

Collective Action among Non-Governmental Organizations (NGOs) Working in  
Maternal and Child Health in Haiti

by

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## ABSTRACT

This mixed-methods research study examined the level of collective action that is occurring among non-governmental organizations (NGOs) working in maternal and child health in Haiti. This study takes the view that health, and by extension, maternal and child health, is a global public good; global public goods are most efficiently provided by the means of collective action. Therefore, to the extent that maternal and child health services are provided efficiently in Haiti, collective action should be occurring.

This study utilized a semi-structured interview approach to gather both qualitative and quantitative data. A total of 17 participants who were managers or executives of NGOs working in maternal and child health in Haiti were interviewed. The interviews also gathered quantitative data that characterized types of cooperation that were occurring among NGOs. The qualitative data that were collected in these interviews were analyzed using thematic analysis, and quantitative data were analyzed using social network analysis. The findings concluded that while there is cooperation occurring among NGOs in Haiti, the cooperation levels are low, networks are not very dense and there is overall general consensus that more cooperation is needed

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## CHAPTER 1 INTRODUCTION

This chapter reviews the literature that supports the theoretical framework of this dissertation study. This study views health as a global public good, which are most effectively and efficiently provided through the provision of collective action--groups or individuals working together in order to achieve a common goal(s). Collective action, however, as theorized by Olson (1971), is not achieved voluntarily. Individuals or groups must be forced or coerced to cooperate, due to rational and self-interested behavior.

Non-governmental organizations (NGOs) are vehicles through which the provision of public goods, such as health, are often delivered, particularly in developing countries, which often lack sound infrastructural and social services that would help to ensure effective provision of such services. Much of foreign aid today, including aid that supports the provision of health services, is channeled through NGOs. However, aid, while essentially well-intentioned, has been the subject of criticism for decades. Aid failures abound, and while there have been measured successes, there is substantial room for improvement.

NGOs are not always held to legal requirements in developing countries, and often they operate without any type of official oversight or governing body affiliation. Therefore, their accountability to the larger aid community is limited. Collective action theory says that their voluntary cooperation will also therefore be limited. This literature review explores these concepts in detail, and argues for the urgency of collective action among stakeholder organizations to improve health outcomes.

## **Global Public Goods**

Non-governmental organizations (NGOs) that work in health provide a global public good. Economic inputs to human well-being are classified as either public goods or private goods (Cornes & Sandler, 1996; Kaul & Faust, 2001). Whether a good is public or private depends on its consumption properties. A private good is “excludable” and includes items such as food and clothing (Kaul & Faust, 2001). Clear property rights are assigned to private goods and it is the owner’s choice as to how, when, and by whom that private good is enjoyed (Kaul, 2009). A private good’s consumption means that another person cannot enjoy that same item; the enjoyment and consumption of an excludable good means, as the description implies, that others are excluded from enjoying it (Kaul & Faust, 2001). Public goods, on the other hand, are “non-excludable” goods and their enjoyment does not mean others are excluded from being able to enjoy that same item (Kaul & Faust, 2001). Examples of public goods are air and national defense. Public goods are in the public domain and are available for all to consume. Peoples’ preferences for certain public goods may vary, based on a wide variety of factors (political, socioeconomic, geographic, cultural) but all have access to the same public goods at the same provision level, whether or not someone else is enjoying the same good (Kaul, 2009).

The main problem involved in the provision of public goods is what is termed the “free rider” issue. The free rider problem, taken from the analogy of a firm operating in a market, holds that in a competitive market, firms might cooperate to maintain high prices on their goods. In this case, cooperation is collectively rational. However, for the small

firm that believes it can increase output without affecting overall price levels, non-cooperation is optimal. This is because that small firm can capture a larger portion of the market and keep higher profits for itself (Gillinson, 2004). The firm maintains a lower price than the others, while reaping a more substantial benefit than would occur if the small firm cooperated with the price collusion. Thus, the small firm “free rides” off of the cooperation of others. The challenge with public goods and the free rider problem is that there is generally a weaker incentive for private provision because their benefits are non-excludable and their consumption cannot generally be made exclusive (Gartner, 2012). Thus, it is optimal for individuals to “free ride” off of the production of public goods. This also means that public goods are under-produced because the consumer who has access to the good has little reason to pay his or her appropriate share. Unless that consumer is a highly moral person, he or she is likely to be a free rider (Kindleberger, 1986).

In the case of public goods, providers may not adequately be compensated by the market and therefore there is no incentive to produce them. To avoid this, governments often implement policies to ensure cooperation and equitable burden-sharing, such as taxes to finance parks and roads (Kaul & Faust, 2001).

Health is not easily categorized as either a public good or a private good, but the classification of health as a private good is difficult. As previously mentioned, private goods are those that are excludable to others, and those to which the owner of the good can assign a clear value and property rights (Kaul, 2009). While it is certainly not outside the realm of possibility that health care can be a private good and assigned a price and withheld from those who cannot afford to pay for it, this is highly unethical. In addition,



private goods usually possess benefits that rival those of another commodity (Karsten, 1995). This is not the case with health care; it is not like choosing to buy either a car or a motorcycle. On the other hand, health care is not easily classified as a public good. Public goods are those that do not possess the exclusion principle; that is, they are available for anyone to enjoy and consume regardless of one's ability to pay. This is not the case with health care; in many instances, people must pay at least some amount in order to receive care. In addition, health care does not have infinite resources at its disposal. As with the examples of national defense and air, everyone can enjoy those public goods regardless of where a person lives. In health care, location, especially in resource-limited settings, dictates the amount and frequency of health care that can be consumed.

Many public goods have assumed a global dimension and a global effect (Kaul, 2009; Nordhaus, 2010). These types of goods are known as *global public goods*, which are goods that have a global impact, and that impact is spread indivisibly around the globe (Nordhaus, 2010). Public goods become global when the benefits of those goods flow to more than one country, and no country can effectively be denied access to those benefits (World Health Organization, 2014). The costs and benefits of global public goods transcend national borders and have impacts on countries in several regions (Kaul, 2009). The World Bank (2011) identifies five areas that encompass global public goods: the environmental commons, communicable disease, international trade, international financial architecture, and global knowledge for development. Global public goods are increasingly becoming a significant issue due to the rapid globalization that has occurred in recent years. This rapid pace does not show any signs of slowing in the near future. No longer can countries limit themselves to providing certain public goods on a national

basis. In fact, many public goods have gone from being national public goods to global public goods.

While the provision of national public goods presents challenges, global public goods are arguably the most difficult public goods to provide in adequate, reasonably distributed quantities (Edwards & Zadek, 2002). Their global scale is intimidating, and the number of actors that are needed to work together and cooperate poses serious challenges. Global public goods differ from other economic issues in that there is no workable mechanism for resolving their issues both efficiently and effectively. There is currently no market or government mechanism that contains both the political means and the appropriate incentive to implement an effective outcome (Nordhaus, 2010; Gartner, 2012). Markets can solve many problems, but they cannot solve the problems inherent in the effective and efficient provision of global public goods. Global public goods are susceptible to the general challenges that public goods pose, except the challenges are magnified, due to the global scale.

Global public goods raise many problematic issues, primarily due to what has been termed the Westphalian dilemma. When a social, economic, or political problem arises, one of the very first questions to be addressed concerns the organizational level at which the issue should be resolved. Should it be addressed at the individual, household, local, state, or federal level? The Treaty of Westphalia, passed in 1648, recognized the system of sovereign states, which gave each state the political sovereignty to govern its own territory. Over time, the system of sovereign states developed and the current system of international law evolved which now dictates that international obligations may only be imposed upon a sovereign state with its consent (Nordhaus, 2010). When issues of

global public goods arise, no state can be forced to provide them in any quantity. Since there is no international rule of law that sovereign states are required to follow, all provision of global public goods is completely voluntary, and heavily depends on the cooperation of states. Those states that do not cooperate free ride off the cooperation of others. Sovereign nations cannot be forced into any action, and have no overriding authority to whom they answer. Their actions, or inactions, cannot be dictated by any governing body, including the United Nations. With no governing body to police global public goods, any action on global public goods provision is completely voluntary and up to the discretion of an individual nation.

Article 25 of the Universal Declaration of Human Rights states:

“Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances” (United Nations, 1948).

This declaration clearly delineates that health is a basic human right to which everyone around the world is entitled, regardless of circumstance. The Brighton Declaration declared in 2004 that health is a global public good and that health is a key component of collective human security (United Kingdom Public Health Association, 2004). Generally, global public goods as they apply to health tout the prevention and containment of infectious and communicable disease as the “classic case” of global public goods (Gartner, 2012). Communicable diseases themselves are global public “bads” and their containment is a global public “good” (Kaul & Faust, 2001). Some do consider “health” itself to be a private good, as previously discussed. However, even though communicable disease is inherently a threat to the global collective good and well-being, health itself

can also be considered a global public good. Some consider the prevention of SARS and avian influenza, diseases that can rapidly spread around the world in a matter of hours, to be the only true global public “bads” as they relate to communicable disease. However, other communicable diseases, such as malaria and HIV/AIDS, while not able to spread as rapidly or as widely as SARS or influenza in such a short timeframe, are also just as destructive and pose as much, if not more, of a threat to the global collective good. Allowing these disease burdens to persist poses a threat to economic globalization, international peace and security, and the prosperity and well-being of industrialized countries (Kaul & Faust, 2001). HIV/AIDS can have a destabilizing effect in heavily-burdened countries, which can eventually give rise to a global economic impact (Smith & MacKellar, 2007). In addition, given that the countries with the highest disease burden are developing countries and therefore in need of high levels of foreign aid to combat these issues, this creates an economic drain that pulls resources from higher income countries where that money could otherwise be spent elsewhere. Finally, unhealthy people are generally less productive than their healthier counterparts. It has been proposed by several theorists that “people are prosperous not as individuals but as members of a prosperous society” (Karstens, 1995, p. 131). For a society to prosper, its individuals must be healthy so that they are productive and can contribute to economic output.

### **Collective Action Theory**

Global public goods are best provided when people and entities work together to produce and provide optimal levels (Kaul & Faust, 2001; Smith & MacKellar, 2007;

Kaul, 2009; Buchan et al., 2011; Gartner, 2012). This, however, takes a concerted effort on the part of many, and ensuring effective cooperation is an extremely difficult task. Cooperation on this level, where individuals or groups come together to achieve a common goal, is known as *collective action*. However, collective action theory, first recognized by Mancur Olson (1971) in his seminal work, argues that any group of people who is trying to provide a public good will have trouble doing so efficiently. Olson (1971) argues that it is often taken for granted that groups with common interests will collectively organize to achieve those common interests. This erroneous belief is based on the premise of rational and self-interested behavior. In other words, it has widely been considered to follow logically that if rational and self-interested individuals would all be better off if their common goals and objectives were achieved, then they will work together to achieve them. Olson (1971), however, debunks this myth and asserts that in fact, this is not the case, stating “unless the number of individuals in a group is quite small, or unless there is coercion or some other special device to make individuals act in their common interest, rational, self-interested individuals will not act to achieve their common or group interests.” (p. 2). Stated differently, individuals will not *voluntarily* cooperate and work together to achieve their common goals unless they are either forced or coerced to do so.

Olson (1971) gives the example of a nation state, which has never been able to achieve its goals through any type of voluntary taxation. Patriotism and pride in one’s country is a powerful emotion, and even though the nation-state has the ability to evoke these emotions in people, it still has never been able to collect taxes through voluntary means. Taxation is a forced mechanism in which citizens are required by law to

participate. Therefore, Olson (1971) argues, if a state, with all of the emotional resources at its disposal, cannot motivate voluntary tax payments, organizations may very well have the same problem motivating employees or groups of individuals to collectively organize voluntarily to advance common interests.

Unfortunately, as with any firm in a market, these groups fall prey to the free-rider problem. While all members of a group may share an interest in achieving a collective benefit, they do not necessarily share an interest in paying the entire cost of providing that collective good. Each member would prefer that others pay the entire cost while still being able to receive the benefit even if that particular member did not pay any of the cost (Olson, 1971). Organizations, or individuals within an organization, may not be motivated to put in the necessary effort to provide a public good if shirking these efforts will not be noticed and the public good can still reasonably be provided, even if the provision is not as efficient or as effective as it would be had all organizations or individuals cooperated.

In addition to the free rider problem, organizations also face the issue of size. The larger the organization or group, the more difficult it will be for that organization or group to provide the optimal amount of a collective good. There are three reasons this happens. First, as a group gets larger, the fraction of total group benefit any person acting in the group receives becomes smaller. This also means that the reward for group-oriented action is less than adequate. Second, as the group becomes larger and the share of the total benefit going to any individual becomes smaller, it becomes less and less likely that any single individual will gain enough from the provision of the collective good to entice him or her to bear the cost and burden of providing it, even in small

amounts. Third, the larger the group, the greater the costs to the organization, and therefore it becomes increasingly difficult to provide the collective good in any amount. In a small group, there may not be a need for any type of formal cooperation and all members may get along and agree. In a larger group, however, no collective good can be obtained and provided without some sort of agreement or coordination (Olson, 1971). The larger a group becomes, the more agreement and organization is needed. In a very large group, also called a “latent” group, if one member does or does not assist in providing the collective good, no other individual member will significantly be affected and therefore no one has any reason to act (Olson, 1971). As this latent group grows even larger, this issue is magnified.

How are these problems to be resolved? Olson (1971) states that only a separate and selective incentive will stimulate a rational individual in a latent group to act in a group-oriented way. Selective incentives can be negative by coercing and punishing those who do not act in the group interest, or they can be positive by rewarding those who act in the interest of the group. Partnerships to achieve a common goal can be beneficial, but they can be extremely difficult to work with and become more unsuccessful as the number of partners increases. Cooperation and coordination may be in the best interest of the group, but the degree to which this cooperation and coordination actually occurs will generally determine the outcome of public goods provision.

Many of today’s global issues are social dilemmas (Buchan et al., 2011). Social dilemmas, including public goods dilemmas, exist whenever the cumulative result of reasonable, individual choice is a collective disaster (Brewer & Kramer, 1986). Individuals must choose whether to participate in behaviors that have primarily a self-

serving interest or to participate in behaviors that benefit the collective good. For example, many people may prefer not to contribute their hard-earned money to public health and medical research, but if everyone chooses not to contribute, the population does not benefit in the long run. In a public goods decision, an individual must decide whether to give up an immediate benefit for him or herself in order to benefit a collective group (Brewer & Kramer, 1986). The public goods dilemma applies to a situation that is directly costly to the individual and beneficial for all members of a group (Frank, 2010). It is in these public goods dilemmas where the temptation to free ride is high. If only a few individuals free ride, it is not likely to have a large effect on the provision of the public good. However, if many choose to free ride, the provision of the public good is limited and far less than optimal. Two variables have been found to influence the outcomes of social dilemma situations: group size and the social group identity of the individual decision makers (Brewer & Kramer, 1986). As group size increases, public goods decisions that favor the collective good decrease. This effect, however, can potentially be overridden when collective group identity is high (Brewer & Kramer, 1986). The degree to which individuals see themselves as part of a group determines the outcome of public goods decisions, and will determine if they cooperate. Levels of cooperation are higher when individuals possess a shared in-group identity or when group members strongly identify with the collective than when individuals do not possess a shared identity (Buchan et al., 2011; Wit & Kerr, 2002; De Cremer & Van Vugt, 1999; Brewer & Kramer, 1986). Two mechanisms that have emerged to explain this cooperation as a result of strong social identification are expectancies and values. Expectancies refer to the belief that people within a group have that others will cooperate



because they are all a part of that same group (Foddy, Platow & Yamagishi, 2009). The expectation that other people will cooperate dispels some of the fear that one's own cooperation will be in vain (Buchan et al., 2011). It is important to point out, however, that the expectation that other people have the full intention of cooperating is not sufficient to generate and guarantee cooperation. This is magnified in large, dispersed groups (De Cremer, Dewitte & Snyder, 2001). Although trust reduces fear, it does not eliminate greed. If everyone else is expected to cooperate, noncooperation takes advantage of other people's contributions; in very large groups where monitoring may be minimal, the temptation to take advantage of other peoples' cooperation and free ride is large (Buchan et al., 2011). Values can increase cooperation, as well. Strengthening group identity increases the value that people attach to the group's well-being, as opposed to only their personal well-being (Buchan et al., 2011). Individuals that attach themselves to a larger group identity see themselves interchangeably—their sense of self dissipates as their sense of "group" increases (Buchan et al., 2011; Turner, Hogg, Oakes, Reicher & Wetherell, 1987). Pursuing the group interest therefore takes precedence over pursuing self-interest.

Public goods games experiments have been the subject of multiple studies. In a typical public goods game experiment, the person leading the experiment will give each individual in a group the same amount of money. Players may then decide whether to keep the money or invest it into a common pool. Whatever monetary amount is placed in the common pool is then doubled and divided equally among the players, irrespective of each individual player's contribution amount. If all the players cooperate and contribute the maximum amount to the individual pool, each player will end up with a maximum

amount once the common pool is divided. However, players are tempted to free ride on others' contributions. Rational individual behavior predicts that no player will contribute to the common pool, even though it is to everyone's advantage for all players to cooperate and contribute their entire individual amount to the collective. Experiments show that actual contribution levels fall somewhere between 20% to 70% of each player's individual total (Cressman, Song, Zhang & Tao, 2011). In many public goods experiments, players will tend to cooperate initially, but this initial cooperation declines quickly over time (Branas-Garza & Espinosa, 2011; Xu, Wang & Zhang, 2010). These experiments usually confirm that public goods dilemmas generally fail to produce the collective benefit that is desired (Milinski, Semmann & Krambeck, 2002).

Buchan et al. (2011) studied the influence of social identity on group behavior. The experiment was a multi-level public goods dilemma that was conducted in six countries. Selected countries (United States, Italy, Argentina, South Africa, Russia, Iran) were those that represented high variability in environmental factors. The purpose was to see whether participants chose to make contributions that benefitted themselves, a local group, or a worldwide group. Men and women aged 18-75 who represented varying levels of socioeconomic status were sampled ( $n=1195$ ) and asked to make contribution decisions at the local, national or global level. Results indicated that global social identity is a factor in an individual's decision to contribute to collective goods even if there is no expectation of a return on that individual's investment. Across all countries, self-reported identification with a global community was a predictor of the size of contributions to a global collective (Buchan et al., 2011). Overall, the study showed that a strong social identity and sense of belonging to a larger collective will positively influence an

individual's cooperative behavior. The study suggested that in the absence of monitoring and punishment of non-cooperative behavior, strong social identity and in-group belonging is essential to facilitating cooperation.

De Cremer and Van Dijk (2002) tested the effects of identification level, social value orientation, and feedback on contributions in a public goods dilemma. The study sought to determine whether those who identify more strongly with a group would contribute more to the collective based on their social value orientation and the feedback they received regarding the success or failure of other group members to contribute sufficiently to the collective pool. Social value orientation was measured and participants were classified as either prosocial (those interested in maximizing joint outcomes and concerned with the equality of outcomes), individualistic (those interested in maximizing their own personal outcomes regardless of the outcomes of others), or competitive (those interested in maximizing the difference between their own outcomes and the outcomes of others). Participants ( $n=142$ ) in an introductory social psychology course took part in the multi-round experiment. Type of identity was manipulated in the first round by telling participants that researchers were interested in either the individual outcome or the group outcome of the contributions. Feedback was manipulated by telling half of the participants that the group failed to sufficiently contribute to the common pool and by telling the other half that the group had successfully managed to contribute sufficiently to the common pool. Results showed that those participants who were told that their group failed to sufficiently contribute to the common pool motivated those who held a strong social identity to contribute more to the collective in the second round. This is consistent with the goal-transformation hypothesis, which states that a strong group identity can

transform peoples' motives from the individual to the group level (De Cremer & Van Dijk, 2002). Participants with a weak group identity contributed less to the common pool in the second round, as could reasonably be expected since they most likely had low expectations about their fellow group members' behavior. Both this study and Buchan et al.'s (2011) study demonstrate that a strong group identity is recommended in order to facilitate optimal cooperation levels.

### **Provision of Public Goods**

Given the issues that providing public goods poses, one is left to wonder the best way in which to deliver them optimally and efficiently. Historically, public goods have been provided either publicly or privately. Before the 19th century, public goods were actually privately financed and provided. It was not until the 19th century that the idea of what is now the modern "welfare state" emerged. Around this time, the idea that public goods should be publicly provided began to replace the privatization ideal (Li, 1996). The state provided public goods for years, and today that ideal still does prevail—the public sector should be responsible for providing public goods. However, in recent years, there has been a shift in the division of responsibility between the public and private sectors for the delivery of public goods (Ghatak, 2005). In most developed countries, there is a mix of both public and private provision of public goods. Today, the state does continue to provide many public goods, such as infrastructure (including gas, sewage, and roads). Some of these public goods are also provided privately, but they require regulation. Other public goods, such as defense, are often publicly provided but private contractors deliver certain aspects of the good. While the government does provide a large portion of

national defense, it also contracts with private providers to assist with the provision of services. However, despite the provision benefits that both sectors have, neither private nor public provision of public goods is optimal nor efficient. Public provision is not as effective as private provision, as public provision tends to produce less efficient outcomes because often the public good is severely under-provided (Slavov, 2014). This is often because public goods provision is dependent on either voluntary contributions or taxation. Voluntary contributions will always be lower than what is needed, as an individual bears the full marginal cost of providing the public good, but receives only a small portion of its nonrival benefits (Slavov, 2014). If a public good is provided through taxation, it can be efficiently provided, but only if a nation's tax structure is solid and the citizens can afford the tax—in developing countries, public goods provision by taxation is, therefore, not an effective solution. Private provision, on the other hand, does a better job of optimally providing a public good, but from a welfare standpoint, produces a sub-optimal outcome (Warr, 1983). This is because “efficiency” does not take into account other aspects of effectiveness, including issues such as equity, inclusion and social justice. There may be policy measures in place to redress this situation, but these measures may not be implemented (Warr, 1983). In addition, economic theory dictates that the market does not efficiently allocate goods that involve externalities (Ghatak, 2005). Ultimately, private provision of public goods can be effective, but only inasmuch that a nation's infrastructure is strong and sound. A market can only be as effective as the environment in which it exists.

While developed countries may still struggle with optimal provision of public goods through public or private means, they generally can produce sufficient outcomes.

In developing countries, however, a strong public sector usually does not exist and therefore cannot provide public goods in any sort of sufficient measure. Private organizations have sometimes been tasked with trying to remedy this situation in the absence of a strong state, but, this, too, has generally failed, as there is no profit incentive for the private sector. In many developing countries, a phenomenon has emerged to provide public goods. This phenomenon is known as the “third sector,” and consists of NGOs. NGOs now provide many public goods, such as health, to developing countries. The state cannot effectively provide public goods to its population due to its weak governance and lack of resources, and the private sector cannot effectively provide public goods due to the private sector’s responsibility and fiduciary duty to its shareholders. NGOs are left to fill in the gap, and in some cases, have completely circumvented the state in regards to public goods provision. NGOs, like the private sector, are considered to be “value-driven”; however, whereas the private sector derives value from profits, NGOs derive value from benefitting and providing goods and services to their target populations—usually, the poor (Ghatak, 2005). The vast majority of developing countries have therefore, either by choice or by outside pressures, turned to NGOs to provide many public goods. In most developing countries, NGOs provide the bulk of public goods to the population.

Each sector (private, public, and NGOs) has valuable attributes to contribute to the provision of public goods. The private and public sectors have proven their inefficiency in providing public goods, specifically health, especially in developing country contexts. This has placed the disproportionate burden on NGOs to provide public goods. While there have been successes, there still remains, in many cases, a largely

ineffective provision of public goods by NGOs. While they are essential players in providing public goods, they are not necessarily efficient.

### **A Brief History of International Aid and the Rise of NGOs**

NGOs usually are considered part of the “aid agenda,” where richer countries send money and human resources to poorer countries for the purpose of improving social and economic conditions for the population. They are also known as the “third sector”, or that sector that is neither public (state-run) nor private. In many instances, especially in developing countries, NGOs provide the bulk of social services to the population that normally would fall under the responsibility of state provision, but they are not accountable to either the state or to the population which they serve.

NGOs, and for that matter, international aid as it currently is defined, are relatively new phenomena. The term NGO was first used in the United Nations charter in 1946, which means that they already had to have existed at that time (Ahmed & Potter, 2006). NGOs actually were present as early as the 19<sup>th</sup> century. For example, the earliest NGOs in Germany that are still active today were founded in the 1830s, though at the time of their founding, the term NGO would not have been used to describe them (Ahmed & Potter, 2006). However, while NGOs in their current form are relatively new, the idea of helping the poor is decidedly not a new phenomenon. Many NGOs are involved in what could be termed “care and welfare” activities (Bagci, 2003), which historically were tenants of the church in earlier times. Historically, the church carried out the functions of care for the poor. Eventually, the idea of having organizations devoted solely to this activity made its way into mainstream society. These early

organizations were generally developed and founded by the church itself. The oldest development NGO was founded in 1743 in Switzerland, and while most of the earliest mission activities overseas were focused on proselytizing and converting the populations in Africa, Asia, the Middle East and Latin America, eventually many organizations began to develop schools and hospitals (Chabbott, 1999). Early missions raised funds directly from churches and individuals and kept contact with donors (Chabbott, 1999). These donors received regular updates about conditions in the “developing” world, which raised their consciousness level and cultivated a compassion for the poor people throughout the world who were victims of circumstance. This attitude still continues today.

Prior to World War I, there were not many NGOs on the world stage, especially in comparison to today’s numbers. Boli and Thomas (1999) found that NGOs only began to grow rapidly beginning in the latter part of the 19<sup>th</sup> century, with about ten organizations per year being founded beginning in the 1890’s, with a peak of 51 foundings in 1910. After 1910, the number of NGOs being founded dwindled and remained that way until after World War II, when the founding NGOs, specifically international NGOs, exploded. By 1947, over 90 NGOs per year were being founded, and that pace continued through the 1960s (Boli & Thomas, 1999). Post WWII, during the period of 1946-1985, more than 80% of all development international NGOs that currently exist today were founded (Chabbott, 1999).

The reasons for the explosion in NGOs after WWII are several fold. First, the destruction and devastation that wreaked throughout the world created an urgent situation that governments were not capable of addressing by themselves. The famine and disease that followed WWII prompted the creation of many new NGOs, including Oxfam,



Catholic Relief Services, World Relief, and CARE, which continue to operate today and are some of the biggest international NGOs (Chabbott, 1999). Second, the Cold War was on the horizon and the United Nations Relief and Rehabilitation Administration, which was founded in order to assist with reconstruction after WWII, channeled the majority of the aid it received from the Western powers to Eastern Europe. The Western alliance became concerned that the aid it was sending was being used to prop up puppet Communist regimes throughout Eastern Europe and recommended that going forward, the majority of aid being dispersed throughout the world be channeled through bilateral (government-to-government) transfers or through US-based NGOs, rather than through multi-lateral (a group of countries or an institution representing a group of countries) transfers, in order to better control the aid's destination (Chabbott, 1999). The final reason for the incredible growth in the number of NGOs appearing on the world stage after 1945 is that the developed world began to see international development as an essential global undertaking, which created a demand for organizations such as NGOs to be able to operationalize that concept (Chabbott, 1999).

Post-WWII also saw the creation of “aid” as we now have come to know it today. Two major occurrences took place in the post-war era that played pivotal roles in shaping the current development aid sector. The first occurrence was the convening of the Bretton Woods Conference, which was held in New Hampshire for the purposes of restructuring international finance, establishing a multilateral trading system and constructing a framework for economic cooperation that would mitigate the circumstances that led to the Great Depression in the 1930s. Recognizing that Europe would never rebuild unless huge injections of aid were poured into it, this conference established the International

Monetary Fund (IMF) and the International Bank for Reconstruction and Development (now known as the World Bank). In sum, the World Bank was tasked with the responsibility of facilitating capital investment for reconstruction and the IMF was tasked with managing the global financial system (Moyo, 2009). Eventually, during a later period, both institutions would come to play a large and powerful role in our current understanding of development aid, but in their original forms, both the IMF and the World Bank managed reconstruction, and not development. The second occurrence took place in 1947 and culminated in the Marshall Plan, a radical proposal that called for a rescue package for Europe to the tune of US\$20 billion. By the time the period of the Marshall Plan had ended (1948-1952), the United States had transferred assistance to fourteen European countries worth approximately US\$13 billion (Moyo, 2009). The Marshall Plan has largely been hailed as successful and set a precedent for what aid should look like in the twentieth century. The Marshall Plan's directive helped restore Europe and returned the continent to the economic powerhouse and rich cultural hub that it was pre-war. What proponents of the Marshall Plan have failed to realize, however, is that Europe, while damaged, had an existing physical, legal and social infrastructure that simply needed fixing (Moyo, 2009). Since the continent already had a strong framework around which to rebuild, it appears obvious that all that was needed was a capital injection in order to emerge as a world leader. The success of the Marshall Plan ushered in the prevailing view that investment capital was critical for economic growth (Moyo, 2009), and indeed, today's development aid sector was largely designed after the Marshall Plan's model of large injections of cash and capital. After all, if it worked in Europe, it surely would work elsewhere.

The following decades of development aid could largely be characterized by the prevailing mindsets that dominated each era regarding how development should be approached, how low-income nation-states were viewed by the developed world, the role NGOs played in development, and the dominant discourse that dictated aid's role.

The 1950's was dominated by the idea that comprehensive economic planning was essential to growth. Low-income nation states were seen as sovereign and autonomous. It was believed that by responsibly managing domestic resources, each nation state could achieve modernization; foreign technical assistance could assist in achieving modernization more quickly. The role of NGOs during this period was seen as minor. They mainly were only called upon for emergency relief purposes (Chabbot, 1999).

The 1960's brought the decade of industrialization. This decade emphasized using aid funding for large scale industrial projects (such as roads and railways), since it was believed that these projects had long-term payoffs and were not likely to be financed by the private sector (Moyo, 2009). Low-income nation states, while still viewed as sovereign nations, were seen as dependent on high-income countries for this foreign investment. This was different from the previous decade, where low-income nations were viewed as responsible for their own development (Chabbot, 1999). The 1960's also saw a rise in material affluence in developed nations, which was attributed to new citizen attitudes. This affluence created a solid middle class whose concerns were no longer solely rooted in material and economic stability, and extended to equity and social justice (Ahmed & Potter, 2006). The role of NGOs during this time was limited to technical assistance and the management of schools and hospitals, many of which the NGOs were

already managing (Chabbot, 1999). But while NGOs were largely attributed with running these small-scale operations, it was also realized that they had a pulse on what was occurring “on the ground” in these low-income nations, which made them the perfect conduits through which to address citizens’ social justice concerns.

In the 1970’s, aid began to change directions, and took a poverty focus. As in the 1960’s, the dominant view of the state having ultimate accountability remained, but now there was an added element of state responsibility for ensuring that development did not exacerbate any existing inequalities among the population (Chabbot, 1999). In 1973, the Arab oil crisis occurred, sending the world economy into a state of turmoil (Moyo, 2009; Salamon, 1994). Middle Eastern oil exporting countries placed an embargo on oil in response to the United States’ support of Israel in the Yom Kippur War. As a result of this embargo, oil prices around the world soared. Of course, oil exporting nations pocketed a large profit off of these increased prices. These oil exporting nations deposited the cash into international banks, who then, flush with heavy cash reserves, lent this money to the developing world. Now developing countries were borrowing more and as a result, increased their debt burden. As oil prices rose, food and commodities prices also rose and much of the developing world saw a recession take hold (Moyo, 2009). This, of course, led to increased poverty and destitution in developing countries. As poverty levels continued to increase, the Western world began to place conditions on their development support: governments of low-income countries would need to demonstrate their commitment and ability to alleviate poverty among their populations. It is at this time that many donors began to use what are now commonly known as development indicators, such as infant mortality rates and other quality of life indicators (Chabbot, 1999). In the

mid-1970, approximately two-thirds of aid was still being channeled to large infrastructure projects, but the proportion of development aid going to poverty-oriented programs had increased from 5% in the late 1970's to 50% by the early 1980s (Moyo, 2009). NGOs were also increasingly seen as instrumental in being able to assist in carrying out poverty alleviation programs. While their overall role was still somewhat limited in terms of the scope that they now encompass today, they were now taking on small-scale rural social service delivery pilot projects and engaging in grassroots advocacy that empowered the poor and made them active participants in development programs (Chabbot, 1999; Salamon, 1994).

The aid theme of the 1980's was that development aid should be used as a tool for stabilization and structural adjustment. In 1982, Mexico's Secretary of Finance called the United States Chairman of the Federal Reserve, the United States Secretary of the Treasury and the IMF's managing director to inform that that Mexico would be unable to meet its upcoming debt obligations to international bank creditors. This became an issue that was mirrored across the world, and many other countries soon announced that they, too, would be unable to meet their debt obligations (Moyo, 2009). This crisis threatened to crash the global financial sphere, and lenders and creditors alike knew that a solution needed to be created in order to avoid a catastrophic global financial crisis. Because the developing world had sunk so far into crushing debt, could no longer meet its debt obligations, and continued to spiral into poverty despite the poverty-alleviation programs that had begun to be enacted in the 1970s, donors decided to enact stabilization policies and then structural adjustment, which eventually gave way to a series of structural adjustment programs. Stabilization meant reducing a country's imbalances to reasonable

levels, such as the government's fiscal position and the country's import-export ratio (Moyo, 2009). Structural adjustment was basically a free-market approach to solving the economic woes of each developing nation. It encouraged trade liberalization and the removal of subsidies (Moyo, 2009). Structural adjustment programs (SAPs) placed a series of "conditionalities" on countries in order for them to both continue to receive aid and qualify for lower interest rates on loans. The intent of the SAPs was to enable the developing nations to be able to pay down the enormous debt that they had incurred in the previous decade. One of the ways in which SAPs were structured (one of these "conditionalities") was that developing countries' governments had to reduce spending. Unfortunately, this meant that many governments slashed spending on social programs, many of which benefitted the poor. Without these critical social programs, populations sank further into poverty and were unable to rely on resources that previously had been available to them. It is at this point that NGOs began to emerge as powerful substitutes for the state by providing many of the social services that the state could no longer afford to offer. The World Bank incorporated various activities in order to soften the effects of these SAPs, which mainly focused on a country's governmental ability to monitor the SAP effects on the poor. At the same time, the World Bank promoted NGO programs to mitigate those effects (Chabbot, 1999). Effectively, NGOs emerged as a "third sector"—neither public nor private, yet responsible for the provision of services that the state could not provide to its population.

The 1980's also saw the rise of the school of thought known as "neoliberalism." Neoliberalism emerged as the solution to the critique of the welfare state. It advocated for a small government and for the free market as the solution to economic woes. The

neoliberal philosophy included rallying for reducing trade barriers, privatizing public sector activities, and deregulating industry. The line of thinking believed that services that were normally provided by the public sector should be privatized (Edwards, 2000). The structural adjustment programs run by the World Bank and the IMF largely derived the program structure from this neoliberal line of thinking. The negative repercussions of this school of thought would eventually be felt further down the line.

The 1990s aid paradigm focused on the idea that governance was the reason for aid failure and good governance was needed for sustainable economic growth. Good governance was synonymous with strong, reputable institutions, a democratic rule of law and corruption-free economies (Moyo, 2009). The 1990s also was concerned with sustainable development. Themes of this decade provided a broader mandate for development organizations to scrutinize the governments in low-income countries, which only served to further erode government autonomy. Both bilateral and multilateral donors, in the aftermath of the Cold War, began to pursue a “new policy agenda” which elevated NGOs and gave them prominence in poverty alleviation, social welfare and civil society development (Bagci, 2003). Eventually, NGOs became the social service delivery agents of choice for most aid donors and became an essential counterweight to traditional state power (Chabbott, 1999; Bagci, 2003). Additionally, the West started to become increasingly concerned with the spread of democracy throughout the world. Democracy, according to the Western powers, was the way by which countries would experience economic growth and development. In the West’s mind, democracy was the answer to successful aid—it was the ultimate key (Moyo, 2009). Two themes dominated the foreign aid agenda of the 1990s. First, the multilateral agencies (i.e., World Bank and the United

Nations Development Programme) dominated the lending and provided the most money for development purposes. Much of this aid was made available on a concessional basis, and the vast majority of it was in the form of grants—more than 90% of official development aid was constituted by grants by 1996. Second, donor fatigue started to set in towards the end of the decade (Moyo, 2009). This fatigue paved the way for the upcoming decade, which saw the rise of a different type of aid altogether.

The 2000s was characterized by the rise of “glamour aid.” The President of Tanzania gave a speech in February of 2005, in which he excoriated the aid industry, calling it a “scandal that we are forced to choose between basic health and education for our people and repaying historical debt” (Moyo, 2009). This fatigue opened the door for celebrities to begin to campaign to raise money for aid assistance. Raising money for emergency aid and humanitarian disasters had proven to be a huge success in the past, and this success was replicated in raising money for development aid. Despite all of the different faces and phases of aid, it has become apparent that aid is not working as effectively or efficiently as its designers have intended. Donors, policymakers, and development agencies alike need to examine other potential aid failure reasons, as it is clear that aid has had uneven success (Moyo, 2009).

### **Cooperation & Coordination**

It is important to distinguish between the terms “cooperation” and “coordination.” Cooperation entails working together to achieve a common outcome, whereas coordination is about avoiding getting in each other’s way (Chandy & Kharas, 2011). Typically, most of the literature focuses on aid coordination—coordination is, by default,



easier to achieve and entails much less communication than true cooperation. Both cooperation and coordination are important elements that are needed for the successful provision of public goods, but given that collective action theory involves working together to achieve a common goal, cooperation is going to produce more effective outcomes than simply coordination.

The issue of aid effectiveness has been on the international agenda for years, but the focus has overwhelmingly been on coordination. The Paris Declaration and the Accra Agenda for Action both explicitly address coordination between countries, donors, and sectors, but do not address or mention cooperation. The Busan Partnership for Effective Development Cooperation in 2011 was one of the first major documents to spell out the need for cooperation and explicitly called for inclusive development partnerships (Bigsten & Tengstaum, n.d.). Both cooperation and coordination are critical in the quest for effective public goods provision.

Cooperation implies that a group of individuals is working together, but it does not mention whether this cooperation is voluntary or coerced. While it might seem irrelevant to distinguish whether cooperation is voluntary or coerced (after all, the outcome of cooperation is what many are most interested in), it is, in fact, an important distinction to make. There are information costs associated with coerced cooperation. If cooperation is coerced, that means a central authority is needed in order to enforce it, and that central authority will be disadvantaged when it comes to receiving or collecting information. Additionally, there are positive benefits associated with voluntary cooperation that are lost when cooperation is coerced (Gillinson, 2004). Grootaert (2001) found that in a study of cooperative water projects in least developed countries (LDC's),

returns seen in voluntary projects were greater than those returns seen when these water projects were enforced by the government.

Voluntary cooperation can be either purely voluntary (motivated by the desire for goodwill or even the fear of societal sanctions) or incentivized. Cooperation that is motivated by goodwill is the most effective form of cooperation and will generally produce the best outcomes, because the information costs are low and participant commitment is enhanced (Gillinson, 2004). Titmuss's study (1970) on blood donation argued that voluntary blood donation would produce greater quantities than incentivized (financial) blood donation, because the desire to do good would motivate people more than the desire for financial compensation. When compensation is offered, people would be tempted to conceal bloodborne diseases, such as Hepatitis B or HIV. In addition, under an incentivized system, many people would donate out of financial desperation, even if they are not necessarily qualified to give blood. This action actually increases negative externalities (ill health) and places a strain on the health care system (Gillinson, 2004). Mellstrom and Johannesson (2010) tested this blood donation theory and found that Titmuss was actually partially correct. In this study, subjects were divided into three different treatment groups: the first group was asked to donate without any financial compensation, the second group was offered financial compensation in exchange for donating, and the third group was given the choice between receiving financial compensation or donating that financial compensation to charity. The results showed that, although among men, there were no significant effects between the three experiment groups, among women, the number of willing donors decreased by almost half when financial compensation was offered. While incentivized cooperation still induces people

to cooperate, it is not as effective as purely voluntary cooperation that is motivated out of goodwill.

Cooperation and coordination are critical to the successful provision of public goods and failure to do so is sub-optimal for several reasons. First, it results in fragmentation and incomplete information. Fragmentation is costly for both recipients and for donors (Halonen-Akatwijuka, 2007), and incomplete information can lead to negative consequences. In the extreme, failure to cooperate and coordinate can cause disastrous consequences. One example of such a failure occurred in Banda Aceh, Indonesia in the aftermath of the devastating tsunami that swept the country in 2005. A little girl presented to physicians with an unusual case of measles. Upon rigorous examination and interviews, it was discovered that the girl had actually received the measles vaccination three times, from three different organizations, and her symptoms were the result of her over-vaccination. Second, failure to cooperate and coordinate leads to resource misallocation and inefficiencies (Chandy & Kharas, 2011). An example of this would be if NGOs are notified that a certain population segment or area of a country needs an increase in medication and do not coordinate or cooperate to determine distribution, that particular population segment or area might receive too much medication at the expense of another group receiving needed and critical medication. Third, it can result in waste (Cooley & Ron, 2002). Returning to the previous example, the population segment that was overloaded with medications could mean that a lot of those medications go to waste because they are unable to be used before their expiration date. Finally, failure to coordinate and cooperate can result in duplication of programs and services (Barr & Fafchamps, 2006). If more than one NGO is operating in an area

and providing the same or similar services, duplication occurs and a situation such as the Banda Aceh story is likely to happen.

### **Levels of Cooperation**

How is cooperation to be assessed? It is more than just simply assessing if it is occurring or if it is not occurring. Cooperation has been broken down into levels and “operationalized” by Koch (2011). Koch delineates three levels of cooperation, from Level I (a low level of cooperation) to Level III (a high level of cooperation).

Level I cooperation has high selective benefits for NGOs as individual organizations, but does not necessarily have benefits for the group. This level of cooperation is most often applied to joint fundraising efforts or proposal writing resource workshops. Olson (1971) states that this type of cooperation can occur between groups, and various social psychologists believe that if the interests of the various groups are in alignment, cooperation is likely to occur at this level (Koch, 2011).

Level II cooperation provides selective benefits for individual NGOs and also for the group. Examples of this type of cooperation include the establishment of joint training centers for staff or a joint quality control system. Overall, these types of activities improve the quality of operations work of the individual organizations and improve the overall quality of the output. Some benefits accrue to the individual NGOs, but the majority of the benefits that are created accumulate to the group as a whole. This type of cooperation is believed to occur in small groups, and as group size increases (which increases agglomeration), decreasing selective benefits result in decreasing levels of cooperation (Olson, 1971; Koch, 2011). Olson (1971) believes this type of cooperation is

the maximum level of cooperation that can exist and that only specific types of groups will actually achieve Level II cooperation.

Level III cooperation results in selective benefits for individual NGOs while high benefits accrue for the group. The type of cooperation that occurs at this level includes activities like coordination of regional and thematic priorities. These types of activities are good for the group as a whole because they help to reduce waste, duplication of services and reduce inefficiencies. This type of cooperation is seen as difficult to obtain, as this type of cooperation generally requires that any competition is set aside. In an environment where resources are often scarce and survival takes precedence, this type of cooperation is very scarce. Some do believe that this type of cooperation can occur if the collective benefits are high enough (Wade, 1988)

### **Cooperation & Coordination Among NGOs**

The issue of coordination in the health sector began to receive attention in the 1990's as calls for increased aid effectiveness became louder. What followed were four distinct transitions: coordination within the sector, sector-wide coordination, coordination across sectors at the national level and, most recently, global-level coordination (Hill, Dodd & Haffeld, 2012).

Once it became evident that fragmentation and duplication of services were serious issues in international aid, the call for coordination within the health sector was put out. This coordination was mainly donor-driven and mainly occurred only among donors and was not done in conjunction with other stakeholders within the health sector. Donors essentially tried to formalize their coordination activities within the sector

amongst themselves (Hill, Dodd & Haffeld, 2012). Eventually, within-sector coordination gave way to sector-wide coordination, or sector-wide approaches (SWAp's). SWAps differed from within-sector coordination in that it aimed to coordinate the entire health sector and its accompanying resources, instead of coordinating parts of a whole from within the sector. SWAps moved the coordination responsibility from donors to national governments, and they also elevated the dialogue from simply discussing various project guidelines and implementation plans to creating national policy frameworks. While the SWAp concept was an improvement in coordination efforts, it was plagued by issues; donors were generally very supportive of SWAps but administrative rules and bureaucracy prohibited many of them from being able to participate in certain instances. In addition, weak governance and lack of transparency at the national level created issues that the health sector was incapable of addressing. Eventually, the concept of SWAps had to be redesigned (Hill, Dodd & Haffeld, 2012).

Although SWAps were not as successful as their creators had hoped, they did lend some important central tenants—namely, local leadership, local policy alignment, and harmonization—to the coordination approach's next iteration, which was national level coordination. The national level coordination approach began with Poverty Reduction Strategy Papers (PRSPs), which were originally a World Bank requirement in order for countries to remain eligible to receive new loans and continue to qualify for low interest rates (Hill, Dodd & Haffeld, 2012). PRSPs describe a country's macroeconomic, structural and social policies and programs and aim to promote growth and reduce poverty (International Monetary Fund, 2014). PRSPs quickly became a way for governments and donors to align priorities and initiatives. However, as with SWAps,

weak governance and lack of national-level transparency caused national-level coordination to fail (Hill, Dodd & Haffeld, 2012).

The 2000s ushered in the era of global coordination. The issue of coordination received increased attention and focus, and the rapid increase in stakeholders (global civil society networks, private foundations, etc) demanded a new type of coordination effort. As the donor landscape continues to add new members, the pressure for coordination at every level (national, sectoral, and even disease-specific) increases (Hill, Dodd & Haffeld, 2012). While coordination efforts indeed have, at their core, good intentions, it appears that the focus has remained on the intention rather than any type of coordination achievement. Focus needs to remain on achievement if coordination improvements are actually to be made.

The question then becomes: if cooperation and coordination are good and result in positive results, why are organizations choosing not to do so? First, although NGOs have altruistic missions, they still compete with each other for resources, which, oftentimes, are scarce (Cooley & Ron, 2002; Prakash & Gugerty, 2010; Molenaers, Jacobs & Dellepiane, 2014). The presence of many NGOs in an environment, combined with the fact that many of these NGOs are working in the same sphere, means that they compete with each other for resources. Many times, these NGOs are trying to win contracts and obtain funding from the same donors, and this does not decrease a competitive atmosphere, it only exacerbates it. This is known as the multiple principles problem. The more “agents” (NGOs) there are, the more each NGO’s position and survival might seem insecure or tenuous, and therefore NGOs will seek to undermine other NGOs (who are seen as competitors), hide information and act unilaterally (Ron & Cooley, 2002).

Second, cooperation and coordination require time, effort, and resources; NGOs do not necessarily have any of these elements. In an environment where resources are already scarce, finding additional resources is difficult. In addition, cooperation and coordination usually require regular meetings or communication, which take time and effort. In environments where NGO's are already stretched thin, it is difficult to entice management to work voluntarily with other organizations when it takes time away from their own daily work. Third, there is no incentive for NGOs to work together. While it may be socially optimal for them to do so, working together does not necessarily provide any immediate and measureable impact that would entice organizations to cooperate and coordinate. In addition to no incentive being given, there are also no negative consequences or punishments that are handed down as a result of not working together. The lack of incentive and the lack of negative consequences will make it very difficult to encourage NGOs to work together. Finally, it is critical to keep in mind that most NGOs receive funding from donors on the basis of project and program success. There is a heavy emphasis on being able to produce measureable results (number of vaccines given, percentage decrease in disease prevalence, percentage decrease in infant mortality, etc) to demonstrate to donors that a particular NGO is capable and competent at carrying out contracts and managing funds. When NGOs work together, it becomes not only difficult but nearly impossible for an individual NGO to demonstrate that it was the sole reason for the success of a program; the other NGO or NGOs who also worked on the project cannot necessarily be disentangled from the others in being able to prove success. In a competitive environment where future funding is usually contingent on past successes,



working together threatens the survivability of NGOs and threatens their future funding. Each NGO wants to be able to demonstrate successful results to donors.

Several studies have been conducted on cooperation between and among NGOs. Ron and Cooley (2002) conducted three separate case studies that illustrated the “multiple principles problem” in the NGO environment. The first case study consisted of 30 interviews with for-profit corporations in Kyrgyzstan that were operating under one-year renewable contracts from various Western governments, the United Nations and international financial institutions. This case study showed that the reliance on short-term contracts created an environment of competition, and it also motivated contractors to withhold and hide information that might negatively influence the renewal of the following year’s contract. The presence of several donors in the same sector created a multitude of problems, including project implementation delays and even project cancellations, all as a result of inter-organizational competition (Ron & Cooley, 2002). This particular case study suffered from a major limitation in that it studied only for-profit entities; however, it should be noted that in competitive environments, non-profit entities will often behave in the same or similar ways as their for-profit counterparts. If organizational survival is at stake, the incentive to compete in order to win new contracts is high. The second case study drew on 35 discussions with employees of a large, respected non-profit organization that operated a refugee camp in Goma, Democratic Republic of Congo during the period of the Rwandan genocide. During that time, more than 200 organizations set up operations in Goma in the hopes of securing UN contracts. Even though it was a common belief that more organizations would mean better and more efficient services for refugees, this was not the case. The presence of so many

organizations created an environment of competition where the overarching concern was the securing of a contract. This resulted in suboptimal services for the refugee population. The third case study took place in Bosnia during the Bosnian War in the 1990's. The presence of a multitude of NGOs created uncertainty and competition among the organizations. One source stated that the local NGOs were "quick to fall into competition with each other, vying for donor attention and funding" (Ron & Cooley, 2002). This competition undercuts cooperation and makes cooperation virtually impossible, as organizational survival takes precedence over working together to achieve a common goal.

Another study on aid fragmentation was conducted in Belgium. Since it was recognized that aid fragmentation results in high transaction costs, administrative overlap, and undermines aid effectiveness overall, a specific case in Belgium was investigated. Belgium received heavy criticism from the OECD because it suffered from a lack of synergy between the Belgian Directorate General of Development Cooperation and NGO aid (Molenaers, Jacobs, & Dellepiane, 2014). A total of 115 NGOs were included in the study sample (which also happens to be the number of NGOs receiving official development aid from Belgium). The sample showed that 40% of NGOs coordinate assistance with their own partners in several areas, including problem identification, coordination, exchange of information, project execution and monitoring and evaluation. The NGOs also claim to cooperate with other local organizations and the local government, but this cooperation is not as involved as the cooperation with identified partners—only 20% self-reported as working closely with these other entities and government. Overall, the NGOs themselves stated that there was a lack of

communication and coordination among each other and other development actors in Belgium (Molenaers, Jacobs & Dellepiane, 2014).

Koch (2011) conducted a study that examined cooperation among NGOs. The overall question was whether agglomeration of NGOs enhances or decreases cooperation. The study took place in a simulated environment with 37 NGOs, consisted of three rounds, and was a repeated interaction game. A total of four to six NGOs played against each other in each game, but they also had to cooperate as a team against other NGO teams that were playing the game. There were two possible “winning” situations (one in which a prize was given for the NGO that ended the game with the most money, and another in which a prize was given for the NGO that ended with the most joint projects for the community). These two winning situations were meant to replicate the types of dilemmas that NGOs face: do NGOs prefer financial security or do they actually cooperate to achieve better outcomes for their target population? The results showed that agglomeration did actually decrease cooperation levels and enhanced competition. To supplement the game results, the study authors also conducted 47 semi-structured interviews with NGOs working in Arusha, Tanzania. The NGOs were independent from the government, all were classified as non-profit, they were funded by foreign donors, had local offices in the region and were carrying out projects in the Arusha area (response rate was 67%). The survey findings concluded that although there was some cooperation occurring among the NGOs located in the city, they cooperated fewer hours per week than those NGOs that were located in less agglomerated areas. In addition, NGOs that worked in very rural areas also cooperated less than those NGOs that were located in semi-remote regions (medium agglomeration). Overall, cooperation rose with increasing

agglomeration but it decreased when agglomeration reached a certain high level (Koch, 2011). International NGOs were more apt to cooperate with other NGOs, and this was thought to be because their funding was more secure than local NGOs. NGOs were generally only willing to cooperate when clear benefits to their organization were guaranteed and stopped cooperating when organizational benefits were not guaranteed, which supported Olson's theory of collective action.

### **Health NGOs, Public Goods, and the Need for Collective Action**

Today, NGOs are seen by governments and donors as a much better conduit through which to channel aid to provide services than country governments (Zaidi, 1999). Plagued with perceptions of corruption, developing country governments are often bypassed by aid dollars and instead must rely on NGOs to deliver the bulk of aid services and projects. NGOs are increasingly seen as the solution for all ills that afflict underdeveloped countries, and additionally, any issue that the private or public sectors cannot address is automatically expected to be undertaken and delivered by NGOs (Zaidi, 1999). In fact, NGOs deliver more development assistance today than the entire UN system (Mathews, 1997). While the exact number of NGOs that exist in the world today is unknown, it can be said to probably be in the millions.

Many NGOs in developing countries provide health care, which this paper has established as a global public good. Public goods are best and most efficiently provided when collective action—that is to say, cooperation—occurs. The question remains, however, what levels of cooperation are occurring between NGOs in the health sector. This is an important policy issue, as financing of development activity has received

increased scrutiny over the years, especially following the worldwide economic crisis of 2008. Resources need to be channeled effectively and efficiently, and outcomes need to improve. Lack of collective action produces waste, duplication of services, and overall inefficiencies. If collective action is one of the keys to greater efficiency and better outcomes, it follows that it is necessary to know both the level of cooperation that is currently occurring and the barriers to cooperation so that specific policy measures can be designed to encourage collective action.

Collective action appears simple in theory, but in reality, it is very difficult to achieve. Although it may be optimal and may produce the most effective and efficient outcomes in the delivery of global public goods, it is difficult to achieve for many reasons. In the case of NGOs, a competitive environment exists in which the need for survival trumps the desire to effectively and efficiently deliver services. Even when collective action does exist, there are still barriers to success. One of these barriers is the free-rider problem, in which some actors will not participate in collective action yet receive some of the benefits of collective action. In addition, it becomes more difficult to deliver public goods optimally and efficiently as the size of the group increases. Given that there are often a large number of NGOs in developing countries trying to deliver services in the same sector, collective action will be difficult to achieve.

Yet, while collective action will, in practice, be difficult to achieve, it is an issue worth investigating. Its study will uncover information on why it is not achieving that may be specific to the sector in which the organizations work (in this case, health). Is the failure of collective action one of the underlying, unexplored reasons why aid has been an overall failure?

## STATEMENT OF THE PROBLEM

While some progress has been made, it seems that the same mistakes are made time and time again, and aid continues to fail. Aid failure has been the subject of many papers, policy documents, and presentations, yet no one seems to have the answer as to why it is failing. As Kaul et al. (1999) states, “The pervasiveness of today’s crises suggests that they might all suffer from a common cause, such as a common flaw in policy making, rather than from issue specific problems. If so, issue specific responses, typical to date, would be insufficient—allowing global crises to persist and even multiply” (p. xxi). While the “common cause” by which all aid seems to fail may be difficult to uncover, it is worth trying to uncover issues that previously have not been considered. As Kaul and colleagues (1999) also suggest, is it time to look at a possible deeper reason for why we are not succeeding? Is it time for a change in perspective?

A change in perspective would imply that deeper causes of aid failure perhaps need to be examined. The traditional reasons given, including failures by donor countries, donor institutions, and recipient governments, are easy targets and therefore receive most of the blame. However, there may be deeper, underlying reasons why aid is failing. NGOs, while traditionally seen as the “saviors” for aid implementation, are a part of the aid problem. It is only recently that they have received any scrutiny for failing to deliver and implement aid properly. The Henry J. Kaiser Family Foundation recently put out a series of reports assessing donor coordination in global health, stating that the “proliferation of donors has created challenges for negotiating, coordinating, and delivering effective programs that strengthen country ownership, support civil society, and uphold other established principles for development assistance” (Henry J. Kaiser

Family Foundation, 2014). While the examination of donor involvement and coordination is surely beneficial for trying to understand previously unexamined underlying causes of aid failure, it neglects to study another very important piece of the puzzle, which are NGOs. NGOs deliver the vast majority of aid, yet are not always scrutinized in the same manner that donors and recipient governments have been. While studying donor coordination and cooperation is indeed relevant, NGO cooperation and coordination should also be studied. Much can be learned from studying this “third sector” and how it provides public goods. Where are the inefficiencies? How are NGOs working (or not working) together to provide services? Indeed, the literature has highlighted the limitations of public actors in providing public goods, and inter-organizational cooperation is needed (Steffek, 2013).

NGOs provide an array of services, including health services, in Haiti. Health services are largely needed in the country, as Haiti has the worst health statistics and the worst health outcomes in the western hemisphere. The life expectancy is only 62 years, maternal mortality is 380 per 100,000 live births, and only 37% of women give birth in health facilities with skilled birth attendants, to give a brief overview. Communicable disease also remains a serious issue: the malaria prevalence rate is 2% to 3%, HIV/AIDS prevalence is 2.2%, and tuberculosis remains a problem, with almost 14,000 new TB cases reported in 2010 alone (World Health Organization, 2015). Cholera also continues to pose a threat to the country. In 2010, shortly following the devastating earthquake that hit Port au Prince, a cholera outbreak began that quickly swept through the country, killing thousands and affecting hundreds of thousands. While the epidemic has already reached its peak, it still continues to affect many in the country today

Haiti in particular has a high number of NGOs currently operating, with estimates being as high as 10,000 in existence. This has led to Haiti being dubbed the “Republic of NGOs,” as Haiti has the second-highest number of NGOs in operation in the world, behind India (Farmer, 2011; Kristoff & Panarelli, 2010). Haiti is often propped up as the prototypical failed state—a “little piece of sub-Saharan Africa” (Edmonds, 2012). Haiti received almost \$1.3 billion in official development aid (ODA) in 2012 (World Bank, 2012). Over 25% of all ODA is allocated to health and population, which also happens to be the sector that receives the highest proportion of aid (OECD, 2013). Despite the money that flows into Haiti each year and is specifically allocated to health, Haiti continues to have the worst health outcomes in the western hemisphere and health has not significantly improved. It is fair to say that the best efforts of Haiti’s NGOs have failed to build a stronger state, failed to strengthen infrastructure, and failed to provide the necessary services to the population.

Given the high number of NGOs, the dismal health outcomes, the high amount of ODA that flows to Haiti, and the increased scrutiny on fiscal spending, Haiti is an ideal environment in which to study collective action in the provision of health, a global public good. To what extent is the failure of NGOs to help produce sufficient outcomes a result of a lack of collective action? What levels of cooperation are occurring, if any, between health NGOs in Haiti? What incentives would encourage collective action? Given that it has been difficult to pinpoint why failures are occurring, and also given that prior research has stated that it is time to shift the focus to NGO accountability instead of continuing to scrutinize donors, it follows that this case study will advance the research



agenda and contribute meaningful results that can be applied on a practical level to the field of global health.

## CHAPTER 2 METHODOLOGY

This chapter outlines the research methodology for the study. Given the justification that was presented in the previous section, Haiti remains an excellent research site for the investigation of the level of collective action that is occurring, or not occurring, among NGOs.

I personally spent a year as the executive director of a non-profit that operates a health clinic in a rural area of Haiti. Even though Haiti has thousands of NGOs, when I began the position, I did not know if any other health NGOs worked in the area, and upon inquiring about this to the board of directors, was told that they had “heard” of some other health NGOs but were not sure of the name or who ran them, despite the fact that this particular organization had been in operation for almost 15 years at the time. This inspired me to start some preliminary, non-academic research to find other health NGOs with whom we might partner. I was able to connect with one other organization that also worked in health, and this organization was able to provide needed services to some of my organization’s patients that the clinic could not. Likewise, my organization was able to provide some contacts and assistance with shipments to the other organization. This led me to wonder: if two organizations working together could increase efficiency and offer improved and expanded services, what could a network of health organizations do? Olson’s (1971) seminal work has ultimately inspired a plethora of research into organizational cooperation, including my own. My particular outreach had been done voluntarily—were there others doing the same? If not, what could incentivize health organizations to engage in collective action?

Armed with these questions, I set out to design my dissertation research, which was to study collective action occurring among NGOs working in maternal and child health in Haiti. Starting with my own short list of NGO contacts, through snowball sampling, I recruited additional participants to complete a 25-question, semi-structured interview protocol. The results of the interview were analyzed qualitatively via thematic analysis. During the interview, participants were also asked to generate a list of all NGOs working in maternal and child health in Haiti, then to identify various levels of cooperation with the NGOs with which they each worked. This data were analyzed using social network analysis.

Two formal research questions were developed in anticipation of this research:

**RQ1:** What is the level of cooperation that is occurring between NGOs working in maternal and child health in Haiti?

**RQ2:** What incentives would encourage NGOs to cooperate?

This research study entailed a mixed-methods approach to data collection. Data collection entailed the use of a semi-structured, 24 question interview protocol. Further, internet research was completed on each participating organization, in order to collect information on the incorporation of collaboration and partnerships into each organization's mission, vision and/or values, which was then measured against some of the qualitative data.

## Participants

In order to gain a better understanding of organizational cooperative behavior, semi-structured interviews took place with people who were managers or executives of NGOs that work in some aspect of maternal and child health in Haiti. It was theorized that managers and executives establish not only the overall mission and goals for an organization, but that they also strategize how the mission and goals will be achieved. Therefore, managers and executives are in an excellent position to describe the importance (or non-importance) of collective action, as well as assess the level at which it is occurring.

Semi-structured interviews occurred with 17 participants. I identified and contacted seven participants by virtue of my own personal relationships through my time spent working in Haiti. Each of these participants listed other organizations with which s/he works or with which s/he was familiar. I selected additional participants using a snowball sampling method. Researchers can often use snowball sampling in an attempt to access marginalized or hard-to-reach populations (Atkinson & Flint, 2004). In this particular instance, a snowball sampling method was chosen because it is difficult to pinpoint NGOs working in Haiti, much less NGOs working in a particular area. There is no central database whereby NGOs can be found, and there is no official registration process for NGOs operating in Haiti. Indeed, NGOs can operate in Haiti without being officially recognized by the government as such. This is a large factor in what makes it so difficult to track NGOs in Haiti. The use of snowball sampling in organic social networks is useful for bringing to light two important concepts: social knowledge and power relations (Noy, 2008). While snowball sampling has sometimes been viewed as a “last

resort” sampling method when other options have been exhausted, it is, in its own right, a particularly informative procedure that delivers a unique type of knowledge (Noy, 2008). Snowball sampling in this research afforded the opportunity to examine existing knowledge (or lack of knowledge) among NGO social networks and the subsequent power relations and dynamics that occur between organizations. By virtue of referrals, I examined existing networks and used this information to analyze how these networks interact with each other, knowledge that might not be observable in using a traditional random sampling method. Additionally, participants who work for NGOs could be reluctant to share data if it is not tied to donor funding. Using a snowball sampling method provided a way for me to be “introduced” to new organizations and networks that otherwise might be closed to outsiders with whom these organizations are not familiar.

The inclusion criteria for this study included three elements. First, the participant needed to be a manager or executive of an NGO. Second, the NGO needed to work in Haiti, though the NGO did not need to solely work in Haiti. The NGO could have operations in other parts of the world, but part of its operations needed to take place in Haiti. The third criterion was that the organization needed to work in maternal and child health, though the organization did not need to work exclusively in maternal and child health. The NGO could provide other services, so long as part of the organization’s services included the provision of maternal and child health. See Table 2-1 for a listing of participants and descriptors (mission, length of service, MCH services provided, whether local or non-local and operating budget).

The snowball sampling method proved to be useful to an extent; unfortunately, many emails sent to organizations by virtue of being referred were unreturned. Because

of this, an additional recruitment approach was utilized in order to yield a higher sample size. An email was sent to "The Corbett List," an email listserv that has a wide readership among people working in Haiti and interested in Haiti. This email list began in 1994 and continues to operate today. Though it is unknown how many subscribers the list currently has, between 1999 and 2007, 30,000 messages were posted (Corbett, n.d.). Information on the number of messages posted since that date is not available, but the list maintains an active membership, with an average of 5-10 emails sent to the list each day. I first learned about this list through an associate of mine, who encouraged me to sign up to "stay connected" to Haiti. I knew that this had the potential to be a valuable recruiting tool. The email that I sent to the list invited additional participants to be included in the research. This strategy resulted in three new participants, who also were able to give me additional referrals, resulting in two additional participants; the list outreach gave me a total of five additional participants who I would have otherwise been unable to recruit.

### Procedure

Semi-structured interviews with a total of 25 questions took place with the participants. Semi-structured interviews have a flexible and fluid structure (Mason, 2004; Galletta, 2012) and are ideal for this particular research study because they allow the participant and interviewer to divert from the set of interview questions to explore ideas, themes, and narratives that might arise during the course of the interview. Because semi-structured interviews are relatively flexible, open and interactive, they allow for the interviewee to share his or her "own perspectives, perceptions, experiences, understandings, interpretations and interactions" (Mason, 2004, p. 1021). A more rigid

interviewing structure might unduly impose the researcher's own interpretations and understanding onto the gathered data (Mason, 2004). Advantages to using semi-structured, personal interviews to elicit data include:

- 1) They are ideal for exploring values, attitudes, beliefs and motives
- 2) They provide the opportunity to validate participant answers through informal member checks (discussed later in the "Validation strategies" section)
- 3) They allow for comparability of answers by ensuring that respondents answer all questions
- 4) They avoid the issue of low-response rates that are typical of questionnaires (Barriball & While, 1994).

One of the hallmarks of semi-structured interviewing is the use of probes in questioning. Probes are used in interviews to elicit additional explanation from participants (Roulston, 2008). Probes allow the researcher to gather additional data that cannot be elicited in a structured interview; they allow for the organic emergence of new themes that might not result from a structured interview. Because the semi-structured interview is flexible and has an open-ended component, it is also ideal for the exploration of areas that might not be well understood. It is also ideal for those who hold elite positions, as there is flexibility in question and answer structure and participants can explain elements that might have previously been unknown to the researcher, resulting in a fluid exchange between researcher and participant.

Fifteen interviews took place either over the telephone or by Skype audio call, and two interviews were sent via email with answers in a Microsoft Word document. This was necessary because cell phone coverage was very low in the areas in Haiti where

these two participants were located, and internet bandwidth did not allow for Skype calls. Audio interviews were recorded and transcribed by the researcher. All interviews took place in English. This was a limitation to the data collection process, as there are NGOs from multiple countries working in Haiti (Canada, Switzerland, France, etc). Interviews in French would have therefore been a way to potentially elicit more participants.

Interviews were halted at 17 participants because the point of data saturation had occurred. Data saturation is an important concept in qualitative research; since qualitative studies often involve labor intensive analysis, one should aim to cease collecting data once data saturation is reached. Data saturation is considered to have occurred "when the collection of new data does not shed any further light on the issue under investigation" (Mason, 2010, para. 2). Further, if there are no new themes that are emerging, then this goes hand in hand with the idea that no new data needs to be collected (O'Reilly & Parker, 2012).

The major themes that were explored in my interview protocol centered around the type of cooperation that was occurring between organizations; the level of cooperation that was occurring between organizations; the limitations, barriers and benefits of cooperation; and specific stories about both successful and failed cooperation efforts. These themes were believed to be beneficial in helping to understand not only the type and level of collective action that was occurring in Haiti, but also to highlight and understand the benefits that can accrue from ongoing (and not solely in an emergency) organizational collective action in the global health sphere. When asked his opinion of the three most urgent global health issues in today's environment, Dr. William Foege, one of the preeminent global health leaders of modern times, stated, "Three, we need



collective action on improving our public health infrastructure. From global to local" (Foege, 2016). Advancing collective action is clearly important; first, however, it is necessary to evaluate what collective action is occurring, if at all. Please see the interview protocol in the Appendix for a list of questions (Instrument 1).

### **Data Analysis**

This section details the three methods of analysis that were utilized in this study. An analysis of organizational website information was conducted in order to gain insight into whether cooperation was incorporated into the organization's mission, values and/or vision. Thematic analysis was used to analyze the semi-structured interview data. Finally, a social network analysis was conducted in order to gain insight into the organizational networks that exist among actors.

### **Internet Background Information**

Research was conducted on each participating organization's website. I looked at the organization's mission, vision, goals and values if stated and available online. In addition, The organization's website was investigated for mention of collaborative efforts or partnerships with other organizations. This would give a framework for understanding if collaboration was embedded in the organizational actions.

In addition, if available online, annual reports were studied for any mention or discussion of cooperation, collaboration or partnerships. Any mention of cooperation, collaboration, or specific partnerships was documented and incorporated into the overall thematic analysis. One of the semi-structured interview questions asked participants to

describe how their organization worked to achieve their overall mission and/or goals. In this, I was looking to see if how the website described the mission and goals matched up with what the participant stated regarding collaboration.

This information was used to corroborate information elicited in the interviews. I was looking to see if what was mentioned on the website aligned with what was discussed with participants in the interviews.

### Thematic Analysis

Thematic analysis was used to analyze the data. Thematic analysis does not rely on counting words or phrases, but moves beyond this and seeks to identify and describe themes, or implicit and explicit ideas that are embedded in the data (Guest, MacQueen & Namey, 2012). Applied thematic analysis strives to either build theoretical models *or* find solutions to real-world problems. The intent of this particular research is to discover what hinders cooperation between NGOs and determine what might encourage or incentivize them to cooperate, ultimately resulting in suggestions on how to encourage cooperation for improved health outcomes, which are both “real world” problems.

Possible themes were identified before the interviews took place, by virtue of the interview protocol. These themes included areas such as: cooperation between NGOs, type of cooperation (information sharing, resource sharing, materials sharing, etc), barriers to cooperation and benefits to cooperation, among others.

Themes were actively identified; i.e., they did not “emerge” from the data. Stating that themes emerge from the data is a passive account of the analytical process, and

ignores the active role that the researcher plays in the entire process (Braun & Clark, 2006). The thematic analysis consisted of the following steps:

- 1) Familiarizing myself with the data
- 2) Generating initial codes
- 3) Searching for themes
- 4) Reviewing themes
- 5) Defining and naming themes (Braun & Clark, 2006).

#### Step 1: Familiarize myself with the data

In this step, I familiarized myself with the data. This was done by reading and rereading the data, and searching for key words, trends, ideas or themes in the data (Guest, MacQueen & Namey, 2012). I made notes on potential themes that began to emerge, and also made note of ideas for coding (Braun & Clark, 2006).

Initial ideas for coding were identified on the basis of the questions themselves. Each question touched on an important theme in my research. Some questions overlapped, but all questions elicited important information from participants. These ideas for initial coding included: competition, barriers to cooperation, benefits of cooperation, and the desire to cooperate. However, knowing that there was additional important information in the data, these initial notes were very preliminary.

Transcription also occurred during this stage. Transcription is itself an important step in the data analysis process, as transcription allows the researcher to become familiar with his/her data (King & Horrocks, 2010). During the transcription phase, I was able to further familiarize myself with the data. I conducted partial transcription. Since I was

looking for common themes across a number of interviews (and not conducting a discourse analysis), a full, verbatim, word-for-word transcription that makes note of pauses, laughter, and other conversational fillers was not necessary (King & Horrocks, 2010).

#### Step 2: Generating initial codes

In this step, I generated initial codes. After reading and rereading the data, I concluded that I could initially identify themes on the basis of the questions themselves. To capture this, I did a “first round” coding that entailed structural coding. First, I made decisions on what type of text segmenting strategy would be utilized. Text segmentation defines boundaries around themes and is an important part of the analysis because it assesses and documents data quality and also facilitates exploration of themes, including their similarities, dissimilarities and relationships. The researcher has some considerable flexibility around where the text segment begins and ends, as well as flexibility in deciding how much text to include (Guest, MacQueen & Namey, 2012). Given that this flexibility exists, there is great potential for “chaos” in the analysis. To minimize this, I chose text boundaries that allowed the thematic features of the segment to be clearly distinguished when taken from the larger context of the interview (Guest, MacQueen & Namey, 2012). Here, questions and accompanying answers were used to identify the text boundaries.

Since themes were identified on the basis of the questions themselves, I made the decision to initially segment the text by question and accompanying answer.

After the decision regarding text segmentation was made, I completed structural coding. Structural coding is used to “identify the structure imposed on a qualitative data set by the research questions and design” (Guest, MacQueen & Namey, 2012). Each question, accompanying answer, and any probe was considered its own structured code. For example, the question, “Can you think of any instances where you thought cooperation/collaboration might have been beneficial, but did not actually cooperate?” and its accompanying participant answer was assigned the code: **DID NOT COOPERATE**. A total of 31 initial structural codes were developed and on this basis, my codebook was formed. This structured coding resulted in my initial codes. Generating codes is an important step in the analysis process because it allows the researcher to organize the data into meaningful groups (Tuckett, 2005).

One of the advantages of using structural coding as my initial coding method is due to its usefulness in efficiently organizing the data. The thematic analysis that I conducted for this research used the essentialist/realist method, which reports experiences, meanings and the reality of the participants (Braun & Clark, 2006). This research did not purport to ascribe meaning to participant narratives; it simply sought to report the narratives themselves, and describe participant realities.

### Step 3: Searching for themes

After structural coding was finished, I read and reread my data in order to search for any themes. It was during this phase that additional codes were added to the codebook, as I identified recurring patterns of information. Additional codes were created to complement my initial structural coding. In total, 45 codes were included in the

codebook (an additional 14 codes were included, in addition to the initial 31 codes that were completed based on my structural coding).

Themes were identified at the semantic level. This approach means that I only searched for themes within the explicit, or surface meanings of the data, and did not search for anything beyond what the participant stated (Braun & Clark, 2006).

There is some considerable flexibility in how the researcher defines what constitutes a “theme.” At the most basic level, a theme encapsulates something that is notable or significant about the data in relation to the research question. It will also represent a patterned response, at some level, within the data set (Braun & Clark, 2006). While there is varied agreement on how a “theme” is identified in terms of prevalence and space across the data set, in this research, I identified a theme in terms of the number of different speakers who articulated a particular theme across the data set.

An example of collating codes into themes comes from one of my protocol questions that asked participants to identify specific instances where they had experienced the issues of fragmentation, duplication of services, incomplete information, and resource misallocation (all of these are said to be consequences of failing to engage in collective action). While many participants were able to identify specific instances during this question where these instances occurred, there were clear patterns of these situations occurring when participants responded to other questions. One example is the participants’ responses to my protocol question: “Are there any instances where cooperation has been the intention, but it failed?” Multiple participants ascribed instances of failure to issues such as fragmentation, duplication of services, incomplete information

and/or resource misallocation. Thus, while initial structural coding had assigned a code to each of these (**FRAGMENTATION, DUPLICATION OF SERVICES, INCOMPLETE INFORMATION, RESOURCE MISALLOCATION**), the initial structural codes were also identified as broader themes within the data set, given that they were patterned responses within the data set, and not just responses to the original protocol question. Another example arises from my original structural code **BENEFITS**. While I did specifically ask the question: “What are the benefits of cooperation?” there were several other questions throughout the protocol where participant answers included mentions of actual benefits resulting from cooperative experiences. Thus, on this basis, one of my main overarching themes was **COOPERATION IS BENEFICIAL**, given that participants continuously invoked actual benefits throughout the protocol.

#### Step 4: Reviewing themes

In this step, I reviewed the codes that were identified in step 3. I took note of overarching themes that were occurring in the data, and was able to clearly recognize where codes merged into themes. This step involved a two-level process. At the first level, I reviewed the coded data extracts to ensure that themes formed a coherent pattern (Braun & Clark, 2006). Once I was satisfied, I moved on to the second level, which also involved reviewing the coded data, but this was done in relation to the entire data set. The method that I used to identify my overarching themes was done on the basis of *repetition*, which is the most common method researchers use to identify themes. I did not identify a specific number of times that a theme needed to be repeated in order to be included as a theme; this was left up to my own judgment as it related to my research’s overall analytic

objective (Ryan & Bernard, 2003). Generally, those patterns that were repeated throughout the protocol in response to several different questions were identified as themes.

#### Step 5: Identifying and naming themes

In this step, I named the themes and described them in detail. I considered the story that the themes told me about my data (Braun & Clark, 2006). I had four main themes, each with accompanying subthemes. Subthemes were identified on the basis of repetition, much as the overarching themes. Many of the participants identified issues within the overarching themes that were recurring. My four, overarching themes were:

#### **1. BARRIERS**

#### **2. CONSEQUENCES**

#### **3. COOPERATION IS BENEFICIAL**

#### **4. THERE IS A NEED TO COOPERATE**

**BARRIERS:** This theme describes obstacles, difficulties or impediments that hindered effective cooperative relationships. These could be either physical (i.e. geography, infrastructure, etc) or non-material (attitudes, time, etc). Subthemes included: competition, egos, infrastructure issues, lack of time, lack of resources and rogue groups.

**CONSEQUENCES:** This theme describes the consequences that both can and do occur as a result of not cooperating. Subthemes included: duplication of services, fragmentation, incomplete information, and resource misallocation.



**COOPERATION IS BENEFICIAL:** This theme described the benefits to cooperation, both in theory and in actual instances. Subthemes included those specific benefits of cooperation that participants identified: share information and resources, learning from other organizations, providing better patient care, and maximizing efficiency.

**NEED TO COOPERATE:** This theme described the participants' belief that cooperation among NGOs was needed in Haiti, either by a formal or informal mechanism.

### Social Network Analysis

In addition to the themes that were identified through the interview data, interviews were also used to collect social network data. I gathered this data by asking participants a series of prompts, in which they were asked to list relationships with organizational actors. The social network data was exploratory only, in order to determine whether it could feasibly be done in the context of Haitian NGOs, given the limitations in trying to recruit participants

The first question asked participants to name all NGOs working in maternal and child health in Haiti. This question produced a list of actors by which I could then ask more specific questions that probed the nature of relationships with each actor.

The second question asked participants to identify all organizations with which they work, based on the organizational list that was compiled in response to the first question.

The third question inquired about the type of cooperation that characterized each relationship. Participants were asked to characterize the type of cooperation from the following categories: share information, share resources and/or materials, participate in a joint effort (such as a meeting, workshop, or fundraising initiative) or other type of cooperation not listed. A level of cooperation that emerged from the probing included “referring patients,” so this was added as its own category. Accordingly, there were five categories by which organizations could characterize their cooperative relationships. Participants were not asked to characterize a network; they were simply asked to characterize the nature of their relationship with each identified organizational actor. I used this data to construct the networks in the social network analysis.

A complete list of organizations was listed in an Excel sheet, with the list of organizations horizontally and vertically in the sheet mirroring each other. A separate sheet was made for each level of cooperation: share information, share resources/materials, joint effort, and refer patients. Organizational relationships were represented by either a "0" (no relationship) or a "1" (relationship exists). These results were then imported into UCINET, a social network analysis software package. Measures of reach, density, and degree centrality were run in UCINET, and NetDraw, a UCINET feature that visualizes the networks, was also used to transform the dichotomous data into a network picture.

Reach is a measure of closeness and indicates how close actors are to each other in the social network. The reach closeness sum is less as each actor is further from each other—described as two steps from each other, three steps from each other, and so on (Hanneman & Riddle, 2005). The reach measure was useful in this study because it

illustrated the extent to which all actors are connected to other actors; this measure shows how directly tied each actor is to the other and also shows how many steps an actor has to go through to “reach” another actor.

Density measures how mutually connected a point’s contacts are to one another. A high-density network tells the researcher that many of a point’s contacts are directly connected with each other and are not solely connected through the “ego”, or focal point; a low-density network implies that these connections are much more segmented. Density is measured on a scale of 0 to 1, with 1 representing a 100%, high-density network (Scott, 2012). In this particular research, this measure illustrated the extent to which fragmentation exists in the NGO network under study.

Degree centrality measures the connectedness of members of the social network. It shows who is the most connected, central, or “hub” of the social network. It is analogous to a bicycle wheel (Scott, 2012). This measure resulted in showing who the most central actor in the network is, and which actor maintains the most ties with other actors. Originally, I intended to also use this measure to study any type of power dynamic that might have existed within the network. However, given the lack of strong cooperative networks that emerged, I was unable to use this measure as originally intended.

### Validation Strategies

To ensure data validity in the qualitative research portion, I utilized three approaches. First, methodological triangulation was used. Methodological triangulation, or “mixed methods,” allowed me to explore the existence of current social networks

among NGOs in Haiti by drawing upon various data sources. Triangulation in this sense consists of using more than one type of method to study a phenomenon (Bekhet & Zauszniewski, 2012). In this particular study, methodological triangulation consisted of analyzing the data both by thematic analysis and by social network analysis.

Triangulation allows the opportunity to compare findings for either convergence or divergence (Guest, MacQueen & Namey, 2012; Casey & Murphy, 2009). It is useful for research validity because it confirms findings, provides a more comprehensive set(s) of data, and enhances the understanding of the phenomenon being studied (Bekhet & Zauszniewski, 2012). Triangulation has been noted to have some limitations, but there are various ways in which to overcome these issues. The use of a well-focused and clear research question is imperative, as is the rationale for using triangulation (Casey & Murphy, 2009). In this particular study, triangulation allowed me to confirm various aspects of my data. For example, from my interview data, I gathered from participants that there were generally low levels of cooperation in Haiti. The social network analysis confirmed this finding. The social network analysis also provided the opportunity to visualize the data that was given in personal interviews, and the measures used in the SNA provided quantitative results to complement the qualitative results.

I also used the qualitative research analysis method of “member checks” as an additional measure of validity. Member checks, or respondent validation, ensure that researchers are correctly analyzing the data; they confirm that researcher understandings align with participant intentions (Sandelowski, 2008). Member checks ask participants to give feedback and evaluate whether researchers accurately described the experiences that the participant discussed; this is known as descriptive validity (Sandelowski, 2008).

Member checks were appropriate for this particular study specifically because I did not attempt to discern any type of hidden meaning in the data; therefore, it actually behooved me to use member checks. Member checks in this manner are important in qualitative research, as they provide a certain “quality control” by decreasing the incidence of incorrect data and help to ensure that the overall findings are authentic (Harper & Cole, 2012). As I gathered qualitative data on what does or does not occur regarding cooperation between NGOs, the participant him/herself was in the best position to validate the data that was given. The use of member checks gives the participant the opportunity to correct and/or clarify any data that is given, which assists in ensuring data validity.

Formal member checks were conducted with two key informants. I provided the key informants with a summary of the main themes that emerged from our conversation. I also gave the informants the option to review the transcript if desired; I did this in order to give participants a choice—dubbed “participatory member checking,” (Doyle, 2007, p. 908), it offers participants an opportunity to choose how they will validate their own words. Member checking was important in this research because one of the key informants was able to explain her interpretation of one of my findings a bit further to add clarity. For example, one of my first main summary points in the first member check was

*“Overall, there are many NGOs in Haiti, some registered and non-registered. While there are advantages to being non-registered, one of the significant disadvantages is that there is no sense of community.”*

The participant clarified that while there was lack of community among all NGOs, both registered and non-registered, being unregistered meant that people were not accountable to country leaders or others in the same field of work, which led to isolation and no sense of community.

Finally, I utilized inter-coder agreement for the coding validity of my qualitative data. The type of inter-coder agreement method that was used was the "percent agreement" method. Percent agreement is calculated by dividing total number of times analysts' coding is in agreement by the total number of code comparisons" (Guest, MacQueen & Namey, 2012, p. 89). An agreement of 80% or more is considered to be a "good" rating (Guest, MacQueen & Namey, 2012). In this particular research, the percent agreement score was 77% for the first transcript and 75% for the second transcript. Although this was not 80%, it is still in the acceptable range.

In summary, data collection methods included website organizational information gathering and semi-structured interviews. This mixed-methods approach allowed for data triangulation, whereby results and conclusions could be verified. The interview data was analyzed using both thematic analysis and social network analysis. The following chapters will detail the results of the thematic analysis (Chapter 3) and the social network analysis (Chapter 4). The concluding chapter will discuss how the overall findings can be used to inform policy and to encourage collective action.

## CHAPTER 3 THEMATIC ANALYSIS RESULTS

The results of the thematic analysis yielded four overarching themes: *Cooperation is Beneficial*, *Barriers*, *Consequences*, and *Cooperation is Needed*. Each overarching theme also had various subthemes. The results are organized by first discussing that cooperation was overwhelmingly found to be beneficial and participants identified several reasons why this was so. Second, while participants described the overwhelming benefits that cooperation afforded, they also recognized the barriers that hindered effective cooperation. Third, even though participants did identify multiple barriers, there were often consequences to not cooperating, both actual and implied. Finally, participants recognized the overwhelming need to cooperate in Haiti.

### **1. Cooperation is Beneficial**

Overwhelmingly, participants described cooperation as extremely beneficial to not just the individual organizations, but to patients and the overall population. Thirteen participants (76%) stated that their organizations currently engaged in cooperative efforts with other organizations that were also working in some aspect of maternal and child health. Between these 13 participants, there were a total of 56 identified cooperative relationships with and between organizations. These cooperative relationships show up in the social network analysis, but the networks are generally separate and distinct; i.e., many of them are silo-like in nature. Of these 56 cooperative relationships, participants described 51 of them as "beneficial." Four sub-themes emerged in this category. Participants described cooperation as beneficial for four main reasons: the opportunity to

**share information and resources, learning from other organizations, providing better patient care, and maximizing efficiency.** Many participants could give specific examples of when cooperative efforts resulted in these beneficial outcomes.

### **1.1 Share information and resources**

The opportunity to share information and resources was commonly cited as a benefit of cooperation. Of the 56 identified cooperative relationships, 45 of these relationships shared information and 33 of these relationships shared resources and materials. More than one participant stated that the collaborative relationships that shared information and resources resulted in reducing resource inefficiencies and also provided fewer instances where services might be duplicated. When asked specifically if the various partnerships and collaborative efforts were beneficial, eight participants provided examples where sharing information and/or resources had benefitted either the organization or the organization's mission:

*"The biggest benefit with [Organization X] is that they have so many more resources...They ...give a lot of supplies. There's never enough. There's never enough gloves, I mean midwives are doing deliveries without gloves sometimes. But I would say that without their presence and resources...it would be really, really difficult for us to stay. So they are throwing money at us and we are glad they are."*

Multiple participants reported having the opportunity to collaborate on various occasions, usually through attending an inter-agency meeting or forum, and most participants found those efforts beneficial. However, not all participants found collaboration opportunities beneficial, as either things were not accomplished or "collaboration" actually masqueraded as something else:



*"Usually [when people approach me for a collaboration opportunity], they're looking for resources, not collaboration. Not like you're going to share something. They look for resources from me. But every little NGO is struggling for resources so you really can't do that."*

While overall cooperation opportunities were seen as beneficial, it was noted that not all opportunities produced fruitful outcomes. Overall, however, sharing information and resources benefitted organizational missions, patients and communities at large.

## **1.2 Learning from other organizations**

Participants also cited the opportunity to learn from other organizations as an important benefit of cooperation. Six of the thirteen participants (46%) that have established partnerships cited learning from other organizations as a specific benefit of cooperation. These participants often cited the "expertise" of other organizations as a benefit that helped them to improve their own organizational programs:

*"I would say [it has been beneficial] because they have more expertise than we do and they have more experience. They are aware of other resources like a maternity hospital that is available for emergency maternity care. They have helped us delineate what is an emergency and what's not on a couple of occasions."*

As one participant stated, cooperating and learning from other organizations allows the opportunity to not "*reinvent the wheel*" which ultimately maximizes efficiency.

### **1.3 Providing better patient care**

Cooperation also enabled participants to provide better patient care. Often, participants cited that this was the case because organizations with which there were established partnerships could provide complementary services or provide services that some organizations could not. Eight participants (50%) cited providing better patient care as a benefit of cooperation. Four of the 13 participants who have established partnerships (31%) could give specific instances where collaborating had resulted in providing better patient care. One participant, whose organization runs a primary care clinic, shared a story about the high prevalence of malnutrition in the catchment area. Knowing that the clinic itself could not provide the needed services to address the malnutrition, she and other staff members partnered with an organization whose sole mission was to address malnutrition. Of the outcome, she stated:

*"[It was] absolutely [beneficial]...We needed to do something immediately...The program was already in place...they have been wonderful."*

Clinics in Haiti, particularly primary care clinics, cannot always provide the level of services that some of the more acutely sick people need. Partnerships have allowed multiple participant organizations to expand the level of care that patients need and adequately address various medical issues.

### **1.4 Maximizing efficiency**

Seven participants (41%) identified maximizing efficiency as a benefit to cooperation. Cooperation provided the opportunity to build capacity and provide services to the population while minimizing waste. One organization was able to rapidly scale up

after the 2010 earthquake as a result of partnering with an organization that was already present in the community and had deep knowledge of the area and local population:

*"...right after the earthquake, we were able to scale up our emergency response much more quickly than we would have been able to had we not partnered with [Organization Y], due to the large network of community health workers that they work with."*

Participants also discussed how operations and programs were able to expand due to existing relationships that partners had. Having partners that had established relationships in place allowed for a better opportunity to expand program services:

*"They had a presence in the community so it was a good way to branch out through that network."*

Finally, overall capacity building was another specific example given in how partnering can maximize efficiency:

*"Not to mention the capacity building. To come and train up nurses and to train our community health workers on deworming, immunizations, iron deficiency anemia, malnutrition."*

Overall, participants felt that without some of the partnerships that they had built and established, that organizational programs and outcomes would not be as strong nor as effective as they are currently. Even though there were multiple benefits that resulted from cooperation, participants did recognize that substantial barriers existed that hindered cooperation from occurring.

## 2. Barriers

"Barriers" was a common theme throughout the project. The difficulty inherent in collective action was expressed through mention of **barriers**, both explicitly identified and told through personal stories of failed cooperation or opportunities to cooperate that ultimately did not occur.

Participants stated that they thought cooperation was difficult, mainly in part due to the many barriers that existed. Interviewees identified many barriers to cooperation that hindered effective collective action, which constituted several subthemes: *competition, egos, infrastructure, time, rogue groups* and *lack of resources*. The results from each identified subtheme is discussed below.

From a review of the literature, it was believed that competition would be a significant identified barrier for effective cooperation, as this has been identified as a barrier to effective cooperation among NGOs. Therefore, several questions were designed to elicit this potential theme. While one question specifically asked about barriers, where participants were given the opportunity to identify competition as a barrier, another question asked specifically, "Do you feel that an environment of competition between NGOs in Haiti?" If the answer was affirmative, participants then were asked to give more detail and to identify specific areas in which organizations compete (services, funding, results/achievements). Further, participants were also asked to outline in detail specific times when cooperation may have been beneficial but did not occur, as well as specific instances where cooperation was the intention but it failed. This was an opportunity for participants to exemplify, with anecdotes, specific barriers that were identified to effective cooperation.

## 2.1 Competition

When specifically asked about barriers to cooperation, *competition* was the most common barrier identified. A total of 11 out of 17 (65%) participants identified *competition* as a major barrier to cooperation. NGOs compete for funding, particularly as it has become much more scarce after a spike in available funding following the 2010 earthquake in the Port au Prince area. Several participants mentioned the desire for NGOs to receive "full credit" for projects and success stories, particularly because this could result in increased funding. The very nature of the funding environment renders it competitive (i.e., if one organization receives funding, that is at the expense of other organizations not receiving that same potential funding). The threat of losing funding was a common theme throughout participant narratives that discussed competition. As one participant stated:

*"With NGOs, everybody is vying for the same dollar. We are all trying to raise money for our interests, so to speak. I think people get really possessive when it comes to partnerships and money and that hinders working together."*

*Competition* was expressed in personal stories of failed cooperation efforts:

*"...we had the issue of them coming in wanting to do their part in the community and ignoring that another NGO had been working there, instead of coming and asking how they could partner. You see this a lot in Haiti...they are competing for territory because the territory means more population served and eventually more funding."*

The theme of competition was not surprising, as this has been identified in previous literature as a common issue in the NGO environment. Participants repeatedly mentioned competition throughout the interview, and when they were specifically asked if they believed there was an environment of competition among NGOs in Haiti, 15 of 17

participants believed that there was competition among NGOs. Given how important competition was a barrier was, participants also mentioned "egos" being a barrier, as egos often accompany a competitive nature.

### **2.1.1 Egos**

One way in which competition was commonly expressed was mention of *egos*. *Egos* were often identified in tandem with *competition*. Six of the 11 participants who identified *competition* as a barrier also stated *egos* were a barrier. Participants described other organizations as both lacking flexibility and the desire to learn from others who might be approaching issues in a different, or sometimes better, manner:

*"I think peoples' egos is a barrier...People just think they know what is best and they don't need help, they are doing the best in Haiti, they are the only ones."*

Some participants believe that many NGOs think they "know what is best" and this can impede effective cooperation. One interviewee discussed a personal story of failed cooperation that resulted from this belief:

*"When we do the joint training with the other organization, there was a third organization involved in it initially and we had wanted to do a three-way joint training but the third organization was adamant about doing it one way and the other two of us didn't feel that it was appropriate."*

Participants generally believed that NGO ownership for projects, results and accompanying successes impeded cooperation, and that egos kept organizations from effectively working together.

## 2.2 Infrastructure issues

*Infrastructure issues* was another barrier that was commonly mentioned. Eight of 17 participants (47%) cited infrastructure as a barrier to cooperation. The infrastructure environment in Haiti is often challenging, with poor roads, inadequate transportation, communication issues, and distance identified as specific infrastructural issues that impede effective cooperation. Electricity is often intermittent, and cell phone service can often be unreliable, particularly in the rural areas. Roads can be rough and unpaved, and can easily wash out when heavy rains occur, which further impedes travel. As one participant stated:

*"...collaborating is so difficult because of the roads. Because of the electricity, it isn't always good so you don't always have phones...transportation is an issue...a lot of infrastructure issues."*

One participant specifically stated that distance was the reason why a particular cooperative effort with another organization had not been a beneficial endeavor:

*"With this particular organization, I think it's just because...the distance is far. It's further than the other places."*

These infrastructural issues can render collaboration difficult, as a simple phone call or attending a forum or meeting can often be infeasible, thus adding additional layers to the inherent difficulties that already exist in effective cooperation.

## 2.3 Lack of time

*Lack of time* was yet another barrier that was identified by multiple participants (six out of 17, or 35%) as a barrier that hinders cooperation. Many NGOs are under-

resourced, particularly smaller NGOs, and finding adequate time to network and meet with others can be difficult:

*"It takes a lot of time to sit down with these organizations and then they have to go back to their board and pass through these other people...everyone is overworked."*

This sense of lack of time was mentioned multiple times in various interviews as to why cooperation between NGOs did not occur more often.

## **2.4 Lack of resources**

*Lack of resources* also was commonly expressed by participants (six out of 17, or 35%). As mentioned above, many NGOs in Haiti have difficulty in obtaining the necessary resources to fully accomplish their missions:

*"We have been painted this picture that there are billions of dollars being poured into the charitable sector in Haiti...but...that still misses the point that despite all those NGOs and all those resources...there are still huge unmet needs. So when you want more resources and the other organization that you collaborate with is also under-resourced...it's hard to again see a value in getting yourselves together because it's just an underequipped sector."*

One story of failed cooperation exemplified how lack of resources was an impediment to successful cooperation:

*"We had several cooperative efforts...that have fallen through. For a period of time we stopped delivering babies [at our facility] because there was a new delivery ward that was donated and built after the earthquake. It was a beautiful building but they didn't have the staff and the midwives to operate it. So we supplied the midwives which meant we couldn't then do deliveries but we thought we would combine forces. We moved our staff over there and closed our doors for deliveries. It just didn't work out...[we lack] the resources it takes to make something happen. Oftentimes we think narrowly about a problem. It takes something very broad to keep it going. You might buy an ambulance for somebody and you're going to share the ambulance but can you keep the*



*ambulance going, do you have all the spare parts, the mechanic and everything else it's going to take for long range planning."*

Lack of financial capital and lack of human capital were common reasons identified by participants as barriers to effective cooperation.

## **2.5 Rogue Groups**

The idea of *rogue groups* was expressed by six participants (35%). Rogue groups refer to people or organizations who come to Haiti to deliver care, but do so without consulting local population needs or desires. As one participant stated:

*"I also personally feel that the proximity to the U.S. and the decades of "missionary" groups has exponentially increased the number of organizations "doing their own thing"--not really taking into consideration the needs or desires of the communities where they work."*

Participants described rogue groups with terms like "renegade," "do it yourself" and "single mindedness." Participants discussed how rogue groups have a mindset that they must be some of the first people who are addressing the issue or issues in Haiti, and a false sense of knowing what is best for approaching a particular problem. One participant shared his thoughts on groups who continue to visit Haiti without having done any research into the local community needs:

*"...you ride on an airplane and it seems like you meet people at the airport who are going to Haiti for a second or third time and they're going down to tackle this problem, build a school, start a clinic. You don't have to ask very many questions about what foundational research have they done. Have they done house to house surveys to find out where people are going to get their vaccinations? Or going to deliver their babies? People aren't really doing the work ahead of time to know what the need is. They go in and do it in a silo."*

Participants felt that this "do it yourself" spirit does not lend itself to effective cooperation, particularly as there is a lack of organization, and, as one participant stated, "dysfunction."

Even though substantial barriers exist that make cooperation difficult, participants did acknowledge that lack of cooperation has consequences.

### **3. CONSEQUENCES**

As is consistent with the literature, there are common consequences to not cooperating: duplication of services, fragmentation, incomplete information, and resource misallocation. Many participants could identify personal stories that exhibited each of these consequences, illustrating that not only are these "perceived" issues, they also occur in reality.

#### **3.1 Duplication of services**

A total of twelve (70%) participants told personal stories of duplication of services that occurred. This commonly occurs in Haiti, due to multiple reasons, but one dominant reason is that with the Haitian population, people will often go to where care is free, even if it is duplicated care. This can be problematic, particularly when there are visiting medical mission teams that visit the areas where some of these NGOs are located:

*"...you have this patient who has been your patient for a while, but then they are going to this mobile clinic and they are telling the foreigners that they have hypertension. They are already getting the medicine from us and then they got medication from this other team too. So you don't know how the medications will interact and what they will do. You are duplicating services but you are also putting the patients at risk."*

Lack of adequate record keeping in Haiti means that there will often be patients who visit multiple places, but there is no information on what services were received:

*"Mothers will come to [us] and they will have had three or four prenatal visits at three or four different sites. And they may have had two or three clinic visits because they felt ill and went in to see a doctor here or there."*

One participant did discuss how cooperating resulted in two organizations not duplicating services, as they were able to meet and discuss which services each would offer to have maximum population health impact:

*"...[they were] gung-ho about providing every service...that you could imagine. Pediatrics, geriatrics, surgery, etc. They asked us for help and we said you're actually going to be duplicating some of our services, which is not fruitful and we will suffer financial strain very quickly. Why don't you concentrate on one thing and do that one thing well, which is pediatrics...they said that sounds like a great idea. They kept their end of the bargain and they added some additional services that we don't have, like dentistry."*

Clearly, this is an example of how effective cooperation can positively impact the community and overall population health.

### **3.2 Fragmentation**

A total of eleven participants (65%) had experiences with fragmentation occurring, particularly in the areas of service delivery and care. The definition of being fragmented is "existing or functioning as though broken into separate parts; disorganized" (Oxford Dictionary, n.d.) Fragmentation in health care refers to services that are not cohesive; they might occur separately and service providers therefore see only parts without being able to piece those parts into the overall "whole" health picture (Stange, 2009). Similar to one of the main issues involved with "duplication of services," Haitians

will often go from provider to provider for services; while there may not necessarily be duplication of services, the lack of understanding the patient's medical history and provider visit history can be problematic, particularly when working with a population that is overwhelmingly uneducated. The lack of cooperation means there is no clear history of services, and the "whole" health picture cannot be obtained. One participant stated:

*"...they have scraps of paper from each of these different places that are incomplete and often they're not very authentic. It looks like it was scratched on a piece of paper. It doesn't look like a medical record. You don't know the quality of care they've had, you don't know their background, and no they're coming to deliver a baby. So you really have a poor fragmented history."*

Fragmentation also occurs within the entire spectrum of NGO health services, not just maternal health. One participant described the lack of an understanding of "comprehensive care" in the Haitian population, as well as a lack of comprehensive care services that are available in the country:

*"...especially in maternal health. There were pieces of it being done in different places on the island but the women had no idea where they went...They know what a c-section costs and where to get an ultrasound but there was no comprehensive care notion in their minds. So fragmentation from that standpoint-a fragmentation of service delivery and education."*

Another participant described the lack of coverage in certain areas of the country that may be more difficult to work in effectively.

*"Organizations...come to the same spots and leave other spots uncovered. The consequence is lack of coverage...NGOs have an affinity for some areas. Some areas are easier to work in than others. The most challenging areas, people don't go there."*

Yet a third participant described the lack of communication between organizations resulting in fragmented care:

*"...if I need to refer a patient who has a problem with their eye, I need to send them to an eye clinic. But I can't get ahold of someone in the eye clinic, and all I have is an address, and there is no other contact information. I try to send the patient and I'm trying to cooperate with that clinic but that patient goes and it's not a day they work. Or they need to call first...They travelled two hours...but because there wasn't good communication between the two institutions, the patient isn't getting the care when they need to get it."*

Fragmentation clearly can negatively impact patient care and health outcomes.

### **3.3 Incomplete Information**

A total of eight participants (47%) could identify instances where incomplete information resulted from lack of cooperation. This often accompanies "duplication of services." Often, patients will come to an organization's clinic and those patients have been seen elsewhere, but there is no or incomplete information on what services were provided, what prescription drugs may have been given, or what a diagnoses may have been. Sometimes, this incomplete information can be fatal, as was evidenced in one participant's story:

*"...an 18-month old child...had been taken to a hospital...which is known for pretty darn poor care...[the parents and child] left against medical advice...I looked at the child, listened to his chest and said 'This child has pneumonia, let's start him on an antibiotic'...I left the country on Friday and before I got home, the child died...I wrote the ED of the organization funding the hospital...supposedly there is more to the story than we were told...the kid was given an IV, put on antibiotics, given oxygen...We have all this miscommunication, who knows whatever really happened to this poor family...I'm not even convinced the kid was 18 months old...Did I misdiagnose because I was told he was 18 months and he was only eight months? There is a big difference between a child who is eight months and 18 months and how that child can handle pneumonia."*

Incomplete information can also affect the quality of care that patients receive, particularly if there is a need to coordinate specialty services during a time period that a surgical team might be visiting. One participant told a story of incomplete information resulting in ten patients not receiving surgery when a team was visiting. Overall, participants agreed that incomplete information was an issue related to both lack of cooperation and low health literacy among the Haitian population.

### **3.4 Resource Misallocation**

Seven participants (41%) could identify instances where resource misallocation (where resources are being used or distributed in ways that are not optimal) occurred. Most often, this was seen in how resources were not evenly distributed and therefore could not be used before an expiration date, as was the case in an instance where a large shipment of vitamins was received. The donor could use some of the resources, but not all:

*"Resource misallocation. We are guilty of this ourselves. I was in Haiti last year and a truck pulls up and they were unloading boxes for like two hours. This was a fairly small building, what's in all those boxes? They were vitamins. Some organizations wanted to donate vitamins and they sent a whole truck full. These things are going to expire. Then we had to figure out what other healthcare programs we could give them to."*

Another participant stated that without cooperation, often times resources can go to waste:

*"With medications, they might expire. When you have excess supply of medicine, they would be wasted if you do not have collaboration with other organizations that could utilize them."*

Similarly echoed by another participant:

*"Resource allocation is always an issue when you get a call from an organization and they'll say, 'I've got XY and Z' and they didn't realize it but they just reached their expiration date, could you use this stuff? And it's like, um, you could have called me three months ago. Allocation of resources is always important."*

Lack of cooperation can contribute to resource misallocation, because, as one participant mentioned, not having established cooperative relationships with other organizations can result in waste when one might otherwise be able to donate resources that cannot be effectively used.

#### **4. NEED TO COOPERATE**

Overwhelmingly, participants agreed that there is a strong need for NGOs to cooperate in Haiti. When asked if cooperation should be required by donor agencies as a condition of receiving funding, 14 of 17 participants (82%) stated "yes." However, most of these participants did stipulate that it would depend on the situation and what type of collaboration was required:

*"It would depend on the situation. I think there are situations where it would be beneficial, but there are other situations where it would not be beneficial or appropriate. If you mandated that I meet with people who work in Cap Haitien once a week [from Port au Prince], I would laugh at them and say keep your money because I can't do it."*

Similarly, when asked if cooperation should be required by the Haitian government, 14 of 17 participants (82%) agreed that it should be required by the government. Most participants felt that the government did not do enough to regulate NGOs and that the government should put more effort into doing so. However, it was

acknowledged that the capacity of the government to do so was minimal, as the government currently has very weak enforcement mechanisms. Therefore, the seriousness with which it would be perceived was questionable:

*"With all due respect, I think a lot of people would consider it a bit of a joke because of the reputation that the Haitian government has for doing things more poorly than a lot of the private sector, the NGOs. This leads to other organizations not wanting them involved. They feel that working with the Haitian government slows the process down without benefitting it. So I think that there wouldn't be initially a lot of respect for it and yet I don't know if it's a bad idea because ultimately to see a stronger Haiti you need a stronger Haitian government who is going to be active in improving the health and social service sector."*

It was brought to my attention that there is, indeed, a governmental coordinating body in Haiti whose sole purpose is to coordinate the work of NGOs. L'Unité de Coordination des Activités des ONG (UCAONG), or the NGO Activity Coordination Unit, is responsible to "...guide, approve, coordinate, promote, supervise and monitor NGO initiatives across the country" (Ministère de la Planification et de la Coopération Externe, 2014). However, it must be noted that this unit is only responsible for supervising and coordinating those NGOs in the country that are registered with the government. Haiti has thousands of NGOs (it is estimated that the country has 10,000) but not all are registered with the government. The latest list of registered NGOs that was able to be found was from 2012, and that list named only 461 NGOs that were officially registered with the government (Haitian Resource Development Foundation, 2012). Of the participants that were interviewed for this research, only two organizations were currently registered with the government. One of these participants shared that upon becoming officially registered with the Haitian government, his organization received an email from UCAONG inviting two representatives to give a presentation at their



government office, but that there had been no formal interaction with UCAONG since that time several years ago. The other participant whose organization was registered shared her frustrations of working with the unit:

*"You have to have an accountant that is affiliated with the DF and those accountants ask for a standard 10 to 20 percent [of our annual budget]. So now we are like what is the point of getting NGO status. It doesn't even make you tax exempt and it just makes you more known so that they can get money from you."*

Only three participants had actually heard of UCAONG. Registering with the government is seen as a cumbersome process, it is often confusing, and clearly there was not a full understanding of what agencies were involved with NGO coordination and oversight. All participants were aware of the need to register with the Haitian government, but very few had actually heard of UCAONG. Though almost all participants who were not registered with the government stated that they were currently in the process of becoming registered, the general sentiment was that becoming registered with the government was difficult, costly and did not particularly bring any additional benefits:

*"They collect a lot of taxes and fees, but don't offer much guidance and coordination. When I first heard about them, I thought they were going to better monitor NGOs and help them be compliant. They were also supposed to coordinate those in like fields (medical, education, orphan care, etc). They might be doing it some, but not much and not enough for it to have any effect or second thought from a foreigner."*

The overall consensus from participants was that there is a strong need for cooperation in Haiti, but that the current mechanisms that encourage cooperation did not have much effect on the level of cooperation that is taking place. This was evident, since most participants were not even aware of UCAONG.

Finally, all 17 participants believed that there should be a coordinating mechanism through which all NGOs can share information. The general consensus was that this could best be done through an online forum, where information can be shared and ideas solicited.

## **5. EARTHQUAKE AS A RELATIONSHIP MARKER**

Another theme that emerged during coding was the demarcation of what Haiti NGO activity was like "before the earthquake" and "after the earthquake." Haiti experienced a devastating earthquake in January 2010 that killed over 200,000 people and displaced millions. Four participants classified NGO activity in terms of "before the earthquake" and "after the earthquake." This was a clear marker in time of what NGO activity looked like in Haiti.

Even though one of the protocol questions asked about cooperation during the earthquake, the clear demarcation of "before" and "after" the earthquake appeared in various reference forms throughout the interviews. NGO activity before the earthquake was seen as "good" activity, as many of the NGOs had been operating for a significant period of time, were familiar with the country, and could work effectively. As one participant described:

*"The earthquake was a huge factor...the number of NGOs here, the number of foreigners here, the type of foreigners here. Everything changed after the earthquake. We have been here since 1994. We had many years to know what it was like. The earthquake was the turning point that flipped all of NGO Haiti..."*

The earthquake was a marker of an influx of NGOs that, while initially helpful in terms of disaster relief, have not been effective in the long run. As one participant stated:

*"It was this huge influx of NGOs and everybody was doing their own thing [when the earthquake occurred]. It was good up front because we needed all the help we could get as far as emergency disaster relief...[but] they stayed too long and didn't have a good exit strategy for Haiti. They disrupted the long term medical care...sometimes people stay longer than they need to and they disrupt the system."*

There were attempts at cooperating, as the World Health Organization would hold cluster meetings (where NGOs working in particular sectors would come together to share information), and while they may have been somewhat helpful at the time, the cluster meetings have continued without significant results. Trying to continue the cluster meetings indefinitely did not necessarily yield fruitful results:

*"There is a Ministry of Health nutrition cluster meeting. It's in Port au Prince every month and it's all the nutrition partners from around the country...everyone just basically goes around and reads off numbers and no one listens. Everyone presents data that is not correct...Nothing really gets accomplished there."*

The earthquake was also seen as a turning point in how organizations interacted with each other. Some participants did not feel that there was much competition until the earthquake occurred. As one participant stated:

*"After the earthquake, people really came together a lot better because everyone was massively stressed and it was horrible. Everyone cooperated a lot more and then when the sun started going down then everyone starts bickering more. It's more of a competition because they are competing for funds because funds are so low."*

Another participant echoed the belief that the "after the earthquake" environment resulted in more competition:

*"There was a huge influx of money coming into Haiti after the earthquake. They were practically handing it out like candy. NGOs got used to this, and over the last two years, the funding has drastically dropped off as Haiti is no longer on the "emergency/disaster" global radar...this drop in available funding has caused a respective increase in competition of organizations--holding onto their ideas, approaches to remain "innovative." So ultimately, they want to hang onto their successful ideas which could benefit so many people [and these ideas] are not shared with other organizations."*

The earthquake had an effect on not only NGO activity, but in many ways, increased competition among NGOs. Competition was identified as a main barrier to effective cooperation, and the earthquake exacerbated this barrier.

This portion of the research (semi-structured interviews and ensuing thematic analysis) produced valuable information that was helpful in understanding how participants talked about, perceived and described cooperation between NGOs. This is important information to know, as analyzing how participants talk about collective action in the provision of public goods (health) can help to foster a greater understanding of how collective action is occurring, barriers to effective collective action, and examples of successful collective action; all of these, in turn, inform future strategies for improving collective action.

### **Limitations**

While the thematic analysis on the qualitative interview data was indeed valuable in terms of yielding important information, it should be noted that there was a significant limitation: the qualitative data in this particular research did not allow for networks to be visualized. In other words, I could understand how participants perceived and talked about collective action, but I could not gain a solid understanding of what particular collective action networks (if there were any) existed. For this reason, I conducted a

social network analysis, so that I could visualize and quantify potential existing networks.

This social network analysis is detailed in Chapter 4.

## CHAPTER 4 SOCIAL NETWORK ANALYSIS: KUMBAYA AROUND THE CAMPFIRE OR WORKING IN SILOS?

Chapter 3 presented the results of the thematic analysis. This chapter presents the results of the social network analysis. First, however, it is useful to briefly discuss the levels of cooperation that were assessed and how they were operationalized. Koch (2011) operationalized cooperation at three levels, with Level I being the lowest level and accruing the least number of benefits for the collective group but high individual benefits for the NGO, and Level III resulting in high benefits for the overall group but low benefits for individual NGOs. In line with my hypothesis that low levels of cooperation were occurring among NGOs, it was inappropriate to apply Koch's levels of cooperation, as Koch operationalized the lowest level of cooperation as consisting of a joint effort. Therefore, for the purposes of this study, levels of cooperation were broken down into three main categories:

- Type I: Share Information (Coordination)
- Type II: Share Resources/Materials
- Type III: Participate in a Joint Effort

Type I was actually classified as typical “coordination,” as information sharing essentially seeks to coordinate efforts based on available data.

As described in the Methodology chapter, in order to conduct the social network analysis, participants were asked to characterize their cooperative relationships with other organizational actors. As listed above, cooperative categories were as follows: share information, share resources and/or materials, participate in a joint effort, refer patients, or other. Recall that the "refer patients" category arose during the interview process as

one that should be included, as many organizations engaged in this type of relationship, although this relationship was not always reciprocal.

Participants could also choose "Other" if cooperation efforts did not fit any of the above categories. Each ascending type of cooperation resulted in a higher degree of cooperation; i.e., "Share information" was theorized to be the level of cooperation that required the least effort, while "Participate in a joint effort" was theorized to require the highest level of effort. A fourth category that emerged during the study, though it was not categorized into a level, was "refer patients."

The information collected in this stage allowed for the creation of matrices that were then used to calculate several social network analysis measures: degree centrality, reach and density. All of these calculations provide insight into the networks and their interconnectedness.

In the following section, I will discuss the results of the social network analysis calculations.

### **Degree Centrality**

The measure of degree centrality is an important measure because it shows the relative advantaged position that some actors may have in relationship to others. Actors that have many ties may have access to and be able to cull more resources from the entire network as a whole. It is important, however, to distinguish between an actor's "in degree" and "out degree" centrality measure. An actor who receives many ties, or has a high "in degree" score, can be viewed as prominent in the network or be an actor with high prestige. In other words, this actor may be seen as one who is very important in the

network, as the high number of received ties indicates that many other actors may seek out that particular actor. In contrast, actors with a high number of "out degree" ties indicates that actor is able to exchange with many other actors, or might be able to impress his or her views on many others. These types of actors are said to be influential actors (Hanneman & Riddle, 2005).

Central actors have the most ties to other actors in the network. In a simple network graph that resembles a circle, all actors have one tie to another actor, as each actor is perfectly situated around the entire circle. Because each actor is positioned around the circle with no more than one tie to another actor, no actor is the most central in the network. In this type of network, all actors would have low degree centrality. In a simple network graph that resembles a star, one actor will have ties to all other actors, and these other actors will only have one tie to the central actor (Wasserman & Faust, 1994). In this type of network, one actor is considered central (and therefore would have high degree centrality) and the other actors are not considered central (and therefore would have low degree centrality).

Degree centrality was calculated in UCINET for each level of cooperation: Sharing information, Sharing resources/materials, Joint effort, and Referring patients. Only those actors with number of in-ties and/or out-ties of one or greater are included in the table. This is because of the entire network that was developed, many actors had no in-ties or out-ties (as they were only identified and not interviewed), and therefore these isolates could not be fully incorporated into the analysis. It is important to note here that my research is biased towards those who are actually cooperating; many organizations identified may not be actually cooperating with others, and while they may be interesting



and noteworthy as social isolates, for purposes of this study, they were not included. My social network analysis findings are conservative findings, because I am only including those organizations that report cooperating with others. Further, as I was unable to conduct a whole social network analysis due to limited participants, results should be interpreted as exploratory.

Actors who reported sharing information "Sharing information", (Table 5-1), which correlated to Type I cooperation, had 42 total out-ties and 41 total in-ties. Figure 5-1 displays the UCINET NetDraw visualization of the network for actors who report sharing information.

Actors who report sharing resources (Table 5-2) had 32 out-ties and 32 in-ties. Sharing resources, which was categorized to correlate to Type II cooperation, exhibited a similar pattern as sharing information (Type I), which showed rather dispersed networks (Figure 5-2), with one network exhibiting a perfect "star" design (where one central actor has ties to all other actors). However, Type II cooperation (sharing resources) had fewer ties than Type I cooperation (sharing information), which was expected given that Type II indicates a higher degree of cooperative effort.

Joint effort, which was categorized as a Type III cooperative effort, had the lowest number of ties--14 out-ties and seven in-ties (Table 5-3), which is consistent with the theory that each increasing level of cooperation will result in fewer cooperative efforts. The social network visualization was less dense than the other two levels of cooperation (Figure 5-3), which is consistent with the theory that ascending types of cooperation will result in fewer ties.

The cooperation type of “refer patients” had a total of 16 out-ties and 15 in-ties (Table 5-4). While referring patients was not placed into its own cooperative category, it does indicate a level of cooperation among actors. When this network was visualized in UCINET (Figure 5-4), it did show that organizations had a fair level of cooperation in this category.

### **Analysis**

A clear pattern for degree centrality emerged in the social network analysis. As each cooperative level increased (from Type I to Type III), the number of cooperative efforts, or ties, decreased, which is consistent with Koch's (2011) theory that as cooperation requires more effort, cooperative relationships will decrease. A gradient was observed throughout the levels of cooperation, with decreasing number of ties as the cooperative level increased. This can be seen by the number of in-ties and out-ties; as the level of cooperation increased, both in-ties and out-ties decreased. Share information, which was categorized as a Type I cooperative effort, had the highest number of in-ties (42) and out-ties (41). Joint effort, which was categorized as a Type III cooperative effort, had the lowest number of ties--14 out-ties and seven in-ties. This is consistent with Koch's (2011) assertion that each level of increasing cooperation will result in fewer cooperative efforts, as it becomes considerably more difficult to cooperate effectively. Type I cooperation (which was actually labelled as “coordination”) exemplified “staying out of each others’ way.” Less communication is involved in a coordination effort than in a cooperation effort. While this data should not be interpreted with finality, due to sample size limitations, it does exhibit the expected pattern that Koch (2011) describes.

In analyzing the data from Table 5-1 it is noticeable that most actors do not share information with many other organizations working in maternal and child health with the exception of Actors 4, 11 and 68. As exemplified in the visualization of the "Sharing information" network (Figure 5-1), there are small clusters of networks, but they are separate and distinct from one another. This holds true for other visualizations (Figure 5-2: Share resources/materials and Figure 5-3: Joint effort); there are small clusters of networks, but they are separate and distinct from one another, and the number of ties decrease as the level of cooperation increases. These visualizations also show that the number of actors in the networks decrease as the level of cooperation increases.

Actor 68 is worthy of some additional commentary. This actor formed a network of birthing centers; that is, the intent of the organization was to create its own network. which explains why this actor has the highest number of ties for information sharing, sharing resources/materials and joint effort. The nature of forming a network would indicate that effort would be put into having as many established, cooperative relationships as possible at various levels of cooperation. What is interesting to note is that, even though Actor 68 does exist to form a network, Koch's (2011) theories still hold true throughout each level of cooperation. Actor 68's ties decrease as the level of cooperation increases.

Based on the above degree centrality information for each level of cooperation, it can be said that there are no highly prestigious or prominent actors in the network, with the exception of Actor 68. Some actors exhibited a high number of ties relative to the others, but these actors were generally central within their own network; in other words, networks were generally separate and distinct. In the context of this exploratory social

network analysis, Actor 68 can be said to potentially have a fair amount of influence on its network, as it exhibits the highest number of out-ties for sharing information, sharing resources and joint effort. Given that Actor 68's network exists to improve birthing practices in Haiti, this actor has an opportunity to influence all other actors.

### **Closeness centrality: Reach**

Degree centrality is useful for understanding how many ties an actor might have to others, but this measure only takes into account the immediate ties each actor has, rather than the number of indirect ties. Closeness centrality is a useful measure because it focuses on how far each actor is from another. Reach tells users what portion of actors that ego--the central actor in the network--can reach in various steps, with steps representing distance (one step, two steps, three steps, etc) (Hanneman & Riddle, 2005). Shorter paths are desirable in this study, because effective cooperation would in part depend on the speed with which information can be shared. A desirable score is closest to one; a score of one means that every actor in the network can reach ego in one step. The further the score from one, the further actors are from ego.

Reach is calculated by measuring the "reach distance" to or from each ego. The maximum score (which is equal to the number of nodes) is achieved when each actor is one step from ego (Hanneman & Riddle 2005).

Calculations for reach in UCINET were run. For all types of cooperation, scores were low; the highest scores for each level of cooperation are shown in tables 5-5, 5-6 and 5-7.

Table 5-5 shows inward and outward reach for "share information" for actors who had reach scores higher than .03. Any actors with reach scores below 0.03 were excluded from the table. The reason for this was because actors with reach scores below 0.03 were generally the social isolates who were not interviewed for this particular study. The mean reach score for "Share information" for both inward reach and outward reach was 0.01, and the range was 0.105 to 0.01, indicating that most actors cannot reach ego. A few actors had scores that were higher than 0.03, but most actors had reach scores of 0.01; this substantially brought down the mean. In this case, the mean is misleading in the sense that there were some actors that had scores that were a fair degree higher than 0.01, but these actors were very few. This would indicate that there are a few actors in their own networks, but that the networks are dispersed and not connected.

Table 5-6 shows inward and outward reach scores for "share resources." Only those actors with scores of higher than 0.03 were included. The mean inward and outward reach score for "Share resources" was 0.01 for both measures, and the range was 0.095 to 0.01. Again, this shows that the actors cannot reach "ego" very easily, and as is the case for the "share information" measure, most actors cannot reach ego, as the networks are dispersed.

Table 5-7 displays reach scores for "joint effort." Only those actors with inward and/or outward reach scores of 0.03 were included in the table. The mean for this measure was 0.01 and the range was 0.076 to 0.01. As in the previous two reach measures (share information and share resources), actors cannot reach ego very easily and the networks are quite dispersed.

As is exhibited in the data, the social networks in this research are not very close in terms of "reach distance." In other words, actors cannot reach ego easily, and in fact, many could not reach ego at all. In this particular study, the data indicated that networks were dispersed; reach scores confirmed this. It should be stated that these measures should be interpreted as exploratory only, given sample size limitations.

### **Cohesion: Density**

Density is a measure that shows the connectedness of a network--is the network tightly cohesive or loosely connected? The density of a network can give insight into how quickly information diffuses among actors, as well as the extent to which actors have high levels of social capital. The density of a network is the proportion of all possible ties that currently exist (Hanneman & Riddle, 2005).

As is seen in Table 5-8, it is clear that the network in this study is very loosely connected, as density is considerably low. A score that is closer to one indicates a highly dense network; a score closer to zero indicates a "loose" network. Dense networks are those that have high connectivity, and actors in a dense network would, for purposes of this study, exhibit a high level of cooperation. A loose network in this particular study would indicate that actors are not exhibiting a high level of cooperation; this study showed that the networks that exist are rather loose, and therefore not exhibiting high levels of cooperation.

After interviews were conducted and the social network analysis was constructed, I investigated each participant organization's website for mention of collaboration, cooperation or partnerships in the organization's vision, mission and/or goals. In addition,

if available, annual reports were analyzed to investigate whether or not there was discussion of collaborative efforts with NGO partners. Then, these findings were compared to the results of the semi-structured interview, in particular, the answer to the question, "How do you work to achieve your goals?"

I conducted background research on each organization after the semi-structured interviews occurred. I decided not to use background information on each organization for interview probing, because I theorized that if cooperation was truly embedded in the organization's purpose, mission and values, then it would be fairly simple for participants to produce a list of partners. While gathering a list of organizations that each participant listed on its website ahead of the interviews, and then using this list as a probe, may have gathered more complete information, I was interested in how organically partnership and collaboration was embedded in each participant organization's work. Further research could take this approach to gather more complete and extensive network information.

Eleven of the 17 participants mentioned partnerships or collaborative efforts in their mission, vision or values statements on their websites. One example is an organization that directly linked its "values" to its stated approach to achieving its mission and goals. This organization stated that one of its values was to "...strive to be in genuine partnership with those who share our vision." The organization also stated in its approach:

*"We work in collaboration with Haiti's Ministry of Public Health and Population and other organizations to deliver culturally appropriate, high impact health interventions."*

Of the 11 organizations that had information concerning collaboration on their websites, six of them specifically listed their partners on their websites. This was generally shown by having a separate area of the website where a list of partners was visible. One of these participants not only had a list of partners, but also included reasons why partnership with them was beneficial. These benefits included "minimum investment for large impact," "goal of sustainable social enterprises" and "established network."

If available, annual reports were also investigated. Five of the 11 organizations that had information concerning collaboration on their websites also had annual reports posted. Of these five organizations, only one participant organization included mention of a partnership with another organization. The value of partnerships with other NGO collaborators was stated in the annual report:

*"[We] partner with other organizations to promote sustainable livelihood programs that improve economic health and in turn physical health in [our] communities."*

This partnership was collaboration on an animal husbandry project, which is not directly related to maternal and child health, but indirectly supports maternal and child health by providing food and income (distal determinants of health).

When comparing the findings from the website analyses with the interviews, I found that although multiple organizations stated and recognized the value of partnerships and collaboration on their websites, very few stated that partnerships and collaboration were essential for achieving their mission and goals in relation to maternal and child health.

Only one participant directly stated that working with a partner organization was essential to achieving organizational goals. The organizational goal was to establish a



network of maternal health services. The way in which the participant stated that the organization worked to achieve that goal was:

*"We have been...active in trying to help provide information and the necessary tools that [the community] needs. We sent two of our community health workers to the mainland to be trained by [one of our partners]. So our activity has mainly been in supporting [the community's] request for better maternal services."*

Further, this particular participant's organizational website listed partners and had a "Manual of Best Practice and Guiding Principles," where one of the guiding principles listed was "Partnerships, collaboration and networking." This Guiding Principle listed prerequisites to partnership, some of which included:

- 1. The partnership will collaborate with other entities only if the relationship is transparent and consistent with the stated mission of the partnership.*
- 2. The partnership will collaborate on the basis of shared values, common ground and for the good of society.*
- 3. The partnership will collaborate only on the basis of equitable and genuine mutual benefit to each organization and with full transparency and a two way flow of information. (Note: This website is not cited in the document to protect the identity of the participant).*

The participant discussed in the preceding paragraphs was the only participant whose website information aligned with the qualitative data in regards to working in collaboration to achieve goals.

One other participant mentioned that her organization worked with the Haitian Ministry of Public Health and Population (MSPP), but did not mention working with other NGOs. Another participant mentioned working with a community group to achieve organizational goals, but did not mention working with other NGOs. Yet a third

participant discussed working with grassroots organizations and local community groups, but did not list NGOs as being a part of this collaborative effort to achieve goals.

It is clear from this data that the value of partnerships and collaboration are recognized among participant organizations, and that it is listed on official documentation as an important part of achieving organizational goals. However, there is some discrepancy between what is listed on websites and official documentation and how participants describe the manner in which they work to achieve their goals. Throughout the majority of the rest of the interviews, however, participants did recognize the value of partnerships.

### **Limitations**

It is critical to address the limitation of this social network analysis. As mentioned previously, this social network analysis was exploratory only, so results should not be interpreted in the same way as a full social network analysis. It was difficult to recruit study participants, the number of actors that were able to be properly interviewed was low. Often, reciprocal ties could not be assessed, due to the low number of participants.

The language in which the interviews were conducted was English, and this limited potential participants. There are a number of NGOs working in Haiti from countries other than the United States, and conducting interviews in Spanish, French or Creole would most likely have expanded the potential participant sample.

My recruitment strategy resulted in a total of 17 participants, which generated a free-list total of 106 organizations. Only 16% of this network that was established was able to be interviewed, and therefore, social network calculations should not be

interpreted with finality, as the low number of total participants limits any inferences that can be made.

I asked participants to free-list organizations with which they work. Had I examined organizational websites beforehand and used the information gained in this endeavor, or had I probed participants with a listing of other organizations that had previously been listed, I may have been able to construct a more robust organizational list.

When looking at mean scores, it should be considered that averages can be difficult to interpret. This is particularly the case with the density measure. As the values are small, it can be misleading, because as group size increases, density decreases as actor degrees remain unchanged (Wasserman & Faust, 1994). Given that the majority of actors that were produced in this network were not interviewed, relationships could not accurately be assessed.

These limitations should be taken into consideration when interpreting the results of the social network analysis. Further research into the actors listed in this network is needed in order to draw an accurate conclusion on social network measures, particularly density. In order to successfully complete a whole network analysis on this population, a higher number of participants would need to be recruited so that proper inferences can be drawn.

## Tables and Figures

Table 2-1  
Participant Organization Descriptions

Actor	Mission	MCH Services Provided	Length of operation	Local or non-local	Revenue (2015)
1	To provide excellent physical, spiritual, emotional, educational and economic care for at-risk children and families in Haiti.	Nutrition, prenatal, foster care	29 years	Non-local	\$1.25 million
3	A mutual relationship of supporting education for children and adults, improving access to healthcare and nutrition, assisting with economic development.	Testing and monitoring, prenatal vitamins, vaccinations, birth control, follow-up care post-partum, children's nutrition	30 years	Non-local	\$405,000
4	To provide essential health services to the people of Southern Haiti, especially the most vulnerable.	Maternal & Neonatal Health Center (pediatric care, NICU, skilled birth attendance)	28 years	Non-local	\$6.9 million
6	To provide primary care	Maternity care	6 years	Non-local	n/a*

	to vulnerable population in Artibonite region	(birthing home)			
7	To serve the poorest of the poor in the developing world.	Primary care, prenatal care, ultrasounds	28 years	Non-local	\$560,000
10	To support Haitian communities in their efforts to build and sustain healthy families by developing best health care practices to share across Haiti and other low-resource communities.	Cervical cancer prevention and treatment, safe motherhood programs	17 years	Non-local	\$850,000
11	To minister to the people of Haiti with the love of Christ	Prenatal care, nutrition, malnutrition inpatient clinic for children	11 years	Non-local	\$605,000
15	To strengthen families by serving the health and nutritional needs of children while reaching families with the gospel of Jesus Christ.	Outpatient malnutrition for children	3 years	Non-local	\$510,000
35	To improve life in	Water purification	11 years	Non-local	\$225,000

	developing countries by identifying and encouraging the use of affordable water purification systems, teaching the importance of proper household water treatment and creating new business opportunities for local people.	and treatment			
38	To bring transformation to Haiti through the message of Jesus Christ.	Health clinic (primary care)	n/a	n/a	n/a
41	To collaborate with the people of the Artibonite Valley as they strive to improve their health and quality of life.	Full service hospital	60 years	Non-local	\$8.7 million
45	To support healthcare, community and education.	Prenatal and childcare (primary care)	10 years	Non-local	\$155,000
61	To achieve a better quality of life for the people in Gran Bois,	Primary care clinic	11 years	Non-local	\$383,000

	Haiti.				
68	To share and promote good birth practices and birth home models in low-resource communities	Intrapartum, prenatal and postnatal care	One year	Non-local	n/a
95	To raise a healthy generation of children in Haiti, who can in turn raise Haiti from poverty, through training programs, community development and direct nutrition and health care	Acute malnutrition community management, inpatient treatment of severe acute malnutrition, maternal health	13 years	Non-local	\$640,000
97	To increase access to skilled maternity care in Haiti.	Training skilled birth attendants and traditional birth attendants	7 years	Non-local	\$770,000
105	To maintain a clinic and health care initiatives in Haiti.	Primary care	18 years	Non-local	\$1.1 million

\*Organization is non-U.S., and does not adhere to same reporting requirements.  
Information not available

Table 5-1. Social Network Analysis: Degree Centrality Scores for Actors who Share Information

Actor	Out Degree	In Degree
1	1	0
2	0	1
3	0	1
4	7	1
7	0	1
8	0	2
9	0	3
10	0	2
11	3	2
14	0	1
15	0	1
20	2	0
21	0	1
23	0	1
24	1	0
25	0	1
35	2	0
38	1	0
41	0	1
42	0	1
43	0	1
45	2	1
47	0	1
53	2	1
57	0	2
61	3	0
62	0	1
64	0	1
65	0	1
66	0	1
67	0	1
68	10	0
80	0	1
95	8	0
96	0	1
97	0	1



98	0	1
99	0	1
100	0	1
101	0	1
102	0	1
103	0	1
105	0	1

Table 5-

2. Social Network Analysis: Degree Centrality Scores for Actors who Share Resources

Actor	Out Degree	In Degree
1	1	0
3	0	1
4	7	1
7	0	2
8	0	2
9	0	2
11	2	1
14	0	1
15	0	1
20	1	0
21	0	1
24	1	0
25	0	1
34	1	0
35	1	1
41	0	1
42	0	1
43	0	1
45	1	1
47	0	1
53	2	1
57	0	2
61	4	0
62	0	1
63	0	1
64	0	1
65	0	1
66	0	1
67	0	1
68	9	0
69	0	1
89	0	1
95	2	0
96	0	1

105	0	1
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Table 5-3. Social Network Analysis: Degree Centrality Scores for Actors who Participate in a Joint Effort

Actor	Out Degree	In Degree
11	2	1
20	2	0
21	0	1
23	0	1
35	1	0
38	0	1

47	0	1
53	2	0
57	0	1
68	7	0
80	0	1

Table 5-4. Social Network Analysis: Degree Centrality Scores for Actors who Refer Patients to Other Actors

Actor	Out Degree	In Degree
1	5	0
3	0	2
4	4	1
6	0	1
7	0	1
10	0	2
11	1	0
15	0	2
35	1	0
38	0	1
41	0	1
45	1	2
61	1	0
95	3	0
97	0	1
105	0	1

Table 5-5. Social Network Analysis: Closeness Centrality (Reach) Scores for Actors who Share Information

Actor	Outward Reach	Inward Reach
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68	0.105	0.010
95	0.086	0.010
4	0.076	0.019
45	0.052	0.019
11	0.043	0.029
53	0.038	0.024

Table 5-6. Social Network Analysis: Closeness Centrality (Reach) Scores for Actors who Share Resources

Actor	Outward Reach	Inward Reach
68	0.095	0.010
4	0.076	0.019
45	0.048	0.019
61	0.048	0.010
11	0.033	0.019
53	0.033	0.019

Table 5-7. Social Network Analysis: Closeness Centrality (Reach) Scores for Actors who Participate in a Joint Effort

Actor	Outward Reach	Inward Reach
68	0.076	0.010
53	0.038	0.010

Table 5-8. Social Network Analysis: Density Scores for Actors who Share Information, Share Resources and Participate in a Joint Effort

Cooperation Level	Density
Share Information	0.004
Share Resources	0.003
Joint Effort	0.001

Figure 5-1. Social Network Visualization for Actors who Share Information

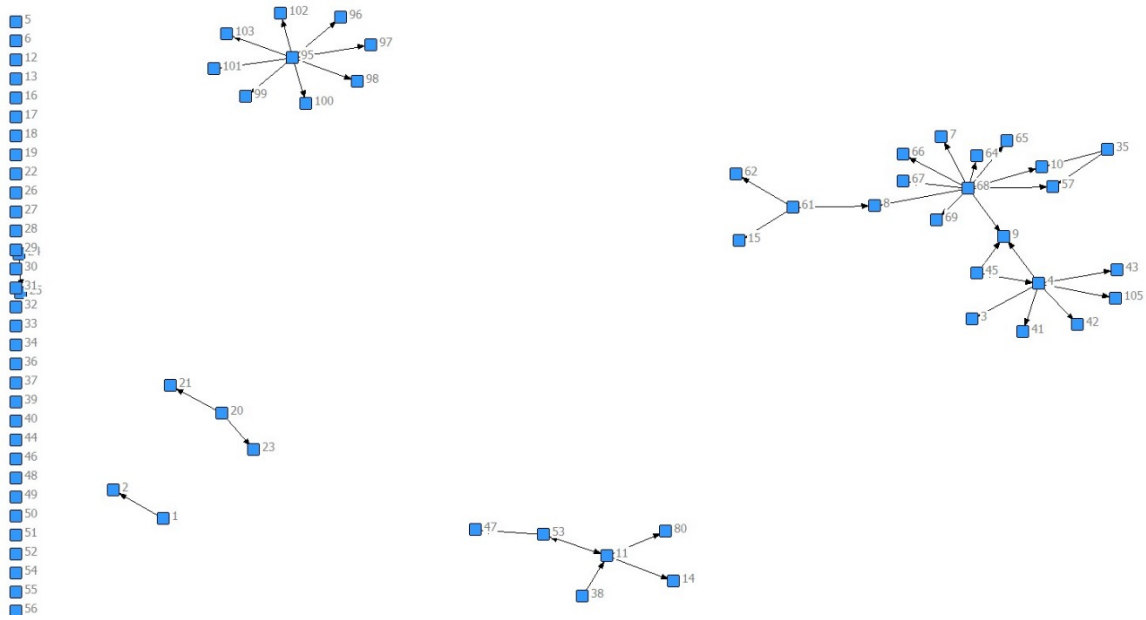


Figure 5-2  
Social Network Visualization for Actors who Share Resources

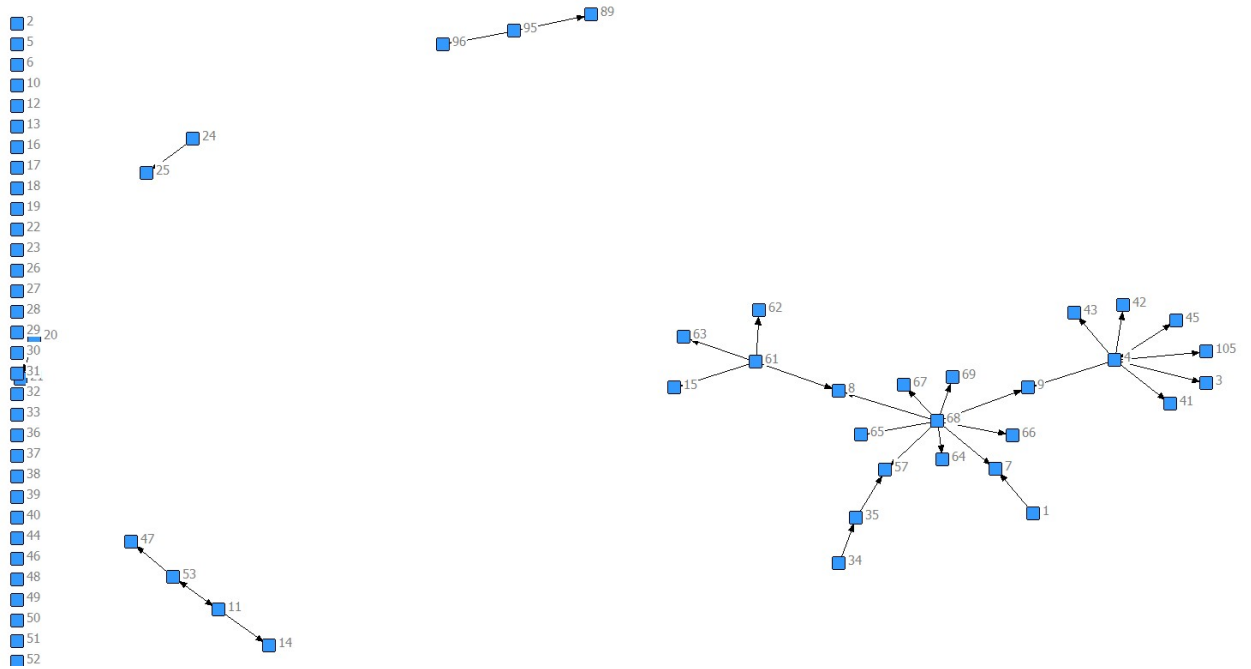


Figure 5-3. Social Network Visualization for Actors who Participate in a Joint Effort

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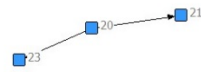
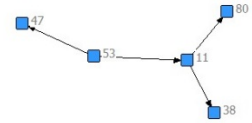
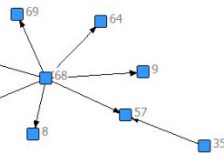
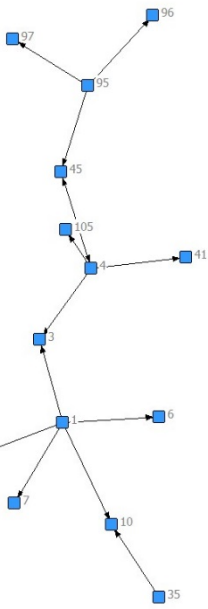


Figure 5-4. Social Network Visualization: Degree centrality for Actors who Refer Patients

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## CONCLUSION

The main goal of this research was to gain a deeper understanding of the level of collective action that was occurring among NGOs working in maternal and child health in Haiti. As there is currently little research on collective action among NGOs, and in particular, little to no research on collective action among NGOs in Haiti, Haiti constituted a perfect site in which to study this phenomenon.

The literature on collective action finds that collective action is difficult, in practice, to achieve. Further, the literature also finds that in the provision of public goods, collective action is the most effective and most efficient way to deliver public goods to the population. Using health as a public good, it therefore follows that collective action in the provision of health services is the most optimal way to deliver said services to the population.

This research found that, consistent with the literature, collective action in Haiti is low. With the exception of one particular actor (Actor 68), collective action in Haiti is limited.

The results from the social network analysis, which, overall, displayed low cohesion and exhibited loose networks, support the qualitative data. As was evidenced in the social network data, few networks exist among NGO actors. While there are a fair number of relationships that exist, they are often at the lowest level, and true to Koch's (2011) theory, the number of relationships decrease as the level of cooperation increases.

It is fair to say that while cooperation is occurring among NGOs working in maternal and child health in Haiti, it falls far short of true collective action. There are

relationships that share information, but fewer relationships that share resources and materials, and even fewer relationships that participate in a joint effort.

While Actor 68 follows this same gradient, it is an outlier in comparison to the other research participants. Actor 68 exists to form a network of birthing centers. The network's sole intent is to improve maternal health outcomes in Haiti; it envisions doing this by bringing together organizations working in the maternal health space so that information and best practices can be shared, and common goals achieved. Actor 68 exhibits, at its core, true collective action.

Though this research yielded important information on collective action in Haiti, it should be noted that, as mentioned in previous chapters, there are some significant limitations. First, it should be noted that the snowball sampling method yielded only 17 participants. Given that it has been estimated that Haiti has over 10,000 NGOs (though the number specifically working in maternal and child health is unknown), there is substantial room for improvement in sample size in future research. Though data saturation did occur in the qualitative portion of the research, a more robust sample size might yield additional insight. Second, a full understanding of the cooperative networks that are occurring in Haiti could not be completely assessed, as a map of networks could only be created on the basis of these 17 participants. Again, given the sheer number of NGOs that exist in Haiti, it is indeed conceivable that additional, and perhaps denser, networks exist. Finally, collective action among NGOs that are working in maternal and child health was the only type of collective action assessed. In other words, there was cooperation occurring among organizations that worked in different, and often



complementary, fields. This type of cooperation cannot be discounted, as it can and does yield important population level health benefits.

Substantial literature has been written on global health partnerships, but the majority of the literature has addressed public-private partnerships. The role of such partnerships in the global health space cannot be discounted; indeed, public-private partnerships are vital for advancing global health interests. Less attention has been given to studying local non-profit partnerships; that is, partnerships between organizations working in-country to advance a health agenda.

The importance of partnerships was a focal point for the Millennium Development Goals--Goal 8: Develop a global partnership for development (United Nations, n.d.). The Sustainable Development Goals (SDGs) continues this vision with Goal 17: Strengthen the means of implementation and revitalize the partnership for sustainable development (United Nations, 2016). There is the recognition in the SDGs that one of the pillars of their success hinges on a renewed sense of partnership (Barnes, Brown & Harmon, 2016). Achieving effective partnerships is critical to advancing the global health agenda and improving outcomes, including in maternal and child health.

While people generally agree on the importance of partnerships, and there are certainly many partnerships that currently exist, less is known about what this partnership actually means for the stakeholders who are responsible for operationalizing it and putting it into practice (Barnes, Brown & Harman, 2016). Further, while collaborative quality improvement initiatives are prevalent in the United States, the United Kingdom, and other developed nations, few have been reported in low-and middle-income countries. Broad partnership recommendations abound--the Paris Declaration of 2005

emphasizes harmonization--donor countries should coordinate, simplify procedures and share information to avoid duplication. The Accra Agenda for Action advances inclusive partnerships (OECD, n.d.). The World Health Organization considers itself a lead convener (Lorenz, 2007). Yet the difficult question remains: how should partnerships actually be implemented? What do they look like?

To answer these questions, it is important to first consider the context. While broad partnership recommendations can be made (and often are), a "one size fits all" approach is inappropriate. It is necessary to first understand the socio-cultural and political dynamics within a specific health system context (Barnes, Brown & Harman, 2016). Therefore, seeking out information from local actors, as this research did, will help the researcher to contextualize the situations in which partnerships occur and form, as well as understand the complex dynamics that are at play that might hinder effective cooperation.

Ramaswamy et al. (2016) summarize the components of a successful partnership in global health:

- 1) Recognize and accept the need for partnership
- 2) Develop clarity and realism of purpose
- 3) Ensure commitment and ownership
- 4) Develop and maintain trust
- 5) Create robust and clear partnership working arrangements
- 6) Monitor, measure and learn

The participants in this research clearly recognize and accept the need for partnership (component #1), but the presence of some of the other components are murkier. There is little clarity that exists around which partnership visions can be formed (component #2); further, while there may be a sense of commitment to a partnership,

ownership issues (component #3) may be difficult to disentangle, as there is an intense feeling of competition and egos in the Haiti NGO community. This would need to be lessened, if not eliminated, if the fourth component--develop and maintain trust--were to be achieved.

As stated previously, one cannot take sweeping generalizations and apply them in a "one size fits all" attempt. However, researchers can analyze what has worked in various settings and modify those results for specific contexts. For example, Ramaswamy et al. (2016) conducted a multiple case study on Kybele, a 501(c)(3) that is "dedicated to improving childbirth safety through innovative partnerships in low resource settings" (p.2). The findings concluded that Kybele had four partnership principles that were paramount to ensuring partnership success:

- 1) Select an engaged champion
- 2) Obtain stakeholder support
- 3) Ensure partner involvement
- 4) Learn from the data

Any unsuccessful partnership in which Kybele engaged was missing at least one of the aforementioned principles. The Kybele model could be adapted and used in Haiti to engage stakeholders working in maternal and child health. Actor 68 would be a natural engaged champion; Actor 68 already has broad based support from a number of current partners, and actively seeks out additional support from potential partners. Given that Actor 68 already liaises with multiple partners, it can be inferred that it has an overall broad base of support from those partners.

It is recommended that Actor 68 be further studied, as it represents a promising approach to using partnership to improve maternal and child health outcomes in Haiti.

Further information is needed: what is Actor 68's approach to partnership? What principles underlie its vision and goals?

Actor 68 has plans to expand into other countries. Following its expansion, studying barriers, as well as modifications to local contexts, will be beneficial for contributing to the advancement of knowledge on successful partnership formation, implementation and most importantly, sustainability. Further, a more complete mapping of the social networks in Haiti will provide additional insight into the networks that exist and how these networks are working together. Not only will these future research directions contribute to the literature, but they will advance the field of global health on a practical level, as they have important implications for understanding best practices in collective action efforts.

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APPENDIX A  
INTERVIEW PROTOCOL  
DATA COLLECTED OCTOBER 2015-APRIL 2016

- 1) What aspects of maternal and child health services do you provide? About what percentage of services are dedicated to maternal and child health services?
- 2) What is your goal/mission in relation to maternal/child health?
  - How do you work to achieve these goals?
- 3) What other NGOs exist in your geographical region that you are aware of?
  - What area do they work in? Education, health, general development?
  - Are you aware of any other organizations in your geographical region that also provide maternal child health services?
- 4) In your estimation, how many NGOs do you think are currently working in maternal and child health in Haiti?
- 5) Please name all other NGOs working in maternal and child health in Haiti that you can think of. Please include all organizations that you know of, and not just ones with which you might work or have a personal relationship.
  - Participant will list all organizations

6) Now, of the organizations that you just listed, with which ones do you work?  
 (Participant will name all organizations with which s/he works)

- Please tell me about NGOx. What is your level of cooperation? Please select the type of collaboration that you have with NGOx:

Organization	Information	Resources/Materials	Joint efforts (meetings, workshops, fundraising)	Other*

\*If participant chooses “Other”: What type of collaboration do you have?

- Please tell me about your experience with NGOx. How long have you been working with this organization?
- How often do you have contact with NGOx?
- Do you feel that your relationship with NGOx has been beneficial? Why or why not?
- If you do not currently work with any other entities, why not?

7) Have you ever been contacted by another NGO for the purposes of collaboration/cooperation?

- What was your response?
- What type of collaboration/cooperation was requested?
- What was the outcome?
- If favorable, tell me about this. If non-favorable, tell me about this.

8) Have any opportunities arisen for cooperation/collaboration?

- Probe: such as a forum, inter-agency meetings, etc?

- What was your response?
- What was the outcome? Favorable? Non-favorable? Why?

9) Have you experienced cooperation/collaboration in an emergency (i.e., World Health Organization clusters during the aftermath of the earthquake)?

- If yes, what was the extent of that cooperation/collaboration?
- What was the experience like?
- What was beneficial about that cooperation?
- What needed to be improved?

10) *If participant does NOT currently work with any other organizations:* How do you feel about the prospect of cooperating/collaborating with other agencies?

11) Are there any instances in which you have thought that cooperation/collaboration might be beneficial, but did not actually cooperate? What instances are those? (list each separately and ask the follow-up questions separately for each instance):

- Why would cooperation have been beneficial in this instance?
- What hindered you from cooperating?
- What conditions would need to have been in place in order for cooperation to occur in this instance?

12) Are there any instances where cooperation has been the intention, but it failed?

- Tell me about this
- Why did it fail?
- What conditions might have made cooperation successful?

13) What are the benefits of cooperation/collaboration?

14) What barriers do you feel exist that hinder cooperation/collaboration?

15) What conditions would need to exist in order for you to voluntarily cooperate/collaborate (informally) with other NGOs? (*if person does not currently collaborate*)

16) Why do you think cooperation/collaboration does not occur more often between NGOs in Haiti?

17) Do you think cooperation/collaboration should be required by the Haitian government?

- Why or why not?

18) Do you think cooperation/collaboration should be required by donor agencies?

- Why or why not?

- 19) What would be the benefits to forced cooperation/collaboration?
- 20) What would be the barriers to forced cooperation/collaboration?
- 21) Do you think there should be a formal registration or information sharing forum/arena for NGOs working in Haiti?
- Why or why not?
  - If yes, what would this look like?
- 22) Do you feel that there is an environment of competition between NGOs in Haiti?
- If yes, could you tell me more about it?
  - In what aspects do you feel you compete? Services, funding, overall results/achievements?
- 23) Some of the previous research on cooperation and collaboration in the provision of public goods, such as health, has found that failure to cooperate can result in the following: fragmentation, incomplete information, resource misallocation and inefficiencies, and duplication of services. Have you experienced any of these situations:
- Fragmentation? If yes, tell me more about it.
  - Incomplete information? If yes, tell me more about it.
  - Resource misallocation/inefficiencies? If yes, tell me more about it.
  - Duplication of services? If yes, tell me more about it.
  - If you have experienced any of the above, to what degree do you believe failure to cooperate caused any of these situations?
  - If have experienced any of the above, and you do not believe that failure to cooperate was responsible for any of the situations, what was responsible?
- 24) Is there any other information that you would like to add to assist me in better understanding any of the things we have discussed?