsidies but kept in public hands the unemployment insurance, familial subsidies, as well as non contributive pensions, which remained funded through the solidarity mechanisms of the old regime. This midway reform, contrast sharply with the fully market oriented Chilean reform that put in the hands of the AFP² the administration of pensions and related social benefits.

Divergent paths, common crises: the reform of health sector

As part of the social sector, the healthcare services were also subjected to reformist winds, though in this case the endeavor seems to be far from producing the expected results. Compared with the transformations occurred in the realm of social security or even education, the field of health services appears as a still pending matter, particularly affecting the access to good quality care of low income households. Dissatisfaction of users of public networks, overcrowded municipal and ministerial primary clinics and long waiting lists at public hospitals appear as the visible symptoms of a public health system that, despite differences in both countries, hasn't provided adequate responses and enough guarantees to patients' needs.

¹ The public enterprise is currently holding the larger share in the market of pension funds administrators.

² Acronym for *Administradoras de Ahorro Provisional* (Pension Fund Administrators)

A closer look at the itinerary of health systems reveals important contrasts between the studied countries and provides different casual explanations for their current situation. Initiated under the Pinochet regime, the first wave of reforms to the Chilean healthcare sector were legally approved in 1979 and implemented in 1980. Though there wasn't a desperate call for reforming the old system at that time, administrative inefficiencies coupled with excessive levels in public expenditure and existing gaps in coverage, prepared the ground for the advancement of new policies which were developed in tandem with reforms to the social security. To simplify, the Chilean health reform can be portrayed around four main axes:

- a) *The creation of the ISAPRES.* Under the new system formal workers have the possibility of choosing between receiving services in the public network of clinics and hospitals or registering with one of the Private Health Providers (ISAPRES³). In all cases affiliated workers contribute with 7% of their salaries being able, in the case of the ISAPRES, to improve the scope of services and reduce the co-payments by means of increasing their premiums. Thus, health plans offered by private providers in the new system operate as individual insurance policies with varying costs for users depending on the assessment of their risk factors. In this context, the income level of the affiliated became a crucial element in determining the extent of coverage and quality of services provided.

³ Acronym for Institución de Salud Previsional

b) *A segmented public sector.* For the public network the reform proclaimed the equal access to the benefits eliminating some of the previous distinctions between white and blue collar workers, and created sliding scales of payment for services according to the income level of the patients, reaching a total subsidy in the case of indigents and extreme poor. Like in other spheres, the subsidiary role of the State was the guiding principle of the reform. According to this notion, State participation in the production or provision of goods and services has to be limited to the areas where there is not sufficient capacity or interest of the private sector. Thus, services provided by the public network should target those groups excluded from the market or with insufficient resources to access its benefits. Two additional inspiring principles of the reform were the “freedom of choice” and the “targeting of health expenditures”. Aligned with the former, those affiliated to the public network were allowed to demand services in the private sector through the issuing of vouchers that subsidized demand⁴. Regarding the later, the philosophy of the military regime was to keep the subsidies for low income households but substituting the existing “crossed” contributions with direct ones. By doing this, they expected to concentrate the access to free health services in the indigents and low income groups, while avoiding the usage of public resources by those who had some financial capacity⁵.

c) *The decentralization of health services.* The 54 areas that composed the National Health System were transformed into 26 decentralized regional entities that operated

⁴ This modality was called “FONASA free choice”, opposed to the “FONASA institutional attention”, where patients were only entitled to receive health care in the public network facilities.

⁵ For further description about the targeting of subsidies in health care during military regimes see Miranda (1994).

with administrative and financial autonomy. The health ministry retained the normative and planning functions for the public sector, through the *Fondo Nacional de Salud* (FONASA), and created the *Superintendencia of ISAPRES* in 1990 for supervising and controlling the private providers. At the regional level the MINSAL (Health Ministry) was represented by a secretary which supervises the services provided by public hospitals and primary clinics inside its jurisdiction.

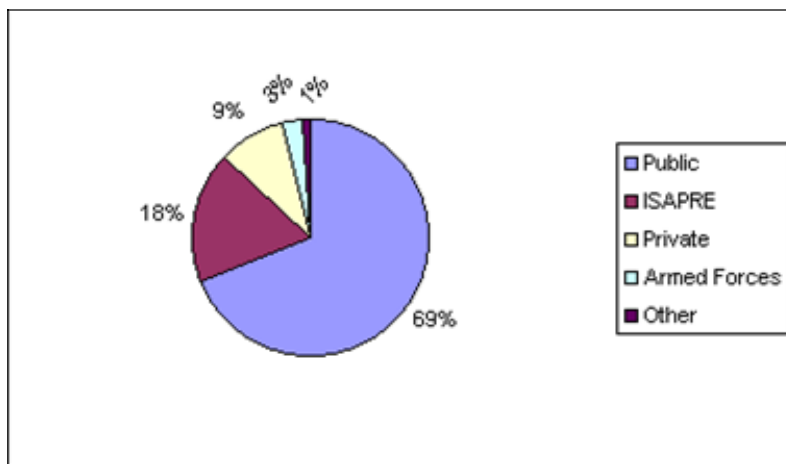
d) *The municipalization of primary health care.* Since 1980 the primary health clinics (CAP⁶) were transferred to municipal governments as a move to improve the control and fiscal performance of the services, particularly those who were distant from the central supervising units. Additionally, the reform sought to match the services to the needs of the population, increase the participation of the community in the decision making process and enhance the bases for a more integrated and coordinated action between the different social programs. The reform was also expected to allow for greater mobilization of local resources and municipal funds in order to make the necessary improvements in services and infrastructure. By 1988 92% of urban CAPs and 100% of rural clinics were already transferred to the *comunas*.

Since these reforms were implemented the per capita expenditure in health has been following a divergent path, favoring those affiliated to the ISAPRES compared with the users of public services. Though the public expenditure on health was multiplied by 2.4 during the 1990s, an extended dissatisfaction with the Chilean health system prevailed in large sectors of the population. Since the ISAPRES rely heavily on the level of income

⁶ Acronym for Consultorios de Atención Primaria

and the risk profile of the affiliated, the system proved to be discriminatory for women and the elderly. The cost of premiums can increase up to eight times for elderly compared with the price of young members. Also for women in reproductive age the cost of the ISAPREs' plans can be three or four times higher than those of men in equal conditions, with some providers offering "*plans without uterus*" in order to discourage pregnancy and keep health costs under control. As could be seen in the chart below, only 30% of the women are covered by other healthcare providers than the public network, a number which resembles the proportion of women in the labor force (Arteaga, 2003).

Chart 1. Female population in the health insurance system



Source: Arteaga, 2003.

The municipalization of primary health clinics had divergent impacts depending on the level of income of the *comunas*, increasing the disparities in the health expenditures across districts according to their resources availability. Some evaluations suggested that the ministerial authorities haven't intervened to smooth these inequities and when they have done it the gaps were accentuated. (Miranda, 1994)

To close these and other equity gaps the current government is promoting a new wave of reforms aiming to implement a universal health plan that assures a minimum package of health care for every Chilean citizen. The so called *Plan AUGE (Acceso Universal con Garantías Explícitas)*, which has become the leit-motif of Ricardo Lago's administration, promotes equal access to health care for a list of medical services and pathologies that has been largely disputed before their approval. The new plan is currently in its pilot phase being, along with *Chile Solidario*, the major policies of the current government in the social sector.

Compared with the Chilean system, the Uruguayan health sector didn't exhibit such reformist vocation, though transformations did take place in a much more subtle and implicit manner. Historically, the health system in Uruguay has been integrated by private providers (popularly known as *mutualistas*, but technically named as IAMC, *Instituciones de Asistencia Médica Colectiva*) which provided almost total healthcare for middle and high income classes, and a public network of clinics and hospitals which assist those who can't afford the costs of private institutions. In the 60s and 70s different agreements between public agencies and the IAMC enabled the affiliation of public employees to the collective medicine institutions. Later some categories of private workers were given the right of affiliation to the *mutualistas* leading to a universal and obligatory insurance in 1984 when all formal workers were definitely included. This converted the collective medicine institutions (IAMC) into the hegemonic actors of healthcare services in Uruguay, covering half of the national population with 1.400.000 affiliations in 1988. At that point, the public system attended roughly 1.000.000 users,

assuring an almost complete coverage for the entire population, along with the services provided by the military and police hospitals, as well as other private providers.

(Filgueira, 2003)

The services provided by the IAMC are financed by contributions from workers and employers, which are administered by a public entity (DISSE) that operates as an intermediary agency and is responsible for contracting with the private providers. The system has redistributive connotations since deductions from salaries are proportional to the earned amount. However, the implementation of increasing co-payments as a means to control the excessive usage of services, posed serious restrictions to the access of low income users who are affiliated but can't afford the additional expenses. With the expansion of the system the massive incorporation of new users unveiled existing structural and financial problems in the mutual sector, leading to increasing public subsidies in order to prevent the collapse of the system. More recently, the rise in unemployment and the correspondent loss in social benefits also provoked a major impact on the vulnerable budget of *mutualistas* which have been experiencing a substantial leakage in their affiliations.

Explained by an increase in the amount of public subsidies, the gap between the expenditure in public health sector and the contributions to the mutual system has been widening in recent years. Like in the Chilean case, there has been a notorious increase in the private expenditure in health with increasing distances between salaries paid in the public and private sector. All this has affected the quality of the services dispensed at

public facilities which have been swamped by an increased level of demand, substantially expanded by the arrival of former clients of *mutualistas*. A substantial increase in the costs of the services provided by these organizations, by means of new tickets, fees and co-payments has limited the use of their services, pushing low income workers to use the double institutional affiliation as a strategy to cope with excessive expenses in the private sector.

Chart 2. Evolution in the monthly fees of *mutualistas* in Montevideo, 1993-2001. (In U\$\$)

Years	1993	1994	1995	1996	1997	1998	1999	2000	2001
Monthly Fee	27.86	33.59	26.30	42.02	44.22	45.86	46.30	45.06	44.22

Source: Organización Panamericana de la Salud, 2002.

To control this situation, in 1997 the government implemented a national registry of users through a computerized network that prevented those affiliated to the mutual system from being assisted in the public facilities. This policy left without coverage important sectors of the population which had the public network as a second provider when they couldn't afford the costs of private care. Currently, the mutual system is facing the major crisis in its history characterized by large debts, the demand of more subsidies to sustain ongoing services, and the delay of structural reforms. Some changes are being recently observed, as required by a rescue program funded by the International Development Bank, leading to the fusion, closure or drastic intervention of these institutions. Some authors have labeled the Uruguayan path as a **privatizing reform "by default"**. Oppositely to the

reforms observed in the fields of education and social security, the health system didn't pursue any major transformation, just introducing palliatives that produced, in most cases, regressive effects for the healthcare of the disadvantaged groups while trying to keep the benefits of middle and high income groups.

Also the decentralizing attempts as well as the efforts to increase the autonomy of public hospitals have led to few results, despite the existence of a legal framework that allows to deconcentrate services to municipal and private providers. A law passed in 1987 allows the public providers to transfer their services to municipalities, negotiate agreements with private institutions or with "supporting groups" (*grupos de apoyo*) formed by members of the community. Though many analysts have seen in this instrument an incipient kickoff to the decentralization reform in the health sector, the truth is that little had been advanced in this direction. Only in the capital city of Montevideo where the ministerial primary health clinics in poor communities have been saturated by an expanding demand, the municipality has fostered a more active strategy running 20 clinics and some mobile units. Interestingly, not until past year the municipal and ministerial level began to coordinate actions, by mutually accepting some basic prescriptions from their respective medical teams. Furthermore, within the different public services there are no formal referral and counter-referral mechanisms, which motivates significant lack of coordination between the different levels of attention.

In this context, is not surprising that the pure private options have encountered an important boost in recent years. The private emergency units have become major

providers offering a wide range of services by a prepaid minimum fee. For some households, this became the second best option when going to the *mutualista* was not affordable. Overall, the Uruguayan case can be depicted as a stratified system with three main sectors: a) those who cannot pay for private options and receive assistance in the public providers, b) those who paid for the mutual system but cannot afford their contingent (at this point permanent) costs, and c) those who complement their affiliation to a *mutualista* with an additional provider. Finally, a small group relies exclusively on private insurance and purely private assistance, a trend that has been increasing in recent years as another token of the fragmentation of the Uruguayan society.

Exploring Our Initial Hypothesis

Hypothesis 1: Is decentralization enhancing new opportunities for NGOs?

“The extent and nature of NGO activity in the health sector varies according to the degree of devolution of responsibility for health care to localities. As a consequence of the combination of neoliberal economic policies and political democratization, most governments have decentralized health care administration to some extent; however, nations differ in the extent to which they have actually devolved responsibility and decision-making to the municipal or local level. The degree of decentralization and devolution will define the domain of opportunity for NGO activities”. (Angel, 2004).

According to our hypothesis, we expected different levels of NGO activity given the existing variations in the degree of implementation of decentralization policies. In Uruguay, a retarded and embryonic decentralization reform of health services, combined with a strong presence of the State and a low associative tradition (Arroyo 2003) might be some of the causes behind in low levels of visibility and articulation of civil society organizations. Though the *Intendencia Municipal of Montevideo* promotes the successful

results of their decentralized health clinics and their achievements in mobilizing the community, the true is that none of these efforts have reached the massive dimensions that the phenomenon attained in Chile. The municipalization of primary health services in Chile, can be directly related to the emergence of large numbers of community organizations constituted by clients and users of the municipal health clinics. As part of a revitalization of the participation in Chilean Civil Society, primary health centers create the conditions for the emergence of a constellation of groups usually agglutinated around a specific pathology or concern, such as diabetes, cardiovascular problems, hypertension, drug rehabilitation, bipolarity, etc.

In some cases the organization is structured around a specific public service, like a hospital or a specialized center, as a means to provide extra support, facilitate the access or enable the satisfaction of subsidiary needs than cannot be covered by the public service. The dependency on the public facility is sometimes materialized in the geographical location of the organization in the surrounding area of the service in order to facilitate the contact with the target population. Similarly, in Uruguay a law promoting the decentralization of health services suggest the creation of “supporting groups” (*grupos de apoyo*) to improve the performance of public hospitals, though these instances didn't parallel the magnitude observed in the Chilean case.

Some authors like Gonazalo de la Maza (2001), have analyzed these experiences in the context of a new type of participation. To illustrate this point, we may consider the case

of the *comuna* of *La Florida* in Santiago⁷, one of the areas visited during our past summer fieldwork trip. In the realm of health related initiatives we found a significant number of local groups formed by users of the public health network, articulated around the public municipal clinics. These groups mobilize residents of different socioeconomic origins, particularly affected or sensitive towards specific health situations. Patients with chronic diseases, groups of health promoters, elderly people connected to health centers, women who share a common health concern, relatives of juvenile drug abusers, teenager mothers, can be some of the examples of this new type of associative forms. These informal types of organization, though they were highly valued by the participants, appear with limited potential to transform the living conditions of the members of the community. Although there is a significant increase in the spaces of participation at the local level, participation in this context is never seen as a right or as demand, but as a natural and spontaneous interaction. The result, as De la Maza (2000) has pointed out, is a type of participation with **low levels of “productivity” and limited transformative power**, given the tough conditions that some of these communities must overcome.

Similarly, these organizations lack sufficient structure to generate transformations at the level of services and have problems in competing for resources other than those offered by municipal governments. Whether they actively collaborate with the municipal health clinics, hospital authorities or municipal staff, they will encounter tremendous difficulties in reaching higher instances of central government. The economic resources they usually need (when required) is provided by the local government, generating opportunities for

⁷ The *comuna* of *La Florida* is a middle class jurisdiction allocated in the south metropolitan area of Santiago, mostly populated by middle class working families and some highly isolated poor housing units.

clientelistic practices at the level of local governments. Thus, is difficult to assert that decentralization generated genuine and sustainable sources of funding for these organizations.

These sources are mostly reserved for more trained, qualified and structured organizations. As we discover it in our fieldwork, traditional and historical NGOs, -those originated under dictatorship or as result of democratic transition usually associated with high levels of professionalization - have transcended the municipal level and articulate directly with central government agencies in their respective area of specialization. This process has been favored in Chile by an advanced State reform that professionalized several health policy fields by constituting units in charge of defining the national strategies in critical health problems like HIV/AIDS (Conasida), drugs (Conace) or elder care (Adulto Mayor). Additionally, from a comparative perspective is clear that the reform of the State in Chile expanded the “culture of NGO” inside the public structure. By contrast, the Uruguayan government still shows some resistances to articulate efforts with non governmental associations, usually derived from more corporatist interests.

The effects of decentralization could be portrayed in terms of more opportunities for NGOs but also higher levels of segmentation of the NGO universe. The situation of historical and more traditional NGOs, contrast with the isolation and lack of resources of community based organizations. It is very difficult for local groups to transcend the circle of their municipal services and compete in the larger scenes. We may hypothesize that the decentralization process, far from breaking this pattern is reinforcing it. The situation

creates additional problems that fall outside the scope of this paper, related to the impact that the concentrated channeling of public fund in larger and traditional NGOs has in poor areas. By fostering this strategy, the government might be prioritizing the urgent delivery of some public goods to the construction of more long standing and enduring social capital.

HYPOTHESIS 2. DO NGOs HAVE COMPETITIVE ADVANTAGES?

“Health care NGOs have a competitive advantage relative to the State and appear more successful when they (a) focus their efforts on the bounded needs of specific sub-populations; (b) respond to short term crises; and (c) when they provide ancillary instrumental assistance in situations in which the core problem is dealt with by the State.” (Angel, 2004).

A key concern of our study was to determine the main areas of interventions of NGOs and the reasons why they operate in these specific fields of health care and not in others. Unlike other fields of social policy, the delivery of medical care is difficult to transfer to non profit entities given the requirements of technology and coverage. Thus, a basic assumption of our approach was that public services still play a major and irreplaceable role as health providers, particularly among poor communities. Our previous experience in the field shows us that is very difficult to find non governmental organizations assuming substantive roles in the core areas of curative and specialize medical care. Many of these areas required specialized technology and high trained professionals, two requirements difficult to meet for local and even more developed organizations. However, the question still remains about where and why NGOs exhibit a significant presence.

Through the analysis of local directories and with information provided by programs related to NGOs, we could identify and group the organizations given their major fields of intervention. The suggested grouping doesn't imply the absence of associations outside these domains, though imply a higher level of concentration of initiatives in these fields. Assuming the exploratory character of this study we acknowledge that the development of precise measures to assess this concentration and its magnitude is still a pending task. Also the fact that NGOs usually devote themselves to more than one field of action, shifting mission over time, discontinuing and resuming on going projects create serious difficulties for the analysis. Overall, the following areas were documented as those with higher number associations, greater number of human and financial resources, greater visibility among key informants and more relevance in the perspective of public officials. As we already said, a precise and well developed measure of the salience of these fields is a methodological challenge that will be faced in future steps of the project.

a) HIV/AIDs. In Chile and Uruguay this may be considered one of the largest fields of work and activity for health related NGOs, though none of them is considered a high risk case in terms of the prevalence of the disease. If we take a closer look to the organized civil society in HIV, we will find in both countries a similar phenomenon. On the one hand groups of persons infected with HIV that organize themselves in larger structures, to demand quality services from the State and promote changes in the realm of public opinion and national legal systems. On the other hand, organizations formed by professional and volunteer personal, which take a more paternalistic approach and work towards the prevention of the disease or the assistance of those affected. The division line

among the two groups is clear and provides useful insight to understand the differential patterns of relationship that they have with governmental structures. While the former have a more political agenda and their goal is to advance the rights and demands of HIV patients, the latter deploy a more amicable approach to public services and are usually identified as less political organizations.

b) Sexual and reproductive health. A second group of organizations, though working in different areas, can be grouped under the label of sexual and reproductive health. In this category we included organizations that work in the subfields of teenager pregnancy, domestic violence, abortion, sexual rights of minorities, family planning. It is clear that organizations working on HIV are also part of this group and many of them have combined objectives. However, given the salience of the HIV crisis and the large number of organizations working specifically on this issue, we prefer to give these associations a separated treatment. Interestingly, many organizations place their actions as part of wider objectives towards the advancement of “sexual and reproductive health”, though their scope of action might be a narrow one. The so called “rights approach” seems to be impregnating most of the organizations in this field, despite their divided nature between those who are effectively service delivers and those who advocates for changes in the health and legal system. As has been documented in other studies, the numbers of organizations mobilized around gender issues has been increasing substantially in recent years. This is true for both countries, though in Chile they have achieved greater visibility as a result of their participation in public campaigns and involvement in high profile debates.

c) Drug rehabilitation/prevention and mental health. The intervention of NGOs in these fields proved to be critical for advancing new models of intervention and new approaches to relevant health issues. The distinction between more formal/structured organizations and community based organizations is one that should be kept in mind when analyzing this group. For the case of Chile our research identified many groups operating at the local level trying to provide support to mental patients and drug consumers. These organizations play a significant role in cooperating with the municipal services by bridging the patients with the services, providing spaces for longer rehabilitation process and assuring spaces of group support. The existence of therapeutic communities publicly funded and run by associations of professionals is another example of community based experiences that articulated efforts with municipal services. However, more traditional and formal organizations are playing an important role in advancing new models of intervention at the central level. Despite their impact as direct service providers, these organizations are quite effective in setting the agenda and nurturing the government with new expertise, experience and approaches. An interesting example in the field of mental health was observed in the new approach fostered by some therapeutic communities in Santiago and Montevideo, based on the social reinsertion of patients instead of the traditional institutionalization. Similarly, in the field of drugs prevention and treatment, NGOs are promoting a more communitarian approach to the problem, taking into account the social networks operating at the community level. Overall, these organizations have relative advantages compared with public services since their intervention rely on their long standing bonds with the community.

d) Child maternal health care. Despite failures in the system and some problems in some areas of specialization, the primary level of attention is one of the strengths of the public network in Chile. Public clinics provide high levels of resolutions of problems related to pediatric and obstetric visits, which constitute one of the major reasons for attending the center. However, the situation in Uruguay differs substantially, with a saturated public network as a result of decreasing access to collective medicine system. This situation created major challenges for organizations working in these areas as they deal with the barriers in the access to local services while being unable to provide the required services. At the time we conducted our fieldwork we observed a new approach to the problem, one that may deserve close attention given the nature of the intervention. The *Programa CAIF* in Uruguay is a publicly funded program that support local associations, “*juntas de vecinos*” and “*comisiones de fomento*” to provide preschool day care to children in low income areas. With funding from the International Development Bank, the program has recently increased its coverage and expanded its range of services, promoting a more integral approach to the community, one that also includes the provision of health services. During my visit to Montevideo, important efforts were being made to bridge these local associations with public clinics and hospitals since the new changes required more articulation between the two organizations. Whether this initiative prospers or not, it constitutes an interesting experience to follow, based on a more integral approach to health and the community.

e) Elder care. In both countries this field constitutes a major area of intervention and activity for NGOs and community organizations. Directories of local or municipal non profit associations are filled with large numbers of social, recreational and sportive associations that provide opportunities for social integration to the elderly. However, is clear that are very few them can transcend this auxiliary/complementary level and be brought into the field of curative and specialized medical care. As a matter of fact, with the exception of Hogar de Cristo and a few other cases in Chile, most of medical care services for this age group are in the hands of public or purely private providers. Exceptionally, organizations like “*Hogar de Cristo*”, have built a nationwide reputation based on years of visible work with the poor under the umbrella of the Catholic Church and incorporating managerial tools that allowed them to move away from State dependency.

f) Clients/Users organizations. Urged by their demands over public services or linked with corporatist interest, some users and clients of the public network have formed groups with the purpose of controlling the quality of the services provided and holding the State accountable. Our interviews in this field show substantial alignment between the interests of these groups and the strategies of medical corporations. In context of health reforms, and institutional changes affecting relevant interest in the health sectors, the organizations of client and users of public services constituted manifestations of some of the interests that are being challenged by reforms.

Despite the likely existence of other areas of intervention, it is important to reflect upon the commonalities observed across these fields and inquire about the prevailing reasons for an increasing presence in these areas relative to others. After asking “where are the NGOs?” we now need to answer “why in these areas and not others?”. It is clear that the above mentioned areas refer to fields of intervention where a) the state need to extend coverage and have limited resources to do it by itself, b) is not being able to articulate effective and adequate responses to cope with the demands, c) has not accumulated enough expertise or lack trained human resources, d) needs to adopt new models of interventions and abandoned old practices, e) may not be legitimated to do so in front of the public opinion.

From the perspective of the NGOs these areas also shared some commonalities that need to be pointed out. Usually these sphere of intervention refer to areas where the organizations a) have accumulated significant expertise and have trained human resources, b) have direct access to the target groups or communities involved, c) can make a claim of representing the interest of target groups (though this is different from the effective entitlement), d) NGOs are capable of anticipating new models of intervention and approaches, e) they find available resources to sustain their actions.

Thus, to respond to our initial hypothesis we may suggest that NGOs are where the State needs them and in less degree where they want to be. The State has a major role in opening new spaces for NGO intervention, creating quasi markets where these organizations can compete for funds under the patronage of the State. In both countries,

channeling funds to deal with specific problems or into geographical areas become a potent mechanism to attract and take advantage of organizations with expertise in particular fields or zones. This strategy led to a pattern of relationships that see the other as partners more than enemies.

However, we also need to account for a group of organizations and experiences that draw upon the prevalence of a *right approach* and whose main objective is to hold the State accountable. These set of organizations deployed a more political agenda while leaning towards more confrontational patterns in their relationship with the State. Following the steps suggested by Stella Theodoulou in “*Making Public Policy*” (Theodoulou), these organizations are major players in the “problem recognition”, “issue identification”, “agenda setting” and “policy formulation”. Though our focus was posed on the importance of NGOs as service providers we were surprised by their leading role in setting the agenda around some critical issues and holding the state accountable respect different citizen rights. Instead of partners, in this case the prevailing vision is one of NGOs as challengers of the State.

In simple terms, the governmental agencies needs the participation of NGOs to “get the job done” while NGOs also requires to access the economic and political resources in public hands to expand their view and promote their actions. These two forces operate in the same direction by shortening distances between the organizations and the States. The risk, as observed in the field, is that many NGOs may be operating more as quasi public entities than private associations with public goals. The major challenge is how to

articulate the double nature of NGOs as partners and challengers of the State at the same time without blurring their identity.

HYPOTHESIS 3. HOW COOPERATIVE OR COMPETITIVE ARE THE NGOS?

“The reduction in funding from the international cooperation and a shift towards public resources creates more competitive scenarios for NGOs. The cooperative pattern of relationships coined under dictatorships was substituted by competitive relations that limit their impact and prevent from sharing accumulated experience and articulating strategies. The turn to the State as a major financier for NGOs posed additional risks to the autonomy of these organizations”.

The NGO sector underwent several simultaneous changes derived from the consolidation of the national democratic process and the redefinition of the roles of government and civil institutions in the region. Maybe the most significant process refers to the loss of centrality of the NGOs as political and social actors, since traditional movements and political parties were regaining their lost role in the political and social arenas. The crucial role that the movement played under dictatorship in opposing violations of human rights, struggling for democratic values, and providing basic social services, was now recovered by political parties, labor unions and governmental structures which were considered the “natural” actors to handle these issues. With the restoration of democracy and the reopening of Parliaments as spaces for debate and building consensus, the oppositional role of NGOs was no longer required, leading to a rapid process of demobilization of their human resources and political militancy.

Additionally, central and local governments partially recovered their responsibility as social service providers, competing with NGOs for the funding of their projects in the context of international cooperation and redirecting substantially the supply of funds. But

also changes in the nature of international cooperation itself seriously affected NGOs. The restoration of democracy changed the perspective of international financial agencies and other external funding sources, leading to a reassessment of their priorities at a global level. For most of them, the situation in other regions of the world appeared to be more critical, provoking a significant reduction in the supply of funds to the region. Though the origin of the crisis has not to be found in the reduction of international cooperation, this certain reality gave the *coup de grace* to an already weakened sector.

The portrayed situations provided the context for a generalized crisis of identity in most NGOs, individually considered and as collective actor. The new scenery was requiring the deployment of new strategies, an actualization of their institutional missions and different responses from the ones the movement had exhibited in former times. This period of crisis was marked by periodical waves of resizing and reductions in the number of workers and employees, as dramatic attempts to fight for institutional survival in a context of lack of resources and vacuum of identity⁸. Many of these organizations were not able to succeed and literally disappeared during the first decade of democratic restoration⁹.

As a result of the new environment, many NGOs redefined their role by reassuming new modes of social intervention, building alliances with new partners, and recreating their links with the government, now based more on cooperation than in opposition. The

⁸ One typical NGO in Montevideo, a survivor of this process, underwent at least four waves of reduction in its staff after peaking in the first years of democratic regime.

⁹ Being a social researcher in an NGO devoted to defend the rights of organized laborers in the middle 90s, I witnessed the sudden closure of the institution, followed by a give away of the existing inventory in order to pay the owed salaries.

emergent NGO can be featured as a more pragmatic one (in both discourse and practice) and with higher levels of flexibility and adaptability, mainly driven by their survival instinct. Additionally, the movement seemed to have assumed that they no longer were the unique expression of civil society neither could NGOs claim to represent it. In fact, a more diverse group of organizations came to existence that reshaped the face of civil society bringing increasing complexity and diversity to the no longer uniform realm of “civil society”.

Perceiving themselves as unique and distinctive actors, and in need of cooperation and mutual support, NGOs strengthen the links with each other and converged in the defense of their common interests in dialogue with the State and other Civil Society Organizations (CSO). As a result, in the 1990s several associations of NGOs emerged all over the region signaling the consolidation of the distinctiveness and uniqueness of this group compared to the rest of Civil Society Organizations¹⁰. It was not a coincidence then, that between 1990 and 1992 most organizations and federations of NGOs were born. *ABONG* (Associação Brasileira de Organizações não Governamentais) and *ACCION* (Asociación Chilena de ONGs) were founded in 1991, *ANONG* (Asociación Uruguaya de ONGs) was created in 1992. Also in this year, a significant meeting of NGOs took place in Argentina organized by *Red Encuentro*. The objectives of these initiatives responded to the need of spaces to articulate common strategies and strengthen their negotiations with other key actors like multilateral and governmental agencies.

¹⁰ A typology of the full range of Organizations of the Civil Society (which includes NGOs) can be found in the document issued by LBJ School of Public Affairs with the preliminary findings of our summer research project (Angel et al. 2003)

Our research for the case of Chile and Uruguay showed that these second-grade organizations were mainly integrated by traditional and “developmental” NGOs, while community based and grass roots organizations (GROs) were not included in this formal collective. The use of the adjective “developmental” was introduced by historical and formal NGOs as an attempt to differentiate themselves in a context where almost all organizations of civil society made use of the acronym “NGO”. This particular reference to development as a signal of identity respond to the specific focus that original NGOs exhibited in social and economic issues and their original concern to achieve alternative and sustainable models of community development.

Beyond the existence of formal national associations, also theme-specific groups are constructed with different levels of formalization to coordinate strategies and articulate approaches. In both countries it is common to find networks of NGOs that group those working in the same geographical area, with the same target population, or contracted by the same public agency. Those which share the condition of being counterparts of a particular ministry or public program may articulate efforts to increase their power of negotiation and enhance their influence on the public agents, though this process is not exempt from tensions among the affiliated members. Our primary exploration yields that there is scarce articulation around health specific issues or in health related networks of NGOs. There is significant coordination of demands around health issues but mostly articulated in spaces that are not health specific, like was the case of a network of formal NGOs in Casavalle (Montevideo) or a network of children’s NGOs that operate on a nationwide basis.

In Chile, second level organizations like the network “*Vivo Positivo*” that articulates groups of patients with HIV from all over the country and the “*Foro de Derechos Sexuales y Reproductivos*” were important actors in attaining some specific political and legal outcomes related to sexual rights and non discriminatory policies.

Overall, the collected information shows that despite competitive environments, NGOs are capable of creating spaces for the articulation of strategies and strengthen their positions in the face of other key actors. However, as a Chilean author has pointed out these spaces are not allowing for substantive sharing of experience and knowledge, missing significant opportunities to enhance the impact of their actions. In terms of knowledge and expertise, NGOs have exhibited a more opened attitude towards the State than towards their pairs.

HYPOTHESIS 4. ARE NGOS BUREAUCRATIZING THEIR STRUCTURES?

“In the competitive environments in which they operate NGOs face economic hardship and upward accountability requirements that impel them to develop in ways that lead them to resemble either the bureaucratic government agencies they sometimes replace, or the private sector businesses to which they are meant to offer an alternative”. (Angel, 2004)

As our hypothesis suggested we were looking for process of bureaucratization in the structures of the NGOs. The evidence yielded that those organizations facing economic hardship and the pressure of the state for results and granting funds, either followed one of two paths: disappeared or change their structure. As we mentioned in the previous section, many organizations couldn’t survive under the new circumstances as a

consequence of the funding constraints, but mostly, as the result of the inadequacy of their structures to the new scenario. In consequence, the universe of NGOs is characterized by high levels of institutional mortality, something that posed serious challenges for the construction of our framework.

Overall, we found few large structures, being most organizations medium and small scale, usually working with reduced number of professionals as permanent personnel and expanding their staff on a project basis. The “Hogar de Chile” - a successful NGOs attending several basic needs throughout stages in life course, constitutes an exception in the region due to the number of employees, large budget and low level of dependency from public funding.

Additionally, the pressures that the State exercise upon the NGO structures are quite ambiguous. Though the legal framework is more adequate and further developed in Chile than in Uruguay, in none of these countries NGOs are hold accountable by State.

Controls are loose and NGOs are rarely audited, weakening their credibility particularly in the face of private donors. Should the State hold NGOs more accountable, private donors and corporations might be tempted to contributed more generously.

To summarize, bureaucratization doesn't seem to be a feasible risk for current health NGOs in Chile and Uruguay. The changing environment has already eliminated those that didn't manage to adapt to the new circumstances, forcing the survivors to become more flexible and precautionous. Of course, this doesn't mean that organizations do not

grow, expand or contract new employees, but that they do it in such a way that they remain flexible and ready to size down when the next crisis come.

HYPOTHESIS 5. OPTIMUM COMBINATION IS KEY TO SUCCESS?

“Access to basic health care for poor community residents will be enhanced or impeded by the extent to which local NGO health providers are able to combine the need to professionalize their operations and secure funding while retaining a community-based orientation”. (Angel, 2004).

As we have made clear before, the expertise and accumulated knowledge about a specific community or target group yielded by NGOs is a source of attraction for governmental structures. However, after 15 and 20 years of democratic restoration (Chile and Uruguay respectively), NGOs have experienced an accelerated flow of human resources –mostly professionals and technicians. Given the strong experience that NGO staffs acquired in their field of specialization, the re-constituted public units under democracy required their expertise in order to accomplish their new challenges. As a result, the public sphere made use of the expertise that had been accumulated in the NGO sector through the cooptation of their most qualified human resources¹¹. One of the NGO leaders interviewed in Chile portrayed the problem in very clear and direct terms: “The State is permanently complaining that we do not generate alternatives, that we never bring new proposals,... But how can we innovate if they take away our most valuable personnel!”.

Regarding their relationship with community members and other constituencies, a specific pattern can be identified in more traditional and historical NGOs. Those which

¹¹ The preliminary findings of a research project in progress in Chile (Oxcenius, De la Maza and Gutierrez) suggests that this flow towards the State is mediated by participation in political parties and determined by technical and professional skills.

played a significant role under dictatorships and during democratic transition, have been experiencing a progressive detachment from their basis, a process that some informants called as “des-territorializacion”. This increasing distance from the bases, is usually coupled with the transformation of many of these organizations in consultant services, think-tanks, evaluation providers for governmental and international agencies.

We are not stating that this process occurred to all organizations that emerged after democratic restoration. However, we have identified a pattern among those who can be considered the “historical”, the more visible and more legitimated actors due to their original ties with the social movements. With a few exceptions, a process of detachment from the bases took place while they prioritize more academic and policy oriented jobs (the NGO La Caleta Sur can be cited as an exception).

When we combined the two forces that operate over traditional NGOs, these are, cooptation of professional staff and progressive lost of territorial bases, we realized the great difficulties faced by these organizations to maintain their roots and their accumulated expertise. Therefore, we can say it is true the assertion that those that could retain significant levels of presence across both dimensions, are now the more successful. The key of the successful role of the HIV patients network articulated around “Vivo Positivo” derives precisely from its combination of professional skills as well as their representative character of their constituencies.

Final remarks

A first analysis of the material brought from the fieldwork showed that the effects of globalization forces upon NGOs structures are ambiguous and difficult to standardize. Health reforms as well as decentralization are creating new opportunities for States in both countries, despite contextual differences. Though lacking sufficient regulation, the State intervention is “shaping” and transforming a market of NGOs in which –as in all markets- there are winners and losers. But is also true –as we have seen- that NGOs are enhancing and opening spaces for new models of intervention among governmental structures. Mental health, HIV, drug prevention and rehabilitation are examples where organization of civil society have promoted changes in the public agenda, bringing to the fore the entitlement of new rights, holding the state accountable and promoting new paradigms to tackle major problems.

Wisely, the State has taken advantage of this expertise building alliances and partnerships with many of these organizations. Process of cooptation and transfer of professional resources from one sphere to the other, are more radical expressions of this process of approximation, one that may pose serious perils for the survival of the organizations. The gradual detachment of their social bases, seems to be harming their legitimacy in the long run, though may enable a concentration on more academic and intellectual fields.

In any case, as the story goes, NGOs has been moving along a continuum in their relation with governmental structures: against the State, with State, within the State. Though the

last scenario has not been fully developed yet, it may entail serious risks if the identity of NGOs is subsumed in the governmental space. It is clear that the State needs NGOs, and not “QUASO” (Quasi State Organizations) as someone named those structures that resembled public bureaucracies. If identities get blurred as a result of this process, both parts will surely lose.

Bibliography

Abramson, Wendy (1999). Partnerships between the Public Sector and Non Governmental Organizations: Contracting for Primary Health Care Services. Health Sector Reform Initiative, No. 25. Family Planning Management Development Project. Boston.

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

Angel, Ronald (2004). Global Process, Local Impacts: Non-Governmental Organizations and the Distribution of Health Care Services in Developing Countries.

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

Bebbington A. and Riddell, R. (1994). “New Agendas and Old Problems: issues, options and challenges in direct funding of southern NGOs”, paper presented at the Workshop on ‘NGOs and Development: Performance and Accountability’, University of Manchester, 27-9 June.

Bebbington, A. and Thiele, G. (eds) with Davies, P., Prageer, M. Riveros (1993); “NGOs and the State in Latin America: Rethinking Roles in Sustainable Agricultural Development”, London: Routledge.

Beyer, Harold; Rodrigo Vergara (Ed) (2001) ¿Qué hacer ahora? Propuestas para el Desarrollo. Centro de Estudios Públicos. Santiago.

Bombarolo, Felix (2002). Fortalecimiento de la participación ciudadana frente a los retos de la desigualdad social en América Latina. Paper submitted in the Primer Congreso Nacional de Políticas Sociales in Argentina.

Brunner, José Joaquín; Elacqua, Gregory (2003). Informe del Capital Humano en Chile. Universidad Adolfo Ibáñez. Santiago.

Cancino, Bernardita; Darío Vergara (1996). La Asociación de los Privados. Organismos Privados de Desarrollo. Colección Estudios Sociales Ediciones Sur. Santiago.

Carroll, Thomas (1992). “Intermediary NGOs: The Supporting Link in Grassroots Development”, West Hartford: Kumarian Press.

Celedón, Carmen; Nelson Guzmán; Marcela Noe (1999). Mecanismos de Control Social sobre los Servicios Públicos. Una Aplicación a la Atención Primaria en Salud. Informe de

avance de la consultoría del CIEPLAN y del Fondo de Políticas Públicas del Departamento de Ingeniería Industrial de la Universidad de Chile. Santiago.
CEPAL/PNUD (1999), “Activos y estructuras de oportunidades. Estudios sobre las raíces de la vulnerabilidad social en Uruguay”. Montevideo.

Clark, John. (1991) “Democratizing Development: The Role of Voluntary Organizations”, West Hartford: Kumarian Press.

Cruz, Anabel and Fernando Barreiro (2000). “Sociedad Civil en el Cono Sur de America Latina”. Instituto de Comunicacion y Desarrollo, Montevideo.

Dagnino, Evelina. (2003) “Sociedade civil, participacao e cidadania: de que estamos falando?” Presentation delivered at the International Colloquium “Políticas de Ciudadanía y Sociedad Civil en Tiempos de Globalización”. Buenos Aires.

De la Maza, Gonzalo (2000). La igualdad está en la diferencia. Ponencia presentada en la conferencia contra el racismo, la xenofobia y otras formas conexas de discriminación.

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.

De la Maza, Gonzalo (2001). Espacios Locales y Desarrollo de la Ciudadanía. 30 Innovaciones para construir democracia. Programa Ciudadanía y Gestión Local. Santiago.

De la Maza, Gonzalo; Carlos Ochsenius (2001). Acción Internacional de las Redes No Gubernamentales Latinoamericanas: ¿Reflejo o superposición a las realidades nacionales?. (Not Published)

Eade, Deborah (1993) Editorial. Development in Practice 3 (3): 161-62.

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.

Edwards Michael and David Hulme (1996). “NGOs, Performance and Accountability: beyond the magic bullet” London: Earthscan.

Edwards Michael and David Hulme (1997). “NGOs, State and Donors: too close for comfort?”. Macmillan

Farrington, J. and Bebbington A. (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. The Third World Institute. Montevideo.

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

Fowler, Alan (2000). "Civil Society, NGOs and Social Development: changing the rules of the game". Geneva: UNRISD.

Fox Jonathan and David Brown (1998). "The Struggle for Accountability: the World Bank, NGOs and Grassroots movements", Cambridge MA: MIT Press.

Franco, Rolando (1996) Los paradigmas de la políticas social en América Latina. CEPAL. División Desarrollo Social. Santiago.

Gómez, Sergio (1989) Nuevas Formas de Desarrollo Rural en Chile. In Una puerta que se abre: los Organismos no Gubernamentales en la Cooperación al Desarrollo, Rodrigo Egaña, ed., 327-356. Santiago.

Gonzalez Meyer, Raul (1999). "Relaciones ONGs-Estado en Chile: Aportes para un balance de la decada del 90" In Revista de Economía y Trabajo, No. 9, PET, Santiago.

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

INAP (2003). De Pacientes a Ciudadanos. Experiencias Democratizadoras de Salud. División Organizaciones Sociales. Ministerio Secretaría de Gobierno. Santiago.

Jiménez de la Jara, Jorge; Thomas Bossert (1995). Chile's health sector reform: Lessons from Four Reform Periods. In Berman, Meter, ed. (1995). Health Sector Reform in Developing Countries. Making Health Development Sustainable. Harvard University Press. Boston.

Kaztman, Ruben; Fernando Filgueira (2001). "Panorama Social de la Infancia y la Familia en Uruguay". Programa de Investigacion sobre Integracion, Pobreza y Exclusion Social, Universidad Catolica del Uruguay. Montevideo.

Kolehmainen-Aitken, Riitta-Liisa (2000). State of Practice: Public NGO Partnership in Response to Decentralization. Health Sector Reform Initiative, No. 22. Family Planning Management Development Project. Boston.

Korten, David. (1987) "Third Generation NGO Strategies: A Key to People-Centred Development", World Development, vol. 15, supplement, pp. 145-59.

- Long, Norman (1999). “The Multiple Optic of Interface Analysis”. UNESCO. Wageningen University. Netherlands.
- Loveman, Brian (1994) Las ONGs Chilenas: su papel en la transición a la democracia. Published in Reilly, Charles; Nuevas Políticas Urbanas: Las ONGs y los gobiernos municipales en la democratización latinoamericana. Arlington.
- Miranda, Ernesto (1994). La Salud en Chile. Evolución y Perspectivas. Centro de Estudios Públicos. Santiago.
- Mosser, Caroline (1998). “The Assets and Vulnerability Framework: Reassessing Urban Poverty Reduction Strategies” in World Development, Vol 28.
- Organización Panamericana de la Salud (2002). Perfil del Sistema de Servicios de Salud de Uruguay. Programa de Organización y Gestión de Sistemas y Servicios de Salud. División de Desarrollos de Sistemas y Servicios de Salud. OPS. Montevideo.
- Pan American Health Organization (1999). Chile: Profile of the Health Services System. Program for Organization and Management of Health System and Services. Division of Health Systems and Services Development. PAHO. Santiago.
- Pearce, Jenny (1993). “NGOs and Social Change: Agents or facilitators” Development in Practice 3 (3):222-27.
- Pearce, Jenny (2000) “Development, NGOs and Civil Society: the Debate and its future” in Deborah Eade (ed)., “Development, NGOs and Civil Society”
- Pereira, Javier (2003). “Reports from the Battlefield. Unveiling the politics and anti politics of they NGOs movement in the Southern Cone”. Mimeo. Austin, University of Texas.
- PNUD (1998). Las paradojas de la modernización. Informe Nacional sobre Desarrollo Humano en Chile. Programa de Naciones Unidas para el Desarrollo. Santiago.
- Porzecanski, Rafael (2002) Despeño social de los gobiernos militares de Chile y Uruguay, 1973-1981. Published in Cuadernos del Claeh No. 85. Montevideo.
- Roberts, Bryan (2001) Las Nuevas Políticas Sociales en América Latina y el Desarrollo de Ciudadanía: Una perspectiva de Interfaz. Documento elaborado para el Taller Agencia, Conocimiento y Poder: Nuevas Direcciones. University of Texas, Austin.
- Roberts, Bryan (2003) Citizenship, Rights and Social Policy. University of Texas, Austin.
- Robinson, M. (1993). “Governance, democracy and conditionality: NGOs and the New Policy Agenda. In Governance, democracy and conditionality: What role for NGOs?” Edited by A. Clayton. Oxford: International NGO Training and Research Centre.

Sabatini, Francisco; Gonzalo Caceres y Jorge Cerda. (2001). “Segregación residencial en las principales ciudades chilenas: Tendencias de las tres últimas décadas y posibles cursos de acción”. Revista EURE, Vol 27, no. 82, pp 21-42, Santiago.

Salinas, Judith; Giorgio Solimano (1994) Las ONGs de salud en Chile. Published in Reilly, Charles; Nuevas Políticas Urbanas: Las ONGs y los gobiernos municipales en la democratización latinoamericana. Arlington.

Silva Rojas, Patricio (1998). Sistema de Salud en Chile. Published in Cuad. Méd. Soc. XXXIX, 1, 1998/ 46-53. Santiago.

Solimano, Giorgio; Judith Salinas (1992). Salud con la Gente. El rol de las ONGs en las políticas públicas en América Latina. Corsaps. Corporación de Salud y Políticas Sociales. Santiago.

Valdés, Alejandra (2002). La Participación Social y Ciudadanía en Salud. Informe Preliminar de la Consultoría “Capacitación y Asistencia Técnica a Políticas y/o Programas Públicos de la Reforma de Salud y Políticas Participativas en Salud”. Instituto de Asuntos Públicos de la Universidad de Chile. Santiago.

Valdés, Alejandra (2002b). La Participación Social y Ciudadanía en Salud. Informe No. 2 Preliminar de la Consultoría “Capacitación y Asistencia Técnica a Políticas y/o Programas Públicos de la Reforma de Salud y Políticas Participativas en Salud”. Instituto de Asuntos Públicos de la Universidad de Chile. Santiago.

Veronelli, Juan; Aron Nowinski; Benito Roitman; Alvaro Haretche (1994). La salud de los Uruguayos. Cambios y Perspectivas. OPS/Editorial Nordan. Montevideo.

White, Sarah (2000). “Depoliticizing development: the uses and abuses of participation”. In Deborah Eade (ed)., “Development, NGOs and Civil Society”

Zaffaroni, Cecilia; Daniel Alonso, Pablo Mieres (1998). Encuentros y desencuentros. Familias Pobres y Políticas Sociales en el Uruguay. Centro Latinoamericano de Economía Humana. CLAEH. Montevideo.