INFECTIOUS DISEASES AND INDIGENOUS NON-GOVERNMENT ORGANIZATION MITIGATION EFFORTS: A QUALITATIVE STUDY OF POTENTIAL CAPACITY DEVELOPMENT ACTIVITIES WITHIN NIGERIA

by

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Infectious Diseases and Indigenous Non-Government Organization Mitigation Efforts: A Qualitative Study of Potential Capacity Development Activities within Nigeria

A Dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at George Mason University

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LIST OF ABBREVIATIONS OR SYMBOLS

AI ........................................................................................................ Appreciative Inquiry
CACSH .......................................................... Center for the Advancement of Collaborative Strategies in Health
CAF ................................................................................................. Capacity Assessment Framework
CAFS .............................................................................. Centre for African Family Studies
CBO ................................................................................. Community-based organizations
CCGHR ..................................................... Canadian Coalition for Global Health Research
CDC ................................................................................. Centers for Disease Control and Prevention
CDHAM .......................................................... Center for Disaster and Humanitarian Assistance Medicine
CIDA ................................................................................... Canadian International Development Agency
CIPD .......................................................... Chartered Institute of Personnel and Development
CoF ................................................................................... Council on Foundations
DFID ................................................................. UK Department for International Development
DIA ................................................................................... Defense Intelligence Agency
DoD ...................................................................................................... Department of Defense
DoS ...................................................................................................... Department of State
ECA ................................................................................... Economic Commission for Africa
EID .......................................................................................... Emerging Infectious Disease
FMoH ..................................................................................... Federal Ministry of Health
GAO .................................................................................... Government Accountability Office
GMU .................................................................................... George Mason University
HERFON ................................................................ Health Reform Foundation of Nigeria
ICRC ................................................................................... International Committee of the Red Cross
IIBA ...................................................................................... International Institute of Business Analysis
INTRAC .......................................................International NGO Training and Research Centre
IO ........................................................................................... International Organization
IRC ...................................................................................... International Rescue Committee
IWEI .............................................................................. Iraqi Women's Educational Institute
JICA ................................................................. Japanese International Cooperation Agency
LGA ...................................................................................... Local Government Area
MDG ..................................................................................... Millennium Development Goals
MEND ........................................................... Movement for the Emancipation of the Niger Delta
MoH ................................................................................................. Ministry of Health
NCMI .................................................................................. National Center for Medical Intelligence
NGO ..................................................................................... Non-governmental Organization
NIC ...................................................................................... National Intelligence Council
NNNGO ...........................................................................Nigeria Network of NGOs
ABSTRACT

INFECTIOUS DISEASES AND INDIGENOUS NON-GOVERNMENT ORGANIZATION MITIGATION EFFORTS: A QUALITATIVE STUDY OF POTENTIAL CAPACITY DEVELOPMENT ACTIVITIES WITHIN NIGERIA

William E. Sumner, M.S.

George Mason University, 2014

Dissertation Director: Dr. Stefan Toepler

This dissertation examined non-governmental organizations (NGOs) operating within the Nigerian health care sector and analyzed their ability to mitigate the spread of infectious diseases and their potential to contribute to the ability of the Nigerian government, and its constituent parts to achieve its stated health care objectives. Structured as a qualitative, illustrative case study, NGOs were assessed against their potential to do the following: (a) create and implement strategies supporting the development of sustainable capacity to respond to the spread of infectious diseases, (b) generate an internal capability to supply critical resource shortfalls, and (c) implement mitigation programs in conjunction with the public health sector through mutually beneficial partnerships. The results and conclusions indicated that as a group, NGOs are not able to support the Nigerian government and its health care system in responding to the spread of infectious diseases or contribute to the development of a national capacity.
Review of findings from a regional or individual organizational perspective however, illustrates that there is a high potential for indigenous NGOs to supplement local government area capacity by operating in an emergency management function. Findings of this research provide a resource for organizations and individuals seeking to mitigate the impact of infectious disease through the development of capacity within the Nigerian health care sector.
CHAPTER ONE: INTRODUCTION

1.1 Background

Commenting on Nigeria’s health service has become rather boring and unproductive. It is like kicking a dead horse…only those who have been victims of our health care system know the extent of the rot. (Shehu, 2004)

“Within Africa, one of the most significant challenges to governance and public stability is the deterioration of national public health systems” (DoS, 2008, p. 44). So concludes a 2008 State Department report which goes on to say “African health care delivery systems are fragile and under increasing stress due to growing populations, increased demand, changing demographics, epidemiologic shifts and urbanization” (DoS, 2008, p. 44; Okeniyi, 2011). The failure of these systems has also been exacerbated by several recent crises which are varied in nature, impact and duration, ranging from extensive military conflict to the impact and spread of infectious diseases in the population (WHO, 2011). Infectious diseases are of particularly great concern because they can amplify instability, further secondary disease transmission leading to possible pandemics, and magnify economic strife through their negative impacts on the “economies, governments, and militaries of key countries and regions” (Fox, 1998, p. 127; Metz, 2000; Price-Smith, 2001; USAID, 2006).

Infectious diseases have been especially detrimental to sub-Saharan Africa, which has endured substantial outbreaks of yellow fever, cholera, meningococcal meningitis,
viral hemorrhagic fever/Marburg, Ebola hemorrhagic fever and avian influenza over the last ten years (NIC, 2006; WHO, 2011). Spillover effects of the disease burden have resulted in an excessive “toll on productivity, profitability, and foreign investment” and are reflected in continuing economic losses, further restricting the ability of the respective governments to provide basic services to their expanding populations (DoS, 2008, p. 44; Fox, 1998; Metz, 2000; NIC, 2006; UNAIDS, 2008; USAID, 2006). Until viable health care systems can be instituted that address the spread of infectious disease, rising mortality rates and a sickening population will continue to plague African nations. The problem will continue creating negative secondary and tertiary effects, hampering African development and undermining regional, political and social stability.

Laboring under this significant disease burden and hampered by poor infrastructure, suffering from a dearth of qualified doctors and nurses, and a general lack of resources, the Nigerian public health care system has virtually collapsed (Asuza, 2004; MIST, 2008; Ossai, 2008). Health care services within Nigeria have continuously been rated as “poor to very poor” and indicators point to a further decline for the foreseeable future (DoS, 2011; NCMI, 2010; The Economist, 2010). This rating is reflective of past governmental efforts to address the spread of infectious diseases. At the 2002 International Conference on AIDS, it was stated that a majority of endeavors have been met with a “lack of political will and commitment” (Aina, Oyekan, Adeniyi, Adetoro, & Oke, 2002). Dr. Gro Harlem Brundtland, past World Health Organization (WHO) Director-General, attributed the responsibility for developing and maintaining a health system to the government. “The health of people is always a national priority:
government responsibility for it is continuous and permanent” (Obinna, 2008; WHO, 2000, p. 7). The government of Nigeria, however, does not have the capacity to treat the innumerable medical issues of its population, and as a result, it has abdicated many of its responsibilities to a combination of public and private providers (IRIN Africa, 2007; Sam, 2008; WHO-AFRO, 2002). This abandonment of national responsibility, which is not a recent phenomenon within Africa, combined with a continually failing health system, contributed to an environment in which Non-Government Organizations (NGOs) flourished, becoming an integral, yet uncontrolled, component of the Nigerian health care structure.

1.1.1 The Importance of Nigeria

Nigeria is a member of the UN Security Council, a global oil producer, a leader in ECOWAS, a major peacekeeping contributing country, and a stabilizing force in West Africa. (Pike, 2009)

There is a cliché that states, "As Nigeria goes, so goes Africa” (Klein, 2010). Nigeria is a lynchpin for change on the continent; if Nigeria prospers, then it will be an example and leader for the development of Africa. If it does not, then neither will Africa.

Nigeria is important for three primary reasons: First, it is the prevailing economic and political power in West Africa, and as such, the nation wields a tremendous amount of influence, acts as a “hub for disseminating information, entertainment, and ideas,” and has traditionally played a major role in pan-African organizations (Akande, 2006; Harding, 2007; Jane's, 2008, p. 552; Rotberg, 2007, p. 3). Secondly, as the most populous country in Africa, Nigeria’s prosperity and stability are also “essential to growth and
stability in West Africa and in sub-Saharan Africa” as a whole (USAID, 2010, p. 4). The size of Nigeria’s population, estimated to be 146 million, is expected to overtake Brazil as the world's 6th largest. If population growth continues along predictable patterns, the United Nations Population Division estimates that by 2050, Nigeria will have reached 289 million people, almost double its 2007 numbers. This dramatic expansion of its population, characterized by a huge “youth bulge and massive urban growth” will further concerns regarding national stability and economic viability (Africa News, 2010; Beehner, 2007; Gavin, 2007, pp. 220-222; Ploch, 2009, p. 24). Finally, and perhaps the most important characteristic of Nigeria, is that the nation exports hydrocarbon resources to 26 countries throughout the world (DoS, 2011; Ploch, 2009; U.S. Energy Information Administration, 2011). According to a report by the Council of Foreign Relations, the production of energy from Africa will substantially increase in the next 10-15 years. This enlargement of the energy supply further increases reliance on Nigeria’s resources and closely ties other countries to the success of Nigeria.

Public health problems threaten the stability of Nigeria and have created a series of “shocks” that are continuously being experienced throughout the economic structure of the country. Although pathogens capable of growing into pandemics are widely emphasized in western media, endemic diseases such as malaria and cholera are much more insidious because they have become part of the deteriorating cycle that attacks a nation from within over a much longer period of time (Weil, 2008). During 2006, “sixty-five percent of all deaths in this region of Africa were caused by infectious diseases” and morbidity and mortality rates, which are being driven higher by "rudimentary health care
delivery and response systems, the unavailability or misuse of drugs, the lack of funds, and a multiplicity of ongoing conflicts” (Barbiero, 2006, p. 8; NIC, 2006, p. 14). As the burden of disease increases, Nigeria will gradually suffer from an “excessive toll on productivity, profitability, and foreign investment” which will be reflected in continuing economic losses, further restricting the ability of the government to provide basic services to its expanding population (Brower & Chalk, 2004, p. 59; CDC, 2002; Jamison, Breman, Measham, Alleyne, Claeson, & Evans, 2006; NIC, 2006, p. 26).

The health care system of Nigeria is one of several lynchpins that promote economic development. Unfortunately, Nigeria suffers from a “general lack of public health resources” available to the nation and is characterized by a “lack of infrastructure, wide-ranging access to safe drinking water, and adequate sanitation within populated areas” (Abuja Vision FM, 2007; Awosika-Olumo, 2008; Fasua, 2005; Paulson, 2001). These problems not only limit the life expectancy of the population, but they contribute to the further spread of diseases creating added demands on an already stressed populace and government system (WHO-AFRO, 2006, p. xxiv). Examples of diseases that have occurred in Nigeria since 2000 include outbreaks of “yellow fever, cholera, meningococcal meningitis, malaria, and polio” (Thani, 2007; WHO, 2011). Additionally, an “estimated 367,836 cases of tuberculosis, the fourth highest burden in the world and the highest in Africa,” occurred in the country during 2002 (DoS, 2008, p. 44). The overall public health situation is further worsened by the “rising occurrence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in approximately 5.4 percent of the population” and the outbreaks of the H5N1 avian
influenza in February 2006 (Loeb, McGrath, & Devalia, 2009, p. 14; WHO, 2008). In September 2010, the nation underwent one of the worst outbreaks of cholera in its history (Ogbebo & Muh'd Sani, 2010). All of these outbreaks challenge Nigeria’s human and economic development and limit its ability to create stable and sustainable health systems that can address the needs of a national population (African Union, 2007; Daini, Erinosho, Idoko, Ikpeazu, & Lecky, 2004; USAID, 2006).

The extensive growth of Nigeria’s population has also been impacted by the disease burden. Infectious diseases have contributed to a youth bulge as the disease takes its toll on the adult population. The large bulge, which is being driven by the severe impact of HIV/AIDS and aggravated by high unemployment, is particularly critical since the demographic transition is creating a large group of individuals who are prone to radicalization (Beehner, 2007; Urdal, 2006; MCIA, 2007). According to Herbert Moller,

The presence of a large contingent of young people in a population may make for a cumulative process of innovation and social growth; it may lead to elemental, directionless action-out behavior; it may destroy old institutions and elevate new elites to power; and the unemployed energies of the young may be organized and directed by totalitarian rulers. (Moller, 1968, p. 260)

Given the Nigerian government’s lack of control within the Delta region and the rise of groups like Movement for the Emancipation of the Niger Delta (MEND), it is conceivable that transnational criminal or terrorist organizations could use this disaffected population as a source of recruits (Adeyemi, 2008; Junger, 2007; Lubeck, Watts, & Lipschutz, 2007; MCIA, 2007; PINR, 2006; Rotberg, 2007). It is also
conceivable that the youth bulge could be the source of future instability and fuel outbreaks of sectarian violence that will consume all available resources as the government seeks to quell uprisings and secure its major sources of export in order to maintain its power base (DoS, 2011; NIC, 2008; PINR, 2006). If this youth bulge trend continues as projected, the youth population, that is already associated with the emergence of political violence and civil conflict, will export instability as they move beyond local borders (NIC, 2008). The long-term effects of these community dynamics will likely be significant and are liable to continue to negatively impact Nigeria’s human development for many generations (Brower & Chalk, 2004).

Until a sector wide approach centered on strengthening health systems is implemented across Nigeria, infrastructure deterioration and rising mortality rates will continue to plague the overall population, creating negative secondary and tertiary effects that could result in long-lasting instability, governance failures, and economic collapse. It is therefore imperative to concentrate on the causes and/or contributing factors to instability in order to reduce economic disruptions, promote political stability, and improve governance. Otherwise, the problems of Nigeria will not stay confined within its borders and will instead become problems that are felt well beyond Nigerian borders.

1.1.2 The Nigerian Health Care Sector

Those who need health care the most, get it the least because they are hampered by the costs of private medical care and so have to “make do” with a deplorable state of the government funded health care system. (Egbunike, 2011)
The public health care system is divided into a network of primary, secondary and tertiary facilities, each run by a different tier of the Nigerian government. The first level of care, considered the cornerstone of the Nigerian health system, consists of primary care facilities, which are comprised of local health centers, small clinics, dispensaries, and medical posts (Nnamuchi, 2007). The facilities generally provide “health education, diagnosis and treatment of common ailments,” although even simple treatments may be lacking in a large portion of the facilities (Ademiluyi & Aluko-Arowolo, 2009, p. 105; Iyayi, 2009). At this level, the 774 local government areas (LGA) are each responsible for funding, managing and providing, “general preventative, curative, promotive, and pre-referral” care to their respective communities (Chankova, Nguyen, & Chipanta, 2006, p. 3; Khemani, 2006, p. 286). Prior to the 2008 Health Care Bill, LGAs were the primary means of implementing policies enacted by the Federal government. Supporting the LGA health actions, state governments were responsible for providing training, logistical support, and any financial assistance that was necessary to fully enact the policy (HERFON, 2006; Khemani, 2005). Funding has been erratic, however, and as pointed out by the World Bank, deductions implemented at the state government level have periodically resulted in “zero allocations” to the LGAs to support the primary care system (Khemani, 2005, p. 6; World Bank, 2010, p. 76). Nigeria is a large country with a huge population and as such, it is challenging to provide care throughout each of the regions when factors such as poor physical infrastructure, lack of skilled personnel, and a heavy disease burden are considered. As of 2004, there were a total of 23,640 registered public health care facilities, but staffing and operational effectiveness limited their overall
ability to provide services (WHO-AFRO, 2004). In many of these areas, NGOs have flourished, and in some cases, taken over service provision in their operational areas. This research will work almost exclusively with mitigation efforts conducted at the primary level of care in order to best determine how long lasting capacity can be developed in conjunction with LGA, state and federal efforts.

The secondary level of care is characterized by established hospitals that provide specialized care and laboratory services. They are involved in supporting preventative measures as well as somewhat complex medical care involving “x-rays, simple surgical services, or providing pathological services” (Ademiluyi et al., 2009, p. 105). Typically, individuals can receive both inpatient and outpatient care at these district-level facilities. At this level, states provide the funding and oversight for functions carried out at the various facilities. Dr. Ibrahim Oloriegbe noted that within Nigeria, the 36 states in the Federal system have “considerable economic power” yet, in these same states, the health system is in a state of “near collapse” (Gyoh, 2008; Oloriegbe, 2009, p. 2). This is due in part, to the way in which money is distributed between the Federal, state, and local governments. Instead of being allocated by need, the current system uses a system of allocation that appears to favor the wealthier, oil producing states, leaving the states with fewer resources to rely more heavily on outside sources to close gaps in service provision (Chankova, et al., 2006; Oloriegbe, 2009).

The final level of the health care system consists of tertiary facilities. Services are provided by federally supported “teaching hospitals and medical centers” which function as resource and referral centers (Chankova, et al., 2006, p. 3; HERFON, 2006, p. 163).
Facilities at this level are also tasked with providing care for specific diseases and treating complex health emergencies and are staffed with advanced equipment and personnel, although this is not often the case (Akande, 2004). Facilities such as the Lagos University Teaching Hospital, University College Hospital, Ibadan, National Orthopedic Hospital, Igbobi Yaba, and the psychiatric hospitals in Lagos are encompassed in the tertiary level (Ademiluyi & Aluko-Arowolo, 2009). According to the World Health Organization and the Federal Ministry of Health (MoH), there are a total of 52 teaching hospitals and medical centers, allowing at least one tertiary facility within each of the Nigerian states (Oloriegbe, 2009).

In theory, these three systems should be mutually supportive and address the full scale of patient needs. In practice however, the provision of services falls far short of the intended goal. A health services assessment conducted by the National Center for Medical Intelligence (NCMI) in 2006 points out that the entire health care system is considered “underdeveloped and struggling with a wide range of diseases that could be dramatically reduced or eliminated with the proper resources” (Brubaker, 2010). The assessment specifically highlighted shortages of medical personnel and supplies at all levels of the Nigerian health care system. Personnel are considered to be unequally distributed throughout the nation, tending to stay concentrated in urban areas, leaving rural areas, which encompass 65 percent of Nigeria’s population, virtually unstaffed (Brubaker, 2010; Chankova, et al., 2006; Olujimi, 2006; Uzochukwu, Onwujeke, Soludo, Nkoli, & Uguru, 2009). Exacerbating this issue is a scarcity of routine medicines, supplies, and specialized equipment, meant to support activities throughout the various
facilities. NCMI stated in its assessment that even if large increases in funding and resource allocation were to occur over the next five to ten years, the health care system would not likely be able to make dramatic improvements due to “increased demands for care” and an infrastructure that is in “shambles” (Brubaker, 2010).

The private sector, which makes up a sizable portion of the health care system, is a diverse conglomeration of both for-profit and not-for-profit health providers, Faith Based Organizations, NGOs, philanthropists, clubs/societies, other community based organizations and cooperatives (FMoH, 2005; Hanson & Berman, 2000; HERFON, 2006). According to a 2009 study completed in conjunction with the United States Agency for International Development (USAID), a total of 9,992 registered, private facilities exist throughout Nigeria (Dutta, Kariisa, Osika, Kombe, Lecky, & Oyemakinde, 2009). The majority of these facilities, 7,312, consist of “basic health clinics, health centers, community health centers, primary health center, maternity homes or nursing homes” (Dutta, et al., 2009, p. 7) which correspond to the primary level of care provided by the Nigeria government. The next largest grouping of 2,317 facilities was at the secondary level, representing hospitals and comprehensive health centers (Dutta, et al., 2009, p. 7). The USAID study illustrates that a vast majority of these private sector facilities are concentrated in urban areas, compounding a problem of limited service provision for rural patients. Patients in these areas must travel further or typically pay more for medical services offered in urban settings.

Paul Chuke’s (1988) review of the Nigerian health care system in its entirety stated that the 1975 Third National Development Plan recognized “shortages in
personnel, disparity in the distribution of health facilities, inadequate preventative health services, and poor management of health institutions” (p. 237). Chuke further observed that the problems within the health sector were so overwhelming that any solution would require “massive physical inputs into critical areas” if services were to “keep pace with the rapid growth of Nigeria’s population” (Chuke, 1988, p. 238). Over thirty years after the Third National Development Plan was enacted, the goal of “health care for all by the year 2000” has not been met (Chuke, 1988, p. 239). Failures to make clear progress toward supporting the general health care requirements of the population has led to a reliance on support from other nations and NGOs to respond to disease outbreaks and related medical crises (DIA, 2007). Dr. Prosper Igboeli, President of the Nigerian Medical Association, advised the President to declare a “state of emergency” within the health care sector (Nigerian Compass Online, 2009). He noted in his plea that outbreaks of meningitis in 2009 were responsible for the deaths of over 1,500 citizens and the death toll would have been significantly higher if foreign donations had not become available to buy medical supplies (MSF, 2009; Nigerian Compass Online, 2009; UN News Service, 2009). Finally, Minister of Health, Professor Babatunde Osotimehin, cited a host of problems rampant within all three levels of the health care system including obsolete equipment, departure of qualified staff to developed nations, low financial expenditures, and inadequacy of medical facilities, among others, as the root causes of a failing system (Ademiluyi & Aluko-Arowolo, 2009, p. 110, Nigerian Compass Online, 2009).

The 2008 National Health Bill is the latest attempt to reverse decades of neglect by establishing roles and responsibilities for the different levels of government across the
health system. Prior to this, there were no firmly established directives in the 1999 Constitution, which created duplication, ineffective coordination, and failures to adequately provide funding throughout the health care sector (Oloriegbe, 2009). The bill provided clear lines of responsibility for funding, management, and regulation of the health system in its entirety. Limited changes have been implemented since the 2008 bill was introduced, but at the primary care level funding still appears to be a significant factor. Local governments do not have a significant amount of political power and combined with a lack of local oversight, state governments often do not provide adequate funding to support the primary care facilities (Anyia, 2009; Brubaker, 2010; Oloriegbe, 2009). Despite the government’s commitment to “halt and reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases” by 2015, poor medical infrastructure, personnel availability, and funding issues will eliminate the chance to make meaningful progress (Brubaker, 2010). As such, the quality of care is not expected to improve over the next five years, leaving NGOs, private sector organizations, and practitioners of traditional medicines to provide the essential elements of health care service to a disproportionate amount of the Nigerian population (Adepoju, 2010; Brubaker, 2010).

1.1.3 The Role of Corruption in the Nigerian Health Care System

It’s corruption. Corruption has been a problem in Nigeria since the first days of independence, long before oil money started to flow. (Cunliffe-Jones, 2010)

The country has virtually institutionalized corruption as the foundation of governance. Corruption in the health sector,
for instance, is at the root of our poor health care delivery system. (Ojimele, 2011)

Whether right or wrong, the impression many people have of Nigeria is one of rampant corruption and fraud. The nation was ranked by Transparency International as the 33rd most corrupt nation out of a total of 176 nations (Burnett, 2012). Perceptions of the country’s widespread corruption problem are also shared by many Nigerians. In early 2013, the researcher met with a number of Nigerian military officers while deployed to Africa. Asked about their views of corruption in Nigeria, they gave a variety of responses, including unrestrained corruption, failed leadership, failing institutions, and weak governance. The impact of such pervasive corruption means that “money earned by the state does not go to education, health care, roads, or bridges,” which not only inhibits future development but also limits the nation’s capacity to manage its own affairs as infrastructure deteriorates and public service functions cannot be performed (Cunliffe-Jones, 2010, p. 130). Corruption has had an especially large impact on the health sector within Nigeria and has been declared to be “at the root of our [Nigerian] poor health-care delivery system” (Madike, 2013).

Corruption in the public health sector ranges from outright financial theft through counterfeiting schemes to nepotism, which restricts skilled professionals’ ability to move into more challenging and honored positions and eventually forces them to seek employment abroad. Other, more notable instances of corruption include preferential drug disbursement, mismanagement of funds, absenteeism, charges for normally free services, and abuse of hospital procurement contracts. Examples from among this litany
of offenses appear regularly within the Nigerian media, indicating the presence of a problem that will not be easily solved.

A short review of news headlines from Nigerian newspapers such as *Punch*, *Vanguard News*, *Premium Times*, *Daily Post*, and *The Daily Trust* illustrate just how serious financial mismanagement, pharmaceutical chain irregularities, and the general lack of resources within Nigeria have become. Between May 1 and May 7, 2013, the following headlines appeared in Nigerian media:

- “In Africa, a Third of Malaria Drugs Sold Are Substandard” (Onyegbula, 2013).
- “Three Nabbed Over Fake Foreign Health Insurance Certificates” (Usman, 2013).
- “Teera-Ue, Community without Health Facilities, Cries Out” (Dumnamene, 2013).
- “Counterfeit Drug Responsible for Delay in Attaining MDGs” (Uzoma, 2013).
- “We Use Torchlight from Handset for Child Delivery—Nigerian Midwives” (Ibeh, 2013).
- “Shocking—Nurses Use Mobile Phone Torchlights for Delivering Babies in Nigeria” (Ibeh, 2013).
- “Gawu Community Decries Poor Water, Health Facilities” (Isah, 2013).
- “Time to Prevent another Doctors’ Strike” (Opoola, 2013).
• “Federal Medical Centre Birnin-Kudu Staff Decry Non-payment of Salaries” (Alabi, 2013).
• “Gadoro Community Decries Lack of Health Centre” (Isah, 2013).
• “Battling Malaria without Drugs or Knowledge” (Ekeanyanwu, 2013).

Headlines such as these are far from uncommon and are part of a prevalent theme in Nigerian news reports (Okonkwo, 2010). The most revealing news about corruption in the Nigerian health-care sector arose in late February 2008, when Adenike Grange, Nigeria's then-minister of health and a former director of the Global Alliance for Vaccines and Immunization, was arrested for the misallocation of 300 million naira ($2.5 million USD) (Idonor & Akor, 2008). Accusations of corruption spread as it was learned that public funds had allegedly been transferred to personal accounts (Hassan & Scott, 2008). On March 18, 2008, Dr. Iyabo Obasanjo-Bello, chairperson of the Senate Committee on Health and daughter of former President Olusegun Obasanjo, was also implicated in the ongoing investigation and subsequently resigned from her position (Okuwa, 2008). In the following days, more resignations followed, including “Minister of State Gabriel Adduce, Permanent Secretary Simon Ogamdi, Director of Administration H. B. Oyedepo, Director of Finance Hanafi Muhammed,” and 11 other officials (Agande & Shuaibu, 2008). The interesting part of this story is how Grange and her compatriots were caught. The activity was not discovered through a coordinated anti-corruption campaign. Instead, a “whistleblower” who was dissatisfied with his share of the money complained to authorities (Hassan & Scott, 2008). While this may have been the largest recent corruption case to be brought and later dismissed, diversions of public funds to
private accounts are not uncommon and only serve to highlight problems within the country’s health-care system.

Corruption at the national level translates into substantial problems for local communities (Moszynski, 2006). In a review of corruption across Nigeria, Smith (2007) stated that the Ministry of Health “operates like every other Nigerian bureaucracy in the sense that it is run on the principles of patronage and a good deal of money and resources meant to serve the public end up in the pockets of bureaucrats and political appointees” (p. 76). The actions of officials at the national level have affected leadership throughout the public health sector. Cunliffe-Jones (2010) wrote that corruption “washes around Abuja, the capital. It floods through the 36 states of north and south, and it seeps down into the level that Nigerians consider the most corrupt of all: the 774 local governments spread right across the nation” (p. 135). Local governments are responsible for building and operating an “estimated 13,000 government-run primary health centers” which provide the first level of response for treating basic medical maladies, dispensing medications to combat malaria and tuberculosis, and supplying maternity and pediatric care (Human Rights Watch, 2007, p. 12). Unfortunately, services provided by these local governments have in many cases been essentially eliminated, either due to insufficient funding allocations or because of outright theft (Oji & Oji, 2010).

Neglected and deteriorating public service facilities are common, especially in rural areas. Local governments are often willing to collect initial project funds but then fail to support long-term maintenance or provide necessary equipment and personnel. This type of neglect was apparent in one clinic in the Auwo Odofin local government
area (Lagos). It had been built by an international NGO, turned over to local authorities, and shortly thereafter abandoned as the funding for salaries, equipment, and medications was never allocated (Irikefe, 2009). This resulted in a coverage gap that was quickly filled by for-profit entities who charged for services that would otherwise have been offered at reduced rates. A survey of construction sites in the southern delta region identified more than 800 similar projects that had been started and subsequently abandoned by local governments (Cunliffe-Jones, 2010, p. 138). When such facilities are constructed, future operation and maintenance are often not deemed a priority by the local government areas, and support is typically found to be in short supply. A review of local newspapers, NGO reports, and local health-care discussions produced the following examples of the direct effects of corruption upon local health services, most notably in the area of resource misappropriation. Although only a few examples are cited below, the situations noted represent a much larger and more widespread problem within Nigeria.

In Kogi State, an inventory of health-care facility equipment revealed that less than 25 percent of facilities had approximately “half of the required minimum operating equipment,” while 40 percent had less than “a quarter of the minimum equipment package” (Lewis, 2006).

A local government in Anambra State directed the construction of a specialized hospital and 23 clinics. Following their completion, equipment and medicines purchased for operations disappeared. It is suspected that the materials were “sold for private profit” by authorities responsible for the facilities’ oversight (Blair, 2005; Eboh, 2007). These losses caused the subsequent closure of those facilities.
In Rivers State, the Human Rights Watch assessed primary health centers in multiple local government areas:

All but a few lacked even a basic supply of medicines and other equipment and did not have access to a reliable supply of water, any sort of toilet facilities, or electricity. Some [centers] were housed in structures nearing the point of actual collapse, and others had simply been abandoned by their demoralized staff. (Human Rights Watch, 2007)

Assessments from outside organizations may tell of a health care system in crisis, but more revealing insight into corruption’s impact comes from the medical personnel who staff these facilities:

I am in a local government area, in Edo State, with 13 primary health-care centers. I was the only doctor covering just one of the centers. The other centers were covered by community health extension workers, who were not as qualified as a licensed registered nurse, and matrons, some of whom visit the centers that they are supposed to cover once or twice a week. In a period of 11 months, I had an electricity supply that could be added up to four months. I had no hope of laboratory investigation services in any form. I usually had to send patients to a nearby town, which is 30–40 minutes away on a bike. Most times, I had to buy and transport fuel to the center in order to run my generator for two hours every day. I have lost count of number of times I have had to deliver a pregnant woman with torch and lantern. Yet we have to keep the cost as low as possible, or else women would deliver at home or at the farm. (Leopantro, 2010)
There is no water, no toilet; how do you expect a doctor to come and give service? During birthing, we go outside. If you want to go and relieve yourself, you go to a bush toilet. Where is the sense in this way of life? (Irikefe, 2009)

Our facilities are not adequate at all. We are lacking many things. We have beds but no mattresses; the patients must bring their own. We have no toilet; patients will use the toilets of the people who live nearby to here. We have no running water. The pump is there, but it is out of use for two years. We have no light; we are not even wired to the nearby power lines running through town]..... When it rains, the place will flood—the environment of this clinic is one of our major problems. (Human Rights Watch, 2007, p. 43)

Stories and articles about ill-funded or non-funded community care appear to be endless; however, the impact of corruption on the public health sector extends far beyond the relatively straightforward misallocation or outright theft of equipment or maintenance funds. The salaries of health workers have also been a long-standing target of funding mismanagement, and this is reflected in abnormally high rates of absenteeism.

Worker absenteeism spurred by the non-payment of salaries at the primary and secondary levels of Nigeria’s health-care system has set new records over the last decade. In 2006, the country saw a nationwide peak of 42 percent (Lewis, 2006). Long-term failure to compensate employees, especially for more than six months, transformed health staff into little more than volunteers who were forced to either seek other employment or
turn to more nefarious activities. A Human Rights Watch assessment of health care facilities in the delta region indicated that salaries were “consistently three to four months in arrears” and that leave allowances had not been paid for “more than five years running” (Human Rights Watch, 2007, p. 149). The absence of trained health workers reduces the options available to potential patients and forces individuals to seek treatment at secondary and tertiary hospitals, creating an overburden that displaces research and higher-level medical activities. In some cases, members of the local community forego medical treatment entirely, while others turn to traditional healers and untrained chemists to meet their medical needs. Remedies provided by unskilled or untrained “doctors” are often counterfeit or have their effectiveness reduced through improper handling, storage, or misuse. In the best cases, no lasting harm is done to the patient. At worst, these substandard pharmaceuticals can have lethal effects.

Perhaps the greatest and deadliest impact has been on the supply and distribution of pharmaceuticals. In 2000, drug sales and distribution within Nigeria were generally unregulated, and prescribed medications could be purchased openly in stores, open-air drug markets, or traffic intersections (Ayodele, 2011; Oji & Oji, 2010). Approximately 70–80 percent of medications available within the country around that timeframe were thought to be counterfeit. Such medications were also suspected of being the direct causes of multiple deaths (Moszynski, 2006). Reports indicate that hospitals in Nigeria were using “fake adrenalin to restart hearts, sub-strength muscle relaxants for patients undergoing surgery, and contaminated intravenous drips” during routine medical procedures (Frenkiel, 2005). The problem with counterfeit medications became so
pervasive that in 2001, Dr. Dora Akunyili, who had been appointed to Nigeria’s National Agency for Food and Drug Administration and Control, began an internal campaign to eliminate corruption and remove potentially lethal medications from the streets (Dyer, 2006). Three years later, her campaign had reduced the quantity of unregistered drugs by almost 80 percent (Dyer, 2006; Ogbeidi, 2012). Akunyili’s strong leadership was the singular driving factor in creating a strong, functioning institution, but following her departure, the trouble with counterfeit medications, the diversion of funds for new medications, and the influence of corruption rose once again.

Paul Orhii, the current (2013) Director-General of Nigeria’s National Agency for Food and Drug Administration and Control, blames the flood of counterfeit medicines on “a shambolic [medical] system and porous borders” (Blease, 2012). Regardless of the cause, the effects of institutional decay and corruption are still a serious threat to people who need effective medicines to treat their sicknesses. The World Health Organization conducted a survey of the antimalarial medication supply in Nigeria in 2011, which found 64 percent of the medicines examined to be counterfeit (Blease, 2012). Another example of the “shambolic system” involved the Federal Medical Centre Lagos. A visit by Rep. Abdul Musa Msheliza from the House Committee on Health determined that the facility’s medicine stock had expired (Hassan, 2013). A final example relates to the growth of drug markets within the nation. In 1998, only four such markets were in existence. By 2010, that number had jumped to 20, and these markets featured large numbers of counterfeit, expired, or pilfered medicines (Ayodele, 2011; Business Day, 2013; Yesufu, 2011).
It is clear from these continuously recurring examples that corruption is “why things are the way they are” in the Nigerian public health sector (Yesufu, 2011). Its impact on the Nigerian population has been staggering. Children still routinely die from “measles, diarrhea, malnutrition and other preventable illnesses,” while people actively avoid public health centers, which, if properly staffed and equipped, could potentially save lives (Okonkwo, 2010). A resident of the Akuku-Toru local government area in Rivers State expressed his frustration with the situation when he was asked if he had visited the government-run primary health center near his house: “Why would we go there? There is nothing inside of that building—no staff and no medicine. So why would we go there?” (Human Rights Watch, 2007, p. 156).

1.1.4 The Rise of Nigerian Health NGOs

A growing challenge is for governments to harness the energies of the private and voluntary sectors in achieving better levels of health system performance. (WHO, 2000, p. vii)

The roots of NGO involvement in Nigerian health stem from the spread of missionaries throughout the African continent. In the late 19th century, Protestant missionaries traveled into Nigeria and established compounds and mission villages. From these areas, missionaries, who became more specialized in areas such as the provision of education and medical assistance toward the end of the century, organized health care for the inhabitants of their parishes (Chuke, 1988; Hastings, 1996; Isichei, 1995). In 1895, as a result of these efforts, the first hospital, the Sacred Heart Hospital, was established in Abeokuta, run by a Catholic Mission (Chuke, 1988). The provision of services by NGOs
continued to expand slowly, fueled by nationalistic organizations such as the Nigerian Medical Association, until the early 1990s when NGO growth was propelled forward by dissolution of all democratic political institutions under the General Sani Abacha regime (WANGO, 2007).

The Abacha administration, which was deemed as one of the most “corrupt and despotic regimes” in Nigeria’s history, sought to eliminate the influence of NGOs within the nation (Gordon, 2003, pp. 171). Due to the ruthless actions of Abacha and his staff, and the failure to hold democratic elections, development aid being sent to the government was diverted by donors to NGOs as a means to circumvent institutions that were deemed fraudulent and ineffective (Falola, 2008; Okumu, 2003; Smith, 2007). As a result, the number of NGOs operating across all sectors of Nigeria exponentially grew as donors sought new ways to infuse money into failing systems. After the death of Abacha, NGOs continued to play a significant role in Nigerian society as they were perceived to be a critical means to “legitimize the new democratic government” (Bennett, 1995; Smith, 2007, p. 102). Donors, no longer content to deal with agencies engaged in conventional government politics, sought to simplify financial links and the general flow of money by directly applying funds to perceived problems via NGOs. This enabled NGOs to bring a substantial sum of money to bear on a specific problem area while retaining a sense of operational independence. It also had the effect of promoting corruption, spawning duplication of services, and in some cases, due to donor priorities, created groups that directly competed with the government (Smith, 2007).
Unfortunately, the sudden increase in NGOs during the 1990s failed to translate into a sustainable impact on the Nigerian health care system. The additional support provided by NGOs benefited government programs as organizations leveraged specialized expertise and provided additional aid in the form of supplies. However, since they often operated “independently of any national goal” and are still generally “funded by private donations,” organizational agenda’s sometimes opposed national programs and established goals (Anya, 2009; Iheme, 2004, pp. 1-17; Ogunbekun, Ogunbekun, & Orobaton, 1999, p. 174). Currently, many of the NGOs now operating in Nigeria have been unable to create sustainable, repeatable results due to their project locations, staff, or administrative shortfalls due to limited projects that cannot be reproduced at the national level (Bob, 2002; Calderisi, 2007; Okumu, 2003). There have been several exceptions such as efforts involving smallpox eradication and progress in the control of polio, guinea-worm disease, onchocerciasis (River Blindness) and measles, but for the most part, even these programs have failed to implement long term solutions within the public health care system (WHO-AFRO, 2006).

One substantial problem that has plagued even the most successful of Nigeria’s NGO programs is the focusing of efforts on a single disease which creates what is known as a “vertical program” (USAID, 2010, p. 13; WHO-AFRO, 2006, p. 106). These programs, according to the World Health Organization, “suffer from lack of coordination between vertical programs, duplication of effort, and poaching of skilled staff from essential health-care services,” and can also damage a health care system in the long term by failing to turn short term gains into long term successes (Anya, 2009; Gass, 2011, p. 5;
NGOs with strong, successful programs sometimes supplant local government programs in the same area and since local government programs tend to suffer from a lack of resources, administrators are generally grateful for any additional assistance (Anya, 2009; Okeniyi, 2011). Upon completion of a project however, organizations will cease activity and establish another project. Unless some form of collaboration with the government has occurred to take over service provision, patients can and have been, left with no care to address their medical needs (Anya, 2009; WHO-AFRO, 2006). Better regulation and coordination of NGO activities, in conjunction with government programs, can reduce the instance of such incidents from occurring, but bringing some sort of organization to the health sector may be an insurmountable challenge for the government (Lyayi, 2009; Oloriegbe, 2009).

Currently in Nigeria, there is a profusion of indigenous NGOs operating within the private sector ranging from community-based organizations, which draw members from a specific geographic region, to international NGOs that have operational departments in the country (Iheme, 2004; Gordon, 2003). Unfortunately, there is no general registry of NGOs, nor is there a strong NGO-specific regulatory system in place to better coordinate ongoing efforts (Iheme, 2004; WANGO, 2007). However, NGOs do have the option to register as “companies limited by guarantee or incorporated trustees” under Nigerian law. Using this system, the Corporate Affairs Commission, which maintains a register of companies and incorporated trustees, has placed over 45,000 NGOs on their roles as of 2005 (COF, 2010; Charity Commission, 2010). Given the sizable nature of this sector, NGOs have the potential to impact the development of the
Nigerian health care system in a positive manner once both NGOs and the government take advantage of opportunities to leverage existing partnerships, minimize mistrust, and coordinate crucial support programs.

1.1.5 Social Conflict

Social conflict and an all-encompassing culture of corruption/neglect are major issues within Nigeria. This research did not study the role of social conflict at length, but instead incorporated instances of conflict that directly impacted NGO operations into the data set. It is important to understand however that widespread violence has occurred in Nigeria over the past decades and has affected the way in which NGOs function in certain areas of the nation. NGOs have been impacted by numerous military coups, pervasive corruption that arose on the heels of increased oil profits, and ethnic violence spanning the five decades since independence. Most recently, actions by militant groups have threatened to destabilize the nation even further, potentially leading to restrictions on how aid is delivered and where organizations can work safely.

Seven heads of state have been either killed or disposed of by military coups since the establishment of the first republic in October 1960 (Lewis, Robinson, & Rubin, 1998). Ethic violence spread across the nation following each coup as revenge for real or perceived slights was carried out by the various tribes. Now, extremist groups such as Boko Haram and the Movement for the Emancipation of the Niger Delta (MEND) have carried out violent attacks against the government and civilians in the north and southern delta region. The actions of MEND have lessened since members were granted amnesty in 2009, but kidnappings, attacks on civil infrastructure, and illicit trafficking of weapons
and drugs still occur in the Delta region. Boko Haram however has become an ever increasing threat to the stability of Nigeria. The organization began in 2002 and seeks to abolish the current system of government establish Sharia law in its place (Karimi & Carter, 2014). The death of Mohammed Yusuf, a cleric who helped establish Boko Haram, caused the group to become more violent. Since his death, leaders have instigated a series of coordinated attacks against both citizens and government forces in the north eastern states. One of the more recent actions attributed to Boko Haram directly affecting the health care sector involved the February 2013 killing of polio vaccination workers at two separate clinics near Kano (BBC, 2013; Daily Trust, 2013; Smith, 2013). Due to the increased violence, polio vaccinations were halted and activities of NGOs within the North were severely curtailed, creating the possibility that polio may once again gain a foothold in northern Nigeria. Other Boko Haram sponsored violence has continued to worsen with the most recent attack that resulted in the kidnapping of over 100 girls from the Chibok government secondary school in north-east Borno state and the bombing of a bus station in the capital of Abuja (Abubakar, 2014; Karimi & Carter, 2014). Each new attack serves to erode the already low quality of life and contributes to the overall progression of violence, infrastructure deterioration, and institutional decay in northern communities.

1.2 Problem Statement

The Nigerian health care system is in disarray and needs urgent attention. The government is trying currently to correct the situation, but cannot do it alone. (Nasidi, 2008, p. 12)
In Nigeria, the government has clearly failed to establish and sustain a viable health care system and the continued suffering of its people, illustrated by an extraordinarily high child mortality rate, low life expectancy, and reoccurring outbreaks of treatable diseases, shows no sign of abating (DoS, 2008; Ileuma, 2004; Nwaobi, 2005). The government lacks the capacity to fully development a health care system and appears to have abdicated its role in providing services to a combination of private sector and NGOs operating throughout the country (DIA, 2007; Fasua, 2005; Orabuch, 2005; Paulson, 2001). It is doubtful if the government of Nigeria, despite their repeated commitments to reinvigorate the health care sector, has the capacity to meet such a goal given their low levels of health expenditures in relation to the national Gross Domestic Product. NGOs, which are already deeply rooted in Nigeria, provide a means of facilitating development and building capacity in the health sector (Aina, et al., 2002; Dixon, Hawkley, & Evans Scott, 2003; Narel, 2008). Unfortunately, it is not fully known if NGOs involved in the health sector have the ability to provide services and the capability to coordinate ongoing mitigation efforts in conjunction with government efforts (Dixon, et al., 2003; Erinosho, 2009; Gyoh, 2008; Prodi, 2000). The researcher contends that although a majority of NGOs are not sufficiently capable of providing the level of support needed by the Nigerian government to mitigate the spread of infectious disease, they are the best and in some cases, only, source of assistance to create a functional and responsive national health care system.

It is vital that the Nigerian government utilize the skills, abilities, and resources available among potential NGO partners within the region and in the local health sector.
in order to develop a robust national capacity to address public health threats. Through such cooperation, Nigeria can “strengthen existing frameworks that are complementary to national capacity without undermining established systems” (Oke, Faweya, & Sklaw, 2002; U.S. Congress. Senate, 2005, p. 14). This collaboration will reduce the impacts of infectious disease which threaten to create a drag on the national economy, furthering what has become a downward spiral leading toward additional governance and public instability.

In response to the ongoing failure of the health care system, the private sector, which includes NGOs, has expanded dramatically and constructed a near parallel system but without any of the regulatory practices that encourage efficiency and establish an overall level of quality (Iheme, 2004; Grange, 2007). It is estimated that fully 65 percent of national health care expenditures take place within the private sector, but the services that are delivered normally consist of low quality products and sub-standard medical care (Barnes, Chandani, & Feeley, 2008; Hanson & Berman, 2000; WHO, 2010). The majority of these services center on treatments for routine problems such as headaches, minor wounds, etc., or for chronic disease related medical issues due to the lucrative nature of the business. For instance, at the lowest level of service, an individual can receive treatment from a ‘chemist’ who provides various drugs, much like a drug store that can be encountered in other nations. According to Ike Anya, a public health physician, these individuals generally “tailor their treatments to the pockets of the patient. The patient might say, I have a stomach ache and ten Naira, what can you give me for ten Naira?” (Anya, 2009). At higher levels within the private health care sector, the same
lack of regulation drives private clinics, such as those midwife led facilities in rural areas (Erinosho, 2009; Health Partners International, 2011). Some health workers have discovered that it is quite profitable to go to the rural areas and set up a private hospital or health facility because they are poorly regulated and other options for treatment can be non-existent for a local population. While these services do meet a common need, their overall lack of quality continues to hamper the advancement of Nigeria’s health care system (Irikefe, 2009).

The private sector has attempted to fill the dearth of primary health care needs, but due to skills, personnel, and infrastructural shortages, they have not been able to truly address outbreaks of infectious diseases. Infectious diseases exact a far greater toll on the population and lead to long lasting negative implications at the national level. They are of particularly great concern in countries such as Nigeria, because they can amplify instability, further secondary disease transmission leading to possible pandemics, and magnify economic strife through their negative impacts on the economies, governments, and militaries (Fox, 1998; Metz, 2000; Price-Smith, 2001; USAID, 2006). Response efforts dealing with disease outbreaks have generally fallen to international organizations (IOs), supported by NGOs operating at both the international and local levels. In the past, partnerships between these NGOs and the Nigerian government have resulted in short term, vertical programs targeting a single disease or specific outbreak (Anya, 2009; Grange, 2007; WHO-AFRO, 2006). Furthermore, these partnerships have produced fragmented efforts that “have not been the desired capacity building initiatives” that are needed if Nigeria is to strengthen its national public health sector (Grange, 2007). As
individual programs progress, capacity development diminishes leaving the population with no means to seek continued treatment once the response has effectively ended.

Past outbreaks have illustrated that, although there are numerous agencies, both local and international, poised to respond, short-term collaboration and long-term capacity-building efforts have not been entirely successful. Public health emergencies in many developing nations like Nigeria are based on the collective effort of multiple groups; for this reason, it is imperative to understand how one of the major contributors supports the ability of the Nigerian government to mitigate and respond to the spread of infectious diseases. Otherwise, NGO efforts to supplement health care becomes a long term endeavor and does nothing to build both capacity and long term capability within the Nigerian health care system.

1.3 Purpose of the Study

People get sick and die in many cases because the systems for disease prevention and control are not in place or – if they are – they do not function properly. (WHO-AFRO, 2006, p. 105)

The overall topic of this study is influenced by one potential area of research identified by Dr. Richard G. Wamai, University of Helsinki, in his 2004 dissertation, "Recent International Trends in NGO Health System Organization, Development and Collaborations with Government in Transforming Health Care Systems: The Case of Finland and Kenya." Wamai’s research focused on “portraying a systematic and analytical picture of the health system operated by NGOs in Finland and Kenya with regard to service provision, promotion and participation in policymaking” (Wamai, 2004,
During the course of his study, Wamai illustrated that the “NGO-isation of health care increased debate about collaboration,” and the governments of both Finland and Kenya displayed “glaring gaps in knowledge, information and research on the operations of the NGO sector” within the health sector (Wamai, 2004, p. 301).

Furthermore, the study identified that due to the importance of NGOs, an “extensive and yet diverse collaboration needs to be nurtured and strengthened” primarily because of benefits arising that range from economic to political (Wamai, 2004, p. 302).

In concluding his study, Wamai advocated for “deepened analyses of the different roles various types of health NGOs play with regard to service provision, promotion and participation in policy work with a view to coordinating them well within the overall health system” (Wamai, 2004, p. 305). While Wamai primarily directed his efforts toward policy development within the more holistic health care system of two distinct nations, he tested no hypothesis resulting in a “more investigative study” designed to produce a “primer study on the subject” (Wamai, 2004, p. 14). Although this study was influenced by his overall approach, the Nigerian health care system that is involved with the containment of infectious diseases was emphasized with the distinct intent of demonstrating the shortcomings in both services and coordination that have hamstrung ongoing mitigation efforts. This study draws somewhat from the overall qualitative methods and analysis techniques used to carry out the 2004 research, but the study diverged from Wamai’s original theme in order to gain a more developed understanding of individual NGOs operating within Nigeria and their overall importance to both the general populace and the government.
Using Wamai’s material as a reference, this qualitative case study examined the framework of NGOs operating within Nigeria and analyzed their ability to mitigate the spread of infectious diseases and contribute to the development of a strong national capacity. NGOs are assessed against a model, termed the *Capacity Development Triad*, designed to measure the potential to: (a) create and implement strategies supporting the development of a national capacity to respond to the spread of infectious diseases, (b) generate an internal capability to address critical organizational resource shortfalls, and (c) implement mitigation programs in conjunction with the public health sector through mutually beneficial partnerships. The development of the triad is described in section 2.3.2. In order to accomplish this aim, the study seeks to present a systematic overview of how NGOs operate developmental programs and what impact national policy and regulation have had on the ability of NGOs to contribute to government efforts.

Reports from conferences such as the 2004 “Nigeria – Partnership for Health,” the 2004 and 2009 Nigerian National Health Conferences, published articles in humanitarian journals, WHO assessments, and NGO project reviews illustrate that the government of Nigeria is incapable of implementing long term programs to combat the spread of infectious disease without significant NGO support (Barnes, et al., 2008; Grange, 2007; Gyoh, 2008). The researcher hypothesized that despite several notable efforts in the past, NGOs are not sufficiently capable of mitigating the spread of infectious disease, or contributing to the national health capacity due to limitations in resources, skill sets, and the inability to maintain enduring programs. These shortcomings undermine the viability of any project undertaken and in some cases, such as the outbreak of a particularly
virulent disease, may exacerbate existing deficiencies resulting in a greater loss of life or misuse of limited resources.

In order to address the purpose of this study, one primary research question, supported by three subsidiary questions was selected. From an overall standpoint, the study focuses on the following question: Can indigenous NGOs support the ability of the Nigerian government and its health care system to respond to the spread of infectious diseases through the implementation of local programs that contribute to a robust national capacity? Addressing this question required a three part approach that is covered through the subsequent questions. The first portion of the study concentrates on how strategies for developing capacity in the health care system have been developed and implemented by selected NGOs? This question measures to what extent an organization has defined and implemented a strategic plan that guides capacity building activities, mobilizes available resources, establishes lasting, sustainable partnerships within the health care sector. Data will be used to determine to what extent NGO strategies focused activities and resources over both the short and long term, aligned efforts with other organizations and government activities, and met the needs of communities where programs were implemented.

The second part of this approach addressed the question, have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions that limit the spread of infectious disease? This question was used as a basis for examining the projects being undertaken by the selected NGOs. Projects were analyzed in terms of the stability, equity of services, and impact on the
communities that they were meant to serve. The study also sought to identify information such as organizational configurations, coverage areas, funding sources, available skill sets, and known affiliations, among others. Analysis of this material will determine the ability of NGOs to support the health care system with critical shortfall capabilities, the second component of the Development Triad. Data also assisted in establishing why NGOs are important to the overall health care system and how they have contributed to the care of the populace in the past. Finally, data will illustrate disparities between the public and private sector organizations within the nation. This latter point is important when determining the level of influence that a NGO, or group of NGOs, may have on the crafting of policy or acquisition of public resources.

The final part of the study concentrated on the question of how have NGOs affected the development of national capacity through partnership and collaboration with the public health sector? The larger outcomes of NGO-government collaborations, particularly NGO influence in the development of health care plans and formation of policy and legislation, were studied to determine the dynamics of any established relationship. This question also addressed barriers to collaboration resulting from cultural, process, or policy frameworks and what changes NGOs have had on the social-economic structures in the regions that they serve. Relationships between the government and the populace, and associated advocacy efforts, are key to understanding how NGOs function within the nation, what their overall level of importance to the health care system is, and how they facilitate, or fail to facilitate, government led mitigation activities.
1.4 Definition of Terms

Several terms used throughout this research require clarification due to their varied, and sometimes conflicting, use by aid agencies, interagency organizations, and the medical community. Terms are defined below in order to provide a base level of knowledge for the reader to make use of when assessing the results of this research.

Capacity

The development of a strong national health capacity is the central idea of this study. The notion of what constitutes capacity however varies amongst organizations within the community and can range in both scope and usage. It is important to note that capacity is a means to “achieve something, and is not an end in itself” (UNEP, 2002). Within this body of work, capacity at the systemic/national level has been defined as “the ability of the Nigerian government, and its constituent parts to achieve stated health care objectives” (Goodman, Speers, McLeroy, 1998; Morgan, 2006). Although there are numerous methods to facilitate the growth of national capacity, this study sought to understand the role of indigenous NGOs and how their efforts could be incorporated into the process.

NGOs were identified as a potential way of developing existing national capacity and contributing to the creation of new capacity at the federal, state, and local government levels. Capacity at the organizational/NGO level is different from the systemic level and is primarily concerned with the performance of a “broad range of functional capabilities consisting of the collective attributes, skills, abilities, expertise, and resources” common to the operation of an NGO (OECD, 2006). In order to create a
distinction between the two levels, this research refers directly to organizational capabilities and attempts to determine if NGOs have the internal capability to sufficiently aid in the process of developing national capacity.

The process of developing capacity is another area where there are variations in both usage and meaning. The researcher used a definition proffered by the United Nations Development Program as a baseline for the execution of this study. Capacity development is defined as “the process by which organizations and institutions increase their abilities to: 1) perform core functions, solve problems, define and achieve objectives; and 2) understand and deal with their development needs in a broad context and in a sustainable manner” (Panday, 2002, p.68).

**Infectious and Emerging Infectious Diseases**

Although the term infectious disease is generally ubiquitous in modern society, it has been included within this research to reinforce the scope of the topic being studied. This research only addresses efforts related to mitigation of, or response to, infectious disease related health problems and outbreaks. No attempt was made to encompass chronic diseases, which are generally considered non-communicable. Chronic diseases are generally of “long duration and slow progression” and include “heart disease, stroke, cancer, chronic respiratory diseases and diabetes” (CDC, 2011; WHO, 2011). While these long lasting diseases do significantly impact the Nigerian populace and create a drain on the limited resources available to the health care system, they are outside of the scope of this research.
Infectious diseases are caused by a biological pathogen that penetrates the body and multiplies, creating an infection. These diseases are also considered “communicable or contagious” meaning that they can be transmitted from person to person through contact, contact with contaminated bodily discharge, or through a vector source such as mosquitoes (Hart, 2004, p. 26; Merriam-Webster, 2006; Mosbey, 2008; Rothman, 2002, p. 40; WHO, 2011). Examples of infectious disease include, but are not limited to: Avian Influenza, Cholera, Crimean-Congo Hemorrhagic Fever, Ebola Hemorrhagic Fever, Human Immunodeficiency Virus, Legionellosis, Malaria, Marburg Hemorrhagic Fever, Poliomyelitis, Smallpox, Tuberculosis, and Yellow Fever.

In some cases, infectious diseases have mutated into a drug resistant strain, or a new type of disease has surfaced from within a community. These sorts of diseases have been defined as an “Emerging Infectious Disease” or EID. An EID is an “infectious disease that has newly appeared in a population or that has been known for some time but is rapidly increasing in incidence or geographic range” (Marsh Inc., 2008, pp. 1,4; Merriam-Webster, 2006; WHO, 2011). The definition was further elaborated upon in a 1992 Institute of Medicine report, stating that “emerging infectious diseases include those whose incidences in humans have increased within the past two decades or threaten to increase in the near future” (CDC, 2007; Institute of Medicine, 1992).

Health Care System

This research uses a definition derived from the World Health Organization Report 2000, which is dedicated to the overall status of national health care systems. In this report, health systems are defined as “comprising all the organizations, institutions,
and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services, or through inter-sectorial initiatives, whose primary purpose is to improve health” (Farlex, 2011; Wamai, 2004, p. 30; WHO, 2000, p. 5). This explanation of the term appears to be widely accepted throughout the health community with minor deviations arising in the specification of primary and secondary systems, as well as organizational responsibility for the system as a whole. For instance, Coddington (1994), in Integrated Health Care: Reorganizing the Physician, Hospital and Health Plan Relationship, states that a health care system combines “physicians, hospitals, and other medical services with a health plan to provide the complete spectrum of medical care for its customers” (p. 7). The lack of formal organizational responsibility is reflected by Gordon Marshall, in his 1998 Dictionary of Sociology, in which he defined a health care system as the “arrangements in a given society for the provision of health-care (both preventive and curative) whether organized into a coherent system or not” (Marshall, 1998). In Nigeria, public sector services are supplemented, or in some cases replaced, by a mixture of private and NGO providers. This has produced a complicated, decentralized structure that is a significant challenge to the construction of a strong health system. Even though the structures and providers may vary in nature however, the existing health care system remains the underlying factor in defending against outbreaks and effects of disease.

Nongovernmental Organization (NGO)

The definition of a NGO can vary by those who use it depending on the activities, structure, and end goals of the organization being considered. In order to alleviate
confusion, this study has adopted the United Nations Rule of Law definition of a NGO as a “not-for-profit group, principally independent from government, which is organized on a local, national or international level to address issues in support of the public good” (UNRoL, 2014).

Understanding the Nigerian environment requires an explanation of NGOs that pursue operational or advocacy based agendas. The World Bank has defined these two categories as follows: “1) operational NGOs - whose primary purpose is the design and implementation of development-related projects, and; 2) advocacy NGOs - whose primary purpose is to defend or promote a specific cause” (Duke University, 2007). The World Bank further breaks down operational NGOs into

1) community-based organizations (CBOs) - which serve a specific population in a narrow geographic area; 2) national organizations - which operate in individual developing countries, and; 3) international organizations - which are typically headquartered in developed countries and carry out operations in more than one developing country. (Duke University, 2007)

Within the context of Nigeria, there is a wide variety of each type of organization, but numerically CBOs represent the largest share of the NGO presence (Iheme, 2004). For the purposes of this research, operational NGOs in all three forms were included in the sample population. Differentiations between CBOs, national, and international NGOs were made as appropriate to their impact on the study.
1.5 Assumptions

Research into the ability of NGOs to contribute to the ability of the Nigerian government and its health care system was conducted under the following assumptions:

First, it was assumed that the Nigerian government continually seeks to improve the performance of its overall health care system and fully develop the services offered to the populace. As previously stated, Dr. Gro Harlem Brundtland attributed the responsibility for developing and maintaining a health system to the government. He said the “health of people is always a national priority: government responsibility for it is continuous and permanent” (WHO, 2000). While this responsibility may have been abdicated in the past by a parade of questionable leaders, the previous decade has seen a resurgence of initiatives designed to improve the failing health system. In November 2005, the National Policy on Public Private Partnership for Health in Nigeria was published, articulating “the dimensions of public private partnerships and interactions, and how these should be strengthened in order to serve the people of Nigeria” (FMoH, 2005, p. 6). This policy was followed by the Health Promotion Policy which stated that it “provides the framework for Nigeria’s bold attempt to enable Health Promotion to play a vital role in the National Health Care delivery system” (FMoH, 2005, p. iv). Most recently, the Nigerian government passed the National Health Bill 2008, in early 2009, which was designed to provide a framework for the regulation, development and management of a national health care system (Federal Republic of Nigeria; Senate, 2008; Policy and Legal Advocacy Center, 2009). These programs have resulted in increased spending on health care, although the expenditures are well below the regional averages (Amaghionyeodiwe,
2009; WHO, 2011). Despite problematic implementation and poor results achieved by government directed programs, legislative endeavors, along with the National Health Insurance Scheme, several cooperative state-level health initiatives, and limited advances in improving care in rural areas demonstrate an on-going commitment to improve the performance of Nigeria’s overall health care system (Anya, 2009; Gyoh, 2008; Health Partners International, 2011; Okeniyi, 2011; Sam, 2008).

Second, this research was developed under the assumption that the NGO community will not only work with the government to improve the health care system, but the community is also a key component of the system as a whole. Mitigating and responding to the spread of infectious diseases require a holistic, coordinated and multi-sector approach. A large number of NGOs, along with private sector representation, have surged to fill the voids in the Nigerian health care system (Barnes, et al., 2008; Ileuma, 2004). While there is, and will continue to be, a level of mistrust among organizations vying for the same resources and seeking to grow their operational base, it must be assumed that they still seek to improve health conditions for the populace and the nation as a whole (Hanson & Berman, 2000; Iyayi, 2009; Williams, 2008). Organizations ranging from the Clinton Health Access Initiative and Africare Nigeria to the Amukoko Community Partners for Health and the Our Lady of Mount Carmel Care Foundation, all form an integral part of the current health care system and without their efforts, essential services would not be available to the local populace. Additionally, these organizations all advocate for an improvement in the overall provision of services while several, such as the Health Reform Foundation of Nigeria and the Department for International
Development have devoted their efforts to the reform of the health care system (DFID, 2011; HERFON, 2011). Given the number of health NGOs in Nigeria and their organizational goals, it is assumed that they will collaborate with the government on efforts that improve health care provision as long as such actions do not jeopardize their operational independence or violate their founding principles.

Third, it was assumed that the disease burden of sub-Saharan Africa will remain constant, or worsen, over the next 15-20 years, further stressing the operation of the Nigerian health care system. World Health Organization statistics show that since 2000, there have been outbreaks of Cholera, Avian influenza, Meningococcal disease, Poliomyelitis, and Yellow fever in Nigeria (WHO, 2011). Nigeria additionally carries the second largest HIV burden in the world (SACIDS, 2011; Tol, 2007; USAID, 2011; Wilcox, 2005). Throughout the remainder of the sub-Saharan Africa region, the tally of disease outbreaks is significantly worse. Infectious diseases account for more than “sixty-five percent of all deaths on the continent and due to changes in both ecology and land use patterns”, the region is predicted to be under an increased risk of outbreaks over the next decade (Aikins, 2010, p. 2; Bates & Kundzewicz, 2008, p. 80; Patz, Olson, & Gibbs, 2008; Young, 2009). Death rates will also continue to exceed other, more developed areas, until health care capacity becomes more robust and is able to mitigate the impact of the disease burden (NIC, 2006). Unfortunately, health care systems may not be able to fully develop in the near future. In conjunction with the spread of infectious diseases, the World Health Organization “projects that over the next ten years the continent will experience the largest increase in death rates from cardiovascular disease, cancer,
respiratory disease and diabetes” (Unwin, 2001; WHO, 2005). This additional yoke on fragile health care systems will divert much needed resources from efforts to bring existing or emerging diseases under control thus creating challenges impacting national development, governance, and economic stability.

1.6 Research Method

This research utilized qualitative methods, specifically an illustrative case study method, supported by key informant interviews, to obtain information on the capability of indigenous NGOs to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity.

A case study, as defined by Yin (2013) in his book, *Case Study Research: Design and Methods*, is an “empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context especially when the boundaries between phenomenon and context may not be clearly evident” (p. 16). A less technical description provided by Merriam defined case studies as “an examination of a specific phenomenon, such as a program, an event, a process, an institution, or a social group” (Merriam, 1998, p. 9). The illustrative aspect of the case study method is used to describe one or two instances of a particular phenomenon in order to assist in the interpretation of a selected situation (Mann, 2006; Merriam, 1998; Yin, 2008). This method is a demonstrated, comprehensive research strategy that used both qualitative and quantitative research to detail efforts to mitigate and respond to the spread of infectious diseases. Its major strength, which enabled this research, was to “deal with a variety of evidence” that included interviews, materials provided by both NGOs and government sources, health
statistics and archival data, and other similar material associated with the Nigerian health care system (Merriam, 1998, p. 8; Rowley, 2002). It also allowed for the restriction of bias and maximized the researcher’s ability to interpret capacity and performance of the sample population.

The case study was selected as the primary qualitative method because the research sought to understand the involvement of health NGOs within an “important contextual condition” (Yin, 2013, p. 16). Without the contextual understanding of infectious disease outbreaks and the existing health care system, the contributions of health NGOs would not be easily applied to specific capacity development activities as multiple variables were involved throughout response and mitigation efforts that sometimes convolute organizational intent. The case study method allowed the researcher to improve control of the variables and multiple evidence sources in order to better “collect multiple types of qualitative and quantitative data, analyze the information, and report the results” (GAO, 1990, p. 23; Johansson, 2003, p. 7; Merriam, 1998, p. 8; Yin, 2008). The case study method was also the most suitable method for this study due to the researcher’s desire to convey a thorough understanding of the dynamics of NGO activities within Nigeria. By illustrating the process and the ongoing projects, the research was able to communicate a substantial description of activities that allowed for a reasonable interpretation of the ability of health NGOs to build capacity within the Nigerian government and its health care system (Guba & Lincoln, 1992; Kenny & Grotelueschen, 1980; Merriam, 1998; Sanders, 1981).
1.7 Relevance for the Field of Biodefense

And when disease goes unchecked in any corner of the world, we know that it can spread across oceans and continents. (WHO, 2009)

Biodefense is the field of study based on the combination of knowledge of policy, science and technology necessary to “address the challenges to national and international security posed by the threat of biological terrorism” (GMU, 2007). This field has also grown to "include the study of infectious diseases that are emerging from populations around the world," with the intent of saving lives and reducing the mortality rate of an affected population while reducing the spread of disease outbreaks that could potentially migrate to the United States (Garrett & Fidler, 2009, pp. 24-25; GMU, 2007). This latter threat, combined with the media coverage of avian influenza, severe acute respiratory syndrome, disease resistant tuberculosis, attacks using anthrax, and other outbreaks of disease has illustrated the need to develop layered defenses aimed at reducing or eliminating a public health threat at its source before a disease has the opportunity to take root in a community. By actively engaging public health threats overseas, a concerted effort by aid agencies, in combination with host governments, could not only reduce the impact of a disease upon the population of Nigeria, but it could also reduce the potential impact of a disease upon our own population as the pathogen spreads beyond its borders (Markel, 2005; Thani, 2007).

This study is especially relevant to the field of Biodefense due to its emphasis on the cooperation of groups with a wide range of knowledge and capabilities which can potentially reduce the impact of a biological threat if they were to work more effectively
as a coherent entity. The focus area of this study typically carries 25 percent of the world’s disease burden, but contains only 1.3 percent of the world’s health workforce (Enogholase, 2010; Okeniyi, 2011; WHO, 2008). These astounding statistics, combined with a decrease in the skills and resources necessary to respond to large scale public health emergencies, increases the potential for an outbreak to spread quickly beyond the initial outbreak area and be transmitted to other nations. The first line of defense against such a virulent outbreak in developing nations will, in many cases, be local NGOs already operating in an outbreak area. These organizations are a diverse set of groups often operating “independently of any national goal and are funded by private donations, local donors, or by international organizations” such as the United States Agency for International Development or the United Nations High Commissioner for Refugees (Ainscough, 2006; Okumu, 2003). As such, attempts to bring an outbreak under control have the potential to be “disjointed, lack an overarching structure, logistical trains, technical support, and political support, to respond to a given situation” despite the near heroic dedication of select NGOs to provide health care to their respective populations (Carligeanu, 2009; Edwards & Hulme, 2002, pp. 3-4; Fowler, 2000). Ministry of Health personnel at the state and local governmental level within Nigeria often operate in similar conditions to NGOs, but in many cases, they lack the logistical capacity, resources, and overall medical skill sets to meet the needs of the national population (Bob, 2002; Calderisi, 2007; ECA, 2004). Their efforts to respond to day-to-day health problems can be limited, at best, and the occurrence of a particularly virulent disease can tax already limited resources.
In the event of a truly massive public health event in Western Africa, an infectious disease outbreak could dwarf all ongoing response efforts and overwhelm national health and medical capabilities, "potentially resulting in hundreds of thousands of deaths, millions of hospitalizations, and hundreds of billions of dollars in direct and indirect costs" (DIA, 2007; Homeland Security Council, 2005). It would be well beyond the capability of any NGO, and most MOHs, to respond to this situation in an effective manner without a fully orchestrated effort and as a result, a disease would most likely spread far beyond the initial area where the outbreak occurred. Prior to a situation becoming this dire however, an effective collaborative framework can be established by NGOs in high risk areas in order to control any outbreak though a rigorous program of planning and capacity development. This study is important in this regard since it specifically addresses the latent capacity already available and how stronger collaborative frameworks can be established between NGOs and the public health sector. This research also uncovered issues that specifically inhibit collaboration between NGOs and the Nigerian government and recommends ways to overcome the obstacles. Findings can be applied to other countries, thus creating a means to bolster health care systems throughout sub-Saharan Africa.

As stated in the 2005 National Strategy for Pandemic Influenza, "We rely upon our international partnerships, with the United Nations, international organizations and private non-profit organizations, to amplify our efforts, and will engage them on a multilateral and bilateral basis. Our international effort to contain and mitigate the effects of an outbreak of pandemic influenza is a central component of our overall strategy. The
character and quality of the U.S. response and that of our international partners may play a determining role in the severity of a pandemic” (Homeland Security Council, 2005).

The relationships between NGOs and the national Ministries of Health will indeed play a major role in the containment and mitigation of a biological outbreak in Western Africa. These same relationships, which are central to this study, will also potentially play a role in reducing the spread of any such contagion to the United States from Western Africa, and mitigating the public health impact should an outbreak occur.

1.8 Dissertation Structure

This research is divided into a total of five chapters which are defined as follows:

Chapter one provides a background to the subject material, defines the problem, outlines the significance of the study, and identifies each research question that was used to conduct the research. It introduces the topic of the Nigerian health care system and impact of the burden of disease. It further establishes the influence of indigenous NGOs in the overall system and the role that they play in responding to the mitigation of infectious disease.

Chapter two reviews the literature surrounding the origin and implementation of capacity development activities; the major elements associated with the capacity development triad consisting of strategy, capability, and partnership; and NGO strategic models with the intent of identifying best practices applicable throughout the health care system.

Chapter three describes the research design and methodology used to structure the overall the study. A brief summary of the research question is included, followed by the
rationale for selection of a qualitative methodology. The research population is then identified, along with collection techniques and instrumentation used to gather data. When discussing the data collection, software, storage protocols, and data analysis procedures are detailed in order to summarize the administrative management of collected material. The various aspects of the methodology and administration are meant to improve validity and reduce the introduction of bias into the study.

Chapter four presents the findings and associated analysis of the collected data from the primary research question, and three subsidiary questions. The chapter analyzes how NGOs developed comprehensive strategies to implement sustainable programs. Organizational structure, resources, service provision, and mission goals are evaluated to contextualize their contribution and collaboration potential. Following this analysis of NGO activities, the research presents data associated with how NGOs affected the overall development of the Nigerian health care system through the partnership with public sector organizations.

Chapter five reviews the findings and conducts a synthesis of the data with the goal of establishing whether or not NGOs are capable of providing the support necessary to enable the public health sector to respond to the spread of infectious diseases. It demonstrates the importance of this study and potential ways in which the data can be applied toward improving the Nigerian health care system, thus improving the provision of services to the population, reducing the burden of disease, and improving the role of local government in rural areas. The chapter concludes with the implications of the research and potential areas of future research.
1.9 Conclusion

It is a sad reality that Nigeria has a health care crisis of ominous proportion. (Orabuch, 2005)

Within Africa, one of the most significant threats at this time is the dramatic public health crisis that ranges from the absence of basic health services to the spread of infectious diseases throughout the population. During the course of a three-year period (2003–2005), a total of “53 major outbreaks of disease occurred in 28 countries involving 22 separate and unique pathogens” (Medilinks, 2008; WHO, 2011). Unfortunately, the most notable of these outbreaks were never aired by national or international news organizations and many response efforts were plagued by “poor interagency coordination, logistical failures, and a simple inability to establish effective control measures” (WHO, 2005, p. 86). Each situation illustrated that, although there are numerous agencies, both local and international, poised to respond to an outbreak, short-term collaboration and long-term capacity-building efforts have not been entirely successful.

Such public health emergencies are multi-faceted problems impacting multiple domains and require the collective effort of many dissimilar groups. Nigeria’s health care delivery system is “fragile and under increasing stress” due to “growing populations, changing demographics, epidemiologic shifts and increasing urbanization” (DFID, 2008, p. 3; DoS, 2008, p. 6; Schneider & Moodie, 2002). In order to first stabilize the health care system and then make improvements, it is imperative to understand how NGOs and the government work in concert in order to develop an effective health care capacity within the nation. An opportunity exists to seize upon “established partnerships,
minimize mistrust, and provide support to the organizations” that would most likely be
the primary responders to a health crisis, thus reducing the impact to the local population
(African Union, 2007). Although there are also abundant organizational restrictions,
existing partnerships, and conflicting mission goals that complicate any such response,
failure to develop a framework for collaboration between NGOs and the government will
lead to continued difficulties in improving health service provision and developing the
capacity necessary to respond to, or mitigate public health threats before they have a
chance to adversely affect the Nigerian people. Furthermore, by developing capacity
within the health care system, not only will public health services be improved during a
crisis, but the day to day care available to a needy population may also be increased
leading to reduced mortality rates and potentially to increased stability within Nigeria.

The end goal of this study is to contribute to the literature regarding how NGOs
can potentially contribute to the development of a robust national health care capacity.
The study also seeks to identify a means to improve capacity development efforts within
the health sector by promoting, if possible, the development of a framework for
collaboration between NGOs, the existing private sector and the Nigerian government. It
is hoped that the results of this research can be applied across the numerous Nigerian
states, thus providing a means to build capacity and mitigate the effects of the many
public health threats that the country currently faces. However, the analysis of any NGO
capacity development efforts may not yield a single-model solution to the problem, but
may instead show the components of success that can be built upon by each member of
the health sector. Due to the complexity of the interconnected relationships and the need
to rely upon conditions that change from moment to moment, there may not be an
optimal solution to this problem, but only a “best guess” at how things might be resolved.
CHAPTER TWO: LITERATURE REVIEW

2.1 Context of the Review

Capacity development must be taken into the core of development planning, policy and financing if it is not to be an ineffective add-on or after-thought. (Dervis, 2007)

As discussed in chapter one, Nigeria’s government has failed to develop a health care system that is capable of adequately supporting the needs of the national populace. Reasons for failures are diverse but include the reduction of available health care services resulting from Boko Haram sponsored violence in the north and MEND attacks in the south (Adeyemi, 2008; Junger, 2007; Lubeck, Watts, & Lipschutz, 2007; MSF, 2012); reoccurring outbreaks of Cerebrospinal Meningitis, measles, and cholera, which have stressed national health care capabilities (DoS, 2008; Fox, 1998; Metz, 2000; NIC, 2006; UNAIDS, 2008; USAID, 2006); chronic underfunding of health care facilities; and a pervasive environment of corruption throughout the Nigerian health sector (Lewis, 2006; Moszynski, 2006; Smith, 2007). In 2000 the World Health Organization ranked Nigeria’s health system as being “187th out of 191 countries” and over the past decade, high child mortality rate, low life expectancy, and reoccurring outbreaks of treatable diseases have been a constant theme throughout the nation (Abuja Daily Trust Online, 2009; DIA, 2007; DoS, 2008; Enogholase, 2010; Fasua, 2005; WHO, 2000). The government has sought to enact reforms, but has failed to make any long lasting improvements to the
health care system. In some cases, leaders have undertaken ill-advised measures, such as the suspension of polio vaccination in 2003, which contributed to a further decline of care and contributed to the spread of disease within the nation (Abuja Vision FM, 2007; Aina, et al., 2002; Grange, 2007; The Associated Press, 2009; UN IRIN, 2006).

In the case of polio vaccination, the World Health Organization in conjunction with the government and multiple NGOs, has sought to bring the disease under control. However, almost nine years after the initial outbreaks, Nigeria is still seen as a major, albeit declining, reservoir of the wild poliovirus (AllAfrica, 2011; CDC, 2010; Thani, 2007). Efforts to control the epidemic relied heavily on outside support from NGOs, including the Bill and Melinda Gates Foundation, who contributed over 750 million dollars toward eradicating the disease (AllAfrica, 2010; Bill and Melinda Gates Foundation, 2011). Without this support from outside the government, the “lack of commitment from political leaders, traditional leaders, policy makers and the health sector” would have been a substantial barrier to the potential elimination of the wild poliovirus (WHO, 2010).

NGOs, like those who supported the poliovirus immunization campaign, provide a significant means of developing long term capacity within the health sector (Aina, et al., 2002; Dixon, et al., 2003; Narel, 2008). However, it is not fully known how widespread, or sustainable, the ability to develop capacity is among the current NGO population; recent successes have varied due to issues such as project locations, community involvement, staff, or administrative shortfalls (Bob, 2002; Calderisi, 2007). It is the central assertion of this research that the ability to develop a national capacity is
the key means in which NGOs will be able to support the ability of the Nigerian
government and its health care system to respond to the spread of infectious diseases.
Without a strong capacity, the Nigerian health care system will never be able to fully
support its population, which will create the potential for further economic hardships and
political instability. As such, the review of literature has been designed to examine the
theory, practice, and assessment of NGO organizational capacity. The review will further
focus on how NGOs have typically carried out individual development projects and
identify the “practical needs that are not currently being met” within the health care
sector (Randolph, 2009).

Literature ranges across numerous topics, but findings generally maintain the
supposition that indigenous NGOs, on the whole, lack robust organizational structures
capable of long term strategic planning. While the contributions of NGOs are an essential
part in improving national capacity development activities, there are inherent obstacles
within each organization that limits their overall effectiveness. There will always be
NGOs which will operate outside of the norm and be held up as an example for the rest of
the community, but these tend to be the exception, rather than the norm. Finding a means
to not only identify, but assess these obstacles is an important part of this research.
Therefore, while reviewing the literature associated with each variable, the research also
sought to determine an effective system for assessing the variable, in conjunction with
established theories and how that assessment could be applied to the review of a
particular organization. The outcomes of these assessments are incorporated into the
methodology portion of the study and used to interpret findings gathered from the targeted NGOs.

2.2 Capacity Development Background

When it comes to Africa, the outsiders have always behaved as if they know better than Africans what is good for Africa, and the result is that without the needed cooperation and support, Africa has particularly always been derailed from pursuing relentlessly and vigorously the agenda it has set for itself. – Abebayo Adedeji, Executive Secretary of United Nations Economic Commission for Africa. Cited in (Nugent, 2004, p. 326).

Capacity development is the latest incarnation of a term used within the development community to illustrate projects and aid efforts being carried out in developing nations. While this term has been in use since mid-1990, its roots date back over sixty years to the creation of the Marshall Plan in 1947. Despite the decades of usage however, capacity development remains an ill-defined subject that is constantly being learned, and then relearned by thousands of indigenous NGOs throughout the world.

Efforts that began in 1947 to rebuild Europe formed the core of what became to be known to the emerging development community as “institution building” in the 1950s and 1960s (Lusthaus, Adrien, & Perstinger, 1999, pp. 2-4; Smillie, 2001, pp. 8-9; UNESCO, 2005). According to Lusthaus, the objective of institution building was to “equip developing countries with the basic inventory of public sector institutions that are required to manage a program of public investment” (Lusthaus, et al., 1999 p. 3). Implementation of this objective was carried out and was tied to individual institutions
and people. Through the provision of training and skill enhancement, it was thought that
gaps in performance could be bridged (Eade, 1997; Lusthaus, et al., 1999; UNESCO,
2005; Verity, 2007). Institution building became institutional strengthening, and was then
re-coined as development management, followed by the push for human resource
development (Lusthaus, et al., 1999; Martin, 2009, Smillie, 2001). Until the late 1980’s,
the need to strengthen indigenous capacity in conjunction with local institutions clashed
with donor driven policies, national objectives, and the desire to quickly establish a basic
inventory of services using pre-packaged methodologies. What developed was a system
in which a charity model prevailed and a one way flow of resources went to the world’s
poorest communities instead of a system where self-sustaining sectors were created using
a combination of “capital resources, tools, and education” (Lavergne, 2003; Malhotra,
2000, p. 658; Mallaby, 2004; Moyo & Ferguson, 2009; Nugent, 2004; OECD, 2006;
Smillie, 2001; World Bank, 2008). During the 1990s, development efforts began to be
viewed negatively due to continued dependence on outside organizations, collapse of
supported institutions, and a failure to produce long term results (Eade, 1997; Smillie,
2001). This downward trend in perception set the stage for a new transformation within
the development community.

The continuous stagnation of work conducted in the previous decade directly
impacted the execution of development efforts in the 1990s. Seeking a means to develop
results that could be sustained over time, organizational development efforts began to
focus on “cross-sectorial approaches” that promoted partnerships between institutions,
key stakeholders, and local communities (Lusthaus, et al., 1999, p. 3; Hawe, King, Noort,
Gifford, & Lloyd, 1998; Smillie, 2001; UNESCO, 2005). Emphasis on development activities changed from individual institution building to a more holistic, sector-wide approach that emphasized accountability and “institutional responsiveness” (Craig, 2007; Eade, 1997, p. 16; Lusthaus, et al., 1999; Verity, 2007). The importance of ownership at the grassroots level was also promoted over the more traditional transfer of resources model in order to ensure that growth would be embraced, and more importantly, sustained by the local populace (Lavergne, 2003). During this timeframe, the term ‘capacity development’ emerged as a “catch-all phrase in donor discourse” since this new paradigm was used to integrate organizational activities “with a long-term vision for sustainable change” (Gillespie, 2005, p. 11; Laverne & Saxby, 2001; Lusthaus, et al., 1999, p. 8; Morgan, 1998; World Bank, 2005). Lusthaus, among many others, stated in his work that this new term is now viewed as the “aggregate of many other development approaches” and essentially has become “the way to do things” in the development community (Lusthaus, et al., 1999, p. 2).

Capacity development has continued, but studies indicate that successes are still fleeting and failure to address capacity issues are commonplace. In 2003, the Alliance for Nonprofit Management conducted an evaluation of capacity development efforts which incorporated lessons learned from over 80 non-profit organizations. Respondents incorporated university programs, sizable institutions such as the Rockefeller Foundation, and smaller organizations including the Community Resources Exchange and Social Venture Partners. While the study primarily centered on NGOs operating from developed western nations, as opposed to local NGOs operating in developing regions, the findings
indicated that the holistic vision of capacity development instituted by these outside organizations was not being fully realized. Findings of the study included the following (Linnell, 2003, pp. 22-26):

- Evaluation of capacity development is still uncommon,
- Existing evaluations do not compare the effectiveness of different capacity-building interventions — they are single-project focused,
- Conducting assessments is important to defining the baseline information from which change can be measured—it should be linked to stakeholder involvement.

Despite the rather bleak outcomes of the study, there are several citations demonstrating a growing recognition that infrastructure development and the creation of sustainable community programs are two key ways in which NGOs conduct their operations (Linnell, 2003). Larger institutions are also coming to realize that locally based organizations vary widely in scope and scale thus eliminating the “one size fits all” mentality toward the development of capacity (Linnell, 2003, pp. 20, 64). An important aspect of this realization was the consideration of practical ways to evaluate capacity development efforts in the area where projects are being carried out. Results of interviews and reviews of evaluation reports illustrate that there are numerous rudimentary issues, such as the need to plan how progress will be evaluated prior to starting a project or determining the actual needs of the community where a project will be implemented, spread throughout the development community. The study does put forth several valuable
lessons for NGOs to incorporate into their organizational practices. One such lesson is the “evaluations should fully engage the people most involved in and affected by the capacity building itself” (Linnell, 2003, p. 73). This insight is incredibly valuable, and somewhat obvious, since the participation, ownership, and potential for sustainability can be gauged through a transparent and open discourse with the people who will be most impacted by donor-directed projects.

As the Alliance for Nonprofit Management was providing a series of lessons from development efforts, other institutions were also reviewing activities that had occurred as capacity development efforts began to transform the way in which aid was given to developing nations. Following a series of capacity building reports published between 1995 and 2004, the World Bank released a culminating study, *Building State Capacity in Africa*. The study, which assessed “the relevance and effectiveness of Bank support for public sector capacity building in Africa over the past 10 years” illustrated the gradual transition from individual institution improvement to a more holistic approach focusing on accountability and sector wide reform. World Bank support for capacity development efforts were critical to progress in the African region. According to the report, the Bank supplied more than “$9 billion in lending and close to $900 million in grants and administrative budget to support capacity building in Africa” during the study period (World Bank, 2005, p. 43). Unfortunately, internal assessments conducted by the Operations Evaluation Department show that officials tended to view capacity development efforts as a collateral objective to any sponsored project which negatively
impacted long term success rates (World Bank, 2005). The Operations Evaluation Department noted the following findings (World Bank, 2005, p. 44):

- The Bank has not established a body of knowledge to guide its capacity building work. As a result, the capacity to implement capacity building activities is often overestimated and proven approaches to building human resource capacity on a sustainable basis are underdeveloped,
- Most support for capacity building remains fragmented—designed and managed operation by operation,
- Traditional capacity building tools and training have often proved ineffective in helping to improve sustained public sector performance,
- There are no standard quality assurance processes for the underlying diagnosis and design of measures, and capacity building interventions are not routinely tracked, monitored, and evaluated.

Implementing changes to overcome performance gaps have been crucial to programs throughout Africa as the World Bank is still a substantial supplier of funds to numerous development activities. Based on their lessons learned, the World Bank purports to have “broadened its support for public institutions, added new diagnostic tools, and expanded corporate and regional programs directly supportive of capacity building” (World Bank, 2005, p. 49). Emphasis was placed on the role of public institutions in order to enable the enhanced provision of services and support to the populations that they serve. Projects undertaken in accordance with World Bank
guidelines were refocused to treat capacity development as “a goal in its own right, not merely as a means for achieving other development objectives” (World Bank, 2005, p. 8). Additionally, public sector developments were linked to improving human, organizational, and institutional capacity while factors such as demand for services were brought to the forefront as a development consideration (World Bank, 2005).

The Operations Evaluation Department of the World Bank offered several recommendations regarding how to improve Bank operations and also highlighted the need to better guide donor support, but one of the more salient points of this study arose from the review of established country programs. This review stated that the Bank should “ensure that all operations that aim to build public sector capacity are based on adequate assessments of capacity needs and have ways to monitor and evaluate capacity building results” (World Bank, 2005, p. 45). Assessment efforts are a reoccurring theme within the growing body of literature at the end of the 1990s. The World Bank’s emphasis on assessments into its funding process was a significant reinforcement of the need to determine if a sponsored project was doing what it was actually intended to do (World Bank, 2005). Recommendations spurred the construction and distribution of evaluation tools that could be used to measure capacity development in developing nations and helped alter the way in which donors developed their individual engagement strategies.

Donor contributions and strategies were the centerpiece of a 2006 study entitled The Challenge of Capacity Development; Working towards Good Practice, produced by the Organisation for Economic Cooperation and Development (OECD). The OECD is a “forum where the governments of 30 democracies work together to address the
economic, social and environmental challenges of globalization” (OECD, 2006, p. 2). The forum recognized that while capacity development is a significant issue for both “donors and partner countries” it is also one of the most “difficult areas of international development practice” (OECD, 2006, p. 11). In their review of capacity developing challenges, it was noted that the process was inundated with solutions designed and in some cases implemented, without considering the needs of the impacted populations (OECD, 2006). Efforts based on this approach yielded poor results as they tended to be solely obsessed with producing outcomes that could be used as a means to further organizational goals (Dichter, 2003; Fukuda-Parr, Lopes, & Malik, 2002; Potter & Brough, 2004). This attraction to completing short term goals placed too much emphasis on the project and neglected the development of more robust institutional abilities.

In an effort to redirect development aid toward more successful outcomes, the 2005 Paris Declaration on Aid Effectiveness sought to establish stronger partnership commitments between donors and their associate countries. One of the declarations of the session included partner nations committing to “Integrate specific capacity strengthening objectives in national development strategies” while donors committed to “align their analytic and financial support with partners’ capacity development objectives and strategies, make effective use of existing capacities and harmonize support for capacity development accordingly” (OECD, 2005, p. 17). These statements were meant to promote mutual accountability, alignment of strategies, and managing projects for results (OECD, 2005). The OECD study and the Paris Declaration on Aid Effectiveness further reinforce that capacity development “goes well beyond the technical co-operation and
training approaches that have been associated with capacity building in the past” (OECD, 2006, p. 18). Both cite that development activities occur differently in each country and there is a great need for donors to align their strategies with national plans. Donor compliance with this plan will be a key factor in ensuring that capacity development occurs as donors are often responsible for identifying a problem that they want to address, provide skilled experts, and support the effort through the provision of sufficient funding necessary to attain a given goal (Dobie, 2002). The OECD study illustrated a number of ways in which both donors and nations can move from the “right answers” to a “best fit” approach to implementing development practices. However, due to the large amount of donors, multitudes of NGOs, and the varying political environments within the developing nations, there is no guarantee that changes can be successfully implemented in a manner that will develop capacity in a given sector or region. Unfortunately, until there is wide-spread commitment to the ideals outlined in the Paris Declaration on Aid Effectiveness, donor driven projects and individual organizational goals will remain the focal point of development activities (Boyd, 2009; Eade, 2007).

Several additional studies and workshops were completed in 2007, each reinforcing the need to understand and evaluate the context of capacity development efforts, develop skills both in the NGO and the community being served, and conduct evaluations that can be used to determine the success of development efforts (Angulo, 2007; IRSPP, 2007; Verity, 2007). Each study illustrated that while some progress has been made, development was still sporadic, at best, across a variety of sectors, namely in health, procurement, and the environment areas. A 2009 study carried out by AIDSTAR-
Two, for the U.S. Agency for International Development, confirmed that capacity development efforts being conducted by both governments and NGOs in the communities in the health sector are failing to make a long term impact. The study shows that not only is there “little consensus about what constitutes a best practice for capacity building” but efforts are “insufficiently evaluated and reported upon” (AIDSTAR-Two, 2010, p. 8; Berman, 2009). The study went on to present the following findings about ongoing capacity development efforts (AIDSTAR-Two, 2010, p. 11; Berman, 2009):

- No rigorous, controlled studies demonstrating that capacity building leads to changes in service delivery,
- No widely applicable indicators of progress with which to measure capacity-building,
- No common standards of what is acceptable or ideal,
- Lack of local ownership,
- Limited uptake of tools, which affects the implementation of capacity building programs,
- Donor demands and the competitive nature of development funding means that capacity builders may be unwilling to evaluate and share outcome results that might be negative.

The significant point to understand is that these findings “threaten the responsiveness, ownership, and sustainability of any intervention and risks diverting scarce resources from where they are most needed” (AIDSTAR-Two, 2010, p. 9). This
study is but the latest in a series of reports and literature that illustrate shortcomings in the
capacity development process. Despite the two decades of change that has occurred in the
development community, it appears that little wide spread internalization of lessons has
occurred, especially within larger organizations where massive amounts of funds appear
to drive development efforts.

The AIDSTAR-Two study ends with a restatement of a basic societal
fundamental; “efficient and effective government and civil society institutions are
essential to all societies” (AIDSTAR-Two, 2010, p. 17). Almost every study that was
evaluated as part of this literature review yields similar conclusions. Despite this most
basic and fundamental statement, the message appears to not have been fully
acknowledged. However, in spite of copious findings showing confusion and lackluster
performance, the study also stated that the capacity development “community is
committed and executing excellent programs” (Berman, 2009). Unfortunately, the
overriding concern is that these same groups are, on the whole, failing to meet
development expectations and in some cases, may be doing more harm than good (Bob,
2002; Cohen, Figueroa, & Khanna, 2008; Malhotra, 2000; Moyo, 2009).

2.3 Capacity Development Gray Literature

While conducting the review, it quickly became apparent that there was a vast
amount of literature on the development of capacity, as well as numerous theories that
could be applied to the organization and execution of development activities. However,
there is no separate academic discipline associated with capacity development, and
because of this lack of foundation, scholarly contributions are limited in nature. In order
to overcome the dearth of scholarly contributions, the study relies heavily upon what has
been termed “gray literature” typically consisting of “technical reports, working papers,
business documents, and conference proceedings” (AIDSTAR-Two, 2010, p. 4;

Identification of literature was conducted by first searching the Library of Congress, PUBMED, Medline, Google Scholar, ProQuest, JSTOR, and several U.S. government document databases including those of the Defense Technical Information Center and National Medical Intelligence Center. A general search of internet sources was then conducted, primarily targeted at individual organizations such as the United Nations Development Programme, in order to identify best practices and related material published to support development efforts. Title searches consisted of the following key words and phrases: (a) capacity development; (b) capacity building; (c) capacity development strategy; (d) capacity building strategy; (e) NGO capacity development; (f) NGO capacity building; (g) Africa health care capacity; (h) Nigeria health care capacity; (i) infectious disease capacity development; (j) NGO infectious disease Africa; (k) NGO infectious disease Nigeria; (l) NGO foreign aid capacity health; (m) health care partnership Africa; (n) capacity development models; and (o) capacity building models.

An initial set of 2,653 documents were identified using the aforementioned key search words and phrases. The researcher terminated queries early based on the saturation point of a particular title search in order to restrict results to a manageable number. This mass of literature included programs being implemented by international organizations, governments, discussed the many infectious diseases on the continent, and covered a
wide range of capacity building. Materials were reviewed and excluded based on the following criteria in order to further target data sources useful to the research (Boffin, 2002, pp. 1-4):

1. Capacity development efforts did not occur within developing nations,
2. Capacity development efforts did not have a linkage to the health sector,
3. Capacity development is only tangential to the central topic of the article,
4. Document did not have a discernible linkage to strategy, organizational structure, or long term partnership activities,
5. Document consisted of book reviews or abstracts.

Documents remaining after the initial exclusion, numbering 117, were reviewed again and used as a means to identify secondary citations and other potential sources of material. This cumulative technique yielded an additional 36 articles, after exclusion criteria were applied. A third and final review added 13 more articles. Concurrently, promising avenues of research were explored by contacting authors, researchers, and other stakeholders. These interviews provided valuable perspectives and led additional lines of inquiry and articles that could be added to the research assemblage. Results of this interaction were folded into the data search.

Thirteen percent of the articles cited in this work were published from 1995 to 2000 while the remainder occurred during the 2001-2010 time period. The bulk of the earlier articles represent evaluations of projects that were carried out as the concept of capacity development was taking hold in the various aid communities. Since then, a large amount of material has been produced illustrating lessons learned, methods for
implementing the new development paradigm, and project updates or reports. Articles occurring from earlier than 1995, such as the 1947 citation of the Marshall Plan, were used as historical references or included as tools to support the research’s methodology.

Noted earlier, the articles used in the study consisted of “technical reports, working papers, business documents, and conference proceedings” (AIDSTAR-Two, 2010, p. 4; Mathews, 2004, p. 125). A partial listing of gray literature documents has been provided to illustrate the material used as an analysis base within this study. See Table 1.

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<thead>
<tr>
<th>Document Name &amp; Source</th>
<th>Document Description</th>
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<tr>
<td><em>Patani Flood Project: Refugee Camp Project</em></td>
<td>Project report of Nigerian NGO including material on future prevention efforts in the Delta Region</td>
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<tr>
<td>Rural Africa Health Initiative (2012)</td>
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<tr>
<td><em>Water Sanitation, Health and Hygiene Program</em></td>
<td>Project report of Nigerian NGO</td>
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<tr>
<td>Water Initiatives Nigeria (2011)</td>
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<tr>
<td><em>SFH Malaria Prevention Programs</em></td>
<td>Project report of Nigerian NGO</td>
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<tr>
<td>Society for Family Health (2013)</td>
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<tr>
<td><em>First Quarter Report</em></td>
<td>Report of quarterly organizational goals, capabilities, and projects being conducted by Nigerian NGO</td>
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<tr>
<td>Adolescent Health Education and Development Centre (2013)</td>
<td></td>
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<tr>
<td><em>Organogram of the GCHF, Nigeria</em></td>
<td>Organization structure and roles of the Global Community Health Foundation. Data also included expenditure reports and communiques</td>
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<tr>
<td>Global Community Health Foundation (2013)</td>
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<td>Document Name &amp; Source</td>
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<tr>
<td><em>Capacity 2015: Building on Lessons and Successes</em></td>
<td>Journal article depicting how capacity development efforts could be designed in the future to increase success</td>
</tr>
<tr>
<td><em>The Human Organisation: Challenges in NGOs and Development Programmes</em></td>
<td>Journal article discussing both internal individual and organizational development in the NGO community</td>
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<tr>
<td>‘Capacity is Development’ A Global Event on Smart Strategies and Capable Institutions</td>
<td>Report of the ‘Capacity is Development’ Global conference which focused on “Smart Strategies and Capable Institutions for 2015 and Beyond”</td>
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<tr>
<td><em>Infrastructural Distribution of Healthcare Services in Nigeria</em></td>
<td>Journal article examining the effect of western styles of bureaucracy on Nigerian hospital structures</td>
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<tr>
<td>Journal of Geography and Regional Planning (2009)</td>
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<tr>
<td><em>Malaria Control for Primary Health Care Workers</em></td>
<td>Project manual depicting training, roles and responsibilities of staff workers assigned to primary health care centers</td>
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<tr>
<td>Roll Back Malaria/Federal Ministry of Health (2005)</td>
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<tr>
<td><em>Democracy in Nigeria: the Challenge of Infectious Disease Control</em></td>
<td>Journal article discussing the need for Nigeria to develop an infectious disease surveillance and response capability.</td>
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<tr>
<td>Journal of Infection in Developing Countries (2008)</td>
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<tr>
<td><em>Fighting Disease or Strengthening Health Systems?</em></td>
<td>Journal article addressing the potential to use individual disease programs to develop the capacity of primary health care systems</td>
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<td>Capacity.org (2011)</td>
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<tr>
<td><em>NGO Accountability and Sustainable Development in Nigeria</em></td>
<td>University paper examining NGO accountability in Nigeria with an emphasis placed on its role in developing sustainable programs</td>
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<td>Owolabi (2010)</td>
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<th>Document Name &amp; Source</th>
<th>Document Description</th>
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<tr>
<td><em>The District Health System in Enugu State, Nigeria</em></td>
<td>Research report depicting a system in which health workers and facilities are organized to serve a specific population or geographic region</td>
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<tr>
<td>University of Nigeria (2009)</td>
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<tr>
<td><strong>Patronage or Partnership</strong></td>
<td>Book examining the need to build local capacity to address emergency or post-emergency events in developing nations.</td>
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<tr>
<td>Smillie (2001)</td>
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<tr>
<td><strong>Community Capacity Building; A Review</strong></td>
<td>Department of Health, Australia, publication designed to review community capacity building efforts in developing nations.</td>
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<td>Verity (2007)</td>
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Analysis of the gray literature focused on how a “certain intervention has been applied,” in this case capacity development, and how “groups of people carry out a certain practice” (Randolph, 2009). Findings indicate that although NGOs have learned and implemented many ways of making programs more effective, knowledge is not uniformly spread throughout the development community. Organizations cited in the literature have implemented programs in a different manner due in part to factors such as specific leadership principles, cultural or environmental concerns, or logistical capability (Cooke, Booth, Nancarrow, & Wilkinson, 2006; Gillespie, 2005; H.D.T., 2009; Verity, 2007). These implementation disparities have contributed to the establishment of numerous capacity development methodologies, each based on a unique approach reflecting the NGO’s organizational objective. Individually implemented designs have unfortunately inhibited the creation of common standards, universal indicators of
progress, comprehensive assessment tools, or even a dependable body of knowledge that can be used to guide new projects in developing nations such as Nigeria (Eade, 1997; Morgan, 2006; PACT, 2010). This latter point has been addressed to some extent by NGO networks or larger institutions who publish information about how to organize and operate development organizations. Program implementation assistance for instance, is supplied by both USAID and the UNDP which are arguably two of the largest sources of information for NGOs seeking to establish programs in a variety of geographic regions. Guidance from these and similar organizations has influenced the way in which many projects are executed and has also assisted in engraining the capacity development concept throughout the development community. Unfortunately, as instances within the literature demonstrated, there is still an immense amount of effort needed to make indigenous NGOs successful to the point that they can affect capacity development changes within at both the community and national level.

Reviewing the gray literature produced several knowledge groupings that were essential to the development of the Capacity Development Triad, described in the following section. In the area of management and organizational missions, it was noted that smaller, indigenous NGOs generally have more issues creating long-term systematic approaches to program implementation due to inadequate staffing, lack of practical skills, and inability to establish enduring relationships within the public sector. Strategic approaches to identify resource needs and forecast essential skill sets were limited, as was the ability to generate long term approaches to ongoing issues. Strategic plans were generally absent from project reports and with the exception of wide ranging and all-
encompassing organizational mission statements, little concrete evidence of strategy
development was uncovered illustrating a base understanding of the basic tenants of
strategy and how viable plans can minimize the likelihood of program failure.

Government sponsored agencies, such as USAID and WHO, by comparison,
appear to be well staffed and resourced organizations with decades of experience
operating within Nigeria. These organizations have found it much less difficult to
develop long term strategies due in part to established relationships with the Nigerian
government, a comparative wealth of resources, and prior experience in capacity building
gained from implementing projects in a wide variety of geographic settings. Mature
international and government sponsored agencies tended to have established training
programs for developing internal staff skills, as well as external programs to instruct
outside organizations on key tasks. Larger agencies are also able to hire and retain
specialized skill sets that allow for the development and execution of programs that
support strategic objectives. Strategies of the larger organizations, however, tend to be
based on one critical assumption: All rely heavily on the distribution of outside resources
and the presence of indigenous NGOs in order to execute programs so operational
objectives can be achieved. This reliance on outside organizations, specifically
indigenous NGOs, provides an excellent opportunity to conduct skill transfers, establish
lasting partnerships, and become more flexible when responding to changes in the
implementation environment. This relationship must be adequately managed however to
avoid the dictation of requirements that will inhibit indigenous NGOs from becoming full
partners in the capacity development process.
Another knowledge grouping related to the organizational capability of NGOs and the omnipresent range of developmental problems they continually encounter. Studies indicated that program implementation was commonly impacted by a lack of coordination with other organizations or elements of the community. Program benefits and long term sustainability were also restricted due to either inadequate coverage areas, failure to establish an economy of scale, or a lack of planning that would otherwise ensure that sustainable solutions are implemented.

Organizational governance and staffing issues were the most commonly reoccurring problems identified in reviews of program implementation. According to the literature, the governance and management of many NGOs is thought to be led by charismatic leaders with a strong commitment to a specific cause. The Center for Disaster and Humanitarian Assistance Medicine (CDHAM) goes so far as to state that NGO leadership typically consists of “well-traveled, multi-lingual, individuals with advanced degrees” (Frandsen, 2002, p. 32). These same people are also identified as “dedicated to the people that they are serving, highly motivated, and extremely knowledgeable about the regions in which they work” (Frandsen, 2002, p. 32). While there is truth in both of these statements, their generalization is not always applicable, and in reality, many NGOs typically experience significant problems in both leadership and management because enthusiasm and passion does not make up for a lack of experience and organizational skills.

In Nigeria especially, an individual with the skills noted above, may not be an accurate portrayal of reality. Smith, in his work *A Culture of Corruption: Everyday*
Deception and Popular Discontent in Nigeria states that a common joke for Nigerians upon graduating college is deciding between starting a church or an NGO (Smith, 2007, p. 226). He goes on to say that because of the lack of available work, starting an NGO is seen as a way to acquire money from the copious amount of foreign aid that is flowing into the nation. Another example is offered by the Economist in the article Sins of the Secular Missionaries. NGOs, as the article explains, were once a fairly loose knit group of charities started by local members of a community, but now with the influx of foreign aid, they have become “big business” and individuals who control the aid, have significant influence within their communities (The Economist, 2000).

In 2001, the Centre for African Family Studies, conducted a study of NGO leadership in Africa to assist in analyzing the foundations for successful partnerships and collaborative efforts. The study, entitled A Situation Analysis of NGO Governance and Leadership in Eastern, Southern, Central and Western Africa found that the keys to successful endeavors were “transparent leadership, stable governance and sustainable structures” (CAFS, 2001, p. 40). Through their research, it was determined that smaller NGOs sometimes suffered from what is termed, “founder – member syndrome” wherein the original person who established the NGO is loath to release authority to other decision making bodies within the organization (CAFS, 2001, p. 19). Finally, it has been identified that both leaders and governance boards sometimes fail to properly establish clear direction for their organizations because of lack of knowledge or expertise in organizational management, or a failure to properly development and advocate for an appropriate strategy (NRC-NFE, 2001; Padaki, 2007). Although these problems are
generally widespread throughout the NGO community, they are by no means
insurmountable obstacles to overcome.

Developmental problems in the literature can generally be attributed to basic
issues in staffing and absence of critical skills that enable successful project
implementation. While leaders can range from semi-skilled to highly educated
individuals, the staff of indigenous NGOs is often comprised of volunteers who may have
no formal education, training, or applicable skill sets. A Peace Corps study found that
volunteers were often hired with “a greater amount of motivation than competence”
(Osborne, 2001, p. 16). The heavy reliance on volunteers is necessary by indigenous
NGOs that work at the grassroots level because projects typically require large staffs
working across large or remote areas performing tasks such as ring vaccinations, general
immunizations, or providing educational materials throughout the local population
(Natsios, 1995). Volunteers come with a wide variety of skill sets and serve either part or
full time depending on the location and operational span of projects being undertaken.
Shaw, (2004), in her work with NGOs during humanitarian efforts, noted that staff
members she encountered were often, “young, idealistic aid workers who operated with
little or no guidance and frequently relied on local hires” to perform the basic tasks
associated with the services being delivered by the NGO (p. 3). Osborne, (2001),
confirmed this observation in his research noting that while NGOs generally do not
attempt to hire unqualified people, they sometimes do hire people with “greater amounts
of motivation than competence” (p. 16). It is because of these diverse skill sets that
leadership and governance issues must be firmly resolved if the volunteers supporting the
organization are to be effectively utilized. While it is the leadership’s role to develop strategies, organize resources, and coordinate overall efforts, the true effectiveness of the NGO lies with the feedback and efforts provided by the staff working in the field to accomplish the specific tasks that determine if an NGO will succeed or fail.

A final grouping of knowledge related to the ability and frequency of NGOs to partner with other organizations in both the public and private sector. A central point to the literature is that where single public sector agencies have failed in the past, the involvement of multiple organizations working toward the achievement of a common objective has the potential to advance toward common objectives. Partnerships were once almost non-existent between the public and private sectors, leading to parallel activities, duplicated efforts and lost opportunities to capitalize on economies of scale within the health care sector. Within the last two decades, development activities have changed and partnerships are becoming more common as a means to harness limited resources and expand coverage areas. Collaborative efforts do not guarantee success and there are several instances where well intentioned programs have failed due to inconsistencies in administration and reporting, lack of trust, changes in strategy, confusion or uncertainty in ownership of programs, and miscommunication between the stakeholders engaged in a project (Steward, 1999).

Corporate literature cites multiple benefits of partnerships, including the establishment of mutual trust, familiarity with both personnel and organizations, and an enhanced understanding of an organization’s core operational mechanisms. These facets of a joint endeavor help to mitigate problems that typically arise during program
implementation. Ideally, both organizations will be able to work closely with one another toward a common objective, thus establishing a foundation for future efforts. Without this type of foundation, sustainable programs cannot be fully realized and the attempt to create a more robust national capacity will suffer. Unfortunately, the direct lessons of partnerships were rarely seen in the NGO literature reviewed as part of this study. References to partnerships were fleeting and those that did occur, mainly involved thanking a particular agency for providing funding or some like resource. Most relevant studies cited were the product of corporations or umbrella NGO networks that sought to increase the frequency of public-private sector partnerships. Very little concrete examples outside of these conclusions were cited in the “gray literature” of available NGO material. The researcher presupposes that in the case of building capacity, establishing partnerships between the public and private sector is a worthwhile action. Assessing the value of these relationships and fostering continued joint programs where credit and successes are equally shared, however, is a much more complicated matter that must be examined objectively, outside of any particular NGO or public sector program.

In order to fully understand how NGOs build capacity, the impact and context of development issues must be analyzed in conjunction with several key variables (Hart, 2005). These variables, and the interactions between them, are essential to understanding the overall qualitative phenomenon and provide a framework for assessing ongoing and future development efforts (Alexander, 2008; Creswell, 2005; Patton, 2002; Polit & Beck, 2003). This study identifies the central phenomenon as the ability of NGOs to develop a national health care capacity for the purpose of mitigating the outbreak and
spread of infectious diseases. Within this phenomenon, a number of measures have been
developed in conjunction with the study of capacity development. This research
consolidated capacity indicators into three major variables that will be used to synthesize
and evaluate the relevant literature (Lopes, 2002; Mizrahi, 2004; Otoo, Agapitova, &
Behrens, 2009; UNDP, 2011; WHO/WPRO, 2003). Grouped under the Capacity
Development Triad, this study uses strategy, capability, and partnership as its key
independent variables.

2.4 Capacity Development Triad

Formation of the Capacity Development Triad arose during the review of capacity
development literature. Although a substantial amount of literature exists regarding the
implementation of capacity building programs, there are no “widely applicable
indicators” or “commonly accepted standards” being applied towards assessing if
programs are achieving proposed objectives (AIDSTAR-Two, 2010, p. 11; Berman,
2009; World Bank, 2005, p. 44). Cited indicators varied between organizations and
tended to reflect a specific program instance or address a particular regional
implementation issue. In order to create a common tool for assessing NGO performance,
the researcher sought to establish a core set of variables from the excess of indicators
characterized in the vast bulk of development literature. Following the application of
exclusion criteria to the 2,653 literature documents, data from the remaining 166
documents were entered into the NVivo analytical software package developed by QSR
International. This tool was chosen to provide both a framework and an information
management standard that could be applied to the development of this study. Indicators
were first assigned descriptive codes in order to expedite both data retrieval and grouping of like codes (Bazeley, 2007; Coffey & Atkinson, 1996; Corbin & Strauss, 2008; Patton, 2002). According to Coffey and Atkinson (1996), coding of the data not only involves “identifying and reordering” the material, but also it provides the opportunity to “re-conceptualize the data” and view it within different analytical settings (p. 30). In the case of this research, the initial set of coding led to the establishment of new relationships between the data and aided in developing new interpretations of how the original data could be, or is currently, applied in an operational environment.

The initial sequence of applying codes to capacity development indicators involved sorting results into their perceived topic areas (Richards, 2005). Topic coding, as defined by Richards (2005), allowed the researcher to assign codes to a “broader area” that served to expedite a preliminary analysis of data (p. 100). Within the NVivo software, these topic areas are referred to as nodes. Multiple nodes, 43 in total, were identified during the initial groupings. Seven nodes were eliminated after further consideration, as they did not fully fit within the context of the study. Individual nodes were then reassessed for commonality and grouped under 10 parent nodes. Commonality of classification was determined using accepted terms defined within organizational design theory. Parent nodes reflect aspects of the core functions and interactions that make organizations or their chosen programs generally successful (Beckhard, 2006; Burton, Obel, & DeSanctis, 2011; Daft, 2009). An example of node relationships can be seen in Figure 1.
The final stage in the establishment of a core set of variables consisted of examining node clusters within the software through a modified frequency analysis query. This query assisted in allocating coding references to selected portions of data based on the incidence of occurrence in the body of literature.

Unlike a traditional frequency analysis query, which tabulates how often a word occurs in a particular source, the researcher sought to identify how many sources from the body of literature in total contained the identified target indicator. This eliminated undue emphasis on a particular indicator because of multiple uses within a singular document and instead, it illustrated how widespread the indicator was throughout the body of literature (Denhardt, 2006; Hatch & Cunliffe, 2006; McNamara, 2006; Scott, 2003; Tompkins, 2004). Indicators addressing some form of personnel skills, training, or organizational makeup proved to be the most numerous, tallying 137, or 83 percent, of
the all documents. Although collected data ranged from staff employment and funding to volunteer usage, emerging patterns of data enabled the coding of nodes structures under a single root node entitled “capability.” Likewise, a strategy-based root node emerged, which depicted indicators that assessed the ability to conduct objective-based planning and provide strategic leadership in support of an organizational mission. Documents highlighted 134 instances, or 81 percent of documents, reflecting the establishment and monitoring of strategic plans and objective achievement. Finally, a root node containing indicators designed to collect data on partnerships, community engagement programs, or joint efforts with other organizations accounted for 113 total references, or 68 percent of documents. Other indicators—such as those directed towards stock records, information management systems, and participation in training events—produced smaller, less defined clusters within the literature. These were identified as being extraneous to this study and thus eliminated from consideration. The most notable identified clusters were used as the foundational root nodes for the Capacity Development Triad, consisting of the strategy, capability, and partnership variables. The entirety of the Capacity Development Triad is depicted in Figure 2. Individually, variables and their subordinate structures provided a means to analyze and interpret data collected via the study’s research instrument. Each variable, described in the following sections, focused on a specific aspect of NGO operations that was considered key to answering the primary research question.
Having established the Capacity Development Triad as a means to interpret data, the study sought to portray an analytical picture of indigenous NGOs operating in Nigeria. Unlike existing assessments of NGO activity, which tend to focus on larger, more well-established organizations supporting USAID or WHO objectives, this study emphasized smaller indigenous groups working within their communities or regions (Aina et al., 2002; Calderisi, 2007; Dixon, et al., 2003; Narel, 2008). Examining these NGOs through the lens of the Capacity Development Triad provided insight into how they functioned and contributed to the development of national capacity. Data tied to the strategy variable illustrated the extent to which NGO strategic planning focused both
activities and resources over both the short and long term; aligned efforts with other organizations and government activities; and met the needs of communities where programs were implemented. Analysis of capability-centric data depicted the stability, equity of services, and impact on the communities they were meant to serve. Investigation of partnership-related data, meanwhile, highlighted NGO-government collaborations and identified barriers to collaboration resulting from cultural, process, or policy frameworks. Data also showed how selected NGOs function within the nation, their overall level of importance to the health care system, and how they facilitated—or failed to facilitate—government-led mitigation activities. When outputs of the model are combined, stakeholders are provided with a detailed operational level oversight of capabilities that are commonly generalized or stereotyped throughout the NGO sector. Though the data represented a relatively small cross section of the active NGO population, interpretation of the results using the Capacity Development Triad as a guide presented a common measure of effectiveness and a level of information about the manner in which NGOs organize and operate, thus supplementing and improving upon the existing knowledge base.
2.4.1 Strategy Variable

A core, and arguably the most important, variable of the Capacity Development Triad is strategy. The strategy variable contributed to the creation of the subordinate research question: How have strategies for building capacity in the health care system been developed and implemented by selected NGOs? This variable assists in the evaluation of how organizations have defined and implemented a strategic plan that guides activities, integrates the target population, and builds capacity within the health sector.

Coding of material within the 166 reference documents culminated in the development of 12 nodes including, but not limited to: service demand, community engagement, risk management, and the overall effectiveness of implemented programs. Nodes depicted the most regularly emphasized aspects of NGO operations and were later grouped by commonality into parent nodes. The parent nodes, labeled Strategic Vision, Objectives, Ownership, and Implementation, were key in the development of the research instrument and allowed for the creation of nested questions that sought out specific data. See Figure 3.
Each parent node is defined as follows:

1. **Strategic Vision Parent Node**: Strategic vision relates to the ability of NGO leadership to define and implement a strategic plan detailing the organization’s overall mission, vision, and long-term objectives, within a complex operational environment. The presence of a formal board of directors, documented mission statement or organizational vision, and annual operating plans are considered indications of a NGO’s ability to formulate an overarching strategy and guide supporting programs.
2. Objectives Parent Node: Objectives illustrate the ability of NGO leadership and staff to operationalize strategic plans, create near term, supporting objective, and implement programs that contribute to achieving the organization’s mission. A structured planning process that includes staff-wide input, constituent involvement, and an assessment or feedback mechanism to incorporate lessons learned following program implementation is a measure of how effectively an NGO can execute a long-term strategy.

3. Ownership Parent Node: Ownership depicts the ability of an NGO to create sustainable programs in the communities where they work. Efforts to promote community involvement in the planning and implementation of a program, the ability to transition program operations, and the establishment of long-term partnership ties are indicators of a NGO’s level of capacity to enable long-term health care solutions.

4. Implementation Parent Node: Implementation portrays the ability of an NGO to establish programs within a community that achieve operational and strategic objectives. The creation of monitoring and evaluation systems, sharing of information with stakeholders, and established partnerships with the local community are indictors of effectively implemented programs.

The building of health sector capacity in Nigeria is not something that can be accomplished without significant effort and an enduring strategy. Reflecting this, the World Bank’s *Capacity Building in Africa* report stated that capacity building challenges “require long-term, systemic approaches” (World Bank, 2005, p. 3). Government
sponsored and well-staffed and resourced organizations, such as USAID and WHO, have
operated within Nigeria for decades constantly revising and expanding their strategic
objectives. Where smaller organizations may have found it challenging to implement or
sustain projects, the aforementioned groups have found it much less difficult due to
established relationships with the Nigerian government, a comparative wealth of
resources, and prior experience in capacity building gained from implementing projects
in a wide variety of geographic settings. Strategies implemented by larger organizations
provide partnering opportunities for NGOs with limited staff and resources, like those
identified in this study, to establish or strengthen their own services and capabilities.
These same strategies also provide a means for the Nigerian government to utilize the
skills, abilities, and resources available among potential NGO partners in the local health
sector to more fully develop a national capacity for addressing public health threats.

The existing literature on the mitigation of public health threats offers illustrates
several attempts to reduce specific aspects of the Nigerian disease burden. Combating the
spread and impact of infectious diseases, along with strengthening the health care system
is a core objective of many strategies. NGOs are essential to the implementation of any
strategy since they provide the staff and local knowledge necessary to gain the support of
local communities. They can also readily define ways of implementing sustainable
programs designed to achieve strategic objectives in conjunction with government
efforts, thereby closing gaps in service coverage areas and growing capacity within the
public health sector. Unfortunately, due to the diverse nature of NGOs, aligning efforts
across the entirety of the health sector is difficult, at best, and failures at the community level can jeopardize the execution of a strategic plan.

Data incorporated into each of the four identified parent nodes contributes to the understanding of how an organization develops and implements a strategic plan. There are other numerous, interlinked factors necessary to the formulation and execution of an effective strategy, but strategic vision, objectives, ownership, and implementation have been identified as especially significant elements of strategic growth and critical to the isolation of viable strategies from the various obstacles that can cause them to fail.

There are no infallible methods to ensure the success of a strategy. All organizations, but especially those with limited resources and staff, need to manage risk to the fullest extent possible. Interpreting NGO operations using the structure of the Capacity Development Triad provided the researcher with the means to identify performance gaps and understand the strategic vision of a selected organization. Regardless of the complexity of an organizational vision, a well-designed strategy will help guide the long-term actions of a group while allowing the flexibility to change based on opportunities that arise within the environment. This is critical to building capacity within the health sector as strategies must be both practical and synchronized with government directed efforts if systemic changes are to be realized.
2.4.2 Capability Variable

Capability is the second variable of the Capacity Development Triad and it is a key factor in an organization’s ability to deliver services, build internal capacity, and establish partnerships that will lead to the development of a stronger national health care system. With the large diversity of indigenous NGOs operating within Nigeria, it is important to consider whether or not a given organization has the internal means to build capacity. If there are identified structural gaps, then interventions can be created to mitigate problems and enhance performance. Otherwise, NGOs cannot fully contribute to creating a strong foundation for capacity development within the nation, leading to a continued promulgation of disease related difficulties that will have to be borne by the base population. The capability variable supported the development of the subordinate research question: How have selected NGOs operating in different areas of the nation developed the sufficient capabilities which are necessary to create sustainable solutions to limit the spread of infectious disease?

Nodes were developed based on the coding of material selected from the 166 gray literature reference documents. The coding ended in the creation of 12 nodes including, but not limited to: knowledge transfer, resource acquisition, funding sources, and the infrastructure in selected operational areas. Nodes depicted the most frequently emphasized aspects of NGO operations and were grouped by commonality into parent nodes. The parent nodes, labeled Critical Skill Sets, Logistics, Funding, and Operational Environment, were key in the development of the research instrument and allowed for the creation of nested questions that sought out specific data. See Figure 4.
Each parent node is defined as follows:

1. Critical Skill Sets Parent Node: Critical Skill Sets portrays the ability of an NGO’s staff to internally train or externally locate personnel with critical skill sets necessary for successful program implementation. Indicators of success include the execution of internal training programs, integration of volunteers with paid staff, and the sufficient coverage of skill based performance gaps with an in-house capacity to contract for outside support.
2. Logistics Parent Node: Logistics illustrates the ability of NGO leadership to effectively obtain and distribute resources in support of organizational programs. The presence of a documented accounting mechanism, a means to distribute supplies, and some adherence to the basic tenants of supply chain management are indicators that an NGO can administer resources beyond singular point-of-service programs. A strong logistical capability is also an indicator that NGOs can quickly and effectively move medications and other related supplies to the site of an infectious disease outbreak or other response operation.

3. Funding Parent Node: Funding depicts the ability of an NGO to identify sufficient funding sources and acquire the support necessary to fully implement programs supporting organizational goals. Multiple revenue streams, program specific funding plans, and the continuation of services despite monetary shortfalls are all indicators of a financially resilient organization able to marshal sufficient resources to implement organizational programs.

4. Operational Environment Parent Node: Operational Environment relates to the influence of environmental variables including social conflicts, cultural beliefs, and corruption on NGO operations. The ability recognize and exert some measure of control over these potentially negative influences provides an indication of how well an organization is able to conceive a feasible,
acceptable and adequate plan that can be realistically implemented within a community by staff members and volunteers.

Reviewing data associated with this variable provided a structure for understanding an organization’s structure, personnel skills, and resources, and their influence on an NGO’s ability to implement programs. No single template can be applied across the multitude of NGOs found within the health care sector to describe how a “standard organization” should be organized to achieve a particular goal or vision (Frandsen, 2002, p. 16; Natsios, 1995, p. 406; Shaw, 2004, p. 3). However, by identifying and interpreting the key aspects of NGO programs, it is possible to construct a vision of how selected NGOs are striving to meet their chosen objectives.

The four identified parent nodes served as an effective mechanism to group data collected during the later portion of this study. As data was incorporated, a greater understanding of how the selected indigenous organizations operated was gained. Knowledge of individual structures, personnel skill sets, and necessary resources framed NGO operations and assisted in the development of answers to the associated subordinate research question.
2.4.3 Partnership Variable

The final variable of the Capacity Development Triad is “partnership.” The partnership variable was the basis of the subordinate research question: How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

The review and coding of partnering related activities in the 166 gray literature reference documents helped to develop the nodes used in the development of the partnership variable. The coding concluded in the creation of six nodes including, but not limited to: challenges and constraints, collaboration, and outcomes. The two sets of three nodes are essentially similar when reviewing public and private sector partnerships as the collaborative emphasis is the same, only varying by the political status of the partner organization. Nodes depicted the most commonly emphasized aspects of NGO attempts to partner with other organizations operations. These nodes were grouped by commonality into two parent nodes. The parent nodes, labeled Public Sector Partnerships and Private Sector Partnerships, were essential to the development of the research instrument and allowed for the creation of nested questions that sought out specific data. See Figure 5.
Each parent node is defined as follows:

1. Public Sector Partnerships Parent Node: This factor demonstrates the ability of an NGO’s staff to establish and maintain partnerships with Nigerian federal, state, and local government agencies for the purpose of influencing the development of health care plans, promoting the formation of policy and legislation, mitigating the effects of disease outbreaks, and eliminating barriers to health care service provision. Existing or planned partnerships, documented agreements of mutual support, and instances of prior
collaboration are all indicators of a strong capacity to establish and maintain partnerships with public sector agencies.

2. Private Sector Partnerships Parent Node: This factor illustrates the ability of NGO leadership to establish and maintain partnerships with international and local NGOs, community based organizations, and for-profit industries and businesses. Partnerships with the private sector are best established in order to overcome barriers to service provision, maximize resource use, and facilitate the mitigation and response to outbreaks of infectious disease. Indicators of partnership capacity include prior collaboration with other NGOs, the participation in of NGO coalitions or associations, and the routine incorporation of other private sector entities into organizational planning and program implementation.

Partnerships between the public and private health sectors are a vital component to developing sustainable capacity within Nigeria. Over the last two decades, leaders both inside and outside of the public health sector have looked toward private sector organizations as a potential solution for addressing service shortfalls (Nasidi, 2008; Steger, Salzmann, Ionescu-Somers, & Mansourian, 2009). This approach to delivering services and implementing policy has become widespread, especially within developing nations as governments seek to efficiently apply their limited resources to solve community issues (Osborne & Murray, 2000; The World Bank, 2011). In some cases, nations have advocated relying less on government provided services and more on joint efforts between the public and private sectors to meet population needs (McQuaid, 2000).
In Nigeria, a series of informal partnerships have existed at some levels since 1999 when the nation ended thirty-three years of military rule; but not all were successful (Nasidi, 2008). In combating the growing HIV/AIDS problem prior to 2002, the Nigerian Federal Ministry of Health tended to “concentrate response activities within the government” and block NGO participation (Oke, et al., 2002). Substantial efforts and resources were allocated to the treatment and prevention of the disease, but these were mostly government driven efforts. Partners for Health Reformplus, a USAID health system strengthening project, assessed that “public-private partnership is virtually non-existent, and the majority of the private sites do not receive any form of support from the government” (PHRplus, 2004, p. 22). This exclusion resulted in the development of parallel activities that duplicated efforts and squandered opportunities to lower HIV prevalence rates. Since then, strained relations between the public and private sectors have begun to ease and the government has gradually accepted the fact that improving national health will need to be undertaken in conjunction with outside organizations. The creation of mutually beneficial partnerships is still considered a work in progress as government agencies work through the details of developing stable, long lasting relationships with their private sector counterparts.

The importance of laying the groundwork for future endeavors is critical if programs implemented within the health sector are going to be sustainable. Capacity development without sustainable outcomes will undermine the overall objective of achieving adequate health care within the nation as well as jeopardize progress made toward meeting Millennium Development Goals. Sustainable programs also provide a
solid base from which to enact further improvements and expand initiatives into other sectors of the government (Olujimi, 2006). Expansion of this nature will yield further results as issues in the public health sector rarely are isolated in nature and change in one sector, such as road construction, can benefit the provision of services in rural settings.

The development of effective partnerships, while difficult, is a fundamental means of shaping the Nigerian health care sector (Crisp, Swerissen, & Duckett, 2000). Where single public sector agencies have failed in the past, the involvement of multiple organizations working toward the achievement of a common objective has the potential to advance toward common objectives. Viewing this development as a systems approach, it is easy to envision multiple partners as a series of interrelated parts working with local institutions, communities, and government agencies to affect change (Lusthaus, et al., 1999). Functionality of the system however, is contingent on the willingness of all parties to participate equally. In the past, the Nigerian government had excluded NGOs from development activities but this self-imposed segregation has gradually changed.

Establishing partnerships between the public and private sectors has proven to be a complex undertaking and the added complications associated with the operational environment have done nothing to ease the burden. The two identified parent nodes served as an effective mechanism to review and group data collected during the later portion of this study. As data was incorporated, a greater understanding of the obstacles to creating effective partnerships was identified. Knowledge of the challenges and in some cases, the underlying institutional problems assisted in the development of answers and subsequent recommendations to the associated subordinate research question.
2.5 Conclusions

Better to let them do it imperfectly than to do it perfectly yourself, for it is their country, their way, and your time is short. Adaptation of a statement made by TE Lawrence. (Brown, 2006, p. 54)

The latter part of the 20th century saw an exponential growth of NGOs within the development community. This growth was also paralleled by an expansion of models, theories, initiatives, and best guesses centered on how to effectively implement capacity development programs. Successful programs are rare and growing capacity at a national level is still a long term goal, rather than an objective that has been achieved. This is because development efforts are exceedingly complex undertakings, affected by a multitude of variables and influenced by hundreds of political, military, economic, social and infrastructural drivers and events. Additionally, as the literature illustrates, there are multiple, environmentally dependent approaches to developing capacity, including the organizational, institutional, and whole of system methodologies. Every approach has some merit in a particular setting and all must be considered within the narrow confines of an NGO’s operational environment.

In order to place Nigerian capacity development efforts into the greater context of work being undertaken in developing nations, a series of models, reports, and supporting themes reflecting recent methodologies and development strategies were reviewed. These materials provided a means to understand and evaluate the many ongoing NGO initiatives in Nigeria and how they support the ability of the Nigerian government and its health care system to respond to the spread of infectious diseases through the development of a national capacity.
Chapter two began with a discussion the evolution and realities typically encountered within the capacity development field. After reviewing the various obstacles and opportunities within the field, the variables, strategy, capability, and partnership and their interrelationships with the capacity development phenomenon were reviewed. Each of the variables, forming the capacity development triad, is a critical component to not only understanding, but also evaluating and applying capacity development principles. The variable of strategy was evaluated in order to determine how organizations define and implement strategic plans that guide its activities, integrate the target population, and build capacity within the health sector. Following this section, the variable of capability was assessed to determine how an organization’s structure, personnel skills, and resources influenced an NGO’s ability to implement programs that support communities and build both local and national capacity. The final component of the capacity development triad, partnership, examined how the public and private sectors could form viable working relationships in Nigeria and what enablers have been established within the nation in order to realize cooperative goals. Within each of the three previous sections, a method to best judge the impact of each variable was determined. These selections will contribute to the assessment of research findings in the following chapters and also serve as a means to ways to improve future endeavors in the development field. The last portion of this chapter reviewed literature findings and summarized the central phenomenon along with its supporting variables.

Chapter three presents a discussion of the how the case study method, supported by key informant interviews, obtained information on the capability of indigenous NGOs
to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity. The chapter begins with an overview of the research method and its appropriateness to this study. Second, the research design and a review of questions that guided this study are discussed. Third, issues of sample populations, internal and external validity, and collection of data are addressed. Finally the chapter concludes with the perceived limitations of this study. In the remaining two chapters, findings from the literature review are compared with findings gathered from the sample population.
CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

Qualitative analysis transforms data into findings. No formula exists for that transformation. Guidance, yes. But no recipe. Direction can and will be offered, but the final destination remains unique for each inquirer, known only when—and if—arrived at. (Patton, 2002, p. 432)

The purpose of this qualitative, illustrative case study was to examine indigenous NGOs operating within the Nigerian health sector and analyze their ability to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity. NGOs are a crucial component within the interwoven network of Nigerian health care providers, often supplying resources and skills that are not readily accessible. Despite the promising nature of their involvement in the health sector, however, it is not fully known if they possess the ability to provide needed services or have the capability to coordinate ongoing mitigation activities in conjunction with government efforts (Dixon, et al., 2003; Erinosho, 2009; Gyoh, 2008; Prodi, 2000).

It was hypothesized by the researcher that indigenous NGOs are not sufficiently capable of mitigating the spread of infectious disease, or contributing to the national health capacity due to limitations in resources, skill sets, and the inability to maintain enduring programs. In order to test the hypothesis, the study examined how selected NGOs mobilized resources and implemented programs in response to community needs.
or event-driven requirements. Investigating this most basic and foundational aspect of capacity development provided the researcher with the means to evaluate an organization’s ability to mitigate the spread of infectious diseases through the development of a more robust national capacity. According to the methodology, if patterns are identified in the collected data set depicting the capability to mitigate the spread of infectious diseases and contribute toward building national level capacity, then the hypothesis would be disproven (Gall, Gall, & Borg, 2003; Yin, 2008). Conversely, if data were identified showing that indigenous NGOs are unable to marshal the necessary material and skill sets to implement sustainable mitigation programs or partner with government agencies, then the hypothesis would be validated.

In order to gather the necessary data to test the aforementioned hypothesis, a case study format was selected based on the nature of the primary and supporting questions, types of data sought, and the conditions defining the research’s framework. NGO data were gathered through two means of communications: questionnaires sent via email and direct phone contact. Selected participants were asked to respond to three questionnaires, each consisting of eight–ten questions over a two month time period. Questionnaires focused on different aspects of an NGO’s structure, including strategic objectives, internal staffing, and partnering activities. Organizations were contacted after each questionnaire submission in order to gain additional insight or clarify responses, thus limiting the possibility of misinterpretation of collected data. Secondary data, such as organizational mission statements, project data, and other related material were collected directly from participant websites and other online sources where possible. Further details
of the research design, participant selection, and data analysis process are presented in the remainder of chapter three.

Chapter three begins with a brief summary of the research question, followed by the rationale for selection of a qualitative methodology. The research population is then identified, along with collection techniques and instrumentation used to gather data. Data collection, software, storage protocols, and data analysis procedures are detailed in order to summarize the administrative management of collected material. The various aspects of the methodology and administration are meant to improve validity and reduce the introduction of bias into the study. Finally, the chapter concludes with a discussion of the perceived limitations of the study, including a statement of potential researcher bias.

3.2 Research Questions

This research was guided by one overarching question, which was supported by three subsidiary questions, each designed to address a different aspect of indigenous NGO operations within the health care sector. The overarching question of this study is:

*Can indigenous NGOs support the ability of the Nigerian government and its health care system to respond to the spread of infectious diseases through the implementation of local programs that contribute to a robust national capacity?*

Addressing this complex topic required a three part approach, each of which was covered by the subsequent questions:

1. How have strategies for developing capacity in the health care system been developed and implemented by selected NGOs?
2. How have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions to limit the spread of infectious disease?

3. How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

Each subsidiary question is associated with one aspect of the three-variable-based model, designated earlier as the Capacity Development Triad. The model measures an organization’s potential to do the following: (a) create and implement strategies supporting the development of sustainable capacity to respond to the spread of infectious diseases, (b) generate an internal capability to supply critical resource shortfalls, and (c) implement mitigation programs in conjunction with the public health sector through mutually beneficial partnerships.

3.3 Research Methodology

3.3.1 Qualitative Design

Relationships that exist between NGOs, the local community, and the various levels of government can be complex and influenced by numerous outside factors. Understanding these relationships and how an NGO functions within its community, from the perspective of the individuals who both provide and receive services, was essential to the conduct of this study. This need drove the selection of the research design and led to the eventual adoption of a primarily qualitative approach, supported by a limited quantitative method, to manage and interpret the entirety of the data set.
There are two definitions of qualitative research that influenced the development of this study. First, Creswell (1998) stated that qualitative research is a method in which the researcher develops a “complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (p.15). Second, Denzin and Lincoln (2011) defined qualitative research as a means to “study things in their natural settings, attempting to make sense or interpret phenomena in terms of the meanings people bring to them” (p. 10). These definitions suited this study, as the interpretation of social phenomena and social settings as well as interactions between individuals and groups were not easily quantified (Yin 2008; Patton 2001; Creswell 1998). Furthermore, qualitative methods are particularly useful in studying processes and process designs, and this aspect of the qualitative approach assisted the researcher in understanding how NGOs functioned, implemented projects, and developed strategy by providing insight into the business patterns of each organization (Patton, 2002).

A particular attraction to the qualitative approach developed from the way in which qualitative researchers went about conducting their studies. The mannerisms were outlined in a book by Gall et al. (2003) in a section entitled, “Differences between Quantitative and Qualitative Research.” Qualitative researchers were said to “assume that social reality is constructed by the people in it and consistently constructed in local situations” (Gall et al., 2003, p. 25). Given the dynamic social-cultural-political environment of Nigeria and the need for NGOs operating there to continually adapt, the researcher found this aspect of qualitative research to be especially relevant. Gall et al. (2003) also stated that qualitative researchers tended to become “personally involved
with the research participants,” as opposed to taking a wholly objective stance toward the subjects (p. 25). The researcher’s past experience with NGOs, described in section 3.8.4, Researcher Bias, led him to become involved with NGOs in order to better understand how they implemented their programs in Nigeria. Developing a rapport with NGO staff also enabled the researcher to build rich, holistic descriptions and assisted in interpreting the phenomena being studied. This immersion of the researcher into the perspective of the participants is contrary to methods outlined in quantitative research, and it was determined that results obtained in this manner would portray a significantly two-dimensional perspective, lacking the depth and context necessary to answer the study’s research questions. Finally, the complexities of NGO operations and the sheer effort that is required to implement a project were best understood when presented using “verbal and pictorial” means instead of relying purely on numerical data. Conducting this study using the qualitative approach allowed the researcher to construct data in such a way as to provide viewers of this study with the means to form their own interpretations of the data and apply results to their own research or projects. Most importantly, however, the qualitative approach provided the researcher with the tools to tell the story of NGOs operating in Nigeria and their ability to contribute to the development of a national capacity.

Having chosen the qualitative approach as the primary method, the researcher did opt to use a quantitative methodology, albeit in a subordinate role, to collect and analyze data within the United Nations Development Program (UNDP) Capacity Assessment Framework (CAF), discussed later in this chapter. The key reason for selecting a mix of
Qualitative and quantitative methods lies in the way in which data is interpreted in each of the two methods. The numerical data collected assisted in either reinforcing qualitative data, or it provided insight into other factors or phenomena that may have influenced the study (Creswell, 2005; Greene, Caracelli, & Graham, 1989; Tashakkori & Teddlie, 1998). Used in this manner, quantitative and qualitative methods were complimentary, allowing the researcher to increase confidence in both research findings and conclusions.

3.3.2 Case Study Methodology

This research was designed to follow an illustrative case study approach using the methodology outlined in Yin’s (2008) *Case Study Research Design and Methods* as a guideline. Although there are numerous authors such as Merriam (1997), Stake (2005), Gerring (2006), Ellet (2007), Simons (2007), and Hancock (2011), among others, who have developed ways to implement the case study approach, Yin’s method was found best suited to this study, as it emphasized the case study as a process rather than simply an end product.

As noted in Chapter One, Yin (2013) defined the case study approach as an “empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context especially when the boundaries between phenomenon and context may not be clearly evident” (p. 16). Yin also described a case study inquiry as something that “copes with the technically distinctive situation in which there will be many more variables of interest than data points and relies on multiple sources of evidence, with data needing to converge in a triangulating fashion.”
Using Yin’s definition as a guide, the case study approach was considered as the primary qualitative method due to the researcher’s need to understand the complexity of indigenous NGOs within an “important contextual condition” (Yin, 1994, p. 23). Without a proper contextual grounding, the contributions of indigenous NGOs would not be easily assessed with regard to capacity development activities, as multiple variables routinely complicated organizational intent. The case study method also allowed the researcher to improve control of variables of interest and use multiple evidence sources in order to better “collect multiple types of qualitative and quantitative data, analyze the information, and report the results” (GAO, 1990, p. 23; Johansson, 2003; Merriam, 1998; Yin, 2008). Yin’s interpretation of the case study approach as the process of investigation was especially attractive to the researcher as it permitted the creation of a substantial description of activities that allowed for an interpretation of the ability of health NGOs to build capacity and their potential for future collaborative efforts in the creation of a national capacity (Guba & Lincoln, 1992; Kenny & Grotelueschen, 1980; Merriam, 1998; Patton, 2002; Sanders, 1981; Yin, 2008). Based on Yin’s definition and approach to the conduct of case studies, it was decided that this method would be best suited for the research, as it most effectively allowed for the understanding and interpretation of the many processes and dynamics that govern NGOs and their activities in Nigeria.

### 3.3.2.1 Rationale for Using the Case Study Method.

Yin stated that three conditions must exist in order for a case study methodology to be both relevant and applicable. Conditions consist of “(a) the type of research question posed, (b) the extent of control an investigator has over actual behavioral events,
and (c) the degree of focus on contemporary as opposed to historical events” (Yin, 2008, p. 5). Table 2 summarizes five different potential research strategies and their associated conditions.

<table>
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<tr>
<th>Strategy</th>
<th>Form of Research Question</th>
<th>Requires Control of Behavioral Events?</th>
<th>Focuses on Contemporary Events?</th>
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<tbody>
<tr>
<td>Experiment</td>
<td>How, why?</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Archival analysis</td>
<td>Who, what, where, how many, how much?</td>
<td>No</td>
<td>Yes/No</td>
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<tr>
<td>History</td>
<td>How, why?</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Case study</td>
<td>How, why?</td>
<td>No</td>
<td>Yes</td>
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</table>

Examining each condition in turn reinforces the applicability of the case study method to this research. First, the supporting research questions seek to illustrate how an indigenous NGO has either implemented a strategy, developed a capability, or collaborated with a national agency. Data captured during the answering of these questions are more explanatory in nature and when combined, illustrated the ability of an NGO to support the Nigerian government and its health care system in responding to the spread of infectious diseases through the development of a more robust national capacity. While the overall research question may not appear to readily conform to a “how” style...
of question, it was the intention of the study to explain “how” NGOs function and “why”
their associated strategies, capabilities, and partnership succeeded or failed to be fully
implemented. These types of questions, as Yin recommends, examined linkages between
NGO operations and program implementation over a period of time instead of seeking to
gather data calculated to show “frequencies or incidence” (Yin, 2008, p. 5).

Based solely on the types of questions being examined, an experiment, history, or
case study approach could have been applied to this research. Narrowing the options
required assessing the need of the researcher to control or access behavioral events
associated with data collection (Yin, 2008). The execution of this study required no
special controls or access, as the researcher was not focused on an isolated variable or a
limited set of data points. Conversely, this study looked at organizations that are
influenced by multiple variables that fluctuated over the life cycle of a program. Each
variable and its associated data points provided insight into the operation of an NGO. Yin
states that situations such as this justify a case study approach, as the inquiry method,
“copes with the technically distinctive situation in which there will be many more
variables of interest than data points; and relies on multiple sources of evidence, with
data needing to converge in a triangulating fashion” (Yin, 2008, p. 13–14). The need for
control or access to behavioral events could not be justified, resulting in the elimination
of the experimental approach from consideration, leaving only a historical and case study
approach as possible avenues to conduct the research.

The final condition considered in selecting the case study approach was the focus
on contemporary as opposed to historical events. Yin stated that the case study and
historical approach share many common aspects and in some cases, overlap in their execution. The differentiating factors, however, revolved around the ability of a researcher to directly observe events as they occurred and the ability to obtain the first hand perspectives of individuals involved in the event through the execution of personal interviews (Sommer & Sommer, 1991; Yin, 2008). Unfortunately, the researcher was unable to directly observe NGO program implantation due to a combination of security concerns and travel restrictions. Detailed questionnaires, combined with personal interviews, were extensively used to gather data from the selected participants. For the researcher, the inclusion of personal interviews was a means to understand what is currently happening in Nigeria and how NGOs are able to implement programs toward the development of capacity while simultaneously addressing the multitude of environmental factors (Hartley, 1994). This desire to focus on the contemporary clearly eliminated the historical method as a suitable option for this research.

Dismissal of the previous four strategies—experiment, survey, archival analysis, and history—left the case study method as the most relevant and applicable strategy for the conduct of this research (Yin, 2008).

3.3.2.2 Case Study Approach

The intent of the research generally guides the type of data collected and how it is subsequently analyzed. Yin (2008) stated that every research method can be used for three types of purposes—explanatory, descriptive, and exploratory—although each may overlap to some extent with the other. Subsets of the three aforementioned approaches have been identified to more narrowly define each approach. These include intrinsic,
instrumental, collective, illustrative, critical instance, program implementation, program effect, and cumulative studies, among others (Cohen; 1989; Fry, Ketteridge, & Marshall, 2009; Mann, 2006; Stake, 1995). Selection of any one is generally driven by the overall intent of the study, and each has a particular use when addressing different circumstances.

Reviewing each of Yin’s (2008) approaches assisted in guiding the development of this study. Explanatory studies seek to explain causal relationships within a data set related to a single event or series of events. Explanatory studies are generally tied to “how” and “why” types of questions and attempt to show if the implementation of a program, for instance, led to specific effects (Yin, 2008, p. 6). Descriptive studies present a full account of a selected phenomenon within its context (Baxter & Jack, 2008; Yin, 2008). Exploratory studies, the last identified by Yin, are meant to be carried out prior to performing a larger, more intensive investigation. This type of study is generally chosen if there is uncertainty about the phenomenon being studied, and an initial review must be performed in order to select measurement constructs, identify questions, and determine the feasibility of gathering the right data sets (Mann, 2006; Yin, 2008). After reviewing the three main approaches, it was determined that either the explanatory or descriptive approach could be applicable to this study. Further review, however, revealed that the explanatory approach was more suited to present data gathered from program implementation and program effects types of studies. Neither application of the explanatory approach was applicable to the findings being sought. Even though this study was built upon a series of “how” formatted questions and assessed limited casual
relationships, the descriptive approach was determined to be the most suitable for providing a detailed account of the ability of NGOs to develop capacity in the Nigerian health sector.

Descriptive case study designs can take several forms. This research examined the illustrative and critical instance case study approaches as the two most likely foundations from which to execute the study. The critical instance aspect of the case study method typically examines a small selection of sites of unique interest for one or two purposes (GAO, 1990; Merriam, 1998; Yin, 1994). Critical instance studies can also “serve as a critical test of an assertion about a program, problem, or strategy (GAO, 1990, p. 38). Illustrative studies, by contrast, are used to describe a small amount of instances of a particular phenomenon in order to assist in the interpretation of data (Davey, 1991; Yin, 2008). Instances chosen for inclusion in this type of study are meant to represent a typical situation instead of typifying a number of extreme or divergent events (Mann, 2006).

The critical instance and illustrative approaches both appeared to support the goals of this research, but the application of a critical instance approach was deemed to be unsuitable. A core element of the critical instance approach is the focus on a “specific event or situation of unique interest,” or on an incident that significantly impacts a phenomenon (GAO, 1990; Mills, Durepos, & Wiebe, 2010, p. 247). Questions associated with this approach are inquiries seeking to address, for example, the person who may have been involved in a particular event, what that person’s role was, and how did their actions contribute to a particular outcome (Mills, et al., 2010, p. 247, Yin, 1994). No significant defining or critical event marks the operation of NGOs within Nigeria. The
emphasis of the research is instead placed on determining how a selected NGO, judged to be typical relative to other NGOs, dealt with infectious diseases and if they could support the development of a national capacity. Given this perspective, the illustrative approach to implementing the case study methodology was determined to be the best framework for the study.

3.3.2.3 Case Boundary and Unit of Analysis.

Selection of the unit of analysis was critical to the development of this case study and was informed by the “purpose of the research, the types of questions developed, and theoretical context of the phenomenon” (Rowley, 2002, p. 19). Yin (2008) stated that although classic case studies typically involved a single person, recent research has identified cases as being “groups of persons or organizations, key decisions, public programs, or organizational change” (p. 237). Other noted authors such as Stake stated that a case was a “specific, complex, functioning thing,” while Merriam identifies a case as a “thing, a single entity, a unit around which there are boundaries” (Stake, 1998, p. 2; Merriam, 1998, p. 26). Bearing this in mind, the researcher began with the central phenomenon of this study and identified the case through a narrowing of subjects until the case was sufficiently identified and bounded.

This body of work identified the central phenomenon as the ability of NGOs to develop capacity within the context of the Nigerian health care system for the purpose of mitigating the outbreak and spread of infectious diseases. The most fully encompassing boundary identified was the entirety of the Nigerian health care system. Within this initial boundary, the researcher created a secondary boundary around the private health sector
where NGOs typically operate. This eliminated all public sector organizations at each of
the three levels of government. The next boundary to be established denoted what kinds
of NGOs would be the target of this study. Indigenous NGOs were defined as non-profit
organizations headquartered in Nigeria that implemented the majority (+75 percent) of
their projects/efforts within the nation. This distinction eliminated for-profit groups,
international organizations such as the United Nations World Health Organization, and
similar entities. This boundary was important, as it formed a divider between specific
groups and the particular functions that they perform. See Figure 6. The next two
identified boundaries sought to narrow organizations in terms of what activities they
carried out. The infectious disease mitigation boundary encircled NGOs whose main
efforts lie in preventing the spread and recurrence of disease. Other types of groups
responsible for more chronic problems such as heart disease and diabetes prevention were
eliminated from consideration. Finally, the last boundary established isolated NGOs
whose programs incorporated some element of capacity development. This boundary
eliminated NGOs that solely worked as advocates or that were identified as awareness-
building groups.
Based on the boundaries used to bracket potential units of analysis, a “case” was identified as a group of indigenous NGOs operating within the private health care sector to mitigate the spread of infectious diseases through the development of a sustainable capacity. The single case approach did not fully meet the needs of the researcher and as such, it was determined to apply a single case, embedded design to execute the study.

Yin (2008) stated that a case may have a “main unit of analysis and also one or more subunits of analysis” (p. 328). Incorporating subunits into the study, which in this instance were individual NGOs, increased both the complexity and the overall amount of data that had to be analyzed. The benefit of including individual NGOs, representing typical cases, as subunits of analysis provided the researcher with the opportunity to analyze data in different ways. Subunits could be analyzed “separately, in conjunction
with other subunits, or across the entirety of the group” (Baxter, 2008, p. 550). This combination of analysis techniques came into play when considering NGOs operating in different geographic areas. Nigeria’s distinct religious and ethnic lines that constitute the northern, southern, and western areas of the country aided in segmenting NGOs into smaller groupings within the case. As a result, NGOs operating in the North could be assessed both as individuals and as a group. Furthermore, the northern group could then be compared to the southern group in relation to the higher level research question addressed by the study. A drawback of this embedded design can also be found in the subunit levels of analysis. If the analysis of the various subunits becomes the central effort of the study, thus ignoring the global level of analysis, then the case study target will change and the “phenomenon of interest will become the context and not the target” (Yin, 2008, p. 52).

3.4 Research Population and Sampling Technique

The research population of this study consisted of indigenous, operational NGOs working within the Nigerian health care sector that are implementing programs designed to respond to or mitigate the effects of infectious disease outbreaks. NGOs were designated as indigenous and operational if their self-declared mission sets: 1) served a specific population in a narrow geographic area, and 2) included the design and implementation of development-related projects as opposed to purely advocacy-based initiatives (Duke University, 2007; Iheme, 2004). Personnel working in conjunction with indigenous NGOs, including representatives from the Nigerian Ministry of Health, United Nations agencies, U.S. Government agencies such as USAID, and the U.S.
Diplomatic Mission to Nigeria, were selected to participate in the study in order to obtain a third party perspective of ongoing NGO operations and capabilities.

The selection of individual NGOs for inclusion into the sample population was challenging, as the researcher was not able to conduct in-person interviews within the target country, nor carry out site visits due to ongoing violence within Nigeria. Due to this, the ability to conduct non-probability, purposeful sampling that sought “information-rich” cases for exhaustive study relied upon the identification of a typical sample population and then expanding the search through snowball sampling until an acceptable population size was achieved (Chein, 1981; Patton, 1990, p. 169; Rovai, Baker, & Ponton, 2012). The latter technique was important to identify sources that could not readily be found through other methods. The review of likely participants sought to identify NGOs that would “yield the most information and have the greatest impact on the development of knowledge” (Merriam, 1998; Patton, 1990, p. 174). These information-rich sources would be crucial to the study due to the “special experience and competence” that could be garnered about a given topic (Chein, 1981, p. 440). Identifying organizations that could be categorized as “information-rich” also eliminated the need for an expansive sample population and allowed the researcher to focus data collection efforts in a more productive manner.

The researcher elected to identify a typical sample population derived from health sector organizations operating in rural areas without the benefit of fully developed infrastructure and support mechanisms. It was rationalized that if an NGO is capable of developing capacity in a limited to highly austere environment, then development would
occur more easily in locations where services were better established. Selecting a sample population in this manner did limit programs to a particular setting or situation and created a threat to external validity (Hardy, O’Brien, & Gaskin, 2004; Trochim, 2006). While a “typical” sample represents an organization that is “not in any way extreme, deviant, or intensely unusual,” it is possible that organizations operating in a particular geographic setting may have adapted programs in such a way that findings would not be readily applicable to NGOs operating in other geographic settings (Patton, 1990, p. 173). Furthermore, it is also possible that this method of sampling introduced a sampling bias, skewing the already limited generalizability of the results and provided an incomplete view of the problem being researched (Hebel & McCarter, 2006). In all cases, the researcher sought to mitigate these issues by a rigorous screening of participants with the goal of eliminating mortality threat, triangulating data, and conducting regular key informant validations meant to clarify or expand upon collected data (Gilchrist, 1992; Holloway & Wheeler, 2010).

The primary means of locating suitable NGOs centered on general Internet searches, review of NGO directory-based websites, forums, list-serves, social media sites, United Nations or other Government sponsored sites, and personal recommendations made by other NGOs or development subject matter experts (SMEs). See Tables 2 and 3 for search results. From these sources, a large number of potential NGO participants were cataloged and then reduced by applying the following criteria. Potential participants had to:

1. Operate within the Nigerian health care sector as of December 2012,
2. Implement the majority (+75 percent) of their projects/efforts within Nigeria,
3. Focus efforts on the prevention of or response to infectious disease outbreaks as part of their organizational mission,
4. Implement projects outside of a 50 mile radius from an urban center with a population of one million or more. These urban centers, as of December 2012, include Lagos, Kano, Ibadan, Kaduna, Port Harcourt, and Benin City,
5. Exhibit the ability to implement tangible projects that encompassed more than advocacy or educational campaigns.

After organizations were identified, a review of ongoing and past projects, mission statements, and other associated data, was conducted to determine their level of involvement within the health sector toward the prevention of infectious diseases. This further refined results and aided in the establishment of information-rich cases. In all instances, the researcher applied his subjective judgments as to which NGOs were selected to participate in the study.
The search for suitable NGOs started with a review of NGOs cited on ReliefWeb, PreventionWeb, Interaction, USAID’s Nigeria site, the World Health Organization Nigeria site, and the United Nations NGO Directory of Development Organizations Nigeria Country Finder 2011 edition. These sites produced a total of 476 potential sources. Using the selection criteria as a guide, specifically criteria number 2: Organizations must implement the majority (+75%) of their projects/efforts within Nigeria, 467 were eliminated from consideration. This elimination was due to the fact that initially identified sources tended to be larger organizations whose work in Nigeria
was a small portion of a much larger project portfolio. Nine NGOs meeting the selection criteria were selected for participation, two of which agreed to participate in the study.

In an effort to identify local NGOs consisting of lower level advocates who would be more likely to respond to participation requests, the researcher conducted a review of NGO networking or coalition sites including the World Association of NGOs (WANGO), Idealist.org, the Integrated Regional Information Networks (IRIN), and the Coalition of NGOs in Nigeria, Transition Monitoring Group. During this process, 1,765 potential NGOs were identified, but 1686 were eliminated from consideration. This substantial reduction was based on the application of the selection criteria and stemmed predominately from the elimination of NGOs not involved in the Nigerian health care sector and/or programs related to infection disease mitigation.

WANGO produced the most likely sources, initially numbering 907 total member organizations operating in Nigeria. Applying the selection criteria, however, reduced this number to 15 NGOs suitable for inclusion in the study. Idealist.org was the next most productive source, numbering 271 organizations. Potential NGOs were reduced to a total of 19 organizations after the application of selection criteria. Review of the IRIN, a humanitarian news and analysis service, over a three month period produced 11 possible participants. The Coalition of NGOs in Nigeria, which has 339 total members, produced 17 possible participants.

The most relevant NGO networking site was the Nigerian Network of NGOs (NNNGO), boasting 1174 members. Organizations belonging to this network are required to submit a detailed application including information on the services they perform, staff
composition, and documented constitutions or by-laws. They are also obligated to sign a membership agreement promoting a Code of Conduct, pay a reoccurring set of dues, and participate in NNNGO activities. This membership screening assisted the researcher in obtaining access to NGOs who were prone to be more stable and tied into a support system of like-minded organizations. The NNNGO periodically hosts development conferences and publishes operating procedures designed to build internal capability by assisting members to expand services and improve management techniques. Although the researcher identified 237 potential candidates from the membership list, the NNNGO leadership disseminated an introduction and initial question set to the entirety of their members. Six responded to the participation request, but only two were selected for further involvement.

The researcher then used a combination of social media sites to further identify likely participants for the study. Facebook, LinkedIn and YouTube sites were the three primary search sources. Facebook searches identified 23 potential NGOs focused on health issues in Nigeria. Contact was made with 11 NGOs, four of which accepted the invitation to participate. The LinkedIn site identified 261 individuals and 14 groups whose experience and work positions ranged from Public Health Physicians to NGO program managers. A total of 18 members were contacted, four of which responded favorably to the participation request. As the final social networking site reviewed, YouTube yielded numerous video logs from NGOs working within Nigeria. Searching for health care-centric NGOs working with infectious diseases produce 1,651 results with the majority, 1,290, focused on malaria, polio, or HIV/AIDS. A review of these videos
aided the researcher in identifying NGOs and potential key informants for inclusion in the study. Applying the inclusion criteria and eliminating duplicate entries narrowed search results to 38 potential participants. Following a review of their available data, 12 of these NGOs were contacted. Two responded favorably to the participation request.

The final stage of the search was conducted using a general internet search designed to identify any NGOs that may not have appeared in the previously identified areas. A total of 65 NGOs were identified, but after eliminating the numerous duplications and reviewing available organizational data, only eight were considered suitable for inclusion in the study. Unfortunately, all of these organizations either failed to respond to the research invitation or declined to participate.

3.4.1 Demographic Profile

The sample population of this study consisted of six indigenous, operational NGOs working within the Nigerian health care sector. NGOs were considered indigenous and operational if their self-declared mission sets 1) served a specific population in a narrow geographic area, and 2) included the design and implementation of development-related projects as opposed to purely advocacy-based initiatives (Duke University, 2007; Iheme, 2004). Using the same selection criteria noted in section 3.4 to identify potential candidates, six NGOs were chosen to participate in the study. Due to confidentially requirements, they have been given the following nomenclatures:

1. Faith Based NGO
2. Response Centric NGO
3. Recently Established NGO

4. Multi-Sector NGO

5. Diaspora Led NGO

6. Water & Sanitation NGO

During the selection process the researcher favored smaller community based organizations reflecting the communities being served. The primary operational area for each NGO is depicted in Figure 7. For the purposes of this research the *Faith Based NGO* and *Recently Established NGO* are designated as northern-based NGOs. All others are characterized as southern-based NGOs. In addition to the sample population, personnel working in conjunction with indigenous NGOs in either the public health sector or as part of an international organization were considered subject matter experts and asked to comment on findings in order to provide a third party perspective on the ability of NGOs to implement programs and develop capacity. This perspective helped with the triangulation of data and improved confidence in material collected from selected NGOs.

Each of the six NGOs selected for this study are described below in further detail. Organizational descriptions form a basis for understanding the mission, vision, operational areas and activities implemented by each organization. Additional details relating to the NGO and its programs are contained in the analysis portion of this chapter.
Characteristics of all NGOs in the sample included the emphasis of prevention efforts centered on one or two diseases, while engaging in a variety of supporting activities, including health education, counseling, literacy development, general medical treatment, and outpatient care. Malaria prevention was incorporated as a primary outreach effort by four of the six NGOs. HIV/AIDS and water borne diseases were each a focus area of the remaining two NGOs. Tuberculosis, HIV/AIDS, Cholera, and Polio treatment and/or prevention were all secondary diseases being addressed within the scope of health service provision. Finally, five of the six NGOs studied used mobile clinics as the main service delivery mechanism to reach rural populations, although the size,
duration, and capability of these medical engagements varied. The sixth NGO maintained epidemiological assessment teams as part of its core capability to identify causes of water borne pathogen outbreaks and then formulate strategies leading to disease mitigation.

**Faith Based NGO**

*Faith Based NGO* is a not-for-profit relief charity established on October 13, 2000, in the northern Nigerian city of Bauchi. Organizational leadership has not registered the NGO with the Corporate Affairs Commission as of September, 2013. The NGO has a full time staff of five but is supported by a limited number of volunteers hired to assist in program implementation. The *Faith Based NGO* is a faith based organization and uses the teachings of Islam as the foundation of its humanitarian activities. These activities involve the care and feeding of the sick, protection of women and children, and the education of those individuals who have not been exposed to formal education, or have not had the opportunity to attend an educational establishment. Through the work of the NGO, *Faith Based NGO* leaders intend to develop respect and compassion among the various groups within Nigeria and promote a greater understanding of Islam. *Faith Based NGO* leadership states that the organization serves all people, regardless of religion, ethnicity or gender, but due to its location, Muslims are the primary recipient of services. The organization operates primarily in the northern region of Nigeria. See Figure 7 for details.

The mission of the *Faith Based NGO* has not been codified into a traditional statement of purpose. Instead, the NGO has organized itself around a set of goals supported by an ever more diverse range of activities. Goals of the *Faith Based NGO* are
to “increase the overall level of awareness of diseases threatening the lives of deprived communities in Nigeria; improve health services in rural areas; and aid vulnerable populations” (Faith Based NGO, personal communication, May 15, 2013). Faith Based NGO staff and volunteers also seek to “help organize the vulnerable to develop projects and support the self-help initiatives of rural communities through the development of teaching programs, conflict resolution, and other developmental projects” (Faith Based NGO, personal communication, May 15, 2013). Finally, the staff interviewed referred to alleviating poverty, creating a “spirit of volunteerism” in rural communities and promoting sustainable economic development through community involvement (Faith Based NGO, personal communication, May 15, 2013). When taken in total, the combined goals can be seen as holistic approach to serving the local community, although at first glance, they appear to lack a coherent, focused strategy.

Response Centric NGO

Response Centric NGO is a private, not-for-profit NGO founded in November 1999 to improve access to health care services in the rural, riverine communities of the Niger Delta. The NGO is headquartered in Port Harcourt and registered with the Corporate Affairs Commission as an incorporated trustee. Response Centric NGO has a staff of eight, but these personnel are supported by a network of volunteers and consultants, both within Nigeria and through a widespread Diaspora that are assembled to participate in specific projects or events. The organization operates exclusively in the southern, delta region of Nigeria and has implemented multiple programs in Akwa Ibom,
Bayelsa, Cross River, Delta and Edo states, via a set of mobile clinics and emergency response teams. See Figure 7.

The mission of Response Centric NGO is to “support health and wellness in communities by providing treatment, education and health care services.” This mission, while somewhat vague in nature, covers a wide range of activities being performed by staff members. The NGO was included in this sample population due to its work in the rural areas to mitigate the spread and impact of malaria. Five of the seven most recent programs reviewed during the study indicated that Response Centric NGO distributed insecticides and long acting insecticide treated bed nets as a base means of reducing infectious disease in the creek communities (Response Centric NGO, personal communication, May 13, 2013; Response Centric NGO, 2013). Malaria prevention is one aspect of how Response Centric NGO meets objectives designed to accomplish an organizational goal. Another aspect of the Response Centric NGO mission is the development of sustainable programs that can treat more traditional illnesses, or chronic medical problems within a community. To this end, Response Centric NGO leadership has sought to either equip or refurbish small hospitals throughout the region and staff them with “unemployed medical professionals” sourced from across Nigeria (Response Centric NGO, personal communication, May 13, 2013; Response Centric NGO, 2013).

The organization has been able to achieve many successes in the rural areas of the delta region due in part to the ability of the leadership to organize the appropriate personnel and resources as well as draw upon relationships across both the public and private sector.
Recently Established NGO

*Recently Established NGO* is a relatively immature not-for-profit NGO established in September, 2009. The organization and its eight member staff operate from its headquarters in Katsina, Nigeria. *Recently Established NGO* is not registered with the Corporate Affairs Commission, but the leadership plans to apply for Incorporated Trustee status within the next two years, depending on organizational growth. The NGO was formed with the goal of improving access to health care services and eliminating disease from the rural areas of northern Nigeria. Operations as of September, 2013 have been centralized on Katsina’s outlying areas, with additional projects planned in the southern area of Katsina state to begin before the year’s end.

The mission of *Recently Established NGO* is to “drastically reduce the level of malaria in Nigeria” (RAMI, personal communication, June 18, 2013). This statement, clearly focused on one particular type of infectious disease, appears to be the starting point for future growth of the organization. *Recently Established NGO* leadership stated that the organizational envisions a time when they are able to provide “free medical care to the paupers,” build new, or reopen, medical facilities in the rural areas of Nigeria, and eliminate the spread of malaria, tuberculosis, and HIV/AIDS in the areas where they work (*Recently Established NGO*, personal communication, June 18, 2013). Leadership acknowledges that they are still in the building phase of their organizational development and over the next two years, they seek to expand *Recently Established NGO* program areas, further develop a core business unit, and improve staff skill sets in order to locate
additional funding sources both within the Government of Nigeria and from international donors.

**Multi-Sector NGO**

*Multi-Sector NGO* is self-declared non-for-profit, development NGO formed in 1994 and registered with the Corporate Affairs Commission as of July 3, 2001. The organization and its 11-person staff is headquartered in the southern city of Lagos and conducts operations in the nearby rural areas. The organization was founded upon the principle of developing sustainable solutions to community based problems, leading to the “alleviation of human suffering” (*Multi-Sector NGO*, personal communication, 27 April, 2013). *Multi-Sector NGO* leadership further stated that this type of development is carried out through “capacity building and hands-on projects” in a variety of operational sectors, while also creating advocacy programs within the community.

The multi-sector intervention approach to capacity development is essential to understanding *Multi-Sector NGO* as its stated missions range wildly from sector to sector, depending on the projects being implemented and the funding sources being approached. *Multi-Sector NGO* was originally selected for this study based on its treatment of HIV/AIDS and its efforts to limit further infection. As research into the organization unfolded, it became apparent that the organization was involved in not only the prevention of infectious diseases, but also a number of other efforts. Reflected on the Kabissa network, which is a social media website “designed to connect people and organizations working in Africa for peer learning and information sharing,” *Multi-Sector NGO* leadership declared that the organization is involved in numerous sectors and/or
activities including the following: health, water, environment, agriculture, human rights, child protection, crisis resolution, election monitoring, anti-corruption, counter narcotics, provision of micro-credits, and occupational safety (Kabissa, 2013). Undoubtedly, some or all of these activities do occur, but after reviewing project reports and press releases, health and anti-corruption projects appear to be the bulk of this NGO’s efforts since 2009. *Multi-Sector NGO* leadership confirmed that these two sectors consume the majority of resources, but anti-corruption programs are planned to be emphasized in the remainder of 2013 and the first two quarters of 2014 (*Multi-Sector NGO*, personal communication, 27 April, 2013).

Seven different mission statement variations, typically tailored to a specific sector being targeted, were identified during the course of this study. In five of the variations, *Multi-Sector NGO* uses the reoccurring language of aiding “vulnerable groups through and mobilization for self-sustaining development, and advocacy, based on the values of integrity, transparency, accountability, inclusiveness and legitimacy” (UNODC, 2013). Common language also included the following terms: building capacity, raising public consciousness, and improving skills and knowledge at the community levels. Following this review, the researcher isolated one mission statement with the help of *Multi-Sector NGO* leadership that centered on the NGOs health activities. In addition to the reoccurring language noted above, the *Multi-Sector NGO* stated that their health sector mission is to “use the opportunities at our disposal to fight the high incidence of prevalent diseases ravaging Africa… as a contribution to poverty alleviation and possible
eradication” (Multi-Sector NGO, personal communication, 27 April, 2013; WiserEarth, 2013).

**Diaspora Led NGO**

*Diaspora Led NGO* was established in 2003 as a not-for-profit NGO, operating from the capital of Owerri, Nigeria with a staff of between five and ten, depending on the number of programs being implemented. It is a registered with the Corporate Affairs Commission as an Incorporated Trustee. As stated in *Diaspora Led NGO* documentation, the foundation was created as a memorial to a Nigerian politician, civic leader and philanthropist. It is noted that the politician sought to develop rural communities through the building of schools and the provision of other needed services to the underprivileged in order to promote growth and prosperity. It is with this legacy in mind that the *Diaspora Led NGO* began to operate by conducting educational seminars to educate people about HIV/AIDS, breast cancer and numerous chronic diseases that can be found in the rural areas. Four years later, the *Diaspora Led NGO* expanded its capability to include implementing medical missions in rural communities in nearby states. Operations, as of 2013, were once again expanded and now extend from the epicenter of Owerri in southern Nigeria to multiple states including Kebbi State in the northwest, Gombe and Adamawa States in the east, and Kogi and Enugu States in the central region. See Figure 7.

*Diaspora Led NGO* is unique in comparison to other NGOs in the sample population as it was registered as a non-profit in the United States in 2010, and incorporated an eight member board of directors. Operating out of East Orange, New
Jersey, the *Diaspora Led NGO* was classified as a “170(b)(1)(a)(vi) organization” indicating that it receives a “substantial part of its support from a governmental unit or the general public” (GuideStar, 2013). This move allowed the foundation to expand its monetary base resulting in a likewise expansion of services. It also provided clarity of vision that is carried through its public messaging campaign. The mission of *Diaspora Led NGO*, as stated within organizational literature, is to “provide people in rural Nigeria with access to free medical care and basic skills training to help them improve their economic well-being and that of the country.” Objectives are met through a combination of medical missions, educational training and skills development. *Diaspora Led NGO* programs have all been expanded since the reorganization of the foundation.

**Water & Sanitation NGO**

*Water & Sanitation NGO* is a not-for-profit, community based organization established on 10 August 1998 and registered as an Incorporated Trustee with the Corporate Affairs Commission. The organization and its six full time staff members are headquartered in Benin City, Nigeria. Member data varies, but the NGO claims to have over 200 volunteers supporting projects within its operational area. *Water & Sanitation NGO* was founded upon a mandate outlined in Agenda 21 of the 1992 Rio de Janeiro Earth Summit. Per the mandate, the organization seeks to promote sustainability of resources and health through the effective management of Nigerian fresh water assets. *Water & Sanitation NGO* operates primarily in the southern region of Nigeria, but has a project office located in Kano working on water supply issues and the environmental impact of dams in the northern region. See Figure 7.
The mission of Water & Sanitation NGO, which varies slightly amongst available
documentation and interview respondents, centers on the improvement of access to safe
water, sanitation, and health care facilities. Water & Sanitation NGO leadership also
stated that the NGO functions as a human rights-based organization, expecting the
“government to protect and provide for its citizens and ensure the sustainability of the
resources that are vital for their wellbeing” (Water & Sanitation NGO, personal
communication, July 11, 2013). Water & Sanitation NGO’s Board of Trustees
acknowledges that organizations have a role to play in the support of government efforts,
and as such, Water & Sanitation NGO seeks to highlight community issues and develop
advocacy campaigns affecting the development and implementation of government
programs.

3.5 Research Instrument

This research used a set of three separate questionnaires, each focused on a
different variable of the Capacity Development Triad, and participant interviews to drive
data collection efforts. Questionnaires were designed to be both a data source and a
means to engage NGOs in more intimate discussions documenting their firsthand
experience with implementing projects and building capacity. The latter engagement goal
was accomplished through follow-up interviews guided by a supplementary set of open-
ended questions.

Each questionnaire was divided into two parts: a short series of open-ended
questions and a longer set of selection questions designed using a Likert scale. The
questionnaires were sent out over a period of two months, at three week intervals, to
selected participants. The schedule varied slightly based on NGO schedules, commitments, delayed responses, and in one case, a desire to expedite the process. Participants were asked to type responses to open-ended questions directly into the attached document. Responses to Likert scale questions were based on one of five selections arranged along an ordinal scale: Strongly Agree, Agree, Disagree, Strongly Disagree, Not Applicable. Following the completion of the questionnaire, participants were asked to send the completed file back to the researcher via email. Multiple file formats were created in case a participant had difficulties opening the original document.

After individual questionnaires were returned, the researcher contacted respondents to discuss answers via a phone call. This was done to clarify answers and expand upon collected data. It also provided the opportunity to ask additional, prearranged and unstructured questions. Conducting a follow-up interview in this manner allowed a greater depth and range of information to be gathered from the respondent. NGOs used the opportunity to share experiences and pertinent information that might not otherwise have been typed into a questionnaire form. See Figure 8.
3.5.1 Questionnaire Composition

Questionnaire 1—Strategic Leadership—was designed to answer the supplementary research question: How have strategies for developing capacity in the health care system been developed and implemented by selected NGOs? Four primary questions with 18 associated Likert scale questions were sent to the respondent via an email exchange. Twelve open-ended questions were asked during a follow-up phone call. The researcher sought to understand how long-term objectives were established, if a suitable plan to enable the achievement of organizational objectives had been developed, how community involvement occurred, and how sustainable projects were implemented. Appendix C depicts the questions in their basic form, the types of questions presented, delivery methods, and the manner in which primary and supplementary questions were linked.

Questionnaire 2—Organizational Capability—was designed to answer the supplementary research question: How have selected NGOs operating in different areas
of the nation developed sufficient capabilities necessary to create sustainable solutions limiting the spread of infectious disease? Four primary questions along with 24 associated Likert scale questions were sent to the respondent via an email exchange. Twelve open-ended questions were asked during a follow-up phone call. The researcher sought to identify how the internal structure of selected NGOs functioned and if they were able to apply their resources toward the development of health care capacity. The questionnaire centered on critical skill sets, provision of resources, and the ability to acquire funding in support of organizational activities. The final part of the questionnaire sought to discover what other challenges—cultural, religious, or political—that may have impacted the implementation of NGO projects (Refer to Appendix C for details).

Questionnaire 3—Partnership and Collaboration—was designed to answer the supplementary research question: How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector? Four primary questions with 18 associated Likert scale questions were sent to the respondent via an email exchange. Twelve open-ended questions were asked during a follow-up phone call. In this final questionnaire, the researcher sought to determine how the selected NGO partnered with either government agencies or other NGOs in order to implement their projects. The researcher also focused on what impediments, if any, limited the ability of an NGO to partner with receptive organizations (Refer to Appendix C for details).

Questions selected for the three questionnaires were intended to be “nested” in the broader Capacity Development Triad. Constructing supporting relationships between the
questions was important in this study, as each question linkage eventually culminated in the collection of data necessary to answer the overarching study question. The nesting of question linkages is depicted in Appendix E.

3.5.2 Developing the Research Instrument

Questions selected for inclusion in this study were partially derived from a combination of the UNDP’s Capacity Assessment Framework (CAF), the Peace Corps Capacity Development Profile, and the Center for the Advancement of Collaborative Strategies in Health’s Partnership Self-Assessment Tool (PSAT), described in the literature review. The first two of these tools were designed to assess NGO organizational capability, while the latter established a means to gather data about relationships that exist between NGOs and the public sector. Each of these public use instruments, validated by their respective organizations, provided the researcher with an established and tested survey tool to deviate from. The researcher chose to combine elements of these multiple tools into a single instrument since no one available tool could address the full range of variables identified within the study, thus limiting the overarching operational picture being sought. The CAF, CDP, and PSAT, forming the basis of the capacity and partnership assessment, have been detailed within this chapter in order to provide the reader with a better understanding of each tool and its role in supporting this study. Questions selected for use from each tool and descriptions of variations or modifications made to original content have been detailed in the following sections.
3.5.2.1 UNDP’s Capacity Assessment Framework

The UNDP CAF was selected as a way for conducting an assessment of both NGO organizational capability and strategic leadership. The UNDP methodology, in its entirety, focuses on three means of measuring the development of capacity. Emphasis is initially placed on an “institution’s ability to perform and sustain performance over time,” followed by the provision of “responses that can drive improvement” (UNDP, 2010, p. 3). The final part of the methodology involves the creation of a suitable framework that can “capture the resulting change” in performance. The end goal of the methodology is to manage and measure development in the most tangible manner possible. Establishing links between capacity development and organizational development was a core reason for the selection of the CAF to support this study. With the large diversity of indigenous NGOs operating within Nigeria, the identification of organizational performance gaps was identified as a critical part in the development of an internal means to build capacity.

The UNDP’s assessment framework was designed to encompass a five step, iterative process, depicted in Figure 9. Past UNDP programs have either focused on the entirety of the process, or have been limited to individual parts, depending on the problem under consideration. This research contained its involvement within the confines of step number two, “Assess capacity assets and needs.” This portion of the process consists of an “analysis of desired capacities against existing capacities” and illustrates ways in which to either optimize or strengthen current capabilities (UNDP-B, 2008, p. 11). Actions that occur as part of the assessment process are key components of a larger systematic review of critical knowledge and information related to the ability of
organizations to function, where gaps might exist, and what must be done to close them. A full description of the other process steps and outcomes can be found within the 2008 UNDP Capacity Development Practice Note or on the UNDP capacity website.

The UNDP CAF is organized around a set of dimensions that provide assessors with an adaptable method to: a) focus team efforts; b) determine the best approach to conducting an assessment; and, c) establish a point of departure from which the assessment can be modified to meet the unique circumstances of a given program or project. Most important to this study, questions forming the basis of the assessment vary

Figure 9: UNDP Capacity Development Process. Source: UNDP Capacity Development Practice Note (UNDP-B, 2008, p.8)
depending on which dimensions are selected for consideration. The framework depicted in Figure 10 shows the three overarching dimensions: points of entry, core issues, and technical/functional capacities (UNDP-A, 2008).

The UNDP CAF identifies three points of entry for conducting assessments: enabling environment, organizational, and individual levels. Establishing the focal area for the assessment assists personnel to direct efforts and better frame data that are being
sought. The CAF is designed to conduct assessments surrounding the enabling environment and organizational points of entry. Individual points of entry, typically encompassing the “skills, experience and knowledge that allow each person to perform,” are deemed to be subsets of the organizational level as individual actions and activities can generally be placed “within the context of an organizational” assessment (UNDP-B, 2008, p. 9).

This research used the organizational point of entry to assess NGO capacity. According to the CAF framework, the organizational level “refers to the internal structure, policies and procedures that determine an organization’s effectiveness” and is the ideal place to determine how the inner workings of an NGO can drive the establishment of effective, sustainable programs (UNDP-B, 2008, p. 10). The enabling environment was deemed to be far too broad in nature, as it is designed to assess the entirety of social systems and processes that drive and govern civic engagement.

Following the determination to begin the assessment at the organizational point of entry, four core issues reflecting the most commonly encountered problems to developing capacity were reviewed. These issues, including institutional arrangements, leadership, knowledge, and accountability, are defined below:

- Institutional arrangements consist of the “policies, practices and systems that allow for effective functioning” of an NGO (UNDP-B, 2008, p. 11).
- Leadership is the ability to “influence, inspire and motivate others and the ability to anticipate and respond to change” (UNDP-B, 2008, p. 12). Within this area, the research also sought to assess the ability to provide strategic
oversight, how long-term vision was communicated and transformed into actionable objectives and goals.

• “Knowledge, or ‘literally’ what people know, underpins their capacities and hence capacity development. Seen from the perspective of the points of entry, knowledge has traditionally been fostered at the individual level, mostly through education” (UNDP-B, 2008, p. 12). The presence of appropriate skill sets and the application of knowledge toward developing sustainable capacity development solutions were a key aspect of conducting assessments in support of this research.

• Accountability, within the context of the CAF and this research, addressed the “willingness and ability” of NGOs to establish and maintain “systems and mechanisms to engage citizen groups, capture and utilize their feedback as well as the capacities of the latter to make use of such platforms” (UNDP-B, 2008, p. 12). Accountability also involves the creation of self-regulatory procedures ensuring that funding is channeled correctly and that NGOs are answerable to the community or individuals that they serve.

All four of these core issues were selected for incorporation into the conduct of this study due to their importance in understanding if the NGOs within the sample population are capable of developing capacity through their ongoing or future programs.

The last dimension of the UNDP CAF, technical/functional capacity, is a key means of understanding the full capability of an NGO. Technical capabilities are associated with a specific area of expertise or emphasis, such as HIV/AIDS, or an
upcoming election. Functional capabilities, however, are not associated with a particular program or sector and are a reflection of the ability to “create, manage, and review policies, legislations, strategies, and programs across all levels of capacity” (UNDP, 2008-B, p. 13). Five components make up the functional capability category: engage stakeholders; assess a situation and define a vision and mandate; formulate policies and strategies; budget, manage, and implement; and evaluate. The assessment of organizational capability involved a combination of all five capacities, defined below. They assisted the researcher in better framing the study and selecting base questions for use in the data collection and analysis process.

- Engaging stakeholders refers to the ability of an NGO to establish relationships and develop consensus among relevant stakeholders. Within this process, emphasis was placed on “creating partnerships and networks, managing group processes, and establishing collaborative mechanisms” (UNDP, 2008-B, p. 13).

- Being capable of assessing a situation and defining a vision and mandate means an NGO is “fully understanding the operational environment and developing/articulating a vision or goal informed by the objectives to be achieved” (UNDP, 2008-B, p. 13). Components of this capacity include gathering and combining multiple data sources into usable products and objectives. The most important aspect of this capacity for this study, however, was the ability of an NGO to identify a community need and the associated assets required to execute a program.
• Formulating policies and strategies involves the ability of an NGO to set objectives, create priorities, and establish firm, accountable policies that span the entirety of their programs (UNDP, 2008-B, p. 13).

• Budgeting, managing, and implementing programs is one of the more important capacities reviewed during the study, as it is a reflection on the ability to bring the former capacities to bear and serves as a performance indicator of the organization as a whole. Within this capacity, the CAF drew attention to the formulation of “plans and program management, financial and human resources management,” and the creation of program support mechanisms (UNDP, 2008-B, p. 13).

• Evaluation of program performance, accountability, and knowledge development forms the last of the five capacities. As in traditional business cases, evaluation are a critical part of ensuring that resources, both human and financial, are being applied in the most efficient manner possible to achieve a given objective. It also helps to further establish accountability of actions and verifies that the programs being implemented achieved the goals they were originally designed to complete.

Each of the three overarching dimensions—points of entry, core issues and technical/functional capacities—were used to frame the assessment of an NGO’s capability to build capacity. Figure 11, a Modified Capacity Assessment Framework, graphically depicts the areas selected for inclusion in this study. These choices guided the types and numbers of questions and their subsequent analysis that would be used as a
basis for a portion of Questionnaires 1 and 2. It must be noted however that neither the framework nor its questions are a complete solution to assessing the capability of an NGO. As recommended within the UNDP user guide, the researcher used the tool as a point of deviation and supplemented the assessment with additional questions, made modifications where necessary, and eliminated sections that did not meet the intent of the study (A full listing of CAF, organizational level questions are provided in Appendix F). Questions selected for this study are identified in Appendix G, while the data analysis process is outlined in section 3.7.5.
The researcher developed questions based on selective questions and indicators derived from the CAF. These questions were meant to provide additional information and context to the primary line of questioning and, as such, were designed to either be secondary or Likert scale-type questions. Secondary and Likert scale-type questions were both designed to support a specific open-ended question by providing additional perspective or a supplemental means of verifying responses made by the participant. See Appendix E for a depiction of the linkages. Questions within the CAF that were not
selected for inclusion were dismissed from consideration. These questions were deemed insufficient to provide data supporting the primary line of research questions or were identified as being redundant.

3.5.2.2 Peace Corps’ Capacity Development Profile

The Capacity Development Profile (CDP) is a tool used by the Peace Corps to enable volunteers to assess an “NGO’s systems in a structured way” for the purpose of strengthening a selected organization (Peace Corps, 2003, p. 65). The CDP was based on a modification of the Foundation for Civil Society’s “NGO Characteristics Assessment for Recommended Development,” which was fielded after an extensive test of NGOs in Slovakia in 1997–1998 (Peace Corps, 2003, p. 66). The CDP, released in 2000, guides a volunteer in the collection of data from six potential areas, each relating to a function system: Programs, Governance, Management, Human Resources, Financial Resources, and External Relations (Peace Corps, 2003, p. 75). The scope of the collection and follow-up analysis can vary depending on the number of systems that the volunteer intends to address. Limiting functional area focus has normally been conducted in order to emphasize a particular area where positive change appears most likely to occur.

The application of the CDP is straightforward and can be conducted with a minimum of time and effort compared to other similar tools. Use of the tool follows the following procedure: A volunteer meets with the representatives of an NGO, conducts interviews using the preselected questions (column one) and then records the responses for analysis See Appendix H for a full list of questions. Following the interviews, the volunteer then compares answers against a series of indicators identified in columns two,
three, and four of the CDP. The indicators assist the volunteer to establish what level of
capability the NGO has in each of the chosen functional areas. Areas identified to have
limited or growing capacity may be targeted for further improvement until a higher level
of capacity is achieved.

This research incorporated multiple CDP questions into the survey instrument See
Appendix I. Questions contained within the CDP spanning the full range of strategy,
capability, and partnership activities were felt to form a solid basis for data collection,
and they supported the development of thick descriptions for each of the study’s research
variables. Indicators were also used in some instances to develop new questions suitable
for inclusion in the instrument. Questions that were not included either did not pertain
directly to the three areas being evaluated or were deemed to be redundant in nature. Use
of the CDP for analysis was limited, and indicators were only incorporated into the data
analysis process to assist in identifying areas where improvements to NGO capabilities
could be made. These indicators framed the levels of development achieved by an NGO
and were incorporated into the data analysis process as additional data points to compare
and contrast.

3.5.2.3 Center for the Advancement of Collaborative Strategies in Health’s
Partnership Self-Assessment Tool

The CACSH tool was designed to produce a limited assessment of how a selected
partnership is functioning in the areas of leadership, efficiency, administration, and
management as well as the sufficiency of its resources (CACSH, 2006). The PSAT, like
the Peace Corps’ CDP, is a straightforward means of assessment designed to be
administered to internal members of a partnership. The tool itself is a combination of Likert scale-type and close-ended, yes or no selection, questions designed to help partners (CACSH, 2006, p. 4) do the following:

- See how well their collaborative process is working
- Learn how to make their collaborative process work better—while they still have time to take corrective action
- Document the "hidden" strengths of their collaborative process to partners, funders, and the community
- Make their partnership more responsive to its partners and the broader community
- Get partners more involved in the leadership and management of the partnership

Results of the PSAT are obtained by calculating combinations of the 67 questions and ranking results on a 1.0–5.0 scale (CACSH, 2006, p. 6). Scores ranging from 1.0–2.9 are considered to be in the “Danger Zone”, meaning that significant improvement is needed in order to maintain and promote an effective partnership. Scores from 3.0–3.9 fall into a “Work Zone,” identifying that there is a solid base to build upon in order to establish and expand on a “partnership’s collaborative potential.” Scores from 4.0–4.5 are interpreted as being in the “Headway Zone,” depicting a strong existing partnership, but with areas remaining where improvements can be made. Finally, scores from 4.6–5.0 are located in the “Target Zone,” which is the optimal area that a partnership should seek to attain.

This research incorporated multiple PSAT questions into the survey instrument. See Appendix K. Due to the formatting of the questions in the Likert scale format, three
questions were incorporated with no changes. The remaining questions were used with slight modifications. Although several other questions were considered for inclusion, these were eliminated, as they were redundant to questions already selected from either the CAF or CDP (The full range of questions on the PSAT can be seen in Appendix J).

Use of the PSAT for analysis was limited. Results from these supporting questions were used to build a rich, thick description for analysis within the case study. Numerical data associated with these questions were incorporated into the data analysis process identified later in this study.

3.5.3 Questionnaire and Interview Structure

Questionnaires were structured using two question formats, open-ended response and Likert scale selection. These were chosen for use within this study based on their ability to provide a rich source of data for the research. Open-ended questions allowed the study participant to develop their own response to a question, which allowed for both a greater variety and deeper level of information to be obtained (Babbie, 2009; Patton, 1990; Rallis & Rossman, 2012). It was important to use open-ended questions for data gathering since the researcher sought to understand the nuances of project implementation in a given environment as well as personal opinions and attitudes regarding the functioning of the NGO itself (Patton, 2002). NGO contributions can be a sensitive topic to someone who works within the organization, and the use of open-ended questions allowed respondents to fully articulate organizational positions and achievements. These types of questions also provided the researcher with the prospect of
examining a particular answer in greater detail, which occurred during follow-up contact in the form of semi-structured interviews.

Likert scale questions were used to support the interpretation of the primary open-ended questions. These types of questions ask participants to depict their “level of agreement” with a given statement and were deemed questions that could be both easily understood and completed by the participants (Creswell, 2010; Gall et al., 2003, p. 211; Jamieson, 2004). As an example, a primary question asked in Questionnaire 1 stated, “How are/were the organization’s overall strategic objectives established?” Six Likert scale questions were then asked in order to gauge if the leadership had the necessary skills and experience to develop the objectives, what role donors played, and how the social/cultural issues and local community contributed to objective development. In some instances, redundant questions were developed in order to assist in triangulation efforts as well as provide additional perspective on the primary lines of inquiry. While the data garnered from these questions were valuable in their own right, their ability to emphasize, validate, or further refine elements provided in the open-ended questions was considered both necessary and critical to the development of an “information rich” data set.

Semi-structured, open-ended interviews were chosen to support the questionnaires because through this type of personal interaction it was possible to derive a better understanding of the context and meaning of the typed responses (Kvale, 1996; Merriam, 1998; Talmage, 2012; Yin, 2008). Engaging participants directly allowed the researcher to further examine topics and comments as they were communicated during the interview as well as “supplement data that was acquired through other methods” (Gall et al., 2003,
Interviews conducted during this research were especially important since data gathered depicted events and processes that “could not be directly observed” by the researcher (Corbin & Strauss, 2008; Patton, 1990, p. 196). An example of the semi-structured interview process started with the sending out of the base questionnaire. The participant was asked to answer the open-ended question, “What is your organization’s long-term strategic plan or mission statement?” After the questionnaire was returned, the researcher contacted each participant and sought to gain more information on strategic planning efforts by asking follow-up questions about how the organization’s mission and objectives have changed, what the greatest challenges were, and how the organization could be made more effective. See Appendix C. Participants were allowed to freely communicate their own personal experiences on these topics, which led to further probing of the topics by the researcher. Collected data reflected the respondents’ perspectives, attitudes, and biases toward the capability of NGOs to implement their projects, all of which were extremely valuable in understanding the complex Nigerian operational environment.

3.6 Validity and Reliability

Qualitative research relies upon the concepts of validity and reliability in order to “produce reliable knowledge” (Merriam, 1998, p. 198). In order to maximize these two items, this research drew on concepts most closely related to case study design in order to ensure that both the instrument and the study itself were designed in the most effective manner possible. Three types of “validity criteria and one reliability criteria,” formed the basis of the assessment meant to reduce threats to the quality of this study (Gall et al.,
Criteria included construct validity, internal validity, external validity, and reliability. While there are other alternative constructs to choose from, including credibility, transferability, dependability, and conformability, the more established criteria were selected, as they are more widely accepted and not viewed as further proof that qualitative studies are inherently unreliable (Corbin & Strauss, 2008; Lincoln & Guba, 1985; Robson, 2002).

3.6.1 Construct Validity

Construct validity refers to the extent “to which a measure used in a case study operationalizes the concepts being studied” (Merriam, 1998, p. 460; Yin, 2008). In practice, construct validity helped to determine if the items selected for measurement were indeed what the study sought to measure through the research instrument. Following recommendations outlined by Yin (2008), this research clearly identified the concepts being studied and then used multiple sources of evidence to identify and collect the necessary supporting data. Furthermore, as Yin suggested, the researcher established and maintained a strong audit trail throughout the duration of the study. This served two functions: 1) gathered data could be tracked back to its sources during any point in the study, and 2) complete collections of data could be referenced, ensuring that nothing was lost due to “carelessness or bias, and therefore fail to receive appropriate consideration” during the data analysis phase (Yin, 2008, p. 42). In both events, the establishment and the maintenance of an audit trail not only supports construct validity, but also promotes the reliability of data, leading to a higher quality product (Merriam, 1998; Yin, 2008).
3.6.2 Internal Validity

The second criterion to be addressed is internal validity. Typically, internal validity is concerned with the ability of the researcher to establish “casual relationships” and draw inferences based on the collected data (Gall et al., 2003, p. 460; Kirk & Miller, 1986; Merriam, 1998; Yin, 2008, p. 42). In this type of descriptive case study, the establishment of casual relationships within the data set was not a targeted outcome, and as such, the criteria of internal validity did not necessarily apply (Gall et al., 2003; Yin, 2008). However, multiple inferences were made throughout the study, ranging from the impacts associated with NGO implemented projects to the operational capacity of an organization. Essentially, since the researcher was not able to directly observe the NGOs and their work within the operational environment, inferences had to be made based upon the set of data collected through interviews, questionnaires, and secondary data. Making inferences in this manner created the potential for numerous validity threats to arise.

Three strategies to mitigate threats to validity included triangulation, member checks, and peer examinations.

Triangulation is the use of multiple data sources or methods to confirm findings, clarify meanings, and validate interpretations of collected data (Merriam, 1998, p. 204; Stake, 1995, p. 241; Yin, 2008). The process of triangulation is widely documented and uses a systematic process to identify “common themes and categories” (Creswell & Miller, 2000, p. 17). During the conduct of this research, findings within the dataset, gathered from a range of sources, were compared and contrasted and then reviewed against the literature review findings and conclusions. Data obtained through interviews
associated with the three questionnaires were predisposed to provide a triangulated perspective as questions were meant to clarify and expand on previously submitted responses. Additionally, the semi-structured nature of the follow-up interviews provided the researcher with the opportunity to clarify meanings or interpretations of any given question or response. Finally, the researcher used a form of observer triangulation to further enhance the validity of the study (Gall et al., 2003). Contrasting opinions from subject matter experts within the Ministry of Health and larger international organizations, including the United Nations and the United States Agency for International Development were contacted to comment on the findings as they were collected. Inputs derived in this manner were valuable to identify and reduce respondent biases, as organizations sought to portray their efforts in the most positive light possible.

Member checking formed another important part of the data collection and analysis process. Presentation of the statements made within the research to the various participants aided in both the “verification of facts and determining the completeness” of any given statement (Gall et al., 2003, p. 464; Gilchrist, 1992; Merriam, 1998; Stake, 1995). Checking with the original sources nullified any incorrect characterizations and eliminated the inclusion of misrepresented facts into the data set by the researcher. The checking of facts with the original source had the additional benefit of eliciting additional details about a given event. Although this only occurred in two instances, the data collected greatly enhanced the researcher’s understanding of how projects were implemented by the selected NGO. Combined with triangulation, this member checking assisted in the improvement of study validity and overall quality.
Finally, the study used a basic peer review process to look at findings of the study in order to comment on unexpected results or lend perspective to data as it emerged (Merriam, 1998). Peer review was conducted with the support of the U.S. Diplomatic Mission to Nigeria, USAID Liaison to United States Africa Command, the Nigeria desk officer for U.S. Army Africa, and two NGOs with expertise in implementing projects in the West Africa region.

During the conduct of the study, the researcher sought to establish a prolonged relationship with the participants over the two months of data collection, but it is unknown to what degree this actually developed. Relationships varied from participant to participant and it is unknown to what extent this actually affected the collection of data. Acknowledging that it is critical to develop relationships to the fullest extent possible, the researcher chose not to include this in an attempt to mitigate threats to validity and reliability due to the uncertainty of what biases may be developed, the relatively short length of the data collection effort, and the low level of confidence in the strength of any given relationship that developed (Jorgensen, 1989; Robson, 2002).

3.6.3 External Validity

The third validity criterion, external validity, refers to the degree that “results can be generalized to a wider population, cases, or situations” (Cohen et al., 2000, p. 109; Merriam, 1998; Trochim, 2006; Yin, 2008). Case studies posed an interesting challenge when the researcher sought to address validity threats. Literature indicates numerous difficulties associated with generalization in case study research. Difficulties stem from the fact that generalizations in case studies are analytical in nature and not statistical,
making the expansion of datasets to encompass other cases exceedingly complex (Corbin & Strauss, 2008; Gall et al., 2003; Merriam, 1998; Yin, 2008).

The researcher acknowledges that the generalization of the study’s dataset and findings may be limited in nature, partially due to the NGO interaction with aspects of political, social and cultural issues that comprise the Nigerian operational environment. Accounting for local conditions and the “decay of generalizations over time” was put forth by Cronbach (1990) in his proposal to use the concept of “working hypothesis” in lieu of generalizations (p. 124–125). Patton (1990) supported this concept and further proffered that “qualitative research should provide perspective… and context-bound extrapolations rather than generalizations (p. 491). While the researcher agrees with the concept that the usefulness of generalizations declines over time, especially in a dynamic environment like Nigeria, an effort was made to improve the ability to make generalizations by creating a “rich, thick description” of the NGOs being studied. The study was also designed in such as manner as to ensure that the sample population reflected a “typical case,” thus improving the probability that findings can be applied in other, similar settings (Gall et al., 2003, p. 466).

Development of rich, thick descriptions and the emphasis of a typical case made it possible for individuals viewing this study to develop their own conclusions about what can be generalized and how results may be transferred to meet the needs of a reader’s particular circumstance (Gall et al., 2003; Merriam, 1998). Walker (1980) framed this approach, termed “reader or user generalizability,” by stating, “It is the reader who has to ask, what is there in this study that I can apply to my own situation, and what clearly does
not apply?” (p. 34). This method, also termed “case to case transfer,” is characterized by an individual in one setting adopting an idea, concept, or program that had been cited in another case (Firestone, 1993, p. 17; Leedy & Ormrod, 2010; Lincoln & Guba, 1985). It is not the intent of this study to place the onus of developing generalizations completely on the reader, but given the changing environment and the nature of NGOs operating within Nigeria, it was felt that letting readers extract, generalize, and apply the information in a manner that best suited their situation would be the most practical way to address the external validity criterion.

3.6.4 Reliability

The fourth and final criterion to be addressed was reliability. The concept of reliability is situated upon the principle that “findings and conclusions can be replicated” if the same operational procedures are used to carry out a study of the original case (Yin, 2008, p. 45). In terms of conducting a study, reliability means that if another researcher were to use the same procedures created to study indigenous NGOs in Nigeria, they would develop the same findings and come to the same conclusions that were identified by the original researcher. Unfortunately, it is generally easier to conceive of achieving this form of reliability than putting it into actual practice. The difficulty of meeting reliability requirements in qualitative research can be traced to the nature of human behavior. Merriam (1998) stated that since the goal of a researcher, within the context of a case study, is to “describe and explain the world as those in the world experience it,” then trying to establish reliability is not feasible, as participant’s experiences and the researcher’s views may alter the outcomes of the study if it were to be repeated (p. 205).
Lincoln and Guba (1985) recommend that in lieu of reliability, researchers should focus on consistency. Essentially, they argue that the findings are not important, but rather what is important is that the “results of the study are consistent with the data collected” (Lincoln & Guba, 1985, p. 285). Consistent and dependable data can be created using the same methods for establishing validity, namely triangulation and the use of an established audit trail (Merriam, 1998; Patton, 2002). This study used both, as described earlier, to address the reliability criterion.

The study also included a statement of researcher reflexivity, which involved the explanation of biases, positions on the subjects being studied, and beliefs about the study as a whole (Creswell & Miller, 2000; Merriam, 1998). Finally, Yin provided the best guidelines for establishing reliability that had been encountered by the researcher. He stated that the researcher should “make as many steps as operational as possible and to conduct research as if someone were always looking over your shoulder” (Yin, 2008, p.45). In all cases, a significant effort was made to fully document the research process and create a procedure that could be followed by other researchers should they embark upon the same endeavor.

3.6.5 Pilot Study

Questions forming the research instrument were derived from three separate tools and the past experience of the researcher. A limited pilot study of the survey instrument was conducted to ensure that questions were adequately nested and were able to produce data that supported research objectives. Three subject matter experts (SMEs) represented by two indigenous NGOs and a USAID representative were selected to participate in the
pilot. Experts were asked to review the introductory letter and the letter of informed consent, complete the three questionnaires, and participate in an abbreviated series of phone conversations. In addition to these tasks, the experts were specifically asked to comment on question structure, perception of what result the question was seeking to obtain, and how the questions in their totality addressed the goal of the study. Comments were consolidated and changes, consisting mainly of grammatical irregularities, were implemented into the final survey instrument.

3.7 Data Collection and Analysis

3.7.1 Informed Consent

Letters of informed consent were sent via email to each NGO or key informant once an agreement to participate in the study was received. Letters informed the selected individual or organizational representative about the study’s purpose, associated risks and benefits, and arrangements made to ensure information confidentiality. Furthermore, it was stated that participation within this study was voluntary and that involvement could be terminated at any time and for any reason without penalty. See Appendix B.

In an extreme instance, when the consent form could not be sent in advance of an interview, the form was presented verbally prior to the commencement of the interview process. At the end of this statement, the participant was given the opportunity to opt out of participating in the study or allowed to inquire further about data usage, study details, or other relevant matters. Once satisfied, a verbal consent was noted by the researcher. The researcher created a tracking spreadsheet and entered the corresponding date that
verbal confirmation of consent was obtained. This file was encrypted and kept within the administrative data files.

3.7.2 Confidentiality

Data collected during the conduct of this study were considered confidential. In two instances, NGO personnel reiterated that they did not want to create the appearance that they were speaking on behalf of the entire organization in an official capacity. As a result, the researcher masked the names of the NGOs and replaced them with descriptive designation. Data were coded in such a way as to allow the researcher to analyze data, but safeguard the privacy of the respondents. All email exchanges were limited to individually addressed messages and no group mailing was allowed to take place. This limited the potential for participant identities to be disseminated beyond the researcher’s immediate control.

Protection of information included enacting the following protocols: (1) individual and/or organizational identities were not included on the surveys and other collected data; (2) a unique code was associated with the questionnaires, interview transcripts, and all other collected data; (3) through the use of an identification key, the researcher linked the analysis findings to the participant’s organizational identity; and (4) only the researcher had access to the identification key. Findings, when shared during the peer review process, were assigned random numbers in order to obscure participant identification. While it is understood that no computer transmission or encryption technique can be perfectly secure, the researcher made all reasonable efforts to protect the confidentiality of participants.
3.7.3 Information Management

Data collected during the course of this study were stored in two primary formats: electronic files and a duplicate hard copy format. Electronic materials used in this study were organized into three categories; administrative documents, literature, and participant data. The first of these categories—administrative documents—comprised working copies, drafts of chapters, archives of correspondence, participant consent forms, and similar material. Documentation in this category were organized by topic in an established file structure and stored on an encrypted, external hard drive in a locked fire safe. The second category of material—literature—consisted of articles, research, and other associated data, accumulated during the course of study, either as part of the literature review, or in conjunction with other efforts. This data, like those addressed in the administrative documents category, were stored on the primary external hard drive and archived on a weekly basis. Literature data was not encrypted due to the lack of security or confidentiality concerns. A portion of this data was also co-located on a secure internet file server for immediate access from remote locations. The final category—respondent data—required confidential access. Data included returned questionnaires, interview recordings and transcripts, organizational reports, and related material that could be used to identify an individual participant. While data was stored on the primary, encrypted, external hard drive, it was further protected by placing security access codes on each individual file. An archive of all material was made weekly and stored on a separate encrypted disk placed in a different geographic location in order to reduce the risk of catastrophic data loss.
This study made every effort to digitize materials and store them according to the procedures outlined above. Limited hardcopy backups were made, encompassing backups of respondent data, notes and transcripts from interviews, memos, confidentiality forms, and university administrative data. These files were categorized in the manner noted above and kept in a locked filing cabinet. Access to all locked files was limited exclusively to the researcher.

3.7.4 Data Collection

The following three qualitative methods were the primary means of gathering data: (1) questionnaires, (2) oral interviews, and (3) review of written documents and media. Questionnaire and interview structures were discussed in section 3.5.3. The last qualitative method used in the collection of data was the review of written documents and media.

Qualitative and quantitative data supporting the questionnaires and interviews were assembled from records developed by NGOs, media sources, and the different levels of government, where possible. Figure 12 depicts the major data sources where both qualitative and quantitative material was obtained. Secondary data sources consisted of written documents including NGO policies, mission statements, annual reports, national regulations, press releases, and project reports, among others. These sources provided additional perspective to strengthen the data collected through questionnaires and interviews. Secondary data sources also provided a historical reference point from which the attitude and position of the group can be analyzed at a given point in time.
3.7.5 Data Analysis

The analysis of data collected during the execution of this single-case, embedded design study revolved around presenting a rich description of the phenomenon (Stake, 1995; Merriam, 1998). Analysis was guided by the reliance on theoretical proposition strategy, proffered by Yin (2008), which states that propositions that guided the development of research questions will also shape how particular data is emphasized or organized.

This study used both a qualitative and a quantitative process, although emphasis was placed on qualitative data handling. A smaller subset of quantitative data was developed within the UNDP CAF supporting tool, explained later in this section.

The qualitative analysis process used to conduct this research consisted of the following phases: (1) working with data, (2) developing codes and writing memos, (3) category development, and (4) data interpretation (Creswell, 2002).
Phase One: Working with Data

The first step of data analysis involved the creation of a system capable of managing multiple data sources, including interview transcripts, audio recordings, documents, and other media assets. As interviews, questionnaires, and other forms of participant interaction were concluded, notes were reviewed and transcribed into a digital format. Initially, this took place in Microsoft Word©, but later all notes and data were transferred into the NVivo software package. The NVivo qualitative software tool is designed to assist in data analysis and supports the creation of linked memos, visual flow diagrams, and other organizational constructs (Bazeley, 2007). Due to its ability to store and manipulate data, this software package served as the main database of information used to conduct this study.

Data collection and analysis were combined to the maximum extent possible. The researcher collected and conducted an initial analysis of data as participants returned the first questionnaire and secondary documents were identified. Simultaneous data collection and analysis efforts assisted the researcher to avoid becoming overwhelmed by large amounts of “redundant or unfocused data” (Merriam, 1998, p. 162). Preliminary reviews of the material also aided the researcher in placing content into perspective and identifying ways in which findings could best be presented at the end of this study. Initial analysis of materials produced a series of observations and memos used to “stimulate critical thinking” and provide the researcher with a means to note items of interest (Bodgan & Biklen, 1992, p. 159; Merriam, 1998; Yin, 2008).
The researcher validated data and mitigated threats to validity by conducting member checking, peer reviews, and triangulation activities (Gall et al., 2003; Merriam, 1998; Stake, 1995; Yin, 2008). Figure 13 shows a depiction of the triangulation process as it was conducted during the course of this study. It is important to note that this process was implemented throughout data collection efforts and was not limited to a particular phase or timeframe. The initial iteration of the triangulation process involved working with data supporting the strategy variable. Data was accumulated from Questionnaire 1 findings, subsequent personal interviews, and a range of secondary documents and media. Material was then compared and contrasted, checked by participants for accuracy, and commented on by subject matter experts. The first iteration was closed as data became either exhausted or saturated (Gall et al., 2003). Second and third iterations of the process were repeated, generally after a three-week interval, as the data centered on capability and partnership variables were collected and analyzed.

![Figure 13: Triangulation process used to conduct this research. Source: Modification of figure from Woodside's Case Study Research (Woodside, 2010, p. 7)]
Phase Two: Developing Codes and Memos

Following the accumulation and transcription of material from the initial set of questionnaires, interviews, and document analysis, data were reviewed on a line-by-line basis and coded within NVivo. Coding, as described by Merriam (1998) is “nothing more than assigning some sort of short-hand designation to the various aspects of your data so that you can easily retrieve specific pieces of data” (p. 164). Merriam’s definition somewhat masks the importance of the coding process however. Developing an initial series of code that identify, name, categorize, and describe phenomena found in the various data sets will ultimately assist in the development of a quality product (Charmaz, 2006). Strauss (1987) reinforced this by stating, “The excellence of the research rests in large part on the excellence of the coding” (p. 27). The researcher sought to create more meaningful codes through the process of constant comparison (Merriam, 1998; Strauss & Corbin, 1998). As codes were developed, they were compared with previously developed labels and adjusted as necessary in order to maintain a better organizational structure that would eventually support the grouping and categorization of data.

Constant comparative also served as a method to control the risk of introducing bias into the study due to the researcher’s prior experience with this topic (Glaser & Strauss, 1967). As data were compared within the study, a validation, modification, or rejection of observations occurred. This reduced the impact of prior experience overwhelming other assumptions within the study. Although this method could not completely eliminate the influence of the bias of prior experience, it reduced its overall effect on the outcome of the study.
Coding took place in two main stages: initial and focused coding. During the initial coding, the researcher assigned individual fragments of data to nodes within the NVivo software. This process was guided by following Yin’s (2008) data analysis strategy of relying on theoretical propositions. The essence of the strategy is that during the analysis, the propositions that led to the development of the case study can be used to emphasize or ignore certain types of data (Yin, 2008). Following this approach, the researcher developed the first sets of codes based on some aspect of each of the three variables identified in the capacity development triad. This bracketing of data limited the amount of free nodes created and helped to group data into categories. An example of the initial coding process, using data from the limited pilot study, is depicted in Table 5.
Table 5: Initial Coding of a Partnership Interview Transcript

<table>
<thead>
<tr>
<th>Respondent Statement (Pilot Nigerian NGO)</th>
<th>Initial Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are determined to work in collaboration with the Ministry of Health in Nigeria when we have fully established health centers at some rural settlements.</td>
<td>Collaboration dependent on contingencies</td>
</tr>
<tr>
<td>We shall require assistance of health personnel and long-term supply of medicine.</td>
<td>Require source of skills and supplies</td>
</tr>
<tr>
<td>Our doors are open to Ministry if they would work in collaboration with us.</td>
<td>Willingness to collaborate</td>
</tr>
</tbody>
</table>

Focused coding was a much more directed process and has been determined to be more "selective and conceptual than the line by line, word by word and incident by incident" (Glaser, 1978). Initial codes provide basic analytic direction, while the focused coding is used to explain larger groupings of information captured during the data collection process (Charmaz, 2006). The most useful of the initial codes, determined as adequate for explaining a section of information, were selected and used as a basis for further data comparison and memo creation.

The creation of memos for the various identified codes was a key event during this stage. This step was important because the development of memos forced the researcher to analyze data early in the process, which helped to identify relationships and gaps within the material (Charmaz, 2006). Memos ranged in size and depth, but were constructed to convey what the researcher thought what was happening within the study environment as well as to use these observations to gather additional data, compare observations with subject matter experts for validation, or develop new relationships.
within the data set (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Memos were written very informally and at times resembled a series of notes or short paragraphs reflecting what the researcher saw in the data and ways in which he could organize it. As memos were developed and compared, gaps became evident and were targeted to be addressed in the next stage of the analysis by conducting a limited sampling procedure designed to gain the additional data necessary to fully saturate categories.

**Phase Three: Category Development**

The compilation and grouping of the codes into viable categories was the third phase of data analysis. Category establishment “reflected the purpose of the research” and was designed to follow the structure of the capacity development triad (Merriam, 1998, p 184). In the previous phase, free codes were developed and organized into a series of NVivo nodes. The nodes were then clustered and arranged in a series of “tree nodes” around subsets of the triad variables. An example of a node tree, using two subsets of the strategy variable, is shown in Figure 14. A full depiction of these subsets can be seen in Appendix E.
Memos created in phase two, designed to expand upon and saturate codes, became an integral part of building categories since they provided ways to better define categories, identify specific conditions of a category, note how categories are maintained or changed, and potentially identify relationships between categories (Chamaz, 2007). Notes and perspectives contained in code-specific memos contributed an additional layer of rich information to a category, around which other data could be compared. In one instance, the memos written about skills development highlighted that the skills themselves were of secondary importance to other attributes (gender, ethnicity, religion, etc.) of people employed by an NGO. This information was used to better define the critical skills category and narrow its focus within the data set.

Constant comparison and contrasting of data both within and amongst categories was an ongoing process in this phase. Nodes were shifted between the categories as themes began to fully emerge in the data. In several instances, the comparison process
drove the coding of new nodes or recoding of old nodes as the researcher better
developed his understanding of the material. A portion of the collected data did not
readily fit into the identified data categories. When this occurred, data was left as free-
standing nodes to be reviewed later in the process. Where free nodes were found to
support the research questions, they were incorporated accordingly. If a relationship
could not be established, the nodes were eliminated.

**Phase Four: Data Interpretation**

Yin (2008) identifies five analytic techniques that are commonly employed during
data analysis: pattern matching, explanation building, time series analysis, logic models,
and cross case synthesis. This study was constructed using the pattern matching
technique to analyze data and guide the development of themes and observations. Pattern
matching, at its base, involves matching patterns obtained from analyzing data to patterns
that were predicted based on previous experience, logic, or theory (GAO, 1990; Trochim,
1989; Yin, 2008). The researcher used his prior experience with NGOs, outlined in
section 3.8.4., to construct patterns for each of the three variables of the capacity
development triad. Patterns were confirmed as findings matched the expectations. In
cases where the findings did not match the preconceived pattern, expectations were
adjusted and additional narrative was devoted to explaining why a pattern did not develop
(GAO, 1990).

Identifying patterns and associated themes within the data was made significantly
easier through the use of tools built into the NVivo software package. NVivo had a robust
capacity to cross-examine data through the use of matrix coding queries, leading to
inductive searches of the nodes. The software was also able to generate models depicting potential relationships (linkages) between data and then graphically array these relationships in the form of both models and matrices (Bazeley, 2007). Analyzing these relationships involved using a deductive approach, which when combined with the aforementioned inductive search capability, furthered coding validity.

**Quantitative Data Analysis**

This research extracted limited quantitative data directly from questionnaires sent to participants. Additional quantitative data were created when a combination of primary and secondary open-ended responses and Likert scale-type formatted data were used to populate the UNDP CAF Supporting Tool. The Microsoft Excel®-based spreadsheet provided a way to interpret the level of capacity development for a given organization in a particular area. Areas selected for consideration were identified in section 3.5.2.1.

Data taken from questionnaires and interviews were entered into the UNDP CAF Supporting Tool based on guidance from the user’s guide. Both qualitative and quantitative data were used to populate spreadsheet cells. After questions within the tool were sufficiently associated with relevant data, the researcher applied a numerical code, based on his interpretation of the data, using the following scale (Dervis, 2007):

1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity
Numbers tabulated in the supporting tool provided an approximate level of capacity for each of the questions. As noted in section 3.5.2.1, secondary and Likert scale-type questions were both designed to support a specific open-ended question by providing additional perspective or a supplemental means of verifying responses made by the participant. See Appendix E for a depiction of the linkages. Following the input of data in each of the selected areas, the average score was calculated within the spreadsheet and assigned to individual sections. See Figure 15 for a depiction of data entered into the UNDP CAF Supporting Tool spreadsheet.

![Figure 15: Modification of UNDP CAF Supporting Tool Spreadsheet](image-url)
Final tabulations were used to construct a numerical overview of where each NGO stood in relation to a developed internal capability. This scale coincided with the same scale used to assign a number to each question. These numerical overviews were further added to the base of information being gathered in NVivo to develop a rich narrative for the case study. For the purposes of this study, use of the UNDP CAF supporting tool concluded at this point.

3.8 Limitations

This research recognized the following limitations that may have affected the conduct of this study: (1) identification of the sample population, (2) mortality threat, and (3) researcher bias.

3.8.1 Identification of the Sample Population

The first and most important limitation centered on the fact that the author of this study was not able to conduct in-person interviews within the target country, nor carry out site visits to NGOs. This made the study reliant on respondents who not only were located in a particular area, but also were willing to participate in the interview process. Reducing the selection of individuals in this manner increased the possibility that this study contained a selection bias skewing the generalizability of results and provided an incomplete view of the problem being researched (Hebel & McCarter, 2006).

Despite the best attempt of the researcher to identify a suitable population of NGOs, this study does not claim to have developed a fully representative sample of NGOs operating within Nigeria. NGOs selected for participation have been identified
through the aforementioned sources using five criteria to narrow the results. It is conceivable that there are other organizations operating in a given area that will never be incorporated into this study. Unintentionally excluded organizations may not have the means or access to have appeared in the sites searched during this study. Additionally, the number of NGOs that did not respond to participation requests may create misrepresentations in the effectiveness of NGOs to develop capacity. It is anticipated however, that the existing data set can be generalized to a point that will close any coverage gaps that might arise and provide a base of information that will reflect the best efforts of NGOs working to develop capacity within the health care sector.

3.8.2 Mortality Threat

The study design controlled for participant mortality threats to the best extent possible through the selection of a suitable NGO sample population (Trochim, 2006). During the initial phases of the study however, three of the chosen NGOs were eliminated from the data collection process. Two sources were suspected of questionable practices characterized by repeated requests for monetary support from the researcher. One of these two sources was later identified as a “briefcase” NGO by a member of the U.S. Diplomatic Mission to Nigeria as part of the participant validation process, confirming the researcher’s decision to eliminate them from further participation. Finally, the third NGO appeared to be more concerned with the current state of the researcher’s religious commitment rather than with providing relevant material for the study. In all three cases, accumulated data associated with these NGOs were eliminated from consideration and purged from the data archive.
3.8.3 Researcher Bias

The background and perspective of the researcher ultimately frames the problem being evaluated and will influence, for better or worse, the findings and conclusions that arise during the course of the study (Malterud, 2001, p. 483–484). This influence, or bias, is an important limitation that must be addressed over the course of any study. Bearing this in mind, the researcher acknowledges that his past experience working with NGOs has created biases that have the potential to affect both findings and conclusions. Although no study is completely without bias, this statement of reflexivity was an attempt to mitigate undue influence to the fullest extent possible (Woodside, 2010).

The operational capability of NGOs was both a personal and professional interest for the researcher. Experience with NGOs and International Government Organizations started in 1997 when the researcher was assigned as an Army Civil Affairs (CA) Officer. CA personnel typically encounter and work with NGOs on a regular basis and seek to either incorporate their efforts, or mitigate their effects, into military operations. The researcher regularly attended development conferences and sought to establish relationships with NGOs operating in different operational fields. Practical experience with NGOs exponentially increased when the researcher was deployed to Iraq in 2003. During this time, he worked with organizations such as the International Red Cross and Red Crescent, the United Nations World Food Program, and UNESCO. He also worked with numerous smaller organizations including WildAid, Care for the Wild, and other groups that flooded into Iraq to assist in rebuilding the nation and providing aid to local communities. During this time, the researcher became familiar with the logistical needs,
Objectives, and leadership of these organizations. Following the end of his involvement in Iraq, the researcher became interested in emergency management and how NGOs mitigated damages caused by both natural and manmade disasters. This interest developed over the course of several years and eventually became the basis of this study.

Past experience has biased the researcher against the long-term use of NGOs to build a sustainable national capacity. It is understood that the bias originates from the experience of working mainly with emergency management-centric organizations whose sole purposes are to enter an area where the situation is dire, effect a positive change, and then extricate themselves in order to address other, more urgent problems. Capacity development is a separate matter that is orchestrated over the course of years, perhaps decades, and must be examined differently. The researcher acknowledges the important work that is being done by indigenous NGOs, but there is reluctance to link individual successes to the development of a wider national capacity.

Even after identifying this bias, the researcher still has a very favorable, if somewhat skeptical, position on work being conducted by indigenous NGOs. It is acknowledged that without their efforts, the areas in which they work would generally be negatively impacted and the local population would undoubtedly suffer. Staffs are well-intentioned, strongly believe in the programs they implement, and have chosen a path in life that is not easily followed. The researcher has a great amount of respect for the individuals that constitute an NGO, but still believes that often the best of intentions does not readily translate into lasting change.
The study explored if indigenous NGOs had the capability to develop a national capacity in Nigeria. Although the hypothesis stated that this was unlikely, the researcher personally wanted the theory to be disproven. Research objectivity was not compromised, but additional care had to be taken during data collection and analysis to ensure that accuracy of data was maintained. As the study progressed, the researcher periodically reviewed his beliefs about the study to properly orientate himself, especially prior to conducting an interview. Unfortunately, biases do exist, and this study does reflect both the character and beliefs of the researcher. Measures to mitigate their impact, however, including triangulation, an audit trail, and member checking were put in place to reduce or eliminate researcher bias where possible.

3.9 Summary

The purpose of this qualitative, illustrative case study was to examine indigenous NGOs operating within the Nigerian health sector and analyze their ability to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity. A case study format was selected due to the nature of the primary and supporting questions, types of data sought, and the conditions defining the research’s framework. The case study approach was also considered as the primary qualitative method due to the researcher’s need to understand the complexity of indigenous NGOs within an “important contextual condition” (Yin, 1994, p. 23). Without a proper contextual grounding, contributions of indigenous NGOs would not be easily assessed with regard to capacity development activities, as multiple variables routinely complicated organizational intent.
This research drew upon a range of NGOs operating within the Nigerian health sector. While the grouping of NGOs formed the case, embedded units of analysis, consisting of individual NGOs, were used to analyze data from different perspectives. NGOs selected were invited to respond to three separate questionnaires, each focusing on a different variable of the Capacity Development Triad, and engage in participant interviews over a two-month period. Questionnaires were divided into two parts: a short series of open-ended questions and a longer set of selection questions designed using a Likert scale, while interviews were semi-structured to allow for flexible responses.

Questions used to develop portions of this study were directly drawn or modified from the UNDP CAF tool, the Peace Corp’s CDP tool, and the CACSH PSAT, to varying degrees. To ensure that both the instrument and the study itself were designed in the most effective manner possible, threats to validity and reliability were mitigated using the audit trail, multiple sources of evidence, triangulation, peer review, member checking, and researcher reflexivity techniques.

The analysis of data revolved around presenting a rich description of the phenomenon. To assist in this process, the study used both a qualitative and a quantitative process, although emphasis was placed on qualitative data handling. The qualitative data analysis process was carried out in the following phases: 1) working with data, 2) developing codes and writing memos, 3) category development, and 4) data interpretation. Quantitative data was both generated and analyzed when a combination of primary and secondary open-ended responses and Likert scale-type formatted data were
used to populate the UNDP CAF Supporting Tool. Results were incorporated into the NVivo software package and used to further develop a rich narrative.

Chapter four presents the findings and associated analysis of the collected data from the primary research question and three subsidiary questions. The report analyzes how NGOs developed comprehensive strategies to implement capacity development programs. Organizational structure, resources, service provision, and mission goals are evaluated to contextualize their contribution and potential collaboration potential. Following this analysis of NGO activities, the research presents data associated with how NGOs affected the overall development of the Nigerian health care system through the partnership with public sector organizations.
CHAPTER FOUR: RESEARCH FINDINGS

4.1 Introduction

This case study examined indigenous NGOs operating within the Nigerian health sector and analyzed their ability to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity. The researcher hypothesized that indigenous NGOs are not sufficiently capable of mitigating the spread of infectious disease, or contributing to the national health capacity due to limitations in resources, skill sets, and the inability to maintain enduring programs. Data was obtained from a set of three separate questionnaires to test this hypothesis, and each focused on a different variable of the Capacity Development Triad, participant interviews, and an analysis of organizational materials, project reports, and related media.

Chapter four presents the findings of this study in both a qualitative and quantitative format, although emphasis was placed on the qualitative design. Depicting data in this format was consistent with the single-case, embedded design of this study and served to provide the research with a rich description of the core phenomenon (Stake, 1995; Merriam, 1998). Data was categorized to “reflect the purpose of the research” and followed the structure generated during the development of the Capacity Development Triad (Merriam, 1998, p 184). The Capacity Development Triad assessed an organization’s potential to: (a) create and implement strategies supporting the
development of a sustainable capacity to respond to the spread of infectious diseases, (b) generate an internal capability to supply critical resource shortfalls, and (c) implement mitigation programs in conjunction with the public health sector through mutually beneficial partnerships. Each variable of the triad is comprised of the aspects of strategy, capability and partnership, and provided a clear means of grouping information. This enabled comparisons between both individual and multiple themes in the data set.

Data characterization begins with an overview of findings that apply to the entirety of the case, which is identified as a group of indigenous NGOs operating within the private health care sector. Emphasizing this level of analysis kept the phenomenon of interest in the proper perspective and eliminated the sub-units of analysis, i.e. the individual NGOs, from becoming the target of the study (Yin, 2008). In order to provide a quantitative means to gauge the level of capacity development for the range of organizations, results gathered from the analysis of qualitative data were incorporated into a modified UNDP CAF spreadsheet. Numerical data helped reinforce qualitative data and provide insight into other factors or phenomena that may have influenced the study (Creswell, 2005; Greene, Caracelli, & Graham, 1989; Tashakkori & Teddlie, 1998).

When used in this manner, the combination of quantitative and qualitative methods was complementary, thus allowing the researcher to increase confidence in both research findings and conclusions.

Following the documentation of global findings, outcomes of the subunit analysis were depicted within the confines of each variable of the Capacity Development Triad. This level of analysis was important for interpreting data as NGOs operating in similar
regions or facing similar ethnic or cultural environmental factors could be compared either separately or in conjunction with other NGOs (Baxter, 2008). Qualitative data represented in a narrative format was supplemented by expert opinion in order to provide additional clarification or counterpoints to the respondent data. As in the global findings section, the modified UNDP CAF spreadsheet was used to generate quantitative data supporting individual and cross unit analysis.

4.2 Data Analysis Framework

This research was guided by one overarching question and supported by three subsidiary questions, and each was designed to address a different aspect of indigenous NGO operations within the health care sector. The overarching question of this study is: *Can indigenous NGOs support the ability of the Nigerian government and its health care system to respond to the spread of infectious diseases through the implementation of local programs that contribute to a robust national capacity?*

Addressing this complex topic required a three part approach, each of which was covered by the subsequent questions:

1. How have strategies for developing capacity in the health care system been developed and implemented by selected NGOs?

2. How have selected NGOs operating in different areas of the nation developed the sufficient capabilities which are necessary to create sustainable solutions to limit the spread of infectious disease?
3. How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

Data relating to subsidiary questions were analyzed using one of three variables of the Capacity Development Triad. Each variable of the triad contained nested factors that provided a further means of interpreting data by forming categories around which trends in the data set could be more readily identified. The factors were also used in the modified UNDP CAF to provide a means of evaluation for different aspects of NGO operations.

4.2.1 Modified UNDP CAF Spreadsheet

Data taken from questionnaires and interviews from each of the six organizations were entered into the modified UNDP CAF spreadsheet based on guidance outlined in the tool’s user guide. Both qualitative and quantitative data were used to populate spreadsheet cells. Data was compared with UNDP and Peace Corps’ CDP indicators in order to generate a five level numerical code applied to each factor of a variable (Peace Corps, 2003; UNDP, 2009). The specific assignment of any given number was done using the researcher’s previous experience and how data matched relevant indicators. Numerical codes are depicted in the legend associated with Table 6. Detailed explanations are contained within theme descriptions as they vary depending on the factor under consideration. Quantitative results relating to the global findings are illustrated in the modified UNDP CAF spreadsheet.
Selected portions of the framework, including the “desired level of NGO capacity,” were not completed as they did not directly impact the outcomes that this study sought to elaborate upon (UNDP, 2009). Unincorporated data columns and rows were left visible in the different figures in order to maintain the visual integrity of the modified UNDP spreadsheet.

### Table 6: Modified UNDP CAF Spreadsheet - Global Summary

<table>
<thead>
<tr>
<th>Point of Entry</th>
<th>Functional Capacities</th>
<th>VARIABLE SUMMARY</th>
<th>Strategy</th>
<th>Capability</th>
<th>Partnership</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
<td>Existing Level</td>
</tr>
<tr>
<td>1 Faith Based NGO</td>
<td>1.75</td>
<td>2.00</td>
<td>2.00</td>
<td>1.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Response Centric NGO</td>
<td>4.00</td>
<td>4.25</td>
<td>4.50</td>
<td>4.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Recently Established NGO</td>
<td>2.50</td>
<td>1.75</td>
<td>2.50</td>
<td>2.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Multi-Sector NGO</td>
<td>2.50</td>
<td>2.75</td>
<td>3.00</td>
<td>2.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Diaspora Led NGO</td>
<td>3.75</td>
<td>4.25</td>
<td>3.00</td>
<td>3.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Sanitation &amp; Water NGO</td>
<td>3.75</td>
<td>3.25</td>
<td>3.50</td>
<td>3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>3.04</td>
<td>3.04</td>
<td>3.08</td>
<td>3.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difference</td>
<td>0.00</td>
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Modified UNDP Capacity Assessment Framework, Numerical Ranking Legend
1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity

### 4.2.2 Findings: Global

Assessed under the framework of the Capacity Develop Triad, global findings indicate that NGOs possess a partially developed ability to implement sustainable disease mitigation programs. The term “partially developed” is a ranking derived from the UNDP’s CAF spreadsheet. The ranking illustrates that while NGOs have the ability to
carry out basic operational functions in select settings, performance gaps restrict the implementation of fully realized programs capable of mitigating the impact of infectious disease. The sample population as a whole scored 3.06 on the UNDP CAF scale, placing it firmly in the 3.0, partially developed ranking. Variables were scored as follows: strategy (3.04); capability (3.04); and partnership (3.08). No single variable of the triad deviated from the partially developed numerical ranking to any significant degree.

Evaluating the individual factors within each variable, the funding (2.50) and logistics factors (2.83) represented the lowest developed aspects of NGO capability, while the critical skills factor (3.50), assessing the ability of NGOs to resource programs with necessary staff, primarily through the recruitment of volunteers, was the most advanced aspect of the NGOs’ operational capability.

Although there were no large variations between the three variables when the sample was viewed in its entirety, sizable variations did occur when northern and southern based organizations from within the sample were compared. Separated by region, southern NGOs demonstrated more organizational development, trending toward, but not reaching evidence of, a widespread capacity to meet the topic of this research (3.54). In contrast, northern based NGOs scored significantly lower, thereby demonstrating an overall anecdotal level of capacity (2.09) to implement programs mitigating the impact of infectious disease. In individual variable rankings, northern NGOs also demonstrated a lower operational capacity across every factor of the Capacity Development Triad. This perspective was borne out as data from each of the NGOs was accumulated and is elaborated upon within the three variable sections.
4.3 Strategy Variable

The strategy variable was designed to support the subordinate research question: How have strategies for building capacity in the health care system been developed and implemented by selected NGOs? This aspect of the Capacity Development Triad assessed the ability of an NGO to create and implement a long-term, strategic plan, thus enabling leadership to guide capacity building activities, mobilize available resources, integrate the target population and establish lasting, sustainable partnerships.

An organization’s strategy is the key, overarching component of providing services to any identified constituency. A well-designed strategy will help guide the long-term actions while allowing the flexibility to change based on opportunities that arise within the environment. Flexibility is critical to building capacity within the health sector as strategies must be both practical and synchronized if systemic changes are to be realized. Data relating to the development and implementation of an NGO’s strategic vision and the ability to implement programs are discussed below, followed by findings specific to the strategy variable.

4.3.1 Strategic Vision and Organizational Mission

Strategic vision relates to the ability of NGO leadership to define and implement a strategic plan detailing the organization’s overall mission, vision, and long term objectives, within a complex operational environment. The presence of a formal board of directors, documented mission statement or organizational vision, and annual operating plans are considered indications of a NGO’s ability to formulate an overarching strategy and guide supporting programs. Data collected from NGOs through a combination of
surveys and interviews depicted the how the leadership of each organization sought to develop and attain its strategic objectives.

Leadership structures varied widely amongst the selected NGOs, contributing to shortcomings in the design and implementation of programs linked to achievable strategic objectives. Deficiencies in organizational structures were most apparent in three of six NGOs, consisting of northern based NGOs, *Faith Based NGO* and *Recently Established NGO*, and the southern based *Multi-Sector NGO*. As reflected by the objective factor of the strategy variable, these three NGOs only displayed anecdotal evidence of the capacity necessary for the development and execution of long term, objective based strategies. Anecdotal evidence, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “one or few dynamic individual(s) controlling most functions, planning is conducted with limited participation of staff and constituents, and decisions are made without reference to the mission or the agreed-on strategies to achieve the mission” (Peace Corps, 2003; UNDP, 2009). The first of two commonalities between the *Faith Based NGO*, *Recently Established NGO*, and *Multi-Sector NGO* organizations contributed to low objective factor ratings, is the centralization of decision making authority and program planning in one or a select few individuals. The second commonality is the lack of long term planning resulting from a focus on short term problems or an overemphasis on identifying emerging opportunities for local involvement.

The *Faith Based NGO* has a full-time staff of five, but decision authority for all projects is retained by the organizational head. The remaining four members of the staff
carry out administrative functions of the NGO, including the maintenance of outreach programs with local community leaders and the acquisition of supplies. As noted within the demographic profile, a traditional mission statement has not been identified by *Faith Based NGO* leadership. Furthermore, interviews with staff members did not produce any concise organizational objectives, despite the identification of broad program goals. While the improvement of health services in rural areas for instance, is useful as an overarching goal, the intermediate steps to reaching this goal were not readily apparent to the staff. Interviews with NGO leadership did identify that the organization planned to become more involved with the “distribution of medicines, conduct of medical screenings, construction of wells, and development of nutritional programs” but staff responses did not indicate that they were aware of these initiatives (*Faith Based NGO*, personal communication, May 15, 2013). It is unclear if the organizational leadership had defined objectives and simply had not communicated planning details to the staff, or if no individually defined objectives exist and the NGO is reacting to the needs of the surrounding communities as situations arise.

*Faith Based NGO* staff members were asked about how the NGO planned to attain long term goals. Responses referenced ongoing projects, including the drilling of wells, provision of counseling, and distribution of long lasting insecticidal nets, among others, as proof of the organization’s ability to implement programs. Staff members could not provide any clear evidence, documentation, or leadership driven guidance regarding how the wide variety of disparate projects were interlinked to a common, long term strategy. The interviewer was referred to the Zakah pillar of Islam, which refers to the
obligatory Muslims practice of giving charity. According to *Faith Based NGO* leadership, Zakah is an essential part of how the *Faith Based NGO* NGO operates and is reflected in all of the organization’s programs. NGO staff expressed a confidence that a long term strategy is not necessarily as important as ensuring that all programs should firmly adhere to Islamic principles.

The development and implementation of projects in accordance with Islamic principles sets the *Faith Based NGO* apart from the remainder of the sample population. *Faith Based NGO* leadership, when asked about the origins of the NGO, stated that he was “called by Allah” to alleviate the suffering of Muslims in Nigeria (*Faith Based NGO*, personal communication, May 15, 2013). He went on to reiterate the numerous issues affecting the population of northern Nigeria and explained how he was inspired to protect the youth and poor of the region. It was this inspiration that also moved the NGO’s founder to engage with a UNICEF led polio vaccination programs in 2009, followed by subsequent development of medically aligned programs servicing rural communities. In all conversations, faith appeared to play a very active role in the identification of projects as well as determining who will be the beneficiaries of NGO services. *Faith Based NGO* leadership did stress that the NGO does not discriminate against non-believers, nor does it openly proselytize through its work. Unfortunately, little data was collected illustrating that the *Faith Based NGO* has moved beyond the reactionary stage of providing services. Leadership appears to have a goal of how and where the NGO should grow within Islam, but a documented, long term strategy that accounted for objectives, resource
management, and engagement plans was not expressed by any member of the staff during the data collection process.

The NGO Rural Medical Aid Initiative is similar in nature to the *Faith Based NGO* in so much that it operates in the north and is staffed by persons adhering to the principles of Islam, but the NGO is not postured as a faith based organization. The role of religion within the NGO is more passive in nature, meaning that while the *Recently Established NGO* leadership believes that the work should have a religious basis, it is secondary to the needs of those being served. Given that the *Recently Established NGO* works in Katsina, a mostly Muslim state dominated by Sharia law, the needs of the local population and the subtle religious nature of the NGO often coincide in project implementation.

*Recently Established NGO* leadership acknowledged that there are limitations to the effectiveness of the NGO’s structure and they are focused on growing internal capacity, despite having to reduce its staff by two since 2011 because of funding shortfalls. At the time of this research, centralized decision making functions are embodied within a group of three staff members, who are also the original founders of the NGO. It is notable that one of the three was educated in the United Kingdom and returned to Nigeria to support the establishment of *Recently Established NGO*. The remaining five staff loosely share the responsibilities of project management, resource management, and community engagement. Unlike the *Faith Based NGO* or *Multi-Sector NGO*, *Recently Established NGO* leadership has established a singular mission to “drastically reduce the level of malaria in Nigeria” (*Recently Established NGO*, personal
communication, June 18, 2013). Supporting this mission is a structured process to develop projects and partnerships with other organizations. Organizational leadership described the process as,

First, we have our mission, vision, and objectives. Second, we identify challenges and issues around the community that is related to our mission and focus areas. Once an issue has been identified, we develop strategies to solve the issues, and then cost the strategies. These become our projects. (Recently Established NGO, personal communication, June 18, 2013)

The process appears both straightforward and logical to serving the short term needs of their constituent communities. Longer term objective development, spanning multiple years, is not well developed but progress is evident in the projects being undertaken. For example, Recently Established NGO’s malaria eradication program to locate existing or potential mosquito breeding habitats supports the overall mission of reducing malaria in Nigeria. The program does not outwardly appear to be linked to any other supporting efforts that would maximize eradication results or constitute a coherent, holistic strategy.

Long term planning is a known shortfall within the NGO. Recently Established NGO leadership stated,

We don’t do a great job of planning more than a few months out. We get a little too wrapped up in immediate needs and what to do now. What we get caught up in is what we say we do, versus what we do, versus what we want to do that is most effective over the long term. (Recently Established NGO, personal communication, June 18, 2013)
As of June, 2013, Recently Established NGO leadership indicated that a majority of their projects originated “somewhere between the local community and donor ideas” instead of from any long term planning approach (Recently Established NGO, personal communication, June 18, 2013). Strategic conceptualization is further complicated by the inability of the three person leadership team to formalize decisions affecting the attainment of short term objectives. Recently Established NGO leadership stated that when trying to determine what long term goals a project is supposed to achieve, the team splinters a lot. We are challenged organizationally to coordinate all of the different services we offer, or want to offer, into something that will move us forward over time. We do an OK job of evaluating what we can do, but a mediocre job of trying to figure out how to evolve our programs. (Recently Established NGO, personal communication, June 18, 2013)

As the obstacles within the organization are resolved, the Recently Established NGO leadership team plans to further engage international actors. There is a great desire to “show what we can do” to these actors, but it understood by NGO leadership that a rigorous approach to project execution, outcome measurement, and program evaluation, must be implemented before they can “share what they have been doing” outside of their organization (Recently Established NGO, personal communication, June 18, 2013).

Multi-Sector NGO shares some of the same problems associated with short term program focus and ad hoc planning that exist in the Faith Based NGO and Recently Established NGO organizations. The main factor limiting Multi-Sector NGO’s ability to define and execute an organizational strategy is a muddled vision, further constrained by
an overly centralized leadership structure. As noted in the *Multi-Sector NGO* demographic profile, the NGO has seven known mission statements, each covering a different area and appearing on an associated donor or networking driven website. Interviews with the *Multi-Sector NGO* leadership did produce an organizational vision that encompassed all of the organization’s disparate programs but it does not appear to be well circulated amongst the staff. Leadership reiterated a statement that appeared on the Wiser.org web site, saying that *Multi-Sector NGO* strives to “become a factor in the integration of Africa through mobilization of independent organizations, social, political and economic to promote the democratic agenda. We advocate against autocratic incompetency that insists on power without responsibility” (WiserEarth, 2013). Staff members queried about the organizational vision were unable to articulate the same, or similar, vision and tended to reiterate aspects of individual programs implemented by the NGO.

An additional challenge of being a multi-sector, development-focused, non-government organization, as characterized by *Multi-Sector NGO* leadership, is that limited funding and resources applied to each program is restricting potential progress in any given area. Furthermore, without a clear organizational mission or objectives, efficiencies are lost and capacity development suffers. The 11-person staff supporting the myriad of initiatives is divided amongst each of the numerous program areas, although to what extent is not known. *Multi-Sector NGO* leadership stated that the operational size of the staff had been reduced between 2011 and 2013 due to funding issues and problems obtaining suitable resources to execute projects. Reductions were especially large in the
areas of agriculture and livestock farming, neither of which were known to be incorporated into any existing mission statement or documented objectives. Emails exchanged with three staff members indicated that knowledge of other programs was limited and a well-defined set of organizational objectives typically did not extend beyond the program level.

When questioned on how the *Multi-Sector NGO* developed objectives, leadership instead referred back to why objectives were created. It was stated that objectives were established to “address the prevailing problems that the organization’s mission targets, to address the causes of the sufferings of the grassroots, and make government policies recognize the rights of existence of the vulnerable groups” (*Multi-Sector NGO*, personal communication, April 27, 2013). No documented objectives were produced during the course of this study, nor were any strategic plans in evidence. What the *Multi-Sector NGO* does have in abundance is an extremely dynamic leader who seeks to engage local communities within southern Nigeria across a wide range of issues. From the plentiful news articles citing the *Multi-Sector NGO* founder, it is clear that he is the driving force within the organization, determining where and when the NGO becomes involved in a project. Given that the NGO was founded in 1994, a more mature, documented process, supporting applications for funding and program implementation was anticipated; but none was forthcoming. In the case of the *Multi-Sector NGO*, the leadership that is driving the NGO forward also appears to be the limiting factor in its future development.

In contrast to the other NGOs, the Society for Water and Public Health Protection, *Response Centric NGO*, and the *Diaspora led NGO* all displayed widespread evidence of
strategic leadership capacity. Widespread capacity, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by the establishment of a “board/staff reflecting the diversity of constituents, board driven decision making process that determines program priorities and resource allocation, a routinely conducted assessment of program outcomes that are incorporated into an established annual operating plan reflecting the stated mission” (Peace Corps, 2003; UNDP, 2009). Organizational structures across the three NGOs were robust, with established boards of directors, clearly defined mission statements, and subsidiary objectives, with slight variations.

*Water & Sanitation NGO* was operationally distinctive among the NGOs reviewed as its roots are deeply embedded in access to clean water and sanitation issues. The NGO was organized with a board of seven trustees, including three founding members. Trustees were originally selected from constituents located in Nassarawa State who were knowledgeable on the ramifications of dam construction, watershed management, and the impact of flood events. Since that time, new trustees have been added to both widen skill sets and incorporate new experience as the mission set has expanded to include more health related efforts.

The board of trustees, in conjunction with a staff of six, some of whom also sit on the board, has combined an issues-based and goals-based model commonly used in business models to guide the strategic planning process. Issue based planning is reactive in nature and the *Water & Sanitation NGO* uses this construct to align responses to pending changes in government and international policy, such as those derived from the World Bank, or to issues resulting from emergent events like the outbreak of cholera in
the Iuleha-Uzebba, Okpuje, and Okagbon communities in Edo state. In each case, Water & Sanitation NGO identified the prospective issue, weighed its effect on the organization, and evaluated the benefit of involvement. Input was sought from the entirety of the staff as well as community members, thus instilling a whole-of-organization approach with grassroots support. A localized strategy was then formed to address the issue, followed by the creation of action plans to be implemented by Water & Sanitation NGO staff.

Goal based planning by contrast, is tied to the established Water & Sanitation NGO mission and is addressed in a series of five year strategic plans produced by the NGO. Water & Sanitation NGO goals, which center on the “improvement of access to safe water, sanitation, and healthcare facilities in Nigeria without exploiting the environment,” are being met through the Water and Energy Policy Reform Advocacy program, Water, Sanitation and Hygiene (WASH) Literacy program, and the Water-related Disaster Risks Management Campaign (Water & Sanitation NGO, personal communication, July 11, 2013). One program conducted to meet the NGOs goals, occurred in the Ipogun Community of Ondo state. The leadership identified a need to reduce health issues in Ondo stating, “We read about success stories in places like India and we said, this type of program should be piloted here…and see if the community will embrace our work” (Water & Sanitation NGO, personal communication, July 11, 2013). An assessment team was sent to survey access to safe drinking water and attempt to identify the cause of ongoing schistosomiasis outbreaks that had become endemic within the local community. Results were identified and presented to Local Government Areas, community leadership, educational institutions, and to partner NGOs. Recommendations
from the assessment, including the development of an educational program, the resupply of a local health center, and the establishment of a water and sanitation supply system, were then incorporated into future Water & Sanitation NGO programs tied to developing clean water access in Ondo State. Water & Sanitation NGO uses program feedback such as this to inform the future planning and the execution of current strategy.

Supporting the goal and issue based planning process is a documented five year strategy, informed by annual operating plans. The NGO also has an extensive set of documentation relating to programs, conferences, and individual projects that provide both guidance and a historical record for implementing programs. Within the five year strategy, Water & Sanitation NGO’s board outlined a philosophy and a set of core values, stated long term objectives and identified five avenues of program implementation that will lead to the achievement of those objectives. The document also identified a plan to conduct institutional development, staff training, raise funds, and further develop partnerships with both the private and public sector. Annual documents are similar in nature to the five year strategy, but provide more detail on individual programs and funding sources. Combined together, these documents, along with the goal and issues based planning approach provide clear indicators that Water & Sanitation NGO leadership is able to clearly articulate a vision and implement a series of organizational programs to achieve their goals.

Response Centric NGO’s organizational structure is similar in nature to the Water & Sanitation NGO, but control of the board is strongly invested in its executive director. Despite this centralized control, the NGO’s leadership has actively sought to engage the
local communities in the decision making process and has developed internal mechanisms to ensure that a long term approach is maintained while still being able to react to more immediate problems within its southern operational area. Response Centric NGO leadership stated that “developing a program generally begins with a review of the mission, organizational vision, and objectives outlined in our strategic plan” (Response Centric NGO, personal communication, May 13, 2013). Assessment teams then identify the challenges or issues to program development in the community in question. Following this, the board, in conjunction with local staff members, consultants, volunteers and community members propose ways to solve identified challenges. Goals, objectives, and activities are developed and budgeted. In order to implement actual programs the board engages relevant stakeholders in the targeted community.

Community participation is paramount in project implementation right from the planning stage to implementation, and in monitoring and evaluation. When developing a proposal, community members’ opinions and contributions about the project are sampled. Finally, we hand over the project to the community. Sustainability can only be possible if the community was involved in the project right from the planning stage to the finishing. (Response Centric NGO, personal communication, May 13, 2013)

This program lifecycle is central to the operation of Response Centric NGO and can be seen as the base means to achieve the core objectives of the organization’s strategic plan.

In support of the organization’s decision making process, Response Centric NGO leadership developed an assessment and feedback system to better enable future program
implementation. This system was most recently used to conduct a review of actions surrounding the June 2013 floods where hundreds of civilians were killed and millions displaced (Amaize, 2012). Response activities were scrutinized by Response Centric NGO staff, affected Local Government Areas, and national authorities. Response Centric NGO used the establishment of the Patani refugee camp as a case study to identify areas where public-private sector authorities could better collaborate and apply scarce resources. The assessment process is also integrated into Response Centric NGO’s more routine programs and relief missions. Project documentation outlines lessons learned during program implementation, as well as recommendations to avoid obstacles or repeat future successes. Response Centric NGO leadership stated that these recommendations from the implementing staff are taken very seriously and are reviewed as part of the process to identify new programs. Amongst all of the NGOs contained in the sample, Response Centric NGO is the only NGO to use an assessment system to this extent. Even though it is likely that this type of system is in use in other organizations, none are as apparent or as well documented in existing business practices.

Strong leadership, like that of Response Centric NGO, is a core characteristic of the Diaspora Led NGO. It has one of the most developed leadership structures amongst the sample population with its beginnings firmly rooted in Nigeria’s tribal culture. Diaspora Led NGO has expanded dramatically from its 2003 establishment in Obube, owing primarily to the development of a formalized leadership structure and business model. Diaspora Led NGO leadership explained that the organization was started by members of a tribal family and run by one of the siblings as a means to help widows in
the Obube community. Widows were selected as the core constituency for the foundation because of the lack of a suitable social safety network within Nigeria. Programs were initially not planned over the long term and objectives were very limited.

It was being run on an ad-hoc basis because we were not trying to impress anyone. We wanted to help our community which is in Imo state, as well as some nearby communities. It was just family members making a pledge on how much of a contribution to make on each given year. My grandfather was a polygamist. He had ten wives and twenty eight children. Each family member that wanted to participate said that, well, I can give 200 dollars in this year. So whatever amount we arrived at, we used that money to determine what projects that we were going to work on. (Diaspora Led NGO, personal communication, May 20, 2013)

The organizations continued on in this manner until 2007 when the first medical mission was organized. Volunteers participating in the mission suggested a reorganization of the foundation in order to streamline operations, increase available funds, and expand the potential service base.

The reorganization of Diaspora Led NGO occurred in 2009, establishing a United States based board of directors to oversee the development of potential programs and a long term strategy designed to better present a national face for the NGO. A set of formalized objectives, supporting a focused mission statement was also created and used as a means to guide the foundation and support the acquisition of funds. The desire to be involved throughout the nation is the main premise of the documented mission statement and fundraising activities. Diaspora Led NGO leadership stated,
In doing some research, we found out that is need all over the country. They [the family] didn’t want a charity that was only focused on Imo state, so we decided that while yes, resources are limited, but we will approach different communities in different states as part of our outreach. *(Diaspora Led NGO, personal communication, May 20, 2013)*

To implement this vision, the United States board of directors has the lead role in determining where resources are applied. There is a corresponding Nigerian based board of directors, consisting of the original founders, but their interests are solely based in Imo state. Outside of Imo, the United States board has the final authority on program selection. As projects are approved, selected program directors work with identified local community leaders to plan and implement the medical missions or educational event. While no formal decision making process was named, the approach used is similar to the goal and issue based approach adopted by *Water & Sanitation NGO*.

What is missing from the planning cycle appears to be a clear system of feedback and assessment. Newsletters and mission reports all describe number of patients treated, services provided, and fundraisers, but the long term effect of *Diaspora Led NGO* involvement in a local community is not apparent. Discussion of assessments with the foundation’s leadership did not provide any additional insight, leading to the observation that the foundation is program centric and long term community development outside of Imo state is not a core function of the organization at this time. Program implementation also appears haphazard to some extent as medical missions can be implemented in an area with no long term strategy or concept for developing a sustainable solution. For
example, the *Diaspora Led NGO* leadership described the decision to pursue recent medical mission as “We went to the village based on an invitation. There was a priest who found out about our charity. He said why don’t you come and treat my people before they all die?” (*Diaspora Led NGO*, personal communication, May 20, 2013). This means of instigating a program was a reoccurring item during the data collection process. All of the chosen programs could easily be linked back to the foundations mission statement and strategy, but the medical interventions themselves, appear to lack structure beyond their actual execution.

Organizational capacity growth is a focus of the foundation’s strategy and the United States board of directors has incorporated a series of fundraising events tied to its annual meeting to expand services. Regular newsletters are published for its donor target audience. Volunteers, both medical and skill independent, have been incorporated into its long term approach to implementing programs in rural communities. Since the incorporation of a United States based board of directors, revenues have risen by approximately ninety percent, providing wider latitude for the foundation to operate. Despite the growth of medical programs the U.S. Chairman, Board of Directors, plans to prioritize non-medical events, such as education and literacy, over medical missions for the remainder of 2013 and the beginning of 2014. This decision will support the strengthening of different aspects of the foundation, allowing the NGO to better address reoccurring problem sets, such as illiteracy, in targeted communities.
4.3.2 Program Implementation

Program implementation portrays the ability of an NGO to establish programs within a community that achieve operational and strategic objectives. The creation of monitoring and evaluation systems, sharing of information with stakeholders, and established partnerships with the local community are indicators of effectively implemented programs. Data collected from NGOs through a combination of surveys and interviews depicted the how programs were implemented and their linkages to strategic objectives.

All NGOs within the sample population are capable of executing a program within targeted communities to varying degrees of success. Implementation of programs linked to achievable strategic objectives appears to be more challenging to initiate. Data were assessed to determine an NGO’s ability to successfully apply some equation in order to balance limited resources, organizational practices, and desired end states. The use of this equation or related variation enables NGOs to create linkages between the leadership’s vision and operational level programs in order to achieve long term strategic goals.

Deficiencies in nesting programs within an organizational strategy were noted in all surveyed NGOs. The Faith Based NGO, using the modified UNDP CAF ranking system, only displayed anecdotal evidence of the capacity necessary to implement programs supporting the achievement of a strategic plan. Anecdotal evidence, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “the absence of clear demand signals for NGO programs, a lack of program evaluation metrics,
overemphasis of donor involvement in the design of programs, and the execution of programs not linked to an overall strategic plan” (Peace Corps, 2003; UNDP, 2009). The fundamental cause of the *Faith Based NGO*’s low capacity rating was the lack of any identified organizational strategy from which to generate nested programs. Organizational leadership did relate several goals that the organization sought to achieve, noted in the demographic profile, but they lacked specificity or a means to determine measures of performance or effectiveness.

A number of divergent programs have been undertaken in and around Bauchi in order to achieve the compilation of organizational goals. The *Faith Based NGO* has delivered seminars and hosted workshops centered on social development, youth counseling, child-foster activities, and nutritional care for both new mothers and infants. Rural development work has produced new community wells and improvements to village sanitation, along with educational programs to reinforce the necessity of hand washing and cleanliness. No systematic review of implemented programs was available for evaluation.

The most robust portion of the *Faith Based NGO*’s work has been in the area of disease prevention, treatment, and the expansion of access to health services. Programs generally align with the NGO’s desire to improve health care in rural areas and aid vulnerable populations, but programs were not conducted with any overarching plan in mind that balanced resources, staff and risk. Programs initiated by the *Faith Based NGO* include the conduct of medical screenings and the provision of medications and care to local communities. Prominent community engagements by the NGOs consist of hosting
periodic, limited-capability, health clinics in areas were local residents either do not have access to established facilities or cannot afford existing services. A clinic conducted near Ningi in May 2013 focused on the teaching of malaria prevention programs, treatment of parasitic skin infections, provision of obstetrical/gynecological services, dental services, and the dispensing of a variety of medications. Volunteer doctors also provided emergency care where necessary and saw patients suffering from both diarrheal diseases and malnutrition. These clinics appear to be the organizational standard for implementing programs in their operational area. Although a number of local residents are served by the clinics, long term after care is non-existent and many residents are referred to public care facilities due to the inherent limitations in operating a small scale clinic. No reoccurring clinical presence is currently offered, but expansion of the rural clinic program, along with other health initiatives, is anticipated as the NGO grows its staffing and resource base.

The bulk of the sample population, including the RAMI, *Diaspora Led NGO*, *Multi-Sector NGO*, and *Water & Sanitation NGO*, demonstrated a partially developed capacity to implement programs supporting the achievement of a strategic plan. A partially developed capacity, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “the presence of objectives that may or may not be measureable, programs tied to an overall strategic objective, constituency treated as recipients of services, and the need for legislative and/or institutional changes supporting constituents is recognized” (Peace Corps, 2003; UNDP, 2009). NGOs falling into this category were characterized by the implementation of limited scope programs supporting
long term objectives. Programs were often implemented in conjunction with some form of associated educational package or training opportunity. NGOs were not classified with a higher capacity rating as monitoring and evaluation systems were generally absent while measurable indicators for success were still rudimentary in nature and often did not support the internalization of lessons learned into future programs or activities. Additionally, other factors such as donors, logistics and funding limited the potential of certain efforts to be fully realized. These factors are discussed later within this study. Finally, each NGO displayed peculiarities to its method of operations and, where relevant, were discussed within the context of the individual organization.

Recently Established NGO programs are predominantly focused on malaria eradication, emphasizing the distribution of long-lasting insecticidal nets to rural villages. Provision of insecticidal nets has been accompanied by educational programs designed to change the behavior within a community and train local workers to administer preventative therapies within their villages. The Recently Established NGO malaria eradication program also seeks to locate existing or potential mosquito breeding habitats and then aid communities, in conjunction with the Local Government Area, in the elimination of the identified areas. Recently Established NGO programs are supported by small, single day clinics carried out in smaller urban areas and surrounding hamlets. Clinics distribute medications and provide an opportunity for local residents to seek treatment for other common endemic ailments or issues related to maternal health. No follow up medical treatments or evaluations are offered beyond the initial disbursement of medications or referrals to other service providers. These latter activities, which
generally do not appear to support the Recently Established NGO’s malaria eradication mission, serve as a means to attract local residents who can then be exposed to malaria prevention education.

One reoccurring theme that arose during the malaria education process forced a re-evaluation of the ways in which their programs were enacted. Recently Established NGO leadership explained that during the distribution of insecticidal nets it was discovered that many people within the local community did not know how to mount the nets within their homes. “There are NGOs who have thousands of mosquito nets…and they line them up and hand them out, but the people who get them don’t have the expertise to put them up and because of this, they are not useful” (Recently Established NGO, personal communication, June 18, 2013). As a result of this finding, Recently Established NGO will train select community members on the mounting and proper use of an insecticidal net. “The reason that we can give them out is that we have locals on the ground that can go into people’s homes and mount the mosquito nets for them” (Recently Established NGO, personal communication, June 18, 2013). This adaptation of the educational process is one known instance of a lesson learned being incorporated into future programming efforts.

Program evaluation is circumspect despite the fact that Recently Established NGO leadership claims that malaria education and net distribution programs established in the town of Bakiyawa using the day-clinic approach has reduced the spread of malaria infections since 2010 (Recently Established NGO, personal communication, June 18, 2013). It was also noted that no severe cases of malaria in babies have been identified in
their operational areas since May, 2013 and overall rates of infections have been reduced by approximately 30-40 percent. Specific data could not be obtained from the NGO or the Nigerian Ministry of Health to substantiate these assertions. Long term health indicators were also absent and claims did not appear to be supported by any rigorous data collection activities.

Future program objectives cited by Recently Established NGO leadership include the establishment a permanent clinic in Bakiyawa supporting longer term health care needs within the community. Once operational, Recently Established NGO would also like to deploy mobile health clinics, consisting of medical testing and examination facilities, in a number of remote communities. This project is still in the elementary phase of development and partnerships with the Local Government Area and local leaders are being advanced. Another program, focused on sanitation, has been initiated in the town of Tsagero. Efforts to reduce the impact of poor sanitation have been undertaken including community clean-up events and the conversion of trash into usable goods. These events have been enacted through partnerships with the Local Government Area and local community and are part of a wider development effort, also in the initial stages planning and implementation.

Diaspora Led NGO has clearly defined objectives and associated projects which are linked to the strategic vision due to the efforts of the organization’s robust board of directors. Objectives are achieved through the primary mechanism of medical missions, which form the base of Diaspora Led NGO’s activities in Nigeria. Medical missions were implemented during the 2007-2009 time period at a rate of one per year. Following the
reorganization in 2010, the conduct of medical missions surged to an average of 10 per year during the 2010-2012 time periods. Indicators of mission accomplishment are conveyed purely in terms of the number of patients treated, with no explanation of treatment success or potential reduction of future medical issues. This body count style of tabulation was typically reported in Diaspora Led NGO project reports as, “1,055 patients in Amafor Imerienwe, Ihitta-Ogada, in Imo State and Kabba and Akutupa in Kogi States. The team provided free treatment to 325 patients. We ended up treating 466 people at our clinic.” Reporting in this manner does provide donors with an ability to measure Diaspora Led NGO’s engagement ability, but it does not reflect any sustainable impact to a targeted community.

Medical missions conducted by Diaspora Led NGO typically last one or two days and focus on maximizing throughput of potential constituents. This style of execution firmly places the constituency in the role of service recipient. Problems typically arise in the anticipating the number of people that can be treated, which can affect the achievement of program objectives. Diaspora Led NGO leadership stated,

The problem is that there is no accurate way that you can use to estimate how many people will show up at a single clinic. For example, so you ask people let me set up a clinic in village “A” and you inform the villagers that you are coming. Because of the fact that people from different villages intermarry, a woman who lives in Village “A” and whose family lives in village “B” will tell their family. People you did not anticipate will then end up showing up at the clinic. This can
cause us not to plan well and we can run out of medication. (*Diaspora Led NGO*, personal communication, May 20, 2013)

At one clinic, *Diaspora Led NGO* prepared to treat 300 people but over 700 arrived from the surrounding areas seeking treatment, negatively affecting limited supplies.

“Normally, we would give two-three weeks of medication, but we had to cut it down to two weeks or less so that we could see more people” (*Diaspora Led NGO*, personal communication, May 20, 2013). *Diaspora Led NGO* leadership admits that the resources they supply are limited in nature and unlikely to produce long term effects due to the overwhelming poverty of the nation. “To be candid, we can commit all of our resources to one place and still not make a dent” (*Diaspora Led NGO*, personal communication, May 20, 2013). This outlook contributes to the tightly focused mission statement and its associated objectives, making them both achievable and open to future expansion.

*Diaspora Led NGO* medical missions are supported by educational programs such as Lois Reilly Seminars, assorted literacy campaigns, and localized skills training program designed to raise awareness and develop skills able to support economic improvement. Lois Reilly Seminars, according to *Diaspora Led NGO* leadership, are typically implemented in conjunction with a medical mission and teach local residents on topics such as “basic health maintenance, preventive measures against malaria, mitigating the effects of other tropical diseases, and geographically relevant issues such as sanitation and the importance of clean drinking water.” The literacy program, implemented through volunteers is designed to “teach basic reading and writing to farmers” in the rural areas. Finally, skills training programs, teaching trades such as fishing, carpentry and sewing,
help local residents in rural areas to build cottage industries and skills with the goal of increasing their overall standard of living. Program expansion is anticipated as new sources of funding become available. Educational programs are sometimes tangential to the central mission of providing healthcare services to rural communities, but the impact of poverty and the absence of education is so severe that these programs are an essential step in breaking the cycle of poverty and disease within a local area.

*Multi-Sector NGO*’s capacity to implement programs supporting the achievement of a strategic plan was considered to be partially developed due to the adherence to a muddled organizational strategy that broadly encompasses the fight against the heavy disease burden in Nigeria. As noted within the demographic profile, seven mission statements were identified as part of the organization’s multi-sector approach to addressing issues within Nigeria. While the health sector mission of reducing the burden of disease within Nigeria is admirable, there are no documented objectives that can be used to guide the progress of NGO driven programs. Like the *Faith Based NGO*, individual missions lacked specificity and did not have clearly associated measures of performance or effectiveness. Unlike the *Faith Based NGO*, the *Multi-Sector NGO* was able to identify a singular issue to focus on, in this case HIV/AIDS, although it is not directly reflected in the mission statement, and develop a series of programs involving the distribution of medications and delivery of aggressive preventative education in both rural and select urban areas to reduce the spread of the disease.

In 2013, disease prevention programs were almost solely limited to sexual reproductive health and HIV/AIDS programs. *Multi-Sector NGO* leadership stated that
the NGO generally seeks to reduce the spread of HIV/AIDS by providing counseling, raising awareness, lobbying, developing self-help entrepreneurship, and providing preventative care. HIV/AIDS programs at the individual level have sought to provide counseling, distribute food and medications to patients in their homes, and provide other necessary things that are needed. More holistically, the *Multi-Sector NGO* has participated in multiple conferences and educational workshops designed to prevent the spread of HIV/AIDS at the community level through advocacy and the dissemination of information. Preventative care and mitigation has been addressed by providing the means to map, test, and conduct limited treatment of patients with antiretroviral drugs. One program supporting the efforts to reduce HIV/AIDS involved training local community health workers on topics including antiretroviral drug management, hygiene, immunizations, nutrition, and anatomy. Satchels with HIV/AIDS prevention materials were also provided that could be used by the health workers to conduct localized educational campaigns in their respective areas. The programs impact was limited by a lack of funds, bulk procurement of antiretroviral drugs, and continuous turnover of community health workers.

The *Multi-Sector NGO* also implemented a robust tuberculosis control program based on the World Health Organization directly observed treatment, short-course strategy. According to the *Multi-Sector NGO* leadership, but not independently substantiated, the latter of these programs eliminated tuberculosis outbreaks in two rural communities, and prevented the spread to surrounding areas. Through the development of
additional community programs, the NGO plans to replicate this success in other rural areas near Lagos.

*Multi-Sector NGO*’s lack of evaluation metrics is a common theme throughout all of the programs reviewed during this study. Objectives were not clearly identified and while all of the NGO’s efforts could be tied to the strategy of “fighting the high incidence of prevalent diseases ravaging Africa,” no framework appears to be in place that can evaluate the progress of program implementation (WiserEarth, 2013). As previously stated in this chapter, the *Multi-Sector NGO* leadership is very dynamic and trying to address programs within Nigeria across a wide variety of fronts. It is clear that the organization views its constituency as more than mere recipients of services due to the numerous conferences, campaigns and programs that it has become involved with. The scattered approach to conducting business appears to have created a framework where resources are thinly spread across numerous programs. This has resulted in a lack of depth in areas such as program evaluation, future planning, the development of sustainable activities, and the dissemination of lessons learned amongst community stakeholders.

*Water & Sanitation NGO* has had difficulty in implementing its programs and meeting strategic objectives, contributing to its partially developed capacity rating. NGO leadership stated that the organization, has recorded some successes in its activities, although the successes have been quite limited due to many challenges including extremely insufficient funds and unwillingness on the part of government to integrate most of our
recommendations and findings into their developmental plans and activities.

(\textit{Water \& Sanitation NGO}, personal communication, July 11, 2013)

Despite the failure to achieve the level of effectiveness desired by \textit{Water \& Sanitation NGO} leadership, the NGO continues to implement programs and advocate for local communities in its area of operation. Since its establishment in 1998, \textit{Water \& Sanitation NGO} has attempted to institute a number of diverse programs within the scope of the stated mission set including sanitation and hygiene campaigns and water-related disaster response initiatives.

Sanitation and hygiene projects are conducted by \textit{Water \& Sanitation NGO} to improve community health and engage stakeholders in the management of their water resources. The NGO organizes training workshops, seminars, and conferences designed to build community capacity, provide clean water, and improve sanitation programs. As stated by the NGO leadership, successful partnerships with the public sector are not common even though some progress has been made in select Local Government Area areas. One of the more successful programs involved the effort to reduce the incidence of diarrheal disease through simple measures such as hand washing. \textit{Water \& Sanitation NGO} leadership believes that sanitation is generally neglected in favor of other more conspicuous government priorities, which results in low funding of programs and investment of national resources. As part of the sanitation program, the NGO constructed six bore holes at local schools to provide new water sources, tested 18 water points within the local communities, and trained community volunteers using a cascade model, on the importance of hygiene and proper sanitation. No follow-up activities have been
performed in conjunction with this initial effort and it is unknown what overall impact, if any, the campaign has had in the targeted communities.

*Water & Sanitation NGO* disaster response activities related to flooding are typically executed through initial assessment teams, followed by technical response staff, where necessary. *Water & Sanitation NGO* responded to a cholera outbreak in Uzebba, Edo State, by deploying an assessment team to determine where the pathogen originated and how it could be eliminated. The development of this capability arose from the aftermath of the 2010 cholera outbreaks that occurred following the release of water from the Challawa and Tiga dams following heavy flooding (Associated Press, 2010; CNN, 2010). Reports suggest that over 44,000 individuals became infected with over 1,500 deaths from the disease (Aljazeera, 2010; CNN, 2010; WHO, 2012). *Water & Sanitation NGO* reasoned that quickly isolating the source of pathogens and taking steps to mitigate their impact could reduce the impact of the disease. In Uzebba, the assessment determined that corrupted boreholes were the cause of the outbreak and the NGO immediately began to enact a duel information and education campaign to aid in overcoming the problem. No data was collected during or after this intervention limiting the ability to measure the overall effectiveness and impact of the response. Additionally, constituents were merely recipients of services and no long term solutions were put in place. *Water & Sanitation NGO* plans to continue these types of outbreak response assessments through the expansion of its Water-Related Disaster Risks Management Campaign and the WASH Power Project. These two efforts are designed to reduce the
risk of poor sanitation and mitigate the impact of flooding in the southern region of Nigeria (Water & Sanitation NGO, personal communication, July 11, 2013).

Among NGOs within the sample population, Response Centric NGO displayed the most developed means of implementing programs that supported the achievement of a strategic goal. Based on indicators outlined within the Peace Corps CDP and modified UNDP CAF, Response Centric NGO was shown to possess widespread evidence of implementation capacity. In addition to criteria outlined in the partial level of capacity, the widespread level of capacity is characterized by the establishment of “measurable indicators for individual programs, monitoring and evaluation systems presided over by staff on a regular basis, lesson sharing systems with other stakeholders, and advocacy programs designed to address identified shortcomings within a community” (Peace Corps, 2003; UNDP, 2009). Response Centric NGO was able to adequately balance its limited resources, organizational practices, and desired end states with local and public sector partnerships in order to achieve strategic objectives.

The core delivery vehicle for Response Centric NGO health services is a type of mobile clinic that can move amongst the isolated creek settlements of the river delta region. Response Centric NGO mobile clinics are similar in nature to the short term programs implemented by other NGOs, but as a whole, Response Centric NGO programs are better documented and are individually evaluated with lessons learned and recommendations incorporated into future planning cycles. Clinics are typically made up of a team of volunteer medical personnel, including surgeons, optometrists, dentists, and health workers who administer the clinic and dispense medications. During the course of
the clinics, *Response Centric NGO* distributes a variety of medical supplies, presents educational materials and classes, and conducts medical procedures where possible (*Response Centric NGO*, personal communication, May 13, 2013). An example of one such clinic took place in Esit Eket, Akwa Ibom State. In the project report, *Response Centric NGO* staff attempted to prevent the outbreak of infectious diseases in a Bakassi refugee camp. In conjunction with the Niger Delta Development Commission, a joint team of 60 medical professionals distributed insecticides, long acting insecticide treated bed nets, Dihydroartemisinin/lumefantrine (for malaria) and oral rehydration therapy sachets. Another, more routine clinic took place in Opuama, Delta State, where over 4,000 patients were seen by 55 *Response Centric NGO* and community based health workers. In this clinic, staff conducted HIV/AIDS counseling and testing, ophthalmic and dental surgery, and treated a number of chronic medical issues. These types of point of service clinics provide riverine communities with primary care interventions that could not otherwise be expected in the remote, sometimes isolated areas.

*Response Centric NGO* mobile clinics and medical interventions had one other characteristic that set them apart from similar events arranged by the other NGOs. Due to the close partnership with the Niger Delta Development Commission and Nigerian Armed Forces, *Response Centric NGO* was able to set conditions for the successful transition of select programs back to public sector authorities. *Response Centric NGO*’s JTF Warri program treated approximately 9,140 citizens within Effrun and served to strengthen relationships between local citizens and the Nigerian military. Another intervention occurred in Koluama, which centered on communities affected by a gas
explosion. Following the initial push to distribute relief items and implement systems to control the spread of diarrheal/respiratory diseases, the program was transitioned successfully to the Niger Delta Development Commission. The Koluama program, as with other programs, collected lessons learned which were subsequently internalized, and generated future program implementation recommendations for the Delta Commission for consideration.

Mobile clinics form the base of Response Centric NGO operational capacity, but the NGO is also able to quickly respond to crises and provide support for affected communities. In October, 2012, over 3,000 people were displaced by a series of floods in the Delta, Bayelsa, and Anambra states (Amaize, 2012). According to news articles and Response Centric NGO leadership, the NGO was able to arrive at the site of the flooding, establish relief camps, and started to distribute medical supplies and services prior to the arrival of the Nigerian Emergency Management Agency (Amaize, 2012; Response Centric NGO, personal communication, May 13, 2013). As part of their activities, Response Centric NGO sought to mitigate outbreaks of infectious disease created by poor sanitation and unhygienic conditions through the digging of boreholes to access fresh water and the provision of crucial supplies to camp residents. Staff operated the camp for over a month, finally closing the facility on November 9, 2012. Response Centric NGO has engaged in other, similar events, but this effort, according to Response Centric NGO leadership, was one of the most ambitious undertakings in which the organization has engaged (Response Centric NGO, personal communication, May 13, 2013). Following the conclusion of the program, Response Centric NGO published a report on the Patani
response detailing the distribution of supplies, associated costs, and mitigation efforts. The report also detailed the longer term recovery efforts that Response Centric NGO became involved with such as the rehabilitation of the Patani Primary Healthcare Centre, reconstruction of local toilets and wells, and the provision of health care services until the Niger Delta Development Commission was able to resume Local Government Area driven activities. Finally, in an effort to share lessons learned and advocate for communities impacted by the flooding, a conference was held with leaders from both the public and private sectors to discuss events that took place during and after the floods. Response Centric NGO leadership sought to educate stakeholders on the details of how the response was conducted and how emergency response efforts could be better coordinated and executed in the future. Local needs were identified and plans were created to begin a synchronized recovery effort that would draw upon skills and resources from both local NGOs and the public sector.

4.3.3 Findings: Strategy Variable

NGOs on average only possess a partially developed ability to create and implement functional strategies guiding program implementation. Systemic issues including underdeveloped leadership structures, an inability to create a singular organizational purpose, failure to link objectives and resources with an overall vision, and/or challenges with organizational control were identified in half of the sample population. The remainder of the sample population demonstrated a much more widespread capacity to manage organizational growth and implement actionable plans within the context of a structured planning process.
NGOs routinely implemented programs that were not planned to be sustainable, had weak or unsystematic evaluation systems, and were generally organized around one-off medical clinics and/or other limited scope events. Review of NGO activities led to the assessment that NGOs were only able to demonstrate a partially developed capacity to implement programs supporting the achievement of a strategic plan.

Obstacles to strategy development manifested themselves with greater frequency in NGOs headquartered in the northern areas of Nigeria, thereby resulting in the lower operational capacity of *Faith Based NGO* and *Recently Established NGO*. NGOs headquartered in the southern regions of Nigeria and/or those like *Diaspora Led NGO* with a leadership or support structure based outside of Nigeria were still impacted by these same negative factors, but to a lesser extent.

All NGOs attempted to promote ownership within the communities they service to varying degrees of success. Corresponding health training programs, limited educational programs and community leader engagements form the core of ownership efforts. Three of the six NGOs have also incorporated economic training in an attempt to improve the ability of community members to access medications, health services, or other basic necessities.

### 4.4 Capability Variable

The capability variable was designed to support the subordinate research question: How have selected NGOs operating in different areas of the nation developed the sufficient capabilities which are necessary to create sustainable solutions to limit the spread of infectious disease? This aspect of the Capacity Development Triad assessed the
core ability of an NGO to assemble a combination of skills, funding, and resources necessary for the implementation of programs supporting strategic objectives. Furthermore, this variable sought to identify how an NGO mitigated the influence of environmental variables such as social conflicts, cultural beliefs, and corruption on both service delivery and operational capacity.

Capability is the core component of an organization’s ability to deliver services. With the large diversity of indigenous NGOs operating within Nigeria, it was important to consider whether or not a given organization had the internal means to implement programs within their operational areas. If structural gaps exist in personnel skills sets, lack of resources, or failure to maintain accountability persist, then programs were at a greater risk to fail. Data relating to the organizational capability of an NGO and environmental influences on program implementation are discussed below, followed by findings specific to the capability variable.

4.4.1 Identification of Critical Skills for Program Implementation

The ability of an NGO’s staff to internally train or externally locate personnel with critical skill sets necessary for successful program implementation. Indicators of success include the execution of internal training programs, integration of volunteers with paid staff, and the sufficient coverage of skill based performance gaps with an in-house capacity to contract for outside support.

Amongst the entirety of the sample population, the ability to locate suitable staff and volunteers was the most developed aspect of the capability variable. Shortfalls did occur and were most apparent in the northern region of Nigeria. As reflected within the
critical skills factor, northern based *Faith Based NGO* and *Recently Established NGO* displayed anecdotal evidence of the capacity necessary to internally train or externally locate volunteers to support organizational programs. Anecdotal evidence, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “limited numbers of volunteers providing services, staff lacking suitable knowledge to implement programs in support of the organizational mission, and limited staff development opportunities” (Peace Corps, 2003; UNDP, 2009).

The *Faith Based NGO* and *Recently Established NGO* both experienced similar challenges in locating volunteers who possessed specialized skills and/or technical knowledge from amongst the northern population. The *Faith Based NGO* stated that they have had the most difficulty in locating “intelligent, qualified artisans and professionals” who could serve as first aid officers, doctors, dentists, eye specialists, as well as individuals who had experience with finance and accounting (*Faith Based NGO*, personal communication, June 17, 2013). Funding issues were cited as a central reason for the inability to find quality candidates. *Faith Based NGO* leadership said that finding professionals to volunteer can be difficult as there is an expectation of compensation, usually in the form of a consultancy fee. Unfortunately, the *Faith Based NGO* cannot always allocate enough funds for outside services and resorts to employing “community health workers to do some work of doctors and nurses would normally do” (*Faith Based NGO*, personal communication, June 17, 2013). Another complication experienced by the NGO is that professionals who volunteer are also likely to “not want to go and stay more than a day in a remote area where they are needed badly” (*Faith Based NGO*, personal
communication, June 17, 2013). This creates problems in establishing medical services throughout the rural community and inhibits future planning efforts as more funding must be allocated to acquire suitable personnel. As a result of these issues, programs implemented by the Faith Based NGO have been limited by the lack of appropriately trained volunteers and have been altered accordingly to maximize available skill sets.

Locating unskilled labor is less of a challenge and potential complications are routinely overcome through interactions with the leadership of local communities. In many cases, Faith Based NGO leadership stated that this strategy for locating workers has proven very successful. Assisting polio eradication efforts in Bauchi state for example, Faith Based NGO worked with traditional leaders to identify potential workers “because the kinds of skill sets that we are looking for do not require high literacy levels…maybe basic reading and writing skills, just enough to be able to read a question and answer” (Faith Based NGO, personal communication, June 17, 2013). In accordance with the principles of Islam, the NGO sought out women, or young boys, because men, especially men unknown within a community, “cannot enter a house unless the man of the house allows you to enter” (Faith Based NGO, personal communication, June 17, 2013). Once suitable volunteers were identified, Faith Based NGO supported UNICEF’s communication and social mobilization efforts and continued to work with local leadership to facilitate the maximum coverage of vaccinations within their area of operation.

Recently Established NGO had similar difficulty in finding volunteers with suitable skill sets as the Faith Based NGO. The NGO also has sought skilled volunteers
to serve as medical officers, nurses, emergency officers, and individuals who can assist with general healthcare problems. According to the *Recently Established NGO* leadership, the core problem with likely candidates is that “the qualification of people in the north is not as high as the southern based Nigerians. Education levels are very different. Mostly, we make do with what we have available” (*Recently Established NGO*, personal communication, May 29, 2013). When the organization was founded the *Recently Established NGO* leadership stated that they were unable to source funding support from any donors and programs could only be implemented with support from volunteers. The available individuals were not able to accomplish the more specialized tasks required to treat the more pressing medical issues found in *Recently Established NGO*’s targeted community. *Recently Established NGO* staff then decided to train local women as traditional birth attenders in order to provide “service to women and children and refer complications to the primary health center,” but the NGO experienced further difficulties in locating volunteers as “most people we asked for their volunteerism would not cooperate” (*Recently Established NGO*, personal communication, May 29, 2013). Shortly thereafter, *Recently Established NGO* began to emphasize malaria education and prevention. Existing Community Health Workers, supported where possible by other volunteers, were trained to help mount long lasting insecticidal nets and distribute medications. Staff then conducted limited open training sessions with the intent of improving the quality and availability of potential volunteers from within local communities. These efforts have helped *Recently Established NGO* to meet selected...
strategic objectives, but volunteers with more robust skill sets are needed to implement
the more intricate and better structured organizational programs.

The NGO still experiences internal problems with basic business skills and hires
outside staff to “keep our records straight and for proper documentation” (Recently
Established NGO, personal communication, May 29, 2013). The intent of this effort is to
develop internal accountability mechanisms that are acceptable to potential donors.
Leadership believes that if “we are financed or sponsored by a donor like the big NGOs,
we could afford to employ more professional staff and increase our effectiveness”
(Recently Established NGO, personal communication, May 29, 2013). The leadership
also stated that hiring at the moment is “catch as you can” but they are aware that the
capabilities of staff need to be developed if the NGO are to implement the full range of
strategic objectives.

Contrasting with the northern based NGOs, the Society for Water and Public
Health Protection displayed a partially developed capacity to locate volunteers and/or
professional consultants with the necessary critical skill sets to implement programs.
Evidence of a partially developed capacity, as defined within the Peace Corps CDP and
modified UNDP CAF, is characterized by “adequate numbers of volunteers are available
to implement programs, staff knowledge supports program implementation with limited
external input, and staff development opportunities are becoming routine along with
internal performance evaluations” (Peace Corps, 2003; UNDP, 2009). Water &
Sanitation NGO experiences varied from the remainder of the NGOs, primarily due to its
emphasis on assessment teams, water related issues, and the safety of national
infrastructure. As a result, Water & Sanitation NGO reported difficulty in finding professionals who were skilled in the more technical areas of proposal writing, project management, legal advisement, and accounting instead of the more commonly requested individuals with medical backgrounds. The existing staff, while knowledgeable of the water industry, lack basic business knowledge that they attempt to acquire through volunteers and other external professionals. Despite the claim by Water & Sanitation NGO leadership that the NGO has a large following of members and potential volunteers, shortages in the aforementioned technical areas has become a reoccurring issue.

As an additional challenge in locating individuals with desired skill sets, Water & Sanitation NGO leadership stated that education was a universal problem. Volunteers or professionals available for hire as consultants typically do not have sufficient training, or in some cases the necessary degrees required by the programs that the NGO undertakes. Health workers with advanced knowledge were particularly scarce and the organization has debated the inclusion of community health workers to fill staffing gaps until volunteers are located. Those individuals that are hired can be challenging to retain, since “some staff will want to go to organization that has better pay package or more recognized” (Water & Sanitation NGO, personal communication, August 9, 2013). Water & Sanitation NGO leadership also noted that these individuals also “pay less attention on gaining new knowledge and experience and show more concern with their salary package because at the end of the project their services can be terminated” (Water & Sanitation NGO, personal communication, August 9, 2013). Water & Sanitation NGO plans to continue recruitment of likely candidates to fill the more technical positions. To fulfill
this need, leadership has engaged the Nigeria Integrated Water Resources Management Commission and WaterAid in order to take advantage of training programs and locate people interested in volunteering to fill vacancies.

The remainder of the sample population, consisting of the Multi-Sector NGO, DiasporaLed NGO, and Response Centric NGO, displayed a widespread or fully developed capability to locate individuals with the appropriate skill sets to aid in the implementation of organizational programs. Evidence of a widespread or fully developed capacity, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “the internal coverage of required skill sets or the ability to contract out for consultants as required, the integration of volunteers throughout the planning and program implementation process, and the establishment of routine training and evaluation opportunities” (Peace Corps, 2003; UNDP, 2009). Each of the three NGOs varied to some extent, but all were able to resource the appropriate skills necessary to implement their programs or modify objectives to fully use skills that were available.

Multi-Sector NGO displayed a widespread capacity that, while less well developed than Diaspora Led NGO and Response Centric NGO, showed a strong commitment to developing both staff members and volunteers. Multi-Sector NGO’s programs require less technical skills than those undertaken by Water & Sanitation NGO and center around the care of those afflicted with HIV/AIDS. Multi-Sector NGO’s leadership stated that within their HIV/AIDS mission area, the NGO continually seeks to retain social workers, public health practitioners, and workers who can assist in providing counseling or information about the disease. Leadership also stated that finding
volunteers has not historically been a challenge as “many people are willing to volunteer their help towards a worthy cause” (Multi-Sector NGO, personal communication, May 16, 2013). Additionally, the Multi-Sector NGO feels that the internal staff “has diverse qualities and skills which come together to make the organization strong” (Multi-Sector NGO, personal communication, May 16, 2013). There have been staffing shortages as individuals have taken leaves of absence to pursue higher education for instance, but these are temporary in nature as gaps can be filled quickly.

Staff development, which is a strong tenant of Multi-Sector NGO operations, is continuously offered through attendance at conferences, workshops, and relevant courses. Training opportunities for volunteers and consultants have also been developed in conjunction with specific programs in order to provide temporary staff with the necessary skill sets. The Multi-Sector NGO recruits program staff for limited periods of time due to restrictions in funding and has developed training specific for the period of time for which the project staff member was hired. This system allows for the termination of staff employment following the completion of any given program without over allocating resources to any one individual. Selected staff receives short training sessions consisting of seminars, workshops or five to ten days courses in order to allow them to carry out the program associated tasks. Regular Multi-Sector NGO staff selected to implement programs are considered to be more capable and as a result, as not required to attend lengthy training sessions. Typically, three to five days are set aside for the purpose of orientation or to improve selected skills or competencies. In rare cases, Multi-Sector NGO leadership identifies volunteers to be retained as full time staff, although none have
been selected since 2012. In these cases, volunteers receive more thorough training lasting several months through a combination of traditional education and program internships. Following the completion, the volunteer joins the permanent staff and is assigned to positions of leadership on organizational programs.

*Diaspora Led NGO* and *Response Centric NGO* both demonstrated a fully developed capability to locate individuals with the appropriate skill sets to implement organizational programs. While internal development lagged behind *Multi-Sector NGO* initiatives, it was the use of volunteers and consultants that set them apart from the remainder of the sample population. As noted in the strategy variable section, the *Diaspora Led NGO*’s board of directors is located within the United States, providing it access to resources and personnel not normally available to other NGOs. This board of directors experience, combined with the fact that *Diaspora Led NGO* normally only engages in four medical missions a year, provides staff members with the time to locate and arrange for volunteers to travel to Nigeria, or to identify likely candidates to support programs from within the country. *Diaspora Led NGO* plans to conduct clinics with two or three full time staff members, supported by approximately twenty volunteers. Those volunteers who do not have critical skills necessary for the program, are placed in support of other initiatives, such as educational sessions, pharmacy management, taking patient’s vital signs, or other general administrative tasks.

*Diaspora Led NGO* leadership stated that through its contacts both within and outside of Nigeria, locating volunteers has not been problematic. Where possible, the
organization prefers to use domestic workers from the regions where medical missions are implemented.

One of the things that I’ve learned through my years is that when foreigners go to the third world to help, they sometimes get things wrong. And they don’t seem to realize that they get it wrong. They look at what is successful in the west and try to replicate it in the villages without paying attention to the regional differences that might exist. (Diaspora Led NGO, personal communication, June 18, 2013)

The organization’s policy is to work with local contacts and advance teams that can elaborate upon particular issues relating to the community being served, thus mitigating any issues that might otherwise hinder the medical mission.

So if we are in Imo state, we will use doctors and nurses from Imo state for the clinics. We have a western doctor or nurse come and they will work very closely with them… being in the same room as the Nigerian doctor so that if they have any questions they will be able to handle it without a lot of problems. (Diaspora Led NGO, personal communication, June 18, 2013)

According to program literature and Diaspora Led NGO newsletters, an example of using local volunteers from surrounding hospitals occurred in Kabba, located in Kogi State. “A pharmacist and a lead doctor travelled from Lagos, a seven hour journey, bringing a coterie of medications. An ophthalmologist came from Calabar, an even longer journey than Lagos, while other arrived from Bauchi in the far north.” These volunteers, contacted by advance teams, illustrate the relationships that Diaspora Led NGO has
established within the Nigerian medical community and is one aspect of a larger series of partnership networks that the organization has been fostering since its inception.

Another reason for maximizing the use of local medical practitioners is that they are more familiar with the diseases that are commonly seen in a particular region, especially tropical diseases which are not as common in developed nations. “A Nigerian doctor will look at a patient and know that the person has malaria. A western doctor will not be able to do that with such ease. Western doctors just generally don’t have the background or experience” (Diaspora Led NGO, personal communication, June 18, 2013). An exception to using domestic workers arises when surgeries are involved. Diaspora Led NGO leadership stated that the surgical skill sets of Nigerian medical personnel are generally less advanced than those of western doctors. Due to this, Diaspora Led NGO does not regularly incorporate advanced surgical procedures into the routine medical missions, which are limited in both time and scope. In cases where communities require advanced medical care, the organization’s leadership either refers the patients to a public health sector facility or makes arrangements to bring in the appropriate individuals within both time and budgetary constraints.

Response Centric NGO, like the Diaspora Led NGO, makes great use of local talent to accomplish organizational objectives. Specialized healthcare practitioners from a variety of medical fields, including doctors, nurses, health educators, and administrators are continuously sought after and Response Centric NGO leadership has made great use of the large pool of unemployed medical professionals in Nigeria. In exchange for travel reimbursement and ordinary expenses, individuals are given an opportunity to “gain
experience and to keep up their skills” (Response Centric NGO, personal communication, May 29, 2013). This system has been successful as evidenced by the strong participation levels in organizational programs. Response Centric NGO was able to muster approximately 80 volunteers to support the Koluama response project, 32 volunteers to support a medical program in Elem Tombia, and over 60 volunteers to support a program in the Esit Esit community. In each of these programs, volunteers from various medical specialties including doctors, dentists, optometrists, pharmacists and nurses were retained to administer aid and disburse medications in support of organizational goals. Where possible, Response Centric NGO also uses its existing relationship with the Niger Delta Development Commission to supplement the number of volunteers in order to ensure that programs are adequately resourced. In several program reports, Response Centric NGO staff noted that commission personnel bolstered the NGO’s crisis response efforts until additional resources could be identified. It is this combination of available volunteers, the ability to access a skilled resource pool, and strong relationships with local authorities that provides Response Centric NGO the flexibility to quickly respond to events and execute longer term strategies.

While Response Centric NGO can access specialized healthcare practitioners, the most commonly available individuals are general practice nurses, midwives, and limited skilled community health workers. Response Centric NGO staff is also expanding training opportunities for both internal staff and limited outside volunteers. Volunteers and other health personnel are trained, or familiarized with health related issues, such as the diagnosis and treatment of malaria, but training has also extended beyond the medical
field to include more traditional business skills. *Response Centric NGO* leadership stated, “Maybe their [volunteer] development takes longer, but the knowledge and capacity stays in the community that we are working in. We are funding the education of an accountant right now… and that we have been paid back in droves” (*Response Centric NGO*, personal communication, May 29, 2013). Of note, the most important skill set that the organization would like to develop is critical thinking. *Response Centric NGO* leadership stated that it is,

hard to find in individuals who grew up in this educational context… not that it doesn’t exist, but it is just more ‘in’ some people. We have a lot of people who can do a great job, but I would like it more if we were able to provide some additional opportunities for our staff and volunteers. (*Response Centric NGO*, personal communication, May 29, 2013)

4.4.2 Effects of Corruption, Social Conflicts, and/or Cultural Beliefs

The influence of environmental factors including social conflicts, cultural beliefs, and corruption significantly affects the manner in which NGO implement programs and function within their operational area. The ability to recognize and exert some measure of control over these potentially negative influences provides an indication of how well an organization is able to conceive a feasible, acceptable and adequate plan that can be realistically implemented within a community by staff members and volunteers.

The creation of organizational strategies that can adequately guide capacity building activities, mobilize available resources, and establishment of lasting, sustainable partnerships, must take into account the environment in which an organization operates.
A study by Dr. Festus Iyayi, at the University of Benin, indicated fourteen different factors affecting the delivery of public health services in Nigeria (Iyayi, 2009, p.3). During interviews with the sample population, it was apparent that several factors cited by Dr. Iyayi, including social conflicts, cultural beliefs, and corruption dramatically affected all NGOs during the course of their work. Mitigation of these obstacles is a central component to the development of a strategic plan and has a profound effect on the ability of an NGO to provide health care services in the communities they serve.

Social Conflict

The effect of social conflict was alluded to by all NGOs, but it was emphasized by Response Centric NGO, operating in the southern delta region, and the Faith Based NGO and Recently Established NGO NGOs, operating in the north. Violence has been fueled in the southern delta region by an extremist group known as MEND that targets the petroleum infrastructure, carries out kidnappings of foreign workers, and has waged a guerrilla war against government forces since 2004. Response Centric NGO operations, according to the NGO’s leadership have “been hindered in the past due to the unstable security situation and the ongoing threats of kidnapping” (Response Centric NGO, personal communication, May 29, 2013). Project reports from Response Centric NGO illustrate some of the hazards related to traveling within the delta region. The Elem Tombia project report, for example, states, “Travelling in the creeks of the Niger Delta was arduous and risky; the waterways are usually infested with militants and gun-parading military men” (Response Centric NGO, 2008). In a separate incident, a village that had been the focus of a Response Centric NGO project had been “allegedly destroyed
by counter-MEND operations conducted by the Nigerian government’s Joint Task Force” prior to the team’s arrival on site (Response Centric NGO, personal communication, May 29, 2013). Mitigating this type of conflict, while reducing risk to both the program and its staff, was adeptly carried out by the Response Centric NGO leadership. According to the project assessment, Response Centric NGO staff held meetings with the Commandant of the Joint Task Force, enabling the team to “have a safe passage along the waterways” (Response Centric NGO, 2009). Further discussions were held with select segments of militant groups, via a specialized “social mobilization and sensitization team” who engaged potential groups in the planned areas of operation. Response Centric NGO leadership stated that the group, “allayed the fear of the militants that we [Response Centric NGO] are not spies or agents of the military and showed that we meant them no harm but good” (Response Centric NGO, 2008). In another Response Centric NGO program, a refugee camp maintained by the NGO for Bakassi refugees fleeing from Cameroon was infiltrated by “ex-militants who claimed to be members of the Bakassi freedom fighters” (Response Centric NGO, personal communication, May 29, 2013). In order to avoid creating a significant security risk to both the camp and the staff, Response Centric NGO met with the ex-militants and made “emergency provisions” for them, thereby removing this potential threat from the area.

Social conflict, like that experienced by Response Centric NGO, is also rampant in the north although it has taken on a significantly different character. Boko Haram is an Islamic militant organization in the north seeking to instate Sharia Law and eliminate the spread of Western ideas within Nigeria, Niger, and Cameroon. Attacks by Boko Haram
have gained momentum in the north since 2009 leading to a state of emergency being declared by the Nigerian government. The ensuing violence escalated, forcing many international NGOs to curtail or eliminate their operations. NGOs like Doctors without Borders ceased operations after an attack left nine polio vaccinators dead in February, 2013. As an additional perspective, UNICEF representatives interviewed for this study stated,

There are no operations within the North unless we go with some sort of security. For instance, in Kano where the attack took place, we had a nation-wide campaign just recently in March, but because of the attacks on Polio workers, we had to drop out of the campaign. Up to now, we don’t know what is happening… we have a lot of low key visibility and I think that all of the agencies are rethinking and strategizing their approach to polio eradication and immunization in Kano. (Kamara, personal communication, April 11, 2013)

Another account from Betsy Pisik, working with Johns Hopkins on Polio coverage in Kano, stated,

They [Boko Haram] were around and people were afraid of them. The workers were women and killed for not dressing conservatively. There were days when my translator would call and tell me to stay in the hotel. I would say, but I have appointments, and he would say, that he would go to the appointment and have them call me on the cell phone. Obviously, Boko Haram is an issue and I think that you have to keep that in mind. If the NGOs can’t get out, then they can’t do their jobs. (Pisik, personal communication, June 10, 2013)
The nature of the violence has sent ripples through the Muslim community in the north and has slowed the polio vaccination program in many places.

The Faith Based NGO had been working with local Muslim leaders to promote polio vaccination in the areas around Bauchi. Faith Based NGO leadership feels that as a faith based organization, they “have a level of protection that the international NGOs do not” (Faith Based NGO, personal communication, June 17, 2013). Leadership went on to explain that they understand and are a part of the local community. They further stated that the NGO works with local Imams and Mosques during their programs and ensure that their activities are conducted in accordance with the principles of Islam. Faith Based NGO’s role in promoting polio vaccination, which some in the north still see as a Western attempt to depopulate Muslims, may limit the organization’s sense of security. Since the inception of the NGO, it has not been involved with the Boko Haram sponsored violence and plans to implement its programs as resources and funding are acquired.

Recently Established NGO is more cognizant about the ongoing violence and has curtailed their operations since the February, 2013 attacks. Recently Established NGO leadership explained,

I’d say that as a whole, we are working at 70 percent normal. The context of our operations is really changing… some situations are like working in a house of cards. Where we once thought our area of the north was stable, it isn’t and it hasn’t been. (Recently Established NGO, personal communication, June 30, 2013)

The Recently Established NGO has also limited the role of overseas volunteers on their projects due to safety and security concerns.
We had one or two help earlier in the year, we had a real great guy, but the violence started to get to high and he was evacuated from the area. They want to come back, but I don’t think that it is going to happen for a little while. (Recently Established NGO, personal communication, June 30, 2013)

Boko Haram was active when Recently Established NGO was founded, but the leadership did not believe that violence would spread as rapidly as it did. “We thought we were working in a relatively stable environment when the organization started and the ground has shifted beneath our feet. So things are normal…whatever normal is here” (Recently Established NGO, personal communication, June 30, 2013). This latter statement illustrates the resiliency of Recently Established NGO leadership to adapt to its current environment, despite the current operational setbacks suffered by the NGO.

Cultural Beliefs

The cultural norms and beliefs throughout rural Nigeria took many forms in responses from the NGOs surveyed. Multi-Sector NGO and Response Centric NGO leadership noted that their respective programs were not especially impacted by local cultural beliefs. Each NGO has incorporated education and outreach initiatives into their particular programs to address the myths associated with the spread of HIV/AIDS, general disease awareness, and the role of traditional medicine in treating health problems. Other NGOs have found it necessary to further emphasize education as a greater portion of their work to respond to the entrenched beliefs in their operational areas.
Diaspora Led NGO stated that many of the people in the areas they operate believe that spirits still spread sickness in the villages, and the use of witchcraft accounts for other various maladies. Diaspora Led NGO leadership also found that widespread belief in shape shifting was prevalent in two of the villages where medical missions were conducted. Illustrating the seriousness of these beliefs, an article appeared in the BBC news with the title “Nigeria police hold ‘robber’ goat” (BBC, 2009). The article describes how a vigilante group had pursued a car thief, who in an effort to escape capture turned himself into a goat. The group turned the goat over to the police who said “the armed robbery suspect would remain in custody until investigations were over” (BBC, 2009). Water & Sanitation NGO has also had to mitigate the effects of belief systems in their work with malaria prevention and sanitation around Nigeria’s dams. Near the Ikpoba dam, Benin City, for instance, a surge in malaria deaths was found to be caused by an increased number of mosquitos, breeding in stagnant pods created as a byproduct of the dam. Local residents however, expressed that the construction of the dam injured the river goddess, who now sought to punish the people living in the area. Sanitation issues were equally challenging to overcome as residents of the local community held a number of beliefs such as washing hands before eating could cause blisters, or that water was incapable of making people sick. Both NGOs expressed that the only way to overcome these problems was through rigorous and comprehensive education of the local population. Diaspora Led NGO has modified their 2013-2014 objectives to emphasize education over purely medical missions in order to address the general ignorance of health matters amongst their constituency. Water & Sanitation NGO has also launched a
campaign called WASH to address narrowly defined problems in the impacted communities, but the programs are not comprehensive and only target selected issues. Larger concerns, such as the stagnant waters surrounding the dam, have been turned over to the Local Government Area and international agencies to contend with.

In the northern regions of Nigeria, cultural-religious beliefs are intertwined with the ongoing social conflict and have created significant issues for Recently Established NGO and the Faith Based NGO to overcome. Both NGOs reported that suspicion is still prevalent surrounding the polio vaccines and it is only with direct intervention of local traditional leaders that non-compliance gaps are slowly being closed. Faith Based NGO leadership conveyed a typical sentiment that they have worked to overcome in the past. Early in June 2013, a discussion with a seemingly educated local constituent resulted in the following statement during an email exchange. The message was edited for spelling by the researcher in order to make the statement legible.

Polio was deliberately introduced by the devilish-mother America and distributed to our nation. It [polio] is used as a latent means to depopulate religious extremists. To achieve their targeted goals, they [USA] have made a plan for leaders, governors, chairmen, emirs, health workers, and common masses, which were paid some allowances to make their trick a successful one. May Allah save us. Amen. (Faith Based NGO, personal communication, 17 June, 2013)

Sentiments like this are far from uncommon and Recently Established NGO leadership reinforced the point that there is a perceived impression in the north that “the Americans are coming to kill our young ones” (Recently Established NGO, personal
communication, June 30, 2013). Recently Established NGO also noted that this perception is made worse by the general “ignorance of the cause of the disease and that it can be prevented” (Recently Established NGO, personal communication, June 30, 2013). Lack of understanding extends beyond polio and encompasses other diseases like malaria and HIV/AIDS. The answer, agreed upon by both NGOs, is more extensive Koranic education in the rural communities. Recently Established NGO expands upon this by noting that there is also a need for more traditional life/family planning and reproductive health education, beyond what the Faith Based NGO proposes. The Faith Based NGO appears to have a firm grasp on what it takes to implement their concepts in light of the entrenched belief systems in northern Nigeria. Faith Based NGO leadership stated in order to overcome obstacles in rural villages, staff essentially bypass local villagers and go directly to the leadership to enact a program.

Basically, the leaders on the ground, the traditional leaders, really wield a lot of power… so what really happens is that when they say whatever it is to their subjects, it is viewed as coming from the authority… and the villagers actually listen to them. We normally go to the traditional leaders… you just don’t go and start talking to people. (Faith Based NGO, personal communication, 17 June, 2013)

The availability of resources and funding is the limiting factor in creating supporting disease focused education. Recently Established NGO has incorporated the training into their programs to some extent, but the reduction of capacity due to social conflict, among other factors, has limited its potential. The Faith Based NGO on the other hand, has been
able to use its designation as a faith based organization to further educate its constituents, but the lack of program focus and funding has restricted its application.

**Corruption**

The most wide-ranging and difficult influence to overcome by the sample population was that of corruption. The damaging toll that corruption takes on the country cannot be overstated as it is ever present in Nigerian society. Every NGO in the sample population reported that they were affected by the byproducts of corruption to some extent. This, in turn, affected their ability to implement programs. Within the context of the strategy variable, NGOs were evaluated on how they were impacted and what measures were put in place by the organizational leadership to mitigate the negative effects to the fullest extent possible.

Northern based NGOs, *Faith Based NGO* and *Recently Established NGO*, displayed the lowest capacity to adequately mitigate the effects of corruption in their operational areas. *Faith Based NGO* leadership stated that the biggest challenge in their area was “the selling of medications intended to be given away to people for free” (*Faith Based NGO*, personal communication, 17 June, 2013). The limited funding available to public health centers in the area was also seen as a problem, compounded even the most basic of medical equipment was in missing in the rural areas. *Faith Based NGO* does feel that its identity as a faith based organization does give it special standing within the communities they serve, as the principles of Islam forbid corruption in all of its forms. *Faith Based NGO* leadership elaborated on this by saying, “People are more willing to
come to us. They know that we will not give them fake medicine or send them away” (Faith Based NGO, personal communication, 17 June, 2013).

Recently Established NGO also noted the selling of typically free medications in their area, and added that many government-run health care centers in their region had not been supplied with medications for several years. In two separate instances, the centers themselves were not equipped and did not even possess rudimentary infrastructure such as toilets or running water. The NGO has attempted to address these types of issues, but they have been challenged by the lack of MOH support. Recently Established NGO leadership stated that one of their biggest concerns in dealing with the Ministry is that “The MOH does not follow through on projects that are handed over to them. These programs are not kept going and are a waste of resources” (Recently Established NGO, personal communication, June 30, 2013). Due to these failures, collaborations with the MOH are approached with skepticism, limiting organization programs such as the most recent effort to establish a permanent clinic in Bakiyawa. Recently Established NGO leadership lamented the fact that they could not easily expand services to the rural communities. It was stated that, “The resources are there, but because of all of the corruption, we cannot provide all of the services that we would like for the people. Corruption is the problem” (Recently Established NGO, personal communication, June 30, 2013).

Multi-Sector NGO has reacted to corruption by hosting conferences, publishing articles in various newspapers, and advocating for the development of a network of anti-corruption groups at the grassroots level. Furthermore, Multi-Sector NGO leadership
plans to emphasize anti-corruption programs in the remainder of 2013 and the first two quarters of 2014. The executive director of Multi-Sector NGO has gone so far as to openly call for the firing of all police officers in order to “sanitize the corrupt system” (Ogbo, 2012). Ironically, the Multi-Sector NGO leadership has also paid bribes to various officials in order to ensure that the organizations supply of medicine is imported into Nigeria. According Multi-Sector NGO leadership, “This is the way that it is in Nigeria,” implying that the paying of bribes is not a singular affair (Multi-Sector NGO, personal communication, May 16, 2013). An example of the payment of bribes came to a head in June 2013 as police arraigned a clearing agent, Tajudeen Shonde, for fraud. According to the associated newspaper article, Mr. Shonde accepted 105,400 Naira (approximately 660 USD) from to pass medical supplies through the customs process. “All efforts made to clear the consignments or retrieve his money proved abortive as the accused was just giving one excuse or the other,” (Champion, 2013). It is unknown how often Multi-Sector NGO participated in this practice or how much of the organizations’ funds have been diverted to ease the movement of resources into or throughout the country. In all cases, funding spent in this manner limits the pool of resources available to implement programs or maintain an operational status.

While the Multi-Sector NGO mitigates the effect of corruption by active participation, the Diaspora Led NGO has taken a passive approach and actively avoids situations or puts measures in place to reduce the impact of corruption on operations to the fullest extent possible. For example, the Diaspora Led NGO on multiple occasions has had its medications held up in customs by officials seeking money to clear the
shipment, much like the Multi-Sector NGO. In contrast to the actions of the Multi-Sector NGO, Diaspora Led NGO leadership stated,

Our work around has been to ship in plenty of time so that if they hold them long enough, they will eventually end up releasing them. We will not pay bribes. If they want the medications that badly, they can keep them, you know? (Diaspora Led NGO, personal communication, June 18, 2013)

Another work around implemented by Diaspora Led NGO is to buy medications from USAID or local vendors and avoid the importing process in its entirety. Dealing with the impact of corruption had become such a challenge for the NGO that Diaspora Led NGO leadership decided to limit the interaction with the Nigerian government whenever possible. This avoidance approach stemmed from past experiences with Local Government Area and State health officials. Diaspora Led NGO leadership expanded on the decision to limit government interaction by stating,

We’ve reached out to some health ministries, only for them to tell us that they have no resources. But they come in the day of the medical mission, take pictures and make it look like the commissioner of health is the one who brought us in.

(Diaspora Led NGO, personal communication, June 18, 2013)

While the leadership further stated that only the end result of treating people is important, the community is given a false impression of government assistance which can propagate future corruption.
Corruption is so pervasive in Nigeria that it also affected how the Diaspora Led NGO operates. Diaspora Led NGO made the decision to only include one Nigerian on the current United States board of directors. They made this decision because, the level of corruption in the country is astounding. You have to be very careful. We also don’t keep any money in Nigeria. All of the money we raise, we keep it here in the U.S. and then when we need it, we will send small amounts to Nigeria. We just don’t have money sitting in an account in Nigeria waiting to be used because there will always be a reason for people to corrupt the process. (Diaspora Led NGO, personal communication, June 18, 2013)

Maintenance of funds within the United States allows for a level of transparency that is simply not possible within Nigeria. Other NGOs strive to incorporate good financial and accountability practices into their structures, mainly at the behest of large donors who want the ability to track resources and know that the donated funds are being allocated without diversion. In the case of the Diaspora Led NGO, the best way to ensure that money is not misappropriated was to keep it tightly under the control of the board of directors.

Water & Sanitation NGO and Response Centric NGO both cited a lack of transparency and accountability in their dealings with Local Government Areas and elements within the public health sector. Water & Sanitation NGO noted that dams and their supporting infrastructure are rife with opportunities for corruption, including the diversion of maintenance funds, the creation of sole source construction contracts, and similar accounting mismanagement. The Water & Sanitation NGO typically works with
international agencies in these areas and with their assistance; issues with corruption can be adequately dealt with. Emphasizing the work their assessment teams accomplish, Water & Sanitation NGO leadership described problems with inadequate health care facilities, lack of staff and resources, and a general overcharging for medications that was cited by the other NGOs within the sample population. The program assessment teams and typical sanitation projects implemented by the organization do not rely on government assistance to a great extent. This lessens the problems associated with corruption, beyond the routine battle with a stalled bureaucracy, to the point where they are generally not an impediment to Water & Sanitation NGO’s activities. Response Centric NGO leadership has taken a different approach and has formed close ties with the Local Government Areas in their area of operation as well as the Niger Delta Development Commission (NDDC), while acknowledging that there is endemic corruption within the Delta region. It is believed that the relationships formed between the staff and local officials free the organization from some impediments that would normally be encountered by other organizations. Regardless of its partnerships with the public sector, Response Centric NGO has maintained strong transparency and accountability protocols and restricts its own monetary sources to non-government funds. Projects are often conducted in conjunction with federal, state, and local agencies allowing them establish a base of support and mutual understanding between the various groups.
4.4.3 Findings: Capability Variable

Identifying and retaining individuals with critical skill sets such as doctors, nurses, and specialized health practitioners necessary for successful program implementation was a significant issue within all organizations. Assessed by region, northern NGOs only displayed anecdotal evidence of this capacity, while southern based NGOs demonstrated a nearly fully developed ability by mitigating shortfalls through the judicious use of volunteers and program centric staff.

Corruption, social conflicts, and/or cultural beliefs, in order of precedence, negatively impacted NGOs to varying degrees, leading in some cases to the curtailment or interruption of services. Four of the six NGOs were only able to partially mitigate the impact of outside environmental factors on program implementation. The remaining two NGOs displayed a fully developed capacity to mitigate environmental influences on their programs, in part due to a robust organizational strategy and/or partnerships with key stakeholders.

Funding is a perennial issue for all NGOs within the sample population, which is exacerbated in some cases by a lack of financial accountability mechanisms, documented budget-planning processes, and restrictive donor requirements. Amongst the sample population, the northern based NGOs *Faith Based NGO* and *Recently Established NGO* displayed the least developed capacity to adequately acquire and maintain suitable funding, while southern based NGOs or those with international linkages were more likely to have some level of accounting mechanisms present within the organization. *Faith Based NGO* is a distinctive case, because as a faith-based organization funding is
generally acquired from members and associated Muslim congregations, but due to its relative age and location, revenues have not been able to cover program expenditures. *Faith Based NGO* leadership stated that it is experiencing difficulty in sourcing new funds from the government. Additionally, the organization has been unsuccessful in attracting foreign sources that are willing to become donors or supply other resources.

Southern based NGOs also experience significant problems with funding, but some challenges are self-imposed. *Response Centric NGO* for instance, does not wish to accept money from the Nigerian government because of a desire to remain free of potential obligations, thus ensuring organizational independence. *Diaspora Led NGO*, whose funds originate primarily from individuals, also maintains flexibility from strict donor requirements by offering regularly occurring, limited scope medical missions. This has been very successful and assets gathered from their various fundraisers have been donated without the financial or reporting requirements that can sometimes accompany government or corporate involvement. Finally, *Water & Sanitation NGO*’s answer to acquiring suitable funds has been to look outside of Nigeria and approach international organizations such as the Global Greengrants Funds, Healthcare Without Harm, and the United Nations Environment Programme Dams and Development Project for grants. These revenue streams are accompanied by numerous restrictions, but the unique nature of *Water & Sanitation NGO* allows the NGO to approach organizations not normally available to other NGOs.
4.5 Partnership Variable

The partnership variable was designed to support the subordinate research question: How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector? This aspect of the Capacity Development Triad assessed the ability of an NGO to partner with both public and private sector agencies in their respective area of operations in order to implement programs in support of strategic objectives.

Partnerships between the public and private health sectors are a vital component to developing sustainable capacity within Nigeria. Leaders, both inside and outside of the public health sector, have looked toward private sector organizations as a potential solution to address service shortfalls. Collaborations between the sectors are subject to barriers that stem from cultural, process, and policy frameworks. Understanding the ways in which NGOs connect with other organizations and agencies is essential in overcoming barriers and thereby facilitating the development of a national capacity.

Working with the partnership-centric data was unique as material had to be assessed in conjunction with the strategy and capability variables in order to provide a holistic view of an NGO’s operational reach. NGOs that are unable to develop a sufficient organizational strategy or which fail to mitigate the risks associated with staffing or logistically maintaining a program also display indications that the organization is less likely to be effective in meeting the obligations of mutually supportive partnerships. Data relating to how NGOs partnered with both private and
public sector organizations are discussed below, followed by findings specific to the partnership variable.

4.5.1 Establishment of Public-Private Sector Partnerships

This establishment and maintenance of partnerships with Nigerian federal, state, and local government agencies is an essential function in the development of health care plans, promoting the formation of policy and legislation, mitigating the effects of disease outbreaks, and eliminating barriers to health care service provision. Existing or planned partnerships, documented agreements of mutual support, and instances of prior collaboration are all indicators of a strong capacity to establish and maintain partnerships with public sector agencies.

Interpreting partnership data for the entirety of the public sector engagements is difficult as the competency of agencies varies across all three levels of government, and well as throughout all thirty-six states. Reoccurring statements from the NGOs made it clear that some problems are pervasive in the public sector. All NGOs stated that they are wary of the corruption, lack of transparency, and the failure of good governance regardless of where they operate. Five NGOs identified the lack of public institutional frameworks to support programs or to provide even the most basic of services for the rural communities. Three of six NGOs stated that there is an overwhelming suspicion of motives present between both the NGOs and public sector. Finally, three NGOs cited a general “apathy of Nigerians” to engage in efforts that would improve the overall level of health in their respective areas. Faced with issues such as these, the inadequate collaboration levels between the public and private sectors demonstrates that building
capacity development programs within the Nigerian health care sector is both exceedingly difficult and potentially unlikely to occur barring any significant changes in the current state of affairs.

*Diaspora Led NGO* was not provided a ranking associated with this fact due to an internal organizational policy that restricted partnerships with the public sector. *Diaspora Led NGO* leadership stated that they will not partner with public sector agencies due to prior experiences with government corruption and accountability. “As far as the ministries are concerned, they have not been very helpful at all. They don’t seem to have a budget, or any resources” (*Diaspora Led NGO*, personal communication, July 6, 2013). One program that illustrates these shortfalls occurred following the request for *Diaspora Led NGO* to hold a clinic in a newly built Local Government Area hospital.

It is just so that they can show people that they have done something. When you set foot in the hospital, it is completely bare. It’s easier for us to hold the clinic in the school… at least I have chairs and tables to use. (*Diaspora Led NGO*, personal communication, July 6, 2013)

After several instances like this took place, *Diaspora Led NGO* changed their policy towards working with public sector agencies. Based on other data collected, it is likely that the organization could implement joint programs without significant obstructions, but due to the revised organizational policy, no UNDP numerical ranking was applied.

Northern based NGOs, *Faith Based NGO* and *Recently Established NGO*, demonstrated the least capacity within the sample population to establish partnerships with public sector agencies. The leadership of both organizations is fully aware of the
benefits and associated challenges of joint programs, but a combination of poor internal capability and the limited nature of the northern public health sector agencies have restricted the growth of capacity to the anecdotal level. Anecdotal evidence, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “a we versus they relationship with government agencies, limited cooperation in either the same programming sector or geographic area, and restricted attempts to influence public policy or advocate on the behalf of local communities” (Peace Corps, 2003; UNDP, 2009). NGOs falling into this category were characterized by the inability to implement programs in conjunction with public sector agencies and little or no ability to influence public organizations on behalf of rural community residents.

The Faith Based NGO was very resolute in the fact that adequate support from, and collaboration with, the State and Local Governments constitutes the organization’s biggest constraint in implementing programs. Leadership went on to say, “Medical infrastructure in the north is zero. The government is not able or is unwilling to provide services in the northern areas” (Faith Based NGO, personal communication, July 3, 2013). Faith Based NGO staff members described local health centers with no doctors, or in one case, six different centers all run by a single doctor who traveled amongst them to treat patients. Furthermore, staff described a situation when a health center was established, but the staff was not paid. Subsequently, the medical staff abandoned the health center to seek employment in larger regional towns and cities. The absence of trained medical staff further contributes to the degradation of the health sector and allows diseases like malaria and tuberculosis to maintain strong footholds in local communities.
Despite these deficiencies, the organization is still willing to work with the Local Government Area. Several small programs have been initiated, but *Faith Based NGO* claims that the Local Government Area’s weak commitment to proper funding and support undermined any real attempt to implement the joint programs. As a result, three of the programs failed, including two immunization programs and one malaria eradication program, due to inconsistencies in management, communication, and the provision of resources.

*Faith Based NGO* leadership noted, “External support is needed [to implement programs] and would be welcome, but it has not been easy to get. If the Local Government Area can’t increase its capability, then we are forced to sit around and wait for help from someone else” (*Faith Based NGO*, personal communication, July 3, 2013). Developing partnerships with the public sector is difficult in the north according to the NGO, as there is no system of support in place, nor are successful programs likely to be sustained or replicated. In the experience of the *Faith Based NGO* leadership, it is the absence of effective institutions that has become a major destabilizing factor in the entire society and any limited partnerships that are established are just “prolonging the suffering” of people living in the north (*Faith Based NGO*, personal communication, July 3, 2013).

*Recently Established NGO* leadership stated that they also actively attempt to engage their Local Government Area in the development and implementation of program related to malaria eradication with lackluster results. Very few programs have been enacted within their area of operation and two have had to be abandoned when promised
resources were not supplied. It was noted that the dependability of government resources, as well as the massive government bureaucracy, typically hinder the programs because “work slows down when government is involved. In most cases work is not done because of too much protocol” (Recently Established NGO, personal communication, July 13, 2013). Other complications center on program leadership and how the roles of each partner should be determined. Clearly defined roles impact implementation and Recently Established NGO leadership said that a joint program to locate mosquito breeding habitats showed that the Local Government Area did not display any, “professionalism in implementation, and no competency or expertise in the programming, monitoring and evaluation or financial management of the project” (Recently Established NGO, personal communication, July 13, 2013).

Political interest, while less common, was also identified as a problem meaning that the publicity of the event or program is sometimes viewed as more important than the actual event. Recently Established NGO leadership described an incident during which members of the Local Government Area appeared during the distribution of long lasting insecticidal nets, took pictures with recipients, and proceeded to discuss how they had enabled the event to occur. Even though no prior coordination had actually occurred, Local Government Area representatives allegedly politicized the event as a means to improve their perception within the community and obtain votes in the next election cycle. Recently Established NGO continues to pursue partnerships within the Local Government Area, despite the results, as leadership believes that the establishment of
strong relationships is the best way to eventually improve the quality of service delivery to communities in their area of operation.

Interactions between the Recently Established NGO and the Local Government Area have been limited in both scope and results and interactions with the state and Federal levels of government have been even less productive. “We try to engage, obviously, but we haven’t done so successfully. We are trying to make some progress…to get a seat at the table, but we haven’t had any luck so far” (Recently Established NGO, personal communication, July 13, 2013). No firm reasons for the failure to establish any relationships can be produced, but Recently Established NGO leadership believes that the higher levels of government see the organization as being too small to be effectual. Another speculation is that the religious affiliation or views on universal health care differ from that of the Ministry of Health. One last reason proffered by RAMI is that state and Federal governments have displayed “outright apathy” towards any recommended joint initiative. “Most of the people are there simply because they have a government job… and they are happy that they have one. There are real champions but they going against the grain as well” (Recently Established NGO, personal communication, July 13, 2013). Regardless of the actual reasons and despite the lack of progress, Recently Established NGO stated that developing partnerships with the public sector is one of the greatest challenges to developing a national health care capacity, but it is also the best solution.

Ownership is the key at both within the community and public sector. At this point in our development, maybe the best we can hope to achieve is to grease the
wheels we have to, make the partnerships we have to, and then act as a bridge, although it may be more of a platform, for the community to connect with local governance bodies. (Recently Established NGO, personal communication, July 13, 2013)

Southern based NGOs Water & Sanitation NGO and Multi-Sector NGO established a slightly better rapport with the public sector than their northern counterparts. Water & Sanitation NGO has made the most efforts of all NGOs in the sample population to establish partnerships at the Federal level of the public sector. Programs emphasizing water rights and dam regulation have been presented to the Nigerian Ministries of Water Resources, Health, Education, Agriculture, and Environment, but few long term achievements have been made. Water & Sanitation NGO leadership stated that “successes have been quite limited due to many challenges mainly extremely insufficient funds and unwillingness on the part of government to integrate most of our recommendations and findings into their developmental plans and activities” (Water & Sanitation NGO, personal communication, July 11, 2013). According to organizational records, the NGO delivered several lectures and seminars, hosted multiple conferences, developed informational reports for public consumption, and worked to bring community issues to the attention of decision makers within the various ministries.

Two efforts that did succeed involved the passage of the Hydropower Producing Areas Development Commission Bill and the modification of a draft bill on Water Management. The former effort involved the establishment of community level advocacy campaigns, followed by conferences at the state and federal levels that lobbied the
National Assembly which potentially contributed to the passage of the bill into law late in 2010. *Water & Sanitation NGO* leadership stated that the government did not seek the input from within the local communities and their advocacy program help to promote the voices of those impacted by flooding and without access to clean water. The second effort centered on a draft “Bill on Water Resources Management” which did not incorporate “input of dam-affected communities and NGOs” (UNEP, 2007). With the support of the United Nations Environment Programme Dams and Development Project, *Water & Sanitation NGO* entered into a collaboration with the Federal Ministry of Agriculture and Water Resources leading to a national conference “dedicated to discussing issues and concerns around dams and development in Nigeria, identification of potential areas of conflicts and common understanding/agreements on dams, water and energy resources management” (UNEP, 2013). Several recommendations for improvement of water management and dam construction were made as a result of the conference. The actual change resulting from these recommendations is unknown and was not available from either *Water & Sanitation NGO* leadership or the United Nations Environment Programme Dams and Development Project.

*Water & Sanitation NGO*’s successes at partnering with the public sector have been limited to advocacy and consultation programs while the physical implementation and provision of resources has been less positive. Leadership stated that the NGO seeks to develop collaborative solutions to local problems as this will help reduce the service burden on the government and lead to an improvement in health services for those Nigerians living in rural areas. Problems with the partnerships have limited the full
realization of any strategic goals or program objectives. Challenges noted by Water & Sanitation NGO leadership include, “Poor follow-up in rural communities, a suspiciousness of NGOs and the view that we are enemies, constant changes in Local Government Area leadership, poor financing, and the failure to sustain programs that are transferred to public sector agencies” (Water & Sanitation NGO, personal communication, August 24, 2013). Water & Sanitation NGO staff also noted in their Ojirami Dam Impact Study that the government appeared to be unwilling to release information and to NGOs and denied entrance to the dam areas for over six months (Ogbeide, Uyigue, & Oshodin, 2003). Finally, reoccurring issues with the public sector responsibility of staffing and resourcing of primary health clinics, like those described by the other NGOs in the sample population, equally impact Water & Sanitation NGOs health centered programs. Water & Sanitation NGO leadership cited a clinic in the Ipogun area that was under the supervision of a single nurse, who according to local sources was seldom available. Water & Sanitation NGO staff also observed that no drugs were available for treating common diseases such as malaria and cholera, even though multiple cases were reported weekly. Any one of these issues would make collaboration extremely difficult but when combined, the challenge of implementing programs in conjunction with an unwilling or apathetic partner becomes overwhelming.

NGOs Demonstrating Evidence of a Fully Developed Capability to Establish and Maintain Partnerships with Nigerian Federal, State, and Local Government Agencies

Response Centric NGO had the most fully developed partnership with public sector agencies amongst any organization within the sample population. Evidence of a
fully developed capacity, as defined within the Peace Corps CDP and modified UNDP CAF, is characterized by “the conduct of specific projects or sectorial collaboration for a government agency, the provision of input into national policy or issues related to sector expertise, and the recognized role of advocate for a program area and sector expertise” (Peace Corps, 2003; UNDP, 2009). Partnerships have been established with the Delta State Oil Producing Areas Development Commission, Esso Mobil, the National Association of Sea Dogs, the Esit-Ekit Local Government Area, and the educational institutions such as the University of Benin. These partnerships are important, but it is the collaboration with the Niger Delta Development Commission, established in 2000, that has formed the core of most partnerships. Additionally, programs supporting the Ministry of Niger Delta Affairs, established in 2008, and the Nigerian Military are becoming both more numerous and common place as the organizations mature. Both the commission and the Ministry have been tasked with “facilitating the rapid, even and sustainable development of the Niger Delta into a region that is economically prosperous, socially stable, ecologically regenerative and politically peaceful” (MNDA, 2013; NDDC 2013). This mission corresponds with Response Centric NGO’s strategic objectives and as a result, Response Centric NGO’s leadership has been able to form close bonds with all three public sector agencies to increase efficiency and maximize the use of resources while minimizing risk to organizational programs.

Response Centric NGO has closely aligned itself with the Niger Delta Development Commission and often cites the relationship within its program reports. The 2009 Bakassi program which centered on the provision of medical care and relief
supplies to the Bakassi returnee camp, highlighted the NDDC-Response Centric NGO partnership and the government’s role in donating supplies for dissemination to displaced citizens. In the Koluama report, the organization is designated as a “consultant to NDDC on Emergency Medical Relief Services.” During this particular event, Response Centric NGO provided coordinated medical and relief services to local communities following the January 2012 explosion of the K.S. Endeavor shallow water drilling rig. Response Centric NGO leadership noted that “The NDDC/Response Centric NGO partnership was a welcome initiative and a huge success as it went a long way in ameliorating the sufferings of the people in the affected communities.” The most recent documented case of public-private sector partnering occurred in late October, 2012 during the extensive flooding of Delta and Bayelsa states. Significant flooding and displacement of citizens spurred the establishment of a displaced civilian camp in Kabowei Kingdom and the subsequent, temporary takeover of the Local Government Area health centers in Patani and Akugbene. Initial support from the public sector was insufficient and Response Centric NGO took the lead in providing food and care for citizens impacted by the flooding. As the situation became more manageable, government agencies took ownership of the response operation from Response Centric NGO and began to address public issues. Response Centric NGO used the lessons from the 2012 flooding to institute a series of workshops designed to improve collaboration and mitigate the impacts of future emergency events. Government agencies from all three levels, NGOs, and members of the local community participated in the event and developed a series of
initiatives that can be used in future emergencies. As of September, 2013, initiatives have not been formally tested in an emergency.

*Response Centric NGO* has also partnered with the Delta State Government and the Nigerian military’s Joint Task Force in order to develop infrastructure and provide care to remote regions of the Delta. Military engineers have been working to build infrastructure while *Response Centric NGO* provides preventative care, conducts clinics, and trains local volunteers on basic medical practices. Future plans include the opening and operation of health care clinics in remote areas, along with the re-equipping and restoration of facilities that have fallen into disrepair. While *Response Centric NGO* leadership notes that government assets are “spread very thinly and follow through can questionable,” the programs implemented during the partnership, such as creek access and road construction, are starting to have a small, but noticeable impact within the region (*Response Centric NGO*, personal communication, June 27, 2013). *Response Centric NGO* plans to continue with established partnerships and promote emergency response within the Niger Delta region. These efforts are seen as immensely beneficial and the skills and infrastructure that are created during any program can be immediately useful to both the local communities and government stakeholders.

### 4.5.2 Collaboration within the Private Sector, to include International NGOs

The combination of interviews and survey data provided insight into the the ability of NGO leadership to establish and maintain partnerships with international and local NGOs, community based organizations, and for-profit industries and businesses. Generally, partnerships within the private sector are best established in order to overcome
barriers to service provision, maximize resource use, and facilitate the mitigation and response to outbreaks of infectious disease. Indicators of partnership capacity include prior collaboration with other NGOs, the participation in NGO coalitions or associations, and the routine incorporation of other private sector entities into organizational planning and program implementation.

Recently Established NGO, Multi-Sector NGO, and the Diaspora Led NGO all demonstrated the same general capacity to seek out and establish mutually beneficial partnerships with other NGOs. Recently Established NGO leadership stated that “Partnership has been what most of us working as NGOs call for” (Recently Established NGO, personal communication, July 13, 2013). Where possible, the NGO has attempted to establish relationships with other organizations in its northern area of operation as well as seek international partners, mainly for the purpose of locating funding. A challenge associated with the larger, international NGOs is that of familiarity. Recently Established NGO staff stated that “donors do not appear to want to engage new NGOs no matter how competent the NGO is, but prefer using those they are familiar with and have been working with before” (Recently Established NGO, personal communication, July 13, 2013). A second challenge identified by Recently Established NGO is the amount of associations in their operational area, as opposed to structured NGOs.

There are a lot of associations…youth associations, groups, women’s groups, activists all on paper. I don’t mean to belittle that, because there is a lot of good intention, but the distraction created by these associations can make it hard to find
real partners and attract funding. *(Recently Established NGO, personal communication, July 13, 2013)*

*Multi-Sector NGO* leadership noted a similar issue with the sheer amount of associations claiming to support HIV/AIDS programs and attributed the destructive competition from these groups as a reason for difficulty in establishing partnerships with reputable organizations.

Despite the challenges, the *Multi-Sector NGO* has established working relationships with a number of community and international NGOs, most notably supporting the Global HIV and AIDS Initiative Nigeria, coordinated by the U.S.-based Family Health International NGO. Routinely, the *Multi-Sector NGO* coordinates work with the Network of people living with HIV and AIDS Nigeria, the National Youth Network on HIV and AIDS Nigeria, and the Lagos State Action Committee on AIDS, but numerous other NGOs are conferred with as programs are initiated. As of September, 2013, the NGO collaborated with local community based organizations north of Lagos to carry out activities aimed at reaching the youth population. These efforts attracted the attention of other local NGOs and *Multi-Sector NGO* leadership claims that they have received letters from the NGOs asking to participate in *Multi-Sector NGO*’s community development programs. *Multi-Sector NGO* uses these programs to not only create awareness within a community but also to involve other NGOs thereby leveraging resources and knowledge to carry out a program.

*Diaspora Led NGO* leadership stated that “We will work with any NGO that wants to work with us. We have worked with three different NGOs on different medical
missions and the collaboration has been fantastic” (Diaspora Led NGO, personal communication, July 6, 2013). The majority of partnerships described during the study consisted of one or more groups providing resources or skill sets. Following the program’s execution, no collaborative assessments or long term follow-up actions were completed. The leadership also related that several short duration partnerships have been less than successful. In one case, an NGO put both of our names on a banner, as part of their contribution. They put their names in large, bold letters and our name in small print, even though we provided 90% of the resources. We found out later that they used our project to raise funds for themselves. (Diaspora Led NGO, personal communication, July 6, 2013)

While rare, these types of incidents illustrate the competition between NGOs for both funds and support from both the public and private sectors. Diaspora Led NGO has the flexibility to pick and choose partners due to its strong oversight and community base, but other NGOs are not so fortunate and must seek to find new revenue streams wherever possible.

Water & Sanitation NGO and Response Centric NGO are both able to attract support from international NGOs, local communities, and the various organizations of the private sector. Water & Sanitation NGO boasts a number of regular, established partnerships with organizations such as the African Rivers Network, Society for Water and Sanitation, and the African Civil Society Network on Water and Sanitation, all of which help Water & Sanitation NGO connect to other NGOs in order to better service
communities and open access to the federal and state levels of government. The NGO also has a long term partnership established with the World Commission on Dams and the United Nations Environment Programme, both of which serve to increase credibility within Nigerian and provide potential sources of revenue. The major issue with these partnerships is that very little success has come from their establishment. Small advances are made, such as the creation of bore holes, or testing of water in rural communities, but the large scale impact culminating in national policy reform has not been fully realized.

_Response Centric NGO_, by comparison, has been able to call upon assistance as necessary due to the large network of partners and supporters that they maintain. The volunteer program that has been established, along with the linkages to both educational institutions such as the University of Benin, corporate entities such as Esso Mobil, and many local NGOs, is reflected in the many short notice programs that _Response Centric NGO_ can staff with 50+ individuals. Emergency response efforts and other short term initiatives characterize _Response Centric NGO_ programs. The larger programs, such as the revitalization of hospitals, require support beyond the private sector and despite the existing partnerships, it is still difficult to get the local communities to take ownership of the programs that are implemented. _Response Centric NGO_ summed up the difficulty in establishing programs in some delta regions, regardless of the available support by stating, “So the point is, this is an area with no local infrastructure, no medical know how, certainly no drugs or supplies. People have probably never seen a thermometer, let alone anything else. Anything that is going to happen can’t be done overnight, regardless of who is involved” (_Response Centric NGO_, personal communication, June 27, 2013).
4.5.3 Findings: Partnership Variable

Partnerships between the majority of NGOs within the sample population and the public sector have been limited in nature and are characterized by gaps in both performance and resourcing. Existing gaps are exacerbated by weaknesses illustrated in the strategy and logistics variables. NGOs that are unable to develop a sufficient organizational strategy, or fail to mitigate the risks associated with staffing or logistically maintaining a program, also display indications that the organization is less likely to be effective in meeting the obligations of mutually supportive partnerships. Of the six NGOs within the sample population, only one displayed a fully developed capacity to establish and maintain partnerships with Nigerian federal, state, and local agencies. The remainder of the NGOs displayed anecdotal or partial evidence of the capacity necessary to engage agencies in the public sector. The northern based NGOs demonstrated anecdotal evidence of the capacity to sustain public sector partnerships, while southern based NGOs generally exhibited stronger capabilities, although they were not substantially more advanced and barely attained the modified UNDP partially developed ranking. In some cases, deficiencies may be attributed in part to an inadequate internal capacity to properly participate in public sector programs. All NGOs reported a numerous issues within potential government partners that directly impacted their ability to develop partnerships.

Collaboration between NGOs occurs on a fairly regular basis, although both scale and quality vary from program to program. Despite these activities, the conversion of NGO relationships into a practical means of implementing sustainable solutions was not fully demonstrated. Partnerships predominantly centered on the collection of resources
and skills under a single implemented program, disregarding the establishment of long term mutual initiatives. Additionally, international organizations typically placed Nigerian NGOs in the role of a subordinate entity charged with carrying out a specific task. Within the context of health programs, two or more NGOs agree to contribute a combination of educational materials, medicines, or other skill sets towards the completion of a medical clinic. The program is jointly run by the combined NGO leadership with financial demands being evenly dispersed according to prior agreements. Unfortunately, these partnerships serve only short term needs and disregard the establishment of long term mutual initiatives that would otherwise lead to the development of an enduring capacity within any given community. Due to limited engagements or lack of internal knowledge, four of the six NGOs displayed an anecdotal or partially developed capacity to establish and maintain partnerships with both international and local NGOs. The remaining two NGOs, Response Centric NGO and Water & Sanitation NGO, displayed a more widespread capacity to form partnerships and then use the relationships as both a multiplier to improve the overall impact of its programs and as a means to mitigate program risks wherever possible.

Working in conjunction with other NGOs can potentially result in increased efficiency and reduce duplication of efforts in any given area. The partnerships can also be used to expand programs within a community and potentially gain access to areas or people that could not otherwise be reached. In the northern areas for instance, the Faith Based NGO has used its status as a faith based organization to facilitate the access of polio eradication teams to remote communities around Bauchi. It has also assisted
UNICEF in the selection of community health workers who administer the vaccine to local children. In both of these examples, the NGO is acting in the capacity of a fixer and not as an equal partner within the program. Locally, the *Faith Based NGO* which is associated with the AbuZur Islamic Propagation and Empowerment Centre, Katsina, is selective about the organizations that it chooses to work with because of its faith. Islam plays a significant role in the selection of potential partners and leadership has openly stated that they will not work with any organization that does not support the tenants of its faith. Exceptions are made for secular organizations that are run by Muslims or those international organizations like UNICEF that are approved by the Islamic leadership. This stance has all but eliminated any mutual programs with most secular NGOs which contribute to the organization’s overall low ranking.

### 4.6 Summary

Chapter four presented the findings and associated analyses of the collected data from the primary research question and three subsidiary questions. Six indigenous Nigerian NGOs were analyzed to determine their ability to respond to the spread of infectious diseases through the implementation of programs within the health care sector. Data was obtained to test this hypothesis from a set of three separate questionnaires. Each of these focused on a different variable of the Capacity Development Triad, participant interviews, and an analysis of organizational materials, project reports, and related media. The analysis provided insight as to how NGOs developed comprehensive strategies to implement programs, generated an internal capability to supply critical resource
shortfalls, and established and maintained partnerships with both the public and private health sectors.

Global findings were discussed, followed by the evaluation of the data using each variable of the Capacity Development Triad, comprising the aspects of strategy, capability, and partnership. This sub-unit of analysis provided the researcher with a clear means of grouping information and enabled comparisons between both individual and multiple findings in the data set. Qualitative data were further incorporated into the modified UNDP CAF support tool in order to generate a quantitative set of material that could be used to gauge the level of capacity within each of the six organizations. The combination of quantitative and qualitative methods was complementary and increased confidence in both research findings and conclusions.

Chapter five reviews the findings and conducts a synthesis of the data toward the goal of establishing whether or not NGOs are capable of providing the support necessary to enable the Nigerian government and its health care system to respond to the spread of infectious diseases. It demonstrates the importance of this study and potential ways in which the data can be applied toward improving the Nigerian health care system, thus improving the provision of services to the population, reducing the burden of disease, and improving the role of local government in rural areas. The chapter concludes with the implications of the research and potential areas of future research.
CHAPTER FIVE: RECOMMENDATIONS

5.1 Introduction

The Nigerian government has failed to establish and sustain a viable health care system capable of meeting the needs of its vast population. The nation has been characterized by extraordinarily high child mortality rates, low life expectancy, and reoccurring outbreaks of infectious diseases, none of which show any sign of abating (DoS, 2008; Ileuma, 2007; Nwaobi, 2005). Infectious diseases are particularly concerning as they exact a heavy toll on the population and lead to long lasting negative implications at the national level. Nigeria’s disease burden contributes to the amplification of instability and economic strife through negative impacts on the economy, government, and military (Fox, 1998; Metz, 2000; Price-Smith, 2001; USAID, 2006). It is uncertain if the government of Nigeria, despite their repeated commitments to reinvigorate the health care sector, has the capacity to meet such a goal given their low levels of health expenditures in relation to the national Gross Domestic Product.

NGOs, which are already deeply rooted in Nigeria, provide a means of facilitating response efforts and building capacity in the health sector (Aina, et al., 2002; Dixon, Hawkley, & Evans Scott, 2003; Narel, 2008). Public health emergencies in many developing nations like Nigeria are based on the collective effort of multiple groups; for this reason, it is imperative to understand how one of the major group of stakeholders can
contribute to the Nigerian government’s ability to mitigate and respond to the spread of infectious diseases. Otherwise, NGO efforts to supplement health care can remain fragmented, with long term endeavors doing nothing to improve community access to services or build a permanent national capacity. Unfortunately, it is not fully known if health sector NGOs have the internal capability and external reach necessary to provide services in conjunction with, or in support of, government led efforts (Dixon, Hawkley, & Evans Scott, 2003; Erinosho, 2009; Gyoh, 2008; Prodi, 2000).

The purpose of this qualitative, illustrative case study was to examine indigenous NGOs operating within the Nigerian health sector and analyze their ability to mitigate the spread of infectious diseases and contribute to the development of a robust national capacity. The researcher hypothesized that indigenous NGOs are not sufficiently capable of mitigating the spread of infectious disease, or contributing to the national health capacity due to limitations in resources, skill sets, and the inability to maintain enduring programs.

Chapter four presented the findings of the study obtained from a set of three separate questionnaires, participant interviews, and an analysis of organizational materials, project reports, and related media. Chapter five, following a restatement of research questions, reviews the findings and presents a synthesis of data leading to conclusions and implications of the study. The chapter closes with recommendations for additional lines of inquiry designed to expand the functional knowledge base of NGOs and their ability to contribute to the development of a robust national health care capacity.
5.2 Research Questions

One central research question guided the study: *Can indigenous NGOs support the ability of the Nigerian government and its health care system to respond to the spread of infectious diseases through the implementation of local programs that contribute to a robust national capacity?*

Three subordinate questions each associated with a nested variable of the Capacity Development Triad, framed the study:

1. How have strategies for developing capacity in the health care system been developed and implemented by selected NGOs?
2. How have selected NGOs operating in different areas of the nation developed the sufficient capabilities which are necessary to create sustainable solutions to limit the spread of infectious disease?
3. How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

5.3 Summary of Findings

A significant threat to the stability and potential growth of Nigeria is the dramatic public health crisis encompassing a host of problems ranging from the absence of basic health services to the ongoing spread of infectious diseases. Exacerbating this situation is a dysfunctional health care system that is “under increasing stress” due to “growing populations, changing demographics, epidemiologic shifts and increasing urbanization” (DFID, 2008, p. 3; DoS, 2008, p. 6; Schneider & Moodie, 2002). The private sector,
specifically NGOs, has attempted to fill the dearth of primary health care needs, but no significant progress has been made towards reducing the impact of infectious disease or improving the national health care capacity. This is because NGO programs and other health care related efforts can be exceedingly complex undertakings, affected by a multitude of variables and influenced by numerous political, military, economic, social and infrastructural drivers.

This case study examined indigenous Nigerian NGOs and attempted to analyze the dynamics influencing program design and implementation. Participants in the study discussed how their organizations functioned and how programs were implemented to mitigate the impact of infectious diseases. The findings illustrate that while NGOs have the ability to carry out basic operational functions in select settings, performance gaps restrict the implementation of fully realized programs capable of mitigating the impact of infectious disease. No one variable of the triad deviated from the partially developed ranking to any significant degree further showing that as a group, no singular aspect of NGO operational capacity is attributable as the cause of restricted performance ratings. Variations did occur when northern and southern based organizations from within the sample were separated and compared. Northern based NGOs demonstrated less operational capacity across every variable of the Capacity Development Triad than their southern counterparts.

Individually, each of the three variables and its associated factors provided a means to interpret NGO levels of capacity by forming categories around which trends in the data set could be more readily identified. A total of eleven findings were captured
amongst the three variables, six classified as primary and five classified as secondary, depending on their level of importance and relevance to this study.

Findings related to the strategy variable of the Capacity Development Triad indicate that there are systemic issues including underdeveloped leadership structures, an inability to create a singular organizational purpose, failure to link objectives and resources with an overall vision, and/or challenges with organizational control in half of the sample population. The remainder of the sample population demonstrated a much more widespread capacity to manage organizational growth and implement actionable plans within the context of a structured planning process. Furthermore, NGOs routinely implemented programs that were not planned to be sustainable, had weak or unsystematic evaluation systems, and were generally organized around one-off medical clinics and/or other limited scope events. These two findings supported the researcher’s hypothesis, although when NGOs were assessed by region, southern NGOs proved more capable of guiding capacity building activities, mobilizing available resources, and integrating their constituency into sustainable partnerships.

Internal capability findings further supported the researcher’s hypothesis by illustrating that funding and logistical issues remain a significant limiting influence in all NGO operations. However, findings depicting the high level of impact that corruption, followed by social conflicts and cultural beliefs, on NGO operations were unforeseen. It was known prior to the study that corruption was rampant within Nigeria, but the enormity of the impact, as well as its blatant institutionalization within the health care system, had an almost crippling effect on some aspects of NGO operations. One finding
that did challenge the researcher’s hypothesis was centered on the retainment of individuals with critical skill sets necessary for successful program implementation. While northern based NGOs struggled to find the necessary staff to implement projects, southern based NGOs demonstrated a nearly fully developed ability to mitigate critical skill shortfalls through the judicious use of volunteers and program centric staff.

The final variable, partnership, produced findings that supported the researcher’s hypothesis, although not in the anticipated manner. It was assumed that NGOs collaborated with other NGOs to the fullest extent possible, while protecting organizational interests. Partnerships identified in the study, involving one or more NGOs, predominantly centered on the collection of resources and skills under a single implemented program, disregarding the establishment of long term initiatives. This NGO centric stance prevented the conversion of NGO relationships into a practical means of implementing sustainable programs. While it is not unexpected that NGO-to-NGO partnerships act in this manner, it was the relationship with the public sector that produced a somewhat irregular finding.

The finding indicates that partnerships between the majority of surveyed NGOs and the public sector have been limited in nature and characterized by gaps in both performance and resourcing. The unique aspect of this finding is that NGOs viewed public sector agencies as being poorly staffed, resourced, and/or structured, which restricted government participation in joint program implementation. Josephine Kamara, a program manager for an international organization operating in the north, reinforced this finding, stating that,
In the north, at the organizational level, the agencies are falling down and the programs are falling apart. The ability to develop strategies really isn’t there. Programs can’t be supported for any length of time. Some capacity has been built in the north, but without outside help, capacity would drop or fail all together.

(Kamara, personal communication, March 20, 2013)

Due to this, the challenge of establishing joint partnerships is not solely reliant on the NGO internal capability to support mutual programs. Public health sector agencies are equally responsible, if not more so, for the poor record of partnership. The inherent infrastructural, personnel, and performance issues found within public sector agencies may form obstacles that cannot be overcome, despite the efforts or capabilities of non-governmental organizations. As a result, any comparative advantages that NGOs bring to the table may not be sufficient to outweigh the disadvantages of the public sector.

5.4 Conclusions

Findings indicate that NGOs are not able to support the Nigerian government and its health care system in responding to the spread of infectious diseases or contribute to the development of a robust national capacity. This determination is based on the observations of the sample group as a whole and reflects the partially developed performance ratings that span all three of the Capacity Development Triad variables. No singular aspect of NGO operational capacity is attributable as the cause of restricted performance ratings. While there are undoubtedly many other factors that bear upon the ability of an NGO to implement programs, the basic operational capacity to develop a plan, allocate resources, and create mutually beneficial partnerships to maximize
resources are core organizational functions that are not consistently demonstrated by the sample population.

The findings associated with the strategy variable demonstrated the inability of the NGO population to support response efforts or contribute to capacity development due to an inadequate lack of long term planning and program oversight. NGOs committed to action without first developing obtainable objectives. Unguided actions were characterized by short duration events that were limited in both impact and sustainability, thus reducing the full potential of any particular NGO intervention. Furthermore, lack of developed planning processes restricted the effectiveness of resourcing programs with staff and adequate funding. Capacity development is a long term endeavor which cannot be achieved through short term, nonreplicable programs. Action of this nature uses resources inefficiently and in some cases, creates duplication of services and disruptive competition for resources amongst NGOs in the health sector.

NGO capability presented a different set of challenges for the sample population. Funding and logistics, as expected, proved to be a chronic issue and restricted the implementation of programs to various degrees. Procurement of medications and their subsequent storage was one shortfall, followed by problems in physically dispersing resources to their points of use. The biggest impediment to capability, came from corruption, social conflicts, and cultural beliefs. All of the NGOs were able to partially mitigate the full impact of these issues on operations, but in some cases, programs had to be scaled back or eliminated; in others, efforts in entire regions were removed from consideration. Finally, identifying and retaining individuals with critical skills sets were a
significant issue within the sample population. Staffing of programs was heavily augmented by volunteers from both within and external to Nigeria. Due to the short term nature of many programs, this solution proved to be adequate. The use of volunteers can be problematic to sustain over long term programs and creates a higher level of risk requiring detailed planning to mitigate. Given the low level of planning ability within the NGOs surveyed, it is unknown what level of success may be achieved in managing volunteers over a lengthy time span.

The researcher fully expected that findings related to the partnership variable would disprove the hypothesis. In reality, findings supported the hypothesis. It was assumed that partnerships were a routine part of NGO operations and occurred both frequently and amongst established networks of service providers. Partnerships with other NGOs joined resources on a particular program, but due to competition for funding, NGOs were unable to established long term solutions in any particular area. Additionally, instances of disruptive competition were reported leading to duplication of efforts, or in some cases, a reduction of support from potential donors or outside agencies. An article appearing in *This Day Live*, noted,

NGOs are necessary and very crucial in attaining better health care services. However, many NGOs seem to be working at cross-purposes with the frontline objective of saving lives. Since there are no proper checks, NGOs end up grabbing funds meant to provide services to rural people and the downtrodden without any practical results to show for it. Most of these services barely get to the grassroots. (Obi, 2013)
Furthermore, NGOs within the population are not a member of any established organizational network, restricting the pool of assistance that could be drawn upon and potentially creating more conflicts as competition within the NGO community increases. Finally, the biggest surprise in the findings was the lack of public-private partnerships. It was assumed that all NGOs attempted to partner with public agencies in order to gain access to resources and funding. Interpretation of the data indicated that while NGOs generally wanted to establish partnerships, it was the compromised state of the public sector that really restricted NGOs from achieving this goal.

The role of public sector agencies proved to be an important consideration in interpreting this finding within the context of the study. The researcher did not take into the account the full extent of the lethargy of public agencies, or their inability and/or unwillingness to partner with private sector organizations. Only one of six NGOs reported successful implementation of joint programs, and even then, this single NGO described cases of corruption and instances of limited performance that threatened service provision. The others reported public agencies as being poorly staffed, resourced, structured, and rife with corruption, restricting any development of mutually beneficial partnerships. Evaluating the majority of NGO experiences, the researcher speculates that even if the sample population were wholly capable of executing a full range of programs, there would still be significant obstacles to overcome in establishing partnerships with public sector agencies.

Despite these findings, and their support for the researcher’s hypothesis, there is a large amount of potential for indigenous NGOs to contribute to the development of a
robust national capacity, specifically in the mitigation of infectious disease outbreaks. This potential rests on the government’s ability to harness the numerous, random efforts occurring throughout the nation and focus these efforts toward a coordinated goal. Developing such a focus is difficult and is not guaranteed to succeed in the Nigerian operational environment. The researcher sought out other studies and relevant literature for examples of how NGO capability might be improved to the point where the organizations would be able to support larger capacity development efforts. Recommendations identified in the literature review were typically well intentioned but impractical, and did not take into account the complexities of smaller NGOs without an international reach. For example, authors noted that NGOs should:

- Open dialog with the health sector (McDikkoh, 2010, p.283).
- Establish links with international institutions (Guler, 2008).
- Form regional networks (Eboh, 2007, p.95)
- Form think tanks to explore engagement options (Eboh, 2007, p.102)
- Take an inventory of existing links to Nigeria and plan how to expand their work (Aluko, 2006, p. 242).
- Foreign NGOs should sponsor meetings with NGOs to improve linkages across the health sector (Gyoh, 2008).
- Advocate for the development of transparent systems to fight corruption (Malhotra, 2000, p. 662).

These recommendations are all suitable in a purely academic setting or an ideal environment, but are too broad in nature or readily attainable for the whole of the NGO...
population in this study. Attempting to accomplish any one of these recommendations without some firm grounding in the Nigerian health sector would prove illusionary at best and divert scarce resources from their intended constituents. The researcher takes a contrasting point of view and advocates that a national health capacity cannot be improved by broadly trying to develop all aspects of NGOs across the length and breadth of the health sector. Instead, the researcher recommends that a narrow aspect of NGO operations, in this case the provision of emergency aid, be identified and used to supplement a core national capability. Study findings, when reviewed individually or in different groupings, illustrate that this approach is possible, although the generalizability of this approach to other aspects of the health sector is uncertain.

The most effective contribution of NGOs within the Nigerian health sector is as a service multiplier. In this role and supported by this study’s findings, the researcher asserts that NGOs are best suited to reinforce the existing national emergency management function. Larger NGOs have proven themselves to be excellent providers of emergency aid in a diverse range of settings. This principal can be scaled down to the indigenous level in Nigeria, creating a set of organizations that are better trained and able to assist the public sector. Selected NGOs can use their inherent strengths to close performance gaps in public agencies, while retaining the freedom to implement additional programs of their choosing. NGOs working in this role function as a point of service while public sector agencies are responsible for the bulk supplier of core resources. It is understood that typical NGOs cannot provide a large assortment of services to a community due to resource and funding challenges. Narrowly focusing selected NGOs on
services that can be used both during and emergency and in an everyday setting, creates a flexible asset that can maintain performance levels when not involved in crisis situations.

Given the findings from this study, the researcher speculates that the Nigerian government can start to build a select capacity in the public sector by employing NGOs as a service multiplier within the emergency response function. The development of this capability is a gateway event potentially leading to increased efficiencies in other, related portions of the health sector. Findings supporting the creation of this capability were assessed by region, followed by individual variables, and finally by areas that would require further development or outside intervention in order to enact this potential NGO support construct. A hypothetical set of NGOs engaged in this manner could bolster both the Nigerian Emergency Management Agency and selected LGA agencies’ ability to quickly respond to health related emergencies until a full range of support can be mobilized to ensure a more enduring response. NGOs functioning in this capacity are extremely beneficial to the prevention and mitigation of emergencies, response efforts, and finally, long term recovery activities. Core functions of any NGO collaborating with the public sector should be trained in and execute the following:

A) Prevention and Mitigation Activities: Prevention is most effective means of controlling potential outbreaks or disaster event while mitigation activities are designed to reduce the impact of a disaster event, including, but not limited to the “disruption of critical services, causalities, and the instigation of long term recovery actions” (Paton, 2007). NGOs operating in a limited geographic area can improve public agency capacity by acting as a surveillance mechanism for
gathering disease related data for LGA health facilities and the recently established Nigeria Centre for Disease Control. Selected NGOs would also be responsible for developing emergency plans identifying potential hazards in a community, contact points for local leaders, and locations of potential sources of emergency supplies. Finally, NGOs can be an important source of training for local health workers, volunteers, and in some cases, public agency personnel. Training can be beneficial for emergency preparedness, as well as for routine problems that arise within a community.

B) Response Activities: Responding to an emergency event, such as a disease outbreak, is a field in which an NGO working in conjunction with a public agency can best augment public sector capacity (Ainscough, 2006). In this role, a NGO can facilitate the public sector response by serving as the local liaison with community leaders. Due to their local expertise and geographic placement, NGOs are more likely to respond far more quickly to an event than public sector counterparts. As a core function, NGOs will perform an assessment of the situation, determine the extent of the emergency, and report the status of critical infrastructure and/or transportation nodes. In this role, the NGO becomes a conduit of information to the incoming response elements, and a coordinator of follow on efforts. During the response, they are also capable of prioritizing activities and allocating resources, conducting damage assessments, and providing technical assistance until a transition of responsibility can take place with representatives of the public sector. Following the transition of responsibility to a
public agency, the NGO shifts to a more traditional role of managing donations, distributing aid where needed, and providing other necessary services to survivors.

When not engaged in emergency management activities, NGOs would continue to service their designated geographic area, working within donor constraints and organizational objectives. Staff can use the relationships established with public sector agencies to promote health services or pursue other agendas, such as health worker training, health education and prevention courses, or long term care for their constituency. While engaged in these programs, collection of medical data for LGA health agencies would continue, improving the likelihood that outbreaks of infectious disease could be quickly identified and contained.

Identification of an acceptable way to promote NGOs as an emergency response mechanism involved first determining likely areas where the capability would have the highest chance for success. Regionally, southern-based NGOs demonstrated a much higher organizational capacity across all variables being studied. Referring to the modified UNDP rankings, southern NGOs scored a 3.54 average versus a 2.09 average for northern NGOs. See Table 7. This overall rating provides an indication that NGOs operating in the southern regions have a higher potential to successfully implement programs. The absence of positive data regarding northern based NGOs does not imply that the response construct cannot be established in this region. Available data only indicates that efforts may attain better results if emphasis is directed initially in the southern regions of Nigeria. Due to this, the researcher proposes that supplementing the
national capacity must originate within one of the southern LGAs in order to have a higher chance of successful implementation.

Table 7: Modified UNDP CAF Spreadsheet - Southern NGOs Global Summary

| Point of Entry | Functional Capacities | | |
|---|---|---|---|---|
| | Strategy | Capability | Partnership | Summary |
| | Desired Level | Existing Level | Desired Level | Existing Level | Desired Level | Existing Level | Desired Level | Existing Level |
| 2 | Response Centric NGO | 4.00 | 4.25 | 4.50 | 4.25 |
| 4 | Multi-Sector NGO | 2.50 | 2.75 | 3.00 | 2.75 |
| 5 | Diaspora Led NGO | 3.75 | 4.25 | 3.00 | 3.67 |
| 6 | Sanitation & Water NGO | 3.75 | 3.25 | 3.50 | 3.50 |
| Overall | 3.50 | 3.63 | 3.50 | 3.54 | |
| Difference | 0.00 | 0.00 | 0.00 | 0.00 | |

Modified UNDP Capacity Assessment Framework, Numerical Ranking Legend
1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity

The ability to create and implement a long-term, strategic plan, enabling leadership to guide capacity building activities, mobilize available resources, and establish lasting partnerships was well developed (3.50 UNDP ranking) in southern-based NGOs. This core ability assists an organization in determining the roles and capabilities that can be jointly held with a public sector agency. Isolating strategy development (4.0) and objective planning (3.5), the four NGOs displayed a nearly widespread capability to perform a strategic planning process. See Table 8. These rankings illustrate that the southern-based NGOs are more likely to have systems in place to facilitate planning and have personnel capable of developing comprehensive strategies that account for the
numerous environmental influences within Nigeria. Supporting the emergency management function, the NGO must be willing to reorient the organizational mission to support the joint goals of the public sector agency and NGO leadership. The failure to create a shared vision will convolute the eventual implementation of programs and create deficits in service provision.

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>Strategic Vision</th>
<th>Objectives</th>
<th>Ownership</th>
<th>Implementation</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
</tr>
<tr>
<td>Response Centric NGO</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Multi-Sector NGO</td>
<td>2.00</td>
<td>2.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Diaspora Led NGO</td>
<td>5.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Sanitation &amp; Water NGO</td>
<td>5.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
</tr>
<tr>
<td>Overall</td>
<td>4.00</td>
<td>3.50</td>
<td>3.25</td>
<td>3.25</td>
<td>3.25</td>
</tr>
</tbody>
</table>

Modified UNDP Capacity Assessment Framework, Numerical Ranking Legend
1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity

Internal capability of southern-based NGOs was another strong point for NGO operations. According to Heinz Greijn of Capacity.org, the most “persistent weakness in health systems is the lack of capacity to train, recruit, and retain health care workers” (Greijn, 2011). The southern-based NGOs displayed a well-developed ability (4.25 UNDP Critical Skill ranking) to locate individuals with critical skills sets necessary to implement core programs. See Table 9. NGOs also displayed an ability to implement
training programs and educate staff on the core aspects of program implementation. 

*Response Centric NGO* instituted staff development programs which could be expended beyond the organization. These programs are invaluable to promoting local skill sets and can support a wider set of training programs tied to public sector agency objectives. Most importantly, all NGOs made use of volunteers and could tie into the Nigerian diaspora located elsewhere in the world as a source of skills. In an emergency management event, this ability to access a depth of qualified personnel is exceptionally important and provides a flexibility to respond to a wide variety of circumstances. Additionally, short notice acquisition of individuals with critical skill sets is essential to the first stages of disaster response and, as demonstrated in the findings, is a capability shortfall within the public sector.

Although logistics (3.25) and funding (3.25) were not strong points of NGO operations, the relationship with public sector agencies can serve to close any shortfalls. It would not be expected that selected NGOs maintain bulk relief supplies or transport materials within the country. This role falls upon the public sector that can, with the assistance of such entities as the Nigerian military, move materials to predetermined distribution points. Following delivery, NGOs can then manage the delivery of targeted packages within the impacted community. Findings indicated that NGOs implemented programs predominantly at the micro level without the necessary strategies or infrastructure in place to ensure scalability of effort beyond the local community. This limited logistical capacity can still be applied in conjunction with emergency
management events and over time the capability can be increased as NGOs and public sector agencies became familiar with expectations and partner capabilities.

Table 9: Modified UNDP CAF Spreadsheet - Southern NGOs Capability Variable

<table>
<thead>
<tr>
<th>Point of Entry</th>
<th>Critical Skill Sets</th>
<th>Logistics</th>
<th>Funding</th>
<th>Operational Environment</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
<td>Existing Level</td>
<td>Desired Level</td>
</tr>
<tr>
<td>2 Response Centric NGO</td>
<td>5.00</td>
<td>4.00</td>
<td>3.00</td>
<td>5.00</td>
<td>4.25</td>
</tr>
<tr>
<td>4 Multi-Sector NGO</td>
<td>4.00</td>
<td>2.00</td>
<td>3.00</td>
<td>2.00</td>
<td>2.75</td>
</tr>
<tr>
<td>5 Diaspora Led NGO</td>
<td>5.00</td>
<td>3.00</td>
<td>4.00</td>
<td>5.00</td>
<td>4.25</td>
</tr>
<tr>
<td>6 Sanitation &amp; Water NGO</td>
<td>3.00</td>
<td>4.00</td>
<td>3.00</td>
<td>3.00</td>
<td>3.25</td>
</tr>
<tr>
<td>Overall</td>
<td>4.25</td>
<td>3.25</td>
<td>3.25</td>
<td>3.75</td>
<td>3.63</td>
</tr>
</tbody>
</table>

Modified UNDP Capacity Assessment Framework, Numerical Ranking Legend
1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity

Findings indicated that lack of partnerships with public sector agencies, regardless of their location, have proven to be a significant obstacle in the development of a more robust health care capacity. See Table 10. Response Centric NGO, (5.0) managed to overcome potential issues and build a strong relationship with agencies in the Delta region and their collaboration is a model which can be built upon. Given that there are 774 local government areas in Nigeria, it is likely that some public agencies are in a better position to partner with NGOs than the ones cited in this study. For the purposes of explaining this NGO emergency response construct, the researcher used the experiences of Response Centric NGO as a basis for determining how a successful public-private
partnership might be executed. It is assumed that a willing and capable LGA is able to partner with one or more local NGOs.

_Response Centric NGO_ currently serves as a consultant to the NDDC for disaster related events. The partnership has proven to be quite beneficial to the Delta region, as evidenced by the NGOs record of program implementation. The emergency management construct proposed by the researcher seeks to formalize and expand this role with other partner NGOs. Public sector agencies would be required to subsidize NGO activities through a series of grants and potentially provide initial equipment sets and training packages in order to make up for NGO resource shortfalls. Once equipped and oriented to LGA goals, the NGOs would serve as a partial extension of the LGA and provide a means to develop emergency relief efforts in conjunction with long term capacity building activities. It must be understood that in order to strengthen the Nigerian health care sector, uncoordinated service activities are not acceptable. Operating in this manner has led to parallel medical services, created ad hoc responses, and generally undermined government legitimacy at all levels (Ainscough, 2006). Alan Fowler, in _PVO and NGO Futures_, stated that “the days of working in isolation and separation are ending,” (Fowler, 2004). The lackluster performance of the public sector, combined with the almost random acts of kindness from NGOs requires a focused approach. Both the public and private sectors can realize many advantages from the exchange of experience, skill sets, and capabilities from any such partnership. Implementing a joint program focusing on emergency management is both ambitious and simplistic in nature. NGOs, especially in the south have shown an ability to successfully implement limited programs in support of
a strategic goal. The objective now is to link those goals to a national effort and provide resources and political support to begin the reconstruction of a single part of the Nigerian health sector. Success in this endeavor may pave the way towards improvements in other parts of the medical system as lessons are incorporated and programs are expanded.

Modified UNDP Capacity Assessment Framework, Numerical Ranking Legend
1. No evidence of relevant capacity
2. Anecdotal evidence of capacity
3. Partially developed capacity
4. Widespread, but not comprehensive, evidence of capacity
5. Fully developed capacity

5.5 Recommendations

This study was formed to address the impact of disease in Nigeria, which is a regularly contributing factor to the growing instability and poverty the nation. In addition to internal problems generated by disease, Nigeria’s inability to mitigate the impact or contain the spread of disease can have disastrous consequences for countries around the world, as evidenced by the spread of polio to neighboring countries in 2008. A concerted effort by aid agencies in combination with public sector agencies is required to reduce the
disease burden and limit the threat of pathogens spreading beyond national borders. Regrettably, current responses by international organizations and government agencies can quickly deteriorate to disjointed vertical programs, “lacking an overarching structure, logistical trains, technical support, and political support” (Carligeanu, 2009; Edwards & Hulme, 2002, pp. 3-4; Fowler, 2000). With this in mind, the researcher sought to understand how an effective collaborative framework could be established in high risk areas in order to control any outbreak though a rigorous program of planning and capacity development.

The findings of this study indicate that wholesale improvement of the Nigerian health care sector is unlikely. Furthermore, the massive institutionalized corruption and ongoing social conflict lowers both the probability and urgency to enact much needed reforms. Instead of attempting to address the full range and scope health care issues within Nigeria, the researcher has shown through the findings that a narrowly defined part of the health sector, emergency management functions, can be built upon in selected LGAs and then expanded as the core program matures. In order to implement such an initiative, additional research is required to better understand the remaining gaps in knowledge that surround the structure of public-private sector partnerships, delineation of roles, process of data collection, and the establishment of a strong logistical network. Admittedly, there are large knowledge gaps related to the functioning of the Nigerian health care sector and any number of these could form the basis for future research efforts. There is also a large body of work depicting how NGOs operate in various parts of the world that can form the basis of a lessons learned review, with results subsequently
applied at the local level. A large proportion of these works, identified during the literature review, centered on international organizations and their ability to respond to crisis events, manage the large scale movement of supplies, and orchestrate campaigns at the global level. Discussions with NGOs and public sector agencies found that while international organizations appear to be very robust on paper, or in the media, their on-ground presence can be somewhat less impressive. It is therefore important to understand how indigenous NGOs, which constitute a long term presence, and the public sector can work in concert to develop an effective national health care capacity.

Reviewing the Wamai (2004) study that originally influenced the development of this research, many of the areas he noted requiring further investigation are also relevant within the context of this topic. At the conclusion of his work, he recommended that more research was needed to comprehend the “complex relationships with the multi-level public sector” and the “different roles that various types of health NGOs play with regard to service provision, promotion and participation with a view to coordinating them well within the overall health system” (Wamai, 2004, p. 306). This latter point is especially important, but needs to be more narrowly defined if the data produced is to be useful beyond the setting within which it was written. Research can also be directed toward different stakeholders with the intent of broadening the knowledge base and promoting a holistic approach toward engaging indigenous NGOs in the health sector.

Future research should focus on the following topics:

1. Prospective roles of the recently established Nigeria Centre for Disease Control in the control of infectious disease outbreaks and its optimal linkage
to LGAs, the Nigerian Emergency Management Agency, and third party organizations.

2. Current capabilities of the Nigerian Emergency Management Agency to mitigate infectious disease outbreaks and potential areas that can be outsourced to indigenous NGOs in order to maximize response coverage areas.

3. Usage of the Nigerian military to support emergency management efforts and capabilities that can enable or be replaced by indigenous NGOs.

4. Ministry of Health usage of indigenous NGOs to supplement primary health care services in rural areas.

5. Usage of indigenous NGO multi-field collectives to address health problems in conjunction with public sector agencies.

6. Impact of corruption within the Nigerian health care system and ways to minimize the effects at the LGA level.

7. Development of low cost, deployable systems that can support indigenous NGOs when responding to events in rural or undeveloped regions of Nigeria.

8. Establishment and role of an information management system, along with support practices, training, and collection mechanisms, that can best capture and disseminate lessons learned from emergency management events.

Any one of these topics can be used to support the development of a national capacity, and specifically the development of a robust emergency management function. The knowledge gained, while not all encompassing, will combine to form a greater
understanding of how the latent capacity of indigenous NGOs can be used to build a collaborative framework with the public health sector with the intent of reducing the overwhelming disease burden in Nigeria. The researcher suggests that each new influx of knowledge improves the operational capacity of the health sector which can potentially affect, and potentially improve, other factors that are limited the full potential of this developing nation.

5.6 Summary

The government of Nigeria does not have the capacity to treat the innumerable medical issues of its population, and as a result, it has abdicated many of its responsibilities to a combination of public and private providers (IRIN Africa, 2007; Sam, 2008; WHO-AFRO, 2002). An opportunity exists to “establish partnerships, minimize mistrust, and provide support to the organizations” that would, and could, most likely be, trained as the primary responders to a health crisis, thus reducing the impact to the local population (African Union, 2007). Developing capacity within the health care system will improve public health services during a crisis and improve day to day care available to the Nigerian population.

This qualitative, illustrative case study was designed to examine indigenous NGOs operating within the Nigerian health sector and analyze their ability to mitigate the spread of infectious diseases and their potential to contribute to the development of a robust national capacity. The results and conclusions indicated that as a group, NGOs are not able to support the Nigerian government and its health care system in responding to the spread of infectious diseases or contribute to the development of a robust national
capacity. Review of the findings from a regional or individual variable perspective illustrates that there is a high potential for indigenous NGOs to supplement LGA capacity by performing the role of an emergency management task force.

Results and conclusions of subordinate question one indicated that there are systemic issues including underdeveloped leadership structures, an inability to create a singular organizational purpose, failure to link objectives and resources with an overall vision, and/or challenges with organizational control in half of the sample population. When NGOs were separated by region, the analysis changed and southern-based NGOs demonstrated a much more developed capability to develop and achieve strategic objectives. Unfortunately, the programs implemented were routinely not planned to be sustainable, had weak or unsystematic evaluation systems, and were organized around one-off medical clinics and/or other limited scope events. This significantly restricted the potential of NGOs to contribute to the development of a national capacity as projects did not demonstrate sustainability or long-term impact.

Results and conclusions of subordinate question two indicated that the internal capability of NGOs is negatively influenced by funding and logistical issues. The impact of the operational environment, specifically corruption, social conflicts and cultural beliefs, on NGO operations produced unforeseen results. The rampant corruption and its near institutionalization within the health care system had an almost crippling effect on some aspects of NGO operations. The one finding that challenged the researcher’s hypothesis was the ability of select NGOs to mitigate critical skill shortfalls through the judicious use of volunteers and contacts within the Nigerian diaspora. This ability is an
excellent counter point to the failure of the public health sector to “train, recruit, and retain health care workers” in sufficient numbers to ensure coverage of the various LGAs (Greijn, 2011).

Results and conclusions of subordinate question three indicated that partnerships between the majority of surveyed NGOs and the public sector have been limited in nature and characterized by gaps in both performance and resourcing. The unique aspect of this finding was that the poor record of partnership stemmed from poorly staffed, resourced, and structured public sector agencies. Other factors such as corruption, along with inherent infrastructural, personnel, and performance issues, also played a significant role in public sector shortcomings which further limited the likelihood that mutually beneficial partnerships between the sectors could be established. Based on these challenges, the public sector itself appears to be the primary obstacle to the development of a national health care capacity.
Dear ___________,

My name is XXXXX and I am a doctoral student working on my final dissertation. I have chosen to study NGOs operating in the Nigerian health care sector in order to determine how they can prevent the spread of infectious diseases through the development of a national capacity. I am in the process of inviting NGOs to take part in my research and I would like to hear your thoughts on how best to build health sector capacity, as well as challenges that you face in implementing your projects.

Over a period of two months, or less depending on your schedule, I would like to send you three questionnaires, each consisting of four main questions supported by a series of shorter selection questions. The questionnaires focus on a different aspect of your organization including strategic objectives, internal staffing, and partnering activities.

It will take approximately 30 minutes to complete each questionnaire depending on the level of detail that you choose to provide. After each questionnaire is completed, I would like to contact you in order to gain additional insight, or clarify details so that I do not misinterpret your answers. All collected information will remain confidential and will not be shared with outside groups except within the context of the larger body of work.

At the end of our discussion, I hope to have an in-depth understanding of how your organization operates, what role it plays within the Nigerian health care system, and how capacity may be developed in the future.

If this is something that you would like to participate in, I would welcome your insight and experience. If you choose to decline, I completely understand and thank you for your time and your service to the community. If you have questions or concerns, use the information provided below to contact me at your convenience. I look forward to talking with you in the future.

Respectfully,

XXXXX, Student Researcher
George Mason University
Email: xxx@xxxx
APPENDIX B: NGO INFORMED CONSENT AGREEMENT

RESEARCH TITLE

INTRODUCTION
The purpose of this form is to provide you with information that may affect your decision whether to participate in this research study, and to record the consent of those who elect to participate. I hope that you will take the time to involve yourself in this study so that your input can be incorporated into this important research, which will potentially have a direct impact on saving lives within Nigeria.

RESEARCH GOALS
This research is being conducted in order to examine the framework of NGOs operating within Nigeria and analyze their ability to mitigate the spread of infectious diseases in conjunction with public sector efforts. To support the study's goal, the researcher seeks to scrutinize how NGOs within the health care sector are organized, how programs are planned and executed, and how public-private health sector partnerships can be established and sustained.

The knowledge gained from this research will be used to improve the understanding of current infectious disease mitigation strategies and identify ways in which a more robust health sector capacity can be developed through the joint efforts of both government and nongovernmental entities.

RESEARCHER
This research is being conducted by XXXXX, doctoral student in the Public and International Affairs Department at George Mason University, under the supervision of XXXXX, Associate Professor of Nonprofit Studies, Department of Public and International Affairs. For questions or to report a research-related problem, please contact us at one of the numbers listed below. Additionally, you may also contact the George Mason University Office of Research Subject Protections if you have questions or comments regarding your rights as a participant in the research.

XXXXX, Student Researcher
Email: xxx@xxxx
Phone: xxx-xxx-xxxx
RISKS and BENEFITS
There are no foreseeable risks for participating in this research. Although there is no direct benefit to you, a possible positive result of your participation in this study is the identification of viable ways to reduce the spread of infectious diseases through the development of long term national capacity within the health sector.

CONFIDENTIALITY
The data in this study will be confidential, but will be coded in order for the researcher to analyze the data. In order to protect the confidentiality of any information collected as part of this study: (1) your individual name will not be included on the surveys and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an identification key, the researcher will be able to link your survey to your organizational identity; (4) only the researcher will have access to the identification key; and (5) the results of this study may be used in publications or presentations. While it is understood that no computer based form of communication can be perfectly secure, all reasonable efforts will be made to protect your confidentiality.

PARTICIPATION
Your participation is voluntary, and you may withdraw from the study at any time and for any reason without penalty. There are no costs to you or to any other party for participating in this study.

CONSENT
The George Mason University Human Subjects Review Board has waived the requirement for a signature on this consent form. However, if you would like to sign a consent form prior to beginning the research, please contact William Sumner at the number provided in the contact information section of this form. This research has been reviewed according to George Mason University procedures governing your participation in this research.
APPENDIX C: BASE SURVEY INSTRUMENT [INTERNAL USE ONLY]

Survey Questionnaire One – Strategic Leadership

OPEN-ENDED RESPONSES
Primary and Likert scale questions were sent out via email, followed by supplementary phone calls to address secondary questions.

1. What is your organization’s long term strategic plan or mission statement? Please describe the major objectives and policies that constitute your strategy.
   Secondary Questions to be followed up via phone interview:
   a. How has the organization’s mission and objectives changed over the past three years?
   b. What have been the greatest challenges to achieving your organizational objectives? (Challenges may include resources, corruption, funding issues, lack of skills, cultural/ethnic tensions, or other environmental factors.)
   c. What would make your organization more effective in the areas that you implement projects?

2. How are/were the organization’s overall strategic objectives established?
   Secondary Questions to be followed up via phone interview:
   a. What types of models or approaches did your leadership use to develop your strategic plan?
   b. How did/do you manage risk? (Risk typically includes the management of time/schedules, resources are allocated to an effort, funding, worker transition, adaption to local cultural issues, etc.)
   c. How do you know when you have achieved your organizational objectives?

3. How do you build long-term capacity and/or community ownership into your project(s)?
   Secondary Questions to be followed up via phone interview:
   a. What actions did your organization undertake to engage the community where the project was implemented?
   b. What kinds of transition mechanisms did you build into your project(s) that allowed the local community to continue building on positive outcomes?
   c. Do you keep records of stories [testimonies] or ways in which individuals have been helped by the organization? If so, can you share any with the researcher?
4. What project(s) has your organization undertaken in the health care sector, related to the prevention or response to infectious diseases? Describe the project(s) and how the effort affected the region or community.

**Secondary Questions to be followed up via phone interview:**

a. How do you determine the need and level of demand for your services in a particular region or community?

b. How do you know when or if a project is successful? (both during its implementation and at the end of the effort)

c. What kinds of constraints did your organization encounter while working on your most recent projects? (Examples include: donor restrictions; too many patients and not enough staff, or not the right kinds of staff; security issues; shortage of supplies; or problems with access or storage of materials.)

**LIKERT SCALE QUESTIONS**

Answers to these questions were based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.

**Supports Question 2:**

1. The leadership of my organization has the skills and experience to develop a comprehensive strategy that supports both current projects and future efforts.

2. The leadership of my organization is able to easily adjust its mission, values, and methods according to changes in the operating environment.

3. The strategic objectives of my organization are compatible with larger state and national health sector objectives.

4. Donors played a significant role in the establishment of my organization’s strategic objectives.

5. My organization sought input from members of the local community on what our strategic objectives should be.

6. Changes in the physical environment, national laws/policies or issues such as local conflicts, has changed the way in which my organization operates.

**Supports Question 3:**

7. My organization frequently involves the local community in the development of projects.

8. The community had/has the opportunity to provide feedback throughout the implementation of my organization’s project(s).

9. My organization trains members of the local community to take over projects once organizational objectives have been met.

10. My organization employs members of the local community whenever possible to promote local ownership.

11. My organization has a long term plan/process in place to monitor the continued success of projects after they have ended.
12. The projects that my organization has carried out are considered very successful within the community where they were implemented.

Supports Question 4:
13. My organization has a formal selection process to consider what projects will be carried out.
14. Each project that my organization undertakes has clearly defined objectives and a clearly established way to end our involvement.
15. My organization typically requires outside assistance, not including funding, in order to carry out projects. This outside help may include finding trained workers, unusual knowledge, or specialized equipment.
16. Donors influence or direct the types of projects my organization selects to implement.
17. My organization often collaborates with the local community to determine what type of assistance is needed.
18. My organization has internal policies or regulations that limit or restricts project activities.
Survey Questionnaire Two – Organizational Capability

OPEN-ENDED RESPONSES
Primary and Likert scale questions were sent out via email, followed by supplementary phone calls to address secondary questions.

1. How does your organization identify critical skills that employees need to implement programs and improve the competencies of current staff and/or volunteers?
   \textit{Secondary Questions to be followed up via phone interview:}
   a. What types of skills are most in demand (or would you like to have) both within your organization and in the areas where you operate?
   b. How do you transfer knowledge and skills to the constituency throughout the operational span of your established project(s)?
   c. How do you manage shortfalls in essential skills while implementing a project?

2. How does your organization analyze resource requirements and manage physical resources prior to and during the implementation of a project?
   \textit{Secondary Questions to be followed up via phone interview:}
   a. Where does your organization obtain the majority of your supplies/resources used to implement a project?
   b. What types of resource issues do you typically encounter while implementing a project?
   c. How do you distribute your resources to the local community during a project and are there any associated problems with your process?

3. How does your organization typically fund your project(s)?
   \textit{Secondary Questions to be followed up via phone interview:}
   a. What are the major sources of funding for your organization? Please express in the form of a percentage? (Example: Donors 70%, Community Donations 10%, Grants 20%).
   b. How does your organization develop a financial plan to manage a full range of projects?
   c. What internal controls are in place to prevent theft or misappropriation of cash and other assets while implementing a project?

4. What challenges are typically encountered while implementing a project?
   \textit{Secondary Questions to be followed up via phone interview:}
   a. How did local infrastructure conditions affect your ability to provide services in the project(s) area?
   b. How do religious beliefs of the local community impact your ability to implement a project (if applicable)?
   c. How does corruption within the public or private health sector impact your ability to implement a project (if applicable)?
LIKERT SCALE QUESTIONS
Answers to these questions were based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.

Supports Question 1:
1. My organization has a high turn-over rate.
2. Volunteers provide a source of regular and consistent help to my organization.
3. My organization is able to recruit staff or volunteers with specialized skills and technical knowledge when required.
4. Existing staff members have the knowledge and skills necessary to support the achievement of my organization’s mission.
5. My organization regularly reviews and analyzes current and future human resource needs in terms of knowledge, skills, and attitudes.
6. My organization provides the staff/volunteers with opportunities for professional development and on-the-job training.

Supports Question 2:
7. My organization is able to easily adapt project to the changing needs of the community and extend services as more are required.
8. My organization establishes relationships within the community to provide hard to find materials, medicines, or other supplies.
9. My organization establishes a system for the local community to continue receiving resources and supplies after a project has been completed.
10. My organization is able to procure, store, and distribute resources with little or no spoilage/loss.
11. My organization has a plan to align organizational infrastructure and physical resources with our documented strategic objectives.
12. My organization has the capability to ensure, through monitoring and evaluation, proper use of infrastructure and physical resources.

Supports Question 3:
13. My organization has a documented budget-planning process and clearly defined financial controls that regulate spending.
14. My organization has clearly documented policies and mechanisms that ensure financial accountability.
15. My organization has difficulty securing long-term funding for our project(s).
16. My organization is accountable to the community where we serve.
17. My organization prepares and releases general public updates on internal developments and project status on a periodic basis.
18. My organization has a long term plan for developing financial resources.

Supports Question 4:
19. There is a lack of primary and/or secondary health care facilities where my organization operates.
20. Access to clean water and accessible roads is a challenge in the areas where my organization operates.
21. In the areas where my organization has carried out project(s), the local community relied heavily on traditional healers to supplement their health care.
22. Religious beliefs or ethnic tensions have complicated my organization’s ability to provide health services.
23. Corruption within the public health sector has limited the effectiveness of my organization.
24. Fake or bad quality medicines have seriously undermined efforts to fight the disease in the areas where my organization operates.
**Survey Questionnaire Three – Partnership and Collaboration**

**OPEN-ENDED RESPONSES**
Primary and Likert scale questions were sent out via email, followed by supplementary phone calls to address secondary questions.

1. How has your organization collaborated with government efforts at the local or state level? If you have not previously collaborated with a government effort, how do you envision future partnerships taking place?
   
   **Secondary Questions to be followed up via phone interview:**
   
   a. What are the challenges of working with the local or state government?
   
   b. In your past or present efforts, how have the benefits of participating in a partnership compared to the drawbacks? How will you use your experience to improve your next partnership opportunity?
   
   c. How have previous or ongoing partnerships led to the creation/strengthening of relationships between the private sector, the local community, and government agencies?

2. How has your organization collaborated with other NGOs (local/international), development groups, or the business community to support the health care system?
   
   **Secondary Questions to be followed up via phone interview:**
   
   a. What are the challenges or constraints associated with working in conjunction with other organizations or elements of the private sector?
   
   b. What lessons did your organization learn from collaborating with other organizations and how will you use these to improve your next partnership opportunity?
   
   c. What is the ideal level of collaboration between organizations? What steps should/can be taken to achieve the ideal level?

3. How has federal law and regulation within the Nigerian health care system either supported or inhibited your ability to provide health services in the areas where you operate?

   **Secondary Questions to be followed up via phone interview:**
   
   a. How has the National Policy on Public Private Partnership for Health in Nigeria affected your ability to partner with other agencies to provide health services?
   
   b. What are your views on the current national health plan and its impact on your organization?
   
   c. Are you aware of any other plans or policies (such as laws, executive orders, ministerial decisions or resolutions) that focus on the control of endemic diseases or limiting the spread of harmful vectors? If so, which do you feel are effective and why?
4. In your opinion, are the best ways in which partnerships can be created, expanded, or replicated throughout the health sector in order to more effectively respond to and mitigate the spread of infectious diseases?

*Secondary Questions to be followed up via phone interview:*

a. How can local communities’ be best integrated into the capacity development process through involvement with NGOs, government agencies, and the creation of policy and/or regulation?

b. How has foreign aid contributed to or limited the role of NGOs in the capacity development process?

c. Why would the Nigerian government want to partner with your organization to building long term capacity?

**LIKERT SCALE QUESTIONS**

Answers to these questions were based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.

*Supports Question 1:*

1. My organization has an established relationship with the local or state government in the areas that we operate.

2. My organizational leadership is satisfied with the functioning, progress, level of involvement, and interaction of past or present partnerships within the public health sector.

3. My organization plans to continue or expand partnership activities with local or state government in the future.

4. By working together, my organization and its partners were able to identify new and creative ways to solve problems.

5. By working together, my organization and its partners were able to develop goals that are widely understood and supported among both partners and the community.

6. By working together, my organization and its partners were able to carry out comprehensive activities that connect multiple services, programs, or systems.

*Supports Question 2:*

7. My organization has been able to leverage resources and support by partnering with other NGOs or elements of the private sector.

8. My organization plans to continue or expand partnership activities with other organizations or elements of the private sector in the future.

9. My organization and its partners are able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or changes in leadership.

10. Organizations involved in our partnership are open to different approaches on how we can implement our projects.

11. My organization and its partners have a clear sense of their roles and responsibilities.

12. Partnering with organizations within the public health care system has the potential to reduce barriers to implementing a successful project.
Supports Question 3:
13. The project(s) my organization carried out have been significantly restricted by national policies or regulations.
14. My organization has been able to influence the creation or implementation of policies, practices, and procedures through our past or current partnerships.
15. My organization is very involved in the local and state government decision making process.
16. Federal health centric laws and regulations are helping to mitigate the spread of infectious diseases and improve the response to disease outbreaks in the areas where we operate.
17. My organization has aligned its accountability programs and policies with the government’s health related mission and priorities.
18. Local laws and regulations are successful in facilitating the operation of health clinics or similar health facilities in the areas where we operate.
APPENDIX D: FORMATTED SURVEY INSTRUMENT [SENT TO PARTICIPANTS]

Survey Questionnaire – Strategic Leadership

1. What is your organization’s long term strategic plan or mission statement? Please describe the major objectives and policies that constitute your strategy.

2. How are/were the organization’s overall strategic objectives established?

3. How do you build long-term capacity and/or community ownership into your project(s)?

4. What project(s) has your organization undertaken in the health care sector, related to the prevention or response to infectious diseases? Describe the project(s) and how the effort affected the region or community.

ADDITIONAL QUESTIONS

Select one of the following answers for each question based on how you feel about the strategic leadership of your organization: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, I don’t know.

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<th>Strongly Agree</th>
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## Survey Questionnaire Two – Organizational Capability

1. How does your organization identify critical skills that employees need to implement programs and improve the competencies of current staff and/or volunteers?

2. How does your organization analyze resource requirements and manage physical resources prior to and during the implementation of a project.

3. How does your organization typically fund your project(s)?

4. What organizational challenges are typically encountered while implementing a project?

## ADDITIONAL QUESTIONS

Select one of the following answers for each question based on how you feel about the organizational capability of your organization: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, I don’t know.

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Survey Questionnaire Three – Partnership and Collaboration

1. How has your organization collaborated with government efforts at the local or state level? If you have not previously collaborated with a government effort, how do you envision future partnerships taking place?

2. How has your organization collaborated with other NGOs (local/international), development groups, or the business community to support the health care system?

3. How has federal law and regulation within the Nigerian health care system either supported or inhibited your ability to provide health services in the areas where you operate?

4. In your opinion, are the best ways in which partnerships can be created, expanded, or replicated throughout the health sector in order to more effectively respond to and mitigate the spread of infectious diseases?

ADDITIONAL QUESTIONS
Select one of the following answers for each question based on how you feel about the your organization’s ability to partner with other NGOs or the government: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, I don’t know.

| 1. My organization has an established relationship with the local or state government in the areas that we operate. | Strongly Agree | Agree | Disagree | Strongly Disagree | Not Applicable |
| 2. My organizational leadership is satisfied with the functioning, progress, level of involvement, and interaction of past or present partnerships within the public health sector. | |
| 3. My organization plans to continue or expand partnership activities with local or state government in the future. | |
| 4. By working together, my organization and its partners were able to identify new and creative ways to solve problems. | |
| 5. By working together, my organization and its partners were able to develop goals that are widely understood and supported among both partners and the community. | |
6. By working together, my organization and its partners were able to carry out comprehensive activities that connect multiple services, programs, or systems.

7. My organization has been able to leverage resources and support by partnering with other NGOs or elements of the private sector.

8. My organization plans to continue or expand partnership activities with other organizations or elements of the private sector in the future.

9. My organization and its partners are able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or changes in leadership.

10. Organizations involved in our partnership are open to different approaches on how we can implement our projects.

11. My organization and its partners have a clear sense of their roles and responsibilities.

12. Partnering with organizations within the public health care system has the potential to reduce barriers to implementing a successful project.

13. The project(s) my organization carried out have been significantly restricted by national policies or regulations.

14. My organization has been able to influence the creation or implementation of policies, practices, and procedures through our past or current partnerships.

15. My organization is very involved in the local and state government decision making process.

16. Federal health centric laws and regulations are helping to mitigate the spread of infectious diseases and improve the response to disease outbreaks in the areas where we operate.

17. My organization has aligned its accountability programs and policies with the government’s
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STRATEGY DEVELOPMENT
STRATEGY VARIABLE

SUBSIDIARY RESEARCH QUESTION: How are strategies for developing capacity in the health care system created and implemented by selected NGOs?

Survey Instrument – Secondary Open Ended Questions

Mission Emphasis
How has the organization’s mission and objectives changed over the past three years?

Obstacles
What have been the greatest challenges to achieving your organizational objectives?

Effectiveness
What would make your organization more effective in the areas that you implement projects?

Survey Instrument – Supporting Likert Scale Questions

No supporting questions identified.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
**STRATEGY VARIABLE**

**SUBSIDIARY RESEARCH QUESTION:** How are strategies for developing capacity in the health care system created and implemented by selected NGOs?

---

**Survey Instrument – Secondary Open Ended Questions**

- **Models and Approaches**
  - What types of models or approaches did your leadership use to develop your strategic plan?

- **Risk Management**
  - How did/do you manage risk? (Risk typically includes the management of time/schedules, resources are allocated to an effort, funding, worker transition, adaptation to local cultural issues, etc.)

- **Objective Achievement**
  - How do you know when you have achieved your organizational objectives?

---

**Survey Instrument – Supporting Likert Scale Questions**

1. The leadership of my organization has the skills and experience to develop a comprehensive strategy that supports both current projects and future efforts.

2. The leadership of my organization is able to easily adjust its mission, values, and methods according to changes in the operating environment.

3. The strategic objectives of my organization are compatible with larger state and national health sector objectives.

4. Donors played a significant role in the establishment of my organization’s strategic objectives.

5. My organization sought input from members of the local community on what our strategic objectives should be.

6. Changes in the physical environment, national laws/policies or issues such as local conflicts, has changed the way in which my organization operates.

**NOTE:** Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
STRATEGY VARIABLE

SUBSIDIARY RESEARCH QUESTION: How are strategies for developing capacity in the health care system created and implemented by selected NGOs?

Survey Instrument – Secondary Open Ended Questions

Community Engagement
What actions did your organization undertake to engage the community where the project was implemented?

Transition Mechanisms
What kinds of transition mechanisms did you build into your project(s) that allowed the local community to continue building on positive outcomes?

Local Impact
Do you keep records of stories (testimonies) or ways in which individuals have been helped by the organization?

Survey Instrument – Supporting Likert Scale Questions

1. My organization frequently involves the local community in the development of projects.
2. The community had the opportunity to provide feedback throughout the implementation of my organization’s project(s).
3. My organization trains members of the local community to take over projects once organizational objectives have been met.
4. My organization employs members of the local community whenever possible to promote local ownership.
5. My organization has a long term plan/process in place to monitor the continued success of projects after it has ended.
6. The projects that my organization has carried out are considered very successful within the community where they were implemented.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
Survey Instrument – Secondary Open Ended Questions

Service Demand
How do you determine the need and level of demand for your services in a particular region or community?

Program Evaluation
How do you know when or if a project is successful? (both during its implementation and at the end of the effort?)

Constraint Mitigation
What kinds of constraints did your organization encounter while working on your most recent projects? (Examples include: donor restrictions; too many patients and not enough staff, or not the right kinds of staff; security issues; shortage of supplies; or problems with access or storage of materials.)

Survey Instrument – Supporting Likert Scale Questions

1. My organization has a formal selection process to consider what projects will be carried out.
2. Each project that my organization undertakes has clearly defined objectives and a clearly established way to end our involvement.
3. My organization typically requires outside assistance, not including funding, in order to carry out projects.
4. Donors influence or direct the types of projects my organization selects to implement.
5. My organization often collaborates with the local community to determine what type of assistance is needed.
6. My organization has internal policies or regulations that limit or restrict project activities.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
ORGANIZATIONAL CAPABILITY
CAPABILITY VARIABLE

SUBSIDIARY RESEARCH QUESTION: Have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions that limit the spread of infectious disease?

Survey Instrument – Secondary Open Ended Questions

Knowledge Development
What types of skills are most in demand (or would you like to have) both within your organization and in the areas where you operate?

Knowledge Transfers
How do you transfer knowledge and skills to the constituency throughout the operational span of your established project(s)?

Knowledge Shortfalls
How do you manage shortfalls in essential skills while implementing a project?

Survey Instrument – Supporting Likert Scale Questions

1. My organization has a high turnover rate.
2. Volunteers provide a source of regular and consistent help to my organization.
3. My organization is able to recruit staff or volunteers with specialized skills and technical knowledge when required.
4. Existing staff members have the knowledge and skills necessary to support the achievement of my organization’s mission.
5. My organization regularly reviews and analyzes current and future human resource needs in terms of knowledge, skills, and attitudes.
6. My organization provides the staff/volunteers with opportunities for professional development and on-the-job training.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
CAPABILITY VARIABLE

SUBSIDIARY RESEARCH QUESTION: Have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions that limit the spread of infectious disease?

Survey Instrument – Secondary Open Ended Questions

Resource Acquisition
Where does your organization obtain the majority of your supplies/resources used to implement a project?

Resource Shortfalls
What types of resource issues do you typically encounter while implementing a project?

Resource Distribution
How do you distribute your resources to the local community during a project and are there any associated problems with your process?

Survey Instrument – Supporting Likert Scale Questions

1. My organization is able to easily adapt project to the changing needs of the community and extend services as more are required.
2. My organization establishes relationships within the community to provide hard-to-find materials, medicines, or other supplies.
3. My organization establishes a system for the local community to continue receiving resources and supplies after a project has been completed.
4. My organization is able to procure, store, and distribute resources with little or no spoilage/loss.
5. My organization has a plan to align organizational infrastructure and physical resources with our documented strategic objectives.
6. My organization has the capability to ensure, through monitoring and evaluation, proper use of infrastructure and physical resources.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
CAPABILITY VARIABLE

SUBSIDIARY RESEARCH QUESTION: Have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions that limit the spread of infectious disease?

Survey Instrument – Secondary Open Ended Questions

Funding Sources
What are the major sources of funding for your organization? Please express in the form of a percentage? (Example: Donors 70%, Community Donations 10%, Grants 20%.)

Financial Plan
How does your organization develop a financial plan to manage a full range of projects?

Internal Controls
What internal controls are in place to prevent theft or misappropriation of cash and other assets while implementing a project?

Survey Instrument – Supporting Likert Scale Questions

1. My organization has a documented budget-planning process and clearly defined financial controls that regulate spending.
2. My organization has clearly documented policies and mechanisms that ensure financial accountability.
3. My organization has difficulty securing long-term funding for our project(s).
4. My organization is accountable to the community where we serve.
5. My organization prepares and releases general public updates on internal developments and project status on a periodic basis.
6. My organization has a long term plan for developing financial resources.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
CAPABILITY VARIABLE

SUBSIDIARY RESEARCH QUESTION: Have selected NGOs operating in different areas of the nation developed sufficient capabilities necessary to create sustainable solutions that limit the spread of infectious disease?

Survey Instrument – Secondary Open Ended Questions

Infrastructure
How did local infrastructure conditions affect your ability to provide services in the projects(s) area?

Customs and Beliefs
How do religious beliefs of the local community impact your ability to implement a project (if applicable)?

Corruption
How does corruption within the public or private health sector impact your ability to implement a project (if applicable)?

Survey Instrument – Supporting Likert Scale Questions

1. There is a lack of primary and/or secondary health care facilities where my organization operates.
2. Access to clean water and accessible roads is a challenge in the areas where my organization operates.
3. In the areas where my organization has carried out project(s), the local community relied heavily on traditional healers to supplement their health care.
4. Religious beliefs or ethnic tensions have complicated my organization’s ability to provide health services.
5. Corruption within the public health sector has limited the effectiveness of my organization.
6. Fake or bad quality medicines have seriously undermined efforts to fight the disease in the areas where my organization operates.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
PARTNERSHIP and COLLABORATION
PARTNERSHIP VARIABLE

SUBSIDIARY RESEARCH QUESTION: How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

Survey Instrument – Secondary Open Ended Questions

Challenges and Constraints
What are the challenges of working with the local or state government?

Collaboration
In your past or present efforts, how have the benefits of participating in a partnership compared to the drawbacks? How will you use your experience to improve your next partnership opportunity?

Outcomes
How have previous or ongoing partnerships led to the creation/strengthening of relationships between the private sector, the local community, and government agencies?

Survey Instrument – Supporting Likert Scale Questions

1. My organization has an established relationship with the local or state government in the areas that we operate.
2. My organizational leadership is satisfied with the functioning, progress, level of involvement, and interaction of past or present partnerships within the public health sector.
3. My organization plans to continue or expand partnership activities with local or state government in the future.
4. By working together, my organization and its partners were able to identify new and creative ways to solve problems.
5. By working together, my organization and its partners were able to develop goals that are widely understood and supported among both partners and the community.
6. By working together, my organization and its partners were able to carry out comprehensive activities that connect multiple services, programs, or systems.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
PARTNERSHIP VARIABLE
SUBSIDIARY RESEARCH QUESTION: How have NGOs affected the development of national capacity through partnership and collaboration with the public health sector?

Survey Instrument – Secondary Open Ended Questions

Challenges and Constraints
What are the challenges or constraints associated with working in conjunction with other organizations or elements of the private sector?

Outcomes
What lessons did your organization learn from collaborating with other organizations and how will you use these to improve your next partnership opportunity?

Collaborative Levels
What is the ideal level of collaboration between organizations? What steps should/can be taken to achieve the ideal level?

Survey Instrument – Supporting Likert Scale Questions

1. My organization has been able to leverage resources and support by partnering with other NGOs or elements of the private sector.
2. My organization plans to continue or expand partnership activities with other organizations or elements of the private sector in the future.
3. My organization and its partners are able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or changes in leadership.
4. Organizations involved in our partnership are open to different approaches on how we can implement our projects.
5. My organization and its partners have a clear sense of their roles and responsibilities.
6. Partnering with organizations within the public health care system has the potential to reduce barriers to implementing a successful project.

NOTE: Answers to Likert Scale questions will be based on the following scale: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree, Not Applicable.
APPENDIX F: UNDP CAPACITY ASSESSMENT FRAMEWORK QUESTION SET

Questions included in this appendix were taken directly from the UNDP Capacity Assessment User Guide (UNDP, 2008, p. 42-74). Tables were reformatted in order to ensure that data was both legible and accurately depicted within this appendix. Only questions associated with the organizational level of capacity were selected for inclusion in this appendix.

Core Issue
1.0 Institutional Arrangements

Context (per UNDP Practice Note on Capacity Assessment)

Institutional arrangements refer to the policies, procedures and processes that countries have in place to legislate, plan and manage the execution of development, rule of law, measure change and such other functions of state. By its nature, the issue of institutional arrangements shows up in every aspect of development and public sector management. Whether these are ministries of finance or planning, or offices of disaster risk reduction, or whole sectors such as justice and health, the imperative of functioning and efficient institutional arrangements remains a strong driver of capacity and therefore, ultimately, performance. Also by its nature, the parameters of change within institutional arrangements often lie in all three capacity levels. Human resources management, for example, is inextricably linked at all levels – at the level of the individual, at the level of the organization/sector, and then at the level of the enabling system such as through their centrality within civil services by-laws etc...

1.2 Institutional Arrangements – Organizational level

<table>
<thead>
<tr>
<th>Functional Capacity: Engage Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Question</td>
</tr>
<tr>
<td>Additional Questions</td>
</tr>
</tbody>
</table>
**Indicators**

- Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders to discuss formulation and implementation of the organization’s policy and legal framework.
- Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.
- Clarity of the organization’s policy and legal framework to domestic and external stakeholders.

**Functional Capacity: Assess a Situation and Define Vision and Mandate**

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to frame, manage and interpret a comprehensive analysis of the policy and legal environment? Does the organization have the capacity to create a vision for fair and equitable policies, frameworks and mechanisms?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Questions</td>
<td>Not Available</td>
</tr>
<tr>
<td>Indicators</td>
<td>Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on the organization. Quality of action taken as a result of critical events’ analysis of opportunities and threats of most significance to the organization’s policy and legal framework. Existence of clear rules of the game and safeguards that establish legitimate policy processes as leading on policy choice</td>
</tr>
</tbody>
</table>

**Functional Capacity: Formulate Policies and Strategies**

<table>
<thead>
<tr>
<th>Overall Question:</th>
<th>Does the organization have the capacity to develop policies, frameworks and mechanisms that provide a consistent referent for operations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Questions</td>
<td>Not Available</td>
</tr>
<tr>
<td>Indicators</td>
<td>Extent to which societal changes are integrated into the organization’s policy and legal framework. Existence of policy and legal framework that is independent, impartial and fair. Existence of long-term strategic choices on policy and legal frameworks.</td>
</tr>
</tbody>
</table>

**Functional Capacity: Budget, Manage and Implement**

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop policies, frameworks and mechanisms that support an integrated approach to budgeting and implementation?</th>
</tr>
</thead>
</table>
### Additional Questions

- Does the organization have the capacity to:
  - Create a working environment free from corruption?
  - Develop and use policies, frameworks and mechanisms for evaluation?

### Indicators

- Extent to which organizational policy and legal framework contributes to achievement of the organization’s goals and strategies.
- Alignment of policy and legal framework with organization’s mission and clarity and awareness of policy and legal framework among organization’s leaders.

### Functional Capacity: Evaluate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop policies, frameworks and mechanism for evaluation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators</td>
<td>Existence of evaluation guidelines, procedures, etc.</td>
</tr>
<tr>
<td></td>
<td>Level of corruption.</td>
</tr>
</tbody>
</table>

### 1.4 Institutional Arrangements - Financial management – Organizational level

### Functional Capacity: Engage Stakeholders

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to engage stakeholders in the process of developing a financial plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Questions</td>
<td>Does the organization the capacity to:</td>
</tr>
<tr>
<td></td>
<td>- Mobilize external resources?</td>
</tr>
<tr>
<td></td>
<td>- Mobilize internal resources?</td>
</tr>
<tr>
<td>Indicators</td>
<td>Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders on issues relating to financial resource management.</td>
</tr>
<tr>
<td></td>
<td>Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.</td>
</tr>
<tr>
<td></td>
<td>Evidence of ability to satisfy and balance the financial interests of all stakeholders.</td>
</tr>
</tbody>
</table>

### Functional Capacity: Assess a Situation and Define Vision and Mandate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to frame, manage and interpret a comprehensive financial analysis and to create a vision for use of financial resources?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Questions</td>
<td>Does the organization the capacity to:</td>
</tr>
<tr>
<td></td>
<td>- Conduct a cost/benefit analysis in developing its financial plan?</td>
</tr>
<tr>
<td></td>
<td>- Identify and analyze the risks and rewards of potential financial decisions and weigh trade-offs in developing its financial plan?</td>
</tr>
</tbody>
</table>
| Indicators | - Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on policies relating to financial resource management.  
- Quality of action taken as a result of critical events analysis of opportunities and threats of most significance to the organization’s financial resource management policies.  
- Awareness of future resource needs among organizational leadership.  
- Accuracy of financial forecasts. |

<table>
<thead>
<tr>
<th>Functional Capacity: Formulate Policies and Strategies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
<td>- Does the organization have the capacity to develop a financial plan and policies?</td>
</tr>
</tbody>
</table>
| **Additional Questions** | - Does the organization have the capacity to:  
  - Align financial plan with strategic objectives?  
  - Introduce innovative approaches and systems of budgetary planning, e.g., multi-annual budgets? |
| **Indicators** | - Extent to which societal changes are integrated into the organization’s financial resource management policies and mechanisms.  
- Existence of long-term strategic policy options for financial resource management. |

<table>
<thead>
<tr>
<th>Functional Capacity: Budget, Manage and Implement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
<td>- Does the organization have the capacity to manage financial resources appropriately in the implementation of programmes and delivery of services?</td>
</tr>
</tbody>
</table>
| **Additional Questions** | - Does the organization have the capacity to:  
  - Delegate and decentralize financial responsibilities and balance them with central controlling?  
  - Ensure fiscal data are up-to-date and accurate?  
  - Monitor the use of financial resources?  
  - Monitor cost of delivery of standard products and services? |
| **Indicators** | - Organizational control of budget and financial resource policies.  
- Alignment of financial resources with planning budgets (including credit, where appropriate).  
- Degree of enforcement of financial resource management policies and mechanisms.  
- Effective financial management and accounting procedures.  
- Use of budgets as a planning tool.  
- Accuracy and currency of fiscal data.  
- Operational efficiency of organizational subsystems for financial resource management.  
- Alignment of scope of program or other activities with the |
organization’s financial resources.
- Clarity and awareness of financial resource goals and priorities among leaders.
- Transparency of budgeting, planning and allocation process.
- Use of budgets as a monitoring tool. (Extent to which budgets/financial targets are met.)

<table>
<thead>
<tr>
<th>Functional Capacity: Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
</tbody>
</table>
| **Additional Questions** | Does the organization the capacity to:  
- Ensure financial and budgetary transparency?  
- Use modern financial controlling, e.g., through internal financial audits? |
| **Indicators** | Measures of effective use of operating funds (to avoid exceeding any credit limit or under-exploiting resources).  
- Frequency and results of financial audits and inspections (internal and external).  
- Measures of prudent and risk-conscious financial management. |

### 1.6 Institutional arrangements - Human resource management – Organizational level

<table>
<thead>
<tr>
<th>Functional Capacity: Engage Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
</tbody>
</table>
| **Additional Questions** | Does the organization have the capacity to:  
- Create a culture of open, not hierarchical, communication and dialogue?  
- Involve employees, via dialogue and empowerment, in the design of processes?  
- Involve employees, via dialogue and empowerment, in the identification and implementation of improvement? |
### Indicators
- Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and domestic and external stakeholders on issues relating to human resource management.
- Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.
- Degree to which executives (managers) respect the independence and professionalism of their senior-level managers (staff).
- Degree to which senior-level managers (staff) are generally expected to provide frank and fearless advice to their superiors.
- Employee involvement in decision-making processes.
- Employee involvement in improvement activities (e.g., suggestion schemes).
- Employee consultation and dialogue mechanisms.
- Participation in internal discussion groups, meetings with senior management or all-staff meetings.

### Functional Capacity: Assess a Situation and Define Vision and Mandate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to frame, manage and interpret a comprehensive situation analysis of and to create a vision for human resource development?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
- Regularly analyze current and future human resource needs, at the organizational and individual levels, in terms of knowledge, skills and attitudes? |

### Indicators
- Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on policies relating to human resource management.
- Quality of action taken as a result of critical events’ analysis of opportunities and threats of most significance to the organization’s human resource management policies.
- Degree to which staff needs are analyzed in the planning process.

### Functional Capacity: Formulate Policies and Strategies

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop policies and strategies relating to human resource development?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
- Develop clear policy containing objective criteria with regard to recruitment, promotion, rewards and assignment of managerial functions? |

### Indicators
- Extent to which societal changes are integrated into the organization’s human resource management policies and...
- Existence of long-term strategic policy options for human resource management.

### Functional Capacity: Budget, Manage and Implement

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop, use and improve competencies of employees?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
- Ensure transfer of knowledge in heavily donor-funded programmes and projects?  
- Sustain activities and results once programmes and projects are internalized within government’s existing programmes?  
- Align organizational, team and individual targets and goals?  
- Manage a meritocracy?  
- Monitor the development, use and improvement of employee competencies? |

| Indicators | Alignment of human resource management programme with the organization’s mission, priorities and managerial capacities.  
Clarity and awareness of human resource goals and priorities among senior managers.  
Degree of enforcement of human resource management policies and mechanisms.  
Transparency of human resource planning and allocation process.  
Alignment of staff attitude and performance with overall goals.  
Degree of orientation of staff at all levels toward producing results that meet organizational goals.  
Degree to which organizational structure meets needs of efficiency and control.  
Participation and success rates in training activities.  
Level and use of training budgets.  
Use of information technology by employees.  
Staff rotation within the organization.  
Efficiency of organization’s processes.  
Existence of fully developed competency profiles application to all functional areas and specific levels.  
Use of human resource management plan as a monitoring tool. |

### Functional Capacity: Evaluate

| Overall Question | Does the organization have the capacity to evaluate the development and implementation of HR policy and encourage evaluation and feedback? |
### Additional Questions

- Does the organization have the capacity to:
  - Use clear performance standards to ensure staff accountability?
  - Design and conduct periodic staff surveys?
  - Design, conduct and act upon upward feedback, e.g., through 360o appraisals?
  - Consult with representatives of employees, e.g., trade unions?

### Indicators

- Accountability of staff for getting work done according to clear performance standards.
- Effectiveness of systems of goal-setting and performance evaluation.
- Level of employee satisfaction with goal-setting and performance evaluation processes.
- Results of evaluation and/or appraisal.
- Link between individual performance and the quality of services or products.
- Job satisfaction at all levels of the organization.
- Level of staff morale; frequency of evaluation of staff morale.
- Explicit integration of incentive questions as standing feature in mainstream M&E.
- Adequacy of staff in all key positions.
- Staff turnover rate.
- Degree to which monetary and non-monetary incentives support targeted behavior.
- Adequacy and equity of compensation.
- Opportunities for staff professional development and on-the-job training.
- Degree to which recruitment and promotion policies provide for staff growth.
- Level of employee motivation (e.g., response rates for staff surveys, participation in social events, willingness to accept changes, willingness to make an extra effort under special circumstances).
- Level of employee knowledge of the organization’s goals.
- Number of complaints, strikes, etc.

### 1.7 Institutional arrangements – Additional areas of exploration – Organizational level

#### Additional areas of exploration

**Career Management**

- Does the organization have the capacity to:
  - Create and apply competency profiles to all functional areas and levels?
  - Align responsibilities, authorities and tasks?
  - Manage career development/placement in such a way that
capacities developed in one post are applicable to the next post?
- Define and implement a right person in a right place policy, ensuring existing capacities are deployed in appropriate posts?

<table>
<thead>
<tr>
<th>Recruitment and Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Develop and use recruitment and promotion policies that encourage internal and external staff growth?</td>
</tr>
<tr>
<td>- Define leadership and managerial skills, for use in recruitment?</td>
</tr>
<tr>
<td>- Align recruitment and development plans with job descriptions?</td>
</tr>
<tr>
<td>- Manage recruitment and promotion fairly?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incentives</th>
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</thead>
<tbody>
<tr>
<td>• Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Develop and use monetary and non-monetary incentives that support targeted behavior and encourage performance / results-based management?</td>
</tr>
<tr>
<td>- Manage compensation and incentive programmes fairly?</td>
</tr>
<tr>
<td>- Develop an environment that encourages performance (e.g., free of corruption, strong governance)?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Identify, describe and document key processes?</td>
</tr>
<tr>
<td>- Analyze and evaluate key processes, taking into consideration the objectives of the organization and its changing environment?</td>
</tr>
<tr>
<td>- Ensure that core processes support the organization's strategic objectives?</td>
</tr>
<tr>
<td>- Manage and improve key processes?</td>
</tr>
<tr>
<td>- Identify and give responsibility to process owners for improvement?</td>
</tr>
<tr>
<td>- Optimize and adjust key processes based on their effectiveness and efficiency?</td>
</tr>
</tbody>
</table>

**Core Issue 2.0 Leadership**

**Context (per UNDP Practice Note on Capacity Assessment)**

Leadership is the ability to influence, inspire and motivate people, organizations and societies to achieve - and go beyond - their goals. An important characteristic of good leadership is the ability to anticipate (sometimes catalyze), be responsive to and manage change to foster human development. Leadership is not synonymous with a position of authority; it can also be informal and manifest itself in many ways and at different levels. Although leadership is most commonly associated with an individual leader, it can equally reside within a government unit that takes the lead in implementing public administration reform, or in
large social movements that bring about society-wide change.

2.2 Leadership – Organizational level

<table>
<thead>
<tr>
<th>Functional Capacity: Engage Stakeholders</th>
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</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
<tr>
<td>Does the organization’s leadership have the capacity to manage relations with key stakeholders inclusively and constructively?</td>
</tr>
<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>Does the organization’s leadership have the capacity to:</td>
</tr>
<tr>
<td>- Identify all relevant stakeholders?</td>
</tr>
<tr>
<td>- Develop and maintain regular relations with political authorities of the appropriate executive and legislative areas?</td>
</tr>
<tr>
<td>- Develop and maintain partnerships and networks with important stakeholders, e.g., citizens, NGOs, interest groups, industry, other public authorities?</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td>Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders.</td>
</tr>
<tr>
<td>Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.</td>
</tr>
<tr>
<td>Evidence of bureaucratic support for the organization's activities.</td>
</tr>
<tr>
<td>Existence of influential and outspoken champions for ownership and capacity development.</td>
</tr>
<tr>
<td>Organizational ownership of policies, goals and structure.</td>
</tr>
<tr>
<td>Ability of management to effectively represent the organization to external interests.</td>
</tr>
<tr>
<td>Clarity of leadership philosophy to internal and external stakeholders.</td>
</tr>
<tr>
<td>External image of the organization (e.g., image is consistent with goals and objectives).</td>
</tr>
<tr>
<td>Level of involvement with the community in which the organization is based through support (financial or otherwise) for local and societal (social, environmental, etc.) activities.</td>
</tr>
<tr>
<td>Level of awareness of the impact of the organization on the quality of life of citizens.</td>
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<table>
<thead>
<tr>
<th>Functional Capacity: Assess a Situation and Define Vision and Mandate</th>
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<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
<tr>
<td>Does the organization’s leadership have the capacity to frame, manage and interpret analysis of internal and external dynamics? Does the organization’s leadership have the capacity to develop its vision, mission and values based on that analysis?</td>
</tr>
<tr>
<td>Additional Questions</td>
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<table>
<thead>
<tr>
<th>Indicators</th>
<th>Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on the organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quality of action taken as a result of critical events’ analysis of opportunities and threats of most significance to the organization’s development and impact.</td>
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<tr>
<td></td>
<td>Clarity of mission to employees; documentation of mission.</td>
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<table>
<thead>
<tr>
<th>Functional Capacity: Formulate Policies and Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Question</td>
</tr>
<tr>
<td>Does the organization’s leadership have the capacity to translate the vision, mission, value framework into strategic (medium term) and operational (concrete and short term) objectives and actions?</td>
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<tr>
<td>Additional Questions</td>
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<thead>
<tr>
<th>Functional Capacity: Budget, Manage and Implement</th>
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<tbody>
<tr>
<td>Overall Question</td>
</tr>
</tbody>
</table>
### Additional Questions

- Does the organization’s leadership have the capacity to:
  - Translate strategic and operational objectives into an appropriate organizational structure, with accompanying management levels, functions, responsibilities and autonomy?
  - Translate strategic and operational objectives into appropriate plans, priorities, tasks and timelines?
  - Devolve decision-making to the most appropriate level?
  - Delegate operational responsibilities to the most appropriate level?
  - Be clear in what is expected of them and what they expect from others?

### Indicators

- Alignment of organization’s scope of program or other activities with its mission, priorities and managerial capabilities.
- Quality of implementation of plans, strategies and programs (e.g., effective and efficient).
- Actionability of objectives and outputs in organization’s work plans.
- Strength of program delivery.
- Clarity of goals and priorities among managers.
- Level of fiscal and operational awareness among managers (e.g., staff can clearly describe their roles and responsibilities).
- Degree of delegation of management responsibility to second-level managers.
- Evidence of effective staff involvement and teamwork in planning and work.
- Nature and quality of planning, decision-making and benchmarking processes (e.g., iterative).
- Skill level of top management and middle management.
- Level of autonomy of management.
- Depth of organizational management.
- Management style (e.g., participatory and enabling).
- Ethics of leaders (e.g., ethical behavior exhibited, number disciplinary cases reported).
- Receptivity of organization’s leaders to change and modernization.
- Evidence of effective organizational innovation and learning.

### Functional Capacity: Evaluate

| Overall Question | Does the organization’s leadership have the capacity to design, establish and manage a system for measuring financial and operational performance of the organization? |
### Additional Questions

- Does the organization’s leadership have the capacity to:
  - Develop, agree upon and evaluate measurable objectives and goals for all levels of the organization?
  - Set output and outcome targets, balancing the organization’s resources and expectations of stakeholders?
  - Conduct benchmarking to drive improvement?

### Indicators

- Level of awareness and understanding of program outcomes among organizational managers.
- Measurement of program outcomes.
- Degree to which M&E systems and practices yield an evidence-based foundation for planning, decision-making and learning.
- Strength of the organization (meets at least xx% of its targeted objectives, improvements, etc.).
- Impact on the local, national and international economy and society.

### 2.3 Leadership - Additional areas of exploration

<table>
<thead>
<tr>
<th>Additional areas of exploration</th>
<th>Motivation</th>
<th>Innovation</th>
<th>Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Does the organization’s leadership have the capacity to:</td>
<td>- Does the organization’s leadership have the capacity to:</td>
<td>- Does the organization’s leadership have the capacity to:</td>
</tr>
<tr>
<td></td>
<td>- Encourage teamwork?</td>
<td>- Plan, manage and encourage modernization and innovation?</td>
<td>- Develop key messages about the organization (objectives, plans, policies, procedures and performance)?</td>
</tr>
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<td></td>
<td>- Create environment that is conducive to achieving progress?</td>
<td>- Steer change process efficiently (i.e., using milestones, benchmarks, steering groups, follow-up reporting)?</td>
<td>- Develop and leverage channels to communicate these key messages?</td>
</tr>
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<td></td>
<td>- Motivate and support employees to reach their goals in support of organizational objectives?</td>
<td></td>
<td>- Generate public awareness, reputation and recognition of the organization (i.e., image building)?</td>
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<td>- Demonstrate willingness to change by accepting constructive feedback and suggestions for improving leadership style?</td>
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</table>
Core Issue
3.0 Knowledge

Context (per UNDP Practice Note on Capacity Assessment)
Knowledge refers to the creation, absorption and diffusion of information and expertise towards effective development solutions. What people know underpins their capacities and hence capacity development. Knowledge needs can be addressed at different levels (national/local/sector, primary/secondary/tertiary) and through different means (formal education, technical training, knowledge networks and informal learning). While the growth and sharing of knowledge is primarily fostered at the level of the individual, it can also be stimulated at the level of organizations, for example, through a knowledge management system or an organizational learning strategy. At the level of society, knowledge generation and exchange are supported, for example, through educational policy reform, adult literacy campaigns and legislation on access to information.

3.2 Knowledge – Organizational level

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<tr>
<td><strong>Overall Question</strong></td>
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</tbody>
</table>
| **Additional Questions** | Does the organization have the capacity to:  
- Understand the importance of knowledge and learning for the success of the organization/organizational development?  
- Understand that it has a role to play in promoting and sustaining knowledge in the organization?  
- Priorities knowledge and learning and integrate it into its organizational vision?  
- Develop competency profiles and identify what current and future knowledge/skills are required for organizational effectiveness? |
|--------------------------|--------------------------------------------------------------------------------------------------|
| **Indicators** | An organizational vision that recognizes and emphasizes the importance of knowledge and learning.  
- An up-to-date mapping of the organization’s knowledge and education capacity assets and needs.  
- Dedicated staff responsible for knowledge/learning/training.  
- The existence, quality and use of competency profiles.  
- A mapping of the policies, programs and activities of other/similar organizations. |

### Functional Capacity: Formulate Policies and Strategies

<table>
<thead>
<tr>
<th><strong>Overall Question</strong></th>
<th>Does the organization have the capacity to formulate strategies to achieve their vision for knowledge generation and retention?</th>
</tr>
</thead>
</table>
| **Additional Questions** | Does the organization have the capacity to:  
- Identify which type of knowledge or training would be most appropriate to meet its vision? |
| **Indicators** | Existence and quality of an organizational knowledge/skills development strategy |

### Functional Capacity: Budget, Manage and Implement

<table>
<thead>
<tr>
<th><strong>Overall Question</strong></th>
<th>Does the organization have the capacity to mobilize and manage the resources needed to implement their knowledge/skills development strategy?</th>
</tr>
</thead>
</table>
| **Additional Questions** | Does the organization have the capacity to:  
- Incorporate knowledge/skills development activities into its budget  
- Manage the budget for knowledge/skills development  
- Identify opportunities for partnership and develop partnerships |
| **Indicators** | Existence and size of a budget envelope for knowledge/skills development.  
- Extent to which the knowledge/skills development strategy is being implemented within the given timeframe.  
- Partnerships with other organizations in this area. |
## Functional Capacity: Evaluate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>• Does the organization have the capacity to evaluate the outputs and outcomes of its knowledge development/skills strategy?</th>
</tr>
</thead>
</table>
| Additional Questions | • Does the organization have the capacity to:  
  - Design and use feedback systems (ensure link between M&E findings and decision-making processes)  
  - Communicate the findings of their M&E to relevant stakeholders  
  - Set indicators and benchmarks for outputs and outcomes of their knowledge efforts  
  - Assess changes in staff competence to fulfill their functions |
| Indicators | • Availability and quality (comprehensiveness, frequency of use) of competency assessment frameworks  
• Availability and quality of indicators and benchmarks for outputs and outcomes |

### 3.3 Knowledge - Additional areas of exploration

| Additional areas of exploration | Training | • Does the organization have the capacity to:  
  - Develop a training plan based on current and future organizational and individual needs?  
  - Ensure that training and development plans are developed and monitored for all employees?  
  - Ensure that leadership skills are developed throughout the organization?  
  - Ensure that interpersonal skills and abilities to deal with customers, citizens are developed?  
  - Ensure that new hires are supported and assisted, e.g., through coaching, tutoring?  
  - Leverage modern training methods, e.g., multi-media approach, on the job training, eLearning? |

### Core Issue

#### 4.0 Knowledge

**Context**  
(per UNDP Practice Note on Capacity Assessment)  
Accountability exists when two parties adhere to a set of rules and procedures that govern their interactions and that are based on a mutual agreement or understanding of their roles and responsibilities vis-à-vis each other. Put differently, it exists when rights holders and duty bearers both deliver on their obligations. This manifests itself in day-to-day engagements, such as in the relationship between a service provider and a client, between a teacher and a student, between an employer and an employee, between a state and its citizens, between a provider of
development aid and its recipients and so on. Why is accountability important? It allows organizations and systems to monitor, learn, self-regulate and adjust their behavior in interaction with those to whom they are accountable (clients, citizens, partners). It provides legitimacy to decision-making, increases transparency and helps reduce the influence of vested interests. Accountability is therefore a key driver of development results. It includes the creation and use of space and mechanisms that engage both rights holders and duty bearers in a dialogue to monitor and steer their actions, such as through peer review mechanisms or public oversight bodies.

4.2 Accountability – Organizational Level

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
<td>Does the organization have the capacity to develop accountability mechanisms that ensure multi-stakeholder participation?</td>
</tr>
<tr>
<td><strong>Additional Questions</strong></td>
<td>Does the organization have the capacity to:</td>
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<tr>
<td></td>
<td>- Lead stakeholders through the process of developing accountability mechanisms?</td>
</tr>
<tr>
<td></td>
<td>- Publish procedures and criteria for administrative decisions in local language(s)?</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
<td>Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders to discuss formulation and implementation of the organization’s accountability mechanisms.</td>
</tr>
<tr>
<td></td>
<td>Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.</td>
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<tr>
<td></td>
<td>Existence of customer charters’ (or similar undertakings) that establish the obligations of service providers and the rights of users.</td>
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<td></td>
<td>Level of opportunity among employees to express their views to management.</td>
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<tr>
<th>Functional Capacity: Assess a Situation and Define Vision and Mandate</th>
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<tbody>
<tr>
<td><strong>Overall Question</strong></td>
<td>Does the organization have the capacity to frame, manage and interpret a comprehensive analysis of the accountability mechanism environment? Does the organization have the capacity to create a vision for robust accountability mechanisms?</td>
</tr>
<tr>
<td><strong>Additional Questions:</strong></td>
<td>Does the organization have the capacity to:</td>
</tr>
<tr>
<td></td>
<td>- Design and use systems for recording and processing sector-relevant data?</td>
</tr>
</tbody>
</table>
### Indicators
- Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact.
- Quality of action taken as a result of critical events analysis of opportunities and threats of most significance to the organization’s mutual accountability mechanisms.

### Functional Capacity: Formulate Policies and Strategies

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop and manage accountability mechanisms to ensure formulation of clear and transparent policies and strategies?</th>
</tr>
</thead>
</table>
| Indicators       | Existence of organizational structures of accountability to clients and constituents.  
|                  | Quality of mechanisms that ensure mutual accountability.                                                                 |

### Functional Capacity: Budget, Manage and Implement

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop, manage and enforce accountability mechanisms regarding program budgeting, management and implementation?</th>
</tr>
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<tbody>
<tr>
<td>Additional Questions</td>
<td>Does the organization have the capacity to budget, manage and implement programs to develop accountability mechanisms?</td>
</tr>
</tbody>
</table>
| Indicators       | Alignment of mutual accountability program with government’s mission, priorities and managerial capacities.  
|                  | Clarity and awareness of mutual accountability goals and priorities among leaders.  
|                  | Degree of enforcement of mutual accountability mechanisms.  
|                  | Extent to which societal changes are integrated into the organization’s mutual accountability mechanisms.  
|                  | Existence of mechanism (e.g., law, convention) to oblige decision-makers to give reasons for their decisions.  
|                  | Existence of continuing efforts to streamline bureaucracy rendering it more open, efficient and user-friendly for the public. |

### Functional Capacity: Evaluate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to develop and manage accountability mechanisms for evaluation?</th>
</tr>
</thead>
</table>
### Additional Questions

- Does the organization have the capacity to:
  - Evaluate the development and implementation of accountability mechanisms?
  - Develop policies, frameworks and mechanisms for receiving and processing complaints about organizational performance?
  - Comply with international agreements, frameworks, norms, standards related to organizational accountability?
  - Make budget figures publicly available?
  - Prepare and release to the general public updates on organizational developments on a periodic basis either free of charge or at cost?
  - Ensure independent audits are conducted?
  - Provide access to the general public to gift and hospitality registers?
  - Systematically document good and bad practices, learn from mistakes and reward staff for confronting rather than concealing errors?
  - Make public its obligations as a service provider and the rights of its clients (employees, customers), including the right to complain and the process for lodging a complaint?
  - Make timely and truthful information available to all media, without bias or preference?

### Indicators

- Existence of clear and well understood policies, procedures and other mechanisms:
  - Conflict of interest policies, which serve as an effective barrier to members of management from using their positions for personal benefit or interfering in day-to-day administration.
  - Complaint mechanisms (whistleblower protection), and staff has confidence in them.
  - Effectiveness of organizational oversight, access to resource functions (e.g., ombudsman).
  - Receptivity to and action taken on recommendations of external auditors.
  - Accountability of managers for the corruption / inadequate performance of their subordinates.
  - Transparency and accessibility of gift and hospitality registers to the public.
  - Frequency of rotation of employees in vulnerable positions so as to periodically change their physical / functional assignments.
  - Level of citizen/customer satisfaction.
  - Adherence to published service standards (e.g., customers” charters).
  - Level of responsiveness and pro-active behavior.
  - Degree of flexibility and ability to address individual situations.
• Range of internal indicators to measure results achieved (e.g., number of complaints received, responded to; extent of effort to improve public trust in the organization and its services or products)

4.2 Accountability - Inclusion, Participation, Equity and Empowerment – Organizational Level

Context

This category pertains to the capacity for inclusion, participation, equity and empowerment of individuals across all the functional capacities. It covers the systems, process and tools required to assess the vulnerability, exclusion and marginalization of peoples. It also looks at the public space for dialogue and debate, state-citizen consultation and feedback processes.

<table>
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<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
<tr>
<td>• Does the organization have the capacity to engage stakeholders in the process of developing public engagement policies, frameworks and mechanisms?</td>
</tr>
<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>• Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Develop and implement partnerships and networks with key stakeholders, i.e., employees, citizens, customers?</td>
</tr>
<tr>
<td>- Create forums for consultation with external, public, private and civil institutions, e.g., consultation groups, surveys, opinion polls?</td>
</tr>
<tr>
<td>- Ensure that the general public has formal access to and actively participate in public decision-making meetings?</td>
</tr>
<tr>
<td>- Increase representation and participation of marginalized and excluded peoples?</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td>• Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders on issues relating to inclusion, participation, equity and empowerment.</td>
</tr>
<tr>
<td>• Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.</td>
</tr>
<tr>
<td>• Frequency and effectiveness of periodic publicity campaigns (in local languages) explaining the procedures and criteria for administrative decisions or processes.</td>
</tr>
<tr>
<td>• Level of effort to involve citizens/customers in the design of services or products and in decision-making processes.</td>
</tr>
</tbody>
</table>
| • Level of civic engagement and bottom-up influence on the
organization’s policy agenda and development.
- Degree of organizational support for effective functioning of CSO/CBOs.
- Existence of special and/or provisional measures to ensure partnerships with all excluded groups.

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<tbody>
<tr>
<td><strong>Overall Question</strong></td>
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<tr>
<td>Does the organization have the capacity to frame, manage and interpret a comprehensive situation analysis for broad and meaningful participation? Does the organization have the capacity to create a vision for broad and meaningful participation?</td>
</tr>
<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Enable equitable, broad and meaningful participation in conducting situation analyses and creating a vision?</td>
</tr>
<tr>
<td>- Involve citizens, customers in the design and improvement of products and services?</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td>Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on the organization’s policies relating to inclusion, participation, equity and empowerment.</td>
</tr>
<tr>
<td>Quality of action taken as a result of critical events’ analysis of opportunities and threats of most significance to the organization’s inclusion, participation, equity and empowerment policies.</td>
</tr>
<tr>
<td>Adequacy of avenues to ensure equitable/broad and meaningful participation in situation analyses.</td>
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<table>
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<tr>
<td><strong>Overall Question</strong></td>
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<tr>
<td>Does the organization have the capacity to ensure involvement of interested parties throughout the process of developing policies and strategies?</td>
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<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>Does the organization have the capacity to:</td>
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<tr>
<td>- Develop policies that encourage involvement of interested parties?</td>
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<tr>
<td>- Develop clear and simple policies using simply language?</td>
</tr>
<tr>
<td>- Involve employees, customers, citizens and other stakeholders in the development of quality standards for services, products and information</td>
</tr>
<tr>
<td>- Involve employees, customers, citizens in the design and development of information sources and channels?</td>
</tr>
</tbody>
</table>
### Indicators
- Quality of mechanisms that ensure inclusion, participation, equity and empowerment.
- Extent to which societal changes are integrated into the organization’s inclusion, participation, equity and empowerment policies and mechanisms.
- Existence of long-term strategic policy options for inclusion, participation, equity and empowerment.

### Functional Capacity: Budget, Manage and Implement

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to involve citizens/customers in the development and delivery of programs and services?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
- Encourage employees, customers, and customers to organize themselves and support citizens’ groups?  
- Ensure a proactive information policy, e.g., about their processes  
- Ensure that employees, customers, citizens are treated individually?  
- Ensure that appropriate and reliable information, assistance and support are given to employees, customers, citizens?  
- Provide accessibility of the organization, e.g., flexible opening hours, documents in both paper and electronic versions?  
- Conduct electronic communication and interaction with employees, customers and citizens? |

| Indicators | Alignment of inclusion, participation, equity and empowerment programme with the organization’s mission, priorities and managerial capacities.  
Clarity and awareness of inclusion, participation, equity and empowerment goals and priorities among management.  
Degree of enforcement of inclusion, participation, equity and empowerment mechanisms.  
Extent of use of new and innovative ways of dealing with citizens/customers. |

### Functional Capacity: Evaluate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to ensure availability and accessibility of communication and feedback mechanisms for employees, customers and other key stakeholders to be heard?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
- Evaluate the development and implementation of public engagement frameworks and mechanisms?  
- Ensure transparency of the organization, including decision-making and developments, e.g., by publishing annual reports, holding press conferences, posting information on the internet? |
| Indicators | • Existence of clear and well understood inclusion and feedback mechanisms.  
• Existence of mechanisms to register the voice of customers and employees and their perceptions.  
• Accessibility of organization’s management to the media.  
• Availability of information.  
• Number and quality of citizen/customer suggestions received, recorded, acted upon.  
• Degree to which management seeks suggestions and collects ideas for improvement. |

### 4.6 Accountability - Access to information – Organizational Level

**Context**
A second component of this category pertains to the mobilization, access and use of information and knowledge. Attention is given to access to and use of the Internet, the role of the media, the adaptation of global knowledge to local circumstances, knowledge networking, and incentives to encourage learning.

<table>
<thead>
<tr>
<th>Functional Capacity: Engage Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Question</strong></td>
</tr>
</tbody>
</table>
| **Additional Questions** | • Does the organization have the capacity to:  
- Engage stakeholders in the process of developing policies, frameworks and mechanisms to ensure access to information and knowledge?  
- Publish public information in local language(s)? |
| **Indicators** | • Existence and effectiveness of dialogue mechanisms (and other links as appropriate) between the organization and relevant domestic and external stakeholders on issues relating to access to information and knowledge.  
• Quality (e.g., transparent, participatory, engaged, respective) and frequency of dialogue between the organization and domestic and external stakeholders.  
• Availability of public information in local dialects for dissemination to local users.  
• Degree of effort aimed at administrative simplification (e.g., use of simple language). |
## Functional Capacity: Assess a Situation and Define Vision and Mandate

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to frame, manage and interpret a comprehensive situation analysis of the environment relating to access to and provision of information? Does the organization have the capacity to create a vision for equitable, broad and meaningful access to information and knowledge?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Questions</td>
<td>Not Available</td>
</tr>
</tbody>
</table>
| Indicators       | Quality of analysis of environmental influences (at the appropriate level, e.g., market, sector) and their relative degree of impact on policies relating to access to information and knowledge.  
                   Quality of action taken as a result of critical events’ analysis of opportunities and threats of most significance to the organization’s access to information and knowledge policies. |

## Functional Capacity: Formulate Policies and Strategies

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to put in place a policy and blueprint (long-term and strategic goals and plans) for information, knowledge and communications?</th>
</tr>
</thead>
</table>
| Additional Questions | Does the organization have the capacity to:  
                   - Develop an information and knowledge management policy covering content and content architecture, infrastructure, human resources, budget and processes, including information and knowledge creation, storage/archiving, quality management, strategic utilization, security and dissemination?  
                   - Develop a policy to integrate information technologies in accordance with strategic and operational objectives? |
| Indicators       | Existence of organizational policy and blueprint for information, knowledge and communications.  
                   Transparency of organizational policies and code of ethics in information management.  
                   Existence of long-term strategic policy options for access to information and knowledge.  
                   Degree, quality and enforcement of mechanisms that ensure access to information and knowledge.  
                   Extent to which societal changes are integrated into the organization’s access to information and knowledge policies and mechanisms. |

## Functional Capacity: Budget, Manage and Implement

<table>
<thead>
<tr>
<th>Overall Question</th>
<th>Does the organization have the capacity to provide technological, communications and information resources and networks required for the development and delivery of programs and services?</th>
</tr>
</thead>
</table>
### Additional Questions

- Does the organization have the capacity to:
  - Budget, manage and implement programs to ensure technological, communications and information resources and networks are in place?
  - Use an information and knowledge management system?
  - Ensure accessibility and utility of the organization's information services to clientele including disadvantaged groups?
  - Ensure adequacy of personnel skills in electronic access to and management of information?
  - Ensure that all employees have access to the knowledge relevant to their objectives and tasks?
  - Ensure the accuracy, reliability and security of information?
  - Develop and use internal channels to spread information throughout the organization, e.g., internet, newsletters, illustrated magazines?
  - Ensure that externally available information is processed and used effectively?
  - Present information in a user-friendly manner?
  - Ensure that knowledge of employees leaving the organization is retained?

### Indicators

- Existence of organizational information and knowledge management system covering content and content architecture, infrastructure, human resources, budgets and processes, including information and knowledge creation, storage/archiving, quality management, security and dissemination.
- Alignment of access to information and knowledge program with the organization's mission, priorities and managerial capacities.
- Clarity and awareness of access to information and knowledge goals and priorities among organizational leadership.
- Degree of enforcement of access to information and knowledge mechanisms.
- Extent of efforts to improve availability, accuracy and transparency of information.
- Extent to which information is shared openly within the organization.
- Level of access to technological resources needed to operate efficiently.
- Adequacy of personnel skills in electronic access to and management of information.

### Functional Capacity: Evaluate

<p>| Overall Question | Does the organization have the capacity to ensure, through evaluation mechanisms, access to information and knowledge for all |</p>
<table>
<thead>
<tr>
<th>Stakeholders (e.g., employees, customers)?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Questions</strong></td>
</tr>
<tr>
<td>• Does the organization have the capacity to:</td>
</tr>
<tr>
<td>- Evaluate access to information and knowledge?</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
</tr>
<tr>
<td>• Existence of system for generating internal and external feedback on effectiveness of information services.</td>
</tr>
<tr>
<td>• Degree of customer access to organizational knowledge.</td>
</tr>
<tr>
<td>• Amount and quality of information available; transparency of information.</td>
</tr>
</tbody>
</table>

4.7 Accountability - Additional areas of exploration – Organizational level

<table>
<thead>
<tr>
<th><strong>Additional areas of exploration</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judiciary</strong></td>
</tr>
<tr>
<td>• Do judges have the capacity to:</td>
</tr>
<tr>
<td>- Exercise jurisdiction to review the lawfulness of government decisions? If so, are these powers used? Are decisions respected and complied with by the government? Is there a perception that the Executive gets special treatment, be it hostile or preferential? Do the judges have adequate access to legal development in comparable systems elsewhere?</td>
</tr>
<tr>
<td>- Do authorities have the capacity to:</td>
</tr>
<tr>
<td>- Ensure that members of the legal profession make sufficient use of the courts to protect their clients and to promote just and honest government under the law?</td>
</tr>
<tr>
<td>- Ensure access to the courts is as open and simple as it can be?</td>
</tr>
<tr>
<td>- Ensure that legal requirements are not unnecessarily complicated?</td>
</tr>
<tr>
<td>- Ensure that appointments to the senior Judiciary are made independent of other arms of government?</td>
</tr>
<tr>
<td><strong>Local Government</strong></td>
</tr>
<tr>
<td>• Do authorities have the capacity to:</td>
</tr>
<tr>
<td>- Ensure that government is democratically accountable?</td>
</tr>
<tr>
<td>- Ensure that government is subject to independent audit?</td>
</tr>
<tr>
<td>- Ensure that meeting of local bodies are held in public unless there is a legal basis for being restricted?</td>
</tr>
<tr>
<td>Question Sent to Participants</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
</tbody>
</table>
| How did/do you manage risk? (Risk typically includes the management of time/schedules, resources are allocated to an effort, funding, worker transition, adaption to local cultural issues, etc.) | Does the organization the capacity to:  
- Identify and analyze the risks and rewards of potential financial decisions and weigh trade-offs in developing its financial plan? | Risk was a central concept for identifying how the leadership of an NGO accounted for the myriad of problems that can and do, typically arise during the implementation of a program. This CAF limited risk to its financial aspects, but this study sought to understand the wider connotations. The original question was modified to take into account a wider range of possibilities and nested under the development of strategic objectives. |
| What kinds of transition mechanisms did you build into your project(s) that allowed the local community to continue building on positive outcomes? | Does the organization have the capacity to:  
- Sustain activities and results once programs and projects are internalized within government’s existing programs? | Program sustainability was deemed critical to the development of a national capacity. The original question was modified to seek an understanding beyond “if” the NGO had the capacity and instead focused on “how” the sustainment of activities |
<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The leadership of my organization has the skills and experience to develop a comprehensive strategy that supports both current projects and future efforts.</td>
<td>Does the organization’s leadership have the capacity to establish appropriate frameworks for managing policies, legislations, strategies, programs and projects?</td>
<td>The original CAF question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>The leadership of my organization is able to easily adjust its mission, values, and methods according to changes in the operating environment.</td>
<td>Does the organization’s leadership have the capacity to: - Adjust its vision, mission and values; reorganize; and improve strategies and methods according to changes in the operating environment?</td>
<td>The original CAF question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>The community had/has the opportunity to provide feedback throughout the implementation of my organization’s project(s).</td>
<td>Does the organization have the capacity to engage stakeholders in the process of developing public engagement policies, frameworks and mechanisms?</td>
<td>The original CAF question was restated in order to allow for a better response when presented in a Likert scale type format. Stakeholders were identified primarily as the communities where indigenous NGOs implemented their projects.</td>
</tr>
<tr>
<td>My organization trains members of the local community to take over projects once organizational objectives have been met.</td>
<td>Does the organization have the capacity to: - Sustain activities and results once programs and projects are</td>
<td>This question supported the question, “What kinds of transition mechanisms did you build into your project(s) that allowed the local community to</td>
</tr>
</tbody>
</table>
internalized within government's existing programs?

continue building on positive outcomes?" The Likert scale type format was meant to provide an additional perspective and check the consistency of a participant’s answers. The original CAF question was modified to allow for a better response when presented in a Likert scale type format.

My organization has a long term plan/process in place to monitor the continued success of projects after they have ended.

Indicator - Existence of long-term strategic policy options for inclusion, participation, equity and empowerment. Reference the formulation of long term policy.

The CAF used several indicators that could be used to guide and assess questions. This indicator, noted within a section emphasizing the development of long term policy, was deemed critical to the development of sustainable programs and community transition mechanisms. Elements of the indicator formed the basis of the Likert scale type question.

### Capability Questionnaire – Open Ended Questions

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What types of skills are most in demand (or would you like to have) both within your organization and in the areas where you operate?</td>
<td>Indicator - Adequacy of staff in all key positions. Reference to human resource capacity.</td>
<td>The CAF used several indicators that could be used to guide and assess questions. This indicator, noted within a section emphasizing the human resource aspect of the NGO, was modified to an open-ended format question. The final</td>
</tr>
<tr>
<td>Question</td>
<td>Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>How do you manage shortfalls in essential skills while implementing a</td>
<td>Indicator - Adequacy of staff in all key positions. Reference to human</td>
<td>The CAF used several indicators that could be used to guide and assess questions. This indicator, noted within a section emphasizing the human resource aspect of the NGO, was modified to an open-ended format question. This question focused on problems that can arise during the implementation of a project due to changes in staffing and provides insight on how programs are managed on a daily basis.</td>
</tr>
<tr>
<td>project?</td>
<td>resource capacity.</td>
<td></td>
</tr>
<tr>
<td>How does your organization develop a financial plan to manage a full</td>
<td>Does the organization have the capacity to develop a financial plan and policies?</td>
<td>The original CAF question was restated in order to allow for a better response when presented in an open-ended format. The focus of the question sought to determine how the financial planning occurred instead of merely identifying that the capacity was in place.</td>
</tr>
<tr>
<td>range of projects?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What internal controls are in place to prevent theft or misappropriation of cash and other assets while</td>
<td>Does the organization have the capacity to develop, manage and enforce accountability mechanisms regarding program</td>
<td>The original CAF question was restated in order to allow for a better response when presented in an open-ended format. It was</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question Sent to Participants</td>
<td>Question Root</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>My organization has a high turn-over rate.</td>
<td>Indicator - Staff turnover rate. Reference to human resource capacity.</td>
<td>The CAF used several indicators that could be used to guide and assess questions. This indicator, noted within a section emphasizing human resource management within the NGO. A staff turnover rate, as an indicator, was restated as a Likert scale type format question in order to allow for a better response.</td>
</tr>
<tr>
<td>My organization regularly reviews and analyzes current and future human resource needs in terms of knowledge, skills, and attitudes.</td>
<td>Does the organization have the capacity to: - Regularly analyze current and future human resource needs, at the organizational and individual levels, in terms of knowledge, skills and attitudes?</td>
<td>The original CAF question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>My organization has clearly documented policies and mechanisms that ensure financial accountability.</td>
<td>Does the organization have the capacity to develop, manage and enforce accountability mechanisms regarding program budgeting, management and implementation?</td>
<td>The original CAF question focused on if an NGO has the ability to create accountability mechanisms. This question was modified to demonstrate that these types of mechanisms were</td>
</tr>
</tbody>
</table>

Implementing a project?

Budgeting, management and implementation?

Thought that the original CAF question attempted to include too much data and thus needed to be scaled down to meet the intent of this study.
not only developed, but put into place within the organization. Furthermore, the question was modified with the intent of sending to participants in a Likert scale type format.

| My organization is accountable to the community where we serve. | Does the organization have the capacity to develop accountability mechanisms that ensure multi-stakeholder participation? | The original CAF question was restated in order to allow for a better response when presented in a Likert scale type format. A further modification was made to the question to better emphasize local community involvement. Community interaction was viewed as an important aspect of developing sustainable programs. |
APPENDIX H: PEACE CORPS NGO CAPACITY DEVELOPMENT PROFILE
QUESTION SET

Questions included in this appendix were taken directly from the Peace Corps NGO
Capacity Profile (Peace Corps, 2003, p. 89-110). Tables were reformatted in order to
ensure that data was both legible and accurately depicted within this appendix.

1. PROGRAMS

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
<th>Indicators of an NGO with Limited Capacity</th>
<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent do the NGO’s programs reflect the real needs of the community or constituency it serves?</td>
<td>Program development is largely donor driven. The founder(s) designs, implements, and monitors program activities. The NGO views constituents as worthy, but passive, beneficiaries of the services, not as potential partners. The demand for the NGO’s programs has not been determined.</td>
<td>Programs are developed within an overall strategic plan. Constituents’ role is usually as recipient. Certain influential members of the constituency may be consulted and/or invited to participate in some programming discussions. Demand for the NGO’s programs is increasing.</td>
<td>Constituents are recognized as partners and regularly involved in comprehensive program design, implementation, and evaluation. Lessons learned are applied to future programming activities. Full-scale advocacy and lobbying functions are in place. NGO strives for continuous quality improvement of programs.</td>
</tr>
<tr>
<td>Who is involved in designing, implementing, and monitoring program activities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do NGO programs advocate for constituents as well as provide program services to them?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TECHNICAL SECTOR EXPERTISE

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
<th>Indicators of an NGO with Limited Capacity</th>
<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the technical strengths of the NGO’s programs?</td>
<td>NGO has a limited track record in the sector and area of service delivery but has some good ideas for meeting the needs of target constituencies.</td>
<td>NGO is recognized as having significant experience in sector and contributing to sector growth.</td>
<td>NGO is able to adapt programs to changing needs of constituency and to extend service delivery to additional constituencies.</td>
</tr>
<tr>
<td>Does the NGO have access to technical sector experience when required?</td>
<td></td>
<td>Improved targeting of clients and redefined service/technical package.</td>
<td>NGO is recognized for sector expertise and asked to consult on similar projects.</td>
</tr>
<tr>
<td>How well is the NGO performing technically in comparison with similar NGOs?</td>
<td></td>
<td>NGO has ability to access additional sector expertise when required.</td>
<td></td>
</tr>
</tbody>
</table>


# PROGRAM EVALUATION/ASSESSMENT

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
<th>Indicators of an NGO with Limited Capacity</th>
<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What changes in people’s lives occurred as a result of the NGO’s programs?</td>
<td>The NGO has not determined impact indicators or established baseline measurements.</td>
<td>The NGO is aware of the value of evaluating its programs and is exploring how to measure impact.</td>
<td>Measurable indicators of success and impact have been determined for each program goal.</td>
</tr>
<tr>
<td>How is the NGO’s impact and performance measured?</td>
<td>Members of the NGO can recount stories of how individuals have been helped by the NGO’s programs.</td>
<td>Program objectives may or may not be measurable; they may be tangible or intangible.</td>
<td>Studies are done that provide baseline measures, and these data are regularly confirmed and used.</td>
</tr>
<tr>
<td>What information has been gathered to verify that the NGO’s programs are meeting the community’s/ client’s needs?</td>
<td></td>
<td>The NGO can determine cost per client served.</td>
<td>Monitoring and evaluation system are in place; conducted by staff on regular basis.</td>
</tr>
<tr>
<td>How is the NGO performing in comparison with other NGOs?</td>
<td></td>
<td></td>
<td>Cost-benefit data are maintained. Trends are analyzed and used in decision making.</td>
</tr>
<tr>
<td>How cost-effective are the benefits of the NGO’s programs?</td>
<td></td>
<td></td>
<td>NGO shares lessons learned and programming evaluation practices with other NGOs.</td>
</tr>
</tbody>
</table>
## 2. GOVERNANCE
### BOARD OF DIRECTORS

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
<th>Indicators of an NGO with Limited Capacity</th>
<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the board provide overall policy direction for the NGO?</td>
<td>Board members are identified.</td>
<td>Board membership is stable or improving.</td>
<td>Board composition includes leaders in the field of the organization’s mission as well as those capable of providing policy direction, fundraising, public relations, and lobbying.</td>
</tr>
<tr>
<td>How does the board provide oversight of the NGO’s management?</td>
<td>Board does not yet differentiate between oversight and management roles.</td>
<td>Board differentiates between board’s role and that of NGO’s management.</td>
<td>Board has mechanisms in place for obtaining appropriate input from constituency, for monitoring organizational planning, and functioning in relation to mission.</td>
</tr>
<tr>
<td>How does the board provide fundraising leadership?</td>
<td>Board is not active in influencing public opinion or legislators, or raising funds for the NGO.</td>
<td>Board is aware of responsibilities to provide oversight.</td>
<td>Board terms are defined.</td>
</tr>
<tr>
<td>How does the board assist with public relations activities?</td>
<td>Board meetings are infrequent or irregular.</td>
<td>Board is beginning to influence public opinion and/or legislators, fundraise, and perform public relations activities.</td>
<td>Procedures are in place for selecting and orienting new board members.</td>
</tr>
<tr>
<td>How often does the board meet?</td>
<td>The NGO’s constituency is not represented on the board.</td>
<td>Board membership represents some community diversity.</td>
<td></td>
</tr>
<tr>
<td>What is the expertise and experience of board members?</td>
<td>Board members are founders or selected by founders.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How are board members selected?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions to Ask About Service Deliver</td>
<td>Indicators of an NGO with Limited Capacity</td>
<td>Indicators of an NGO with Growing Capacity</td>
<td>Indicators of an NGO with a High Level of Capacity</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Does the NGO mission statement accurately reflect its vision/mission?</td>
<td>The vision/mission is generally understood by the NGO’s founder(s).</td>
<td>The mission is clear to board and staff; strategies, goals, and objectives are based on the mission.</td>
<td>The mission is clear to board, staff, constituents, and interested parties outside the NGO.</td>
</tr>
<tr>
<td>Was the vision/mission determined through a participatory process?</td>
<td>Staff may perform functions that support the mission, but there is no systematic design of job functions based on the mission.</td>
<td>Operational planning is conducted by management and linked to vision/mission but without staff or constituents’ input.</td>
<td>Operating plan grows out of the mission and translates into a set of clear program objectives supported by a realistic budget.</td>
</tr>
<tr>
<td>Is it possible for the NGO to realize its mission?</td>
<td>There may be activities conducted by the members of the NGO that seem unrelated to the mission.</td>
<td>Projects that do not relate to NGO’s mission are sometimes undertaken to secure funding.</td>
<td></td>
</tr>
<tr>
<td>How do the NGO’s programs help achieve the stated mission?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## LEADERSHIP

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who takes leadership responsibility in the NGO?</td>
<td>Within the NGO there are one or a few dynamic individual(s) controlling most functions.</td>
<td>Most decisions are made by the board and management, with some input from select staff.</td>
<td>Board and management have clear understanding of their leadership roles and actively encourage new members to take on leadership roles.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staff is routinely involved in policy development and not just consulted on occasion.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Constituents are encouraged to become involved in leadership roles.</td>
</tr>
</tbody>
</table>
3. MANAGEMENT
INFORMATION MANAGEMENT

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the NGO gather, disseminate, save, and retrieve client, program, and financial information?</td>
<td>No organized system(s) exists for the collection, analysis, or dissemination of data in the NGO.</td>
<td>A rudimentary electronic database system to manage information (MIS) is in place.</td>
<td>MIS operation and data are integrated into operational planning and decision making.</td>
</tr>
<tr>
<td>How is collected information used for planning and decision making?</td>
<td>Information is usually collected randomly and manually.</td>
<td>MIS is used primarily for word processing and bookkeeping; some staff understand database capability.</td>
<td>There is improved project planning based on analysis of information provided through the system.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is no mechanism for integrating MIS-generated information into the NGO’s planning process.</td>
<td>MIS information is readily available to staff management and board.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The NGO learns from MIS information and shares these learnings with stakeholders and other NGOs.</td>
</tr>
</tbody>
</table>
### Questions to Ask About Service Deliver

| Does the NGO have a long-term strategic plan? | Planning is ad hoc with limited participation from staff and constituents. | There may be some input from staff and constituents but they are not involved in decision making. | NGO’s leadership conducts short term strategic planning. |
| Does the NGO do short-term operational planning? | Decisions and plans are made without reference to the mission or the agreed-on strategies to achieve the mission. | Annual operating plans are developed and reviewed throughout the year primarily by management but without connection to review of previous year or analysis of resource availability. | The board decides on program priorities and the use of available resources. |
| How are staff and constituents involved in the planning process? | Staff is responsible for plan implementation, and clients are not involved in planning. | | Each NGO program has an annual operating plan that reflects the mission and is developed with staff and constituent input. |
| Are all plans directed toward achievement of the NGO’s mission? | No assessment of needed resources is included in planning. | | There is a regular review of long term plans based on previous achievements. |
## COMMUNICATION

### Questions to Ask About Service Deliver

| How often are staff meetings held? | Meetings are irregular and dominated by interests of a few. |
| Do staff meetings have an agenda? | There is no predetermined agenda at staff meetings, and staff often does not reach concrete conclusions. |
| Are minutes taken at staff meetings and available for future reference? | Staff provides technical input only and is not involved in or informed of decisions. |
| | No systematic procedure for recording or storage of minutes of staff meetings. |

### Indicators of an NGO with Limited Capacity

| | Staff knows how to participate in meetings and is aware of how decisions are made. |
| | Mechanisms exist for vertical and horizontal communication. |
| | A meeting agenda and minute record keeping are standard operating procedures. |

### Indicators of an NGO with Growing Capacity

<p>| | Staff is increasingly able to shape the way they participate in decision making. |
| | Communications are open and transparent. |
| | Client and other stakeholder input is included at staff meetings when appropriate. |</p>
<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the organizational chart show the most significant units or functions of the NGO?</td>
<td>Supervisors organize work. There is little understanding of the necessity to organize work beyond issuing directives.</td>
<td>Organizational chart exists to explain relationships of work units.</td>
<td>There is a formal mechanism in place for inter-team links and intra-team planning, coordination, and work review.</td>
</tr>
<tr>
<td>Is work organized individually or by teams?</td>
<td>Focus is on individual achievement; there is little understanding of need to work as a team.</td>
<td>There is recognition of the need to create a collaborative work environment.</td>
<td>Teams are self-directed in that they organize their own work around clear understanding of the organization’s mission and the team’s role in achieving the mission.</td>
</tr>
<tr>
<td>Are job tasks and job descriptions consistent with the mission of the NGO?</td>
<td>Hiring is based more on personal connections than applicant’s job skills.</td>
<td>Work plans are developed but not coordinated across positions, functions, or expertise.</td>
<td>Volunteers and constituents are included as active participants in the NGO’s work plan.</td>
</tr>
<tr>
<td>Is there a written employee manual?</td>
<td>Some essential tasks are not carried out because they are not assigned or because the tasks are beyond the expertise of the staff.</td>
<td>Staff is able to make suggestions about how their own work should be organized.</td>
<td>All personnel systems are formalized and understood by staff, and staff members opinions are part of policies and procedures.</td>
</tr>
<tr>
<td>Is hiring a systematic, open process?</td>
<td>Salaries are not determined on the basis of the market value of the work done or performance of individuals.</td>
<td>Basic personnel administration systems exist, but informal employment practices persist.</td>
<td></td>
</tr>
<tr>
<td>Are salaries based on performance and market value of the jobs?</td>
<td></td>
<td>Salary and benefit reward system rewards staff according to job title, not work performed.</td>
<td></td>
</tr>
</tbody>
</table>
### 4. HUMAN RESOURCES

**STAFF**

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
<th>Indicators of an NGO with Limited Capacity</th>
<th>Indicators of an NGO with Growing Capacity</th>
<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff members motivated and committed to the mission of the NGO?</td>
<td>Staff consists of founders and/or unpaid volunteers.</td>
<td>Some gaps exist between job skills required and of existing staff.</td>
<td>Skill areas are competently covered and capacity exists to contract out for other skills as needed.</td>
</tr>
<tr>
<td>Do staff members have the skills and competencies required to support the achievement of the NGO’s mission?</td>
<td>Staff is motivated and committed, but may lack knowledge and skills to implement appropriate programs to achieve the NGO’s mission.</td>
<td>Staff morale is sometimes affected by lack of clarity of their jobs or too much work for available staff.</td>
<td>Interpersonal skills and group training are provided as needed.</td>
</tr>
<tr>
<td>What are the training opportunities for staff to develop job-related skills?</td>
<td>Staff development opportunities are not yet available.</td>
<td>Performance evaluations are ad hoc, mostly when problems surface.</td>
<td>Staff have opportunities to contribute to the organization to the fullest extent of their abilities.</td>
</tr>
<tr>
<td>Are staff members assigned and promoted according to performance?</td>
<td>No system in place for performance evaluation.</td>
<td></td>
<td>Staff performance evaluation done on a regular basis; evaluation criteria are understood by the staff.</td>
</tr>
</tbody>
</table>

Staff morale is high.
### CONSTITUENCY/CLIENTS

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Are constituents seen as human resources of the NGO?</td>
<td>Links with constituency are weak.</td>
<td>There is a well-defined community base and constituency.</td>
<td>Composition of board and staff reflects gender, ethnic, and religious diversity of constituents.</td>
</tr>
<tr>
<td>Does the composition of the board and staff reflect constituency?</td>
<td>Staff and board do not represent constituents on the basis of ethnicity, gender, income, religious, or stakeholder interest.</td>
<td>There is understanding and interest among some board members, management, and staff as to the value and need for representation of constituents, but no policy in place.</td>
<td>There are regular surveys of constituency needs with results integrated into planning process.</td>
</tr>
<tr>
<td>Are constituents treated equally and fairly?</td>
<td>NGO serves existing constituents but does not actively seek new constituents.</td>
<td>NGO welcomes and seeks out new constituents.</td>
<td></td>
</tr>
<tr>
<td>Is the NGO’s constituency growing?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## VOLUNTEERS

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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</tr>
</thead>
<tbody>
<tr>
<td>How do volunteers assist the NGO?</td>
<td>No, or only a few, volunteers are providing services.</td>
<td>Volunteers are mobilized for specific programs/projects.</td>
<td>High integration of volunteers with paid staff.</td>
</tr>
<tr>
<td>Do volunteers have structured tasks?</td>
<td>NGO staff members are unpaid volunteers due to insufficient planning and fundraising.</td>
<td>Management identifies the difference between staff and volunteer duties and activities.</td>
<td>Volunteers are integrated into the planning and evaluation process of the organization.</td>
</tr>
<tr>
<td>How are volunteers mobilized and trained?</td>
<td></td>
<td></td>
<td>Training programs are in place for volunteers.</td>
</tr>
<tr>
<td>Is volunteer help regular and consistent?</td>
<td></td>
<td></td>
<td>Volunteers are recognized and thanked for individual and collective achievements.</td>
</tr>
<tr>
<td>How are volunteers thanked for their service?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 5. FINANCIAL RESOURCES
### ACCOUNTING

<table>
<thead>
<tr>
<th>Questions to Ask About Service Delivered</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Is the accounting system automated?</td>
<td>Accounting tracks only increases and decreases in cash.</td>
<td>A system of accounts including assets, liabilities, fund balance, revenues and expenses is developed and operational.</td>
<td>Financial systems and reports provide reliable current information.</td>
</tr>
<tr>
<td>Do accounting records meet donor’s and government financial reporting requirements?</td>
<td>Financial procedures and reports are incomplete and difficult to understand.</td>
<td>Financial reports are usually timely but still incomplete and with errors and tend to present an optimistic versus realistic picture.</td>
<td>Reports are always timely and trusted, and feed back into financial planning process.</td>
</tr>
<tr>
<td>Are there procedures for reporting and recording in-kind contributions?</td>
<td>Internal reconciliation of bank accounts with cash is done only when there appears to be a problem.</td>
<td>Internal reconciliation of cash is done more often.</td>
<td>Internal monthly or quarterly reconciliation of bank statements and accounting records are done.</td>
</tr>
<tr>
<td>Has NGO ever had an audit?</td>
<td>The NGO has not yet undergone an external accounting review or audit.</td>
<td>Even though NGO recognizes the value of independent audits or external financial reviews, they rarely have them done except to meet donor’s requirements.</td>
<td>Independent audits or external financial reviews are performed with regular and appropriate frequency.</td>
</tr>
<tr>
<td>Does NGO reconcile cash accounts on a regular basis?</td>
<td></td>
<td></td>
<td>The board of directors receives summary financial reports at every regular board meeting.</td>
</tr>
<tr>
<td>How often are financial statements furnished to the NGO’s board of directors?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### BUDGETING

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Does the NGO have a regular budget-planning process?</td>
<td>Budgets are inadequate and infrequent; if they are produced it’s because donors require them.</td>
<td>Budgets are developed for project activities, but projects often go over or under budget by more than 20 percent.</td>
<td>Budgets are an integral part of project management and are adjusted to reflect project implementation results.</td>
</tr>
<tr>
<td>Do financial controls prevent expenditures in excess of budget?</td>
<td>Using budgets as a management tool is not understood, and the reliability of the projections is questionable.</td>
<td>The executive director and/or accountant are the only staff members who know and understand budget information and do not delegate responsibility.</td>
<td>Budgeting is integrated with annual operating plan.</td>
</tr>
<tr>
<td>Are budgets constructed to facilitate cost-benefit analysis?</td>
<td></td>
<td>Donors do not get notice of budget adjustments.</td>
<td>Project staff members are responsible for preparation, justification, and management of project budgets.</td>
</tr>
<tr>
<td>Do budgets show actual costs when known?</td>
<td></td>
<td></td>
<td>Donors are notified when budget adjustments are needed.</td>
</tr>
</tbody>
</table>
## FINANCIAL MANAGEMENT

<table>
<thead>
<tr>
<th>Questions to Ask About Service Deliver</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Are reliable cash flow projections in place to facilitate financial planning?</td>
<td>NGO meets its expenses but not in a timely manner.</td>
<td>NGO meets its expenses in a timely manner.</td>
<td>NGO is expanding its programs and projects, and pays the increased costs in a timely manner.</td>
</tr>
<tr>
<td>Are payroll, petty cash, and basic supply costs paid on time?</td>
<td>Designated project funds and operating funds are not separated in the accounting system or in bank accounts.</td>
<td>Accurate cash flow projections assist management in making cash management decisions.</td>
<td>Adequate controls exist to avoid cross-project financing.</td>
</tr>
<tr>
<td>Are restricted donors’ funds placed in separate bank accounts?</td>
<td>Cash flow projections, if done, tend to be inaccurate.</td>
<td>Account categories exist and project funds are separated, but some temporary project cross financing may occur.</td>
<td>The NGO uses an impressed petty cash fund to track small expenditures, requires two authorized signatures on checks, and uses a voucher system to record inflows and outflows of cash.</td>
</tr>
<tr>
<td>What internal controls are in place to prevent theft or misappropriation of cash and other assets?</td>
<td></td>
<td>Funds not currently needed are regularly deposited in a bank account for safekeeping.</td>
<td>The value of insurance to protect assets is recognized and purchased when available and cost-effective.</td>
</tr>
<tr>
<td>Are funds not currently needed invested to earn a return on the money?</td>
<td></td>
<td></td>
<td>Funds not currently needed are prudently invested to earn interest.</td>
</tr>
</tbody>
</table>
# FUNDING BASE

<table>
<thead>
<tr>
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<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the existing sources of the NGO’s funding?</td>
<td>Funds are solicited for one short-term project and only from one source.</td>
<td>NGO’s funding is from two or more sources with no one exceeding 60 percent.</td>
<td>NGO has funding from three or more sources with no source providing more than 40 percent.</td>
</tr>
<tr>
<td>What is the long-term plan for developing financial resources?</td>
<td>Local fundraising for any income is untried and/or unsuccessful.</td>
<td>There is a developing awareness of local resources, but few resources are actually mobilized.</td>
<td>A long-term funding plan exists that results in the NGO’s self-sufficiency.</td>
</tr>
<tr>
<td>What alternative sources of funding might be available for the NGO?</td>
<td>Project funding is insufficient to meet plans or provide services.</td>
<td>Funding is available for short-term projects, and medium-term funding strategies exist within a funding plan.</td>
<td>All projects have funding plans, and current funds meet project needs.</td>
</tr>
<tr>
<td>What percentage of costs are covered by constituents?</td>
<td>Constituents are not seen as an income source.</td>
<td>NGO is beginning to develop constituent support. Fee-for-service and other cost recovery programs are built into service delivery process.</td>
<td>Basic program delivery can continue even if there is a funding shortfall.</td>
</tr>
<tr>
<td>Does any one source provide more than 40 percent of the NGO’s funding?</td>
<td></td>
<td></td>
<td>Constituent support is evident from their willingness to pay for some services as well as their use of the NGO’s services.</td>
</tr>
</tbody>
</table>
### 6. EXTERNAL RELATIONS
PUBLIC RELATIONS

<table>
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<tr>
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<tbody>
<tr>
<td>To what extent is the NGO known to the public?</td>
<td>NGO is little known outside of its direct collaborators.</td>
<td>NGO is known in its own community, but does little to promote its activities with the general public and government.</td>
<td>NGO mission, programs, accomplishments are clear and are documented.</td>
</tr>
<tr>
<td>What materials does the NGO have that describe its mission, programs, and achievements?</td>
<td>There is no clear image of the NGO articulated and presented to the public.</td>
<td>There is understanding that public relations are a function of NGOs but little understanding of how to implement public relations.</td>
<td>NGO’s work is well known to public and policy makers and used to attract support when necessary.</td>
</tr>
<tr>
<td>Does the NGO make use of mass media to disseminate information about itself and its achievements?</td>
<td>There are no documents or prepared statements available that provide information about the NGO.</td>
<td>The NGO has an annual report.</td>
<td>A public relations plan is implemented.</td>
</tr>
</tbody>
</table>
## LOCAL COLLABORATION/SUPPORT

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>How effective is the NGO in assessing local financial, human, and other resources?</td>
<td>NGO sometimes views the private sector (businesses) with suspicion and distrust.</td>
<td>Community residents begin to support NGO through volunteerism.</td>
<td>Local agencies assist NGO in obtaining and sustaining project results.</td>
</tr>
<tr>
<td>How does the NGO make an effort to engage local citizens as volunteers or individual donors?</td>
<td>NGO does not seek human or other resources, technical expertise, or advocacy support from the private sector.</td>
<td>NGO seeks technical assistance from private sector and government sources.</td>
<td>Staff member serves as development officer and knows the private and public sector donor opportunities.</td>
</tr>
<tr>
<td>How active is the NGO in seeking support from local businesses—donations, gifts-in-kind, and volunteers?</td>
<td>The NGO has a limited relationship with local citizens.</td>
<td>NGO seeks support from service agencies in the private and public sectors.</td>
<td>Private sector and NGO cooperation is the norm, and the NGO is a full community partner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individuals from the private and public sector are recruited to serve on board.</td>
</tr>
</tbody>
</table>
## NGO COOPERATION

<table>
<thead>
<tr>
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<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the NGO cooperate or partner with other local NGOs?</td>
<td>Organization does not have experience working with other NGOs—local, national, or international.</td>
<td>Organization is increasingly known and trusted by the NGO community but has little experience collaborating with other NGOs.</td>
<td>NGO takes the lead in promoting project coalitions and in sponsoring and participating in a formal NGO association.</td>
</tr>
<tr>
<td>Has the NGO established relationships with other national NGOs?</td>
<td>NGO does not try to plan or deliver services in collaboration with other NGOs or see the value of partnering.</td>
<td>NGO tries to work with other NGOs to plan services, but mostly on an ad hoc basis.</td>
<td>NGO is fully integrated into NGO community, which develops and supports formal group advocacy mechanisms.</td>
</tr>
<tr>
<td>Has the NGO established relationships with other international NGOs or development groups?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GOVERNMENT COOPERATION

<table>
<thead>
<tr>
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<th>Indicators of an NGO with a High Level of Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the relationship between the NGO and the local government?</td>
<td>Relationship with government is based on a “we-they” perception. NGO cooperates little with government working in the same programming sector or geographic area. NGO has little understanding of its advocacy or public policy role.</td>
<td>NGO cooperates occasionally with different groups in specific areas of activity. Some understanding that the NGO can influence public policy, but efforts in advocacy are ad hoc, short-term, and not sustainable.</td>
<td>NGO performs specific project or sectoral collaboration or contacts for government. NGO provides input into policy process on issues related to its program areas and sector expertise. Through public contact, NGO is seen as an advocate in its area of expertise.</td>
</tr>
</tbody>
</table>
### APPENDIX I: QUESTIONS SELECTED FROM THE PEACE CORPS NGO CAPACITY DEVELOPMENT PROFILE QUESTION SET

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you know when you have achieved your organizational objectives?</td>
<td>How do the NGO’s programs help achieve the stated mission?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in an open-ended format.</td>
</tr>
<tr>
<td>What actions did your organization undertake to engage the community where the project was implemented?</td>
<td>How are staff and constituents involved in the planning process?</td>
<td>The original question was modified in order to elicit concrete examples of how the community played a role in the implementation of a project. Given that the primary question that this item is supporting is based on a more all-encompassing “how” format, it was felt that an additional level of detail was needed if the participant did not supply enough usable data, or a particular item need to be further elaborated upon.</td>
</tr>
<tr>
<td>Do you keep records of stories [testimonies] or ways in which individuals have been helped by the organization? If so, can you share any with the</td>
<td>Members of the NGO can recount stories of how individuals have been helped by the NGO’s programs.</td>
<td>The CDP root is an indicator provided to help guide questions and assess NGO capability. The indicator presented here represents a limited capability. The researcher</td>
</tr>
</tbody>
</table>
researcher? used this indicator as a means to build a rich, thick description of how NGO programs were impacting the local community.

<table>
<thead>
<tr>
<th>How do you determine the need and level of demand for your services in a particular region or community?</th>
<th>Is there a demand for expansion of the NGO’s programs?</th>
<th>The original CDP question was modified in to identify additional data regarding why projects were implemented in particular communities. Although the root item focused on the expansion of existing programs, this research sought to encompass both existing and planned programs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you know when or if a project is successful? (both during its implementation and at the end of the effort)</td>
<td>How is the NGO’s impact and performance measured?</td>
<td>The root question was modified to allow for a better response when presented in an open-ended format. The research sought to gather data at the project level in order to create a more thick description of an NGOs activities.</td>
</tr>
</tbody>
</table>

### Strategy Questionnaire – Likert Scale Type Questions

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
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</tr>
</thead>
<tbody>
<tr>
<td>My organization sought input from members of the local community on what our strategic objectives should be.</td>
<td>Was the vision/mission determined through a participatory process?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format. It was further modified to emphasize that the target of the participatory process was the local community.</td>
</tr>
<tr>
<td>Each project that my organization undertakes has clearly defined objectives and a clearly established way to end our involvement.</td>
<td>Measurable indicators of success and impact have been determined for each program goal.</td>
<td>The CDP root is an indicator provided to help guide questions and assess NGO capability. The indicator presented here represents a high internal capability. The researcher modified this question wanted to identify if each program had been planned in the appropriate amount of detail that allowed for the tracking of progress and a planned transition point.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>My organization typically requires outside assistance, not including funding, in order to carry out projects. This outside help may include finding trained workers, unusual knowledge, or specialized equipment.</td>
<td>How active is the NGO in seeking support from local businesses—donations, gifts-in-kind, and volunteers?</td>
<td>The CDP original question was used as a source to determine how much an NGO relies on outside assistance. The researcher modified the root question and converted the reliance upon outside sources into the Likert scale type format. Participants used this scale to provide their viewpoint on their dependence on outside assistance when attempting to implement a project.</td>
</tr>
</tbody>
</table>
| Donors influence or direct the types of projects my organization selects to implement. | Program development is largely donor driven. | The CDP root is an indicator provided to help guide questions and assess NGO capability. The indicator presented here represents a limited internal capability. Donor involvement levels were restated in order to allow for a better response when presented in a Likert scale.
My organization often collaborates with the local community to determine what type of assistance is needed. Constituents are recognized as partners and regularly involved in comprehensive program design, implementation, and evaluation.

The CDP root is an indicator provided to help guide questions and assess NGO capability. The indicator presented here represents a high internal capability. Including the community in the development and implementation of projects was determined to be a key part of establishing a sustainable capacity. To better address this program aspect, the indicator was used to develop a question that would allow for a better response when presented in a Likert scale type format.

### Capability Questionnaire – Open Ended Questions

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
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</tr>
</thead>
<tbody>
<tr>
<td>What are the major sources of funding for your organization? Please express in the form of a percentage. (Example: Donors 70%, Community Donations 10%, Grants 20%).</td>
<td>What are the existing sources of the NGO’s funding?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in an open-ended format. The addition of percentages provided a better context of where funding was derived from and how the sources might influence the implementation of programs.</td>
</tr>
<tr>
<td>Question Sent to Participants</td>
<td>Question Root</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>Volunteers provide a source of regular and consistent help to my organization.</td>
<td>Is volunteer help regular and consistent?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>My organization is able to recruit staff or volunteers will specialized skills and technical knowledge when required.</td>
<td>Does the NGO have access to technical sector experience when required?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>Existing staff members have the knowledge and skills necessary to support the achievement of my organization’s mission.</td>
<td>Do staff members have the skills and competencies required to support the achievement of the NGO’s mission?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>My organization provides the staff/volunteers with opportunities for professional development and on-the-job training.</td>
<td>What are the training opportunities for staff to develop job-related skills?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>My organization has a documented budget-planning process and clearly defined financial controls that regulate spending.</td>
<td>Does the NGO have a regular budget-planning process?</td>
<td>The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.</td>
</tr>
<tr>
<td>My organization has difficulty securing long-term funding for our project(s).</td>
<td>Project funding is insufficient to meet plans or provide services.</td>
<td>The CDP root is an indicator provided to help guide questions and assess NGO capability. The indicator presented here represents a limited internal capability. The researcher used this question to provide additional perspective on</td>
</tr>
<tr>
<td>Question Sent to Participants</td>
<td>Question Root</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>How has your organization collaborated with government efforts at the local or state level? If you have not previously collaborated with a</td>
<td>What is the relationship between the NGO and the local government? What is the relationship between the NGO and the</td>
<td>The two CDP questions were combined and focused on how the NGO has collaborated with national and local governments as opposed to local or state governments.</td>
</tr>
</tbody>
</table>

NGO funding sources and potential threats to long term operational capacity. To better address this program aspect, the indicator was used to develop a question that would allow for a better response when presented in a Likert scale type format.

My organization prepares and releases general public updates on internal developments and project status on a periodic basis.

Does the NGO make use of mass media to disseminate information about itself and its achievements?

The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format. Although the focus on the question is less concerned with the use of mass media, the context of the two questions are still fixed on the release of project information to the public in order to maintain accountability.

My organization has a long term plan for developing financial resources.

What is the long-term plan for developing financial resources?

The original CDP question was restated in order to allow for a better response when presented in a Likert scale type format.
government effort, how do you envision future partnerships taking place? | national government? | to stating what that relationship is. The emphasis on the “how” type of question supports the case study format and contributes to the overall understanding of the development of NGO-government relationships.

How has your organization collaborated with other NGOs (local/international), development groups, or the business community to support the health care system? | Does the NGO cooperate or partner with other local NGOs? Has the NGO established relationships with other national NGOs? Has the NGO established relationships with other international NGOs or development groups? | The three CDP questions were combined and focused on how the NGO has collaborated with other local and international NGOs. As with the previous question, emphasis has been placed on providing examples of collaborations that have taken place. This modification allowed the researcher to understand relationships in a much more detailed, i.e. rich and thick, manner.

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization has an established relationship with the local or state government in the areas that we operate.</td>
<td>What is the relationship between the NGO and the local government? What is the relationship between the NGO and the national government?</td>
<td>The original two CDP questions were combined and reformatted as a Likert scale type question. This question provided additional perspective and verification of the primary open ended question.</td>
</tr>
<tr>
<td>My organization has been able to leverage resources and support by partnering</td>
<td>Does the NGO cooperate or partner with other local NGOs?</td>
<td>The original CDP question was expanded upon in order to focus on the</td>
</tr>
</tbody>
</table>
with other NGOs or elements of the private sector. | leveraging of resources between NGOs and other private sector organizations. Additionally, the question was reformatted for presentation in a Likert scale type format.
APPENDIX J: CENTER OF THE ADVANCEMENT OF COLLABORATIVE STRATEGIES IN HEALTH, PARTNERSHIP SELF-ASSESSMENT TOOL QUESTION SET

Questions included in this appendix were taken directly from the CACSH Partnership Self-Assessment Tool (CACSH, 2006, p. 1-15). Tables were reformatted in order to ensure that data was both legible and accurately depicted within this appendix.

Questionnaire

Instructions

This questionnaire asks questions about different aspects of your partnership. It will take about 15 minutes to complete.

The questionnaire allows you to express your opinions and provide information about your experiences anonymously. **DO NOT WRITE YOUR NAME ANYWHERE ON THE QUESTIONNAIRE** and your name will not be attached in any way to the responses you give.

By answering the questions, you will help your partnership learn about its strengths and weaknesses and about steps that your partnership can take in order to improve the collaboration process. The answers that people in your partnership give will be used to generate a report for your partnership. Only the people in your partnership will have access to this report.

There are no right or wrong answers to the questions. Thoughtful and honest responses will give your partnership the most valuable information. **Please answer every question, and please check only one answer per question.**

To complete the questionnaire:

- Please use a BLUE or BLACK ink pen.
- Be sure to read all the answer choices before marking your answer.
• Answer each question by placing a legible check mark or “X” in the box to the left of your answer, like this:

[ √ ] Extremely well  OR  [ X ] Extremely well

• Please return the completed questionnaire in a manner that protects your anonymity, as instructed by your coordinator.
Synergy

Please think about the people and organizations that are participants in your partnership.

a. **By working together**, how well are these partners able to identify new and creative ways to solve problems?
   - [ ] Extremely well
   - [ ] Very well
   - [ ] Somewhat well
   - [ ] Not so well
   - [ ] Not well at all

b. **By working together**, how well are these partners able to include the views and priorities of the people affected by the partnership’s work?
   - [ ] Extremely well
   - [ ] Very well
   - [ ] Somewhat well
   - [ ] Not so well
   - [ ] Not well at all

c. **By working together**, how well are these partners able to develop goals that are widely understood and supported among partners?
   - [ ] Extremely well
   - [ ] Very well
   - [ ] Somewhat well
   - [ ] Not so well
   - [ ] Not well at all

d. **By working together**, how well are these partners able to identify how different services and programs in the community relate to the problems the partnership is trying to address?
   - [ ] Extremely well
   - [ ] Very well
   - [ ] Somewhat well
   - [ ] Not so well
   - [ ] Not well at all
e. By working together, how well are these partners able to respond to the needs and problems of the community?
   [ ] Extremely well
   [ ] Very well
   [ ] Somewhat well
   [ ] Not so well
   [ ] Not well at all

f. By working together, how well are these partners able to implement strategies that are most likely to work in the community?
   [ ] Extremely well
   [ ] Very well
   [ ] Somewhat well
   [ ] Not so well
   [ ] Not well at all

g. By working together, how well are these partners able to obtain support from individuals and organizations in the community that can either block the partnership’s plans or help move them forward?
   [ ] Extremely well
   [ ] Very well
   [ ] Somewhat well
   [ ] Not so well
   [ ] Not well at all

h. By working together, how well are these partners able to carry out comprehensive activities that connect multiple services, programs, or systems?
   [ ] Extremely well
   [ ] Very well
   [ ] Somewhat well
   [ ] Not so well
   [ ] Not well at all

i. By working together, how well are these partners able to clearly communicate to people in the community how the partnership’s actions will address problems that are important to them?
   [ ] Extremely well
   [ ] Very well
   [ ] Somewhat well
   [ ] Not so well
   [ ] Not well at all
Leadership

Please think about all of the people who provide either formal or informal leadership in this partnership. Please rate the total effectiveness of your partnership’s leadership in each of the following areas:

a. Taking responsibility for the partnership
   [ ] Excellent
   [ ] Very good
   [ ] Good
   [ ] Fair
   [ ] Poor
   [ ] Don’t know

b. Inspiring or motivating people involved in the partnership
   [ ] Excellent
   [ ] Very good
   [ ] Good
   [ ] Fair
   [ ] Poor
   [ ] Don’t know

c. Empowering people involved in the partnership
   [ ] Excellent
   [ ] Very good
   [ ] Good
   [ ] Fair
   [ ] Poor
   [ ] Don’t know

d. Communicating the vision of the partnership
   [ ] Excellent
   [ ] Very good
   [ ] Good
   [ ] Fair
   [ ] Poor
   [ ] Don’t know

e. Working to develop a common language within the partnership
   [ ] Excellent
   [ ] Very good
   [ ] Good
Please rate the total effectiveness of your partnership’s leadership in:

f. Fostering respect, trust, inclusiveness, and openness in the partnership

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

g. Creating an environment where differences of opinion can be voiced

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

h. Resolving conflict among partners

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

i. Combining the perspectives, resources, and skills of partners

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

j. Helping the partnership be creative and look at things differently

[ ] Excellent
Please rate the total effectiveness of your partnership’s leadership in:

k. Recruiting diverse people and organizations into the partnership

Efficiency

1. Please choose the statement that best describes how well your partnership uses the partners’ financial resources.

   [ ] The partnership makes **excellent** use of partners’ financial resources.
   [ ] The partnership makes **very good** use of partners’ financial resources.
   [ ] The partnership makes **good** use of partners’ financial resources.
   [ ] The partnership makes **fair** use of partners’ financial resources.
   [ ] The partnership makes **poor** use of partners’ financial resources.

2. Please choose the statement that best describes how well your partnership uses the partners’ in-kind resources (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods).

   [ ] The partnership makes **excellent** use of partners’ in-kind resources.
   [ ] The partnership makes **very good** use of partners’ in-kind resources.
   [ ] The partnership makes **good** use of partners’ in-kind resources.
   [ ] The partnership makes **fair** use of partners’ in-kind resources.
   [ ] The partnership makes **poor** use of partners’ in-kind resources.

3. Please choose the statement that best describes how well your partnership uses the partners’ time.

   [ ] The partnership makes **excellent** use of partners’ time.
   [ ] The partnership makes **very good** use of partners’ time.
The partnership makes good use of partners’ time.
The partnership makes fair use of partners’ time.
The partnership makes poor use of partners’ time.

**Administration and Management**

We would like you to think about the administrative and management activities in your partnership. Please rate the effectiveness of your partnership in carrying out each of the following activities:

a. Coordinating communication among partners

[ ] Excellent  
[ ] Very good  
[ ] Good  
[ ] Fair  
[ ] Poor  
[ ] Don’t know

b. Coordinating communication with people and organizations outside the partnership

[ ] Excellent  
[ ] Very good  
[ ] Good  
[ ] Fair  
[ ] Poor  
[ ] Don’t know

c. Organizing partnership activities, including meetings and projects

[ ] Excellent  
[ ] Very good  
[ ] Good  
[ ] Fair  
[ ] Poor  
[ ] Don’t know

d. Applying for and managing grants and funds

[ ] Excellent  
[ ] Very good  
[ ] Good  
[ ] Fair  
[ ] Poor  
[ ] Don’t know
e. Preparing materials that inform partners and help them make timely decisions

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

Please rate the effectiveness of your partnership in:

f. Performing secretarial duties

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

g. Providing orientation to new partners as they join the partnership

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

h. Evaluating the progress and impact of the partnership

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know
i. Minimizing the barriers to participation in the partnership’s meetings and activities (e.g., by holding them at convenient places and times, and by providing transportation and childcare)

[ ] Excellent
[ ] Very good
[ ] Good
[ ] Fair
[ ] Poor
[ ] Don’t know

Non-financial Resources

A partnership needs non-financial resources in order to work effectively and achieve its goals. For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

a. Skills and expertise (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, community organizing)

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

b. Data and information (e.g., statistical data, information about community perceptions, values, resources, and politics)

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

c. Connections to target populations

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
d. Connections to political decision-makers, government agencies, other organizations/groups

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

e. Legitimacy and credibility

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

f. Influence and ability to bring people together for meetings and activities

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know
Financial and Other Capital Resources

A partnership also needs financial and other capital resources in order to work effectively and achieve its goals. For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

a. Money

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

b. Space

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

For the following type of resources, to what extent does your partnership have what it needs to work effectively?

c. Equipment and goods

[ ] All of what it needs
[ ] Most of what it needs
[ ] Some of what it needs
[ ] Almost none of what it needs
[ ] None of what it needs
[ ] Don’t know

Decision Making

a. How comfortable are you with the way decisions are made in the partnership?

[ ] Extremely comfortable
[ ] Very comfortable
[ ] Somewhat comfortable
[ ] A little comfortable
[ ] Not at all comfortable
b. How often do you support the decisions made by the partnership?

[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Almost none of the time
[ ] None of the time

c. How often do you feel that you have been left out of the decision making process?

[ ] All of the time
[ ] Most of the time
[ ] Some of the time
[ ] Almost none of the time
[ ] None of the time

**Benefits of Participation**

For each of the following benefits, please indicate whether you have or have not received the benefit as a result of participating in the partnership.

a. Enhanced ability to address an important issue

[ ] Yes
[ ] No

b. Development of new skills

[ ] Yes
[ ] No

c. Heightened public profile

[ ] Yes
[ ] No

d. Increased utilization of my expertise or services

[ ] Yes
[ ] No

e. Acquisition of useful knowledge about services, programs, or people in the community
[ ] Yes
[ ] No

f. Enhanced ability to affect public policy

[ ] Yes
[ ] No

g. Development of valuable relationships

[ ] Yes
[ ] No

h. Enhanced ability to meet the needs of my constituency or clients

[ ] Yes
[ ] No
i. Ability to have a greater impact than I could have on my own

[ ] Yes
[ ] No

As a result of your participation in the partnership, have you experienced the following benefits:

j. Ability to make a contribution to the community

[ ] Yes
[ ] No

k. Acquisition of additional financial support

[ ] Yes
[ ] No

**Drawbacks of Participation**

For each of the following drawbacks, please indicate whether or not you have or have not experienced the drawback as a result of participating in this partnership.

a. Diversion of time and resources away from other priorities or obligations

[ ] Yes
[ ] No

b. Insufficient influence in partnership activities

[ ] Yes
[ ] No

c. Viewed negatively due to association with other partners or the partnership

[ ] Yes
[ ] No

d. Frustration or aggravation

[ ] Yes
[ ] No
e. Insufficient credit given to me for contributing to the accomplishments of the partnership

[ ] Yes
[ ] No

f. Conflict between my job and the partnership’s work

[ ] Yes
[ ] No

Comparing Benefits and Drawbacks

So far, how have the benefits of participating in this partnership compared to the drawbacks?

[ ] Benefits greatly exceed the drawbacks
[ ] Benefits exceed the drawbacks
[ ] Benefits and drawbacks are about equal
[ ] Drawbacks exceed the benefits
[ ] Drawbacks greatly exceed the benefits

Satisfaction with Participation

a. How satisfied are you with the way the people and organizations in the partnership work together?

[ ] Completely satisfied
[ ] Mostly satisfied
[ ] Somewhat satisfied
[ ] A little satisfied
[ ] Not at all satisfied

b. How satisfied are you with your influence in the partnership?

[ ] Completely satisfied
[ ] Mostly satisfied
[ ] Somewhat satisfied
[ ] A little satisfied
[ ] Not at all satisfied
c. How satisfied are you with your role in the partnership?

[ ] Completely satisfied
[ ] Mostly satisfied
[ ] Somewhat satisfied
[ ] A little satisfied
[ ] Not at all satisfied

d. How satisfied are you with the partnership’s plans for achieving its goals?

[ ] Completely satisfied
[ ] Mostly satisfied
[ ] Somewhat satisfied
[ ] A little satisfied
[ ] Not at all satisfied

e. How satisfied are you with the way the partnership is implementing its plans?

[ ] Completely satisfied
[ ] Mostly satisfied
[ ] Somewhat satisfied
[ ] A little satisfied
[ ] Not at all satisfied
## Partnership Questionnaire – Open Ended Questions

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the ideal level of collaboration between organizations? What steps should/can be</td>
<td>Please rate the total effectiveness of your partnership’s leadership in</td>
<td>The PSAT root question was used as basis for constructing the new item sent to participants. The empowerment of the various partners and</td>
</tr>
<tr>
<td>taken to achieve the ideal level?</td>
<td>each of the following areas: Empowering people involved in the partnership.</td>
<td>their staff is important to creating a strong and enduring relationship. However, the researcher sought to understand what the optimum levels might be and how the partnership could best be empowered. The PSAT question was expanded and restated in order to allow for a better response when presented in an open ended format.</td>
</tr>
</tbody>
</table>

## Partnership Questionnaire – Likert Scale Type Questions

<table>
<thead>
<tr>
<th>Question Sent to Participants</th>
<th>Question Root</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By working together, my organization and its partners were able to identify new and</td>
<td>By working together, my organization and its partners were able to identify new</td>
<td>No change to original question. Responses were altered to fit into the Likert scale developed for this</td>
</tr>
<tr>
<td>creative ways to solve</td>
<td>and creative ways to solve</td>
<td></td>
</tr>
<tr>
<td>problems.</td>
<td>problems.</td>
<td>study.</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td>By working together, my organization and its partners were able to develop goals that are widely understood and supported among both partners and the community.</td>
<td>By working together, my organization and its partners were able to develop goals that are widely understood and supported among both partners and the community.</td>
<td>No change to original question. Responses were altered to fit into the Likert scale developed for this study.</td>
</tr>
<tr>
<td>By working together, my organization and its partners were able to carry out comprehensive activities that connect multiple services, programs, or systems.</td>
<td>By working together, my organization and its partners were able to carry out comprehensive activities that connect multiple services, programs, or systems.</td>
<td>No change to original question. Responses were altered to fit into the Likert scale developed for this study.</td>
</tr>
<tr>
<td>My organizational leadership is satisfied with the functioning, progress, level of involvement, and interaction of past or present partnerships within the public health sector.</td>
<td>How satisfied are you with the way the people and organizations in the partnership work together?</td>
<td>The original PSAT question was modified to provide more specific partnership examples that the participant could use when considering the how to respond to this question.</td>
</tr>
<tr>
<td>My organization and its partners are able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or changes in leadership.</td>
<td>Please rate the total effectiveness of your partnership’s leadership in: Helping the partnership be creative and look at things differently.</td>
<td>The intent of the original PSAT question was considered useful, but the researcher chose to differentiate the ability to be creative from the ability to respond creatively to diverse situations. The ability of a partnership to apply resources and alter strategies to achieve mission objectives was considered a better indication of a successful relationship. The PSAT question was modified accordingly.</td>
</tr>
<tr>
<td>Organizations involved in our partnership are open to different approaches on how we can implement our projects.</td>
<td>Please rate the <strong>total effectiveness</strong> of your partnership’s leadership in: Creating an environment where differences of opinion can be voiced.</td>
<td>The research sought to understand how relationships between partnerships affected the implementation of projects. The original PSAT question dealt with the ability of leadership to foster an environment where contributions from the various partners are considered equally. The researcher modified the question so that wording was more closely aligned with the remainder of the items in the study.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>My organization and its partners have a clear sense of their roles and responsibilities.</td>
<td>How satisfied are you with your role in the partnership?</td>
<td>The original PSAT question was one of the few that focused on the roles of the individual NGOs within a partnership. Instead of focusing on satisfaction, the researcher modified the question to better understand if roles were identified within either the NGO-NGO or NGO-government relationship.</td>
</tr>
<tr>
<td>Partnering with organizations within the public health care system has the potential to reduce barriers to implementing a successful project.</td>
<td>By working together, how well are these partners able to implement strategies that are most likely to work in the community?</td>
<td>The root PSAT question focused on the ability of a partnership to implement strategies in the community. The researcher modified the question in order to understand if respondents thought that partnerships could reduce potential barriers when</td>
</tr>
</tbody>
</table>
implementing projects in a community. Altering the scope of the question from full project implementation to the singular aspect of barrier removal better framed the question and allowed for a better response from participants.
REFERENCES


Ainscough, M. (2006, September 01). DoD meets NGOs, CSOs, PVOs and IGOs in FHA, CHEs, and HUMROs. Bethesda: Uniformed Services University, Preventive Medicine and Biometrics Department.


from Human Development Reports:


marriottschool.byu.edu/.../Joan%20Dixon%20MEC%20Slides.ppt


Cultural Factors Influencing PHC Services in Nigeria


Development: New Solutions to Old Problems (pp. 61-84). New York: EarthScan Publications Ltd.


http://www.triumphnewspapers.com/archive/DT27042007/as274207.html


http://www.economist.com/node/276931

http://www.economist.com/countries/Nigeria/?CFID=170885574&CFTOKEN=10029957


BIOGRAPHY

Lieutenant Colonel William E. Sumner is a Nuclear Operations and Counterproliferation officer in the United States Army. He is assigned to U.S. Army Africa as the North-West Africa Plans Chief and is responsible for the command’s Pandemic Influenza/Infectious Disease plan.

Lieutenant Colonel Sumner has more than 21 years of military service, both in the reserves and active forces. He has served in numerous positions through his career, including assignments as a Strategic Plans and Policy Officer, Civil Affairs Officer, Chemical Officer and the Deputy Chief of a Nuclear Disablement Team. He has been deployed to both Iraq and Mali.

Lieutenant Colonel Sumner graduated from Florida State University in 1993 with a Bachelor of Science in Political Science, and later a Master’s of Science in Instruction Systems Design in 1996. He completed two certificate programs, one in Geographic Education and another in Cartographic Information Systems in 2003. He went on to receive a second Master of Arts in Archaeology and Heritage from Leicester University, England, in 2004.