TO HELP, OR AT LEAST DO NO HARM: 
THE EVOLVING ROLES OF GLOBAL HEALTH NGOS 
in Health Systems Strengthening

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ABSTRACT

Laura Miniea Hoemeke: To Help, or at Least Do No Harm: The Evolving Roles of Global Health NGOs in Health Systems Strengthening
(Under the direction of Suzanne Hobbs)

Background: International non-governmental organizations (INGOs) have proliferated over the past several decades. As significant actors in global health and development, they can help strengthen health systems in the countries in which they operate. INGOs sometimes, however, engage in practices that weaken health systems, including creating additional management burdens and distorting labor markets, as well as exacerbating inequities by offering higher quality care to some segments of a population. Health systems strengthening (HSS) is an evolving concept and, while little agreement exists on effective HSS metrics, there is consensus in the global health community that strong health systems are essential to achieve global health goals. In May 2008, several INGOs developed the NGO Code of Conduct for HSS to address factors related to the potential negative impact of INGOs; the Code, however, has not garnered significant attention within the global health community.

Study design: This research seeks to understand how INGOs can best support HSS without unintentionally harming national health systems and explores factors preventing the NGO Code of Conduct from gaining momentum. The methodology consists of a comprehensive literature review identifying evolving concepts regarding HSS and INGOs, a review of the NGO Code of Conduct, and analysis of key informant interviews with representatives of 20 INGOs.

Findings: INGOs can mitigate potential negative impact of their work by engaging in more systems thinking and self-analysis to develop greater awareness of their effects on health systems,
especially their work on projects that are disease-focused or implemented in selected districts and not
tnation-wide. Donor agencies can facilitate INGOs’ work to mitigate potential negative impact by
dedicating funding to HSS, especially—but not only—in vertically funded projects, and creating more
flexible funding mechanisms that allow for systems investments. In countries where ministries of health
have greater management capacity, the work of INGOs and all health sector partners contributes more
efficiently and effectively to HSS. Nearly all key informants shared challenges related to the NGO Code of
Conduct for Health Systems Strengthening; they believe the Code should be modified and updated, or
replaced by a simpler list of principles to guide INGOs in HSS.
DEDICATED TO PEOPLE AROUND THE WORLD
WHO LACK ACCESS
TO QUALITY HEALTH CARE
AND TO THOSE WORKING TIRELESSLY
TO DELIVER CARE TO THOSE IN NEED
ACKNOWLEDGEMENTS

This work would not have been possible without the encouragement, support, and patience of friends, family, and colleagues; they are too numerous to name individually, but know who they are. I am thankful to my sisters, who have always been there when I needed them most, and my parents and entire family, for valuing education—and for inspiring my life-long love of learning and discovery. I am especially grateful to Ralph for his loving support, and for keeping me nurtured and nourished, especially during the final phases of this project.

This research was inspired by my 20 years of working and living in low-income countries throughout Africa. I am grateful to the hard-working, dedicated, and inspiring health workers and managers who show up to work every day despite challenging circumstances, including in many cases not being paid for months at a time due to dysfunctional health systems. This work would not have taken place without all I have learned from them over the past two decades.

Key informants who participated in this research were candid and surprisingly forthcoming in sharing the challenges their organizations face and their own experiences. I thank them for their contributions and the trust they placed in me by sharing their recollections and recommendations.

I also thank each of my committee members for their valuable insight, feedback, and advice; each of them provided unique and significant guidance. I would like to acknowledge the support of my committee chair, Dr. Suzanne Hobbs, who reminded me, as well as my classmates, to “trust the process” and ourselves, from the onset of our orientation to this doctoral program. I also would like to acknowledge Professor Thomas Ricketts, who has served as an informal mentor and “sounding board” along the way.
Finally, special thanks to my brilliant classmates in Cohort 7 who were a constant source of support, providing much-needed humor along the way, and inspiring me in their dedication to public health and to making the world a better place.
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LIST OF ACRONYMS

APHA  American Public Health Association
DFID  Department for International Development (United Kingdom Aid Agency)
GFATM  Global Fund to Fight AIDS, Tuberculosis, and Malaria
GHI  Global Health Initiative
GHWA  Global Health Workforce Alliance
HAI  Health Alliance International
HIV/AIDS  Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HMIS  Health Management Information System
HSS  Health Systems Strengthening
IMF  International Monetary Fund
INGO  International Non-Governmental Organization
KI  Key Informant
LMICs  Low- and Middle-Income Countries
MDGs  Millennium Development Goals
NGO  Non-governmental Organization
ODA  Official Development Assistance
OECD  Organization for Economic Co-operation and Development
PEPFAR  The United States President’s Emergency Plan for AIDS Relief
PHC  Primary Health Care
PMI  The United States President’s Malaria Initiative
PVO  Private Voluntary Organization
RBM  Roll Back Malaria
SHOPS  Strengthening Health Outcomes through the Private Sector
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>SWAp</td>
<td>Sector-wide Approach</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
</tr>
<tr>
<td>USD</td>
<td>United States Dollars</td>
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<tr>
<td>USG</td>
<td>United States Government</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1: OVERVIEW AND INTRODUCTION

As funding for international non-governmental organizations (INGOs) has increased, so has their influence as actors in global health and development. INGOs support not only direct service delivery, but also provide technical assistance to contribute to policy development and systems building, and have influence through national and international advocacy movements, allowing them a position of authority with their own governments and the general public (Nelson, 2000). The leadership and management of health systems is ultimately the responsibility of countries themselves (Hafner & Shiffman, 2013). However, opportunities to contribute to strengthening national health systems in the countries in which INGOs operate are plentiful. The growth in the influence of INGOs raises questions regarding how these international organizations can best support national governments without creating disruptions in local health systems.

Health systems strengthening (HSS), a term that did not appear in peer-reviewed literature until the early 2000s, has, over the past decade, leapt “to the top of the global health agenda” (Shakarishvili et al., 2011, p. 316) as the global health community has increasingly perceived stronger health systems as a condition necessary to the achievement of major health goals (Bloland et al., 2012).

As I finalize this research in early 2015, the term “health system” and discussions of the need for stronger health systems are prominent in both mass media and technical publications, as many have cited the 2014-2015 outbreak of Ebola in West Africa as an indication of the weaknesses of health systems in those countries most affected by the epidemic, countries that have received overseas development assistance to support health. Nearly all of the key informants interviewed for this study talked about how the Ebola outbreak has demonstrated the tragic consequences of weak health
systems and the need for investments in stronger systems. Many in the global health community are responding by calling for greater attention to and more resources—as well as more efficient and coordinated use of funding—for building robust and resilient health systems.

Even though the term “health systems strengthening” is relatively new, some suggest that recognition of the need for stronger health systems dates back to the 1978 primary health care declaration of Alma Ata with the goal of “health for all by 2000.” Challenges faced in the implementation of health systems strengthening might be similar to those faced nearly 40 years ago in ensuring the provision of primary health care; they include those related to financing, human resources, civil unrest, and the perpetual emergence of new diseases (Reich et al., 2008).

As countries and partners attempt to scale up successful interventions, systems strengthening investments and system-wide planning, evaluation, and research, though not “a panacea,” are needed (de Savigny & Adam, 2009). With the deadline for the world to reach the Millennium Development Goals (MDGs) later this year in 2015, many global health actors have become increasingly concerned by the impact that weak health systems may have on reaching those goals, and on the negative impact that some vertical, or disease-specific, programs may have on health systems (Hafner & Shiffman, 2013; Travis et al., 2004). A seminal 2009 World Health Organization (WHO) report on health systems strengthening (HSS) noted: “the timing for applying such an approach has never been better” (de Savigny & Adam, 2009).

Much has been written about the role, and sometimes “bad behavior” and lack of coordinated efforts, on the part of INGOs in global development, and on the challenges of “doing good” and minimizing harm, as indicated by a quick review of titles such as “How international NGOs could do less harm and more good” (Barber & Bowie, 2008), “Paved with Good Intentions: Canada’s Development NGOs from Idealism to Imperialism” (Barry-Shaw, Engler, & Jay, 2012), and “Killing with Kindness: Haiti, International Aid, and NGOs” (Schuller, 2012).
However, while much has been written about health systems and the role of a variety of global health actors in HSS, little attention has been paid to the specific roles that INGOs can and should play in HSS and potential negative impact INGOs can have on health systems. Some INGOs working in global health consider “health systems strengthening” as a core competency at the heart of their mission. One reason for the lack of research on the negative impact of INGOs on HSS is that it is not in the interest of INGOs themselves to conduct such research; it also may not be in the best interest of donor agencies that fund INGOs to support such research. Anecdotal information, obtained primarily through grey literature, including organizational websites and global health and development blogs, indicates that INGOs do sometimes, usually unintentionally but sometimes seemingly negligently, have a negative impact on the very systems they are trying to make stronger.

INGOs have the potential, as global health actors, to have a positive impact on health systems and on the overall health of populations of countries in which they operate. However, there is little indication that health-focused INGOs have fully embraced a “systems thinking” approach to health systems. In addition, they sometimes engage in practices that actually can weaken health systems, including creating additional management burdens through parallel systems of data collection and commodity distribution and introducing distortions into local labor markets by hiring staff, including clinicians, away from the Ministry of Health and the public system. The global impact of these practices has not been measured, but country-level case studies and anecdotal information indicate that the problem is prevalent.

**Definition of Key Terms**

Health systems, according to the WHO, are “all organizations, people and actions whose primary intent is to promote, restore or maintain health.” A health system, therefore, is “more than the pyramid of publicly owned facilities that deliver personal health services” and includes non-state sectors such as non-governmental organizations, other civil society organizations, and the private sector (WHO, 2007).
The terms “non-governmental organization” and “international non-governmental organization” seem straightforward, but a myriad of definitions and categories exists, and significant research has been conducted on the taxonomy of civil society organizations, including NGOs. For the purpose of this research, I adapt the definition proposed in the NGO Code of Conduct for HSS, and define INGOs as those NGOs who receive at least some of their funding through donor agency government grants or contracts and have activities in one or more low- or middle-income countries (LMICs). This definition excludes NGOs that rely exclusively on philanthropic donations to fund their work. For the purpose of the literature review, however, it was important to understand and consider the nuanced definitions and categories of NGOs, and terms such as civil society, northern (sometimes called western) NGOs, southern NGOs, and, to use United Nations and WHO terminology, non-state actors. The NGO Code of Conduct for HSS defines INGOs narrowly, as “those organizations that are independently organized and funded from the governments in the countries where they operate.” The Code also states, “These entities are typically based in relatively wealthy countries, and are considered to be providing ‘foreign aid’ to lower-income countries, with some sort of charitable purpose” (NGO Code of Conduct for Health Systems Strengthening, 2008). As described further in the literature review in Chapter 2, “health systems strengthening” is an evolving concept, and one for which several definitions have been proposed. For the purpose of this study, except where otherwise stated, the official WHO definition is implied.

Finally, I intentionally use the term low- and middle-income countries to describe countries that are recipients of global health and development assistance. The use of this term, officially adopted by the Organization of Economic Cooperation and Development (OECD) and the World Bank, is growing in the global health and development community. It categorizes countries according to levels of gross national income per capita, and is considered by many to be less pejorative and more objective than the dated term, “Third World” and more recent terms, “developing countries,” and “least developed
countries.” For the purposes of the literature review, it was also necessary, however, to consider the term “developing countries.”

<table>
<thead>
<tr>
<th>Health system</th>
<th>The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (WHO, 2007)</th>
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<tr>
<td>Health systems strengthening (HSS)</td>
<td>Improving six health system building blocks and managing their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes (WHO, 2007)</td>
</tr>
<tr>
<td>International non-governmental organization (INGO)</td>
<td>Civil society organization formally registered with government that works in at least one low- or middle-income country (outside of the country in which it is incorporated), receives a portion of its revenue from both voluntary contributions and government grants, and is governed by a board of trustees/directors (adapted from Edwards, 2000)</td>
</tr>
<tr>
<td>Low- and middle-income countries (LMICs)</td>
<td>Category of countries in which income, as measured by gross national income per capita is below a certain threshold (low-income is $1,045 or less in 2013; middle-income between $1,046 and $12,745 in 2014) (adapted from World Bank definition)</td>
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**Global Health and Development Governance: Key Concepts**

As interest in global health expands, the traditional structure of development is no longer adequate to represent the multitude of players on the “global health stage,” as the WHO and ministries of health “are now being joined (and sometimes challenged) by an ever-greater variety of civil society and non-governmental organizations, private firms, and private philanthropists” (Szlezák et al., 2010). Given the wide range of actors contributing to, and sometimes challenging, traditional structures of global health and development, global governance of any sort, especially global health governance, is daunting (Fidler, 2005).
Although this study is focused on the global health sector, it is useful to review key concepts related to global development as a whole, and how changes in international aid, especially over the past two decades, have contributed to an increasingly complex and challenging environment. In the last half of the twentieth century, funding for global development, or “foreign aid,” grew substantially, and a large proportion of these financial resources was channeled from donor country governments through multilateral institutions such as UN agencies and the World Bank to recipient country governments, as depicted in Figure 1 (Fengler & Kharas, 2010, p. 8).

As more actors have engaged in global development, especially during the last several decades, more resources have become available, and approaches have become increasingly innovative, as, over the past several decades, “aid is coming from more places and being allocated through more channels” (Fengler & Kharas, 2010, p. 1).
The involvement of more actors and the multiple channels through which global development initiatives are financed “have also added to waste, overlap, and uncoordinated efforts that might be individually successful but that do not add up to the systematic transformation needed for a significant impact on development,” as depicted in Figure 2 (Fengler & Kharas, 2010, pp. 1-2). Fengler and Kharas call for increased coordination of aid at global and country levels, improved aid data systems and greater transparency, and improved effectiveness through cooperation and collaboration to minimize redundancies (Fengler & Kharas, 2010).

In recognition of the challenges that LMIC governments and their partners face in managing and coordinating multiple projects and funding streams, in the 1990s, the global development community began to encourage LMIC governments and donor agencies to collaborate through Sector-Wide
Approaches (SWAps). SWAps were designed to pool donor funding into one “basket,” managed under the leadership of ministries of health (or education), with common goals and indicators. The intent was to increase “local ownership” of aid-funded programs. In practice, however, many donor agencies have not changed their policies and practices to contribute directly to basket funding. Instead, they moved toward ensuring that their funding is used to support sector priorities and contributes to national strategies and programs. SWAps have been endorsed by the Paris Declaration on Aid Effectiveness in 2005 and the Accra Agenda for Action in 2008 (Sweeney, Mortimer, & Johnston, 2014).

In 2000, the global community came together to adopt global health and development goals through the United Nations Millennium Declaration. The declaration committed 147 nations to a new global partnership to reduce extreme poverty with a series of time-bound, measurable, quantitative targets—with a deadline of 2015—that became known as the Millennium Development Goals. The MDGs include specific health targets for the reduction of maternal and child mortality. Although significant progress has been made, results have been not consistently positive in all countries.

Discussions are underway for post-2015 MDGs, called “sustainable development goals,” or SDGs. As the deadline for the MDGs has been approaching, increasing calls has been made, throughout the global health community, for more attention to universal health coverage (UHC), defined by the WHO as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (WHO, 2012). Discussions around health-related post-2015 goals include the need to continue a focus on HSS as a necessary element of UHC (Hill et al., 2014; Boerma et al., 2014).

In the process of attempting to improve global cooperation to support progress on the MDGs, global actors became increasingly aware of the need for a more coordinated approach to aid and development. In 2005, the Paris Declaration on Aid Effectiveness was developed by UN member nations,
including representatives of governments of high-, middle-, and low-income countries. As the introduction to the Paris Declaration states, in developing the declaration, the global community demonstrated the “resolve to take far-reaching and monitorable actions to reform the ways we deliver and manage aid as we look ahead to the UN five-year review of the Millennium Declaration and the Millennium Development Goals (MDGs) later this year” (OECD, 2008).

<table>
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<th>Table 2: Key Principles of Paris Declaration for Aid Effectiveness</th>
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<td><strong>Ownership:</strong> Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.</td>
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<tr>
<td><strong>Alignment:</strong> Donor countries align behind country-led objectives and use local systems.</td>
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<td><strong>Harmonization:</strong> Donor countries coordinate, simplify procedures, and share information to avoid duplication.</td>
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<tr>
<td><strong>Results:</strong> Developing countries and donors focus on results rather than processes; these results are measured.</td>
</tr>
<tr>
<td><strong>Mutual accountability:</strong> Donors and partners are accountable for development results.</td>
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The Paris Declaration sought to improve coordination and synergies among aid-funded development efforts, and to support country-level leadership and country ownership of development. Although the declaration was developed by governments, the intent was that all global actors, including broader civil society organizations, should respect the principles of aid effectiveness outlined in Table 2 (Swanson et al., 2009; Biesma et al., 2009).

Designed to strengthen and deepen implementation of the Paris Declaration, the Accra Agenda for Action of 2008 took stock of progress, and proposed three main areas for improvement: (1) ownership, including stronger leadership on aid coordination; (2) inclusive and effective partnerships, including among donors, foundations and civil society; and (3) measurements of impact, development, and capacity development of LMIC governments. A 2011 evaluation of the declaration found “the
principles and commitments have been applied, if gradually and unevenly, among partner countries, and much more unevenly among donors and agencies” (Ramalingam, 2013, p. 118).

As international bodies developed and adopted the MDGs and the Paris Declaration to address development aid, the field of global health also has seen significant changes. Starting primarily in the 2000s, global health initiatives (GHIs), or vertical intervention- or disease-specific programs and funding streams were launched, such as the Global Fund to fight AIDS, Tuberculosis, and Malaria (the Global Fund, or GFATM), the US government’s President’s Emergency Plan for AIDS Relief (PEPFAR), Roll Back Malaria, the Global Alliance for Vaccines and Immunization (GAVI), the US President’s Malaria Initiative (PMI), and the Stop TB Partnership. GHIs have been praised for raising greater public awareness of global health challenges and for mobilizing significant resources for global health and development in general. They also, however, have been criticized for diverting attention and resources away from other issues, including health systems strengthening efforts. (GHIs are addressed further in literature review findings in Chapter 2.)

Another issue, and a challenge that has escalated over the past several decades, is the global shortage of health workers in general, and the severe shortage in low- and middle-income countries. Effects of the shortage, which in late 2013 was estimated at 7.2 million doctors, nurses, and midwives (GHWA, 2013), are further exacerbated by inequitable distribution of health workers within countries, especially LMICs, in which urban and wealthier populations have greater access to providers than poor and rural populations. This shortage, many believe, is the principal driving factor in the inability of LMICs to make progress in providing access to quality health care to populations in need (GHWA, 2013).

Many speculate that pressure to achieve the MDGs and to respect the principles of the Paris Declaration have contributed to bringing HSS to the forefront. Others suggest that global health initiatives, which resulted in greater attention to the fact that outcomes were nearly impossible to
achieve without more functional health systems, led to the growing interest in HSS (Hafner & Shiffman, 2013).

In 2013, a Lancet Commission produced “Global health 2035: a world converging within a generation.” The report applies economic forecasting methodologies to propose a “new investment framework to achieve dramatic health gains by 2035” (Jamison et al., 2013). The report outlines returns on investments in health, especially in LMICs, in terms of the “value of additional life-years” and calls for use of fiscal policies, at national and global levels, to increase investment in the production of health. This, according to the report findings, would produce a “grand convergence” by 2035, supporting stronger health systems and a progressive move toward universal health coverage, allowing for significant progress in addressing both communicable and non-communicable diseases and injuries.

**NGOs as Global Health Actors: Key Concepts**

As both donor and recipient governments seek to better coordinate aid for health and development, what is the role of NGOs, especially international NGOs? A systematic review of the history of NGOs and global governance is beyond the scope of this study. However, to better understand the challenges of INGOs as global health actors, a review of overall trends and concepts is useful.

INGOs have proliferated over the past two decades; in the 1990s and since the turn of the 21st century, funding for INGOs continued to grow, as “a new wave of democratization in many countries inspired bilateral aid donors to promote the growth of civil society” (Reimann, 2006, p. 48). The evolving and growing role of INGOs in global development in general, and in global health in particular, has been influenced, according to some, by a greater focus over the past several decades on more “people-participatory” forms of foreign aid and the view that financing NGO-implemented projects best embodies that philosophy.

Others, some of whom do not see the growth of funding being channeled to INGOs as a positive trend, suggest that the concept of governments channeling their funding to and through NGOs is
influenced by the “neo-liberal emphasis on free markets, privatization, and the development of an imagined ‘civil society’ necessary for ‘sustainable development’” and that the practice undermines investments in the public sector in low- and middle-income countries (Pfeiffer, 2003). Many suggest that an emphasis, particularly on the part of the US government, on channeling foreign aid through US-based NGOs and other private institutions, began much earlier, with some citing the US government’s Foreign Assistance Act of 1961: “United States cooperation in development should be carried out to the maximum extent possible through the private sector, including those institutions which already have ties in the developing areas, such as educational institutions, cooperatives, credit unions, free labor unions, and private and voluntary agencies” (United States Congress, 1961). Some suggest that this growing, but not new, trend of channeling funding through INGOs has led, and continues to lead, to under-investment in the public sector in LMICs.

Official development assistance (ODA) reached the highest level ever-recorded in 2013, a total of USD 134.8 billion (OECD, 2014). It is difficult to estimate how much development assistance targeted for global health goes to INGOs, primarily because “global health financing is fragmented, complicated and inadequately monitored and tracked.” However, INGOs are “significant spenders of global health finance” (McCoy, Chand, & Sridhar, 2009, p. 413). In 2011, the last year for which such information is available, approximately 20% of overall ODA and 50% of social services-related ODA (including health) was channeled through civil society organizations, primarily INGOs (OECD, 2013). According to a 2009 Bill & Melinda Gates Foundation-funded study, development assistance for health grew from USD 5.6 billion in 1990 to USD 21.8 billion in 2007, primarily due to increases in public funding, especially on the part of the US government, and increased philanthropic donations and corporate contributions. Over the same period, increasing proportions of this funding were channeled through NGOs (Ravishankar et al., 2009).
In supporting global development, donor countries work with INGOs to expand their impact and reach, especially in terms of service delivery and community outreach. INGOs, donors surmise, can respond more rapidly, especially during humanitarian crises. INGOs also, through fundraising and awareness-raising communications, help educate citizens in donor nations about the benefits of foreign aid and contribute additional financial resources to supplement ODA financing (Hedman & McDonnell, 2011). In 2011, INGOs based in OECD member states raised an estimated USD 32 billion from private sources (OECD, 2013).

As “global politics has become much more multilayered, complex, and fluid,” the aid and development industry has changed dramatically with more and more actors, and large NGOs, primarily INGOs, have seen enormous growth in their financial resources, and increasing competition for resources, especially government grants (Ronalds, 2010). Competition among INGOs, especially for grants and contracts awarded by their own governments but also by grant-making foundations such as the Bill & Melinda Gates Foundation and multilaterals such as the World Bank and the Global Fund, means that INGOs routinely compete among themselves, not only for such grants but also for private donations. An increase in the number and kinds of global health actors, due in part to more resources for and greater attention to global health, may actually foster a more “uncoordinated and competitive environment” for all actors, including INGOs (McCoy et al., 2009).

Many INGOs were founded by activists and advocates as mission-based organizations in which the “mission” drives decision making and priority setting. As some of these same INGOs become increasingly dependent on government funding, their mission focus may, in some ways, be compromised, especially when it is related to advocating for changes to development and foreign aid policies in their own countries and by the agencies that fund them (Hellinger, 1987).

INGOs, and all NGOs, are intentionally—and by definition—not part of any government structure, although they are officially registered with governments in the country in which they are
headquartered and often in other countries in which they operate. Being officially registered with governments, both in their own countries and in the countries in which they operate, can give credibility to NGOs. However, because NGOs are not necessarily accountable to any one government, debates about the general accountability of NGOs are widespread. Many studies and several books have been devoted, in fact, to NGO accountability and how NGOs, individually and collectively, can regulate and enforce accountability (Ronalds, 2010). However, as Ebrahim noted in 2003, there is little attention to “how organizations deal with multiple and sometimes competing accountability demands” (Ebrahim, 2003).

INGOs, in particular, especially those who increasingly rely on government grants and contracts, often face “competing demands of multiple stakeholders” and these sometimes competing and conflicting demands “place extensive pressures on NGOs” (Dhanani & Connolly, 2014). As mission-driven organizations, INGOs are ultimately accountable to their beneficiaries, or the individuals and communities that benefit from their mission (Peterson, Mahmud, & Weissburg, 2013). They also, however, are accountable to their donors, both funding agencies and individual supporters.

These multiple streams, illustrated in Figure 3, include what some call “upward” accountability to individual donors and funding agencies, including government agencies, and “downward” accountability to the governments and citizens of the countries in which NGOs operate (Edwards & Hulme, 1996). A third stream of accountability, and one vital to the sustainability of the NGOs themselves, is internal accountability to their own missions, staff, and boards of directors or trustees (Ebrahim, 2003).
Various streams of accountability are important factors in decision-making processes within NGOs (Ahmed & Potter, 2013). How do NGO representatives and their staff make day-to-day decisions when there are conflicting demands on the part of various stakeholders? What happens when a Ministry of Health makes a request that is not condoned by a funding agency or is not, in the judgment of the NGO, in the best interest of the community at large? Answers to these questions are beyond the scope of this research project. However, in exploring NGO practices related to health systems strengthening, the implications of possible answers to such questions are important to consider.

As mentioned above, taxonomies of NGOs, including INGOs, have been developed, and a thorough analysis of the variety of INGOs is beyond the scope of this study. In the field of global health, INGOs espouse a large variety of philosophies, and embrace a wide range of activities and functions. Some INGOs focus primarily on humanitarian emergency relief, defined primarily as responding to emergencies by sending resources, including human resources, and supplies to support countries in responding to natural disasters, epidemics, conflicts, and other urgent situations. Other INGOs focus primarily on service delivery, or implementation of programs and projects designed to help LMICs offer
high-quality health services more equitably. INGOs that focus on “implementation” often specialize in one area of health care, such as maternal and child health, or HIV/AIDS, while some focus more broadly on health and provide technical assistance to support one or more of the components of health systems. Another INGOs function focuses primarily on advocacy, working to influence the global health and development arena by promoting greater and more strategic investments in global health and development in general, or in specific issues or disease responses. Some INGOs focus on developing, testing, and making new technologies or products available to LMICs. Finally, many global health INGOs specialize in, or incorporate, research activities in their work. In reality, many INGOs, including most of those interviewed in this research project, engage in a combination of these functional areas.

Just as INGOs engage in a wide variety of activities, they also employ a variety of different funding models. Some INGOs are funded primarily through individual donations, especially those who engage in child sponsorship model fundraising. Others are funded primarily through donor agency, especially governmental, grants and contracts. Increasingly, INGOs funding streams are a combination of individual donors, governmental contracts and grants, grants from foundations, and various forms of private-public partnerships.

The NGO Code of Conduct for Health Systems Strengthening

The NGO Code of Conduct for Health Systems Strengthening (referred to in this dissertation as the Code) provides the framework for this research to explore the roles that INGOs can best play in supporting global health, especially in helping to build stronger health systems. In response to informal but frequent discussions among different stakeholders, including NGOs themselves, their ministry of health colleagues, and donor agencies, about the potential negative impact of INGOs in the health sector, a group of NGOs worked together during a series of consultations to write and introduce the Code in 2008 to foster “a commitment to help build local systems and use funding in ways that will most benefit comprehensive primary health care” (Pfeiffer et al., 2008, p. 2137). The Code was adopted and
signed onto initially by 22 NGOs, and to date by 58 NGOs. The signatories include INGOs that focus on service delivery as well as those that focus on advocacy. However, many INGOs focused on global health, including those that purport to “do” health systems strengthening, have neither signed the Code nor refer to it in their external communications. A more thorough description of the background and review of the NGO Code of Conduct for HSS can be found in Chapter 3.

Research Question

Global health actors agree that “health systems capable of effectively and efficiently performing critical functions and delivering essential services” (Bloland et al., 2012, p. 1) are essential. According to prominent global health experts, coordination and priority setting among various global health actors—including INGOs—remains problematic and needs to improve to ensure that global health resources are used efficiently to strengthen health systems (Garrett, 2007). National health systems are often weak, and a general consensus that they must be strengthened underlies global health efforts. Much of the global funding for health is channeled through INGOs, often because national governments and ministries of health are deemed not capable of directly using resources most effectively. A belief held by much of the global health community, and stated by Dr. Paul Farmer, a founding partner of Partners In Health, is: “There is a vicious cycle at work: aid bypasses the government because it is weak, and then further weakens the government” (Schuller, 2012).

By shedding light on ways in which INGOs can best support health systems without distorting those systems, and further explore the NGO Code of Conduct for Health Systems Strengthening, this research can contribute by recommending solutions for breaking this “vicious cycle” and better addressing the challenges of coordination to make better use of available resources to strengthen health systems.

The principal research question is: What are the most appropriate and effective roles for INGOs in health systems strengthening?
To establish the most appropriate and effective roles for INGOs in health systems strengthening, the study explores the following sub-questions:

1. How do INGOs working in health ensure that they are strengthening—and not inadvertently weakening—systems?

2. What challenges do INGOs face in strengthening health systems, and how do INGOs address these challenges?

3. What barriers exist to prevent the NGO Code of Conduct for Health Systems Strengthening from gaining more momentum? Can and should the Code be modified to attract more signatories and make it more useful?

4. What recommendations can be made to INGOs, donor agencies, and other stakeholders to help INGOs working in global health avoid creating distortions in the health systems they seek to make stronger?

**Significance of the Problem**

This question is important for several reasons. International support of using aid resources for global health continues, and health systems strengthening is increasingly recognized as the most effective, efficient, and sustainable approach to improving the health of populations (Sundewall et al., 2011). As global health actors, INGOs manage increasing proportions of resources devoted to global health, especially through government grants. They must consider the implications and ramifications of their impact on health systems, ensuring that positive effects are maximized—and negative effects minimized (Swanson et al., 2012). Although health systems are ultimately the responsibility of the countries that own them, global actors, including donor agencies and INGOs, “influence national agendas, control considerable financing and are sources of policy ideas. As such, their behaviour is worth monitoring, as their future decisions concerning organizational priorities will shape the agenda’s future” (Hafner & Shiffman, 2013).
Study Methodology

In considering these questions, I have undertaken the following approach, illustrated in Figure 4.

1. **Background analysis and literature review**: The background analysis considered key issues related to the research question, including a review of global health and development and the evolving roles of INGOs in global health. A comprehensive literature review identifies evolving concepts regarding health systems strengthening and the role of INGOs vis-à-vis HSS.

2. **Review and analysis of the NGO Code of Conduct for Health Systems Strengthening**: An initial review of the Code outlines the articles, key concepts, and underlying assumptions. The analysis of the Code identifies key themes and codes and explores potential challenges. These themes and codes
helped to inform development of key informant (KI) interview questionnaires and organization of key findings.

3. **Key informant interviews with INGO leaders:** To better understand how individual INGOs working in global health address challenges related to health systems strengthening and their operations and to more fully explore why some INGOs have endorsed the Code and others not, I conducted semi-structured interviews with 20 representatives of INGOs. INGOs were strategically selected, as described further below, and represent both signatories and non-signatories to the Code.

4. **Synthesis and analysis of key findings:** I analyzed data from KI interviews, identifying overarching themes related to the overall research question and sub-questions. These data also were analyzed in relation to a systematic analysis of the NGO Code of Conduct for HSS.

5. **Discussion and development of recommendations:** An analysis of data from the KI interviews, along with key concepts from the literature review, formed the basis of recommendations for INGOs and other stakeholders.

6. **Development and presentation of plan for change:** The proposed plan for change is designed to advocate for and foster the adoption of recommendations that have emerged from the research. The plan is based on principles of the ADKAR (Awareness-Desire-Knowledge-Ability-Reinforcement) model for change (Hiatt, 2006).
CHAPTER 2: LITERATURE REVIEW

This literature review is designed to better frame the research question and related concepts in ongoing—and rapidly evolving—discussions in the global health community. Because the topic is of current interest, discussions are sometimes but not always reflected in peer-reviewed literature, and I supplement peer-reviewed publications with gray literature. A limited number of publications include references to the NGO Code of Conduct for HSS, but the implementation of the Code has not been systematically studied, as noted below.

Methodology

In searching literature related to INGOs and health systems strengthening, I consulted several online databases, including PubMed, Scopus, and Google Scholar, and searched gray literature. A search for the combined terms “international NGOs [and the] Code of Conduct for Health Systems Strengthening,” yielded three publications, which are reviewed in the section on the Code itself in Chapter 3. My initial search on PubMed using the terms “health system(s) strengthening” and “international non-governmental organizations [NGOs]” jointly yielded only six relevant publications, including the three publications on the NGO Code of Conduct for HSS and three country case studies. A search of “health system(s) strengthening” on PubMed resulted in a total of 147 articles, 42 of which related to overall health systems strengthening conceptualization or international NGOs and health systems strengthening. A Scopus database search yielded a total of 228 publications related to health system(s) strengthening. After eliminating duplicates and non-relevant articles, I retained approximately 40 documents for review.
I also searched gray literature by consulting websites of organizations cited in peer-reviewed publications, including global health organizations and donor agencies such as the World Health Organization, Centers for Disease Control (CDC), USAID, the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization), the Global Fund, and other global health initiatives. I also consulted websites of INGOs that were cited in other publications or that specifically mentioned “health system(s) strengthening” in their publications, including Health Alliance International, IntraHealth International, Jhpiego, Management Sciences for Health, Partners In Health, Save the Children, and University Research Corporation.

Additional publications related to HSS and international NGOs were identified through continued “snowballing,” reviewing references cited in peer-reviewed and gray literature (Ward, House, & Hamer, 2009, p. 4).

**Exclusion criteria:** The review excluded papers not published in English and papers published prior to 2000, with the exception of background documents on the history of health systems and/or the history and evolution of international NGOs. [Note: Because the term “health system strengthening” did not appear in peer-reviewed publications until 2002, the exclusion criteria did not prove to eliminate any relevant publications.]

**Organization of the Literature Review**

To better understand the most appropriate role for INGOs in health systems strengthening, I first present an overview of the evolution of the concept of health systems strengthening. Next, I present findings from several country case studies. This is followed by a discussion of the genesis of the NGO Code of Conduct for Health Systems Strengthening. Finally, the results of a systematic review that generated 10 key principles of HSS are reviewed to propose a framework for NGOs, especially INGOs, in health systems strengthening.
Limitations of the Literature Review

Several factors limit this literature review. One of the major limitations of the review, which I realized as I advanced in the process, is that there is little consensus on the definition of key terms, including health systems strengthening and NGOs or INGOs. In addition, no systematic reviews of the role of NGOs or INGOs in health systems strengthening were identified. To unpack the question of the evolving role of INGOs in health systems strengthening, and the role of the NGO Code of Conduct in HSS, I found it necessary to review key concepts separately and it was not feasible to fully explore all of the identified key concepts.

In addition, as much of the information on specific INGOs in specific contexts exists in gray literature, on a variety of organizational websites and in project reports, the review also was limited by time to fully explore all of these resources. Time constraints also precluded fully exploring new resources being published as I conducted the review—a reflection on the contemporary interest in health systems strengthening. The review also was limited to reviewing documents published in English, which may have prevented a thorough global understanding of the issues and perspectives presented in other languages.

Finally, due to the contemporary nature of this research subject, I found it necessary to create an end date for the literature review process; this literature review is limited to pieces published through July 2014.

Literature Review Discussion

Health Systems

In its 2000 World Health Report, the WHO defined health systems as “all the activities whose primary purpose is to promote, restore or maintain health” (WHO, 2000, p. 5). Although the definition is not limited to formal health care systems, the report acknowledged that most information is collected on such formal systems organized under a ministry of health or other government body. In the report,
WHO identified three major functions of health systems: improving the health of the population, responding to the population’s expectations, and “providing financial protection against the costs of ill-health” (WHO, 2000, p. 8). The report also acknowledged that health systems influence social determinants of health as well as provide curative and preventive services.

Julio Frenk, the Dean of the Faculty at the Harvard School of Public Health and a former Secretary of Health in Mexico, cautioned that “misconceptions” about health systems abound, and that many see health systems “as a black box, as a black hole, or as a laundry list” (Frenk, 2010, p. 1). Looking at health systems as a “black box” leads to a belief that the complexity of the system is such that considering it can overwhelm the belief that it is possible to improve it. Viewing a health system as a “black hole” may lead to the belief that the system can absorb increasing, and even infinite, amounts of resources without producing more or better results. In the “laundry list” approach, health systems are seen as “as a mere list of the different organizations or persons that participate in producing health services, without requiring that components be coordinated or integrated” (Frenk, 2010, p. 1). Frenk argued that health systems are not made up of components or silos, but are complex systems in which relationships among components must be considered, and in which populations with which health systems interact must be considered (Frenk, 2010).

Effective health systems must be “learning organizations that are continuously working together to create a common future” (Senge, 2006). This approach is necessary because “changing disease burdens to more chronic conditions brings new challenges to health systems that have been designed to deal primarily with acute conditions at a specific point in time” (Swanson et al., 2010, p. iv55). The complexity of health systems means that they cannot be what Skinner called “focused factories” (Skinner, 1974); they must produce many products simultaneously.
Health Systems Strengthening: Evolution of the Concept

“Health systems strengthening” (HSS) is a term not used in peer-reviewed literature prior to 2002 (according to findings of this literature review). However, as noted above, the need for stronger health systems has been acknowledged for several decades starting, perhaps, with the 1978 Alma Ata Declaration that defined “primary health care” with the goal of “health for all by the year 2000” (Reich et al., 2008).

Figure 5: WHO’s Health Systems Framework
(adapted from WHO, 2007)

In 2007, WHO officially engaged in a discussion of health systems strengthening and proposed a health systems framework with six building blocks (WHO, 2007). The framework has been accepted in the years since as the standard framework for every health system, though many global health actors maintain that “community” should be added as the seventh building block, and others argue that
“behavior change,” especially on the part of the population, should be included in the framework (Rashad Massoud et al., 2012). The building blocks are:

1. **Service delivery**: Health services deliver effective, safe, quality individual and public health interventions to those who need them, when and where needed, with minimum waste of resources.

2. **Health workforce**: A well-performing health workforce works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances. (i.e., there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive).

3. **Health information system**: A well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.

4. **Medicines and technologies**: Equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use is needed.

5. **Financing**: A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.

6. **Governance**: Leadership and governance ensure that strategic policy frameworks exist and are combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, attention to system-design, and accountability.

WHO’s 2007 Framework for Action (WHO, 2007) focused on WHO’s role in strengthening systems “in a changing world” and defined health systems strengthening as: “improving six health system building blocks and managing their interactions in ways that achieve more equitable and
sustained improvements across health services and health outcomes” (WHO, 2007). Strengthening health systems, according to this WHO definition, means addressing key constraints related to: health worker staffing, infrastructure, health commodities (such as equipment and medicines), logistics, health information (tracking progress, research) and effective financing. WHO declared: “The best measure of a health system’s performance is its impact on health outcomes” (WHO, 2007).

WHO’s health systems framework of “building blocks” has been critiqued as oversimplifying the complex relationships and interactions within health systems. Approaching health systems as piles of building blocks can lead to reductionist thinking, in which complex and evolving systems become, to use Frenk’s terms, “black boxes,” “laundry lists,” or even “black holes” (Frenk, 2010).

**Systems Thinking and Health Systems Strengthening**

In 2009, the WHO-based Alliance for Health Policy and Systems Research report “Systems Thinking for Health System Strengthening” outlined health systems as “dynamic architectures of interactions and synergies” (as illustrated in Figure 6) and proposed the application of systems thinking to HSS. An annex to the report, outlining the process authors used to conduct a review of HSS interventions, concluded that there are few evaluations that fully assess the effects and impact of systems strengthening interventions, and called for more “robust evaluations” that incorporate systems thinking (de Savigny & Adam, 2009).
Despite the interest in health systems strengthening, the term, according to many, remains vague (Marchal, Cavalli, & Kegels, 2009) and a “proliferation of models, strategies, and approaches,” including the WHO approach, leads to challenges in better understanding the best and most sustainable approaches to HSS (Reich & Takemi, 2009). Several authors acknowledge that this lack of consensus extends to a lack of common approaches to measuring impact and generating evidence for systems strengthening interventions (Marchal et al., 2009) (Swanson et al., 2010) (Hafner & Shiffman, 2013b).

In 2013, Chee et al purported that it is important to differentiate between health system support and health system strengthening (Chee et al., 2013). Health system support, they suggested, comprises any activity that improves services, “primarily by increasing inputs.” HSS, on the other hand, involves “more comprehensive changes to performance drivers such as policies and regulations, organizational structures, and relationships across the health system to motivate changes in behavior
and/or allow more effective use of resources to improve multiple health services” (Chee et al., 2013, p. 85).

Adam et al acknowledge the need to apply a systems thinking approach, addressing not only the components of health systems, but also a “systemic approach” that includes interrelationships and interactions among the components (Adam et al., 2012). Many also note that HSS efforts must be contextual and that the most effective range of approaches “fits countries’ agendas first” (Marchal et al., 2009, p. 1). A systemic approach is necessary to “explore the interconnectedness between different building blocks,” and create “the opportunity to discover both intended and unintended consequences of any health intervention,” considering not only interactions among the building blocks, but between the building blocks and communities (Mutale et al., 2014, pp. 1-2).

Most research on interventions designed to support HSS, however, has focused on one or more building blocks of the health system and not on “whether the intervention worked as intended, and if so, for whom, and under what circumstances” and “none incorporated evaluation designs that took into account the characteristics of complex adaptive systems such as non-linearity of effects or interactions between the HS [health system] building blocks” (Adam et al., 2012).

Several authors, in discussing the need to apply a “systems thinking” approach to health systems, have called for “people-centered health systems,” which the WHO defines as putting “people at the center of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary health care services, including health promotion, disease prevention, curative care and palliative care that are integrated with other levels of care and coordinated according to need, while ensuring effective referral to secondary and tertiary care” (WHO, 2008b).

People-centered systems are illustrated in Figure 6, above. Some authors argue that, to be truly “people-centered,” health systems must be “complex adaptive systems” driven by community needs.
and led by an understanding that “any action at any point in the system has the potential to reverberate throughout the system and affect all its agents, or conversely major activity at one level may have very little impact on the whole; in addition, these adaptive systems would need to have a “well-functioning and focused health workforce,” one “able to continually adapt and respond to individual needs within their community” (Sturmberg, Martin, & Moes, 2010, p. 352).

Donor agencies have their own definitions for health systems strengthening. The US Centers for Disease Control and Prevention (CDC) defines HSS as “those activities that aim to improve a country’s ability to successfully perform the essential functions described or implied by WHO’s building blocks” (Bloland et al., 2012, p. 1). According to the CDC: “HSS is a complex, iterative process. Global efforts at HSS require long-term partnerships with communities, and their governments, that include appreciation for the nuances of local culture and the ever-changing political and social environments” (Bloland et al., 2012). USAID defines HSS as “a process that concentrates on ensuring that people and institutions, both public and private, undertake core functions of the health system (governance, financing, service delivery, health workforce, information and medicines/vaccines/other technologies) in a mutually enhancing way” (USAID, 2014a). In late 2012, USAID created the Office of Health Systems “to elevate the importance of HSS and its ability to help drive in-country ownership and sustainability.” The office “works across the Agency’s entire portfolio of global health and is responsible for technical leadership and direction in health systems strengthening” (USAID, 2014b).

Bilateral donors and global health institutions claim to have increased their funding for HSS (Hafner & Shiffman, 2013b). Global health initiatives such as the Global Fund, GAVI, and PEPFAR also have added HSS streams, as described further below. “This level of attention among global health organizations is fairly new. From the mid-1990s to mid-2000s many organizations involved in global health focused on disease-specific ventures rather than health systems development” (Hafner & Shiffman, 2013, p. 42).
In 2013, Hafner and Shiffman applied John Kingdon’s “policy streams” framework to better understand why HSS has emerged as a global priority over the past two decades. Kingdon’s framework, widely used in policy analysis in a variety of fields, is based on the argument that issues become policy priorities when three independent streams—problems, policies, and politics—converge. (Kingdon & Thurber, 1984) When the streams come together, Kingdon proposed, there are “windows of opportunity” for policy reform and action (Sabatier, 1991).

Applying Kingdon’s framework to the concept of HSS, Hafner and Shiffman proposed that the global health community has brought HSS to the forefront because of the convergence of problems—the global health workforce crisis and problematic relationships between global health initiatives and health systems, policies—a legacy of attention to strengthening health sectors and influence of a health systems research policy community, and politics—pressure to achieve the MDGs and to support the Paris Declaration’s focus on horizontal solutions (Hafner & Shiffman, 2013). HSS is seen as an urgent need, they wrote, due to “fears among global health actors that health systems problems threaten the attainment of the Millennium Development Goals, concern about the adverse effects of global health initiatives on national health systems, and the realization among global health initiatives that weak health systems present bottlenecks to the achievement of their organizational objectives” (Hafner & Shiffman, 2013, p. 47).

**Relationships between Global Health Initiatives, Vertical Funding, and HSS**

Much research around HSS has focused on the impact of vertical, or disease-specific (and sometimes issue-specific) global health initiatives on overall health systems, and the characteristics that distinguish vertical efforts from horizontal efforts that look at the building blocks of health systems. Although the history of disease-specific global health initiatives is long, dating back to the successful and highly focused efforts that led to the eradication of smallpox in 1979 (Greenwood, 2014), some have speculated that growing interest in HSS has emerged, in part, due to more recent large-scale
investments in disease-specific programs starting in the early 2000s and the need for stronger systems to implement these vertical programs (Reich & Takemi, 2009).

Vertical programs, often called “global health initiatives” (GHIs), such as the President’s Emergency Plan for AIDS Relief (PEPFAR), initiated in 2001 under the Bush Administration, GAVI (formerly the Global Alliance for Vaccines and Immunization), the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and the World Bank-supported Multi-Country AIDS Program (MAP), all began as efforts focusing on one or more diseases and not on strengthening systems. In recent years, however, these GHIs have demonstrated that they recognize the importance of health system strengthening (Pfeiffer et al., 2008, p. 2138).

During an “initial honeymoon period” the global health community was supportive of such initiatives, which were seen as necessary to respond to urgent issues. “But the honeymoon is over, and there is now an increasing realization that such initiatives ignore a wider problem—existing health systems in the developing world are fragile and unable to provide effective health services, especially in Sub-Saharan Africa” (Marchal et al., 2009, p. 1).

Some vertical programs, such as those addressing HIV/AIDS, started with an “emergency mentality” in which a Band-Aid solution was deemed urgent and, to some extent, was found to be initially effective (Pal, 2006). Vertical programs do have a role to play. “In a true emergency, of course, it is entirely appropriate to use helicopters to fly in medical supplies; over time, however, it is more effective to repair the road and improve the distribution system” (Chee et al., 2013, p. 87). Research on the impact of interactions between global health initiatives and health systems has generally shown that such vertical initiatives have had mixed results in terms of strengthening—and not creating weakening disturbances—in health systems (Mudenda, 2009).

Selective HSS strategies that focus on a specific disease “may undermine progress towards the long-term goal of effective, high-quality, and inclusive health systems” but “a new window of
opportunity for redefining HSS may be emerging” (Marchal et al., 2009, p. 1). Because “reductionist
approaches to improving global health in the last three decades that witnessed substantial increase in
health investments in selective interventions have been inadequate to address present ills and prepare
systems for future challenges” key “systems thinking” tools and strategies that can create
“transformational change in health systems” rather than disease-specific initiatives are needed
(Swanson et al., 2012).

A systematic review of GHIs, focusing on HIV/AIDS and the Global Fund, PEPFAR, and MAP,
found that the GHIs initially had more negative effects on health systems but, as they evolved they have
made progress in better aligning with country priorities and general HSS, including donor harmonization,
stakeholder participation, and, increasingly, human resources for health, which the review calls “the
main bottleneck to scaling up delivery, especially in sub-Saharan Africa” (Biesma et al., 2009).

Many authors argue that debating between the merits of vertical versus horizontal approaches
is not fruitful and, instead, propose a “diagonal approach” in which health priorities are used to
purposively and systematically create improvements in health systems (Maher, Smeeth, & Sekajugo,
2010; Frenk, 2010). Recently published research commissioned by the Lancet also calls for a diagonal
approach (Jamison et al., 2013).

The WHO and leaders of global health initiatives developed a consortium called the Maximizing
Positive Synergies Collaborative Group to address the following question: “How can GHIs and national
health systems optimize their interactions to capitalize on positive synergies and minimize negative
impacts thereby achieving their common goal of improving health outcomes?” (WHO, 2008a). The group
reviewed real and perceived tensions between disease-specific GHIs and health systems advocates and,
in 2009, developed the Venice statement, agreeing, they had “moved beyond the empty perennial
debates pitting disease-specific health initiatives against health-systems strengthening” (Atun et al.,
2009). Participants agreed to the need to “infuse the health systems strengthening agenda with the
sense of ambition, the scale, the speed, and the increased resources that have characterized the GHIs; agree on clear targets and indicators for health systems strengthening; promote country capacity for strong national planning processes and better alignment of resources with national planning processes; promote the meaningful involvement of civil society organizations in the governance of health systems and the delivery of health services; and improve evidence-based decision making in health by building the capacity of countries to generate and use knowledge” (Atun et al., 2009).

Acknowledgement that vertical disease-specific programs have not uniformly had a positive impact on health systems has led to renewed calls for systems thinking; “a comprehensive systems perspective—a consideration of all individuals and institutions that impact health and their dynamic interactions over time—should be central in future health practice, education, research, and policy” (Sundewall et al., 2011; Swanson et al., 2012, p. iv55).

Health Systems Strengthening and INGOs: Country Case Studies

Although there are numerous publications on specific interventions, case studies that cover the specific role of INGOs in strengthening health systems were more challenging to identify. Primarily through snowballing references, I identified five case studies in peer-reviewed literature that relate to INGOs and HSS. This literature review was not exhaustive in documenting NGOs and HSS as multiple case studies exist in gray literature, specifically in project reports that INGOs produce for donors and ministries of health.

Two pertinent case studies from Mozambique highlighted specific challenges for INGOs. A case study authored by Sherr et al analyzed health workforce migration, both internal and external, or “brain drain” among Mozambican nationals graduating from medical schools between 1980 and 2006. The study found that internal migration, primarily to private practice, donor agencies, and INGOs, accounted for more cases of “capital flight from the public sector” than external migration (Sherr et al., 2012).
In reference to the issue of internal “brain drain,” it is important to note that health worker migration from LMICs to wealthier nations has gotten much international attention, but external migration is not the only human resources constraint for health systems (Willis-Shattuck et al., 2008). Internal “brain drain” refers to situations in which “non-governmental organization contribute to the human resources “brain drain” crisis in Africa when they lure government health workers away into highly paid NGO positions” (Pfeiffer et al., 2008, p. 2137). Human resource challenges can be further exacerbated by better remuneration, including salary top-ups and other incentives provided by vertical programs.

A case study from Mozambique collected data through interviews with 41 Ministry of Health officials and other civil servants. The study found three principal challenges: 1) difficulties coordinating external resources and challenges to local control over the use of resources channeled to international private organizations; 2) inequalities created within the health system produced by vertical funds channeled to specific services while other sectors remain under-resourced; and 3) the exodus of health workers from the public sector health system provoked by large disparities in salaries and working conditions (Mussa et al., 2013).

A case study from Myanmar presented challenges from the perspective of international agencies, both donors and INGOs. A total of 19 semi-structured interviews were conducted. According to those interviewed, major challenges with the implementation of HSS efforts included a lack of consensus on how HSS should be implemented, the inherent creation of vertical systems support by aid interventions, an overall lack of harmonization, and persistent service delivery barriers due to health system weaknesses and bureaucracy, inadequate human resources, unreliable information systems, and logistical challenges (Risso-Gill et al., 2013).

A case study conducted in Pakistan included in-depth interviews with civil servants, NGO representatives, and members of the donor community specifically about the role and position of NGOs
in health systems strengthening in Pakistan’s context. A major recommendation that emerged from the interviews was that all actors, specifically NGOs, support the government in conducting a mapping, both geographical and sectoral, of government needs in the health sector. The study recommended that all actors should also support and facilitate the stewardship of the government and contribute to better define roles and responsibilities, timelines for deliverables, and plans for “scaling up and sustainability” (Ejaz, Shaikh, & Rizvi, 2011).

Finally, a recently published case study from Timor-Leste, based on participant observations, concluded that country leadership and “mechanisms for supervision, monitoring and accountability are essential in managing participation of health NGOs, especially in transitioning from emergencies to long-term systems development.” Authors noted: “NGOs can contribute with their flexibility, innovations, evaluation resources, and technical expertise to support national health system strengthening as long as their relationships with national health authorities and the planning process are well-defined and mutually acceptable” (Mercer, Thompson, & de Araujo, 2014).

Genesis of the NGO Code of Conduct for Health Systems Strengthening

A review of peer-reviewed literature on the combined terms of NGOs and HSS produced few results. The relevant results centered primarily on the NGO Code of Conduct for Health Systems Strengthening and news stories announcing the launch of the Code, which are discussed further in Chapter 5.

In 2008 Pfeiffer and colleagues presented an analysis of challenges related to increasing access to anti-retroviral HIV treatment in Africa, which they argued, “underscore the urgent need to strengthen national health systems across the continent” (Pfeiffer et al., 2008, p. 2137). Pfeiffer et al proposed a framework to enhance understanding of the possible negative and positive impact that NGOs can have on health systems (as illustrated in Table 3), focusing on management burden, operations, and human resources.
The management burden described includes the individual accounting systems and data collection systems imported by NGOs to meet the needs of their own organizations and those of their donors. Fragmentation of the health sector refers to NGOs and their “showcase projects,” in which they produce short-term results in a limited population in specific disease or issue areas, “creating conflict with longer-term system strengthening” (Pfeiffer et al., 2008, p. 2137). Although others argue that the solution is for public service health workers to make a “living wage” and have good working conditions, Pfeiffer et al argue that salary and hiring caps required by structural adjustment programs, such as those set by the World Bank and the International Monetary Fund (IMF) as conditionalities for loans to LMICs, “restrict the ability of governments to compete with NGO offers or train sufficient number of new health workers,” and called upon NGOs to “decry” such programs and advocate for governments being able to invest in their own health systems and health workforce (Pfeiffer et al., 2008, pp. 2137-2138).

<table>
<thead>
<tr>
<th>Area</th>
<th>Negative Impact</th>
<th>Positive Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Management</strong></td>
<td>Burden</td>
<td>Support</td>
</tr>
<tr>
<td></td>
<td>Multiple projects to oversee</td>
<td>Support for management capacity</td>
</tr>
<tr>
<td></td>
<td>Divergent financial and programming reporting requirements</td>
<td>Support for financial coordination and harmonized reporting</td>
</tr>
<tr>
<td></td>
<td>Diversion of planning to meet NGO needs</td>
<td>Support for integrated planning</td>
</tr>
<tr>
<td><strong>Operations</strong></td>
<td><strong>Fragmentation of services, vertical technical assistance</strong></td>
<td><strong>Technical assistance, innovation, pilot projects</strong></td>
</tr>
<tr>
<td></td>
<td>Showcase projects with limited sustainability</td>
<td>New, innovative programs to meet MOH priorities</td>
</tr>
<tr>
<td></td>
<td>Imbalances in geographic and programmatic resource allocation</td>
<td>Contribution of resources to MOH technical assistance priorities</td>
</tr>
</tbody>
</table>
Table 3: Impact of non-governmental organizations on national health systems

(Pfeiffer et al., 2008, p. 2136)

<table>
<thead>
<tr>
<th>Area</th>
<th>Negative Impact</th>
<th>Positive Impact</th>
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<tbody>
<tr>
<td></td>
<td>Vertical programs that undermine service integration</td>
<td>Innovative methods to channel vertical fund intro integrated services</td>
</tr>
<tr>
<td></td>
<td>Concentration of scarce MOH human resources with NGO-related projects</td>
<td>Allocation of human resources to MOH for innovative projects</td>
</tr>
<tr>
<td>Human resources</td>
<td>&quot;Brain drain” to NGOs</td>
<td>Capacity building</td>
</tr>
<tr>
<td></td>
<td>Lack of sustainability for new programs</td>
<td>On-the-job training for MOH staff</td>
</tr>
<tr>
<td></td>
<td>Lower morale among health workers</td>
<td>Funding for additional MOH workforce for new program needs</td>
</tr>
<tr>
<td></td>
<td>Weakened management through loss of skilled staff (to NGOs)</td>
<td>Advocacy to improve work conditions, capacity, and workloads</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of management training and funding for new management tools</td>
</tr>
</tbody>
</table>

Interestingly, Pfeiffer had originally called for “the development of an industry-wide international code of conduct for NGOs in the health sector” to help focus attention on “shortcomings of current approaches” in supporting health systems in a 2003 case study of primary health care in Mozambique (Pfeiffer, 2003, p. 735). In the same case study, Pfeiffer also called for stronger leadership of ministries of health in the determination of technical assistance priorities, longer project cycles on the part of donor agencies, and improved coordination and collaboration among NGOs and between NGOs and other actors.

Principles of Health Systems Strengthening and the Role of INGOs

As this initial review of the evolution of HSS demonstrates, there is a general consensus that stronger health systems are a requisite for achieving national and global health goals, and for improving
the health of populations world-wide, and especially in LMICs. General agreement exists, too, around the need to better monitor and evaluate interventions designed to make health systems stronger. Country studies, though limited in number, point out the need for leadership at the country level and better harmonization on the part of all actors contributing to the health sector. Finally, in the publication that called for the NGO Code of Conduct, authors proposed a framework that could be used to help ensure that the positive impact of NGOs outweighs the negative.

As there are no systematic reviews of how INGOs can best contribute to HSS, developing an overall framework for INGOs in HSS proved challenging. A 2010 systematic review of key principles of HSS, however, provides some guidance that can be useful in considering how INGOs can best support HSS. Reflecting on the expanding consensus about the need for HSS and the need for a common definition, Swanson et al proposed guiding principles that can inform strategic frameworks used to develop policy, practice and evaluations (Swanson et al., 2010). Authors reviewed a total of 633 documents, gathered from peer-reviewed and gray literature, to search for HSS definitions, examples, and explanations, using a combination of PubMed, Google Scholar, Scopus, and Google. A total of 296 documents were excluded because they either did not contain a definition or explanation of HSS, were not related to low- or middle-income countries, or were not available in English. Researchers conducted a full-text review of the remaining 337 documents to categorize HSS definitions by keywords, and data were summarized using a frequency distribution of keywords. A separate researcher then reviewed the 337 documents to identify commonly referred to HSS guiding principles.

During the review process, authors consulted more than 30 global health professionals for feedback and input. Initial results were presented at various global conferences, and the list of principles was refined through “iterative processes that incorporated not only the evidence from the review, but also the considerable field experiences of those who participated in the process, and rigorous discussion amongst the authors of the paper” (Swanson et al., 2010).
The 10 guiding principles that emerged from this systematic review are useful in considering appropriate roles for INGOs in HSS, and proved useful as themes in analyzing data collected through key informant interviews. [Note: All direct quotes in this section come from the 2010 Swanson et al review.]

1. **Holism**: Individual components of systems cannot be disaggregated, as “isolated actions directed to short-term goals may even weaken the overall system.” All actors need to consider the “impact that their activities will have on all major components, processes, and relationships within a health system.” In addition, for every intervention, actors need to consider how local capacity is improved and whether each intervention is the most effective and efficient use of resources.

2. **Context**: Every national and sub-national (district, local community) context is different, and different populations may have different “values and priorities about what health systems are, what they should provide, and how they should be financed and organized.” Actors cannot apply a uniform approach and assume that because a specific intervention worked in one country or community that they can “cut and paste” it into another.

3. **Social mobilization**: Health system changes require substantial policy reform and substantial change on the part of health workers and communities. Health workers need to be trained to understand the social determinants of health and in “social and political advocacy to influence change in those determinants.” At the community level, efforts should be made to ensure that individuals, households, and community leaders are fully aware of what they can and should expect from their health care system.

4. **Collaboration**: “HSS is a complex, iterative process,” requiring long-term partnerships with governments, health workers, and communities. Partnerships need to be based on mutual respect and trust. “Such collaborative relationships must take place on a national level among various ministries, and at district and community levels among and between providers and program planners, implementers, and users.”
5. **Capacity enhancement:** Local ownership is vital, and “local capacity to detect or anticipate challenges and to solve problems is an essential component of a strong health system.” All actors must seek to strengthen capacity at all levels, including capacity of central and local level leadership, capacity of health facilities and health workers, and capacity of communities and households. Capacity building is critical to fostering national and local ownership.

6. **Efficiency:** All actors must contribute to reducing waste in the system, including “redundant measurement, excessive bureaucracy, corruption, and non-productive activity.” Resources must be used in the most efficient way possible. This necessitates collaboration and coordination among partners.

7. **Evidence-informed action:** Strong information systems are essential to facilitating data-based decision making. However, “The evidence base for action at the national, regional, facility-based, and community levels is scant in low-income countries, despite the tremendous need to discern what does and does not work.” All actors should work to support the following: “1) regular, frequent evaluations to measure impact and make changes based on that feedback; 2) flexibility and adaptation to local circumstances; and 3) accountability to constituents.”

8. **Equity:** Strong health systems “minimize systematic disparities that are avoidable by reasonable action.” Health systems, through their organization and financing schemes, can either maximize or minimize disparities caused by social determinants of health. Health systems can ensure greater equity, including gender equity, by the following: “first, measure and report objectives that are disaggregated to highlight disenfranchised populations, and set and report targets in terms of progress among these groups; second, modify service delivery approaches, based on experiences from innovative efforts to reach those who typically are neglected in the health system; and third, empower clients who are poor to play a more active role in the design and operation of health systems.”
9. **Financial protection**: The financing of health systems must include mechanisms to minimize catastrophic financial impacts from ill health. In addition, “health financing (either through taxation or foreign aid) must be continuous and predictable, especially during financial crises when it is needed most.”

10. **Satisfaction**: HSS must “include attention to the satisfaction levels of all persons working within, seeking care from, or involved in programs developed by such systems.” A low level of satisfaction on the part of health workers often leads to lower quality of health care. Low satisfaction on the part of clients can lead to chronic under-utilization of services, especially preventive services. Health systems need to foster a culture of accountability and demonstrate responsiveness to their constituents.
CHAPTER 3: REVIEW AND ANALYSIS OF THE NGO CODE OF CONDUCT FOR HEALTH SYSTEMS STRENGTHENING

In 2007, the NGO Code of Conduct for Health Systems Strengthening (or “the Code”) was developed in response to the growth, especially in the early 2000s, in the number of INGOs involved in global health, the increase in aid flows to global health, and, according to Health Alliance International (HAI), to “support public sector health systems by changing industry-wide human resources practices that routinely undermine Ministries of Health in low-income countries striving to meet the Millennium Development Goals” (HAI, 2010).

Table 4: Overview of the NGO Code of Conduct for HSS

“Launched in May 2008, the NGO Code of Conduct for Health Systems Strengthening is a response to the recent growth in the number of international non-governmental organizations (NGOs) associated with increased aid flows to the health sector. It is intended as a tool for service organizations—and eventually, funders and host governments. The code serves as a guide to encourage NGO practices that contribute to building public health systems and discourage those that are harmful.”

The Code was developed, according to the text of the Code, “as a tool for service organizations—and eventually, funders and host governments.” The Code was designed to serve as a guide to encourage NGO practices that contribute to building public health systems and discourage those that are harmful. The Code was intended to serve as “a guide for international NGOs working to limit their harmful effects and maximize their contributions to strengthening public health systems” and “defines and describes specific actions and practices to be encouraged or avoided for NGOs concerned about strengthening health systems in the countries where they work” (NGO Code of Conduct for Health System Strengthening, 2008).

During a series of consultative sessions held during meetings of the American Public Health Association (APHA) and the Global Health Workforce Alliance, organizations involved included the African Mental Health Association, the APHA, the Commission on Graduates of Foreign Nursing Schools, Global Health Through Education Training and Service, the International Council of Nurses, IntraHealth International, PATH, Save the Children, Wemos, the Western Cape School of Public Health, WHO, the World Bank, and local health practitioners.

An apparent weakness in the development of the NGO Code of Conduct, according to preliminary literature reviews, was that it did not involve extensive dialogue with representatives of LMICs or many donor agencies. There also is little indication that, during the initial development of the cause, efforts were made to involve a wide range of INGOs beyond those present at the conferences during which the Code was discussed. Although no lists were identified of specific INGOs that were part of initial discussions and then later declined to sign the Code when it was finalized, it is clear from the list of signatories that many initially engaged INGOs either made intentional decisions to not sign the Code, or simply were not approached by the promoters. (As discussed in the findings presented in Chapter 5, interviews with some KIs suggest that many current leaders of INGOs were not aware of—or could not recall—any engagement of their organizations in initial development of the Code.)

The Code is published on the website www.ngocodeofconduct.org, which was created at the time of the launch of the Code in May 2008 “to track signatories to the Code and offer a forum for discussion of Code-related issues.” The website, managed by HAI, is designed to allow comments on the
Code at the end of each article, and also provides a landing page for organizations that wish to sign on to the Code.

Currently, as described above, INGOs who purport to “do” health systems strengthening do not communicate about the challenges they face or the safeguards they put into place to avoid having a negative impact on the health systems they seek to strengthen. The drafters of the Code believed that donors have a responsibility, and could help by allowing INGOs to tailor programs to country contexts. “In spite of formidable challenges, the existence of a well-known and widely disseminated code could shift expectations across the aid industry and, thus, provide a kind of professional peer pressure to adhere to certain standards of conduct or risk ostracism and damage to organizational reputation with eventual impact on funding” (Pfeiffer et al., 2008, p. 2138).

In May 2010, HAI self-published a review of the implementation of the Code based on interviews conducted in 2009 with a total of 29 key informants, including signatories of the Code and representatives of organizations that did not sign the Code. The interviews focused on issues of the Code related specifically to health workforce issues. This review examined the implementation of the Code and policies and monitoring mechanisms put in place by the signatories as a result of the Code. In addition, the review looked at reasons that non-signatories had decided not to sign on to the Code.

Interviewees in HAI’s 2010 review included individuals representing the following signatories of the Code: Action Aid, Amref, Equinet, HAI, Health GAP, Oxfam UK, Partners In Health, Physicians for Human Rights, and the People’s Health Movement.

Key findings from the interviews are presented in Table 5, below. Authors note that challenges to implementing the Code include the competitive market for skilled human resources in low-income countries. They state: “Even when they (INGOs) are highly conscious of avoiding hiring practices harmful to the public sector, such as hiring health professionals away from public employment, international organizations seeking to meet their obligations to donors and demonstrate success feel they often
cannot avoid selecting both clinical and programmatic personnel who could otherwise be working for Ministries of Health” (HAI, 2010).

Some signatories to the Code noted that being aware of and respecting the local labor market by keeping their staff salaries at comparable levels is challenging, as “using such policies made it difficult to recruit or retain staff” and other NGOs do not have the same self-imposed restrictions. In general, NGO practices that fully support the public sector may put INGOs at a competitive disadvantage. The solution, according to representatives of INGOs interviewed, is that, “governments, donors and NGOs all agree on a uniform set of principles and aligned incentives” (HAI, 2010).

| Table 5: Implementation Review of the NGO Code of Conduct for Health Systems Strengthening (HAI, 2010) |
|---------------------------------|---------------------------------|
| **Challenges**                  | **Potential solutions**         |
| **Hiring practices**            |                                 |
| When trying to hire outside the public sector, NGOs struggle to meet donor deadlines, find qualified personnel and balance ethical responsibilities. | NGOs consult with MOHs when hiring staff, requesting permission when hiring “moonlighters” and public-sector workers. |
| **Compensation and salary**     |                                 |
| NGOs have trouble attracting candidates in a competitive job market when offering salaries comparable to those of the MOH. | NGOs that compensate at the government pay scales offer other benefits, including professional development and insurance. |
| **Long-term pre-service training and capacity building** | |
| NGOs usually focus on workshop-style training rather than pre-service training that creates new qualified health workers. | NGOs can collaborate with universities and seek funding to support universities and other pre-service training institutions to train new health workers, including nurses and doctors. |

In 2013, according to the Code website and confirmed in interviews with signatories to the Code, signatories to the Code launched what they call “a renewed focus to getting the Code on donors’ agendas.” An informal consortium of NGOs that drafted the Code is, according to the website, “rolling out a campaign to enlist donors as well as ministries of health to use the Code as a key tool to hold NGOs accountable.”
In 2014, Pfeiffer and colleagues published a commentary in the Lancet that discussed the NGO Code of Conduct for HSS in the context of the global goal of an “AIDS-free generation,” asserting that vertical funding streams, lack of support for the public health sector, and “poorly coordinated NGO activity continues to fragment the delivery of health services and increase the management burden for underfunded ministries of health at a time when public health systems require major workforce expansion, infrastructure investment, and management capacity building” (Pfeiffer et al., 2014). The commentary calls on donors to support elements of the NGO Code of Conduct for Health Systems Strengthening, in reference to the global goal of an AIDS-free generation, citing “the lack of donor consensus on the role of the public sector” as one of the challenges countries face in reaching HIV/AIDS-related goals, and stating that donors can have a positive impact on health systems if they “fund projects that support public health systems and insist that grantees follow the Code’s best practices.”

The commentary describes the Code as follows: “The drafters of the NGO Code of Conduct further argued that governments must meet their responsibility to ensure the right to quality health care. Although INGOs can provide health services in niche areas, pilot new approaches, or temporarily provide services while public systems build capacity, government health systems must establish standards of care, achieve equitable coverage, and harmonise healthcare planning. Health-system strengthening begins with increased support to public systems” (Pfeiffer et al., 2014).

Signatories to the Code

The NGO Code of Conduct for HSS was originally signed by 22 organizations, and an additional 36 have signed on since 2008. (See Appendix 1 for a full list of signatories.) Interestingly, the definition of INGOs used in the code, “those organizations that are independently organized and funded from the governments in the countries where they operate,” sets a limited application which, if applied to the letter, excludes 42 of the 58 signatories, based on a preliminary review of information available on organizational websites. Only three organizations (HAI, Medicus Mundi, and Partners In Health) refer to
the Code on their websites. None of the signatories appear on lists of agencies that receive significant funding from the US government. Based on a review of the signatories’ websites, only five list “health systems strengthening” in their core competencies, although several include contributions to health systems in descriptions of their initiatives.

Learning from Other NGO Codes

Although a complete content analysis of the NGO Code of Conduct for HSS and other existing NGO codes of conduct and other mechanisms that NGOs employ to govern and regulate their performance is beyond the scope of this study, a review of several related codes of conduct proved useful in better understanding the potential strengths and weaknesses of the NGO Code of Conduct for HSS. As INGOs are part of global health governance, but non-governmental by definition, they often seek legitimacy by forming associations and coalitions, and by developing and signing on to codes of conduct. Codes of conduct can enforce a sense of “self-discipline in global citizen action” and “self-regulation has a long history in the NGO sector as an alternative to heavy-handed intervention by the state” (Edwards, 2000, p. 5). A major challenge, however, is that they are, for the most part, voluntary, and therefore “lack political ‘teeth’ in terms of holding aid agencies to account for their actions and performance” (Ramalingam, 2013, p. 119).

One World Trust, a charitable institution that conducts research and advocates for accountability in global governance, especially among non-state actors, created an online database of civil society organization self-regulatory initiatives in 2008. The purpose of such initiatives, according to One World Trust, is “building public trust, protecting the political space for CSOs to operate, and supporting the sharing of good practice and learning.” The project has identified 309 such initiatives globally (One-World-Trust, 2014).

Specific NGO codes of conduct related to global health also are numerous, especially in the area of humanitarian response to emergencies (Ramalingam, 2013). One of the most well-known such codes
is the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief. Another noteworthy code is the Code of Good Practice for NGOs Responding to HIV/AIDS, which is also managed by a secretariat housed at the International Federation of Red Cross and Red Crescent Societies. The code sets out the principles and practices required of organizations for responses to HIV and proposes common lobbying and advocacy positions to which all signatories agree in principle. An innovative aspect of this HIV code is that it operates on a three-tiered approach, distinguishing among endorsing organizations, which support the principles of the code, implementing organizations which must either refer to the code in organizational policies or complete a self-certification plan, and champions of the code, who “demonstrate their commitment to the Code through their daily activities.” (Code of Good Practice for NGOs Responding to HIV/AIDS, 2004).

One self-regulatory initiative, called the Sphere Project, refers specifically to NGOs and HSS. The Sphere Project was created in 1997 to “improve the quality of humanitarian assistance and the accountability of humanitarian actors to their constituents, donors and affected populations.” The Sphere Project’s handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response, calls for “a health systems approach to the design, monitoring and evaluation of health services” and for support to national and local health systems and the standardization of tools and approaches, as “The way health interventions are planned, organized and delivered in response to a disaster can either enhance or undermine the existing health systems and their future recovery and development” (Sphere, 2011).

Interestingly, the Sphere Handbook, which is “a voluntary code and a self-regulatory tool for quality and accountability,” does not attempt to enforce compliance and there is no expectation that agencies can meet all of the proposed standards, “some of which are outside their control.” According to The Sphere Project website, “There is no such thing as ‘signing up’ to Sphere, a Sphere membership
or any process of accreditation. The Sphere Project has consciously opted for the Handbook not to be prescriptive or compliance-oriented, in order to encourage the broadest possible ownership of the Handbook” (Sphere, 2011). From the project website, which includes documentation of Sphere-related workshops around the world, it appears that the handbook has been used in multiple settings.

The NGO Code of Conduct for Health Systems Strengthening

This review of the NGO Code of Conduct for HSS outlines the six articles of the Code, designed to “offer guidance on how international non-governmental organizations (NGOs) can work in host countries in a way that respects and supports the primacy of the government’s responsibility for organizing health system delivery,” or “areas where NGOs can do better.” It highlights key assumptions made in each of the articles and clauses within the articles.

Table 6: Articles of the NGO Code of Conduct for HSS

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<tbody>
<tr>
<td>I.</td>
<td>NGOs will engage in hiring practices that ensure long-term health system sustainability.</td>
</tr>
<tr>
<td>II.</td>
<td>NGOs will enact employee compensation practices that strengthen the public sector.</td>
</tr>
<tr>
<td>III.</td>
<td>NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work.</td>
</tr>
<tr>
<td>IV.</td>
<td>NGOs will minimize the NGO management burden for ministries.</td>
</tr>
<tr>
<td>V.</td>
<td>NGOs will support Ministries of Health as they engage with communities.</td>
</tr>
<tr>
<td>VI.</td>
<td>NGOs will advocate for policies that promote and support the public sector.</td>
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The Code’s Preamble states: “The last decade has ushered in tremendous growth in political will, funding support and organizational structures to improve international health. While gains have been achieved in some areas such as the HIV epidemic, ground has been lost in basic primary care and maternal child health. It is now becoming clearer that NGOs, if not careful and vigilant, can undermine the public sector and even the health system as a whole, by diverting health workers, managers and leaders into privatized operations that create parallel structures to government and that tend to worsen the isolation of communities from formal health systems.”
A key assumption of the Code, as described in the preamble, and several articles, is that the focus of health systems and service delivery should be on the public sector. This focus has been challenged by several publications and the approaches of several donor government agencies, including USAID, which encourage public-private partnerships in health and funds a global project called Strengthening Health Outcomes through the Private Sector (SHOPS), and the Department for International Development (DFID), the United Kingdom’s aid agency. According to DFID, “non-state providers (for-profit and not-for-profit, formal and informal) deliver a large share of health services across the developing world and are an important partner in the health system of most countries” and “developing governments’ capacity to contract, regulate, supervise and monitor private provision of services so that non-state providers become an integral part of scaling up cost-effective coverage of quality health services for the poorest is a very challenging but an increasingly pressing need if all people are to be reached with services at reasonable cost.” (DFID, 2013, p. 18) Many INGOs also present their approaches to working with the private sector on their websites.

The Code’s first three articles relate to health workforce issues, specifically hiring practices, compensation practices, and training and support. They are designed to provide guidance to NGOs that enable them to maintain operations without removing much-needed human resources from the public health sector.

**Article I:** NGO hiring practices, Article I of the Code stipulates, should be designed to avoid hiring health or managerial workers away from the public sector or, if they need to, to “do so in coordination and with the consent of local health authorities.” INGOs also should employ national human resources to the extent possible, instead of replacing or displacing national hires with expatriate or foreign workers. The Code also states, “NGOs recognize that they have had a historical role in creating conditions that lead trained and skilled personnel to work abroad in wealthy countries” and that NGOs have a responsibility to “avoid creating incentives for the health workforce to leave their developing
countries for work in international organizations or locations” and to help provide incentives for workers to stay in the public sector.

**Article II:** Compensation to employees of INGOs should be “locally competitive,” according to Article II, but avoid attracting workers away from the public sector. The Code also specifies that NGOs should avoid the practice of paying “top-ups,” or “compensation payments that supplement public salaries.” According to this article, NGOs also should provide national hires with the same benefits that expatriate workers in comparable positions receive. This specific clause, however, appears incompatible with ensuring that compensation of local staff be “locally competitive.” A key assumption in Article I is that NGOs should work to promote and support the public sector. Article I does not discuss the provision of health care by private sector entities, which include for-profit health facilities as well as not-for-profit, often faith-based, health facilities.

**Article III:** This article III focuses on training and support of the health workforce and advises NGOs to invest in educational institutions and continuous professional development rather than training workshops. “Workshops and other short training programs for health workers already in service often divert health workers from their workday responsibilities, while providing minimal benefit to the system as a whole.” The Code recommends, especially in areas where health workers are scarce, that INGOs should invest in increasing the numbers and capacity of health workers. The Code states: “The goal is to transfer skills to national workers and eventually build sufficient capacity to obviate the need for international NGOs.”

**Article IV:** This article of the Code states: “NGOs will minimize the NGO management burden for ministries.” Referring to the Paris Declaration on Aid Effectiveness, the Code states that INGOs should engage in “meaningful joint planning within the ministries’ own planning cycles.” Other clauses of this article state: “NGOs pledge to respect government and health ministry priorities, as well as labor and personnel policies,” and “Rather than building parallel or circuitous structures around inadequate
capacity, NGOs commit to strengthening governments’ ability to operate effectively and efficiently.” The Code also suggests that seconding NGO staff to ministries should be encouraged as the practice can help strengthen the capacity of government entities. Key assumptions in this article include the responsibility of NGOs to build local government capacity—and that they have resources to do so. Another key assumption, and one that emerged in key informant interviews, is that ministries have effective planning cycles and both allow for and support joint planning with NGO partners.

Article V: The fifth article of the Code, “NGOs will support Ministries of Health as they engage with communities” is designed to advocate for NGOs in their role of serving as a bridge between communities and the government, “especially (but not exclusively) in nations where populations or sub-populations are actively oppressed by their governments.” This article outlines the responsibilities of NGOs to “strengthen the capacity of communities to take responsibility for and ownership of their health development…while holding governments accountable for their human rights obligations,” “document and share their work in and with communities to inform host government planning and priority setting,” and “work to protect populations.” This article appears to be primarily aspirational, but challenges NGOs to “holding governments accountable” without explicitly describing how NGOs can do so.

Article VI: The final article of the Code states: “NGOs will advocate for policies which promote and support the public sector.” This article appears to be more complex than others, as it contains a variety of clauses that seek to govern not only the operations of INGOs, but also their relationships with such international institutions as the World Bank and the International Monetary Fund. As detailed in Chapter 5, this article proved to be the most problematic, according to the key informants interviewed, in that it calls upon NGOs to advocate for a variety of positions. Similar to Articles I and II, this article also calls for support to the public sector without reference to the private sector.
The article states: “NGOs will strengthen and support, not supplant, the role of government in making policy,” supporting efforts to involve civil society broadly in the development of policies. The article continues: “NGOs pledge to advocate for removal of political, ideological and financial barriers to the expansion and improvement of public health systems, including unnecessarily restrictive fiscal and monetary policies, and wage bill caps imposed by the international financial institutions.”

Another potentially problematic clause in Article VI states: “NGOs will work in solidarity with their Ministry of Health colleagues to oppose the detrimental policies of the International Monetary Fund, the World Bank and other lenders whose loan conditions limit government expenditures on health or education.” This clause does not distinguish between the IMF and the World Bank, as these two institutions are included in the same sentence. In addition, it makes the assumptions that “Ministry of Health colleagues” are, to some extent, engaged in opposing the policies of these institutions and consider them “detrimental.”

The article also states that NGOs should commit to programs that “reinforce primary health care, foster equity and community involvement, and are generally replicable and financially sustainable over time.” Finally, in the only mention of the term “health systems strengthening,” that exists in the Code, the article states: “NGOs will also advocate with donors to support general HSS in the service of comprehensive national priorities.” Finally, the Code ends with a commitment on the part of NGOs to follow local labor laws and pay taxes.
CHAPTER 4: STUDY DESIGN

This research is designed to answer the following question: What are the most appropriate and effective roles for INGOs in health systems strengthening?

To formulate answers to this question, the following sub-questions are explored:

1. How do INGOs working in health ensure that they are strengthening—and not inadvertently weakening—systems?

2. What challenges do INGOs face in strengthening health systems and how do INGOs address these challenges?

3. What barriers exist to prevent the NGO Code of Conduct for Health Systems Strengthening from gaining more momentum? Can and should the Code be modified to attract more signatories and make it more useful?

4. What recommendations can be made to INGOs, donor agencies, and other stakeholders to help INGOs working in global health avoid creating distortions in the health systems they seek to make stronger?

An in-depth analysis of the Code and KI interviews with representatives of INGOs, although not exhaustive in answering these questions, have provided insight into better understanding the extent to which NGOs confront challenges related to mitigating distortions of health systems and how they address these challenges. This methodology allows for an exploration of potential “best practices” for NGOs, and also points to the importance of donor-related and other constraints faced by INGOs in their attempts to build stronger health systems. The methodology also provides information for the
development of guidance, including proposed modifications, concerning the NGO Code of Conduct for Health Systems Strengthening and recommendations for the way forward.

**Data Collection**

The principal method of data collection is semi-structured interviews with key informants who represent INGOs. The interviews are designed around the sub-questions of the study (Creswell, 2012), specifically designed to gain a deeper understanding of: how INGOs strive to strengthen health systems in the countries in which they operate; how INGOs perceive challenges faced by their organizations and by the INGO community as a whole; INGOs’ perception of challenges faced by other global health actors, including donor agencies and national governments and ministries of health; specific practices that INGOs can adopt to mitigate potential disruptions to health systems; and perceptions concerning the NGO Code of Conduct for Health Systems Strengthening, including (for non-signatories) why INGOs have not signed on to the Code and suggestions to modify the Code, and (for signatories) the role the Code may play in helping their organization ensure that they are strengthening health systems. The Semi-Structured Interview Questionnaire Guide can be found in Appendix 3. [Note: The questionnaire guide was modified after pre-tests with three representatives of INGOs who are not included among the KIs who participated in the final interviews. Modifications were made to include additional questions not specifically related to the NGO Code of Conduct for HSS to ensure that discussions were not limited to only those issues mentioned explicitly in the Code.]

I explored these issues through semi-structured interviews with a total of 20 KIs who are decision makers (presidents, vice presidents, and directors) within INGOs, both US-based and non US-based, though predominantly (14 out of 18) US-based. INGOs interviewed include representatives of both INGOs who are signatories to the Code and of INGOs who are not signatories. Interviews were conducted between late November 2014 and early February 2015.
The selection process was strategic in that, for signatories, KIs who were interviewed represent INGOs who are most prominent in promoting the Code and may potentially be engaged in implementing recommendations related to possible modifications to the Code and, in general, may have the most vested interests in helping to disseminate key findings from this research. According to the description of the development of the Code on the website that currently publishes the Code, three KIs interviewed represent INGOs that were involved, at least initially, in consultative meetings during which the Code was developed, but whose organizations did not sign the Code.

For non-signatories to the Code, I sought to interview representatives of INGOs who are among the largest recipients of US government global health funding, especially in health systems strengthening, are active in various associations and consortia of INGOs, and who, for these reasons, have the potential of actively engaging in helping to disseminate research findings and of participating in follow-on activities proposed in the plan of change, including engaging in working groups to contribute to awareness-raising strategies and tactics. I also intentionally reached out to individuals who I have met throughout my career; this, I believe, greatly facilitated the interview process.

To ensure that organizations selected for KI interviews represented “international NGOs” as defined by this research project and the Code of Conduct itself, I primarily interviewed representatives of organizations that receive funding from the governments in the countries in which they are based, excluding those organizations that are funded only through individual donations and charitable contributions. This exclusion is intentional, as the Code itself defines INGOs as those who receive funding from governments. [Note: In one case, I interviewed a representative of a signatory to the Code whose organization does not currently receive government funding.]

I also intentionally excluded signatories (as well as non-signatories) that are not “international NGOs” as they appear, from their website and promotional materials, to be primarily local NGOs that
implement activities, advocacy groups, research institutions, or ‘think tanks’. I did, however, include two representatives of networks of INGOs, networks that have signed the Code.

The number of interviews conducted and INGOs included in the sample size cannot capture all of the various nuances of INGOs, the challenges they face, the strategies they employ, and their diverse contributions to global health. The range of INGOs included, however, appeared sufficient to develop a representative analysis of the role of INGOs in HSS and key issues outlined in the Code and to propose recommendations that can be generalized to other INGOs and stakeholders, including donors, ministries of health, and others working in global health.

Additionally, although characteristics of the individuals selected, including such variables as their age, nationality, years of experience, and contextual experiences, undoubtedly had an impact on the information they provided, the purpose of this research is to capture their perspectives as representatives of organizations, and not as individuals. Thus, personal data on individual interviewees was not collected. However, it was evident during the interviews that in the process of answering questions and reflecting on the issues, KIs drew on their experiences not only with their current employers, but also on other INGOs and organizations for who they have worked over the course of their careers.

Finally, US-based INGOs are over-represented in the sample of the 20 organizations whose representatives participated in the interviews for two primary reasons. First, I had greater access to individuals who hold leadership roles within INGOs based in the US than in other countries due to my own professional experience and networks. Secondly, and strategically, the US government and US-based agencies are key targets for implementing the proposed advocacy plan for change, as I have greater access, as well, to individuals within various agencies of the US government and US-based organizations, including INGOs as well as coalitions such as the Global Health Council, InterAction, and other alliances.
The following steps were undertaken to conduct the interview process:

1. I contacted a total of 28 potential key informants by email. This initial outreach included an overall description of the research, a copy of the NGO Code of Conduct for Health Systems Strengthening, and a tailored Fact Sheet on Adult Research. In this initial outreach email, I requested suggestions of specific times and dates for the interview. (See initial email outreach in Appendix 3.)

2. For interviewees who responded positively to the initial outreach, or responded positively to follow-up email requests, I asked them to propose times for a one-hour interview. I additionally asked them to read the Code in advance of the interview. [Note: Of the 28 potential KIs contacted, 26 responded to the initial request. Due to challenges in scheduling interviews, I was able to complete a total of 20 interviews.]

3. All interviews were conducted in English through telephone or audio Skype calls and digitally recorded using the Voice Recorder web-based app and transcribed by Scribie, a transcription firm. (The accuracy of Scribie’s transcription services was verified by listening to and concurrently reading three interviews.)

Data Analysis

Qualitative analysis of the transcriptions of the interview recordings was implemented through combined use of MAXQDA and hand-coding to identify themes and codes, comparing and contrasting responses across interviews (Creswell, 2009).

I began the analysis with a specific set of codes, both descriptive and interpretive. This list was refined during ongoing text analysis of the NGO Code of Conduct itself and throughout the interview process as additional themes and codes emerged. As I reviewed transcripts, I added and refined codes, using a combination of deductive and inductive reasoning for the final coding and analysis.
Limitations and Potential Biases of Study Design and Research

My own experience and background, including 20 years of working for INGOs and managing projects, as well as my current position in a leadership role in a major global health INGO, has led me to develop my own perspectives and opinions about the appropriate roles of INGOs in HSS. I attempted, during the semi-structured interviews, to minimize my own potential biases by intentionally not discussing my own experiences or opinions during interviews with KIs. I also ensured KIs that specific information from the interviews would not be shared with my own organization, a prominent global health INGO that both collaborates with and sometimes competes against other INGOs, beyond the aggregated findings presented in the final dissertation and any subsequent publications.

A factor that became increasingly apparent throughout the process of the KI interview process was not only that each INGO is unique in many ways, including, but not limited to its size, mission, operational structure, sources of funding, decision-making processes, and positions or perspectives. All of these variables affect, to some extent, how they perceive appropriate roles for INGOs and other global health actors. In addition, as described briefly in the data collection process above, each KI was selected as a representative of the INGO for which she or he currently works. However, each of the representatives has had a diverse career, and often one that has involved working for several INGOs and other global health actors. Although questions were not focused on the personal experiences of the KIs, their answers and examples they shared represent, to some extent, their experiences throughout their professional careers and lives.

The KIs—and the INGOs they represented—are a small sample relative to the large number of INGOs working in global health. I attempted to mitigate this limitation by including, for the most part, findings corroborated by several interviews, and not all opinions expressed by some of the “outliers.” An indication that the sample is, at least to some extent, representative of INGOs, was that fewer and fewer new themes and perspectives emerged from the interviews as the process continued.
Another limitation is that the KI representatives of INGOs signatories of the Code were not, in all cases, fully familiar with the contents of the Code. (Most, but not all, could explain when, how, and why their organization made the decision to sign on to the Code.) Some, but not all KIs, read the documents shared with them in advance of the interview, including the Code. For nearly all of the interviews, it proved necessary to provide overviews of the background description and talk through the articles and clauses of the Code. Several KIs assured me that they were referring to the document (in a print or electronic version) during the interview.

Finally, as mentioned in the literature review section, and corroborated by the KI interviews, another limitation is that it is often not in the perceived best interest of INGOs to document their own failures. Thus, the number of peer-reviewed journal articles that documented elements of the negative impacts of INGOs on health systems was limited, and some KIs, despite being assured of the confidentiality of the interview process, may have been reluctant to discuss their organizations’ own failures.
CHAPTER 5: OVERVIEW OF KEY FINDINGS

This chapter presents an overview of findings of the key informant (KI) interviews. As discussed above, the overall aim of this research was not limited to analyzing the NGO Code of Conduct for HSS, but rather to explore the ways in which INGOs can best strengthen the health systems of those countries in which they are working using the NGO Code as a framework for analysis of key issues. The Code did provide a useful basis for discussing challenges as well as factors that can facilitate the work of INGOs in helping to build health systems. This chapter is presented in two sections; the first focuses overall on perceptions of the roles of INGOs in HSS, and the second focuses on perceptions of and reactions to the NGO Code of Conduct.

KIs expressed a variety of opinions in response to the question: what roles should INGOs play and how can INGOs best ensure that their work contributes to building stronger health systems? As mentioned above and elsewhere, the recent and ongoing Ebola outbreak came up in several interviews, as many KIs shared the opinion that the outbreak itself and the rapidity with which the virus spread, as well as the perceived inability of both individual countries and the global health community to efficiently and effectively control the outbreak, highlighted both the importance of strong health systems and the need for greater and more strategic investments in health systems on the part of all global health actors. [Notes: All direct quotes from KI interviews are written in italics to distinguish them from paraphrased and general findings. In addition, quotes are intentionally selected and presented to ensure that the identity of the organizations represented by KIs is not revealed.]
General Findings and Perceptions of the Roles of INGOs in HSS

Over-arching themes that emerged from the KI interviews regarding the most appropriate and effective roles INGOs play in HSS were, perhaps not surprisingly, closely aligned with the 10 key principles of health systems strengthening that emerged from the Swanson et al systematic review of HSS discussed in the literature review in Chapter 2. [Note: I did not explicitly discuss these 10 principles in the context of the interviews, and do not, in the presentation of the findings, systematically distinguish between signatories and non-signatories of the Code, as there appeared to be great alignment in the perspectives of both regarding these key principles.] As variations of these principles also became increasingly apparent throughout the data coding process, I decided to use these 10 principles in presenting overall findings. The principles are:

1. holism
2. context
3. social mobilization
4. collaboration
5. capacity enhancement
6. efficiency
7. evidence-informed action
8. equity
9. financial protection
10. satisfaction.

Holism

Several KIs discussed the importance of health systems being seen holistically, as systems in which all components interact with each other. Several also suggested that all actors, including INGOs have, to use the words of one KI, a “moral obligation” to demonstrate their impact on health systems.
All KIs also expressed the opinion that donor agencies play a key role in ensuring that INGOs contribute, in a holistic way, to stronger health systems.

One KI expressed it this way:

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“Everybody involved—including NGOs—should be able to give a clear explanation of how what they’re doing is contributing to building a long-term, sustainable health system in a country. And if they can’t show that, and that goes for global health initiatives as much as it goes for [my NGO], then they probably shouldn’t be doing what they’re doing. I think Ebola is helping us make that argument at the moment, but clearly, most donors aren’t taking a great interest in that. They’re more interested, if they’re in the States, around showing the impact of the American gifts and, if it’s in Britain, it’s showing direct results from investment. Showing short-term impact and results don’t really mean that we are building more functional health systems.”

Several KIs also suggested that INGOs themselves should invest more time in reflecting on the impact that their work as a whole, and the individual projects they implement, have on health systems. An ongoing process of self-reflection, fully integrated into INGOs ethos and strategy, is key, they said, to ensuring that they are, as one said, “truly doing no, or at little as possible, harm.” One KI shared an exercise in which his organization engaged:

“We did a really interesting exercise across [name of INGO] on this, when we ran a big global meeting and we led a whole session in plenary, where we got people in groups to identify four or five projects they did, or four or five activities they did. And we said, ‘Group these by whether you think what we do helps or hurts the overall system,’ or something along those lines. Anyway, we asked people to come up with examples of what would undermine a health system. What was neutral to a health system? What contributed to a health system? And, what actually left a strengthened health system? And so, people kind of worked through the kind of things we did. And we discussed how we could minimize what we do that might undermine health systems, and maximize what we do to build stronger systems.”

Context

During a majority of KI interviews, the significance of “context-specific” actions was mentioned; as one KI jested, “Location, location, location. So much of how we work depends on location.” KIs, for the most part, said that their practices and operations are—according to them, necessarily so—adapted to the contexts in which they work. Several KIs mentioned that INGOs have the obligation to develop a deep understanding of country context and culture, and a need to adapt their approaches to each context. They also shared that an important role of INGOs is ensuring that interventions they propose to
donor agencies, including in response to requests for proposals, are “adaptable” to the specific country or countries in which they are working.

Context- and country-specific factors cited by KIs include the capacity of the ministry of health and other local institutions to manage and lead health systems, the existence and capacity of local NGOs, and the donor environment in each country, including both the level of foreign assistance a country is receiving and how donor agencies interact with each other.

Social mobilization

Several KIs shared that their INGOs engage extensively in social mobilization, and they view contributing to mobilizing communities as a role that INGOs can and should play in strengthening health systems. Specific examples of social mobilization shared included mobilizing communities to participate in vaccination campaigns, building the capacity of health committees, and engaging various representatives of society, including sometimes underrepresented groups such as youth, the elderly, and in some cultures, women, in their activities.

During several interviews, KIs suggested that an important role of INGOs is helping to develop the capacity of local NGOs and other local civil society groups in social mobilization. Several KIs mentioned the importance of taking local context and existing socio-cultural norms into account in developing the capacity to mobilize communities. As one KI noted: “In some countries, the concept of mobilizing communities is not understood in the same way we see it; we think of it as a democratic process that tries to give everyone a voice.”

Collaboration

INGOs, according to the interviewees, need to collaborate with a variety of stakeholders and, to use the words of one KI, “to be able to play well together in the sandbox.” KIs uniformly asserted that both in-country and global collaboration must be strengthened to ensure that health systems are strengthened; several referred to West Africa’s Ebola outbreak as an example that highlighted this need.
KIs shared that INGOs can support collaboration among partners at the country level by participating in national coordination mechanisms, following and promoting national policies and programs (and in some cases, providing technical assistance to improve those policies and programs) and helping to build the management capacity of ministries of health and other local government entities to foster greater country ownership.

KIs also said that ministries of health ultimately are responsible for effective collaboration and coordination, and that INGOs can support ministries in playing this role. Nearly all KIs also mentioned the need for national plans in which all donor agencies and partners engage, including but not limited to INGOs. Several KIs suggested that effective collaboration among health sector actors is possible only when ministries play their leadership role effectively. One KI said:

“For me the only way this [challenge with collaboration] will sustainably change, is if the local governments wake up and say, "Listen, we want this this way. This is how we are going to do it. We want a meeting, can we talk?" They go to the donors, they go to the NGOs, they organize national meetings, they organize regional meetings, they organize global meetings, they talk to... African Union gets involved. If the governments want the change, it will happen.”

In cases in which leadership skills or capacities are lacking within a ministry of health, KIs suggested that INGOs, with the support of donor agencies, can help to improve the management capacity of ministries of health and other government entities. Three KIs also discussed the possibility that all ministries of health are not working efficiently to develop and implement programs that benefit their populations. They also expressed the view that corruption exists within ministries of health, and unless practices that allow for, and in some cases, “almost encourage corruption,” are addressed, effective and efficient HSS is not possible. These three KIs all acknowledged that it is extremely challenging for INGOs to address issues related to corruption and incompetency within ministries of health. One KI admitted:

“We need to acknowledge that, in some cases, the ministry of health itself is also a problem, either because it lacks basic capacity and is ineffective and inefficient, or because it doesn’t make the effort to develop and implement policies and programs that truly benefit communities. This is especially true in fragile states, but also true in countries that are considered, by some, to be
strong nations...and there are other societies and other settings where communities and people have to be protected against the ministry of health which is not working on their behalf...which might be pocketing the money...or even neglecting or damaging the people they are supposed to be serving.”

Capacity enhancement

Capacity building is a key role of INGOs, according to all of those interviewed. Capacity-building interventions include a variety of activities, from providing technical assistance to ministries of health, health districts, health facilities, and health workers, to building the capacity of local communities to take responsibility for their own health care.

Most of the KIs also said that they play a key role in training health workers, and helping to ensure that continued professional development is available to health workers at all levels, especially community health workers, nurses, midwives, and medical doctors. Several INGOs interviewed said that they have developed and implement on-the-job type in-service training programs that are both more effective than short-term off-site trainings, and do not take health workers out of facilities during trainings. Four of the 20 KIs also discussed collaboration with in-country training institutions, and see a key role for INGOs in helping to build the capacity of pre-service training institutions, including nursing and medical schools. INGO support to such institutions, according to KIs interviewed, includes such initiatives as training and support for management, including budgeting and planning, curriculum review and development, and creation of scholarship funds or sliding fee scales.

Efficiency

All of the KIs said that many of the challenges faced by INGOs in their efforts to use resources in the most efficient way possible to strengthen health systems are related to donor agency practices and procedures, including short-term project cycles under which most donor agencies operate and the related pressures on INGOs, to demonstrate rapid results. They also discussed the competitive nature of
funding of donor agencies, through which INGOs are compelled to show that they can achieve rapid results to be viewed positively by donors in competing for future grants and contracts.

One KI said:

“If I were working for a donor agency, I would want to be designing projects that specifically say, ‘What are you doing in the short term? And, what will you leave improved in the long term?’ I think it is possible to design that kind of project. It depends on what your theory of change is, isn’t it? I think if I was a donor, I’d want to see a strong theory of change that showed how I think change happens in a state. And I would expect to see that it’s achieved by building stronger accountability from leaders in a country, towards their population and especially towards the poor, and a poor that are more understanding of their entitlements and their rights, and able to take action...And that’s a key NGO role, I think…”

Several KIs suggested that donor agencies should develop more flexible funding options with more long-term funding cycles. One said:

“Results sound great. Then think about it. And basically making the case that, actually if we’re interested in development, real long-term transformative change that strengthens systems, you have to break away from this idea that, within a three-year project cycle, you can show any meaningful results that really have any validity for development. You can show little charitable projects, but you can’t show development in that time. And, so, you need a much more flexible, looser, long term view around what you could try to do. Which is great, really good stuff. And, I think that that actually is what we have to get behind…if NGOs are going to be dependent on donor money, and we are, then donors need to be encouraged to change their understanding of what the point of what they’re doing is and to maybe remember and get back to the era when we were all in this for development and not in this for short-term results.”

Another KI expressed it this way:

“We’re in an era where getting results from our aid projects is the most important thing for donors and less for the impact of the work that we do on health systems. We’ve recently had commissions and committees looking at international development...one did an inquiry on health systems strengthening, which concluded this...that they have seen donors move away from being a strong champion of health systems and towards being more driven by vertical short-term results.”

Several KIs expressed the belief that donor agencies—governmental agencies and foundations—both at their headquarters levels and at the level of their country offices, do not consistently develop and disseminate long-term plans, leading INGOs to, themselves, have to continuously adjust to changes in donors’ plans and strategies. One informant said:
“So if the donors really had coherent long-term plans, many of these issues would be addressed. They [donors] have the power to actually develop consistent and long-term conditions through which INGOs compete, and to have long-term broad plans. What's the point of asking NGOs to play nice against market incentives when there's no real plan, and when donors’ priorities seem to change on a whim?”

Some KIs said that they believe that donor agencies prefer channeling funding through INGOs instead of directly to recipient governments because they want more efficient use of funds and greater accountability for the use of their funding, and do not believe that ministries of health and finance and other local government entities are capable of accounting adequately for aid funding. One said:

“But the third added value [of INGOs] which is never written anywhere, in my mind, is the fiduciary responsibility for the funding. So what do I mean by that? One reason why the INGOs are used so much is because if you, instead of giving [name of INGO] the 50 million, if you were to give it directly to, let's say the government, then come back and find out how the money was spent... The way the INGOs are audited, if you audit the government using the same approach, I mean you would stop funding global development. That will be the day you will stop development work.”

Interviewees also asserted that the capacity of ministries of health to manage resources and actors is a major factor in fostering the efficient use of resources. This is further described, below, in discussions of the Code of Conduct.

Evidence-informed action

Most KIs mentioned the importance of evidence-based decision making, and see INGOs as playing a role by helping ministries to improve their data collection and develop and implement evidence-based policies and programs. INGOs also see an important role for themselves in introducing innovative and evidence-based techniques and technologies to ministries of health and health systems, and providing assistance in adapting those techniques and technologies to local contexts.

Several KIs lamented that donor agencies are not often willing to invest in the research required to capture the data needed to produce evidence to effectively evaluate the impact of actions. Other KIs, however, mentioned an “over-emphasis,” encouraged by donors and carried out by INGOs, on investing resources to evaluate interventions that have already been proven as effective in a similar context.
“Everything in public health can’t and shouldn’t be evaluated by a randomized control trial,” said one KI.

“Most of the resources should be invested to actually help populations become healthier.”

Most KIs shared the opinion that INGOs can contribute to health systems strengthening by developing their own organizational positions on the importance of evidence-based actions and advocating for the application of evidence-based decision making and interventions at country and global levels. One said: “I feel like if we’re an NGO that wants to have the impact that we do, and have real long-term impact, we can’t not do the advocacy side of things. And that includes advocating for using evidence at all levels.”

Several KIs mentioned the key roles that alliances and coalitions of INGOs (or INGOs and local NGOs together) can play in advocating for change, including change related to evidence-based actions and decision making. One said: “When we want to advocate for change in donor practices, we really have to form a club and do it together. Donors will listen to us when we advocate with a unified voice.”

**Equity**

Several KIs mentioned the obligation of INGOs to strive for equity in the distribution of resources and in access to health services, but also discussed challenges INGOs sometimes face in supporting equity. Several KIs mentioned that they try to ensure equity and support more equitable access to care, but are limited by donors and the results they are accountable for delivering within the boundaries of their funding for specific projects. Several KIs also talked about their advocacy efforts in promoting universal health coverage, the goal of which is to deliver primary health care more equitably to all without causing financial hardship to any.

One KI said:

“What we’re calling health system strengthening is eventually moving toward universal health coverage that should be delivered by people to the people. And universal access says it all: you can’t only provide it only for particular groups of people.”
Financial protection

Of the 10 principles of HSS, financial protection was mentioned the least often in the KI interviews, although several mentioned their engagement in helping to ensure that communities they serve can afford health care, or discussed the importance of policies related to user fees. One role that INGOs should and can play, according to several KIs, is helping to inform citizens of their right to health care, and advocating at the country level for free preventive services, especially for the “poorest of the poor.” KIs who talked about finance and financial protection often referred to it in the context of advocating for universal health coverage, which includes, in its definition, the concept of financial protection.

Satisfaction

Although only two INGOs explicitly used the word “satisfaction” in referring to their roles in strengthening health systems, several mentioned that INGOs have the responsibility of ensuring, to the extent possible, that the needs of communities are met. Several also mentioned that INGOs have a role to play in both ensuring that their own projects and programs are designed to meet the needs of stakeholders—both communities and health workers—and advocating for national policies and programs that meet the needs of communities.

Donors also have a key role to play, asserted several KIs, but ensuring that their funding is not overly restricted and that ministries of health are allowed and encouraged to both strengthen systems and to address disease burden of communities and countries. As one KI said, however, “the funding that pours into a country doesn’t always match up with the real health problems...and it rarely supports basic primary care.”

Key Informants’ Perceptions of the NGO Code of Conduct for Health Systems Strengthening

Key informant (KI) representatives of signatories, unsurprisingly, expressed support of the Code itself and the issues covered in the Code. Of the 10 KIs representing organizations that have signed
and/or were involved in drafting the Code, eight concurred that the Code may need to be updated, primarily because it was initially drafted nearly eight years ago and some aspects of issues mentioned in the Code may have changed. One KI representing a signatory to the Code, who admitted that his organization had not revisited it for the past several years, said: “The code needs to be revised, taking into considerations the major, major changes that have happened in the last few years.” These changes, according to this KI and others, include increased attention to HSS on the part of donor agencies and other members of the global health community, the increased engagement of the private sector, especially through public-private partnerships that support INGO work, and a newfound focus on universal health coverage (UHC) and the corresponding need for strong health systems to make UHC feasible.

KI signatories who expressed the willingness to consider modifications also shared that they would consider making changes that would lead more INGOs to want to sign and help promote the Code. All KI signatories—as well as several non-signatories—expressed interest in learning more about why some INGOs have not signed the Code. Health Alliance International, the organization that continues to manage the website on which the Code is published, expressed, in email exchanges outside the key informant interview process, the desire to re-launch discussions about the Code and appeared willing to consider modifications to the Code to encourage more widespread adoption of the Code itself and more wide-ranging awareness of the issues it addresses. Two KI signatories, however, expressed concern about modifying the Code to make it more acceptable to a wider range of INGOs. One expressed adamant disagreement with the possibility of making changes that might result in “diluting the principles of the Code just to get more organizations to sign on.”

Several KIs whose organizations have signed on perceive the Code as an awareness-raising tool rather than a Code for which an accountability mechanism should be developed. As one KI signatory said, “We see this as a positive contribution to continued reflection and dialogue on the role of NGOs and
other partners in international cooperation and development.” Another noted: “We feel very strongly about a lot of the ideas that the Code embodies and some of the thinking behind it, so I’m happy to help expose those themes to a broader audience, if possible.” Another KI signatory said:

“We know that NGOs are in a quandary when they’re dependent on the government funding, which was, I think, the thinking behind the sort of genesis of this code, is if we could get enough NGOs to sign on, that the donors, themselves, would look at it...But for me, the most important is that this political debate takes place...We risk that people in the so-called developing countries whom we think that they are happy to see us there, that they just at a certain moment refuse to cooperate with us, because they consider us, really being part of the problem and not helpful to their political and economic struggle...”

Only two representatives of INGO signatories said the Code would be more effective if it were re-designed to include some kind of accountability mechanism through which signatories could rate themselves regularly. One asserted:

“If you want it to have more teeth and introduce accountability mechanisms, I would go straightway to the NGOs, I would not go through donors. This would be reframing the code and incorporating analysis and accountability into the instrument and adding a reporting instrument that would be mandatory. It wouldn’t be simple, as supporters would be required to report on the implementation of the code...”

Other KIs, both signatories and non-signatories, suggested that some basic elements of the Code be streamlined and presented as a list of guiding principles. This might, they said, encourage more INGOs to sign on to a document that could more easily be used as advocacy tool. One KI signatory said:

“For me the Code right now is really just a good piece of paper; it has its benefits as talking points. And I think it helps; certainly, it could be used as an eye opener. And having this as an eye opener, you don’t even need a follow-up. And you don’t even need to put in accountability processes and mechanisms linked to the Code if its main purpose is to get conversations going...but we need to get it out there, and get people talking about it.”

Representatives of non-signatories to the Code were, for the most part, unaware that it existed. Three of the 10 key informants representing non-signatories said that they had heard of the Code; two of these KIs were fairly knowledgeable, prior to the interview, of the main elements of the Code. Theoretically, the apparent lack of awareness of the existence of the Code could be a reason that more
INGOs have not signed the Code. However, after reading and discussing the Code, the 10 representatives of non-signatories who were interviewed unanimously said that their organization would not sign on to the code as it is written and that they would not encourage their organization to sign on to the code as written. However, eight of the 10 KIs representing non-signatories said that they may be comfortable with promoting the Code within their own organization, and encouraging their organization to sign the Code if specific changes were made to the Code.

Although only three non-signatory KIs knew of the Code, all KIs, representatives of both signatories and non-signatories, said that they had encountered all of the issues and challenges raised in the Code. One key informant representing a non-signatory INGO summed it up by saying:

“Even though I hadn’t seen the documents [the Code] before, every single one of the issues that is listed in the Code has been discussed at one point or the other by every single NGO. Because you cannot be an international development organization without having run into those issues.”

Key informant representatives of non-signatories, after having read the Code, expressed a wide range of reactions to the Code, from “the language sounds like it was written in the 1980s and would need to be completely updated to reflect the current realities of international aid,” to “with some rewriting for greater consistency, we might be able to sign the Code.”

One principal concern that non-signatories expressed was that the Code contains both aspirational language and more binding, commitment-oriented language. Another concern, nearly unanimously expressed by non-signatories, was that the Code addresses both operational issues as well as advocacy-related issues, making it particularly challenging for INGOs that focus on service delivery and implementation to sign on to advocacy-related commitments in the Code, particularly those included in Article VI.

Non-signatories to the Code also, as described above, said that the Code does not adequately acknowledge the fact that many issues, including those both aspirational and committal, are outside the control of INGOs. The Code, as one KI said, “ignores the elephant in the room” by not outlining, either in
the preamble or in the individual articles, the way in which donor agency behavior drives the behaviors of INGOs implementing donor-funded projects. The Code also is perceived by most of the non-signatories as not taking into account the context-specific nature of the challenges raised, and the need for context-specific solutions in addressing the challenges.

A major criticism of the Code expressed by most KIs, including some signatories to the Code, is that the document places a burden on INGOs to follow specific practices without taking into consideration the various barriers that organizations face, because “Nearly all of the issues raised in the Code are not those that can be solved by INGOs themselves.” In addition, many said that the language in the Code is limited and, according to one KI, “naïve” in that it does not address the system in which INGOs operate. One non-signatory KI said:

“For every single element in the code, it’s the same. You have the donor thing that needs to be changed in order for this to happen and you have the government thing that you can list the things that they need to do. So it’s a tripartite... It should be a tripartite discussion, and perhaps should be a tripartite document as opposed to one for INGOs.”

Another non-signatory KI said:

“But the problem is this, okay, because we have the funders, we have the governments and we have the NGOs, you have to address the dynamic of the three-dimensional system. If you only go to one actor, if you say, ‘Oh NGOs, please, can you please sign under this document?’ And if you do not touch what the donor needs to do and what the government needs to do, you will have very, very, very limited impact.”

Another criticism of the Code made by several KI non-signatories, is that the Code does not adequately address the responsibility of ministries of health themselves in leading and managing health systems and insisting on certain behaviors on the part of all actors, including INGOs, but also local NGOs and donor agencies themselves. One interviewee summed up this issue as follows:

“The philosophical challenge I have is that this code does not place any burden on countries themselves to perform better. Yeah, it’s like we are talking about the patient and they’re saying, it doesn’t say it, but it’s assuming that the governments in Africa are so, look like they are pure, they are victims, or they are patients. We [INGOs] all need to do this and do that. It actually should be them doing it and then we kind of follow, but are they doing their jobs?”
As noted above, KIs also talked about the inefficient—and sometimes corrupt—use of resources within ministries of health. One said:

“A number of reasons why we have also these issues is corruption. Now, nowhere in this code is corruption mentioned, why? Because the obligations of the Ministry of Health, the government, are not mentioned in this code of conduct, only as a recipient of somebody else’s better behavior. The problem really is that part of this is happening because of corruption, and unless we address corruption...you can dance around it, you can have NGOs do this, do that, do this, do that, but it will be really unrealistic to think that anything will change.”

Another factor, mentioned often by KI non-signatories, is that the Code promotes support of the public sector and does not mention the private sector. Although all KIs agreed that ministries of health play a key leadership and coordinating role, several mentioned that the private sector, at many levels, is playing a larger and larger role in both funding service delivery initiatives and in providing health care, through for-profit clinics and other health facilities. In considering signing a new version of the Code, several of these KIs expressed the desire to see references to the role of the private sector. One KI who discussed the need to include more reference to local context in the Code noted:

“NGOs aren’t gonna develop Africa or develop any so-called under-developed country... And in fact, somebody I’ve talked to, he’s like ‘Nope, the country has to kind of develop itself by the policy decisions it makes, etcetera.’ So we can support, and we can do our part, but the government and its citizens will ultimately ‘develop’ themselves. And that includes not only individuals, but also social entrepreneurship and local companies.”

Another KI, in speaking about the growth in the private sector in the provision of health care and the need to update the Code, said:

“I really do think that we are now talking about a different Africa than we were 20 years ago, where most jobs were provided by the government. There are many more homegrown, private companies, many of whom are both making money and developing the local economy—and also seeing and contributing to the social good, including the provision of high-quality health services.”

A final suggestion, one made by nearly half of the 20 KIs, is that INGOs should ensure that they have their own internal organizational codes of ethics to govern their own behavior, and that these codes address some of the issues raised in this Code of Conduct, including hiring and compensation
practices, and “ethical behavior” in working with donors, ministries, communities, and other stakeholders to mitigate potential harm to systems.

All of the KIs interviewed explicitly said that they would like to be involved in future discussions or working groups related to issues raised in the Code. One noted that re-launching a discussion in 2015 could be particularly compelling, as the MDG deadline is approaching and new Sustainable Development Goals are ongoing. This individual suggested:

“We could get a group discussing NGO practices for sustainable health system strengthening linked to the new SDGs, and perhaps come up with a document that could represent the views of more organizations, robust but not overly controversial. The NGO Code of Conduct to Support Sustainable Development in Health has a nice ring to it, doesn’t it?”

The following section outlines perspectives gathered through the KI informants on each of the Code’s articles. The header for each article is followed by the introductory language from the Code related to each article. (The full NGO Code of Conduct for Health Systems Strengthening can be found in Appendix 1.)

**Article I. NGOs will engage in hiring practices that ensure long-term health system sustainability.**

“The role of international NGOs is to supplement — not supplant — the public policy role of host country governments and local institutions to strengthen and expand health systems. The NGO role is to provide research, support and expertise to strengthen civil society and local academic and research institutions in informing public health policy development. We, the signatories to this code, view our role as time-limited; that is, as communities, local institutions and Ministries of Health become stronger and build capacity, the role of the NGO should diminish or evolve.”

The language used in the introduction in Article I was well-perceived, in general, by all KIs, and nearly all KIs agree that an important role for INGOs is “informing public health policy development” by providing expertise and supporting and working with research institutions. Some key informants noted a contradiction in the last sentence between the phrase “our role as time-limited” and the concept that the role of the NGO may, in fact, “evolve” rather than “diminish” over time. Most KIs see the role of INGOs as adjusting to the changing environment, both in countries and globally, over time.
More problematic sections of Article I code, according to KIs, were strictly following the first clause in the article, which states: “In areas where trained personnel are scarce, NGOs will make every effort to refrain from hiring health or managerial professional staff away from the public sector, thus depleting ministries and their clinical operations of talent and expertise.”

KIs, both signatories and non-signatories, discussed the issue of competition for staff, not only between INGOs and ministries of health, but among INGOs themselves, and between INGOs, donor agencies, UN bodies, and, in some countries, the private sector. One KI said:

“With the competition the way it is today, you’re going to always have this competition for better human resources, better people for your proposals. And you will always have organizations, including but not only NGOs, who fight to get the best people out of the Ministry of Health. Why? Because of the condition under which you have to get the funding to implement the projects.”

Several KIs feel that it is important to distinguish between hiring clinicians, especially nurses and doctors, away from a clinical setting in which they provide health care to clients, and hiring health workers away from managerial positions. They also expressed the concern that ministries, in addition to INGOs and other partners, also contribute to taking clinicians out of clinics, and proposed that this issue be addressed at the country level. One KI noted:

“One of the big concerns I have is when we—NGOs and others—hire clinicians and take them away from their expertise and the clients they serve, and often end up using them in roles where that expertise wasn’t required, and their skill set doesn’t necessarily match what’s needed. So you’ve got a doctor that you’ve taken out of a provider role and now you’ve got them acting as a manager, and they suck as a manager…I think our expectation that medical degrees or health professional degrees can translate to the capacity to manage public health projects is wrong. Instead of hiring managers, we hire clinicians and put them in offices, and that to me is one of the most egregious things that we do.”

An aspect raised by several KIs, primarily signatories to the Code was: “The biggest challenge is that the rich countries are recruiting health workers from the poorer countries, leading to the economic crisis in those countries and they are the ones who are mostly suffering.” Several KIs, however, shared the sentiment expressed in the following way by one KI: “This is not something that only NGOs can
tackle; it requires international cooperation, and not just on paper.” Eight of the KIs, all representing signatories to the Code, suggested that INGOs can play a role by helping to raise awareness of and advocate for better adherence by countries, especially “rich countries” to the WHO Global Code of Practice on the International Recruitment of Health Personnel. This code, ratified by the World Health Organization during the World Health Assembly in May 2010, was developed in response to health worker migration, “especially from lower-income countries to higher-income countries, further threatening already fragile health systems” and had a goal of helping “facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.”(WHO, 2010)

Several KI non-signatories, however, said that the NGO Code of Conduct for HSS “ignores the reality of the global economy and global labor market” and their belief that human beings, including health workers, have the right to seek the best possible employment situations for themselves. One said:

“The other force is the market forces, the employment. It's now a global economy. It's a global village. People have human rights. They go from one country to the other, and a lot of us working in global health do, as well... If the market is what it is, you can't arbitrarily just go and say, ‘Hey, let's get these people here to stay here. And these people shouldn’t move to the other place here even though they could get paid more and send their kids to better schools. There is a human rights issue and there is a market issue and if you are not touching them, it will never ever, ever, ever work.”

Some KIs, including one representative of a signatory to the Code, said that their organizations play a role in creating employment opportunities for health workers who would otherwise be unemployed, as some countries are currently producing more health workers, in some cadres, than can be absorbed by the public sector. One said, “Yes, we can advocate for more money to go to the health sector, but in the meantime, are we supposed to let these trained young people hang around and wait?”
Other KIs also said that they have helped the public health sector by hiring health workers and building their skills, in some cases while they are waiting for public sector positions to become available.

One said:

“We're actually almost a feeder. We identify really highly talented, possibly not formally educated individuals or educated individuals who haven't had a chance yet to apply to get hired into the public sector. We give them sort of very intensive training and mentorship, and then they often go on to the public sector. Not necessarily because they'd rather work in the public sector but just because they see it as a long-term, very stable working environment.”

Another KI signatory to the Code noted:

“Sometimes we become an employer ourselves because all those many health workers who are out there with no jobs are the ones that are important and we deserved them and they become key resources for [our NGO] and stay in country. It’s not like we’re going to hire away the Permanent Secretary of the Ministry of Health or the chief cardiologist....but we are sometimes creating jobs for health workers who would otherwise leave our country and find work elsewhere.”

**Article II. NGOs will enact employee compensation practices that strengthen the public sector.**

[Note: The Code does not include any introductory language in this article.]

Article II proved problematic for all of the KI non-signatories and several KI signatories. This article does not include an introductory description, unlike the other five articles in the Code. Most of the clauses within the article address such issues as “fair monetary compensation for work done by all employees, across the health care system, including salaries for community health workers,” the need for INGOs to offer “locally competitive” salaries, but salaries “that are not substantially more generous than the public sector,” the importance of giving the same benefits to local staff and expatriates who have comparable levels of responsibility, and the need for INGOs to collaborate with the public sector to improve conditions if “public sector benefits or pay structures are inadequate” (NGO Code of Conduct for Health Systems Strengthening, 2009).

Many reactions to this article were similar to those discussed above in Article I. KIs shared that they believe in fair compensation, but expressed challenges in strictly adhering to clauses of the article,
particularly given their need for competent staff. Most agreed that INGOs should advocate for equitable
salaries for public health sector employees, but saw this as a long-term advocacy goal, and not a
condition that they could change in the short-term. They also stated that countries and donor agencies
should invest in plans to address health workforce shortages and distribution challenges, plans that
could be supported through INGO expertise in these areas.

KIs, including both signatories and non-signatories, also shared the need of INGOs themselves to
ensure that they have high-quality, high-performing staff, both because their efforts in winning new
projects are often highly dependent on the staff they propose, and successfully implementing their work
means that they need qualified personnel.

Several KIs also alluded to the challenges of categorizing staff, which in the Code are referred to
as “local” or “expatriate.” Several KIs said that their organizations have multiple categories of staff,
including categories such as “third country staff” and “local international hires,” which consist of
individuals who have expectations of receiving higher salaries than “local hires.”

**Article III. NGOs pledge to create and maintain human resources training and support systems that
are good for the countries where they work.**

“NGOs embrace the goal of strengthening educational institutions that train health workers,
while also providing on-the-job continuous education. Workshops and other short training
programs for health workers already in service often divert health workers from their workday
responsibilities, while providing minimal benefit to the system as a whole.”

All KIs agreed that INGOs should help to support training and development for human resources
for health and agreed, in principle, that they should help strengthen educational institutions that train
health workers but, as several mentioned, “we don’t always have the resources to support those
institutions.”

The problems presented by short-term training programs that may take health workers away
from their jobs were familiar to many KIs, several of whom referred to “the per diem culture” through
which health workers supplement their salaries by participating in workshops and short-term trainings solely for the per diem they receive. As one KI said:

“This is a big health system strengthening issue. How many health workers are in their facilities and how many are out getting trained by NGOs? And it’s anecdotal, I don’t know if anybody’s ever studied it. But anecdotally, you know that these staff are living for the per diem that they get from us as the NGOs or the sitting fee or whatever we call it. That they are really spending all their time going from training to training to training, from NGO X to NGO Y to NGO Z, collecting the per diem. The anecdote version of that is somebody saying at the end of one HIV-related training, ‘So, you’re all going back to your health facilities, so tell me one thing you’re gonna do differently tomorrow as a result of this training.’ A health worker raised her hand and said, ‘Oh, I’m not going back. I’m going to NGO X’s training for malaria.’”

KIs said, however, that the “per diem culture” is not cultivated and perpetuated only by INGOs, as donor agencies and other stakeholders such as UN agencies also offer stipends, “sitting fees,” and per diem to encourage workers to participate in trainings and cover the perceived cost of their participation. Several interviewees proposed that one solution to this challenge is working with other partners, under the leadership either of the ministry of health or of the government as a whole, to set standard and equitable per diem fees that cover costs incurred in participating in trainings, including travel and meals, but that are not “inflated to the degree that people just go from one training to the next.” KIs who discussed this solution said that it is essential that the standardized fees be enforced by donors and by the government.

Several interviewees also said that an important role for INGOs is helping to develop innovative ways, such as on-the-job training, that can support continued professional development without “diverting health workers from their workday responsibilities.”

**Article IV. NGOs will minimize the NGO management burden for ministries.**

“NGOs recognize the burden on governments that have insufficient resources to organize their own country’s affairs, while having to juggle the management burden of multiple and sometimes-competing aid organizations from a variety of other countries.”
Key informants all admitted that, in some cases, they have inadvertently placed additional management burden on ministries of health, especially by creating some level of parallel data system to gather data, usually at the request of donor agencies that ask for reporting on indicators for which information is not available from the national health management information system (HMIS). The burden, they said, starts at the level of health workers and health facilities collecting the data, and moves up to the level of the central ministry of health in consolidating various data sources and indicators.

All KIs said that, to the extent possible, data should come from national health management information systems and globally approved surveys such as periodic Demographic and Health Surveys (DHS), which began in 1984 with the support of USAID, with the goal of “advancing global understanding of health and population trends in developing countries.” These surveys, with the support of the US government and countless other donors, have been conducted in 90 countries, with a total of more than 300 surveys implemented over the past 31 years (DHS, 2015).

Several KIs also mentioned a newer tool, called DHIS 2, a standardized open source web-based health management information system that countries can adapt and link to their information systems to collect both routine and survey-type data on a more regular basis than DHS, which are generally conducted every five years. DHIS 2 allows countries to “manage aggregate, routine data...set up data elements, data entry forms, validation rules, indicators and reports in order to create a fully-fledged system for data management...[and] has advanced features for data visualization, like GIS, charts, reports, pivot tables and dashboards which will bring meaning to your data” (DHIS 2, 2015).

Several KIs, however, noted that they sometimes need to gather additional data, especially when introducing an innovative practice or conducting research, especially on pilot-level interventions. They discussed the importance of coordinating such practices with the ministry of health and other
partners, and of collecting only data that will be both used and useful to minimize additional management burden.

KIs see both donor agencies and ministries of health as responsible for adding to the burden to collect additional data and create parallel data collection systems. They shared that donors need to support and encourage globally accepted and approved indicators and data collection systems, and allow and encourage INGOs to use data based on the data generated by national systems, as discussed above, and support ministries of health and INGOs in helping to build the capacities of ministries of health to strengthen their data collection and management systems.

Several KIs, however, acknowledged that in some countries, national information systems are weak. Although they see an appropriate role of INGOs in helping to strengthen a national system, they also acknowledge pressure to produce data—while data systems are being strengthened-- to meet donors’ needs.

One interviewee illustrated this point as follows:

“In some countries, it [accurate data] doesn't even exist. So, for your fiduciary responsibility, you as an NGO, you have to set up a parallel system. So I’m not judging... I know it's bad, we all know it's bad...But what I'm saying is you can't just have the NGO will sign on a paper and then you let the donor continue to issue RFPs [requests for proposals] and RFAs [requests for applications] that are requiring unrealistic M&E systems. So...you cannot have NGOs sign the paper like this and then the government is not addressing its leadership issues. Like the government kind of sit back and does nothing and doesn’t feel a responsibility to coordinate, a responsibility to provide leadership, a responsibility to develop a national strategy, a responsibility to set up an HMIS system that everybody can use. If you don't do anything with that, then there is absolutely no point in getting a code like this.”

Several KIs also suggested that donors explicitly allocate resources to ensure that INGOs and other partners are investing in building the capacity of ministries of health to better manage the landscape of donors, NGOs, and other partners.
One KI said:

“If you really think about it, the donors often are placing the burden on the government system...if in every proposal that we've seen in the last 50 years, if every proposal that will come in the next 10, 20 years, if every one of them, let's say, has 50% of the funding devoted to building government capacity, including capacity to manage donor funding and different actors...that would completely transform the landscape.”

**Article V. NGOs will support Ministries of Health as they engage with communities.**

“NGOs can play an important role as a bridge between civil society organizations and government agencies, especially (but not exclusively) in nations where populations or sub-populations are actively oppressed by their governments.”

The overarching principle expressed in Article V proved to be the least problematic among those interviewed. All KIs interviewed agree that INGOs can and should play a role in supporting ministries of health as they engage with communities. As one KI said, “Number five seems pretty easy to agree with; I mean there’s no controversy around supporting ministries of health to engage with communities.”

A challenge expressed by several KI non-signatories, however, was working to actively oppose the government of a country in which they are working, even when parts of the population may be “actively oppressed.” One interviewee said: “If we’re working with the approval of a country’s government, we can only go so far in being vocal in our opposition to that government....so need to be very careful in how we approach this thing.”

**Article VI. NGOs will advocate for policies which promote and support the public sector.**

“NGOs will actively advocate with civil society, local institutions and donors for policies and programs that strengthen health systems overall. NGOs recognize that vertical programs and selective approaches exacerbate inequities in health systems and ignore underlying determinants of health. We also recognize that funding conditionalities can limit or distort government expenditures and priorities. These unnecessary limitations continue to create barriers to health and development and are unfair and inequitable.”

This article was called the most “controversial,” “problematic,” and “hard to swallow” by several KIs, especially, but not limited to, KIs representing non-signatories to the Code. Although all KIs
expressed a support of “policies and programs that strengthen health systems overall,” and several alluded to the problem of vertical funding “distorting health systems,” many disagree that all “vertical programs and selective approaches exacerbate inequities in health systems,” and most did not see advocating against lending institutions’ policies as falling within their priority advocacy issues or, in several cases, in the best interest of their own organizations.

Most of the KIs, including several KIs representing signatories to the Code, do not agree that “all vertical programs and selective approaches exacerbate inequities in health systems and ignore underlying determinants of health.” Several KIs whose organizations were signatories asked me to indicate the Article and clause in the Code where this statement was articulated as, to quote one KI, “I don’t remember the language in that article talking about vertical funding in such a black-and-white way.” All of the KIs did, however, share that they believe that overly “verticalized” and restricted funding—for example, funding that addresses only one health issue and is not allowed to be used to address system weaknesses—has, in some cases, led to problems in supporting overall health systems strengthening.

However, most KIs, again, including some signatories to the Code, expressed the opinion that vertical, or issue-focused programs, have an important role to play in global health, and in public health in general. As one KI said, “All vertical funding is not bad; it’s how it is used that is important.” Another said: “You are not going to approach malaria the way you approach Ebola.” A KI representative of a signatory to the Code explained the approach of their own organization:

“Our general approach to this question is to not fight against vertical funding but to advocate for, or at least demonstrate, the importance of health system strengthening as an approach. However, we feel that if we can absorb and use vertical funding to help build a good health care delivery system... So for us, we’re demonstrating how you can take vertical funding and use it to do health systems strengthening interventions.”

Several KIs lauded the Global Fund, or GFATM, which was originally developed to tackle AIDS, tuberculosis, and malaria, but has increasingly allowed more flexibility to be used by ministries of health
to strengthen health systems to better manage control of these priority diseases—and primary care in
general. KIs who mentioned the GFATM also appreciated that funding decisions are made by ministries
themselves, and not “determined in Geneva.” Thus, these KIs said, when properly used, GFATM
resources can be used to both strengthen systems and achieve targeted results.

One KI signatory said, in describing their organization’s experience in one country collaborating
with the ministry of health in programming GFATM resources:

“We realized that we couldn’t address HIV unless we had basic primary health care. So the
money needed to be used for essential drugs and supplies and to pay the staff, the public sector
employees in many cases who hadn't been paid in months. We also advised consolidating or
reducing user fees to the extent that was in our power, and hiring and training an army of
community health workers to do active case planning for vulnerable people of any type...So we
set out an HIV program as a health system strengthening program before there was any
discussion or rhetoric about health system strengthening. It was really just the only way we could
imagine to do the work that we had promised the Global Fund we would do. And we had this
interest in health as a human right and we felt like that had to be delivered through the public
sector.”

Another commonly expressed perspective was that disease- and issue-focused funding is
sometimes necessary to encourage ministries of health and other in-country decision makers—as well
as communities—to focus attention on otherwise neglected health issues. Examples mentioned by KIs
included family planning, maternal health, and TB.

Other KIs expressed the need for funding to focus on key public health problems and the specific
disease burden in each country or region, and not only on strengthening health systems. One noted:

“If you look, for example, at the evidence and the high-impact intervention, you realize that the
funding is not following...And those are big issues and important issues that needs to be on the
table. Because you could very quickly change the face of global health by tripling, or, actually,
quadrupling the funding for preventive services such as family planning and immunization.”

Several KIs also shared that they see vertically-funded programs as a mechanism used by donor
agencies to facilitate the tracking of the results of their support and investments. One interviewee said:

“Why is so much funding vertical? I think there's a really deep distrust, especially in the US, that foreign
aid money will be wasted, and it’s just a reflection of that undercurrent of that disposition that’s across the population.”

Several KIs suggested that donors, in addition to, or in some cases, instead of, providing vertical funding streams, also provide funding for health systems strengthening as a whole, or various components of health systems.

All KIs representing non-signatories to the Code said that they would not feel comfortable in advocating, in general, against policies of the World Bank and the International Monetary Fund (IMF). They also emphasized that the World Bank and the IMF are two distinct entities, each with its own objectives, policies, and procedures.

Several KIs said that they are trying to work in collaboration with the World Bank, instead of advocating against it. One said, “These days, we’re much friendlier with the bank and we’re kind of trying to work together...” A commonly expressed belief, among both signatories and non-signatories, was that the World Bank’s policies have improved in recent years, and “the World Bank is not the World Bank of the 1980s anymore.”

Several KIs, especially those representing Code signatories, do believe that the IMF continues to play a role through the conditionalities it places on loans, limitations that lead to “suppression of public sector spending in order to secure IMF loans” and chronic under-investment of domestic budgets in social sectors, especially the health sector. Nearly all non-signatory KIs, however, shared that working to change the policies of the IMF was not among their advocacy priorities, and expressed the opinion that the IMF is, in the words of one KI, “starting to change the way it looks at its relationships with developing countries and the indicators it uses to measure success.”
CHAPTER 6: INGOS AND HSS—SYNTHESIS OF KEY FINDINGS

This research seeks to answer the principal question: What are the most appropriate and effective roles for INGOs in health systems strengthening or, in other words, how can INGOs best strengthen health systems? As described above, to answer this question, I explored several sub-questions, looking at challenges INGOs face, and how they address those challenges. In addition, I used the NGO Code of Conduct for Health Systems Strengthening as a framework for discussing challenges NGOs face in ensuring that they are strengthening, and not inadvertently weakening, systems. The discussion of findings presented in Chapter 5 provides insight into these issues, with the first section focusing on the key principles of health systems strengthening, and how INGOs view their roles vis-à-vis these principles, and the second section focusing on the NGO Code of Conduct itself and providing insight into why more INGOs have not signed the Code.

How do INGOs working in health ensure that they are strengthening, and not inadvertently weakening, systems?

As described above, global health INGOs can help ensure that they are strengthening health systems by aligning their work with the key principles of health systems strengthening: holism, context, social mobilization, collaboration, capacity enhancement, efficiency, evidence-informed action, equity, financial protection, and satisfaction (Swanson et al., 2010). Although no one KI explicitly cited all 10 of these HSS principles exactly as expressed by Swanson et al, they all referred to them in the examples they shared.

One potential “best practice” mentioned by several key informants that can be emulated by other INGOS, and perhaps reinforced through donor agencies’ funding requirements, is that INGOS
become more conscious about the impact that every intervention, project, or country program they implement has on a country’s health system, and implement safeguards to minimize negative impact. Another practice suggested by INGOs was ensuring that principles of health systems strengthening are included in their internal codes of ethics, and that these codes are widely disseminated and enforced.

**What challenges do INGOs face in strengthening health systems, and how do INGOs address these challenges?**

INGOs face a multitude of challenges in trying to ensure that their work results in, and sometimes leaves behind, health systems that are stronger as a result of their work. INGOs, according to the KIs interviewed, are well-intentioned and share an understanding of the need for stronger health systems.

As KIs shared, these challenges often are created by the need to balance donor requirements and restrictions with the need to follow country leadership and the desire to ultimately serve the needs of communities. Some donor funding, especially but not limited to vertical funding, may lead NGOs to operate in ways that do not support the equitable distribution of resources. Donor restrictions and requirements for measurement, evaluation, and data also may lead INGOs to create additional burdens on ministries of health by creating parallel data systems instead of relying on data generated through a country’s health management information system or data generated by regular surveys, such as Demographic and Health Surveys.

Several KIs indicated that INGOs, they believe, do not always address these challenges in the most effective way possible. Because they are competing for resources, both donor grants and contracts, and human resources, INGOs sometimes knowingly engage in practices that may help them get awarded grants and achieve short-term results, but not leave behind stronger health systems in the wake of their time-bound projects and interventions. They emphasized the need for more dialogue among INGOs themselves, and among INGOs, donors, and ministries around the challenges and how
they can best be addressed. They also discussed the importance of joining and participating actively in coalitions and alliances to advocate for change.

**What barriers exist to prevent the NGO Code of Conduct for Health Systems Strengthening from gaining more momentum? Can and should the Code be modified to attract more signatories and make it more useful?**

In Chapter 5, I outline several barriers that appear to prevent the Code from gaining more momentum. One, but perhaps not the most significant barrier, is that INGOs who have not signed on to the Code appear, for the most part, to be unaware of the Code’s existence.

Other barriers expressed by KIs, representatives of both signatories to the Code and non-signatories, include the need to ensure more consistent language across the various articles and clauses, as they perceive the Code as being at times aspirational, and at times more directive. Nearly all KIs expressed the need for the Code to be updated given changes that have occurred in global health and development over the past several years since the Code was originally drafted.

KIs—both signatories and non-signatories—in some cases expressed very divergent perspectives about issues raised in the Code, including its focus on the public sector and lack of discussion of the interplay between the public sector and the emerging private sector in many countries, as well as the global for-profit private sector as a source of funding for the work of INGOs. As expressed elsewhere, INGOs represent a wide range of philosophies and “world views,” and this research demonstrates, to a certain extent, this range and the challenge of successfully convincing a wide range of INGOs to agree on a common Code of Conduct for Health Systems Strengthening. As interviews with some KIs indicated, modifying the Code to attract some new INGO signatories may lead to some current signatories being reluctant or unwilling to sign on to a revised version. As proposed below in the plan for change, a simpler list of guiding principles or “best practices” may garner more success as a tool that can both be applied by INGOs and used as an advocacy tool with donors and other stakeholders than a modified
version of the current Code. Promoters of the Code, if they choose to maintain the Code, also may apply
lessons from other similar NGO codes of practice and conduct, as outlined in Chapter 3, including the
possibility of having various tiers of levels of support for the Code, such as champions, signatories, and
promoters, or the development of short training modules related to key elements of the Code that could
be accessed and used by a variety of INGOs and other stakeholders.
CHAPTER 7: RECOMMENDATIONS AND PLAN FOR CHANGE

As noted above, at the onset of this research project, I identified much anecdotal information about the unintentional but negative effects that INGOs may have on health systems, and that they may be potentially weakening the systems they seek to strengthen. I identified few systematic studies, however, about this phenomenon. As a framework to better understand these key issues and challenges, I used the NGO Code of Conduct for Health Systems Strengthening.

This research seeks to answer the principal question: What are the most appropriate and effective roles for INGOs in health systems strengthening, and how can they “do good” and not “do harm” when it comes to national health systems? I hope that this research helps INGOs and funding agencies engage in self-reflection, becoming more aware of the challenges faced by INGOs, and how to safeguard against inadvertently doing more harm than good. In addition, this research, I hope, will lead to discussions among INGOs, and between INGOs and other stakeholders, including donor agencies and ministries of health, about the most effective and efficient ways in which INGOs can strengthen systems. This research also sheds light on the NGO Code of Conduct in Health Systems Strengthening, particularly why more INGOs have not signed on to endorse the Code and what steps might be undertaken either to strengthen the Code or to replace it with a streamlined list of guiding principles to which INGOs working in global health can agree and adhere.

During the process of conducting this research, primarily from 2014 to 2015, significant events occurred that had an impact on issues related to INGOs and health systems strengthening. In 2014, USAID’s Global Health Bureau commissioned the Institute of Medicine to develop a report to “study the value of health system strengthening in low- and middle-income countries” (IOM, 2014). A key finding of
the report, which encouraged the US government to invest more—and more strategically—in health systems strengthening, was: “Developing a strong health infrastructure in low- and middle-income countries will improve health, and will have consequences that go beyond health to building a more stable and prosperous world” (IOM, 2014).

The 2014-2015 West African Ebola outbreak, mentioned in several sections of this document, cast a new light on the need for health systems support, as the outbreak had a tragic impact in countries with weak health systems, and demonstrated, in a new way, the global interconnectedness of all health systems. Perhaps as a result of the Ebola crisis, political support for health systems strengthening, in the US and elsewhere, appears to have increased, and several donors, including the US government, are placing greater emphasis on health systems strengthening, at least in the language they use to describe their programs.

Finally, with the Millennium Development Goals (MDGs) “expiration date” in sight in 2015, the global health and development community has engaged over the past two years in countless discussions and on-line consultations about the global development goals that should come next, currently referred to as the Sustainable Development Goals. Much advocacy has been conducted around the need to include a goal related to health systems strengthening and universal health coverage, and not just disease- or issue-specific health goals, such as those included in the MDGs related, for example, to reductions in maternal and child mortality. The underlying argument advanced is that strong health systems are required to achieve any sustainable progress in health, including in such priority areas as maternal and child health, HIV/AIDS, tuberculosis, and malaria.

**Recommendations**

The following recommendations are based on research findings, principally information shared by KIs in semi-structured interviews, but also complemented by findings from the literature review. A summary of key recommendations can be found in Appendix 5.
Recommendations to INGOs

INGOs should ensure that their work is complementing, not displacing or supplanting, the work of ministries of health and the public sector as a whole in building strong health systems. [Note: during humanitarian emergency situations, in some cases, and only on a short-term basis, INGOs continue to play a key role in directly delivering services, as demonstrated during the 2014-2015 Ebola outbreak.] All KIs expressed the intent of their organizations to support—and leave behind—stronger health systems, but few discussed how their organizations intentionally ensure that their work strengthens health systems.

To the extent possible, INGOs should invest resources in analyzing the impact of their own work on health systems at all levels, on a project-by-project or country-by-country basis, or globally, to self-monitor their influence on health systems and ensure that they are not unintentionally creating distortions.

In addition, INGOs working in global health should consider developing internal codes of ethics, or modifying their internal codes of ethics, to ensure that they address ethical implications that may have an impact on health systems-related issues such as hiring practices, accuracy in results reporting, and advocacy.

INGOs also should engage actively in country-level working groups, both NGO-led alliances and health sector groups led by ministries of health, to better coordinate their activities and to ensure that they are following uniform standards regarding hiring practices, data collection, and other national standards.

INGOs should, according to literature review findings and most—but not all—KIs interviewed, also seek to create and invest in innovative partnerships, including partnerships with the private sector, to move beyond dependence on government donor agencies as their primary or only funding source.
Finally, global health INGOs should, resources allowing, advocate for change to ensure that health systems strengthening is funded and promoted globally by donor agencies and, at the country level, by ministries of health and other local entities.

**Recommendation to Donor Agencies**

As outlined in key findings from interviews with KIs, INGOs uniformly believe that certain donor practices may be responsible for leading INGOs to act in ways that do not build stronger health systems.

The following recommendations on how donor agencies can facilitate the work of INGOs in building stronger health systems are, according to findings from the literature review and from KI interviews, appropriate for a range of donor agencies, including governmental donor agencies as well as private foundations and public sector partners.

Donor agencies should demonstrate their commitment to HSS while, at the same time, not portraying HSS as a vertical intervention. Donors should consider devoting a percentage of funding of all INGOs projects to health systems strengthening, and require that project proposals include a situational analysis and a description of how the funding will be used to strengthen the health system and complement the work of the ministry of health and health sector as a whole. Donors also can and should include HSS-related metrics in their requests for proposals and applications, and in their evaluation of bids and of the success of the projects they fund.

Donors also should work with countries to invest in short- and long-term planning to address health workforce shortages and distribution challenges. This, according to KIs, could be embedded into a variety of projects.

Donor agencies, at the country level, should participate actively in donor groups that work, in collaboration with INGOs and other partners, and under the leadership of the ministry of health, in setting standard procedures for hiring and compensating health workers, as well as setting standard procedures for in-service short-term training and associated costs, including per diem.
In addition, donor agencies should, both at the country level and globally, continue to work, in collaboration with countries as represented by their ministries of health, on sets of common indicators and data to be collected through health information systems and standardized surveys.

Donor agencies also, to the extent possible, should not ask INGOs to report on indicators that necessitate the creation of parallel data collection systems, which may lead to an inefficient use of resources as well as additional burdens on health systems at all levels, from point of care to the central level.

Interestingly, in late 2014, after the initial literature review was conducted, USAID published the following language on its website:

“During the next five years, USAID’s global health team will take deliberate steps to ensure that health system strengthening is built into all the work that USAID does at both headquarters and in the field. Increased effort will be placed on enhancing staff capacity in health system strengthening; harmonizing tools and standards across health system strengthening projects; generating state-of-the-art evidence on cost-effective approaches to health system strengthening; and pursuing a thoughtful learning agenda to strengthen the evidence base. In addition, a concerted effort will be placed on developing a consensus on standardized indicators to measure progress in health system strengthening and on better communicating concrete achievements. In the field, emphasis will be placed on becoming more effective and efficient with available resources by better incorporating health system strengthening into ongoing health programs, improving and enhancing coordination with other U.S. Government agencies and development partners, and facilitating local capacity development for sustainability. To ensure sound donor coordination at the global level, USAID, with its agency partners, will work with the World Health Organization, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI, and others on indicators, assessment of performance, and cost effectiveness. (USAID, 2014a)”

Many of the issues expressed in the above language of USAID mirror recommendations made by INGOs regarding donor behavior in support of INGOs and HSS.

**Recommendations to Ministries of Health**

All KIs interviewed recommend that INGOs respect the principle of country ownership, and agreed that ministries of health and other local government entities should ensure that they are “in the driver’s seat” and ensure that all partners supporting the health sector follow, to the extent possible,
the same rules and regulations regarding hiring and compensation practices, per diem procedures, and other practices. The Paris Declaration and more recent calls for increased attention to aid effectiveness and country-centered approaches provide opportunities for ministries of health to exert their leadership and should facilitate country ownership of all development work related to health systems.

Ministries of health should negotiate with donors and INGOs to ensure that parallel systems of data collection are not created to meet the need of a specific project or agency.

Ministries of health also should develop and, as appropriate, request assistance in developing joint health sector plans that encompass the work of all partners and ensure that all INGO projects and other donor-funded programs are included in such national plans.

Ministries of health also should conduct, on a regular basis, analyses of health systems strengths and potential weaknesses, or bottlenecks, if necessary requesting the support of donor agencies and others to do so.

Finally, according to those interviewed and findings from the literature review, ministries of health should ask for specific support from donors and other partners to ensure that they have the capacity they need to effectively and efficiently manage and lead the health sector.

Plan for change

The core element of this plan for change is an advocacy strategy that targets INGOs as well as the donor agencies that fund them and, to some extent, ministries of health and other global health partners. As described above, the fact that the Ebola outbreak has led to more discussion and expanded the “political space” regarding the need for strong health systems, creates an opportunity that can be leveraged to raise awareness of how systems can best be strengthened.

In disseminating research findings, I hope to interest stakeholders, especially but not limited to INGOs, in participating in webinars organized to disseminate findings and engage INGOs and others in discussions around these issues. I also plan to organize a virtual working group to discuss the challenges
related to INGOs and health systems strengthening, including, perhaps, the issues outlined in the NGO Code of Conduct for HSS. The outcome of this working group, in addition to general awareness raising among its members, would ideally be either a revised version of the NGO Code of Conduct for HSS, or a streamlined list of guiding principles for INGOs in HSS.

In using the key findings from this research to develop a plan for change, I am applying the ADKAR (Awareness—Desire—Knowledge—Ability—Reinforcement) model of change initially developed by Hiatt in the late 1990s as a way of fostering adoption and maintenance of individual and organizational change, then further adapted for application to community and societal change. Hiatt worked with Prosci, a private company focused on change management research and practice, to develop the Prosci® ADKAR® Model. The ADKAR model was selected for this plan for change because, unlike some other change management models, it has demonstrated application beyond individual organizations. In 2006, Prosci released the first complete text on the Prosci® ADKAR® Model in *ADKAR: A model for change in business, government, and our community.* (Hiatt, 2006) Table 6, below, presents the basic elements of the Prosci® ADKAR® model, as well as change management tactics proposed by the model and how they will be applied in implementing the proposed plan for change. The timeline for this plan for change is presented by quarter, beginning July 1, 2015, and continuing through June 30, 2016.
<table>
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<tr>
<th>Elements of Prosci® ADKAR® Model</th>
<th>Description</th>
<th>Change management tactics (adapted from Prosci ADKAR model)</th>
<th>Specific tactics</th>
<th>Timeline first year, by quarter</th>
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<tr>
<td><strong>Awareness of the need for change</strong></td>
<td>Reasons change is needed; risks of not changing; positive impact of change</td>
<td>Develop effective messages and communications strategies</td>
<td>Awareness raised among key INGOs during process of key informant interviews</td>
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**Desire to participate and support the change**

- Incentives and motivating factors
  - Reinforce support coalitions
  - Equip and support change leaders
  - Be ready to respond to resistance
  - Engage community widely, including ‘unlikely’ supporters of change
  - Incentivize engagement in change

- Key informant interview process appeared to foster a desire, among those interviewed, to contribute to changing the status quo and participate in discussions to raise awareness of key challenges and potential solutions

- Develop and present/share of policy brief with donor agencies, leading (eventually) to motivation and incentives to both donors and INGOs to change potentially harmful practices

**Knowledge on how to change**

- Understanding of status quo and availability of resources on how to change status quo
  - Offer training/education opportunities
  - Develop informative, user-friendly briefs
  - Build on interpersonal communications and networking
  - Organize user groups and forums

- Share key findings with key informants and with coalitions and other alliances of INGOs, NGOs, and other communities of global health partners

**Ability to implement required skills and behaviors**

- Overcoming organizational and individual barriers, both real and perceived
  - Foster ongoing involvement of stakeholders
  - Provide access to subject matter experts and offer opportunities for learning and exchanging perspectives

- Continue personal engagement in subject matter through dissemination of research findings

- Continue to leverage key opportunities to raise awareness and reinforce need for change among key stakeholders
As implementing this plan for change will involve action on my part as the principal investigator as well as the participation of a variety of stakeholders, I also am applying key leadership principles and change management principles from the work of Johnson-Cramer on managing change through networks and values to explore and reach out to my own professional networks to engage individuals and organizations in discussions related to these findings (Johnson-Cramer, Parise, & Cross, 2007).

Research findings will be shared with Health Alliance International (HAI), the current manager of the Code website, to help ensure understanding of the proposed modifications and issues that have led some INGOs to not commit to signing the Code as currently written. (As expressed above, colleagues from HAI have expressed keen interest in the key findings and a commitment to potentially applying the

<table>
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<th>Reinforcement to sustain the change</th>
<th>Measurement of impact of potential change and real change and mechanisms to track change</th>
<th>Recognize and disseminate indications of real change</th>
<th>Ensure absence of negative consequences</th>
<th>Continued working relationship with HAI and other promoters of Code of Conduct in additions to other INGOs engaged in these issues</th>
<th>Continue seeking opportunities to present key findings and ensuring that conversations continue</th>
<th>Continue to help sponsor working groups that create a “safe space” to discuss topics, including need for donor policy change</th>
<th>Leverage opportunities to contribute to public and political dialogue on need for stronger health systems</th>
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findings of this research to modify the Code.) I also am suggesting, to promoters of the Code, a social network analysis that can help them identify the networks of organizations and individuals within organizations, ties among ties within the networks, and essential lynchpins who “spread ideas, information, and resources” (Baker, 2000, p. 85). This social network analysis could be conducted by asking current signatories—as well as non-signatories, including organizations represented by KIs in this research project—to reach out to organizations with which they partner and invite them to participate in working groups that could both engage INGOs in discussing potential modifications to the Code and, in general, facilitate more effective communication about principles related to INGOs and HSS.

**Dissemination of Research Findings**

As demonstrated in the proposed plan for change, implementation of this plan will be successful only through ongoing dissemination of key research findings through multiple channels, as awareness raising and providing opportunities for exchanges among stakeholders are key elements of the plan for change.

I will prepare a brief synopsis of research findings initially through a brief that summarizes the key findings. The research brief will include an overview of results and a discussion guide. The brief will be shared with KIs and with the broader INGO community through the Global Health Council (GHC). The NGO Code of Conduct was initially launched during the 2008 GHC meeting, and current leadership of the GHC has expressed interest in hosting a panel discussion and exploring the possibility of creating a working group on issues related to INGOs and HSS.

I plan to present key findings to several NGO coalitions of which I am a member, including the Frontline Health Workers Coalition, the Health Workforce Advocacy Initiative, and the CORE group. I also have proposed sharing the brief with the leadership of InterAction, a 200-member coalition of US-based NGOs working in global health and development. (I participate actively in several InterAction-led
working groups.) The brief also will be shared with funding agencies, including USAID, specifically the Office of Health Systems.

In addition, and perhaps in collaboration with one or more of these groups, I plan to use a webinar format to organize a discussion of the results among interested KIs, their colleagues, and representatives of other organizations. During the webinar, I will present key research findings and engage participants in continued discussion about INGOs and HSS in general, and the NGO Code for HSS in particular. All KIs expressed interest in continuing to participate in ongoing discussions about issues raised during the interviews.

I will continue to explore opportunities to present research findings at international conferences. I presented initial literature review findings in a panel discussion during the Third Global Symposium on Health Systems Research, held in Cape Town, South Africa, September—October 2014. The conference, organized by Health Systems Global, the World Health Organization, and others, is the preeminent international conference organized for the exchange of health systems research. Upcoming opportunities for presentation may include the next global forum for human resources for health. I also will seek to develop and submit at least one peer-reviewed journal article, likely to be submitted to Health Policy, Health Policy and Planning, or the Journal of Global Health Systems.

Finally, to continue to engage the broader global health community in dialogue around the roles of INGOs and health systems strengthening, as well as the Code of Conduct, I will develop and publish blogs on the websites of IntraHealth International (my current employer), the Global Health Council, InterAction, Devex, and other NGO and global health and development websites.

**Opportunities for Further Research**

As noted above, this research project does not fully explore the perspectives of ministries of health or the role of ministries of health and other government entities in the countries in which INGOs work. The research also does not explore the full range of non-state actors working in global health,
including private sector corporations. A better understanding of the knowledge, attitudes, and practices of representatives of these bodies would enrich this discussion.

In addition, as the concept of “country ownership” continues to evolve, additional research could focus on the application of this principle and the capacity of national ministries of health and governments to manage health system coordination to ensure that all actors, including INGOs, engage in health systems strengthening. This does not analyze, in depth, funding agencies themselves, though it is clear from this preliminary analysis that, in order for the behavior of INGOs to change, donors themselves may have to more thoroughly address how INGOs, as agencies implementing grants and contracts, can minimize practices that may, in the long run, harm health systems.

Another possible area for further exploration is the linkages between universal health coverage (UHC), which has become more prominent over the past two years since I began this current research project, as a global health goal or aspiration, and the need for strong primary health care health systems required to achieve or advance toward UHC. Research that compares the multitude of both global and country-specific NGO codes of practice and conduct related to health and development also could enrich the discussion of the roles of NGOs in general, and INGOs in particular, in strengthening health systems. Such research could be further complemented by analysis of NGO internal codes of conduct.

Finally, as 2015 marks the deadline for the MDGs and the global development community is engaged in finalizing the Sustainable Development Goals that will build on the MDGs, opportunities will emerge for research related to global goals and commitments in relation to universal health coverage, NGOs, and health systems strengthening.
APPENDIX 1: NGO CODE OF CONDUCT
FOR HEALTH SYSTEMS STRENGTHENING


Introduction: The NGO Code of Conduct for Health Systems Strengthening is a response to the recent growth in the number of international non-governmental organizations (NGOs) associated with the increase in aid flows to the health sector. This Code is intended as a tool for service organizations — and eventually, funders and host governments. The Code serves as a guide to encourage NGO practices that contribute to building public health systems and discourage those that are harmful. The document was drafted by a group of activist and service delivery organizations including Health Alliance International (the convening organization), ActionAid International USA, African Medical and Research Foundation (AMREF), Equinet, Health GAP, Oxfam GB, Partners In Health, People’s Health Movement and Physicians for Human Rights. The content was further refined in a series of consultations held in the United States and Africa.

Articles of the NGO Code of Conduct for Health Systems Strengthening

I. NGOs will engage in hiring practices that ensure long-term health system sustainability.

II. NGOs will enact employee compensation practices that strengthen the public sector.

III. NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work.

IV. NGOs will minimize the NGO management burden for ministries.

V. NGOs will support Ministries of Health as they engage with communities.

VI. NGOs will advocate for policies that promote and support the public sector.

For more information or to sign your organization on to the NGO Code of Conduct for Health Systems Strengthening, please visit www.ngocodeofconduct.org.

Preamble

The purpose of this Code of Conduct for Health Systems Strengthening is to offer guidance on how international non-governmental organizations (NGOs) can work in host countries in a way that respects and supports the primacy of the government’s responsibility for organizing health system delivery.

The last decade has ushered in tremendous growth in political will, funding support and organizational structures to improve international health. While gains have been achieved in some areas such as the HIV epidemic, ground has been lost in basic primary care and maternal child health. It is now becoming clearer that NGOs, if not careful and vigilant, can undermine the public sector and even the health system as a whole, by diverting health workers, managers and leaders into privatized operations that create parallel structures to government and that tend to worsen the isolation of communities from formal health systems.
This health systems strengthening code is intended specifically to address international NGOs and their roles in training, securing and deploying human resources in the countries where they work. There are six areas where NGOs can do better: 1) hiring policies; 2) compensation schemes; 3) training and support; 4) minimizing the management burden on governments due to multiple NGO projects in their countries; 5) helping governments connect communities to the formal health systems; and 6) providing better support to government systems through policy advocacy.

This code offers sustainable practices in each of these areas of concern.

Signatories to this Code of Conduct recognize the role of voluntary ethical codes and country-based codes of conduct that have come before us. Those codes, such as the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief (1992), the Code of Good Practice for NGOs Responding to HIV/AIDS (2004), and the Paris Declaration on Aid Effectiveness (2005) offer practical ethical standards for NGOs and donors engaged in development work. These standards aim to improve the quality and impact of their work.

The original drafters of this code are representatives of international NGOs with implementation and advocacy experience in a variety of developing countries; we ourselves have made many of the mistakes that we address.

We hope that our Code of Conduct standards will prove useful for NGOs, governments, local institutions and donors by establishing principles to strengthen health systems. Our commitment helps ensure that “health for all” is not a thousand-year project, but well within our reach.

The code is intended to be clear, direct, succinct and action-oriented.

(Please note that the term “NGO” in this document refers to international NGOs.)

Article I. NGOs will engage in hiring practices that ensure long-term health system sustainability.

The role of international NGOs is to supplement — not supplant — the public policy role of host country governments and local institutions to strengthen and expand health systems. The NGO role is to provide research, support and expertise to strengthen civil society and local academic and research institutions in informing public health policy development. We, the signatories to this code, view our role as time-limited; that is, as communities, local institutions and Ministries of Health become stronger and build capacity, the role of the NGO should diminish or evolve.

1. In areas where trained personnel are scarce, NGOs will make every effort to refrain from hiring health or managerial professional staff away from the public sector, thus depleting ministries and their clinical operations of talent and expertise.

2. When hiring staff, NGOs will make every effort to employ available national expertise, particularly where unemployment of highly qualified nationals abounds. Where qualified nationals are available, volunteer labor will not be used as a substitute for paid staff.

3. In places of scarcity, on rare occasions when NGOs hire health staff already working in the public sector, NGOs pledge to do so in coordination and with the consent of local health authorities. This coordination will be accompanied by a commitment to expand overall human resource capacity in the public sector through pre-service training, salary support and/or other means. Governments and NGOs should work collaboratively to address the chronic underpayment of health workers in all sectors.
4. NGOs recognize that they have had a historical role in creating conditions that lead trained and skilled personnel to work abroad in wealthy countries. NGOs commit to avoid creating incentives for health workers to leave their developing countries for work in international organizations or locations. Instead, NGOs will provide incentives to stay in the public sector, including better working conditions, and good compensation and benefit packages.

**Article II. NGOs will enact employee compensation practices that strengthen the public sector.**

1. NGOs commit to advocate for fair monetary compensation for work done by all employees, across the health care system, including salaries for community health workers.

2. NGOs that hire health workers, managers and other skilled personnel in the countries where they work will offer salaries that are “locally competitive,” striving for salaries that are not substantially more generous than the public sector while providing a fair and living wage to their employees.

3. NGOs sometimes pay “top-ups” (compensation payments that supplement public salaries) to public sector staff to secure their services for contract work. In general, NGOs will avoid this practice, as it creates inequities, increases burdens on existing staff and fails to add new workforce to the health sector.

4. NGOs commit to limiting pay and benefits inequity between expatriate and national, rural and urban, and ministry and NGO workers. Compensation structures that provide incentives for rural service are encouraged and gender-related disparities are disallowed.

5. NGOs will establish benefit structures that are based on the needs of employees and, at a minimum, match public sector practices, including retirement plans. Where public sector benefits or pay structures are inadequate, NGOs will collaborate with the public sector to improve them.

6. Any privileges granted to expatriate employees will also be granted to national employees of similar qualification and responsibility, such as the opportunity to work from home or access to personal transportation.

**Article III. NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work.**

NGOs embrace the goal of strengthening educational institutions that train health workers, while also providing on-the-job continuous education. Workshops and other short training programs for health workers already in service often divert health workers from their workday responsibilities, while providing minimal benefit to the system as a whole.

1. NGOs will preferentially invest in longterm commitments to pre-service education and training, particularly at the in-country university level where there can be lasting benefit.

2. In areas where health workers are scarce, international NGOs will adopt measures that increase the number and capacity of professionals in a country of operation over time.

3. NGOs will support training in a broad sense to support both the service and management capacity of Ministries of Health; the goal is to transfer skills to national workers and eventually build sufficient capacity to obviate the need for international NGOs.
Article IV. NGOs will minimize the NGO management burden for ministries.

NGOs recognize the burden on governments that have insufficient resources to organize their own country’s affairs, while having to juggle the management burden of multiple and sometimes-competing aid organizations from a variety of other countries.

1. In recognition of donor commitments at the 2005 Paris High-Level Forum on Aid Effectiveness and sector-wide approaches to planning, evaluation and coordination, NGOs commit to meaningful joint planning within the ministries’ own planning cycles.

2. NGOs pledge to respect government and health ministry priorities, as well as labor and personnel policies. These policies include those relating to programmatic and geographic deployment of health resources, especially those that foster wider distribution of health workers and promote access to services.

3. NGOs recognize that management capacity in Ministries of Health is often limited. Rather than building parallel or circuitous structures around inadequate capacity, NGOs commit to strengthening governments’ ability to operate effectively and efficiently. This practice may lead to NGOs seconding personnel to direct government service.

Article V. NGOs will support Ministries of Health as they engage with communities.

NGOs can play an important role as a bridge between civil society organizations and government agencies, especially (but not exclusively) in nations where populations or sub-populations are actively oppressed by their governments.

1. NGOs will strengthen the capacity of communities to take responsibility for and ownership of their health development, and to become partners with government in the health system, while holding governments accountable for their human rights obligations.

2. NGOs shall document and share their work in and with communities to inform host government planning and priority setting. In sharing this information, NGOs will guard the privacy of individuals with whom they work, including staff and patients.

3. In places where NGOs are working with communities that are being oppressed, NGOs will work to protect populations.

Article VI. NGOs will advocate for policies which promote and support the public sector.

NGOs will actively advocate with civil society, local institutions and donors for policies and programs that strengthen health systems overall. NGOs recognize that vertical programs and selective approaches exacerbate inequities in health systems and ignore underlying determinants of health. We also recognize that funding conditionalities can limit or distort government expenditures and priorities. These unnecessary limitations continue to create barriers to health and development and are unfair and inequitable.

1. NGOs will strengthen and support, not supplant, the role of government in making policy. NGOs will support efforts to involve indigenous civil society voices in the policy arena by encouraging their participation in developing policy and setting funding priorities.
2. NGOs pledge to advocate for removal of political, ideological and financial barriers to the expansion and improvement of public health systems, including unnecessarily restrictive fiscal and monetary policies, and wage bill caps imposed by the international financial institutions.

3. NGOs will work in solidarity with their Ministry of Health colleagues to oppose the detrimental policies of the International Monetary Fund, the World Bank and other lenders whose loan conditions limit government expenditures on health or education.

4. NGOs commit to designing their activities and programs so that they reinforce primary health care, foster equity and community involvement, and are generally replicable and financially sustainable over time.

5. NGOs will also advocate with donors to support general health systems strengthening in the service of comprehensive national priorities.

6. NGOs will follow national labor laws and pay all relevant taxes on their income and assets in the countries where they work, just as any business would.
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<thead>
<tr>
<th>No.</th>
<th>Organization Name (Country)</th>
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<tbody>
<tr>
<td>1</td>
<td>Academic Forum for Foreign Affairs – Vienna</td>
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<td>2</td>
<td>Action for Humane Hospitals (ACTHU)</td>
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<td>3</td>
<td>ActionAid International USA</td>
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<td>Africa Mental Health Foundation</td>
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<td>African Cultural Exchange</td>
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<td>African Medical and Research Foundation (AMREF)</td>
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<td>7</td>
<td>Afrihealth Information Projects / Afrihealth Optonet Association</td>
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<td>8</td>
<td>Afro-Canadian Evangelical Mission</td>
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<td>9</td>
<td>American Public Health Association</td>
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<td>10</td>
<td>Beijing Yirenping Center</td>
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<td>Burundian Youth for Peacebuilding and Young Refugees Integration (BYPRI)</td>
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<td>Global Health Action</td>
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<td>19</td>
<td>Global Health through Education, Training and Service</td>
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<td>Padang Lutheran Christian Relief</td>
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<td>Organization</td>
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<td>Partners In Health</td>
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<td>People’s Health Movement – USA</td>
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<td>Physicians for Human Rights</td>
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<td>Sark Foundation</td>
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<td>Sharan Nepal</td>
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<td>51</td>
<td>Social Welfare Development (SOWED) Programme Kenya</td>
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<td>54</td>
<td>UCLA Center for International Medicine</td>
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<td>58</td>
<td>Youth Intercommunity Network</td>
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</table>
APPENDIX 3: DATA COLLECTION MATERIALS

Introduction (sent by email and tailored to each potential interviewee)

Dear XXX:

My name is Laura Hoemeke. I am currently pursuing my doctorate in public health (DrPH) at the University of North Carolina Gillings School of Global Public Health. As described in my research abstract (attached), I am interested in learning more about the role of international NGOs in health systems strengthening in general, and specifically how international NGOs address a number of challenges, including multiple streams of accountability to donors and governments and communities in the countries in which they operate. As a framework for my research, I am analyzing the NGO Code of Conduct in Health Systems Strengthening. (See the NGO Code, attached.)

As part of my doctoral research, I am conducting semi-structured interviews with key informants who represent international NGOs, both INGOs who have signed on to the NGO Code of Conduct for HSS and those who have not. I understand that XXX has/has not signed on to the Code. (Sentence tailored to each recipient)

Also attached please find a Fact Sheet for Adult Participants in a Research Study. With the approval of each participant, I will record and transcribe each interview. All responses to questions will be aggregated, to some extent, and the names of individual interviewees will be coded and known only to me as the principle investigator. Names of individuals will not be included in the final dissertation nor any presentation of research findings. Please note that names of organizations participating in interviews will be included in an annex to the dissertation itself.

By way of disclosure, in addition to being a UNC-Chapel Hill student, I am the director of communications and advocacy at IntraHealth International. The information I gather is for the purpose of my research, and specific information collected during the interviews will not be shared with IntraHealth.

Are you interested in participating as a key informant? If you are available for an interview, I would like schedule a time for a telephone (or Skype) call at your convenience. The interview will take approximately one hour. I would like to ask you to review the Code in advance of the interview.

If you are interested and available, I would appreciate it if you could propose a few times within the next week or two that would work for you.

Thank you for your consideration of this request.

Sincerely, Laura Hoemeke
The evolving roles of global health NGOs in health systems strengthening

Background: International non-governmental organizations (INGOs) have proliferated over the past several decades. As significant actors in global health and development, they have the opportunity to strengthen national health systems in the countries in which they operate. At the same time, INGOs, which have multiple streams of accountability to donors, governments, and communities, sometimes engage in practices that weaken health systems, including creating management burdens through parallel systems of data collection and commodity distribution, and introducing distortions into local labor markets by hiring staff away from public systems. In May 2008, several INGOs created the NGO Code of Conduct for Health Systems Strengthening. Although the Code generated initial interest, it does not appear to have received widespread attention on the part of donor agencies, and its impact has not been systematically studied.

Health systems strengthening is a rapidly evolving concept, and though there is limited consensus on the most effective ways of making systems stronger, there is agreement among donors, ministries of health, even disease-specific global health initiatives, and international NGOs, that strong health systems are essential for the achievement of overarching goals in public health, nationally and globally. Little research has been conducted, however, on the intersection between HSS and INGOs who strive to have a positive impact on population health without harming health systems. This research seeks to understand how INGOs can best support health systems strengthening and the global aspiration of universal health coverage.

Study design: This study asks how INGOs can help rather than harm national health systems. A comprehensive literature review identifies evolving concepts regarding HSS and INGOs. These concepts inform the methodology, a comprehensive review of the NGO Code of Conduct for Health Systems Strengthening and key informant interviews with INGO leaders to better understand problems and possible solutions. The research explores possible applications of the NGO Code of Conduct for HSS, and assesses the interplay between INGOs and other actors in the rapidly changing global health landscape.

Significance: This research offers opportunities for a better understanding of the impact that INGOs can have on health systems. It also provides insight for potential modification to the NGO Code of Conduct that may make it more applicable and useful, while shedding light on why more INGOs have not endorsed the Code. These results and recommendations should help INGOs, ministries of health, other government stakeholders, and donors become more aware of challenges faced by INGOs, while helping INGOs safeguard against inadvertently doing harm. More research is needed on how donor policies and
procedures influence INGOs practices, as well as the application of the concept of country ownership vis-à-vis HSS and aid effectiveness, to ensure that ministries of health and governments are capable of managing health system coordination and that all actors, including INGOs and the donors that fund them, use resources effectively and efficiently to build stronger health systems.
Fact Sheet for Adult Participants in a Research Study  
University of North Carolina-Chapel Hill (to be sent by email to key informants)

IRB Study #  
Consent Form Version Date:

Title of Study: The evolving role of global health NGOs in health systems strengthening

Principal Investigator: Laura Hoemeke

UNC-Chapel Hill Department: School of Public Health, Department of Health Policy and Management

Faculty Advisor: Suzanne Hobbs

Study Contact telephone number: 919-360-7799
Study Contact email: Hoemeke@live.unc.edu

What are some general things you should know about research studies? You are being asked to take part in a research study. To join the study is voluntary. You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty. Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

If you have any questions, please contact the researchers named above.

What is the purpose of this study? The purpose of this research to better understand how international NGOs can best support health systems strengthening. You are being asked to participate in the study because you work for an international NGO involved in global health.

How many people will be interviewed for this study? If you decide to be interviewed for this study, you will be one of approximately 10-12 people interviewed for this phase of this research study.

How long will your part in this study last? If you decide to be interviewed for this study, you will be asked to meet in-person or by telephone (Skype) for approximately one hour.

What will happen if you take part in the study? Participation in interviews for this study will involve the following steps:

- Read this fact sheet and the information enclosed to determine your interest in participating in this study.
- Contact the researcher listed on the first page of this form with any questions or concerns regarding your participation.
- Schedule a time to participate in a one-hour interview (interviews may be conducted in-person or by telephone.
- Read the attached NGO Code of Conduct for Health Systems Strengthening before the interview and consider whether or how it aligns with your agency’s/organization’s mission
- Participate in a 45-60 minute interview by Skype/telephone call
- Address follow up questions or clarifications if needed after the interview

What are the possible benefits from being in this study? You may benefit from participation in this study by learning more about current discussions on the role of international NGOs and health systems strengthening and the NGO Code of Conduct for Health Systems Strengthening. This research is being conducted to benefit the global health and development community and low- and middle-income countries in their efforts to strengthen health systems. You will not benefit personally from being in this research study, and will not receive any compensation for participating.

What are the possible risks or discomforts involved from being in this study? There are no known or expected risks to participating in this study.

How will your privacy be protected? The principle investigator, Laura Hoemeke, is the only person who will have access to information that links individual participants to the responses from their interviews. Participants will be asked for permission before being identified in any report or publication about this study.

Records of the interview will be stored electronically in password protected files. At the time of the interview, participants will be asked for permission to record the interview for transcription. If an interview is recorded, a transcript will be made and the audio file will be destroyed. Any hardcopy information linked to an individual’s responses to interview questions will be stored in a locked file cabinet. Although every effort will be made to keep research records private, there may be times when federal or state law requires the disclosure of such records, including personal information. This is very unlikely, but if disclosure is ever required, UNC-Chapel Hill will take steps allowable by law to protect the privacy of personal information. In some cases, your information in this research study could be reviewed by representatives of the University, research sponsors, or government agencies for purposes such as quality control or safety.

What if you have questions about this study? You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact the researcher listed on the first page of this form.

What if you have questions about your rights as a research participant? All research with human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research participant you may contact, anonymously if you wish, the Institutional Review Board at 919/966-3113 or by email to IRB_subjects@unc.edu.
Key informant interview: introduction and consent

Before we get started with the interview, I would like to give you a little bit of background and ensure that we have covered the informed consent procedures.

My name is Laura Hoemeke. I am a DrPH student at the University of North Carolina Gillings School of Global Public Health. This interview is part of a research study that I am conducting my DrPH dissertation and is a research study. By way of disclosure, in addition to being a UNC-Chapel Hill student, I am the director of communications and advocacy at IntraHealth International.

As I indicated in the introductory email, the information I collect as a part of this study is for my dissertation research and is not directly related to my work at IntraHealth. I will not share any details from this interview with colleagues at IntraHealth. I may publish portions of the dissertation, in which case the findings would become publicly available. No individual names will be shared in the dissertation or in any published documents.

Your participation in this research project will benefit the study of international NGOs and health systems strengthening. I will share a summary of key findings of the results with all participants.

You have been selected for a key informant interview because of XXXXXXXXXX (tailor to each individual). You are one of approximately twelve (12) to fifteen (15) key informants that I will be interviewing.

This interview should take approximately 60 minutes, depending on how much you would like to share with me on this topic.

Your participation in this study is voluntary, and there are no foreseeable risks or discomforts to participating in this research. In general, all answers will be reported at the aggregate level and no names of organizations or individuals will be used. Participants will be asked for permission, in writing, before being identified in any report or publication about this study.

Should you have any questions about this research you may contact me at hoemeke@live.unc.edu. You may also contact my faculty supervisor, Dr. Suzanne Hobbs at Suzanne_Hobbs@unc.edu. All research that involves human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Institutional Review Board at 919-966-3113 or by email IRB_subjects@unc.edu.

In order to fully capture your responses today, I would like to record our conversation. May I record this interview? I will be using an app called Voice Recorder to make recordings of interviews for transcription. Do you consent to participate in this research? (Verbal Consent recorded.) If you would like to have me stop the recording at any point in our conversation, please let me know and I will stop the recording.
Questionnaire A—addressed to representatives of INGO signatories to the Code

Thank you, once again, for taking the time to talk with me today.

1. My research is focused on the impact of international NGOs on health systems, specifically on health systems strengthening. Did you have the opportunity to review the research abstract I sent you? (Briefly review the research question and overall goal of the research.)

   The goal of my research is to better understand the roles INGOs can plan in supporting health systems strengthening. Although there is no global consensus on the definition of the term, one definition calls health system strengthening “a process that concentrates on ensuring that people and institutions, both public and private, undertake core functions of the health system (governance, financing, service delivery, health workforce, information and medicines/vaccines/other technologies) in a mutually enhancing way.”

   [Note: I used USAID’s definition during the interviews, as it appears to be more comprehensive than the definition proposed by WHO, and includes a list of the six WHO-defined components of health systems. I intentionally did not indicate that this is USAID’s definition to not influence KIs’ perceptions of the definition itself.]

2. Just to start with an overall question, how do you think that INGOs can best strengthen health systems?
   PROBE: How is [your NGO] working to ensure that you are helping to build stronger systems?

3. I would like ask some questions about the NGO Code of Conduct for Health Systems Strengthening. The code was launched in 2008, and has been signed by a number of NGOs. I noted that your organization is a signatory to the Code. Did you have the opportunity to review the Code in advance of our discussion today?
   (Provide background information: one-page list of the six articles of the Code and complete copy of the Code in advance of the interview.)
   
   a. How did your organization make the decision to sign the Code? (PROBE, as needed: Do you know? Were you aware and/or part of that decision-making process?)
   b. Could you describe any steps that your organization has taken to implement the principles of the Code in your operations?
   c. Do you think that being a signatory to the Code has been beneficial to your organization? To other INGOs? To the global health community?
   d. As you may know/have noted, the Code has not been signed by many of the major INGOs working in global health, including some of those who were involved in some of the original drafting discussions. (Provide additional information as needed.) Why do you think more of the larger INGOs, including those involved in the original drafting, have not signed the Code?
   e. How could the Code be more effective?
Probe: Could you describe any modifications that you think could be made to make the Code more effective? Could you describe any modifications that might make the Code gain more traction and get more INGO signatories?

4. The Code contains six articles, and refers to several issues related to INGOs and public sector health systems.
   Articles I, II, and III related to hiring and compensation practices.
   Article IV relates to the potential additional management burden that INGOs might place on ministries of health.
   Article V describes
   Article VI relates to several advocacy issues.
   NOTE: Share language from each article as necessary, depending on individual’s familiarity with the Code.

   For each Article/issue: How do you think that these elements influence INGOs and health systems?
   a. Which of these are more problematic or present the greatest risk for INGOs? Why?
   b. Could you please share any examples of challenges related to these issues that you or your organization have faced? How did you manage these challenges? Were you successful or not? Why or why not?
   c. Given these challenges, how do you think that INGOs can truly best support health systems strengthening?

5. What advice would you share to help mitigate the potential negative impact that INGOs can have and ensure that INGOs are truly contributing to strengthening the health systems in countries in which they operate?
   a. With NGO management/staff
   b. With donors/funding agencies
   c. With Ministries of Health and other country entities

6. Could you please share any additional thoughts or advice you may have concerning INGOs and health systems strengthening? The NGO Code of Conduct?

**Conclusion**
Thank you very much for your time today. Please do not hesitate to let me know (by email or telephone/Skype) if you have any questions or if you have additional information to share. As promised, I will share with you key findings that emerge from this research.
Questionnaire B—addressed to representatives of INGO non-signatories to the Code

Thank you, once again, for taking the time to talk with me today.

1. Did you have the opportunity to review the research abstract I sent you? (Briefly review the research question and overall goal of the research.) As you noted, my research is focused on the impact of international NGOs on health systems, specifically on health systems strengthening. Did you have the opportunity to review the research abstract I sent you? (Briefly review the research question and overall goal of the research.)

The goal of my research is to better understand the roles INGOs can plan in supporting health systems strengthening. Although there is no global consensus on the definition of the term, one definition calls health system strengthening “a process that concentrates on ensuring that people and institutions, both public and private, undertake core functions of the health system (governance, financing, service delivery, health workforce, information and medicines/vaccines/other technologies) in a mutually enhancing way.” [Note: I used USAID’s definition during the interviews, as it appears to be more comprehensive than the definition proposed by WHO, and includes a list of the six WHO-defined components of health systems. I intentionally did not indicate that this is USAID’s definition to not influence KIs’ perceptions of the definition itself.]

2. Just to start with an overall question, how do you think that INGOs can best strengthen health systems?
   PROBE: How is [your NGO] working to ensure that you are helping to build stronger systems?

3. I would like to discuss the NGO Code of Conduct for Health Systems Strengthening. The code was launched in 2008, and has been signed by a number of NGOs.
   (Provide background information: complete copy of the Code in advance of the interview. Ask if interviewee had the opportunity to read/review the Code in advance of this interview. If not, give background description/history of Code.)

   Were you aware that this Code existed? If yes, how familiar are you with it?
   Probe: If you were aware that the Code existed, has your organization considered signing the Code? If yes, why? If not, why not?

4. The Code contains six articles, and refers to several issues related to INGOs and public sector health systems.
   Articles I, II, and III related to hiring and compensation practices.
   Article IV relates to the potential additional management burden that INGOs might place on ministries of health.
   Article V describes support to ministries in health in engaging with communities.
   Article VI relates to several advocacy issues, including issues related to vertical funding, lending institutions, etc.
NOTE: Share language from each article as necessary, depending on individual’s familiarity with the Code.

For each article, how do you think that these elements influence INGOs and health systems?
   a. Which of these are more problematic or present the greatest risk for INGOs?
   b. What, if any, key issues related to the potential negative impact that INGOs can have on health systems strengthening are included in the Code? If there are, how could they be addressed?
   c. Could you please share any examples of challenges related to these issues that you or your organization face? How do/did you manage these challenges? What were the results?
   d. Given these challenges, how do you think that INGOs can truly best support health systems strengthening?

5. After reading the Code, do you thinking that signing it might be beneficial to your organization? Why?/why not?

6. Could you describe how the Code might be of benefit to the global health community?
   a. PROBE: Do you think that this code is necessary? Useful? Effective? Why?
   b. PROBE: Could you describe any modifications that you think could be made to make the Code more effective? Could you describe any modifications that might make the Code gain more traction and get more INGO signatories?

7. What advice would you share to help ensure that INGOs are truly contributing to strengthening the health systems in countries in which they operate and mitigate the potential negative impact that INGOs can have on health systems?
   [PROBE: Ask for explanation as needed.]
   a. With NGO management/staff
   b. With donors/funding agencies
   c. With Ministries of Health and other country entities

8. Could you please share any additional thoughts or advice you may have concerning INGOs and health systems strengthening?

Conclusion
Thank you very much for your time today. Please do not hesitate to let me know (by email or telephone/Skype) if you have any questions or if you have additional information to share. As promised, I will share with you key findings that emerge from this research.
### APPENDIX 4: ORGANIZATIONS REPRESENTED IN KEY INFORMANT INTERVIEWS

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<th>Signatory</th>
<th>Non-signatory</th>
<th>Brief description</th>
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<tr>
<td>1 Action Aid International</td>
<td>X</td>
<td></td>
<td>Johannesburg, South Africa-based; (former employee interviewed; was actively involved in developing Code</td>
</tr>
<tr>
<td>2 Amref Health Africa</td>
<td>X</td>
<td></td>
<td>Nairobi, Kenya-based</td>
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<tr>
<td>3 Family Care International</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<td>4 FHI 360</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<tr>
<td>5 Health Alliance International</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<tr>
<td>6 Hope through Health</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<tr>
<td>7 IntraHealth International</td>
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<td></td>
<td>US-based</td>
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<tr>
<td>8 International Rescue Committee</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<tr>
<td>9 Jhpiego</td>
<td>X</td>
<td></td>
<td>US-based</td>
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<tr>
<td>10 JSI Research &amp; Training Institute (non-profit affiliate of John Snow, Inc.)</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>11 Medicus Mundi Network</td>
<td>X</td>
<td></td>
<td>Basel, Switzerland-based</td>
</tr>
<tr>
<td>12 Partners In Health</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>13 PATH</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>14 People’s Health Network</td>
<td>X</td>
<td></td>
<td>Technically not an INGO, but signatory to the Code</td>
</tr>
<tr>
<td>15 PSI</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>16 RTI International</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>17 Save the Children</td>
<td>X</td>
<td></td>
<td>Global (UK representative interviewed)</td>
</tr>
<tr>
<td>18 URC</td>
<td>X</td>
<td></td>
<td>US-based</td>
</tr>
<tr>
<td>19 University of Washington School of Public Health</td>
<td>X</td>
<td></td>
<td>US-based; affiliated with Health Alliance International; individual interviewed played a key role in developing Code</td>
</tr>
<tr>
<td>20 Wemos</td>
<td>X</td>
<td></td>
<td>Netherlands-based</td>
</tr>
</tbody>
</table>
| **TOTAL = 20 interviews** | 10 | 10 | ****
### APPENDIX 5: SUMMARY OF KEY RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Key Recommendations</th>
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<tbody>
<tr>
<td><strong>INGOs</strong></td>
</tr>
<tr>
<td>INGOs should ensure that their work is complementing, not displacing or supplanting,</td>
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<tr>
<td>the work of ministries of health and public sector as a whole in building strong health</td>
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<tr>
<td>systems.</td>
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<tr>
<td>To the extent possible, INGOs should invest resources in analyzing the impact of their</td>
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<tr>
<td>own work on health systems at all levels, on a project-by-project or country-by-</td>
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<tr>
<td>country basis, or globally, to self-monitor their influence on health systems and</td>
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<td>ensure that they are not unintentionally creating distortions.</td>
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<td>INGOs should consider developing internal codes of ethics, or modifying their internal</td>
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<tr>
<td>codes of ethics, to ensure that they address ethical implications that may have an</td>
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<tr>
<td>impact on health systems, issues such as hiring practices, conflict of interest,</td>
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<td>accuracy in results reporting, and advocacy.</td>
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<td>INGOs should seek to create and invest in innovative partnerships, including</td>
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<tr>
<td>partnerships with the private sector, to move beyond dependence on government</td>
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<td>donor agencies as their primary or only funding source.</td>
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<td>INGOs should, resources allowing, advocate for change to ensure that health systems</td>
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<tr>
<td>strengthening is supported by donor agencies and, at the country level, by ministries</td>
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<tr>
<td>of health and other local entities.</td>
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<tr>
<td>INGOs also should engage actively in country-level working groups, both NGO-led</td>
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<tr>
<td>alliances and health sector groups lead by ministries of health.</td>
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<tr>
<td><strong>Donor agencies</strong></td>
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<tr>
<td>Donor agencies should demonstrate their commitment to HSS while, at the same time,</td>
</tr>
<tr>
<td>not developing mechanisms supporting HSS as a vertical intervention.</td>
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<tr>
<td>Donors should consider devoting a percentage of funding of all INGOs projects to</td>
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<td>health systems strengthening, and require that project proposals include a situational</td>
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<td>analysis and a description of how the funding will be used to strengthen the health</td>
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<tr>
<td>system and complement the work of the ministry of health and health sector as a</td>
</tr>
<tr>
<td>whole.</td>
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<tr>
<td>Donors can and should including HSS-related metrics in their requests for proposals</td>
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<td>and applications, and in their evaluation of bids and of the success of the projects</td>
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<tr>
<td>they fund.</td>
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<tr>
<td>Donors should include hiring practice and compensation guidelines, particularly</td>
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<tr>
<td>concerning local staff, in their requests for proposals and applications.</td>
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<tr>
<td>Donor agencies, at the country level, should participate actively in donor groups</td>
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<td>that work, in collaboration with INGOs and other partners, and under the leadership</td>
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<tr>
<td>of the ministry of health, in setting standard procedures for hiring and compensating health</td>
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<tr>
<td>Key Recommendations</td>
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<td>---------------------</td>
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<tr>
<td>workers, as well as setting standard procedures for in-service short term training and associated costs, including per diem.</td>
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<tr>
<td>Donors should work with countries to help them, through the expertise of INGOs as needed, invest in short- and long-term planning to address health workforce shortages and distribution challenges.</td>
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<tr>
<td>Donor agencies should, both at the country-level and globally, continue to work, in collaboration with countries as represented by their ministries of health, on sets of common indicators and data to be collected through health information systems and standardized surveys</td>
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<tr>
<td>Donor agencies also, to the extent possible, should not ask INGOs to report on indicators that necessitate the creation of parallel data collection systems, which may lead to an inefficient use of resources as well as additional burdens on health systems at all levels, from point of care to the central level.</td>
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<thead>
<tr>
<th>Ministries of health and other local government entities</th>
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<tbody>
<tr>
<td>Ministries of health should ensure that they demonstrate country ownership and ensure, and enforce as necessary, the compliance of all partners in supporting the health sector by following the same rules and regulations regarding hiring and compensation practices, per diem procedures, and other practices.</td>
</tr>
<tr>
<td>Ministries of health should negotiate with donors and INGOs to ensure that parallel systems of data collection are not created to meet the need of a specific project or agency.</td>
</tr>
<tr>
<td>Ministries of health also should develop and, as appropriate and feasible, request assistance in developing joint health sector plans that encompass the work of all partners and ensure that all INGO projects and other donor-funded programs are included in such national plans.</td>
</tr>
<tr>
<td>Ministries of health should conduct analyses of health systems strengths and potential weaknesses, or bottlenecks, if necessary requesting the support of donor agencies and others to do so.</td>
</tr>
<tr>
<td>Ministries of health should ask for specific support from donors and other partners to ensure that they have the capacity they need to effectively and efficiently manage and lead the health sector.</td>
</tr>
</tbody>
</table>
REFERENCES


