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NGO–government collaboration in Bangkok

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Introduction

The case study that is presented here covers some six years of co-operation between Save The Children Fund-UK and Rajanukul Hospital for Mentally Retarded Children in Bangkok, Thailand. The example is one of a small project, with limited aims, adapting and exploiting opportunities as they presented themselves, gradually enlarging its objectives and increasing the potential impact of its work. The project was not designed with wider impact in mind and the framework that is presented for analysing the process of scaling-up follows a retrospective assessment of experience in this and other projects. However, the authors believe that this framework may have wider (although certainly not universal) applicability in relation to the involvement of NGOs in scaling-up their impact in relation to government services.

Scaling-up: a framework

One of the most frequent models employed by NGOs interested in scaling-up their impact is the 'pilot project'. In essence such a project seeks to provide an example of good practice, in the hope – if not the expectation – that this can be replicated, either by other NGOs or by government. The framework outlined here relates specifically to working with government.

Replicability is a key concept in relation to scaling-up through pilot projects. The initial model needs to provide a practical and appropriate basis for service development on a large scale. Without this the lessons that can be drawn from the pilot project may be too local and specific to have wider influence. The second key concept is *sustainability*, by which we mean the ability to maintain services in the longer run without significant external support. Clearly, there is little point in demonstrating that a model of intervention or service development can achieve results and can be replicated in other circumstances if those circumstances require continuing high levels of external support.

Our starting point, therefore, is that a pilot project which aims to influence government service provision must demonstrate both its replicability and its sustainability. We interpret this to mean that the project must, *from the outset*, be implemented by and entirely within government structures.

NGO-implemented pilot projects that aim to set an example for the government sector to follow can only ever remain just that – pilot projects. NGOs operate in a privileged environment of flexibility, with greater access to funds for innovation and fewer bureaucratic constraints. Neither true replicability nor sustainability can

constraints of government structures. With this in mind we suggest that there are three stages to the scaling-up process, and that the failure to appreciate the essential difference between stages two and three may be one of the causes of the frequent failure of NGOs to influence government systems and structures over the longer term.

Stage 1: Pilot project(s) One (possibly more) project, exploring a new approach to service provision. At this stage it operates within the government sector, but on an exceptional basis and with significant NGO support/input.

Stage 2: Small-scale integration The initial pilot project has proved successful and is replicated. There is greater integration into existing government structures and budgets. However, integration is dependent upon local and essentially personal initiatives.

Stage 3: Assimilation The local example is adopted as an appropriate model, and systems, structures and budgets are adapted accordingly. Policy is reformulated and – most importantly – practice changes.

The essential message of this framework is that stage three is not simply a larger scale version of stage two. Stage two is dependent upon local initiative and committed government officials working creatively within – and extending – their sphere of responsibility. However, the model has not been internalised within the organisation's policies or practices. Thus, the loss (perhaps through transfer or retirement) of one key official can mean that all gains evaporate, practices revert to previous norms, and policy is no longer questioned. A similar effect may be achieved by the withdrawal of external (NGO) support at this stage – the project has demonstrated its replicability, but not yet its sustainability.

In stage two the driving force are those officials who are willing to extend the boundaries of their immediate responsibilities for maintaining existing services. A conscious decision is required from these officials to do more than the minimum. This will often lead to opposition, possibly resentment, within the bureaucracy. New approaches involve change and change means disturbing the balance of power and authority. Those wishing to maintain the status quo generally do not need to take overt action to block the initiative, as the absence of co-operation and support alone allows bureaucratic resistance to drain its energy. Stage two is dependent, therefore, upon personal initiative and sustained positive action to promote change.

In stage three, however, the position is reversed, as the organisation redefines roles and responsibilities. New policies and practices have been adopted officially so they are no longer dependent upon personal initiative. Indeed, anyone wishing to oppose the new policy must now operate outside agreed responsibilities. At this point the organisational requirements for sustainability have been achieved.

We argue that stage three cannot be attained successfully simply by extending or repeating activities from stage two. An entirely different approach is required – one which targets the promotion of change in organisational policy and practice. The implication for NGOs is that scaling-up requires a reassessment and change of approach as stage two moves towards success. It is as if a barrier exists between stages two and three. Repetition alone cannot surmount this barrier. A new strategy is required – in effect it is a new 'project': one which draws on the philosophy and

Moving from stage one to stage two is essentially 'additive' in Edwards and Hulme's terminology (this volume). As such, if the model is appropriate and successful, this move is primarily a question of resource availability. The successful move to stage three, however, is more than this: it must also be 'multiplicative' in extending influence and support, so that the new model may have the opportunity to influence the use of existing, not just additional, resources.

This model is represented diagrammatically in Figure 1.

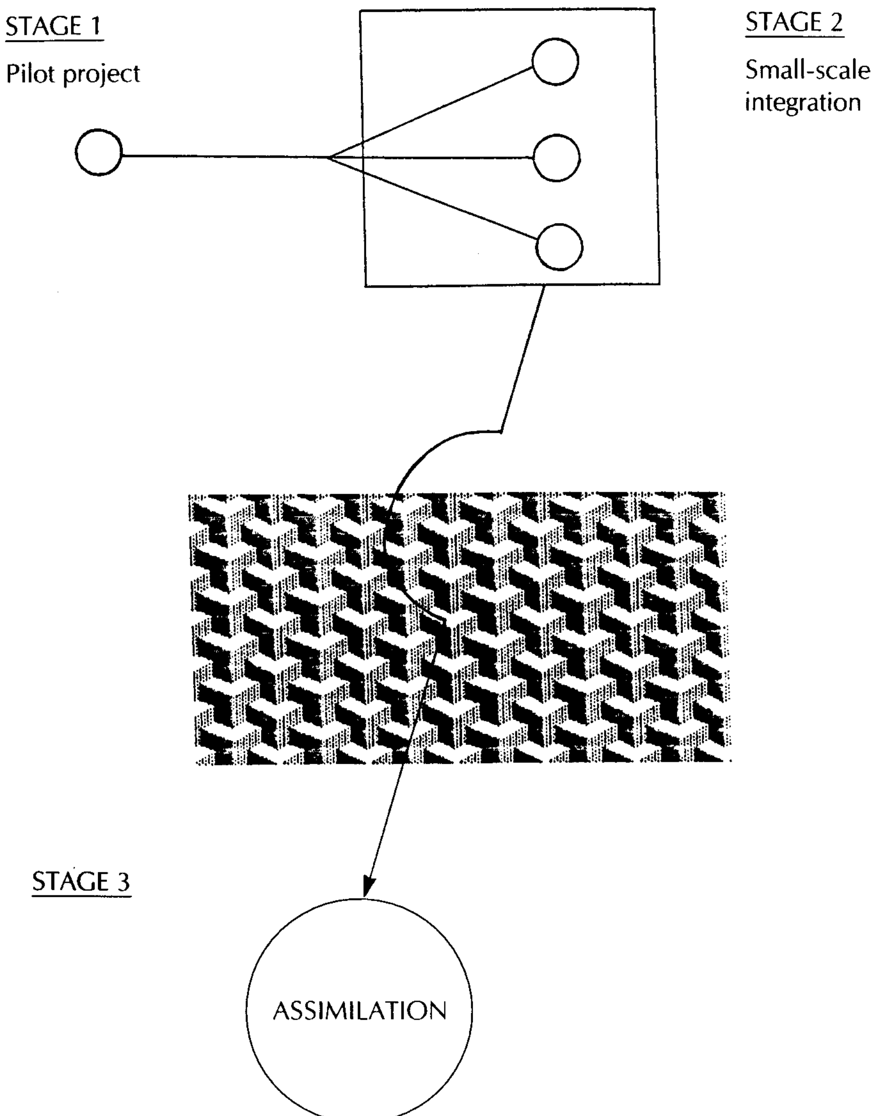

Figure 5:1 *Scaling-up: a framework*

The context

The project used in the case study that follows is concerned with providing support, development and educational opportunities to children who are mentally retarded. To appreciate the context of this project, it is worth recapping briefly some of the significant issues relating to disability and development that have become commonly accepted over the past few years.

In many ways, 1981 (the International Year of Disabled Persons) was a milestone, both in terms of drawing attention to the needs of disabled persons and as the precursor of the United Nations Decade of Disabled Persons (1983–1992). As part of this Decade, the UN General Assembly adopted a World Programme of Action Concerning Disabled Persons. Along with prevention of disability and rehabilitation, this Programme of Action stressed the need for equalisation of opportunities for disabled persons. It stressed, for example, that disabled persons should not be separated from their families and communities and stressed that the education of disabled persons should as far as possible take place in the general school system.

The World Programme of Action represents a significant marker in the wider acceptance that disabled persons have rights as individuals and that those rights require positive action to avoid discrimination, facilitate integration and acceptance within the community, and provide equal opportunities for personal development, support and employment.

The World Health Organisation (WHO) estimates that between seven and ten per cent of the population in developing countries is disabled (Helander et al 1989). UNESCO (Hegarty 1990) reports that there are some 200 million children in the world with a disability and that around 80 per cent of these live in developing countries. It further estimates that less than two per cent of these receive special services of any kind.

Such large numbers include people with a wide range of disabilities. In only a small minority of cases, however, would the disabilities be classified as severe. Nevertheless, opportunities and access to services are frequently restricted for all disabled persons, irrespective of the severity of disability or their ability to integrate (Hegarty 1990).

Disability in Thailand

While Thailand has made considerable economic advances within the past few years, there has been only a limited interest shown in responding to the needs of disabled persons in the country. The statistics that are available concerning the numbers of disabled persons are contradictory and often unrealistic. For instance, compared to the WHO estimate of seven to ten per cent of any population with a disability, the most recent official statistic quoted for Thailand gives a total of 385,560 disabled persons (NSO 1986). In a population of approximately 56 million, this would represent less than 0.7 per cent. Other, disability-specific, information may give a more accurate picture. The results of one recent survey suggest that around two per cent of the population may be classified as 'mentally retarded' (Dheandanoo 1991). This percentage would mean that there are probably around 240,000 mentally retarded children within the age range of 6–14 years and thus eligible for schooling. Against this level of need, it is estimated that only around 5,000, or less than two per cent, are attending school (Dheandanoo 1991).

The case study: Rajanukul Hospital and integrated education[1]

Save the Children Fund's co-operation with Rajunukul Hospital began in 1985. Rajanukul Hospital operates within the Ministry of Public Health and is the only hospital specialising in mental retardation in Thailand. It provides an outpatient clinic for around 40–60 people daily, plus inpatient/residential facilities for mentally retarded children from birth to age 18. There is an early intervention programme for the youngest children, a preschool, primary school and vocational training activities. Over 700 children reside at the hospital, mainly on a permanent basis. The primary criterion for admission to schooling in the hospital is that the children are 'trainable'. The hospital also has a Community Services Department, which is responsible for outreach work within the community.

The first contact between Rajanukul Hospital and SCF was made by a VSO volunteer, an experienced paediatrician and specialist in mental retardation, who was assisting the hospital to develop its outreach and community services. However, at this time the hospital itself was more concerned with the fact that it had a large and growing waiting list and could not meet the demand for residential places. Thus, when the hospital submitted a proposal to SCF for a pilot project, it was 'to help mentally retarded (children) and their parents who are waiting for hospital treatment, or who do not have the opportunity to get it'.

Of the seven objectives listed for this 'pilot project' the first two related to preparation of children waiting for hospital places. With the third objective an element of community orientation was introduced. Overall, however, the original concept appears to have been not so much to create an alternative to institutional care, but to help children prepare for it.

The original project was also very limited in size. A small room was obtained in a government community centre, located adjacent to the hospital. At most this could cater at any one time for ten children, plus staff. Within six months of opening in October 1985, nine children were registered and four attended regularly. A year later 26 children were registered, with ten attending daily, in rotation. The staff comprised two teachers and one care attendant.

After nearly two years the experience of the project was reviewed. SCF drew attention to the lack of involvement of parents and suggested that this should become a greater focus of attention. Using the project as a base for greater contacts and integration within the community was also recommended.

From around this time the objectives of the project began to broaden. A close personal relationship had been established between the SCF staff member responsible for the project and key personnel within the hospital's Community Services Department. At this level it was agreed that the future of the project lay in developing a community-based alternative to residential care.

It was also clear by this time that the existing facility was too small, and it was therefore proposed to find a new location. SCF agreed to fund building works, so that a larger centre could be created in vacant space under an adjoining public-

[1] The authors would like to express their appreciation to past and present officials in Rajanukul Hospital, the Bangkok Metropolitan Administration, and the Ministry of Education, who have co-operated over such an extended period. It must be stressed, however, that the views expressed in this paper are those of the authors alone, and should not be attributed to any of the government officials involved in the case study.

sector housing block. The owners, the National Housing Authority, had on a number of previous occasions given approval to infills of this kind for community purposes.

In developing the revised proposal SCF and the hospital reached agreement that the involvement of the parents would be increased and that the project would attempt to integrate more effectively with the local community. Unexpectedly, however, the National Housing Authority refused the hospital permission to build the centre.

Throughout the first three years the project did not move beyond stage one of the scaling-up process described above. Initially, in fact, it is difficult to see it as a pilot project in providing any wider lessons for service development. As it evolved, however, it did move towards presenting an alternative model. At this stage the issue of sustainability was discussed, but the project was still entirely dependent upon the external assistance provided by SCF. Curiously, it was the rejection of building permission by the BMA that marked the first steps along the way to stage two.

In July 1988 SCF co-sponsored Thailand's first National Seminar on Community-Based Rehabilitation. By drawing together most of the people in the country interested and involved in community-based initiatives for disabled persons, the seminar provided a stimulus to a number of interesting initiatives. One such initiative came from the Bangkok Metropolitan Administration (BMA). The BMA is the authority responsible for regional government in greater Bangkok, including certain aspects of primary education. Their representative at this seminar was interested in the project described by Rajanukul Hospital and the problem of finding suitable, larger accommodation. As a result, contact was made with a local primary school operated by the BMA (Vichuthit School) and approval given to use two of its rooms.

The project moved to Vichuthit School in February 1989. At first it operated within the school as an entirely separate entity, with the hospital providing staff and technical support. However, as part of the strategy to improve sustainability, the hospital negotiated successfully with the Ministry of Education (MOE) for the allocation of a special education teacher to the project.

With the support of an interested teacher from within the school, integration of mentally retarded children into mainstream classes began, on a limited basis, with physical education, and has since spread to music and art. There is considerable preparation at each stage of integration, to make sure that children and teachers are adequately equipped.

The project is considered successful, both by the hospital and the school. The children within the project have better levels of adjustment and development than those residing within the hospital – even though the project caters for children with more severe disabilities. Indeed, in 1990 the project was selected by the Ministry of Public Health to receive an award as an outstanding project of that ministry.

During this period SCF held discussions with Rajanukul Hospital and the BMA about replicating the model and planning for the transfer of SCF's financial input to the government. With some financial assistance from SCF a similar unit was established in another BMA school, and a third was planned, both utilising special education teachers provided by the Ministry of Education.

The programme by now had moved to stage two of the scaling-up process. The initial project was being replicated and there was greater integration into existing