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International NGOs and primary health care in Mozambique: the need for a new model of collaboration

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Abstract

In keeping with the neo-liberal emphasis on privatization, international aid has been increasingly channeled through non-governmental organizations (NGOs) and their expatriate technical experts to support primary health care (PHC) in the developing world. Relationships between international aid workers and their local counterparts have thus become critical aspects of PHC and its effectiveness. However, these important social dynamics of PHC remain understudied by social scientists. Based on three years of participant-observation in Mozambique, this paper presents an ethnographic case study of these relationships in one central province. The Mozambique experience reveals that the deluge of NGOs and their expatriate workers over the last decade has fragmented the local health system, undermined local control of health programs, and contributed to growing local social inequality. Since national health system salaries plummeted over the same period as a result of structural adjustment, health workers became vulnerable to financial favors offered by NGOs seeking to promote their projects in turf struggles with other agencies. It is argued that new aid management strategies, while necessary, will not be sufficient to remedy the fragmentation of the health sector. A new model for collaboration between expatriate aid workers and their local counterparts in the developing world is urgently needed that centers on the building of long-term equitable professional relationships in a sustainable adequately funded public sector. The case study presented here illustrates how the NGO model undermines the establishment of these relationships that are so vital to successful development assistance. © 2002 Published by Elsevier Science Ltd.

Keywords: NGOs; Mozambique; International aid; Primary health care; Social inequality

1. Introduction

The decision to award Doctors without Borders (*Médecins Sans Frontières*), the 1999 Nobel Peace Prize demonstrates the extent to which international non-governmental organizations (NGOs) and their expatriate aid workers have become key players in health promotion in the developing world. Over the last 20 yr, the major bilateral and multilateral actors in international health, including the United States Agency for International Development (USAID) and the World Bank, have increasingly channeled aid to the health sector in poor countries through NGOs (USAID, 1997; World Bank, 1993,1997; Buse & Walt, 1997; Green & Matthias, 1997; De Beyer, Preker, & Feachem, 2000). The proportion of bank-financed projects that included NGOs rose from 20% in 1989 to 52% in 1999 (World Bank, 2000a). The ostensible rationale for this shift rests on the largely unexamined assumption that NGOs have a comparative advantage since they can often reach poor communities more effectively, compassionately, and efficiently than public services (Edwards & Hulme, 1996b; Green & Matthias, 1997; World Bank, 2000; USAID, 1997; Zaidi, 1999; Turshen, 1999). However, this "New Policy Agenda" has been ideologically driven, intimately bound up with the neo-liberal emphasis on free markets, privatization, and the development of an imagined "civil society" necessary for "sustainable development" (Edwards & Hulme, 1996a; Chabal & Daloz, 1999; Powell & Seddon, 1997; Turshen, 1999; Stewart, 1997; Hanlon, 1996; Drabek, 1987). One USAID policy document states, "At all levels of

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development, a flourishing NGO community is essential to effective and efficient civil society….Civil society organizes political participation just as markets organize economic participation in the society…Sustainable development is likely to occur where both civil society and markets are free and open'' (USAID, 1997, p. 2).

In this new climate of privatization, international NGOs have been promoted to fill the gaps in public services created by World Bank/International Monetary Fund-promoted structural adjustment programs (SAPs) that normally slash government health spending (Turshen, 1999; Gary, 1996; Edwards & Hulme, 1996b; Laurell & Arellano, 1996). In Africa, USAID and the World Bank have been the most aggressive proponents of SAPs and have recruited NGOs to provide the social safety nets for the poor as inequality has increased across the region (Anang, 1994; Chabot, Harnmeijer, & Streefland, 1995; Ndengwa, 1996; Okuonzi & Macrae, 1995; Mburu, 1989). However, based on findings from the following case study in central Mozambique, this paper argues that the inundation of the health sector by international NGOs since the late 1980s may have in fact damaged the PHC system. Rather than redistributing resources to promote greater equity and help alleviate poverty, the flood of NGOs and their expatriate personnel has fragmented the health system and contributed to intensifying social inequality in local communities with important consequences for primary health care delivery. The Mozambique experience described here, and certainly replicated in many other developing nations, indicates that a new model for collaboration between foreign technical experts, national providers, and local communities is urgently needed to maintain equity-oriented primary health care.

The NGO phenomenon in the health sector

A familiar mix, or what some have called an ''unruly melange'' (Buse & Walt, 1997), of international donors (bilateral and multilateral) and the health agencies they support, such as Save the Children, Doctors without Borders, Africare, Care, World Vision, Oxfam, Concern, Food for the Hungry International, Family Health International, Pathfinder, Population Services International, and others can be found in many developing country capitals and provinces where they have become key players in financing and implementing primary health care programs. With the collapse of the socialist bloc as an alternative source of capital and technical support, Western agencies have become central fixtures across the neo-liberal socioeconomic landscape of the Third World.

A voluminous literature has developed over the past two decades on the NGO phenomenon, and foreign health aid specifically (Green & Matthias, 1997). It is now widely accepted that the flood of aid agencies into countries such as Mozambique has had a range of negative consequences for local health systems (Cliff, 1993; Pavignani & Colombo, 2001; Pavignani & Durão, 1999; Turshen, 1999; Buse & Walt, 1997). The literature cites the lack of aid coordination and the subsequent fragmentation of health activities in many developing countries. The multiplicity of competing organizations that duplicate program support, create parallel projects, pull health service workers away from routine duties, and disrupt planning processes has generated concern for both donors and recipients. Most of the research and commentary on the issue has focused on the dynamics of policy-making and management at high levels in Ministries of Health and within agencies themselves (Walt, Pavignani, Gilson, & Buse, 1999; Buse & Walt, 1996; Gilson, Sen, Mohammed, & Mujinja, 1994). However, this paper argues that an emphasis solely on the managerial aspects of aid coordination may mask the greater structural transformation in local communities generated by the arrival of NGOs and other foreign agencies within local settings where actual programs are implemented. As illustrated by the Mozambican experience, the fragmentation of primary health care systems is not only the product of difficulties in aid management, but also the consequence of intensified local social inequality produced by foreign aid channeled through NGOs at the expense of the public sector.

NGOs and the expatriate presence

The most direct interaction/confrontation between expatriate NGO aid workers and their target communities occur ''up-country'', in the provinces where foreign aid presumably arrives at its intended destination. In this unusual social interface between highly educated technicians from rich countries and communities in extreme poverty, relationships of power and inequality are enacted in ways that profoundly shape primary health care policies and programs. In this engagement, the exercise of power by wealthy donors over their target populations, including local health workers, is laid bare and the disempowerment of public sector services by international agencies is most visible. Expatriate health workers employed by international agencies can be found at all levels of many developing world health systems; from Ministry of Health offices in capital cities to remote villages where they are involved in health program implementation. These agencies' activities may be integrated into Ministry programs, or conducted completely outside the public system. In addition to their expatriate staff, agencies usually employ small armies of ''nationals'', from trained health professionals and office workers to drivers and guards. Usually these workers are paid far more than their counterparts in the public sector. And, as Chabol and

Daloz (1999) have argued, many among the elite sectors in local populations have learned how to maneuver in the NGO world of the new "civil society" for personal benefit. They state, "The use of NGO resources can today serve the strategic interests of the classical entrepreneurial Big Man just as access to state coffers did in the past…[I]t is as well to recognize that there is an international "aid market" which Africans know how to play with great skill" (1999, p. 23).[1]

The Mozambique case suggests that the manner in which expatriate agency workers engaged both their Mozambican counterparts, and the larger communities where they resided, had an enormous and often negative impact on many PHC programs. These relationships were realized both within formal work settings and in the daily life of the community where expatriates resided, schooled their children, and conducted their social lives. As Uvin has shown in his important analysis of the development industry in Rwanda before the 1994 genocide, foreign aid can contribute to local processes of "exclusion" and "humiliation" that undermine equity-oriented efforts in development (Uvin, 1998). He writes:

> [T]he development aid system contributes to processes of structural violence in many ways. It does so directly, through its own behavior, whether unintended (as in the case of growing income inequality and land concentration) or intended (as in its condescending attitude toward poor people). It also does so indirectly, by strengthening systems of exclusion and elite building through massive financial transfers, accompanied by self-imposed political and social blindness…The material advantages accorded to a small group of people and the lifestyles of the foreigners living in Rwanda contribute to greater economic inequality and the devaluation of the life of the majority (1998, p. 143).

Given how important these social dynamics are to the impact of foreign aid on primary health care in most of the developing world, there is a surprising dearth of research on these relationships. Social scientists, especially medical anthropologists, have contributed to the study of primary health care by examining the presumably problematic health-related behaviors of poor populations, the social world of national primary health care providers, and even the bureaucracies of international agencies (cf. Foster, 1977; Coreil & Mull, 1990; Justice, 1987; Nichter, 1996). However, little research on primary health care has examined the interface between expatriate foreign health agency workers in the field and the poor communities they are supposed to serve. Perhaps the inequalities of wealth and power are so obvious that they are taken for granted, or social scientists are afraid to bite the feeding hand. As Uvin states for Rwanda, "To the extent that some people at some point do realize the political and social stakes and abuses that surround development aid and its projects, they often choose not to react. This has various causes, including fear of rocking the boat, of making enemies, of losing jobs" (Uvin, 1998, p. 156). Publications by many of the major international NGOs themselves rarely if ever allude to the importance of these fieldwork dynamics.[2]

This paper provides a brief ethnographic sketch of these relationships in a central province of Mozambique during the period from 1993 to 1998. The vignette seeks to provide a case study of the social cost to primary health care, and the poor populations it serves, of donor policies that channel aid through foreign agencies at the expense of the public sector.

Background

The health system in Mozambique

After independence from Portugal in 1975, Mozambique established a primary health care system that was

[1] Chabal and Daloz (1999) also argue that the proliferation of NGOs working in Africa, especially national NGOs, does not reflect a flowering of genuine civil society vis-à-vis the state but rather the adaptation by local political actors to conditions laid down by foreign donors. Foreign aid resources still largely flow to the same elites but through new conduits.

[2] Any reflection on the impact of expatriate staff interaction with local counterparts is difficult to find in NGOs' publicly available literature. Oxfam is one modest exception with its references to the importance of "transparency" and openness in international aid dealings, including its own (Oxfam International, 2001). Doctors without Borders emphasizes the moral dilemmas sometimes encountered by NGOs and their workers in the field related to the social, military, or economic context of aid work (cf. Bouchet-Saulnier, 2001). However, there is little mention of expatriate conduct in their day-to-day fieldwork and the impact of their presence on local societies beyond formal project outcomes. Major NGOs based in the United States and Europe also represent a broad range of ideological perspectives on the processes of structural adjustment and privatization that have contributed to NGO proliferation (Green & Matthias, 1997). Those with close ties to USAID, such as World Vision, Population Services International (PSI), and CARE tend to be supportive of privatization efforts. In Mozambique, PSI promotes social marketing of its health products through private sector vendors, while CARE has mounted projects designed to support entrepreneurs in craft production and marketing. Other agencies, such as Oxfam and MSF are wary or critical of privatization and call attention to the inequities created by structural adjustment. However, nearly all appear to embrace the importance of enhancing "civil society" vis-à-vis the state. No documents from major agencies were uncovered in the research for this paper that directly addressed concerns over the use of NGOs as substitutes for public services.

eventually cited by the WHO as a model for other developing countries (Walt & Melamed, 1983). By 1978, over 90% of the population had been vaccinated, and by the early 1980s 1200 rural health posts had been constructed and staffed. Over 8000 health workers were trained and placed in service. During this period about 11% of the government budget was committed to health care (Gloyd, 1996). The war initiated by the Rhodesia and South Africa-backed Mozambique National Resistance, known by their Portuguese acronym RENAMO, targeted infrastructure and personnel in the government health and education services from 1980 to 1992. By 1988, hundreds of health posts were destroyed and many health workers killed, injured, and terrorized. RENAMO-controlled areas, which constituted nearly 50% of the rural areas in some provinces, were devoid of any health services for many years. During this period in 1987, Mozambique initiated an IMF-promoted structural adjustment program in which currency was devalued, government services cut back, prices increased, and a free market economy promoted. By 1990, state per capita spending on health was half of its 1980 level (Cliff, 1993). In that year, the IMF pressed Mozambique to intensify economic reform and privatization (Hanlon, 1996). After over a decade of adjustment, government spending on health care declined to only 2% of the national budget reflecting the shift in priorities away from health demanded by the structural adjustment programs (Gloyd, 1996).[3]

There have been two distinct periods of expatriate technical assistance to the health sector in post-independence Mozambique. In the late 1970s and early 1980s hundreds of left-leaning Latin American, Western European, American health professionals came to support Mozambique's well-known commitment to building a primary health care system. Others came later to help maintain the system in the face of increasing RENAMO attacks in the mid-1980s. Known as *cooperantes* in Portuguese, many worked within government health structures as district doctors and nurses for local pay in difficult living conditions. During this period there were few if any NGOs operating in the country, and nearly all foreign aid was channeled through the National Health Service (NHS) at a national level. However, with the loss of aid from socialist countries and the government's turn toward the IMF, increasing numbers of foreign aid agencies and NGOs began to descend on Mozambique in the late 1980s and early 1990s to tackle the humanitarian disaster created by RENAMO destabilization. By the late 1990s, the NHS received about 50% of recurrent expenditures and 90% of capital expenditures from international donors (Pavignani & Durão, 1997). The state budget paid national staff salaries, while donors paid expatriates working within the NHS. Much of the foreign funding to the NHS came in the form of project aid directed toward specific donor-identified objectives. Nearly 100 agencies were spread throughout the country supporting the health sector by the early 1990s (Hanlon, 1996). By 1996, there were 405 individual projects managed by these agencies within the NHS. As Wuyts points out, most of these projects had high administrative costs (30–40% of project funds) and often failed to coordinate well with other donors (Wuyts, 1996). Even though many projects were integrated into NHS programs, Mozambicans often did not have genuine control over budgets or project development (Cliff, 1993; Hanlon, 1991). Bilaterals such as USAID channeled the bulk of their health funding through NGOs that often operated quite independently of the NHS (Pavignani & Colombo, 2001). Nearly all the provincial capitals in the country filled up with offices, fleets of four-wheel-drives, expatriate aid workers, and their families. By 1992, in the province where this research was conducted, there were 10 foreign agencies supporting the health sector in one form or another, with foreign personnel and offices. Another dozen foreign agencies were active in other sectors.

[3] The merits and achievements of Mozambique's structural adjustment program have been hotly debated in the literature. Some supporters of adjustment argue that the emphasis on central planning and state control in the early years after independence from Portugal crippled the economy and sent it spiraling into debt and economic decline (cf. Arndt, Jensen, & Tarp, 2000). Economic adjustment was necessary and urgent some contend. Since 1992, when the fighting ended, Mozambique has shown significant growth in GDP as privatization has accelerated, thus attracting great praise from financial sectors in the international community (World Bank, 2000b). Critics point out that growth has come at the expense of equity (Fauvet, 2001; Hanlon, 1996) and that structural adjustment has harmed the government provision of social services (Hanlon, 1991, 1996; Cliff, 1991, 1993; Marshall, 1990; Wuyts, 1996). However, it is generally agreed by observers on both sides that in its early years adjustment led to cutbacks in government social sector spending and ushered in an era in which foreign aid and NGOs poured into the country and fragmented existing services. Enhanced public sector investment is now generally viewed as a pressing concern by both proponents and critics of structural adjustment (cf. Arndt et al., 2000; World Bank, 2000b).

Research methods

The findings reported here derive from three-and-a-half years of fieldwork spread over two periods, 1993–1995 and 1998, when the author was program coordinator and country representative for a US health agency working in the health sector in two central Mozambican provinces. To obtain information on the social dynamics of international aid in the health sector, the author conducted numerous formal and informal interviews with (1) expatriates working for international agencies in

the health sector (2) Mozambican workers in the national health system, and (3) members of target communities. These interviews were complemented by participant-observation throughout these periods, based on the author's own involvement as an NGO coordinator working within both the provincial health directorate and the world of international agencies in the province. In order to protect both Mozambican health workers and agency employees, neither the province where most of this information was collected nor the agencies discussed are identified by name.

Findings

Research setting and the primary health care system

The majority of the population in the province is rural and very poor with an estimated annual per capita income under US$100 (at the time of this research). Basic health indicators reflect this severe impoverishment; cumulative under-five mortality is estimated at 200/1000 while maternal mortality may be as high as 1500/100,000 (Ministry of Health, 1997). The primary health care system has been extended into isolated rural areas through construction of health posts and centers that offer basic maternal-child health, immunization, nutrition, first aid, and referral services. After several years of rebuilding after the war, the current provincial health sector consists of nearly 70 rural health posts, and health-worker staff of about 500, including 10 Mozambican doctors and 200 nurses distributed throughout ten districts. The Provincial Health Directorate, or DPS (*Direção Provincial de Saúde*), manages the health system from its offices in the capital city. Each district has a health director who manages local programs with some limited autonomy in decision-making. A provincial hospital in the capital provides limited tertiary care. A provincial Department of Community Health (*Repartição de Saúde da Comunidade*) within the DPS is structured to oversee maternal-child health, nutrition, health education, AIDS prevention, immunization (including mobile vaccination brigades), TB, and a range of other community health programs implemented through the PHC network of health centers and posts.

Expatriates in the community

The arrival of international agencies in the province coincided with the liberalization of the economy initiated by structural adjustment policies. The impact of these two connected factors on the economic and social life of the community was enormous. International aid agencies arrived with large budgets and US dollars to pay out. Three health organizations in the province had budgets of over one million US dollars to spend in the health sector per year, compared to the DPS budget of only $US 750,000. Dozens of expatriate health and development workers and their families set up their homes in the provincial capital in the early 1990s. Two agencies built walled compounds, one with armed guards and a swimming pool, to house their European staff. If not compound-bound, most expatriate workers lived in the larger and better kept homes in the "cement city"; the label given to the central areas of Mozambican cities inhabited by the Portuguese during the colonial period.

Where the expatriates who had worked in Mozambique during the *cooperante* period tended to be idealists committed to supporting a public sector national health system, many of the new group were aid professionals who moved from contract to contract throughout the Third World and expressed no particular interest in Mozambique itself. Most of the new aid set were middle- or upper-middle class Europeans and Americans with at least a university education, and some with advanced degrees in medicine, public health, or international studies. Nearly all had career aspirations in international aid, academia, or public health and many were working their way up the ladder in their respective organizations. Some were younger Europeans who viewed their experiences in Africa as an adventure that alleviated pre-career *ennui*. While most had contracts ranging from 1 to 4 yr, a regular stream of European and American consultants flowed through town to conduct baseline studies and program evaluations on short-term contracts.

During this period two new social figures emerged that were emblematic of the new aid culture. These were self-described "aid cowboys" and "aid mercenaries". The former term was often used to describe the foreign worker who derived a thrill from working in dangerous conditions and told aid "war stories" from places like Sudan, Cambodia, Angola, or Sierra Leone. Aid mercenaries, and there were several in the province who referred to themselves as such, admitted very frankly that their only real interest in working in Mozambique was the money. Most aid workers expressed good intentions, but a majority described themselves in discussions as non-ideological technical specialists and professionals not particularly interested in Mozambican political history, culture, the context of international aid, or philosophical concerns with "development". Several expatriates privately expressed contempt for Mozambique and eagerly awaited their transfer out of the country. Many that were interviewed had little if any understanding of the recent conflict or colonial history of the country. They simply wanted to fulfill their contracts and implement their projects. Their main concerns centered on perceived Mozambican ineptitude and the corruption of their counterparts in the government; corruption that had clearly been fed

and nurtured by the arrival of loosely managed foreign aid. With the exception of two agencies, expatriates were paid from US$1000 to US$6000 per month, usually tax-free. Most agencies provided housing, private access to project cars, and funding for personal vacations. One engineer working for a European agency calculated that at the end of his four-year contract he would have saved nearly US$300,000. Many in the new aid set regularly left Mozambique whenever possible to countries in the region with better tourist infrastructures.

For those who stayed, the provincial capital became, as one foreign worker put it, "a good party town" (but still not as good in his estimation as the capital of a neighboring province). Two local discos filled up on the weekends with aid workers back from the field and Mozambicans who could afford the stiff cover charge at the door. A growing sex work industry emerged around the city's nightspots. On any given weekend, one agency or another was hosting a party at their offices or homes. One particularly well-known European NGO gained a reputation for putting on the liveliest parties, and the sound of European "techno" dance music spread out over the poor *bairros* on many weekend nights. They were attended by other aid workers, and cadres of Mozambicans that had managed to ingratiate themselves to the European aid worker social scene. Some were NGO employees while many others were members of an emergent middle-class, some of whom established intimate relationships with European aid workers. Because of their educational levels, linguistic skills, and social talents, members of this new *comprador* group helped expatriates feel at ease within the Mozambican setting and became perhaps the primary Mozambican beneficiaries of the new aid dollars. Conspicuously absent from most of these social functions were government health workers, the expatriates' poorly paid counterparts in the Provincial Health Directorate.

The foreign compounds also became centers for expatriate social activity. Only a select few Mozambicans could make it past the armed guards at the gates. The construction of one of the compounds in the city by a European agency to house its foreign staff generated great resentment among Mozambican health workers and the community generally. The agency had also constructed several much smaller houses for top-level Mozambican health workers outside the compound walls. The Mozambicans jokingly referred to the walled-in European area as "Pretoria" and the Mozambican area as "Soweto". The compound provided perhaps the most visible representation of the new environment of exclusion created by the arrival of aid in the province.

The professional culture of aid workers

Many hardworking and committed foreign health professionals engaged in harmful organizational practices because their positions demanded it. Appropriate planning, coordination, and concern for maintaining the integrity of existing public programs was often not rewarded by the agencies and donors active in the province. In fact, adherence to the principles of good coordination and planning could lead to poor evaluations and the loss of a job in some cases, if project targets were not met as a result. In the prevailing aid culture, the tireless, dedicated, "results-oriented" project coordinator that stopped at nothing to meet his/her output objectives often produced uncompromising, short-term thinking and planning that undermined the broader goals of the health system. Many donors such as USAID, that funneled much of their aid to the health sector through grants to NGOs, increasingly emphasized the need to show short-term results; that is, measurable improvements in health outputs, such as under-five mortality or nutritional indicators, over short project periods (1–2 yr in some cases). This directive was captured in the slogan "managing for results" promoted during annual meetings of USAID-funded NGOs in Maputo. The short-term orientation fit well with the general aid experience of most expatriates who moved from country to country and contract to contract. One European worker stated, "If you stay longer than two or three years people start wondering "what's wrong with him?". Mozambican counterparts in the health system in general were acutely aware that expatriates would only be there for a year or two at best. One Mozambican planner remarked, "Just when they finally know how things work here, and they finally can speak Portuguese, they leave."

As a result of this orientation and professional imperative, the province was inundated with fast-moving project coordinators who worked 6 to 7 days/week setting up offices, administrative systems, baselines studies, interventions and evaluations. Coordinators had to be competitive and driven to promote both their own specific project goals and the public images of their organizations on the national stage. For many organizations it was important to become well-known for work in a given area, such as nutrition, reproductive health, or AIDS prevention. This self-promotional ethos contributed to the notion among some expatriates that the government was an obstacle to their important, well-planned projects, and to their individual careers. Successful projects for many, usually measured by achievement of narrowly defined project outcomes, also meant the potential for promotion within their organizations. The frenetic pace of expatriate professional lives starkly contrasted with the inertia felt within provincial health offices where poorly paid health staff often found

little motivation to show up, let alone invest significant energy in their work (although many did). Many expatriate workers expressed frustration at the perceived slower pace of their government counterparts who were seen as barriers to project implementation and success.

Foreign aid, social inequality, and structural adjustment

This international aid culture, with its "well-resourced" and driven foreign professional class engaged a society experiencing its own rapid class formation in the privatizing economy. The new free market had stimulated the growth of the local merchant sector, and city stores began filling with gleaming commodities, in contrast to the years of war and socialism when consumer products were difficult to find. As one Mozambican put it, "during socialism we had money but nothing to buy, but now there's a lot to buy but we have no money". The rapid social differentiation was visible throughout the town. New cars here and there, fancier clothes and shoes on some, and roof tops in the cement city bristling with new TV antennae and satellite dishes where several years earlier there had been none. This contrasted with the deteriorating conditions in the poor *bairros* that ringed the city, where most of the population did not share in the new bounty. The removal of price subsidies had made it more difficult for many to gain access to adequate food (UNDP, 1998; Fauvet, 2000). The government's own Poverty Alleviation Unit estimated that the percentage of the population under the poverty line increased during this period around the country (World Bank, 1995; Hanlon, 1996; Fauvet, 2000).

Health workers were among those whose incomes dropped drastically. From 1991 to 1996, nurses monthly salaries dropped from US$110 to <US$40, doctors' salaries dropped from US$350 to US$100 (Hanlon, 1996).[4] Because of constraints on budget expenditures mandated by the SAP, staff salaries could not be increased with foreign aid. In spite of the influx of aid dollars, most of the funds were project-specific and were not used to increase staff salaries or benefits. Deteriorating work conditions contributed to a reportedly declining quality of health services in several ways. As Pavignani (2001, p. 7) characterizes the situation nationally, "the steady reduction in health workers' earnings stimulated the progressive diffusion of under-the-desk charging. Aware of the inadequacy of the salary levels, the MoH was unwilling to curb these schemes. The result was the deregulation of health care provision, where each health worker pursues his/her own compensating strategy, no effective control is possible, patients pay significant sums, and health care for the poor is provided at the discretion of the health worker".

The drop in salaries was matched by mounting material shortages, pharmaceutical deficits, equipment failures, and vehicle breakdowns in the midst of the millions of aid dollars that landed in the province. There were frequent reports that pharmaceuticals were being stolen from the health service and sold to market vendors or administered on a fee-for-service basis at the private homes of health service workers. For example, one survey of health post supplies conducted by the author's organization found that over half the health posts in one district had no chloroquine tablets for malaria treatment even though abundant supplies had been delivered to the province. Health workers asserted that much of the chloroquine had been diverted to private practice or sold to private vendors in the open markets. Fuel shortages and lack of vehicle spare parts reduced the number of mobile motorcycle vaccination brigades into remote areas in some districts. In an unpublished assessment of district health center labs, the author's organization discovered that most of the electric agitators needed to conduct RPR syphilis tests for prenatal care patients were not functioning in the province due to lack of spare parts. These kinds of shortages and the unpredictability of medical supplies fed the increasing demoralization of health system workers.

Brain drain

The drop in salaries and attendant demoralization amidst a growing aquisitive and competitive culture in the towns made many health workers vulnerable to the financial temptations offered by the private sector and foreign agencies. By 1998, a private clinic had opened up in the city that provided fee for service treatment at prices that were unaffordable to the majority of the population. Health system workers, including some physicians and nurses, occasionally left their posts to treat patients at the clinic, or worked there during off-hours. It was widely reported that medical supplies were being diverted from the DPS to the clinic and to private practice in the homes of health staff.

[4] Comparing salaries and their buying power during this period of economic upheaval and change is difficult and complex. For example, in 1991, the war economy meant that few consumer products were available, inflation was high, and scarcity of even basic commodities was a problem for nearly everyone, including educated and well-connected elites. A higher salary during this period had a limited impact on material well-being. By 1996, when the economy was growing steadily, inflation had slowed, and commodities were widely available in towns, even those with lowered salaries may arguably have benefited somewhat from the greater availability. However, it was widely perceived among health workers that their salaries had declined over this period both in real terms and in relative terms when compared to others in the private and commercial sectors of the economy.

The demoralization took its toll on feelings of loyalty to the health service reportedly felt by many Mozambicans in the system's early years. Some Mozambican health workers in the province were lured out of the DPS by high salaries to work for NGOs. NGO salaries for trained health professionals ranged from US$500 to US$1500 per month, compared to the US$50 monthly wage for mid-level staff in the NHS. To get a job with an NGO was like winning the lottery. In one year of work for an NGO, one could potentially earn the equivalent of 20 yrs' salary in the NHS. At these rates, not even retirement benefits and job security in the NHS could motivate workers to stay. Jealousy and conflict within the DPS surrounded any speculation that a DPS worker was being wooed for an NGO position. The author was contacted discreetly on many occasions by counterparts in the DPS seeking work. As a culture of individual promotion crept into the DPS, lower-level staff privately expressed frustration at perceived corrupt practices on the part of higher-level program chiefs. For many talented staff, the DPS seemed to offer few chances for professional advancement, feeding the pervasive demoralization. One Mozambican nurse who had left the DPS to work with an NGO for a two-year period spoke angrily about returning to the DPS. "What future do I have there? They want to control me. And you know how the *chefes* [the head officers] are. They just take everything for themselves. I don't have a future there". Careers in the NHS paled in comparison to a professional life within the well-maintained offices, new cars, high salaries, and social status associated with NGO employment.

Coordinating aid to the health sector

Because Mozambique had a relatively well-developed PHC network and set of community health programs, many foreign agencies sought to graft their projects onto the health system. Others created parallel projects outside the health system. The most popular of the government programs chosen for support were those in maternal-child health such as traditional birth attendant (TBA) training and prenatal care, mobile immunization brigades, nutrition and growth monitoring, AIDS prevention, and health education. In order to manage the confusing array of aid program interests in the province, the provincial health directorate called an annual meeting each January of all foreign agencies with interests in funding specific programs, usually primary health care-oriented, in the province's annual plan. Most foreign agencies arrived at the meeting with programs and pet projects approved by their donors or head offices, with very specific objectives and targets that would be evaluated to ensure their own continued funding. This pressure drove individual coordinators, including this author, to promote their own agendas and interventions, whether or not they made sense in the overall provincial plan. For example, so many organizations wanted to support the TBA training that some TBAs received more support than their counterpart maternal-child health nurses in the health posts who suffered supply shortages (Gloyd, 1998).

The special annual meeting with NGOs and agencies provided an opportunity for all the provincial players in the health sector to sort out who would support which programs. Support could be rationally allocated during the meeting to different districts to avoid overlap. This process appeared very sound superficially, but in practice behind-the-scenes deal-making and turf struggles among foreign agencies actually dominated the coordination process. The deal-making nearly always hinged on the provision of extra financial benefits to health service workers in a new aid-specific patronage system. These strategies were generally considered temporary alternative ways to augment salaries that nearly everyone in the aid community and the health system acknowledged were far too low. However, these special benefits were also used to sway DPS program heads to support one NGOs program over another in disruptive turf conflicts. DPS workers could play NGOs off one another and bargain for better deals, while NGO coordinators placed greater emphasis on achieving their own program targets than supporting vaguely defined ideals of agency coordination.

During one annual coordination process, the author's organization and one other NGO both sought to support an overlapping set of reproductive health initiatives in the provincial capital MoH infrastructure, which involved a wide range of interventions targeting prenatal care, STI screening, HIV/AIDS education, and youth-friendly services. Both organizations had received significant funding from their donors for the projects and were under great pressure to implement the plans. Modification of either NGOs' plans could have led to withdrawal of funding completely by donors. Neither the author nor the other NGO coordinator felt their plans could be abandoned without risking their entire projects. A turf struggle ensued in which each organization curried favor with key DPS personnel in order to lobby for approval of each of their projects. Government workers were offered special opportunities for extra contracts on the projects (all officially legal) as rewards for support. Meetings among the expatriates were held in the compound outside of work hours to sort out the impasse but to no avail. The pressure on both NGOs to produce according to their preconceived plans outweighed the need to coordinate activities. Fortunately, the national MoH maternal-child health chief personally intervened and helped reduce the tension by mediating a solution in which key aspects of an overall reproductive health plan were allocated to each NGO.

These processes of deal-making, patronage and foreign agency influence often hinged on the use of several key financial incentives: (1) per diems, (2) seminar training with per diems attached, (3) extra contracts for work tasks such as surveys conducted during off-hours, and (4) temporary topping off of salaries and travel opportunities for higher-level staff to neighboring African countries and even to Europe. These direct incentives were often complemented by smaller favors such as rides to work provided by foreign agency vehicles, and support for personal home construction. Many of these favors and benefits were provided by foreign workers in a spirit of support and compassion for Mozambican colleagues who could barely feed their families on their formal salaries. However, such favors and benefits were also frequently used for leverage in gaining support for agency programs and securing positive responses from health workers when projects were evaluated by donors.

Per diems, virtually never used during the earlier years of the national health system, gradually became necessary components of all field-based project work. Competition among agencies for access to health system workers contributed to inflationary pressures on the per diem rates. From 1992 to 1998, the average overnight per diem increased from about US$3 to nearly US$15 for mid-level health workers. By 1998, this meant that one week of per diems, on average, yielded higher pay than a month's salary for workers at most levels in the health system. Government and agency regulation was weak. Projects that included per diems for numerous field visits away from home were often favored in annual planning. The per diem phenomenon had immediate detrimental effects on some routine community health programs. In the early post-independence period, mobile vaccination brigades initially relied on local communities to provide food and lodging to visiting vaccination teams. However, by the early 1990s, as salaries plummeted, large per diems were routinely paid to the mobile brigades. Unneeded district personnel often accompanied brigades in order to receive the per diem payments. Much of the funding for per diems was distributed per NGO by district. However, if an NGO decided to stop funding the brigades because its project cycle ended or it changed its program, the per diems would dry up and health workers would then often refuse to make the trips. The provincial head of immunizations became exasperated, "Nothing gets done without per diems anymore. People won't even show up for a training at their own health post if there isn't a per diem attached".

The per diem problem was intensified by proliferation of seminars and training for health workers in the annual provincial plan; training usually designed to upgrade skills for involvement in foreign agency projects. Health workers eagerly supported seminars that required travel since one week of per diems at a seminar was worth more than a month's salary. This proliferation of seminars was jokingly referred to by planners as *seminarite* in Portuguese (or seminaritis). There was little incentive to reduce the number of training sessions since seminars allowed agencies to claim that they were "capacity building", while the per diems provided crucial salary augmentation for local workers. The seminars also pulled workers away from their routine duties leading to major gaps in key activities such as patient consultation, data collection, supervision visits, and reporting.

Most foreign projects included baseline studies, surveys of target communities, evaluations, and additional project activities outside the scope of normal health worker duties. Foreign agencies regularly hired key health system staff to work on these extra activities offering lucrative contracts. A standard payment in 1998 for one day's work on a survey was US$25, almost equivalent to an entire month's salary for mid-level workers. While these contracts sometimes provided valuable experience and training to the workers, they also drew health staff away from their routine duties. At least one organization that worked within the DPS in the province made additional contributions to the salaries of higher-level health workers, ostensibly to compensate them for the extra work they would have to do to participate in the foreign agency's activities. One agency provided travel to Europe for top provincial personnel to visit the home offices of the donor organization. Travel opportunities outside the province, or to neighboring African countries, ostensibly for work purposes, were extended to higher-level provincial personnel who could accumulate significant per diem income from the trips. In themselves, these favors and incentives could be seen as providing valuable experiences and important salary supports. But in the context of foreign agency competition, and health worker competition for benefits, these practices were often part of endless negotiations and power plays around health-project promotion. And as Pavignani and Durão state, "The variety of topping-up, subsidies, incentives, part-time private practice, grants, per diems has reached enormous proportions, and one may wonder if the global cost of these transactions is not approaching, even surpassing, the bill that would be paid by the treasury if the salary levels were adjusted to acceptable levels" (1997, p. 12).

As a result of participation in NGO-sponsored seminars, travel, surveys, evaluations and other activities, the DPS offices began to empty out. By 1998, there were week-long periods in which no community health program heads were conducting routine health system work; all were either conducting NGO-sponsored surveys, or attending training seminars put on by NGOs to prepare for NGO projects.

Health outcomes in the NGO era

Disentangling the effects of poor coordination and fragmentation caused by foreign agencies on health outcomes from the range of other factors influencing health during this period of sweeping change is a difficult if not impossible challenge. Figures for health care utilization, coverage, and some health indicators improved as would be expected in a period of recovery from war (Mozambique Ministry of Health, 1997). Unquestionably the resources that flowed into the province had many positive effects on the system. However, the more appropriate question becomes: If the millions of aid dollars had been provided directly to the NHS to increase salaries, improve health worker conditions, strengthen systems of accountability, and more rationally allocate resources would there have been even better coverage, service quality and health outcomes? There is, however, so much qualitative evidence and general agreement among veterans of the NHS that it is difficult to dispute that the fragmentation caused by disjointed aid projects had a lasting impact on health service effectiveness. In the short-term, reduced mobile vaccination brigades, poorer treatment of patients by demoralized health workers, pharmaceutical shortages, loss of skilled personnel, under-the-table payments for free services, absenteeism from regular duties, and a host of other systemic dysfunctions have clearly undermined NHS effectiveness in significant ways that may have offset much of foreign aid's positive impact.

Discussion

Examples of harmful practices on the part of foreign aid agencies abound in Mozambique and elsewhere in Africa. The stark scenario depicted here emphasizes these negative aspects of NGO activity in the study community to underscore the extent and depth of the problem. To be sure, there are also NGOs and expatriate workers who have conducted exemplary work and contributed a great deal to sustainable improvement of primary health care in Mozambique. However, many readers will undoubtedly find much that is familiar in what has been described in this vignette.

Recent attempts in Africa to confront these kinds of problems signal growing and widespread recognition of the need for change. Local voluntary "codes of conduct" generated by NGO consortiums have appeared in a number of other African settings in recent years including Namibia, South Africa, Ethiopia, and Botswana indicating an increasing concern within the NGO community itself over these concerns (Namibian, 1999; SANGOCO, 2001; The Reporter, 1999; BOCONGO, 2001). The "Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief", created in 1994 in response to problems with NGOs during the Rwanda refugee crisis, and signed by eight of the world's largest international disaster response agencies, is an especially significant recognition of NGO abuses (IFRC, 2001).[5] The document introduction states, "Agencies, whether experienced or newly created, can make mistakes, be misguided and sometimes deliberately misuse the trust that is placed in them" (2001, p. 2).

Acknowledging the problems created by the plethora of NGOs and other foreign agencies in Mozambique, nearly all the major bilateral and multilateral donors active in the health sector signed the "Kaya Kwanga Code of Conduct" in May 2000 that spelled out a new approach to the channeling and management of aid (Mozambique Ministry of Health, 2001).[6] If taken at face value, the document appears to be a significant attempt to address the type of abuses outlined earlier in this article. It asks that signatories "Adhere to agreed national rates regarding remuneration and allowances for civil service employees, remuneration of consultants, payment for conferences, etc." And to "Avoid the departure of qualified personnel through contracting of civil servants for donor consultancies" (2000, p. 3). The donors are urged to "Develop and maintain a climate of transparency, openness, accountability and honesty in all relations and transactions." The document includes a "pledge" to ensure that technical assistance is "driven by MoH priorities" and clearly supports institutional capacity of the MoH (2000, p. 6). Signatories included representatives from USAID, the World Bank, key UN agencies, the European Commission, and most major Western European donor nations. In another sign of change, the World Bank has retreated somewhat in its promotion of private health care and NGOs, and has approved modest increases in support for public sector health services in very poor countries, usually linked to debt relief (World Bank, 1997, 2000a, b). Mozambique has thus been able to gradually redirect more resources to the NHS itself since 1996 (Fauvet, 2000; Pavignani & Colombo, 2001).

While these changes and efforts should be welcomed, one may remain skeptical that the new commitments

[5] NGOs that have registered their commitment to the code include the International Save the Children Alliance, Oxfam, Caritas International, Catholic Relief Services, Lutheran World Federation among others.

[6] The new agreement grew out of Mozambique's "Sector Wide Approach" or "SWAp" process that seeks to better coordinate external support to the NHS. The SWAp concept centers on stronger coordination and management of external aid through a national public sector. The SWAp concept allows for private initiative as long as resources are allocated within an overall long-term coordinated plan (Walt et al., 1999). NGOs have a role in this vision, but within the coordinated national plan to which donors and NGOs should commit.

outlined in the Kaya Kwanga document will be successful in curbing abuses. In spite of the shifts in World Bank policy, privatization is still promoted and NGOs continue to figure prominently in the Bank's "public–private partnership" discourse (World Bank, 2000a). Since the Kaya Kwanga document is non-binding, and a great deal of funding will continue to be channeled through NGOs without any means of "code" enforcement, the same structural incentives to engage in aid abuses in the field will likely outweigh any costs to violating these new guidelines. Donors rather than NGOs negotiated and signed the document thus further weakening any potential to better restrict improper NGO conduct.

Given this environment, the elaboration of a new approach to NGO collaboration could appear quixotic or premature since a fundamental restructuring of international aid delivery may ultimately be necessary to significantly curtail harmful NGO activities. However, the appearance of codes of conduct among donors and NGOs, in addition to the recent shifts in World Bank policy, suggests an opening for change even within the constraints of this current aid climate. Rather than discouraging reform efforts, the continued promotion of NGOs by powerful actors in international health should further underscore the urgent need for more concerted efforts to stem current abuses and their corrosive effects on the public sector.

Promoting new approaches

Perhaps the first step toward a new approach is to overcome the reluctance of policy-makers, health researchers, and others in the NGO world to admit the abuses and failures of the current model. The appearance of local codes of conduct indicates growing concern, however it is still unusual to see these striking problems addressed in development discourse and literature that influences policymakers. Independent research (i.e. not linked to, or funded by, project stakeholders) that examines the broader impact of NGO projects and activities on both local health services and communities is especially rare in the literature.

One potential point of departure for generating discussion could be the development of an industry-wide international code of conduct for NGO activities in the health sector. While local voluntary codes of conduct are unlikely to be very effective, a broad-based discussion focused on an international code among key actors in international health including major NGOs, donors, and host countries would focus attention on the shortcomings of current approaches. As the Red Cross code states the professional world of NGO work is in its infancy and there is still no generally accepted set of standards for professional conduct to guide behavior or hold NGOs accountable (2001, p. 1). An international set of standards would not be enforceable in itself, however it could serve as a point of reference for national governments to reign in violating NGOs and to embolden potential whistleblowers within organizations and target communities to identify violators. The Red Cross code provides a potential model. Ten "points of principle" are laid down that outline general commitments specific to disaster relief work that touch on issues of accountability to local communities, respect for local cultures and customs, and building of local capacity. The document goes on to describe the relationships that NGOs should seek with donor and host governments, and with UN agencies. The code is "self-policing", but its authors suggest that "Governments and donor bodies may want to use it as a yardstick against which to judge the conduct of those agencies with which they work. And disaster-affected communities have a right to expect those who seek to assist them to measure up to these standards" (IFRC, 2001, p. 3).

The creation of a similar code of conduct more appropriate to the work of development NGOs in the health sector will certainly not eliminate abuses or address the structural determinants of these challenges, but it could highlight key concerns and provide an opportunity to expose abuses. Perhaps most importantly, the process of generating an international code of conduct would provide a forum for a badly needed and more fundamental discussion on new approaches to collaboration in the health sector. In this context, insights from the Mozambique experience could be especially valuable to such a discussion given the scale of NGO involvement in the country, and the emergence of the small but important critical literature that has emerged from the encounter (cf. Cliff, 1993; Hanlon, 1991; Pavignani & Durão, 1997, 1999; Walt et al., 1999).

A full elaboration of a new model is beyond the scope of this paper. However, the case study presented here suggests several directions for change in conceptualizing better approaches to technical assistance that take into consideration the impact of structural inequalities and the social environment on aid work. In interview after interview during this research, both expatriates and Mozambicans indicated that aid was most productive when trusting and respectful personal relationships based on commitments to equity were developed between foreign worker, national counterpart, and local communities. The current NGO model often undermined the establishment of these kinds of long-term professional relationships. When trust broke down, or more frequently when trust and respect were never established, projects or programs also failed. The Mozambique case suggests that a new model centered on building such relationships with public sector health workers, rather than achieving short-term project outputs, could help prevent abuses and restore some measure of self-determination to national health sys-

tems. A focus on the transfer and routinization of skills through such relationships could build more sustainable programs. An international code of conduct could help provide a broad-based mutual understanding of what constitutes appropriate NGO activity, thus creating a better foundation for building trust between expatriates and local counterparts. The Mozambique experience suggests several additional specific directions for change that would hopefully be considered in discussions on a new model of cooperation:

1. As expressed in the Kaya Kwanga document, technical assistance priorities should be determined by Ministries of Health, and aid should focus on capacity building within a coordinated plan. However, NGOs need to be formally held to that standard and adherence should be made a condition of their continued operation within the host country.[7] Such an emphasis would also help reduce the number of "showcase" projects and parallel programs that overspend to produce sometimes impressive, but unsustainable results.

2. Project cycles should be longer, at least four years as opposed to the very common two-year project horizon, to provide sufficient time for expatriates to establish trusting relationships with counterparts, adequately transfer skills, routinize project activities, and test for sustainability. Expatriate contracts would therefore be longer as well to ensure continuity and prevent the kind of country-hopping that frustrates local counterparts and interrupts project progress. Finding qualified expatriates to fill longer-term positions, especially in more isolated posts, may create some challenges but if industry-wide standards change it is likely that employment seekers will adjust their expectations to fit the new demands. Expectations of longer contracts in one setting may also attract expatriates better suited to implementing sustainable programs, while weeding out aid "mercenaries" and "cowboys".

3. If projects shift from a focus on short-term results to longer-term professional relationship building and skills' transfer, project evaluations should also have a new emphasis. In the current model, expatriates are pressed to meet narrow output goals and results that often evaporate upon their departure because local staff are not adequately trained or programs are not left with adequate resources in local institutions to survive. Project evaluators frequently ignore or miss these consequences when they focus solely on specific outputs (e.g. number of ORS packets distributed, increase in vaccination coverage, number of children in a nutrition-supplementation program, etc.). Expatriate work and NGO projects should be evaluated on their development of productive long-term relationships, and resulting transfer of skills, within programs firmly embedded in lasting local institutions (i.e. public sector services). Consequently, expatriate project coordinators would avoid circumventing or manipulating local actors and institutions to achieve narrow and unsustainable results. Re-evaluations conducted at least 12 months after the end of the project cycle could become an industry standard to determine whether local actors have maintained activities. While the transfer of appropriate technical skills is essential, the development shibboleth "capacity building" is too often translated to mean "seminars" and "workshops". As the Mozambique experience reveals, the off-the-job seminar training provided by NGOs for their own projects often pulled workers away from crucial duties. While some extra training will always be valuable, a new model should emphasize on-the-job training for skills that clearly contribute to the broader development plan for health delivery. By closely following MoH priorities, duplication of training and seminar proliferation can be avoided.

In a new model of collaboration, project evaluations should also center on coordination of NGO work with local institutions and other NGOs. In the current evaluation model, coordination is rarely a core criterion for assessment and coordinators are rarely rewarded for cooperative efforts, especially if specific project goals are postponed because of those efforts.

4. Opportunities for personal patronage through financial favors such as per diem payouts, salary augmentation, or home construction should be reduced or eliminated. In the current model, the opportunities for NGOs to provide a wide range of favors to counterparts in exchange for project approval, positive evaluations, or access to infrastructure poisons the social environment and undermines the health system's integrity. Given the continued SAP constraints on salary increases, one interim solution might include creation of general NGO funds for extra income distributed to all health service employees in a district or province rather than to those only on a specific NGO project (such arrangements have been tried with some success in several areas of Mozambique). The key point is that NGO support needs to be dissociated from implementation of specific projects to avoid the kind of patronage that has distorted priority setting and program planning.

5. Outside the formal work arena, a new model of NGO collaboration would hopefully sensitize its expatriate workers to the social impact of their presence on very poor communities. The compound residence model should be rejected (except in genuinely dangerous conflict situations in emergency work) since it sends a message of exclusion and creates so much local

[7] There are of course settings in which local states are either so weak, oppressive, or adversarial that building upon local national health systems is not possible. However, in most countries with flourishing NGO communities public sector health systems are key players in health delivery (Green & Matthias, 1996).

resentment. Inequities in living standards between expatriates and their counterparts are unlikely to disappear anytime soon, but compounds are an especially poignant insult to local sensibilities. A new approach to collaboration would expect expatriates to engage more directly and positively in local community life to further build rapport, enhance understanding of local conditions, and establish trust. These kinds of informal dynamics with local communities certainly cannot be mandated, however if expatriate work is evaluated principally on long-term relationship building, cooperation, and sustainability it is more likely that a positive expatriate engagement with the broader community will result.

Significant change in the NGO approach to health sector support will be enormously difficult to achieve under current conditions. The ongoing promotion of privatization both within the health sector and the wider economy in Africa, threatens to reinforce a two-tiered provision of services that siphons off resources and personnel from a poorly funded public system further undermining morale, commitment, and organizational capacity. The current NGO model of cooperation and participation exacerbates the degradation of public primary health care programs in this environment. However, growing disquiet among concerned fieldworkers, donors, and host nations may provide an opportunity to bring these troubling dynamics into full view in the development community. A frank discussion is long overdue.

Uncited References

Cramer and Pontara (1998); Ghai (1991).

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References

Anang, F. T. (1994). Evaluating the role and impact of foreign NGOs in Ghana. In E. Sandberg (Ed.), *The changing politics of non-governmental organizations and African states* (pp. 101–120). Westport: Praeger.

Arndt, C., Henning, T. P., & Tarp, F. (2000). Stabilization and structural adjustment in Mozambique: An appraisal. *Journal of International Development*, *12*(3), 299–323.

BOCONGO (Botswana Council of Non-Governmental Organizations) (2001). *NGO code of conduct*. Botswana: BOCONGO.

Bouchet-Saulnier, F. (2000). *Between humanitarian law and principles: The principles and practices of 'rebellious humanitarianism'*. MSF 2000 International Activity Report. Paris: Medecins san Frontieres.

Buse, K., & Walt, G. (1996). Aid coordination for health sector reform: A conceptual framework for analysis and assessment. *Health Policy*, *38*, 173–187.

Buse, K., & Walt, G. (1997). An unruly melange? Coordinating external resources to the health sector: A review. *Social Science & Medicine*, *45*(3), 449–463.

Chabal, P., & Daloz, J. (1999). *Africa works: Disorder as political instrument*. Oxford: James Currey.

Chabot, J., Harnmeijer, J. W., & Streefland, P. H. (1996). *African primary health care in times of turbulence*. The Netherlands: Royal Tropical Institute.

Cliff, J. (1993). Donor dependence or donor control?: The case of Mozambique. *Community Development Journal*, *28*(3), 237–244.

Coreil, J., & Mull, D. (1990). *Anthropology and primary health care*. Boulder: Westview.

Cramer, C., & Pontara, N. (1998). Rural poverty and poverty alleviation in Mozambique: What's missing from the debate? *The Journal of Modern African Studies*, *36*, 101–138.

De Beyer, J. A., Preker, A. S., & Feachem, R. G. (2000). The role of the World Bank in international health: Renewed commitment and partnership. *Social Science & Medicine*, *50*(2), 169–176.

Drabek, A. G. (1987). Development alternatives: The challenge for NGOs—an overview of the issues. *World Development*, *15*(Suppl.), ix–xv.

Edwards, M., & Hulme, D. (1996a). Too close for comfort? The impact of official aid on non-governmental organizations. *World Development*, *24*(6), 961–973.

Edwards, M., & Hulme, D. (1996b). Introduction. In M. Edwards, & D. Hulme (Eds.), *Beyond the magic bullet: NGO performance and accountability in the post-cold war world*. West Hartford: Kumarian.

Fauvet, P. (2000). Mozambique: Growth with poverty, a difficult transition from prolonged war to peace and development. *Africa Recovery 14*(3).

Foster, G. (1977). Medical anthropology and international health planning. *Social Science & Medicine*, *11*, 527–534.

Gary, I. (1996). Confrontation, co-operation or co-optation: NGOS and the Ghanaian state during structural adjustment. *Review of African Political Economy*, *68*, 149–168.

Ghai, D. (1991). *The IMF and the South: The social impact of crisis and adjustment*. London: Zed Books.

Gilson, L., Sen, P. D., Mohammed, S., & Mujinja, P. (1994). The potential of health sector non-governmental organizations: Policy options. *Health Policy and Planning*, *9*(1), 14–24.

Gloyd, S. (1996). NGOs and the "SAP"ing of health care in rural Mozambique. *Hesperian foundation news*, spring. Berkeley: The Hesperian Foundation.

Gloyd, S. (1998). Personal communication.

Green, A., & Matthias, A. (1997). *Non-governmental organizations and health in developing countries*. St. Martin's, New York.

Hanlon, J. (1991). *Mozambique: Who calls the shots?*. London: James Currey.

Hanlon, J. (1996). *Peace without profit: How the IMF blocks rebuilding in Mozambique*. Portsmouth, NH: Heinemann.

IFRC, International Federation of Red Cross and Red Crescent Societies (2001). *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief*. Geneva: IFRC.

Justice, J. (1987). The bureaucratic context of international health: A social scientist's view. *Social Science & Medicine*, *25*(12), 1301–1306.

Laurell, A. C., & Arellano, O. L. (1996). Market commodities and poor relief: The world bank proposal for health. *International Journal of Health Services*, *26*(1), 1–18.

Mozambique Ministry of Health (1997). *Mozambique demographic and health survey*. Maputo: Mozambique Ministry of Health and Macro International.

Mozambique Ministry of Health (2001). *The Kaya Kwanga commitment: A code of conduct to guide the partnership for health development in Mozambique*. Maputo: Mozambique Ministry of Health.

Namibian (1999). NGO code to push ethical conduct. In *The Namibian* (October 25). Windhoek: The Namibian.

Ndengwa, S. N. (1996). *The two faces of civil society: NGOs and politics in Africa*. West Hartford: Kumarian.

Nichter, M. (1996). The primary health care system as a social system: Primary health care, social status, and the issue of team-work in South Asia. In M. Nichter, & M. Nichter (Eds.), *Anthropology and international health: Asian case studies*. Amsterdam: Gordon and Breach.

Mburu, F. M. (1989). Non-government organizations in the health field: Collaboration, integration, and contrasting aims in Africa. *Social Science & Medicine*, *29*(5), 591–0597.

Okuonzi, S., & Macrae, J. (1995). Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning*, *10*(2), 122–132.

Oxfam (2001). *Towards Global Equity: Strategic Plan 2001-2004*. Oxford: Oxfam International.

Pavignani, E. (2001). *The reconstruction process of the health sector in Mozambique: A messy affair with a happy end?*. Geneva: Department of Emergency and Humanitarian Action, World Health Organization.

Pavignani, E., & Colombo, A. (2001). *Providing health services in countries disrupted by civil wars: a comparative analysis of Mozambique and Angola*. Geneva: Department of Emergency and Humanitarian Action, World Health Organization.

Pavignani, E., & Durão, J. R. (1997). *Aid, change, and second thoughts: Coordinating external resources to the health sector in Mozambique*. Working paper. London: Health Policy Unit of the London School of Hygiene and Tropical Medicine.

Pavignani, E., & Durão, J. R. (1999). Managing external resources in Mozambique: Building new aid relationships on shifting sands? *Health Policy and Planning*, *14*(3), 243–253.

Powell, M., & Seddon, D. (1997). NGOs and the development industry. *Review of African Political Economy*, *71*, 3–10.

SANGOCO (South African National NGO Coalition) (2001). *SANGOCO code of ethics for NGOs*. Braamfontein: SANGOCO.

Stewart, S. (1997). Happy ever after in the market place: Non-government organizations and uncivil society. *Review of African Political Economy*, *71*, 11–34.

The Reporter (Addis Ababa) (1999). Non-governable organizations? *The Reporter (May 19, 1999)*. Addis Ababa: The Reporter.

Turshen, M. (1999). *Privatizing health services in Africa*. New Brunswick: Rutgers.

UNDP (United Nations Development Programme) (1998). *National human development report on Mozambique*. Oxford: Oxford University Press.

USAID (1997). Policy guidance: USAID—US PVO partnership. Washington, DC: USAID.

Uvin, P. (1998). *Aiding violence: The development enterprise in Rwanda*. West Hartford: Kumarian.

Walt, G., & Melamed, A. (1983). *Toward a people's health service*. London: Zed Books.

Walt, G., Pavignani, E., Gilson, L., & Buse, K. (1999). Managing external resources in the health sector: Are there lessons for SWAps? *Health Policy and Planning*, *14*(3), 273–284.

World Bank (1993). *World development report: Investing in health*. Washington, DC: World Bank.

World Bank (1995). *Country assistance strategy. Report 15067-MOZ*. Washington, DC: World Bank.

World Bank (1997). *Health, nutrition, and population sector strategy paper*. Washington, DC: World Bank.

World Bank (2000a). *The World Bank-civil society relations: Fiscal 1999 progress report*. Washington, DC: World Bank.

World Bank (2000b). *World development report 2000/2001*. Oxford: Oxford University Press.

Wuyts, M. (1996). Foreign aid, structural adjustment, and public management: The Mozambican experience. *Development and Change*, *27*, 717–749.

Zaidi, S. A. (1999). NGO failure and the need to bring back the state. *Journal of International Development*, *11*, 259–271.