

Donor dilemmas in a fragile state: NGO-ization of community healthcare in Guinea-Bissau

Sigríður Baldursdóttir, Geir Gunnlaugsson and Jónína Einarsdóttir

Faculty of Sociology, Anthropology and Folkloristics, University of Iceland, Reykjavík, Iceland

ABSTRACT

There is increased emphasis on donor engagement in the world's poorest and most fragile states, but aid modalities tend to differ depending on the recipient countries' governance. In fragile states, donors often bypass governments and collaborate with non-state development actors (NGOs) to prevent aid capture, improve effective delivery and increase effectiveness. Based on ethnographic fieldwork over 20 months in 2009–2012, the aim of this paper is to explore the role of NGOs in community-based primary healthcare *vis-à-vis* the Ministry of Health in Guinea-Bissau. Revitalization of Guinea-Bissau's formerly extensive community healthcare services was initiated in 2010. The Ministry of Health, in charge of its implementation, emphasized ownership, harmonization and alignment that created tension with NGOs. However, as a result of a military coup in 2012, donors bypassed the Ministry and gave NGOs a central role. Through the voices of stakeholders, this paper outlines donors' dilemmas in a situation of state fragility. They found NGO-ization reasonable to protect funds and secure implementation while some worried that it might counteract alignment, harmonization, ownership and sustainability. The paper argues that aid to the health sector in fragile states needs to be long-term and predictable.

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Introduction

In the late 1990s, good governance was assumed to be a prerequisite for effective aid (Burnside and Dollar 1997; World Bank 1998). However, attention was called to the risk that giving priority to a country's performance over need would result in exclusion of the poorest and most conflict-prone countries from assistance (Overseas Development Institute 1998). During this period, countries characterized by political instability, conflict and extremely low income were given the denomination 'difficult partnership countries,' 'fragile states' and 'failed states.' This had a negative impact on aid to these countries and some gained a status as 'aid orphans' (Einarsdóttir 2007; Dietrich 2013; Levin and Dollar 2005).

At the beginning of the twenty-first century, Radelet argued that countries with bad governance 'should not only receive less money, but they should also receive more of it as project aid, it should come with a shorter time commitment, and much of it should be distributed through NGOs' (2004, 18). While some practitioners and scholars increasingly argue for donor engagement in the world's poorest and most fragile states the methods of aid delivery differ depending on the recipient countries' governance (Acht, Mahmoud, and Thiele

2014, 2015; Dietrich 2016, 2013). Donors tend to bypass the government in countries with inadequate governance and, instead, collaborate with non-state development partners such as international and local non-governmental organizations (NGOs), international organizations and private companies. This tactic, Dietrich (2013, 2016) argues, aims to prevent aid capture, improve effective aid delivery and thereby increase aid effectiveness. Dietrich (2016) found that donors that use bypass tactics may be more successful in providing immediate relief to the poor through easily implementable health interventions as compared to donors that focus on the building of institutions in collaboration with the recipient government. Yet, Dietrich argues that bypassing the government can undermine long-term efforts to build up a state that can manage its own development.

Increased 'NGO-ization' of aid has its roots in neoliberal aid policy in the 1980s, when NGOs, being non-state actors, became favored by donors to deliver services mainly within the social sector (Banks and Hulme 2012). Thus, there was a burgeoning of NGOs, both national and international ones, that later found a role within whatever policy trend that followed, such as the

CONTACT Sigríður Baldursdóttir  sib30@hi.is

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post-Washington consensus, good governance, poverty reduction, and the Paris Declaration (Banks, Hulme, and Edwards 2015). Donors often take NGOs to be more efficient, effective, flexible and innovative as compared to recipient governments (Brass 2012; Doyle and Patel 2008). NGOs are assumed to show more compassion and be more committed to democracy and promotion of participatory development, in addition to being seen as more accountable and transparent than governments (Brass 2012; Doyle and Patel 2008; Pfeiffer 2003).

NGOs have also been criticized. Involvement of NGOs can lead to increased fragmentation of aid activities, lack of coordination and inadequate management (Pfeiffer 2003; Buse and Walt 1996; Gideon and Porter 2016). In post-conflict states, formal institutions may suffer from donors' reliance on NGOs, as they, at times, run parallel services that undermine the services of the state, and they also compete with the state for funding and competent staff (Aman and Aman 2014). NGOs often offer local health workers higher salaries than government health facilities which results in a brain-drain from the public to the NGO sector (Witter et al. 2017). NGOs tend to have a short time frame for projects, and their assistance is not as stable as that of bilateral donors (Baldursdóttir 2018; Bhutta et al. 2010; Chilundo et al. 2015; Pfeiffer 2003). Also, since NGOs tend to work in more affluent areas and group together, they may contribute to geographical inequalities in service delivery with specific areas and populations targeted more than others (Buse and Walt 1996). Dependent on donor funding, NGOs may further emphasise their own or their sponsor's preferences instead of local priorities which can affect local budgetary and policy processes. Hearn (1998), who questioned the comparative advantage of NGOs, points out that the process of NGO-ization is not based on the principle of sustainability and can lead to externally oriented and highly dependent health services. She argues that NGO-ization involves 'western sponsorships of private voluntary organisations in order for them to play an increasingly pivotal role in the economic, social and political life of the country' (89) and that it can be understood as an attempt at social engineering undertaken by western donors. In her efforts to understand the position of local NGOs in Africa, Hearn (2007) is tempted to see these as merely managers of foreign aid rather than promoters of locally rooted development.

Despite criticism of NGOs, many donors and international organizations assume NGOs have a comparative advantage in the delivery of health interventions (Doyle and Patel 2008). Already in the 1980s, as a response to an increased number and diversity of donor agencies and NGOs active within the health sector of aid recipient countries, coordination of aid entered the agenda

(Buse and Walt 1997). Development practice within health, as well as in other sectors, was in need of coordination to enhance aid effectiveness (Buse and Walt 1996, 1997; Walt et al. 1999), and contributed to the adoption of the Paris Declaration on Aid Effectiveness in 2005 (Sundewall 2009). The Paris Declaration rests on five principles, including ownership, alignment, harmonization, managing for results and mutual accountability that recipient countries and donors are expected to follow (OECD 2005). Aid delivered in line with these principles was assumed to be more effective and contribute to improved development outcomes and increased ownership of the recipient countries. The principles of the Declaration also aimed to address problems caused by multiple non-aligned NGO-funded projects that were outside governmental control and, at times, unknown to national authorities (Mawdsley, Savage, and Kim 2014; Taylor et al. 2013). A case in point is projects within the health sector (Sundewall 2009; Sundewall et al. 2009), and foreign aid to community-based primary healthcare (PHC) has been and still is channelled through NGOs and their expatriate technical experts (Baldursdóttir 2018; Bhutta et al. 2010; Chilundo et al. 2015; Pfeiffer 2003).

During the last decade, the revitalization of health work inspired by the Alma Ata Declaration and its emphasis on PHC adopted in 1978 entered the global agenda (WHO 2008). PHC was considered to be a way to reach the health-related Millennium Development Goals (MDGs) and is now believed to have a central role in the achievement of the Sustainable Development Goals (Bhutta 2017; Lawn et al. 2008). The Alma Ata Declaration reaffirmed that health is a fundamental human right to which all people are entitled, enshrined in its slogan 'Health-for-All by the Year 2000' (WHO 1978). The concept of PHC, as outlined in the Declaration, includes three dimensions of a well-functioning health system: health services, supportive functions, and community participation, equity and intersectoral engagement. The official healthcare policy of the newly independent Guinea-Bissau was under influence of the ideology that was laid out in the Alma Ata Declaration. In 1977, the Ministry of Health launched a community health program with financial and technical support from bilateral donors, or NGOs in close collaboration with bilateral donors (Baldursdóttir 2018; Chabot and Waddington 1987). Faith-based organizations (FBO) were also involved in community health but limited to specific activities, such as growth monitoring and vaccination. The community was to participate in the construction of a village health unit and to choose community members they trusted to work as volunteers with two distinct functions. Community Health Workers

(CHWs) received training in first aid and treatment of the most common diseases, in addition to preventive activities such as health education and vaccinations. Traditional Birth Attendants (TBAs) were trained in antenatal care, how to assist women to give birth and how to identify risk pregnancies in need of referral to health centres (Baldursdóttir 2018; Einarsdóttir and Gunnlaugsson 2009; and Gunnlaugsson 2007).

After an initial period of expansion of the community health services, there was a period of degradation following cuts in aid to Guinea-Bissau, new priorities in the health policies among donors and a military uprising in 1998–1999 (Baldursdóttir 2018). However, following the global calls for revitalization of PHC (WHO 2008), in 2010–2011 a new community health policy was elaborated for Guinea-Bissau. In line with the global agenda, CHWs were to be trained, and paid workers and TBAs were excluded from the community healthcare (Singh and Sachs 2013; The Lancet Global Health 2017). The CHWs should engage more in preventive work than formerly and they should encourage pregnant women and other patients to seek care at health facilities. Yet, due to political turbulence, and contrary to the initial intention of the Ministry of Health, NGOs operating in Guinea-Bissau became influential actors in the implementation of the new policy.

In this article, we aim to explore the views of donor representatives, international and national NGO workers, Ministry of Health officials and local health professionals on the role of NGOs in community-based PHC *vis-à-vis* the Ministry of Health in Guinea-Bissau, a fragile sub-Saharan state. The focus is on the revitalization of community healthcare following renewed global interest in PHC, and the interplay between NGOs and the Ministry of Health. The article starts with a description of the study context and the methodology used. The main findings are then presented with a focus on the revitalization of community healthcare initiated in 2010 and the subsequent time of tension between the Ministry of Health and NGOs. The effect of the political crisis in 2012 is then discussed and the consequent NGO-ization of community healthcare. Finally, the findings are discussed and conclusions are drawn.

Study context

The Republic of Guinea-Bissau is a small coastal West African state that gained independence from Portugal in 1973/1974 after eleven years of liberation war (Shaw 2015). The population is approximately 1,844,000 (UNDP 2016); in 2010, it was estimated that 69 percent of the population lived in poverty (defined as living on less than 2 USD a day), and thereof 33 percent in

extreme poverty (less than 1 USD a day) (Abreu 2013, 627). In line with this, the country's social and human development indicators are among the lowest in the world; the UN Development Program ranked Guinea-Bissau 178 out of 188 countries in the 2016 Human Development Index (UNDP 2016), and on the Healthcare Access and Quality Index it ranked 193 out of 195 countries (Fullman et al. 2018). Since the late 1990s, the country has been referred to as a difficult partnership country, failed state, fragile state, aid orphan and narco-state (Einarsdóttir 2007, 2011; Shaw 2015; Vigh 2017).

On 7 June 1998, there was a military uprising with ensuing war that lasted for almost a year (Einarsdóttir 2007; Temudo 2008; Vigh 2006). Shortly before the war, the country saw a rapid decline in development assistance; from 180 million USD in 1996 to 124 million USD in 1997 and 1998, the year the war broke out, it was reduced to 96 million USD and 52 million USD in 1999 (Einarsdóttir 2007, 102). In the first decade after the military conflict, there were some failed and violently suppressed coup attempts, several changes of government, and continuous military interventions in politics (Embaló 2012; Shaw 2015). At the beginning of March 2009, President Vieira (Nino) was brutally assassinated by armed militaries following a bomb explosion a few hours earlier that killed the Chief of Staff of the army, General Baptista Tagme Na Waie. These murders are believed to have been the result of an escalation of competition over the trafficking of drugs from South America in which both Vieira and Na Waie were allegedly involved (Embaló 2012; Shaw 2015; Vigh 2017). In 2010, there was a failed military coup but two years later, on 12 April 2012, there was a successful one. A transitional government was appointed, but it was rejected by the international community and sharply criticized for being too lenient towards the coup perpetrators (EIU 2012; International Crisis Group 2012; Kohl 2013). As a result, aid to Guinea-Bissau plummeted from 121,010,000 USD in 2011 to 79,660,000 USD in 2012 (World Bank 2017). Despite elections in 2014, the political situation is still turbulent (Security Council 2017).

In Guinea-Bissau, the Ministry of Health is responsible for coordinating the healthcare system that is organized on three levels. At the local level, there are three types of health centres categorized according to their capacity, and a community healthcare component. At the regional level, there are five regional hospitals situated in Bafatá, Canchungo, Catió, Gabú and Mansoa. At the central level, there is a national hospital, Simão Mendes, in Bissau (Einarsdóttir and Baldursdóttir 2011; Ministério da Saúde Pública 2008). There is a private for-profit sector, situated mainly in Bissau, and a non-profit private sector that includes FBOs and national and international NGOs (Ministério da Saúde Pública 2008). At all levels of

the healthcare system, there is a shortage of staff (Russo et al. 2017; Tyrrell et al. 2010; UNIOGBIS-HRS/OHCHR 2017). Accessibility to facilities is affected by distance, poverty and lack of transport (Einarsdóttir and Baldursdóttir 2011; UNIOGBIS-HRS/OHCHR 2017). Many health facilities remain at a significant distance from the population they serve; in 2008 it was estimated that 40 percent of the population lived more than five kilometers away from the nearest health facility (Ministério da Saúde Pública 2008). However, there is significant difference between regions in the average distance to health facilities. Access to ambulance transportation is often unreliable, and patients need to pay for fuel (Einarsdóttir and Baldursdóttir 2011; UNIOGBIS-HRS/OHCHR 2017).

Government expenditure on healthcare is low or 5.18 percent of the government budget, and the remainder of health funding comes from user fees and donors (UNIOGBIS-HRS/OHCHR 2017). In 2014, the general government expenditure on healthcare was 20 percent of the total costs and out-of-pocket fees represented 62 percent of private contributions (WHO 2016). A World Bank Health Sector Review conducted in 2016 found that Guinea-Bissau had the highest out-of-pocket payment rates in West Africa (quoted in UNIOGBIS-HRS/OHCHR 2017). At the same time, a recent analysis of conditionalities of the International Monetary Fund (IMF) for the period 1995–2014 in 16 West African countries, including Guinea-Bissau, found those to have contributed to reduced fiscal space for the governments to invest in their national health systems, including increased numbers of doctors and nurses (Stubbs et al. 2017). Donor-financed programs are thus crucial for the national health services (Ministério da Saúde Pública 2008), although the political instability has affected donor resources to healthcare provision. Traditionally, NGOs and FBOs have played an essential role in health service delivery, as bilateral agencies have had a limited interest in collaborating with successive governments (Russo et al. 2017).

Following independence, the community health program experienced rapid expansion and consolidation, and was, by community members and health officials alike, considered to have functioned well, albeit not without problems (Baldursdóttir 2018). In the wake of the military uprising in 1998–1999, this expansive period was followed by a decade of degradation. In 2009–2010, the services were functioning with difficulties and lacked funding. However, the program received some financial and technical assistance. The main donors of financial support were UNICEF, the Global Fund, UNFPA, EU and WHO. The international NGOs working in community healthcare included the Portuguese NGOs VIDA, Assistência Médica Internacional (AMI), Saúde em Português and Médicos del Mundo, the Spanish NGO Asamblea de

Cooperación por la Paz (ACPP) and Plan Internacional. There were also some national NGOs, including Alternag, Divutec, EAPP and Parakaten, that worked on the implementation of community healthcare in collaboration with international NGOs and donors. The EU, the Portuguese Institute for Development Assistance (IPAD), the Spanish Agency for International Development Cooperation (AECID) and private actors from these countries were the primary funders of the NGOs. As before, FBOs worked with community healthcare, focusing on growth monitoring and vaccinations. Also, UK based Effective Intervention was implementing a research project in two regions with the aim of lowering child mortality through community health interventions (Boone et al. 2016; King, Mann, and Boone 2010; Mann et al. 2009).

Methods

Anthropological fieldwork¹ was conducted during two periods; first for 18 months from July 2009 to May 2011 and then two months at the end of 2012. This paper is mainly based on semi-structured interviews in Bissau with eight representatives of international organizations, eleven representatives of local and international NGOs and five staff members at the Ministry of Health. Data were also collected through participant observation at two stakeholder meetings at the Ministry of Health. During the revisit in 2012, semi-structured interviews were conducted in Bissau with five representatives of international organizations, six representatives of local and international NGOs, and four staff members at the Ministry of Health. Also, participant observation was carried out during two monthly meetings with CHWs within a pilot project in one region. The data collected during fieldwork was continuously transcribed and analyzed, and the final thematic analysis was done with the qualitative program Atlas.ti used for coding of interviews and field notes (Friese 2014).

The Ministry of Health in Guinea-Bissau was contacted for collaboration and ethical approval. The research was open, and informed consent was obtained from participants at all times. Before asking for permission to record each interview, all participants in the study were informed about the aims of the research. They were also informed that the interview was confidential and that they could stop at any point.

Findings

This section describes the revitalization of community healthcare in Guinea-Bissau that was initiated in 2010, the tension it created between the Ministry of Health and NGOs, and the consequences of the military coup in 2012.

Revitalization of community healthcare

At the end of 2010, the international interest to revitalize community-based PHC, in the spirit of Alma Ata, became evident in Guinea-Bissau when the Ministry of Health organized a two-day meeting, referred to as *Days of Reflection*. UNICEF financed the meeting and provided technical assistance. The stated aim of the meeting was for different stakeholders to meet and discuss the current situation of community healthcare in Guinea-Bissau and identify ways to revitalize it. Two months later a validation meeting was organized, in collaboration with the West African Health Organization, where a draft of a new community health policy, based on the first meeting, was presented and discussed by stakeholders.

In the first meeting, four international NGOs, i.e. AMI, VIDA, ACPP and Saúde em Português, as well as Effective Intervention gave brief presentations of their projects and experiences with community healthcare. A representative from one FBO, Caritas, also participated in the meeting but did not present its work in community healthcare. From the presentations, it became clear that the implementation of community healthcare varied considerably between different actors. Thus, the importance of harmonization was emphasized in both meetings. The Ministry of Health no longer wanted different actors to implement community healthcare in the way that each actor found suitable; they wanted to have more of a say in the implementation process and have a more uniform strategy.

In an interview after the validation meeting, a senior official of the Ministry of Health said that the Ministry should work according to the Paris Declaration on Aid Effectiveness; based on that, he argued, it was time to harmonize the activities of the actors that worked in community healthcare. He claimed that there had been some problems with the collaboration between NGOs and the Ministry, as the system was disorganized and each NGO had its own way of acting. This, the senior official said, was one of the reasons why the Ministry had organized the two stakeholder meetings:

The partners can come from where they come from, but when they come here they have to follow our directives, these are the activities that they should implement in community healthcare in the terrain. I believe we have now defined it, we have decided the way that we should all follow when it comes to interventions on the community level. Regarding funding, I can say that it was working well, but regarding organization, it was not working well.²

The Ministry of Health was trying to organize itself better and have a better overview of what all actors in community healthcare were doing, how they were doing it and

with what funds, the senior official explained, and he added:

We are asking them to elaborate projects together with the Ministry of Health because many times projects are elaborated abroad, they submit them only to get approval, and we can only do small changes. After they are approved and they have gotten the funding we cannot change it. We are in need of assistance, so we have to accept it. But we believe now it is the time to change that.³

Now, he stated, the Ministry of Health believed the time was ripe for all stakeholders to collaborate and for everyone to follow the Ministry's directives on community healthcare that they had all elaborated together. Nevertheless, the final policy document was also under the influence of global health policy and did not take into account some important decisions made by stakeholders.

The international stakeholders were positive about the stakeholder meetings and found it essential to work out a new policy to improve community healthcare. As an NGO representative said after the validation meeting: 'It was a good and important initiative on behalf of the Ministry of Health to invite all stakeholders to participate in the elaboration of a new policy right from the onset.' Nonetheless, there were certain aspects of the stakeholder meetings that led to concerns and annoyances on behalf of some of the NGO representatives. In interviews after the meetings, some of them argued that the Ministry of Health had exaggerated the problems with the NGOs. One international NGO worker did not agree with the criticism of the Ministry of Health and argued that the NGOs were not all working in the same places:

The NGOs are not united, and everyone wants to have their part here and their part there, but I think that they [Ministry of Health] should see NGOs with better eyes because we are a help to them but they don't understand it.

Then, the NGO representative complained: 'They [the Ministry] are always criticizing.' Once the Ministry of Health started to implement the new community health policy, the annoyances from the NGO-side intensified.

Times of tension

After the stakeholder meetings, the different NGOs started to wonder how their projects would fit within the new community health policy. Although the NGOs had participated in the elaboration of the new policy, some NGO workers did not know how to proceed with their projects and became confused about the future

role of the NGOs. One NGO worker pointed out that they had focused on the construction and equipment of village health units. These were no longer an important part of community healthcare, as CHWs were now to do home visits with a focus on prevention, not treatment. Other NGO workers wondered how to proceed with the planned training of CHWs and TBAs. An NGO worker explained that a Ministry of Health official had recently informed him that his NGO was no longer to continue with training, as new CHWs were to be selected and trained by the Ministry. Although the NGO worker claimed he supported the new policy, he argued the change was too rapid, and there was limited time for adjustment, or as he put it:

They just changed the direction in one week, and we were doing that kind of work, and now we are not doing that, and there was no talking [about it] ... they are not saying okay come with us and let's try to pass the information and the things that you were doing and the things that we want to do; I don't know, I really don't know.⁴

Due to the rapid change, the NGO worker argued: 'It is good that our project is not only about health and community healthcare, now if it was like that we had no work anymore because that part is completely out of our project.'

One and a half year after the validation meeting, at least two of the NGOs, which had presented their projects at the *Days of Reflection* meeting, had stopped working with community healthcare as a direct result of the new policy. The representatives of the NGOs argued that although they had participated in the policy-making process, the Ministry of Health had not collaborated with them as planned once the new policy was approved. The same applied to a third NGO that had been training TBAs in one of the regions but did not participate in the stakeholder meetings. The Ministry of Health had contacted these three NGOs specifically and told them to stop their activities, as they did not align with the new policy. The Ministry of Health informed that TBAs had been excluded from the community health program; instead, CHWs were to refer all pregnant women to health facilities for antenatal care and deliveries. However, six months after the military coup that took place on 12 April 2012, the Ministry was starting to realize that it had chased away some NGOs working in community healthcare. Consequently, one NGO representative said that a Ministry official had contacted the NGO and informed that they wanted them to restart their work at the community level. The renewed interest in collaborating with NGOs was apparently fuelled by the change in the political climate after the coup.

Political crisis and donor dilemmas

The public health sector was severely affected by the military coup. The whole country went on hold, and the Ministry of Health was closed for about two months. The planned health activities within the Ministry were postponed, as there was no money available and no minister to sign the cheques for implementing the activities. The donors, upon whom Guinea-Bissau were dependent, did not know at first how to react to the coup. An international actor explained:

There was one big issue at this moment ... a lot of money was given [by donors before the coup], and the biggest fear was that this money would disappear [from the bank]. The bank blocked all accounts, so everything was blocked; all the implementation was blocked. Then came the need to work with NGOs, and even with things that NGOs weren't really used to work with.⁵

Time passed and after two months a transitional government took office. However, most international donors did not officially accept the new government, which resulted in strained relationships between the government and donors; many donors decided to withdraw their assistance and left the country. The majority of the organizations that continued to work in Guinea-Bissau, such as the EU and WHO, suspended institutional cooperation with the government and put support for specific projects on hold. However, direct support to the people and civil society continued through NGOs, which, in turn, collaborated with the Ministry of Health at the regional level. A representative from the donors said that he did not think the government had any problem with this strategy: 'At least we work with them at the regional level.'

The Global Fund, which was one of the most important donors before the coup, practically suspended its assistance directly after the coup. It did, however, resume work in December 2012, but with changes; now it was going to collaborate with a fiduciary agency. Also, it reduced funding and only financed activities that were directly related to the treatment of patients, i.e. practically only the delivery of drugs. The Fund's suspension after the coup had negative effects on the healthcare system, as a senior Ministry official argued, the healthcare system was strongly dependent on external assistance, and the Global Fund was one of the largest donors:

The country does not buy drugs. It is given drugs [by its donors]. We are dependent on donations, if you do not behave well, then the donations will not come, and when it does not come we have problems with healthcare.⁶

So, because of donor withdrawals, there was a disruption in supplies of medicine for HIV, malaria and tuberculosis.

Some of the drugs had, however, gone to the private market where they were sold at high prices. The Ministry of Health had tried to solve the problem by borrowing medicine for tuberculosis for two months from Senegal, but these were immediately used up. UNICEF had also bought medicines to cover the demand for two months.

With the appointment of a transitional government, the Ministry of Health resumed its activities but not to the same extent as before the military coup because they had lost many of their partners. Eight months after the coup, a senior official at the Ministry explained: 'We had partners that we were in dialogue with, and that has reduced. We have partners that have withdrawn their assistance, and we have others that have suspended it.' He took the national hospital Simão Mendes as an example; after construction of the new pavilions was completed the hospital was to be equipped with money from the African Development Bank. 'Furniture had been ordered when the coup took place, but they cancelled everything, which means that we cannot open these pavilions,' he confirmed and added:

The Embassy of Spain withdrew from Guinea-Bissau, they left immediately, they were our main collaborators in the area of health. There are a lot of partners that we lost, we lost some EU projects that were withdrawn, and they continued with others.⁷

Apart from the suspension of funds, international organizations and donors were no longer allowed by their headquarters to collaborate with the Ministry of Health, which complicated the work of the Ministry further. The senior official found it difficult to continue his work when donors were not able to discuss with him as a partner. He argued that this situation had, in fact, affected the implementation of the community health program, as the Ministry could not find partners to help it implement the project: 'If we had not been in that situation we could have found many partners, like UNICEF and other partners. These could mobilize more partners and the Ministry itself could have mobilized more partners around this [project].' Due to the political situation, he explained, the Ministry could not mobilize resources 'because you have partners with whom you are unable to talk.'

Because of the political situation, the Ministry of Health lost much of its power, while the NGOs strengthened their position. Local and foreign donor representatives and NGO workers as well as Ministry officials and health professionals tended to see the bypassing of the Ministry of Health as necessary but unfortunate and argued for the importance of alignment, harmonization

and ownership. For instance, some Ministry representatives found that donors were obliged to respond in this way, and one official argued: 'Donors took these measures because they did not trust the government and they were scared that their money would not go to what it was intended for.' He explained that in case the government would need to resolve some issues urgently they might take the funds, and then be unable to implement the activities for which the money was intended:

That is why they [donors] prefer NGOs, they will not touch the money. The State, on the other hand, could say we will take it [the funds] and later on we will return it. [Later] they will not be able to return the money, and the activities stop.⁸

The Ministry official could understand donors when it came to collaborating with NGOs because 'whenever there is a project, the work goes well because they have enough [funds] to do their work. Always when you are on a project, you want the project to go well, you do not want it to fail.'

There were some who argued firmly against bypassing the Ministry. A representative of an international organization did not agree with the increased reliance on NGOs and explained that use of NGOs had resulted in delays in implementing projects for his agency and others. The representative explained:

We had difficulties to implement our program because we were told that we couldn't work together with the government. We have to work together with NGOs and the population; it became a little bit complicated. It does not facilitate our implementation and our program for the Millennium Development Goals.⁹

The representative was critical of the fact that NGOs were taking over the government's role in implementing activities. When collaborating with international NGOs, 'you have to pay money that could have been used to implement more activities.' As an example, the money could have been used for five activities, but now it would only cover three, as the rest of the money would go to cover the cost of the NGO. Therefore, the representative found it better and more efficient if the money would go straight through the government to the people. There were also local NGO workers who worried about the increased reliance on NGOs and stressed the importance of collaborating with the Ministry of Health. They argued that the Ministry had more technical capacity in healthcare than they did, and worried it could complicate the situation to sidestep the Ministry, claiming that the principal structure responsible for health is the government.

The increased focus on NGOs was noticeable in the implementation of the new directives for community healthcare. In June 2012, UNICEF started a pilot project in one of the regions to implement the directives of the new community health policy. UNICEF decided to collaborate with an international NGO that had worked with PHC projects in the region since 1998. The NGO participated in elaborating a project document together with UNICEF, in consultation with the regional health board. UNICEF financed the project while the NGO implemented it in collaboration with the regional health board. The project duration was to be one year; if successful the plan was to implement it in other regions of the country.

UNICEF argued that the political situation in the country was not the main reason for collaborating with an NGO. A UNICEF representative explained that they had realized that the workload of nurses at the health centres was already too high. The nurses had responsibilities and could not close; someone needed to be there at all times to carry out consultations, vaccinate children and do antenatal care. The nurses also had to do outreach activities to villages situated further than five kilometers from the health centres. Thus, the UNICEF representative argued, it was difficult for health centres to manage all this work and on top of that supervise all the CHWs in their health districts. In contrast, the NGOs only have their projects to implement and do not have other activities that can affect their performance. Thus, UNICEF had decided that it was best to collaborate with NGOs. Yet, it had been decided at the stakeholder meetings at the Ministry of Health, that the health centres, rather than the NGOs, should be the main actors in the implementation of the new community health policy. The UNICEF representative recognized this fact, but argued:

At the time of the Days of Reflection, we thought that in reality health centres could do it. But, the truth is that if you look at the outreach strategies, if you give money for these activities, they are not done because the nurse says that he does not have the time; he has a motorcycle, he has gasoline, and he has everything [to complete the work]. People associate these political aspects with it [the fact that they started to collaborate with an NGO] but even though the political situation [remained the same] it does not affect our perception of who is the best at assisting CHWs.¹⁰

The UNICEF representative pointed out that the organization was not allowed to collaborate with the Ministry of Health with funding from EU. Instead, UNICEF was to collaborate with the Ministry at the regional level.

Many actors, national and international, were worried about the sustainability of the revitalized community healthcare strategy. This applied in particular to Bissau-Guinean health professionals for whom cuts in support were not a new phenomenon. They worried about what would happen once funding was over. Paying the CHWs was of particular concern, or as one health official argued: 'That is why many things fail because they [CHWs] get used to receiving money when you [NGOs] are there, but it creates problems when you no longer have money to give them.' Once the project stops, the health official argued, CHWs would refuse to continue their work. In contrast, an NGO representative argued that in a way the project would be sustainable, as it would lead to changed healthcare seeking behavior by the community that would last beyond the project. A few interviewees argued that giving priority to sustainability over immediate action was not ethical; one should mitigate human suffering and the needless death of people.

Discussion

In response to the international call for increased emphasis on PHC in the spirit of Alma Ata, in 2010 the Ministry of Health in Guinea-Bissau took its first steps to revitalize the once promising and well-received community-based PHC services (Baldursdóttir 2018). Important partners were international organizations and NGOs that at the time worked within the sector but in an uncoordinated and ad-hoc manner. The Ministry of Health emphasized ownership, harmonization and alignment of the community healthcare services in line with the Paris Declaration, which some NGOs received with mixed feelings. Some NGOs stayed on while others became engaged in new activities. As a result of political instability, compounded by a military coup in 2012, suddenly the NGOs became central to the implementation of the community health services when most donors decided to bypass the Ministry of Health.

The observed bypassing of the Ministry of Health through the use of NGOs reflects donors' practice in fragile states (Acht, Mahmoud, and Thiele 2014; Dietrich 2013; Gutting and Steinwand 2017). Although there are some positive aspects of collaborating with NGOs, there are challenges (Banks and Hulme 2012; Banks, Hulme, and Edwards 2015; Buse and Walt 1996; Doyle and Patel 2008; Gideon and Porter 2016; Hearn 1998, 2007; Pfeiffer 2003). The pros and cons of the NGO-ization of revitalized community healthcare in Guinea-Bissau listed by donor representatives, NGO workers, Ministry officials and local health professionals are already recognized in the literature. NGOs, both national and international, tend to work on short-term projects

and to manage these on behalf of their donors rather than the national authorities (Chilundo et al. 2015; Hearn 2007; Pfeiffer 2003). Some of the NGOs active in community healthcare in Guinea-Bissau felt that even though they had participated in the elaboration of the new national policy it did not align with their projects. Thus, they were resistant to follow the policy and instead opted for other activities.

Although most actors found the bypassing of the Ministry of Health regrettable, they understood that the donors shied away from collaboration with the government to protect their funds and to secure effective implementation. Local health professionals and Ministry officials argued however that NGOs, owing to their access to resources rather than competence, were in general more effective than state actors. All actors agreed that local professionals were to be involved in the implementation of the activities to enhance capacity building and sustainability. At the same time, there were some actors, national and international ones, who were against increased NGO-ization and they were concerned that bypassing the government might hamper alignment, harmonization and ownership as reflected in the donor dilemmas described by Dietrich (2016, 2013).

In Guinea-Bissau, UNICEF opted for the NGO-ization of its support to the community health services. This occurred also with the EU-funded scale up of the UNICEF pilot project that had aimed, with some success, to reduce the high maternal and infant mortality rates (Dominguez 2017). An argument for this focus on NGOs was the given assumption that the local health center staff lacked the time to take on the extra work associated with introducing of the new community health policy. Human resources are indeed a limited resource (Russo et al. 2017), but health staff have the closest collaboration with the CHWs as well as knowledge of health-related issues and how to work with the communities. Also, Pfeiffer (2003) points out, the achievements in community health projects can disappear once the involved NGOs depart as most local staff lack adequate training and local health institutions lack resources. This is in line with the findings of Witter et al. (2017) from post-conflict settings, which shows that the health system was not able to sustain health staff whose salaries had previously been paid by NGOs. A study from Mozambique by Chilundo et al. (2015) shows that dependency on donors and NGOs can be problematic for revitalized CHW programs, and could counteract sustainability.

Considering the political instability of Guinea-Bissau, its aid dependency and lack of local resources, the sustainability aspect is relevant. Most national and foreign participants in this research agreed that bypassing the

Ministry with NGO-ization would counteract sustainability, understood as the continuation of community healthcare in the long run. Throughout their professional lives, Ministry officials and health professionals had experienced cuts in aid and abrupt changes in donor priorities (Einarsdóttir and Gunnlaugsson 2005). In line with Radelet (2004), aid to Guinea-Bissau tended to be unpredictable and short-term, and the NGO-ization did not surprise them. They were worried about the continuation of support when community healthcare was no longer high on the global health agenda and NGOs wind down their assistance and turn to other business. Having in mind the experience of aid dependency and the degradation of community healthcare after the departure of donors at the turn of the century (Baldursdóttir 2018), the new policy of paid CHWs was not seen to facilitate retention after withdrawal of support. Two additional arguments about sustainability emerged. The first, an NGO argument, underlines that a revitalized community health program would be sustainable through improved community health knowledge which would remain with the population in the rural villages, despite withdrawal. The second argument questions whether all health activities need to be sustainable, as the fundamental idea is to save lives. For Swidler and Watkins (2009) the idea of sustainability is a self-delusion for funders who should instead determine what projects are effective and then sustain them.

Donors truly face a dilemma in a situation of state fragility, but there is now an increased emphasis on donor engagement in the world's poorest and most fragile states (Acht, Mahmoud, and Thiele 2014, 2015; Dietrich 2016, 2013). Research has shown that avoidance to support fragile states may contribute to increased instability in countries otherwise judged to be unworthy of aid (Einarsdóttir and Gunnlaugsson 2016; McGillvray 2006; Nielsen et al. 2011). Einarsdóttir and Gunnlaugsson (2016) argue that the merit-based allocation of aid ignores the dire conditions of populations suffering both from bad governance and the non-engagement of donors. Allocation of aid is therefore an ethical endeavor that should first of all be need-based.

In line with the findings of Chabot and Waddington (1987), we argue that the implementation of community-based PHC projects is not a cheap option to solve the healthcare needs of poor, rural populations in low-income countries. In health, Dodd and Lane (2010) point out, the provision of donor assistance needs to be long-term and predictable, as most costs are recurrent. Without sustainable community healthcare, substantial resources through global solidarity, enduring involvement and persistence, Alma Ata's original aim, 'Health-for-All,' will not be realized.

Conclusion

The healthcare services in Guinea-Bissau rank among the worst in the world in terms of access and quality. In such a situation, community-based PHC can play an important role to give the mostly rural population at least minimal access to services, and there have been innovative initiatives to achieve this taken over the years. Guinea-Bissau is aid-dependent, and international trends and policies are compounded by political instability. The findings presented illustrate the complexity of the relationship between NGOs and Ministry officials in such a setting. In line with Hearn's (2007) reasoning, the NGOs, whether national or international, became more like managers of foreign development projects than promoters of national development.

Notes

1. See for example: Atkinson et al. 2001; Bernard 2006; Hammersley and Atkinson 2007; Crang and Cook 2007; Davies 1999.
2. Interview with a Ministry of Health official, 12 January 2011.
3. Idem.
4. Interview with a NGO worker, 21 February 2011.
5. Interview with an international actor, 17 November 2012.
6. Interview with a Ministry of Health official, 16 November 2012.
7. Idem.
8. Interview with a Ministry of Health official, 18 December 2012.
9. Interview with a representative of an international organization, 4 December 2012.
10. Interview with a UNICEF representative, 14 December 2012.

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