The art of medicine
An anthropology of aid in Africa

We have been working as medical anthropologists in Mozambique for more than two decades. On a recent trip, we visited several large clinics in central Mozambique where HIV/AIDS first surged 20 years ago. In a health centre in a poor peri-urban bairro in Chimoio, a maternal and child health (MCH) nurse was tasked with the impossible job of providing most of the antenatal, maternity, labour and delivery, child-at-risk, and well child care since the other nurses were out sick or on leave. Filing cabinets were falling apart so patient records could not be properly archived. There were stock-outs of routine tests. In the past few decades Mozambique has achieved a great deal in terms of health care with very little, but has faced challenges at every step.

On this day we were monitoring an intervention study, undertaken with the Ministry of Health, to start pregnant women on antiretroviral therapy (ART) when they first test positive for HIV in the antenatal clinic following WHO guidelines. This approach will better prevent HIV transmission to the infant and treat the mother, but it also means a five-fold increase in new ART patients in antenatal clinics. As part of our project, we measured average waiting and consult times at six clinics. We found that most pregnant women wait for hours in hot crowded conditions for a brief consultation that lasts on average about 7 minutes—just a few minutes to do a battery of tests, conduct counselling for HIV testing, treat malaria, test for and treat syphilis, and deliver other services in integrated antenatal care. Throughout the project, our team has wondered how this struggling health system will be able to absorb so many more pregnant women on ART who will need regular check-ups, counselling, and medication refills. In the few minutes they have with their overworked nurses, how will these mothers receive the quality counselling they will need about HIV, risks to their child, drug side-effects, and a lifetime of drug treatment? Most frustrating of all, it should not have been this way.

Mozambique has a unique history of health system building with important lessons to share with the rest of Africa. After independence from Portugal in 1975, Mozambique quickly constructed a primary health care system based on principles defined at the transformative 1978 Alma-Ata conference. The public system consisted of community health workers, health posts and centres, rural hospitals, and larger provincial hospitals. Mozambique was one of the world’s poorest countries yet still managed to build what WHO considered a model primary health care system in which most Mozambicans still receive care.

We first came to Mozambique through involvement in the anti-apartheid movement during the 1980s. The new government had supported South Africa’s African National Congress and the rebellion against white rule in then-Rhodesia. Mozambique was punished dearly for this support when Rhodesia and South Africa funded the Mozambique National Resistance or RENAMO. The ensuing 15-year conflict nearly destroyed the country. RENAMO targeted health posts, health workers, schools, and teachers. We joined a US organisation called the Mozambique Support Network to educate Americans about the humanitarian catastrophe. Through this network we met Health Alliance International (HAI), a Seattle-based solidarity organisation created by former “cooperantes”, the term used for foreign anti-apartheid health workers who volunteered to work in Mozambique’s health system.

After the ceasefire in 1992, the post-conflict task was to rebuild this health system and extend its reach. Drawn to HAI’s philosophy of support for the public sector, we enthusiastically accepted jobs to work on their project in central Mozambique. Since we were anthropologists, HAI dispatched us into the community to identify local health beliefs, nutritional patterns, prenatal care practices, community health leadership, and other health-related behaviours and practices. HAI helped health facility directors work with communities to develop a Community Leaders Council model adopted nationally by the Ministry of Health. We supported efforts to improve child nutrition programmes, increase syphilis treatment for pregnant women, train traditional birth attendants, improve immunisation coverage, and strengthen health facility management.

We learned much from these communities, but gained even more essential insights from our Mozambican health worker counterparts, who were underpaid and overworked with little time to consider our ideas. We also learned that since 1987, Mozambique had initiated a structural adjustment programme (SAP) sponsored by the International Monetary Fund (IMF) that consisted of macroeconomic austerity policies ostensibly designed to spur economic growth and pay back debt. The SAP required huge cuts to public spending just when the health system needed major investment at the war’s end. The salaries of health workers plummeted and rebuilding slowed to a crawl. Foreign aid for health was increasing, but the SAP constraints prevented public spending on the national health system itself, and aid dollars were given instead to a growing army of international non-governmental organisations (NGOs), including HAI. Substantial funds were spent on a wide range of projects that often did little for health system strengthening: some NGOs actively weakened the health system by luring workers away with high salaries, and many projects evaporated after a couple of years.

In this peculiar new public health landscape, we began to question the focus of our anthropological fieldwork which we had used to hatch plans for improving services, education, and...
behaviour change in impoverished communities. To be sure, we felt that HAI had made contributions, but we continually ran up against the reality of a health system that simply had no more capacity to absorb our approaches because of the SAP. We began to suspect that we were studying the culture and beliefs of the wrong people. We needed to change behaviour in our own community—the NGOs, donors, and bilateral agencies that continued to channel increasing funds into ephemeral NGO projects while the public health system languished. Perhaps an anthropology of donor culture could explain this irrational worldview.

The 2000s brought new hope to Mozambique with dramatic increases in funding for HIV/AIDS programmes through the United States President’s Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Clinton Foundation, and myriad others. Starting in 2004, this huge new injection of donor funding helped thousands of HIV-positive Mozambicans initiate ART. However, 10 years on there is a powerful sense of missed opportunity. Once again, most of the new aid funding did not actually finance health system strengthening. For example, PEPFAR funding was channelled mostly to “implementing partners”, international NGOs who organised the scale-up of services in partnership with the Ministry of Health. HAI was one of these partners from 2004 to 2010. We helped train health workers, renovate infrastructure, provide provincial technical assistance, and pay the salaries of “activistas” (HIV-positive community health workers who support patients on ART) that the system could not absorb financially.

Although we felt proud of this work we were also discouraged. Continued IMF-fostered austerity policies prevented much foreign aid from being invested in long-term health system strengthening and workforce expansion. The 2006 WHO World Health Report on global health workers revealed that Mozambique, like many African countries, needed ten times more doctors and nurses to meet even the minimum standards set by the WHO. But the massive expansion of health workforce needed to manage Mozambique’s many health challenges simply never materialised. The “golden age” of global health aid, as some have called it, was not a golden age of health system building. So after 10 years and millions of dollars, on the day we visited that health centre there was still only one nurse who could provide 7 minutes each to dozens of pregnant women waiting for hours, with leaking roofs, broken filing cabinets, and no activistas (since the funding had dried up)—not because the money was stolen or lost by the government, but because the health system itself received very little of it.

We forge ahead with our intervention that seeks to help HIV-positive mothers start and then stay on ART. In the formative research phase of the project we asked health workers and pregnant mothers what they needed to get this done. The weary answers were all too familiar: more nurses, more orderlies, more activists, new filing cabinets, bicycles, a roof that does not leak, fewer stock-outs.

Back in Seattle with our global health colleagues we work hard at developing cost-effective strategies for service delivery. There is talk of “innovation” and “platforms” and “grand challenges” for new technologies, rapid diagnostic tests, delivery systems, and vaccines for Africa. Attention has turned to “mHealth” (mobile devices for health), electronic medical records, male partner involvement in antenatal care, screening for depression, pre-exposure prophylaxis for HIV prevention. All are vital efforts, but most will be heaped upon already overwhelmed health workers working in difficult conditions. Because of higher level workforce shortages, we often focus on task shifting to lower level staff for new programmes. We should perhaps call it task multiplication for the same health workers who each year are asked to do more and more.

A vital research question in medical anthropology for the 21st century is then how do we change the behaviour of health economists and donor culture to invest more in African public sector health systems? Without nurses, health posts, laboratories, cars with petrol and tyres, and supply systems, innovations simply cannot be delivered. The recent Ebola outbreak in west Africa drives home the point—without strong health systems the next major crisis in Africa could be costly in lives beyond measure. We look forward to a true golden age in global health when austerity ends and real health system building can begin. That grand challenge cannot start soon enough.

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Further reading
Rowden R. The deadly ideas of neoliberalism: how the IMF has undermined public health and the fight against AIDS. London: Zed Books, 2009