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RÉSUMÉ

Lutte populaire et santé de base: Modelo Juán XXIII en République Dominicaine

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Un état faible et une population appauvrie peuvent-ils produire une institution durable et indépendante de financement international? A quelles conditions? Nous présentons le cas d'un projet exceptionnel d'accès aux services de santé en République Dominicaine. Le succès continu de ce projet — dont les débuts remontent à la 'huelga' populaire — résulte de la détermination des réseaux des partenaires à limiter l'influence des hiérarchies conventionnelles. L'évidence quantitative vient d'ailleurs confirmer cette étude de cas: la chance de succès des projets de développement en Amérique Latine est deux fois supérieure lorsqu'ils sont portés par des réseaux de partenaires plutôt que le seul gouvernement central.

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Community Pressure Produces Basic Health: Modelo Juán XXIII in the Dominican Republic

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Introduction

The provision of access to basic health care is generally considered one of the essential, even noble, functions of a state.[1] It is also one of the functions that typically suffer when the state is "soft", i.e., weak, corrupt or even predatory. The Dominican Republic is in some ways an institutionally weak state where private initiatives have increasingly been substituted for governmental action, notably in health and education. Yet it is also a "developmental state" in the sense that the sum-total of elite action has promoted, rather than impeded, necessary transformations.[2] This article describes one such instance where state action, in response to a popular initiative, has produced an outcome desired by all individuals and organizations involved. Why did this happen in an environment where bungling and rent-seeking might have been more reasonably expected? There are some issues here that are relevant well beyond this individual case.

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[1]Parts of this material were included in an internal publication at the Inter-American Development Bank (Locher, 2003). I gratefully acknowledge the assistance of Tahira Vargas, as well as comments received on an earlier draft, by Reynaldo Peguero, Elssy Bonilla, Alejandro Medina, Sergio Díaz, Gricelis Martínez, Danilda Antonia Sasa and two anonymous reviewers.

[2]For an excellent discussion of "predatory, developmental and other apparatuses" see Evans, 1989.

What led the state into a partnership driven by community groups bent on confrontation (*huelga* — popular protest)? The answer lies outside the country. The combination of opportunities offered by the Pan American Health Organization (PAHO) for community-based programs, of medical professionals at PUCMM[3] taking similar orientations and of multilateral agencies increasingly looking for civil society cooperation provided a sufficient push to start a pilot program. As the timeline below shows, it took two decades for the various elements to fall into place. Governmental autonomy thus appears as limited, and negotiated in response to national constituencies as well as international actors.

What led to the success of the program — with success defined as basic health care access for the poor? This study found answers in the operation of social networks constituting the community part of the partnership and came to a surprising conclusion. In a world where health care delivery is exceedingly centralized and hierarchical, success comes precisely with breaking up the centralized governmental monopoly.

What is the institutional outcome of this innovative partnership of state and civil society? In the first place we find a hospital, fully equipped, staffed and functioning — a case of institutional capacity building of the conventional kind. Beyond this we find unquestioned legitimacy and sustainability independent of foreign financing — true institutional development. It is always important to distinguish these concepts when analyzing development of any kind.

The developmental character of the Dominican state, combined with its institutional "softness", results in serious problems for operating new institutional units. In today's neoliberal climate such units are vulnerable to cuts in budgets and personnel, to shifts in political priorities and to the whims of the ever-present multilateral agencies. Institutional capacity building is counterproductive unless the new units are designed to function in an adverse climate. The following sections will address this issue by describing defensive strategies that have helped the project survive.

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[3] Pontificia Universidad Católica Madre y Maestra; here more specifically its Faculdad de Ciencias de Salud.

The Local Context

The rapid and chaotic growth of South-Santiago[4] since 1970 has created a number of problems common in the "belts of poverty" of Latin American cities. A population characterized by low levels of income, education and professional qualifications is typically neglected by government, exploited by employers and deprived of a voice in the political process. Such a population appears to have no hope. Yet South-Santiago is different. Here lives a community that has confronted its marginality by all means available. It has fought for living space by invading open land; it has fought for electricity and water by peaceful revolt, strikes and marches. It has fought for access to health services by mobilizing the population and the media. This is a community that has hope.

What explains the success of this community? In particular, why do we find public health services here of a quality and accessibility that other poor neighbourhoods can only dream of? This is the central question of this study.

Major dates in the emergence of Modelo Juán XXIII	
1966-1978	The "twelve years of danger": grave political crises, crackdowns, increasing social polarization
1978-1985	"La huelga" in South-Santiago: popular protest leads to infrastructure improvements (streets, water, electricity, school)
1970s	University (PUCMM) introduces training in non-conventional approach to medicine ("bio-psycho-socio"), financed by IDB
1980s	PUCMM focuses outreach in nearby South-Santiago
1990s	Government (SESPAS) and Panamerican Health Organization (OPS) start new work in South-Santiago, with community orientation
1991	Creation of the first UROCs; the first 33 Promotoras de salud are trained
1994	CODESA is formed
1995	Project UNISUR starts with tripartite oversight (SESPAS–CODESA–PUCMM) and Kellogg's Foundation grant

[4] South-Santiago refers to the Zona Sur of the city of Santiago de los Caballeros in the Dominican Republic.

The most obvious answer is that the community has organized itself around some concrete needs and demands, one of which was the provision of low-cost, high-quality health services. "Disease is a problem of democracy" was the key idea that put people in motion.

Disease is not destiny but the result of unequal access to resources. People who have a voice and power can prevent disease and preserve their health. Health in South-Santiago, therefore, has become viewed as the result of a political process of popular mobilization, a process that necessarily challenges state authority and the status quo of resource distribution. Hence popular protest movement in South-Santiago with its heroes and martyrs (in 1984) and tangible results.

Two institutional factors favoured the movement. First, in the late 1970s, PUCMM expanded its biomedical programs with a new holistic ("bio-psycho-social") orientation and a geographical focus on nearby South-Santiago. The mutual interests of the great institution and the marginal neighbourhood evolved into an interdependency of partners. The university got its training ground and the neighbourhood, in exchange, received better health coverage. Secondly, around the same time, SESPAS[5] started favouring the provision of health services outside of hospital structures. This new orientation included an emphasis on community participation and the training of community leaders. One result of this new pattern of institutional outreach was the creation (in 1991) of the UROCs[6], oral rehydration units that operate out of the homes of women trained to be leaders in community health education and preventive health measures.

To the participants it is the protest movement that brought about "Modelo Juán XXIII". However, institutional factors cannot be ignored. There is inherently no need for a state or a university to recognize a movement, much less to accept its demands. What made the difference was to a large extent external pressures exercised through the channels of foreign aid. At the same time that the World Bank and the IMF were intent on breaking state monopolies, PAHO was offering money, training and new models

[5] Secretaria de Estado de Salud Publica y Asistencia Social, the Health and Welfare Ministry.
[6] Unidades de Rehidratación Oral Comunitarias.

for health care delivery. Both SESPAS and PUCMM found it in their interest to listen and act, and to accept civil society partners.

This, then, is the context of the "Modelo Juán XXIII": an urban neighbourhood with a history of strong community mobilization, an institutional presence favouring community leadership and participation, and a government experimenting with a decentralized approach to public health. The conditions were as favourable as they had ever been. The program was born. Has it produced tangible results for the 70,000 inhabitants of 24 urban and peri-urban districts it was meant to serve?

Modelo Juán XXIII: What It Is and What It Has Done

Three elements constitute the program called Modelo Juán XXIII: (1) a vision that links health with democracy, (2) a physical structure dominated by a small hospital and (3) an institutional partnership expressed through networks of individuals, community groups and other stakeholders.

Vision. "Democracy means health access for all" is a conviction shared by all partners of the program, but this should not be mistaken as a reference to the formal democracy of Dominican political parties. Despite all the political mobilization, partners will say "ese modelo no es politico" to distance themselves from conventional party allegiances. The democracy of the program is defined above all as community participation and empowerment, and it is through making this form of democracy work for everyone that public health can be served. The vision also has elements of compassion and identification with the disadvantaged. "I am committed to my people" said one participant and another added her concern for "kids that died because their mothers were ignorant". This program is driven by the vision of a mobilized, active community taking charge of its constituents and its destiny.

Physical structure. The Centro de Attention Primaries Juán XXIII[7] is a small hospital of 26 beds that has been in operation in its present form since 1997. It is equipped to administer twelve programs in curative and preventive medicine, nutrition and other

[7] We distinguish between the program ("Modelo") and the hospital ("Centro"), both named after the late Pope.

areas and is financed by government grants as if it were a regular hospital serving a population of approximately 60,000 inhabitants. Other elements of physical infrastructure include two outlying clinics called UBAS[8] and twenty-two community homes called UROCs. The latter are modest points of service delivery of low visibility located at program supervisors' homes. The Centro Juán XXIII is clearly the physical focus and centre of the program.

Institutional partnership. Three institutions share responsibility and oversight of the Centro Juán XXIII: government (SESPAS), a private university (PUCMM) and an umbrella organization of community groups (CODESA[9]). This collaboration of state and civil society is uncommon and admirable in itself; it is even more surprising when we consider that what is being administered is practically exclusively a government hospital and government program funds. The personnel receive government paycheques, all programs apply government standards, and an outside observer could never guess that essential parts of service delivery are decided through community participation.

CODESA is the most unusual element in this partnership. Formed in 1994, it is composed of representatives of all kinds of neighbourhood organizations engaged in bettering living conditions in South-Santiago. The representatives sometimes are health promoters — volunteer workers using the neighbourhood groups as platforms for promoting preventive health issues. SESPAS has long used health promoters in distant rural areas, especially for vaccination campaigns. Under the Modelo Juán XXIII the promoters are something much more central. They are the key link between populations and the Centro, and they work on a wide range of health and social service issues.

It is worth noting that no partner has a monopoly on any part of the program. All three contribute to the vision and mission, all three provide some personnel and all three participate in their own way in the physical and organizational structure. Why do they do this and what are their interests in maintaining the partnership? In answering this question we have to distinguish short-term and long-

[8] Unidad Básica de Salud (Basic Health Unit), also called Clínica periférica de salud (Peripheral Health Clinic).
[9] Consejo de Salud (Health Council).

Figure 1 ***The Partners and Their Contributions to Modelo Juán XXIII***

Partners	Contributions		Outcome
CODESA Community networks	Community input and feedback; Health promoters	→	**Modelo Juán XXIII:** • Networks • Community programs • Hospital
PUCMM University	Professional guidance; administration	→	
SESPAS Government	Financing; Normative structure	→	

term results. In the short term, SESPAS can be proud of getting an extra-ordinary public health program with demonstrable impact for no more than an ordinary investment of public money.[10] PUCMM gets a training and demonstration facility for its new conceptualization of health and approach to health services. CODESA gets the services its constituents have been waiting for.

In the longer term, SESPAS can duplicate and generalize structures and procedures first tried at Modelo Juán XXIII, a process that has already started.[11] PUCMM can use the program's success to leverage local and international support for some of its many other programs. CODESA is strengthening its long-term credibility[12] as a key actor in the never-ending fight for the interests of a disadvantaged population. Every institutional partner profits from this program, both in the long term and the short term.

Most groups in South-Santiago are not organized around health but around sports, cultural, religious, business, gender, and generational or territorial issues. CODESA is hardly known at all to the wider public; only 15% of respondents in a 1998 survey claimed to have heard of it. All the more impressive is the use CODESA makes

[10] This view is not always shared by SESPAS representatives. Political agendas sometimes overshadow objective assessments.

[11] E.g., SESPAS is now exporting the concept of *Unidad de atención primaria* (UNAP — a primary health intervention group), the emphasis on community participation, the wider use of health promoters and the Family Health Booklet.

[12] This credibility will soon be tested, as CODESA is attempting to profile itself as an ARS — *Administradora de Riesgo de Salud* (Health Risk Administrator) under the new Public Health Law, to be funded in proportion to the population served.

of popular groups for its public health mission. At least 72 groups have their health promoter, are represented in a neighbourhood health group and CODESA, and are, therefore, de facto parts of a grassroots health network of considerable scope and depth.

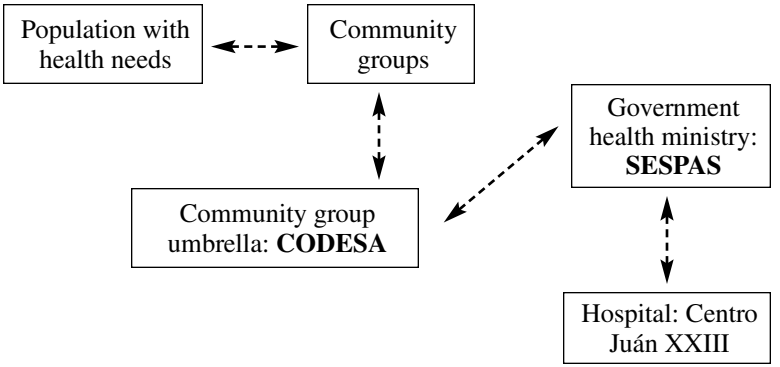
In the previous section I stressed the external factors and institutional pressures — mainly through multilateral agencies — that have made Modelo Juán XXIII possible. An astonishing element must be added here. Contrary to the near-universal practice of donor institutions, the project did not rely much on training certified health professionals and bureaucratic organization. Quite the opposite happened here: rather than creating and expanding a hierarchy of resources, certification and command, it was the small and penniless neighbourhood groups that were given voice and authority.

The Advantage of Working through Networks

David Marsh poses the question: "Do policy networks affect policy outcomes?" (Marsh, 1993: 3) in a general and simple form. For my purpose, I shall reformulate the question in the following way: Does the use of a network approach improve project performance? In other words, does a participatory and consensual management style result in more successful projects and, as a consequence, in greater benefits for the target population? Too often we find an approach appealing without giving much thought to systematically analyzing the empirical evidence. But we need to know "What Works, What Doesn't, and Why" (Dollar and Pritchett, 1998). In the social participation literature, Narayan (1994) has started a trend of scrutinizing project impact but the more theoretical literature on networks remains sterile and unconcerned (Dowding, 2001; Klijn, 1996).

The network approach to managing programs in the social sectors has several advantages compared with conventional, hierarchical, management styles. First, there is greater efficiency since partners' interests, rewards and motivations are closely connected to their contributions. Networks make people work harder. Secondly, monitoring and follow-up are more easily integrated into everyday work, since all partners have an interest in closely watching over their resources. Finally, networks are more flexible, adapting rapidly and economically to changes in environments and resource levels.

Figure 2 ***CODESA network representation and the flow of participation and influence***



In conventional, hierarchical programs all influence over program activities is top-down, from the director to the beneficiary level. Monitoring information flows in the opposite way and is generally handled by people other than the frontline service providers. In the Modelo Juán XXIII the flows are more complex than that. CODESA is an important player that receives much local feedback and has a voice in shaping program activities, hiring and the supervision of personnel. There is, of course, also a need for technical feedback from the field to the hospital, e.g., concerning the efficacy of an immunization campaign or the prevalence of a particular disease, and this technical feedback is handled through conventional reporting procedures. But the extensive reliance on promoters who do house calls and know their "*manzana"* (block) well, rather than on dispensary personnel, does much to make this technical feedback more rapid and efficient.

The network linking CODESA to its community base is efficient since the very same health promoters work in the neighbourhood, represent neighbourhood group interests (sometimes directly, sometimes indirectly) in CODESA and are assisted by supervisors who are closely linked to the program at Centro Juán XXIII. This close connection between the hospital and the community base is essential in particular for carrying out preventive health measures. It is much more difficult to convince a

population of the need to prevent future, potential disease than to implement curative measures once people are ill.

Networks are essential at Modelo Juán XXIII. As we have seen, an inter-institutional network directs the program, an inter-organizational network, through CODESA, constitutes its grassroots base, and many inter-personal networks link beneficiary populations and service providers via the health promoters. Why are these networks effective? There are at least three explanations. First, active networks provide regular, repeated contacts. Partners cannot remain in isolation and issues cannot remain unresolved. Networks inevitably produce constant interaction, and they test and renew the relations and commitment of partners every day and every week. Secondly, networks provide a space for debate and compromise. Like all good programs, Modelo Juán XXIII not only includes divergent interests and occasional conflicts but also has mechanisms to resolve conflicts. CODESA usually decides by consensus; issues are debated until all partners find the solution acceptable. Thirdly, networks enforce rules and boundaries. Non-performing employees and volunteers are forced to change or eliminated. Intrusions by state authority (e.g., in the assignment of medical personnel) have been resisted successfully. Hierarchical structures are vulnerable but networks are inherently adaptive. Modelo Juán XXIII is a survivor by nature and design.

Each of the key actors of the program network contributes more and carries more responsibility than they would in more conventional settings. Among key individual actors, the health promoters have a much broader scope of activity than the SESPAS promoters do, the supervisors frequently head community households (*UROCs*) and the medical personnel free themselves to provide a more holistic, in-depth attention to their patients and their families, by seeing fewer patients per hour than in conventional hospitals. Among the key institutional actors (SESPAS, PUCMM, CODESA, Centro Juán XXIII, Community groups, Neighbourhood health groups) there is not one that is not pushed to act beyond the limits of conventional curative medicine. Working through networks is demanding but productive. The program's vision is correct: it is not medical technology but participation and partnership that are the key to health in South-Santiago.

Health promoter: rewards of unpaid work

- "You learn a lot of things that you wouldn't learn just sitting in your home."
- "They give us workshops about leadership, human rights, violence, citizen's rights, human relations…"
- "We don't work alone: there is the supervisor, the nurse and the doctor."
- "Being able to provide guidance to so many families with sick children."
- "Working for the community."

What is common to all these statements? A sense of personal value and dignity, a satisfaction of being able to make a difference, an emotional reward for unpaid work.

One of the striking characteristics of the individual actors is that most of them are women. This is no doubt to some extent due to the customary concentration of women in helping, service and teaching roles throughout Western societies. Some of the married supervisors and promoters point to a traditional allocation of the "provider" role to the man — which according to their own testimony leaves the woman more time for the volunteering and underpaid positions in the program. In addition, it appears that much of the popular mobilization that pre-dated the program was actually driven by women, especially the bread riots of the 1980s. Finally, Caribbean societies in general have struck social scientists for at least the last two centuries as allocating more power and responsibility to women then contemporary agrarian societies did elsewhere. There may be many diverse reasons for the great numerical dominance of women in the program but the result is beyond doubt: women determine the originality of the program and do most of the work in it.

The Main Activities at Modelo Juán XXIII

The principal program activities fall under three categories: curative medicine, preventive medicine and social service activities. **Curative medicine** is practiced at the hospital in the departments of Obstetrics-gynecology, Internal Medicine, Pediatry, Mental Health, Surgery and Emergency Care. The lower-than-average

caseload per hour and physician is the main difference setting the program apart from what is practiced in other Dominican public hospitals.

Preventive medicine is organized in seven programs: Immunization, Anti-tuberculosis, Family planning and AIDS, Free medication, Training of promoters and supervisors, Community health education, and Staff training at Centro Juán XXIII. Of these, Community health education is the most original part. It rests on the shoulders of the health promoters who are, therefore, the key players in the most innovative activities of the Modelo Juán XXIII.

Social service activities are again the responsibility of the health promoters. These (almost exclusively) women provide community training activities, talks and workshops on such diverse topics as sex education, domestic violence, women's rights, democracy and health, alcoholism, learning difficulties of children, garbage disposal, latrine use and nutrition. Besides, the promoters act as community organizers, detect and report health and family problems at early stages, register births, deaths and family moves, and participate in CODESA activities.[13]

What is original at Modelo Juán XXIII is not so much what acts are performed at the hospital but the range and combination of activities. Having many diverse responsibilities gives each individual actor autonomy and a sense of value that would hardly be present if they were more specialized and bureaucratically managed. This in turn explains the high level of motivation and efficiency.

A word on training activities at the program. One might want to interpret all that is happening in the training of promoters and supervisors, and in their popular education activities as well, as human capital formation. One might further want to interpret the organizational activities in South Santiago as human and social capital formation. There is much to be said for such interpretations since something that is worthwhile, desirable and can be invested

[13] One should not read the enormous scope of issues covered by the health promoters as a call for total change and revolution. It is rather a policy of many small steps that has proven successful during the long years of confrontation. Concrete gains are preferred to unrealistic hope.

in other pursuits –call it capital — has clearly been built up over time. On the other hand, this emphasis on social capital has its weaknesses. It creates the illusion that there is something solid, durable and static which is clearly not the case. The groups, the program and their public recognition are changing all the time. Battles are fought constantly and there is not a day when the program does not have to prove its legitimacy and fight to preserve its originality.

Why is the state permitting and even promoting the project? One of the reasons is evident: the conventional function of curative medicine is taken care of. Certified personnel are working at the hospital, respecting all of SESPAS's rules and regulations. If this was not so, opponents in the health hierarchy would not tolerate this unconventional project; the health centre would most likely be lost. But there is more at play here and the state and the bureaucracy are not the same thing. The pattern of base support and influence observed in South Santiago is precisely the "embedded autonomy" described by Evans (1995) in the functioning of "intermediate state apparatuses." Modelo Juán XXIII has sufficient autonomy and discretion to go beyond the conventional, hierarchical model of curative medicine. Neighbourhood support and pressures are strong, diverse and effective and this provides the anchor (or "bed" in Evans' terms) that maintains autonomy. That these pressures are exercised for step-by-step improvements rather than for total revolution is significant. The state cannot tolerate revolution but it can delegate limited autonomy.

To summarize, what has the Modelo Juán XXIII produced so far? It has provided a health focus to community mobilization, has organized complex networks and partnerships, has helped a disadvantaged community to take charge of its health and has provided a unique platform of collaboration between the state and civil society.

Key Accomplishments and Challenges

The impact of the Modelo Juán XXIII is difficult to estimate because the client population is shifting and expanding, a specific health baseline has never been established and preventive measures can only show their effects over long time spans. Nevertheless, there are several indications of the value of the program's work.

- Before the program, the health indicators for South-Santiago were below those for the province as a whole. Now they are better than those of the general population.
- In 2001, diphtheria claimed seven lives in the province, four in the city but none in South-Santiago.
- In 2001 there were dozens of new cases of Sarampion (Rubella), mostly in the city of Santiago, but none in South-Santiago.
- The systematic vaccination program (through schools) turned out to be more complete and more successful than the occasional campaigns the government unleashes in other parts of the country.[14]
- Thanks to sustained community involvement the meningitis and dengue outbreaks have been contained much better than past outbreaks.
- Private clinics have reportedly lost ground and patients in South-Santiago at the same time that Juán XXIII has gained respect, confidence and clients.
- The government has decided to replicate the model in three more areas of Santiago.
- Evaluations of UNISUR (in 1996 and 1998) as well as interviews with residents and patients (in 2001) have documented a high level of popular satisfaction with the program.

While these points cannot prove program impact in a rigorous statistical sense, they leave no doubt about the generally positive impact. Any program evaluation would come to the conclusion that Modelo Juán XXIII is worth supporting. As two residents noted: "This is not a profit-making institution but one that serves poor people" or, more simply: "They give good service." Nobody could hope for higher praise.

What elements contribute to the model's success? The **origins**: the popular mobilization history has left a permanent stamp on the program. Like the streets, the school, the drinking water and the electricity, health is something that must be fought for. The **vision** of access to health services as part of democracy and a just

[14] In a typical case of misplaced governmental priorities, funding for school programs has now been cut.

Underpaid supervisors : Why don't you just quit?

- "I love the community."
- "Because the people have confidence in me."
- "I have a commitment toward my people."
- "I have committed myself and I am sorry for the children."
- "We can help the poor spend less on health and get educated."

What is common to all these statements? These women get more out of their jobs than the pittance of a salary. Emotional rewards and a strong community spirit explain their commitment.

distribution of resources is a convincing and contagious one. The **strategic focus** on preventive health care is paying off in both health and social terms: a population feels less marginalized if it receives more than just curative emergency services. The **composition** of the networks and partnerships has proven effective, especially during periods of political change, nepotism and budgetary turbulence. Finally, the **quality of service** delivery is in some way itself a contributor to positive impact since the intensive feedback typical of a participatory program does much to maintain the quality of service and target those beneficiaries identified by the health promoters as needing specific attention.

What are the principal challenges to the program? Is there room for improvement? What can be done to ensure a sustained operation and beneficial impact in the future? The following issues can be raised.

A. How to maintain the focus on health education and preventive medicine, and the holistic approach to health in general

This focus demands dedication and extra work from all partners and does not necessarily pay off in the political arena where budget allocations are decided. Simply adhering to the original mission is a major challenge since it involves continuous resistance against governmental lethargy and the conservatism of part of the medical profession.

B. How to influence health policy without becoming embroiled in the partisan political process

Like all visionaries, the individuals involved in Modelo Juán XXIII are convinced of their mission and would like to see their approach in more general use. They will have to engage in serious strategic planning if they want to influence Dominican health policy. At this point they are not yet very experienced in strategic planning, have not clearly identified their political friends and opponents, have only the most personalized and ad-hoc procedures for neutralizing opposition and have not used publicity or public relations to further the case of more general reforms. For example, they have not been active players in the formulation of the new health and social services legislation that will certainly affect them deeply.

C. How to guarantee financial stability

So far it has been possible to operate exclusively with government financing and, to a minor extent, selective collection of user fees. However, there are signs that the budgetary situation is worsening. The program received much more favourable treatment under the previous government than under the present one. Even if the Centro Juán XXIII is part of the regular budget of the health ministry, its fortunes fluctuate with governmental budgetary priorities. Much of the preventive and egalitarian elements of the Modelo are in fact subsidized or entirely paid for by user fees. Such user fees cannot be increased at will without jeopardizing the egalitarian ideology that motivates the partners.[15] Finally, even the (indirect) foreign donor support can conceivably have problematic consequences.[16]

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[15] The downturn of the Dominican economy has drastically reduced user fees received; in 2002 there was a monthly shortfall of RD$ 95,000 (or the equivalent of the user fees for 76 caesarian sections).

[16] Although Modelo Juán XXIII does not receive direct foreign donor support, it can be seen as profiting indirectly. Centro Juán XXIII, the hospital, was built with Lomé IV support, UNISUR had a Kellogs foundation grant, PUCMM receives numerous grants and contracts from various donors, the government runs many programs with IDB and other loans and even some local PVOs have foreign support. Even though it in no way supports Juán XXIII operating costs, all this profits the Modelo indirectly, thus making the program to some extent vulnerable to longer-term shifts in foreign donor support. The program's attempt to become an ARS under the new public health legislation is, in effect, an attempt to receive foreign donor money (mainly from IDB) channelled through the health reform program.

There are some observers who think Modelo Juán XXIII should apply for substantial foreign donor support. This would no doubt increase its budget and its autonomy from government interference — for a few years. But it would come at a great cost and in all likelihood would ruin the originality, the legitimacy and the demonstration effect the program now enjoys. The track record of foreign-supported health programs is quite miserable, as will be shown in the next section of this article. Besides, such programs are frequently unsustainable and betray their beneficiaries when foreign financing runs out. There is no value in showing that foreign money can buy good services — for some time. There is much value in applying home-grown, participatory solutions that can be maintained with local resources, which is what Juán XXIII demonstrates with great success.

D. How to assure continued collaboration of the health promoters and supervisors

As it is, most of the innovative activities parts of the program rely on a single pair of actors, the health promoter and her supervisor. The promoter is a person volunteering her time, with no budget, no salary, no medical training and little logistical support. She is carrying the greatest burden for all that makes Juán XXIII different from conventional hospital operations. The promoter appears to be motivated by community spirit, the satisfaction derived from doing something that is appreciated and the hope for promotion to the paid position of supervisor. The program may have to do more to keep and find enough qualified persons for this key position.

E. How to maintain institutional support

The authority and prestige of the university (PUCMM) and the political agility of its top staff, including the rector, have been critical in preserving the program's integrity, especially following the recent change in government. It is to be hoped that this institutional support will also be there in future crises. However, this is no more than hope. The program would do well to look for broader and more diversified institutional support now that times are good, rather than waiting for the next time a government wants to cut personnel or transfer key staff.

State and civil society: examples of an uneasy partnership	
Government action	***Program-level effect***
Fiscal generosity	SESPAS pays the major part of operating costs (75%), provides physical structure, and tolerates program autonomy.
Administrative intrusion	New government fired 16 employees at Centro Juán XXIII. The decision is eventually revoked.
Friendly initiative	Police organized "Un día en el barrio"; community collaborated, including some promotoras de salud.
Bureaucratic inflexibility	SESPAS does not permit formal meetings between Modelo Juán XXIII and the UBAS, even though much of the program's outreach is through the UROCs which in turn are linked to the UBAS.

F. How to manage the program's growth and success

Through its reputation for the quality and affordability of its services, the program is attracting patients from well beyond the geographical area it is supposed to serve. Since government financing is in the form of fixed grants, this creates a strain on budgets and manpower that is only partially alleviated by the economies inherent in preventive medecine. Besides, as a consequence of their professional recognition, key staff are increasingly drawn into all kinds of time-consuming activities that may be important but are beyond their original terms of reference. Finally, even community-level activities can be expanded to the point where they need resources and logistics not currently available to the program. These factors, especially the over-extension of the staff, will have to be watched. Good programs have in the past fallen victim to their own success.

Beyond the Single Case: Modelo Juán XXIII in Comparative Perspective

The goal of all the work in South-Santiago is social development in the broadest sense. We have become increasingly aware over the past decades that such development is very much

dependent upon well functioning institutions. Modelo Juán XXIII is an impressive case of institutional development and change. A brief comparison with some other health programs will allow us to see more clearly why this program succeeds where so many other programs fail.

At the time of writing, the Inter-American Development Bank (IDB) was financing thirteen health programs in Latin America and the Caribbean.[17] According to the standardized performance monitoring procedures used by IDB, only one of these programs was performing fully satisfactorily (with a rating of 100%) while twelve were in trouble (average rating: 51%). What distinguishes the good program from all the others is that it uses a network of partners, rather than the central government alone, to implement its activities. This finding can be generalized beyond the health sector. Of all 149 IDB projects under study in 2002, only 46 used a Network Approach. Their performance rating was nearly twice as high as that of the other 103 projects. Modelo Juán XXIII is, of course, not part of this group since it does not receive IDB financing. If evaluated according to the same standards, Modelo Juán XXIII would clearly be in the company of the successful minority, both in terms of using a Network Approach to substantial advantage and in terms of satisfactory performance of its components.

A second finding bears relevance in this context. Of all the sectors that receive IDB support (e.g., education, municipal development, health, micro-enterprise, etc.) it is in the health sector that central government dominance is greatest and that partnerships are least present. Only one of the thirteen health projects involves any partner other than the central government at all. This translates into only 7.5% of projects in the health sector using a Network Approach, compared to 33.1% in the other sectors. Not surprisingly, the average performance ratings in health are the lowest of all sectors. Most IDB work in the health sector is hierarchically organized, favours a monopolistic situation of the central government and is unsatisfactory in quality and impact.[18]

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[17] This excludes programs co-financed with other donors as well as some very limited programs in the small islands of the Eastern Caribbean.

[18] Performance ratings are done by IDB officials most closely associated with the projects, in the IDB country offices. Each project component is rated separately.

What are the common features of successful programs? A qualitative analysis of three recent projects has highlighted several surprising characteristics that can also be found in Modelo Juán XXIII.[19] In a general sense, successful programs appear quite unconcerned about their partners' previous experience *in the field of program activity*. Partners pre-date the program itself and have a history of successfully working in their field, whatever that field may be. They choose to collaborate in a new program but they do not owe their existence to this new program. Modelo Juán XXIII selects its key frontline personnel — the promoters and supervisors — from among people who have mostly no medical background at all. What counts is not certified previous experience but a high level of motivation. The rest comes with training.

Characteristics	Modelo Juán XXIII	Three other successful programs
Partners are older than the program itself	Yes	Yes
Partners' expertise is limited to program activities	No	No
A formal contract establishes and regulates the partnership	Yes	Yes
There are inherent rewards for successful partners[20]	Yes	Yes
There is close monitoring and follow-up for all activities	Yes	Yes

What distinguishes successful programs further is that they mobilize diverse networks and respect the autonomy of collaborating partners. Modelo Juán XXIII uses government funds and standards, university medical expertise and community

[19] The three projects are located in Peru, Haiti and the Dominican Republic.

[20] The conventional mismatch between efforts and rewards is one of the things stated recently in a thoughtful "Lament for Development Assistance Lessons Lost" (Lanfranco, 2005). The *health promoter* is in fact a gatekeeper for resources (such as vaccinations, medication, a hospital bed) which improves her status in her organization. Unlike a government official, she is not untouchable and can, therefore, not turn her gatekeeping into rent seeking behaviour.

mobilization capacities and turns all this into a progressive and effective public health program. It even uses sports clubs as instruments of public health. Such diverse networks are adaptive, resilient and stronger than their components alone would be. But these partnerships are not informal. They typically involve a written accord and a legally binding contract specifying the main aspects of partnership. The CODESA statutes are a case in point.

Next, successful programs value the short-term interests of their stakeholders. They do not preach elusive long-term benefits and dreams but produce tangible benefits for all partners in the short term. Modelo Juán XXIII provides an attractive and convincing alternative to conventional care. All partners, both institutional and individual, profit from this program and see it in their interest to continue their participation.

Finally, successful programs manage to neutralize government opposition. Modelo Juán XXIII has done even better than that. The government is a full partner in the experience and has now started applying the approach elsewhere in South-Santiago. In some countries, programs may have to bypass government but this is definitely not the case here. Instead of wasting energy in fruitless battles, state and civil society have found a way of being inter-dependent partners.[21]

Conclusion

Modelo Juán XXIII has built up, over a few years, an impressive little hospital with buildings, treatment facilities, laboratories and equipment, personnel and training programs and all the other elements of institutional capacity. But all this is just capacity and does not in itself guarantee positive impact. True institutional development is more, and more important, and the program has achieved this as well. It has created much public value. Its legitimacy is unquestioned among the beneficiary population as well as among institutions of great stature such as SESPAS and PUCMM. It has achieved permanency beyond isolated actions and

[21] This does not mean that the state has not at times taken an adversarial position. Actually, *all* of the program's crises have been over its autonomy and state interference. But what counts is the result: that Centro Juán XXIII is recognized as part of Salud Publica despite being different and in many ways autonomous and self-managed.

has successfully practiced a new approach to public health. UNICEF has proclaimed a democratic "right to health" in some distant conference. Modelo Juán XXIII has put this claim into practice here in the Dominican Republic.

Can this experience be replicated? Certainly not in the sense that all public health programs could be carbon copies of this one program. Without the tradition of neighbourhood mobilization, without the help of a benevolent and influential academic partner and without the unselfish generosity of a small group of volunteer health promoters the program could never have become what it is. Other cities and districts might not be able to harness such resources and without them, replication will not be possible. However, many programs might find their own adaptations of the basic ingredients of *the vision that gave rise to the Modelo Juán XXIII*: that health is not destiny but a right worth fighting for, that diverse partnerships can be more productive than state monopolies, that prevention is an integral part of health services and that human dignity makes medical technology more, not less, effective**.**

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