Chapter 5

The “Sustainability Doctrine” in Donor-Driven Maternal Health Programs in Tanzania

Meredith G. Marten

Introduction: Unpacking the Sustainability Doctrine

Each year, offices of the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) issue Country Operational Reports (COPs), which outline the “strategic directives” for each country in the following year. In 2008, the peak year of PEPFAR’s funding, the 1083-page COP outlined funding plans and objectives for hundreds of implementing agencies in Tanzania. That year, PMTCT was one of the largest focal areas, with US\$22 million dedicated to PEPFAR’s four-pronged approach: expanding services, increasing mothers’ uptake of antiretrovirals, improving follow-up of children and their HIV status, and strengthening monitoring and evaluation. Each PMTCT-related activity undertaken by partner agencies required a one-paragraph sustainability narrative, which described several plans, including developing partnerships with the public sector (integrating PMTCT into maternal and child health services, in particular), prioritizing capacity building through “training, mentoring, and supportive supervision,” and empowering community groups to be self-sustaining, resulting in local “ownership” of the interventions by HIV/AIDS committees at ward and village levels (PEPFAR, 2008, p. 123–124).

The demand for a focus on “sustainability” by PEPFAR and other donors comes from decades of concern about the volatility and uncertainty of funding and programmatic practice in donor-dependent countries (Yang et al., 2010). The United States Agency for International Development (USAID), for example, has emphasized sustainability for the past twenty years, defining it as “the ability of host country entities (community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcomes” (Mehdi, 1999, p. 1). Nevertheless, the sustainability

M. G. Marten (✉)

Department of Anthropology, University of West Florida, Pensacola, FL, USA
e-mail: mmarten@uwf.edu

plans in PEPFAR's COP reports did not include predictable and reliable support for implementing interventions over the long-term, or account for varying local contexts, hindering the potential sustainability of programs. Rather, the COP report implied a dependence on either unpaid volunteer work after the program period ended or income generation from an unknown source that would support healthcare worker (HCW) labor, both of which are unlikely in resource-poor environments (Maes, 2012).

These sustainability guidelines illustrate what Swidler and Watkins (2009, p. 1184) argue is the often "manifestly unrealistic" yet frequently replicated "sustainability doctrine" employed by many donors, NGOs, and humanitarian organizations in sub-Saharan Africa. Sustainability has "become a conscious policy of donors" to prioritize programs they believe can be sustained once donor funding ends (Swidler & Watkins, 2009, p. 1184). Health care is therefore principally envisioned and implemented by donors and NGOs in short-term, time-limited, vertical programs (Meinert & Whyte, 2014; see also Basilico et al., 2013), which are often operationalized through the planned use of trainings, dependence on unpaid volunteers, and development of income-generating activities (Swidler & Watkins, 2009), all of which were outlined or alluded to in PEPFAR's (2008) COP. Simultaneously, funding to support the necessary but deficient "staff, stuff, space, and systems" – the building blocks of strong health systems and the backbone of sustainable care (Farmer, 2014, p. 7; WHO, 2007; Yang et al., 2010) – is frequently and pejoratively termed "aid dependency" (UNAIDS, 2012).

A fundamental problem with translating sustainability policies into practice is how imprecise the term "sustainability" is despite its prolific use; as Yang and colleagues note, it "has been neither clearly defined nor consistently applied" (2010, p. 130). This may be strategic, allowing organizations to take on the mantle of sustainability despite outcomes that demonstrably undermine it. In many contexts, sustainability functions as a buzzword, concealing more than it reveals, and importantly, providing legitimacy needed to justify policies and interventions (Cornwall & Brock, 2005). As Sullivan (2016) writes, buzzwords "[envelop] actors mobilizing the terms in moral authority, shielding them from critique" (4). Buzzwords can also take on different meanings depending on context. In the case of "sustainable mining," Kirsch (2010) describes the meaning of sustainability shifting between the sometimes-incompatible goals of environmental conservation, social welfare, and economic development, the "triple bottom line" of sustainable development (Sachs, 2012, p. 2206). Sustainability's slipperiness, Kirsch (2010) writes, allows corporations to adopt the language of their critics: "mining is not sustainable" in the environmental sense becomes "sustainable mining" in the economic development sense if it continually employs a large workforce from a particular region. This shifting meaning can lead to paradoxical outcomes: mining corporations with large workforces and prominent roles in local economies can effectively threaten to leave unless environmental regulations constraining their destructive practices are removed, thus undermining the environmental sustainability of a region.

Discussions and debates about sustainability in global health and how to improve it have been longstanding, and the slipperiness of the term emerges in this history.

As Yang et al. (2010) describe, sustainability became a popular criterion for evaluating health programs decades ago, as part of efforts to address the growing concern about the instability and precariousness of health care in aid-dependent countries. Since the early days of Tanzanian decolonization, for example, donors have been largely resistant to pledging the kinds of financial and technical commitments required to support comprehensive health care and health system strengthening (HSS) (Stirling, 1977). Particularly as public health systems were dismantled in the wake of structural adjustment, the intent of promoting “sustainability” was directly *against* the perpetuation of “unsustainable” vertical programs over the long term. As short-term aid implemented by NGOs ballooned in the 1990s to fill gaps that emerged as public sectors faltered (Pfeiffer et al., 2008), advocates of sustainability tried to address “root causes of health problems rather than to palliate their symptoms” (Yang et al., 2010, p. 129).

The proliferation of overlapping vertical programs and global health initiatives was a consequence of the shift away from post-WWII intergovernmental collaboration coordinated by the World Health Organization (WHO) (Storeng et al., 2019). Instead, in the MDG era “unsustainable” vertical programs multiplied in contexts of neoliberalism, “philanthrocapitalism” (Birn, 2014), and broader efforts to transform “international health” practices structured by and through nation-states to “global health” orientations largely bypassing and transcending them (Adams, 2016; Pfeiffer, 2013; Rees, 2014). As Adams (2016) writes, the shift away from nation-states began with the global economic crises of the 1970s and 1980s, and governments’ diminishing capacity to support public health systems. It also derived from a “growing sentiment that national entities often *get in the way* of effective health delivery rather than promoting it” (emphasis in original, p. 5). Non-governmental, humanitarian, and other private sector organizations therefore functioned as the “institutional forms of choice for doing global health work” (Adams, 2016, p. 25). With this shift came an increased dependence on quantitative indicators and cost-effectiveness calculations, rapidly expanding the need for metrics which, Adams (2016) argues, is fundamental to enabling global health initiatives today. The shifting meaning of sustainability in global health contexts mapped on to these broader changes. Rather than indicating support for public sector HSS, in many contexts sustainability has come to primarily mean financing individual NGO-run vertical programs over time, which are more easily measured but less effective in contributing to HSS (Yang et al., 2010; Swidler & Watkins, 2009; Oberth & Whiteside, 2016).

Slow progress in achieving some MDGs – maternal survival in sub-Saharan Africa, in particular – highlighted the shortcomings of this shift in priorities. As Sheikh et al. (2011 p. 3) explain, an “upsurge of interest” in HSS materialized during the MDG era when it became evident that vertical programs could not function effectively with weakened public health systems. This occurred alongside increased emphases on aid harmonization, capacity building, and country ownership as outlined in the 2005 Paris Declaration and the 2008 Accra Agenda for Action (OECD, 2019). Despite these initiatives, in donor-dependent countries like Tanzania, external donors continue to exert undue influence on national agendas and undermine HSS.

Health policies like the sustainability doctrine “are artifices of human creation, embedded in social and political reality and shaped by particular, culturally determined ways of framing problems and solutions” (Sheikh et al., 2011, p. 2). Ethnographic research of how policies are constructed, enacted, prioritized – or rescinded or forgotten – can illuminate the contexts in which they operate, as well as the effects they may have on health systems and population health. In this chapter, I draw on ethnographic findings to describe how sustainability in health has been understood by policymakers and expatriate global health experts and donors in Tanzania, and the ways in which it was undermined by emergent “sustainability doctrine” practices in the MDG era. I illustrate how the sustainability doctrine has been put into practice, and how it has persisted, despite its shortcomings, using examples of donor-prioritized maternal healthcare initiatives in Tanzania rolled out several years apart: prevention of mother-to-child transmission of HIV (PMTCT) and basic emergency obstetric and newborn care (BEmONC) programs in the late 2000s, and more recent (2015) efforts to implement respectful maternity care (RMC) programs.

Considering programs implemented during a period of significant global interest in improving women’s health outcomes, I draw out some of their underlying dynamics. I focus on several issues informants identified as crippling efforts to build a strong Tanzanian health system, particularly the internal brain drain of healthcare workers from the public sector to higher-paying NGO jobs, and the prioritization of types of programs donors believed could be sustained after the funding period ended but could simultaneously erode health sector capacity, such as trainings and workshops. I describe how despite widespread acknowledgement of these fundamental issues, international donors still fear a cultivation of “aid dependency,” prohibiting many from contributing to long-term health system strengthening (HSS) efforts (McKay, 2017a), and prioritizing short-term interventions. From this, a focus on programs and workshops persists – less effective in part because of their time-limited structure, but also because they fail to account for local circumstances and the challenges that come with implementing vertical programs within weakened health systems. Despite good intentions to solve the unintended consequences of donor volatility, the successive promotion of “sustainable” practices can paradoxically contribute to health system precarity in Tanzania.

Methods

Research presented in this chapter draws from a larger ethnographic project exploring donor instability, aid withdrawal, and efforts to develop sustainable HIV and maternal health services in Tanzania.

The bulk of fieldwork took place at a large mission hospital in northern Tanzania over the course of 14 months in 2011–2012, and primarily addressed how HIV+ mothers enrolled in PMTCT care maintained their health and that of their families amidst declining program services and funding (see Marten, 2020). During this

period, donor-funded health institutions and programs, such as this PMTCT program, experienced high aid volatility following the 2008 global economic crisis. Because of this, I spent an additional three months in Dar es Salaam “studying up” to address how global health and development policymakers and program directors managed this volatility and conceptualized “sustainability” in global health contexts. Findings outlined in this chapter are derived from semi-structured interviews, participant observation, and document review. Sixteen semi-structured interviews were conducted with healthcare workers and policymakers, both in the public sector and at Tanzanian and international NGOs. Six informants were either managing directors or sustainability coordinators at five of the six primary implementing organizations partnered with, and funded in large part by, the US Government’s HIV initiative, the President’s Emergency Plan for AIDS Relief (PEPFAR). Among the others, four worked for bilateral organizations in departments focused on health or women’s rights, two worked for a maternal health project associated with a donor-funded hospital, one directed an international NGO focused on health and development, and one worked as a nurse at a large, private hospital. Only two informants worked in the public sector, a limitation of this research: one held a position at the Tanzanian Ministry of Health, Community Development, Gender, Elderly and Children (hereafter, MoH), and another was a medical school professor. Of these 16 informants, nine were Tanzanian, and of those who worked at NGOs, at least four had previous experience in the public sector. Of the remaining, seven informants were expatriate professionals, four of whom were from the United States. I also draw heavily from long-term key informant interviewing with two of these 16 informants, Tanzanian OB/GYNs I call Esther and Sheila, who have worked in maternal and neonatal health care for decades in the public and private/NGO sectors in Dar es Salaam. Finally, I rely on participant observation in various maternal health and HIV contexts over time in Tanzania, which inform much of my evolving perspective on sustainability and health system strengthening. Ethical clearance for this fieldwork was approved by the University of Florida’s IRB and permitted by the Commission for Science and Technology (COSTECH) and the National Institute for Medical Research (NIMR) in Tanzania. All names and other personal identifiers in the chapter have been changed to protect privacy and confidentiality.

Conceptualizations of “Sustainability” Among Policymakers in the Tanzanian NGO Community

In 2011, three years after the financial crisis, The Global Fund announced it was cancelling Round 11 of its funding, citing donor shortfalls. At the same time, PEPFAR funding stagnated, and numerous bilateral organizations announced roll-backs and changes in aid disbursements. One informant at a large bilateral agency headquartered in Dar es Salaam expressed her concerns about the reductions for health care, telling me “this is a larger scope and scale across multiple countries

than I've seen before." Amidst all this, concerns about "aid dependency" and the need for "sustainability" if and when the donors withdrew aid became more urgent (UNAIDS, 2012).

The country director of another bilateral initiative, Isaac, described to me his organization's conundrums with Tanzania's aid dependency. He characterized Tanzania's health sector as "deteriorating" because of its "long history of a culture of dependency." His organization provided critical health services for millions of Tanzanians, and he was doubtful the public health sector could feasibly take it over. Mirroring Adams' (2016, p. 5) observation that many global health actors view governments as "often *get[ting]* in the way of effective health delivery," Isaac continued, "if you want this done you have to do it for them."

In the spring of that year, I endeavored to better understand how sustainability was conceptualized in this context of funding retrenchments and fear of widespread aid exit. I asked informants to explain what they understood sustainability to mean, both in regard to health care and health systems, as well as how their organizations put sustainability into practice. A few participants identified goals for a sustainable health system that closely align with the 17 expansive goals employed by the SDGs (UN, 2017). From this perspective, informants identified sustainability as resting on a foundation of good primary and secondary education, basic health services, roads and infrastructure, electrification, access to safe water, good governance, and a more developed economy that could provide the tax base to fund health care and other social services. For example, when I asked Henry, an expatriate director of an international NGO, what some "best practices" for health sector sustainability might be, he illustrated the need to expand focus beyond the health sector:

Maybe the 'best practice' would be for all girls to finish Form 6? ...I would really overhaul our whole educational system... and work aggressively on rural youth employment, because if all the youth still become hawkers and *boda boda* (motorcycle taxi) drivers on the streets of Dar es Salaam, that is not solving the problem.

Secondly, many of these policymakers and NGO directors identified sustainability as dependent on a robust public health sector. Henry defined it plainly as "the effective running of a health system." To be effective, he said, "it depends on WHO's six building blocks," responsive to the "dynamic nature of public health" and the needs that arise within a population over time. The goal of the WHO Six Building Blocks model (WHO, 2007) is to promote HSS and includes: (1) effective, safe, and quality service delivery; (2) a well-performing health workforce; (3) effective health information systems; (4) equitable access to quality medical products, vaccines, and technologies; (5) a good health financing system; and (6) effective leadership and governance (WHO, 2007).

As Isaac alluded to, financing (block five) is a longstanding challenge. In Tanzania, austerity measures introduced in the mid-1980s reduced public spending on the health system and have been unsuccessful in generating the economic growth and revenue necessary to provide equitable and effective health care for all. Following Tanzania's 1999–2000 Sector Wide Approach (SWAp), the government implemented a series of initiatives to increase revenue, including imposing user

fees, improving tax collection, and expanding health insurance schemes (Marten & Sullivan, 2020). Still, in 2018/2019 government spending on the health sector was only 7% of Tanzania’s national budget, less than half the 15% Abuja target for health spending (Mamdani et al., 2018).

Informants emphasized that the building blocks that make up strong health systems must all happen in concert, as a critical lack of one component can frustrate improvements in the others (c.f. Farmer, 2014). For instance, the human resources crisis remains a formidable challenge in Tanzania; the country has one of the lowest rates of HCWs (physicians, nurses, and midwives) per capita in the world (WHO, 2015). Financing limitations (block five) constrain necessary human resources expansion (Mamdani et al., 2018), but a lack of functioning equipment (block four) also hinders the effective work of HCWs (blocks one and two) in clinical practice. Henry spoke at length about the extent of the problem that he had witnessed over decades in the Tanzanian health sector:

There are smart people here in Tanzania...but a key problem is getting those smart people in a working environment where they can use those skills... You can put a well-trained doctor in a national or a regional hospital, but if there is no blood pressure machine, if there are no gloves, if there are no standard operating procedures for delivering babies, if there are no clinical audits for people who died to find out why they died; if all that is [not] done, you can have a perfectly skilled doctor there but they can’t operate! You can as well put a nurse there, it’s the same thing.

Persistent stock outs of equipment and other logistics in Tanzania’s health facilities not only undermine service delivery but also can, according to informants, undermine trust in health workers and health sector institutions. For example, Esther, an OB/GYN and director of an NGO-funded maternal health program, explained how accusations by the public of nurse bribery in hospital labor wards can sometimes stem from misunderstandings about the constraints limited logistics pose to health-care provision. Esther explained that nurses are oftentimes villanized by the public because nurses frequently ask patients for money in order to get supplies that are necessary for their care and which should be free (Citizen, 2005). The persistent lack of supplies, she told me, meant that nurses often had to procure them from private pharmacies. For this reason, a nurse asking a patient for money may in many cases not be evidence of bribery, but in fact could be a result of equipment or medication shortages.

Infrastructural demands are also acute, but as one informant described, donor hesitancy to contribute to building new facilities is implicated in “staff and stuff” shortcomings. In an email interview with Inge, a European maternal health program manager for a Tanzanian NGO, she described how her efforts to develop a strong program and expand hospital services could be stymied:

Many white elephants have been constructed in Africa and are now not utilised...primary schools without teachers, health centres without staff and supplies, building without utility connections, etc....donors are afraid that hospitals will not be staffed afterwards and maintenance and operational costs cannot be secured...The human resource crisis in health contributes to this, as donors are afraid that infrastructure is easy to put in place but to man it and to keep it running is another challenge.

Paradoxical Outcomes from MDG-era Efforts to Build Sustainability: NGO-Driven Brain Drain in the Tanzanian Health Sector

Many healthcare practitioners and policymakers in Tanzania are acutely aware of the problems that arise when efforts to improve maternal health (and health outcomes, more broadly) are unlinked from HSS. Several informants lamented that vertical approaches to HIV care, treatment, and prevention were inadequate, and in interviews, some expressed deep frustration with a failure to learn from previous attempts to improve population health and change accordingly. As George, a Tanzanian NGO Director, explained:

When TB was a big agenda in the world, we had a kind of vertical [response], it was kind of a reaction to emergency. We thought that we would phase out [vertical programs], because HIV is a problem which would need to be solved by the entire system. But when HIV came, the same thing happened. I don't see that much changes, we don't learn, we don't learn much from what's happened.

During the MDG era in Tanzania, the rapid and widespread implementation of vertical programs contributed to a weakening of the public health sector through various means, but perhaps most significantly through an internal brain drain of Tanzanian HCWs. Aligned with the tenets of the sustainability doctrine, programs were often considered by donors to be more sustainable and “country owned” through the employment of local professionals (c.f. Swidler & Watkins, 2009; Palen et al., 2012), who were simultaneously attracted to the higher wages, benefits, and better working conditions afforded in the offices of international NGOs compared to the overcrowded conditions in public clinics or hospitals (see also Gerein et al., 2006; Ackers et al., 2016). As Bech and colleagues note, since 1978, government health workers have not been able to “live on a government salary without supplementary income” (2013, p. 102–103).

Another director of a Tanzanian NGO, Neema, described to me two principal ways in which the internal brain drain occurs. First, primary care nurses, doctors, and clinical officers were recruited to work in wards and facilities providing disease-specific care, leaving fewer health professionals to provide primary health care. Second was the recruitment of practicing HCWs, particularly MDs, from the public sector to non-practicing “desk jobs” at NGOs, which could include tasks such as developing health policies and guidelines, engaging in program monitoring and evaluation, and working with local government officials to harmonize NGO initiatives with local priorities. Lucia, an MD and professor at the national hospital, and Esther spoke at length with me about the internal brain drain and its effects on the Tanzanian health system, lamenting that the internal brain drain was crippling any effort to create a sustainable system. As Lucia said,

[Those who leave the public sector] “are not working at (the national hospital), so they're not training new doctors, they're not working in the district hospitals in Dar let alone out in the middle of nowhere. They're working for an NGO, and they're doing paperwork.”

As Lucia described, the brain drain leaves its mark on medical schools, too. Despite the current push to educate health workers in Tanzania as part of HSS efforts, overstretched medical school faculty members are seeing some of their most promising colleagues leave for the private sector or abroad, taking with them their years of specialized training. Lucia was concerned for the future of her university when the head of her department retired, because he would not only be leaving himself, but “all the people he has trained are not working in the system,” diminishing the chances that his students will be around to train the next generation of doctors.

Additionally, Esther speculated that some international NGOs actively recruited Tanzanian MDs in part to push through their desired changes in treatment guidelines, which they felt would be more palatable to the MoH coming from a Tanzanian and serve as evidence of being “country owned.” At one particular US NGO focused on maternal and child health, she said “they’ve got three OB/GYNs developing treatment guidelines (instead of doing clinical work), and the reason why they are there is because the NGO wants a Tanzanian face to face the Ministry to push the guidelines.”

Many things that could help build up strong health systems – cooperating with governments to fund structural gaps identified in their systems, for example (IOM, 2014) – do not fit in with donor conceptualizations of sustainability because of the long-term recurring costs involved. As McKay (2017b) describes, when long-term health systems costs are not supported because they are believed to cultivate dependency, the short-term focus and “ephemeral nature” of donor-funded projects come to dominate health systems, leading to their increasing precarity (474). Further, those projects that are funded can erode the public sector, paradoxically undermining the sustainability of health care that donors and implementers claim to be supporting. One principal strategy for sustainability and capacity building is the widespread implementation of off-site training for HCWs.

The Sustainability Doctrine in Practice: Basic Emergency Obstetric and Neonatal Care Trainings and Workshops

When I came to Tanzania in early March 2011, Sheila, an OB/GYN with a donor-funded NGO hospital, was just starting to coordinate and plan curricula for a series of Basic Emergency Obstetric and Neonatal Care (BEmONC) workshops for nurses and midwives in the government clinics and hospitals of Dar es Salaam. A goal of the workshops was to provide continuing medical education for safe deliveries and emergency obstetric care to help bring down the high maternal mortality ratio – 454/100,000 – at the time, far from Tanzania’s MDG #5 goal of 133/100,000 (URT, 2014; MoHCDGEC, 2016a). Her NGO’s hospital coordinated with the District Medical Office and another large, international NGO to run the trainings. I sat in on several days of these trainings, and they resembled others I have observed in Dar. We sat around a conference table, looked at PowerPoint slides, and someone was

positioned with a large flip-chart at the front of the room, writing out important notes that we would later tape to the walls. Participants discussed the emergency obstetric care guidelines (Dao, 2012), and nurses from each clinic were responsible for reporting to the group the results of their internal monitoring of progress in meeting the guidelines at their specific facilities.

The daily workshop schedule included tea around 10:00, a large lunch, and then an afternoon snack before breaking for the day. Every participant received a Tsh 120,000 per diem (US\$75), enough for a hotel and money to buy dinner. Most people participating in the training live in Dar anyway, Sheila explained, so many ultimately save the money. Per diems have become a critical part of the training culture in Tanzania and are a principal reason people participate; they serve as salary “top ups” and can strengthen patronage ties (see also Swidler & Watkins, 2009). Trainings are conducted for a variety of reasons, perhaps most importantly to serve as continuing professional development and education for Tanzanian HCWs, and fill gaps in pre-service curriculum and quality (Necochea et al., 2015). For donors, trainings like BEmONC are considered sustainable because they align with the “teach a man to fish” objective inherent to the sustainability doctrine – hiring experts to train people (or train trainers who will subsequently train others) involves short-term inputs that will not “breed dependency” but “provide all with the capacity to provide for their own needs” (Swidler & Watkins, 2009, p. 1184). Accordingly, the nurses, midwives, and physicians trained in the BEmONC workshop were expected to train others not in attendance in an in-service capacity. Through this approach, the BEmONC training of trainers was meant to “encourage support systems that aim to create an organisational culture of quality, and ultimately make improvements more sustainable” (Necochea et al., 2015).

By 2012, however, trainings had populated the health system and exacerbated the already dire human resources shortages experienced throughout the country. In many cases, trainings took HCWs out of understaffed clinics and hospitals and placed them in what could end up being a revolving cycle of trainings in various new skills and technologies. For example, in an assessment of 24 health clinics in southern Tanzania, Manzi et al. (2012) discovered that on average, 38% of available staff were out of the clinic or hospital for seminars and long-term trainings.

As Robert, a Tanzanian MD with the MoH, described:

One of the things which has really affected the health sector is all these trainings...HCWs spend two to three months moving from one training to another...[and] because people have been moving so much, they don't stay [to work] in the hospitals. Sometimes they move from a TB training to an HIV training, and then from there they go to a laboratory HIV training, and then from a laboratory HIV training they go to a pharmaceutical HIV training.

Because per diems for trainings were a supplement that many depended on to top up their salaries, who was chosen to participate contributed to feelings of inequity among HCWs. As Robert continued, “the thing is, you can't train everybody. Now the problem is if you train just a few, the rest who have not been trained will say ‘no, I'm not doing it because I've not been trained’.” This concern was supported by Sheila's experience, who visited hospitals and clinics for in-service BEmONC

training in the maternity wards, in addition to training trainers in BEmONC workshops. She related to me that considerable resentment was created between those who go to trainings, learn the guidelines, and receive per diem, and those who stayed behind to work in the hospital. What shocked her was that some HCWs who stayed behind claimed that the new guidelines for care were “not their guidelines,” implying that the guidelines were not their responsibility to carry out, because they were not paid to learn them (see also Magrath & Nichter, 2012). Sheila also said that because she herself was conducting trainings in different hospitals, she could not enforce the new guidelines, since she was not available to supervise practitioners to ensure the new skills were correctly employed. An in-service trainee Sheila encountered in one of the clinics in Dar told her fellow trainees openly that they “only had to perform the new guidelines today” while Sheila was there, “and tomorrow we can go back to doing what we always do” because she would not be around to supervise. This example illustrates how HCW trainings – despite their widely recognized importance – became less effective in building capacity because of the failure to take into account the significant structural gaps in the Tanzanian health system.

In his critique of the training model, Robert explained that he thought the expectations for Tanzanian doctors’ performance and professionalism should be much higher. Nevertheless, Robert asserted that compensation for health workers was woefully inadequate, contributing to diminished morale:

Most of the doctors in Tanzania used to be among the best students. [But now] when you start working, after maybe six or seven years of studies, you are the least paid! All these other students who were mediocre performers [in school] are now making more money... because they are working in another system, like the private sector or a bank.

As NGOs’ comparatively higher salaries contributed to significant internal brain drain, practicing staff in the health sector were increasingly overburdened. Over time, the topic of salaries, and perceptions of value tied to salaries, generated many heated conversations and was made particularly contentious when a series of doctors’ strikes erupted in 2012, fueled principally by anger over low salaries, few allowances for housing and transport, and stoked by continuing deficiencies in equipment and resources (see also Prince & Otieno, 2014).

The doctors on strike made several demands: a starting salary of Tsh 3.5 million a month (about US\$ 2,150) for new doctors (starting salaries at the time were about Tsh 950,000 or about \$600), a risk allowance of 30% of their salaries, a housing allowance of 30% of their salaries, health insurance, an increase for on-call allowances, and an allowance of 30% of their salaries for transportation. After a lengthy, antagonistic struggle, the government increased everyone’s salaries in the civil service by 20%, of which doctors are a part (TDN, 2012; Maluka & Chitama, 2017).

Doctors’ demands for higher salaries and supplemental support for housing and transportation are likely also related to the large population of expatriate international NGO workers who regularly receive all these things (see also Smith, 2007). Working side-by-side with expatriate doctors and NGO workers earning significantly more, with supplemental income for housing and vehicles, seemed to have numerous effects. First, the inflation in housing costs, particularly on the peninsula

of Dar es Salaam where the majority of NGO offices were located, frequently prevented Tanzanians from being able to afford nearby housing. These neighborhoods are regularly exempted from scheduled, revolving brownouts; experience less traffic; have more paved roads; and are largely safer. Second, the cost of living was rapidly increasing, with which salaries often did not keep pace (NBS, 2013). Third, many people equated salary with perceived value – which appeared to me to be the most offensive and hurtful to several Tanzanian informants. Esther, who was angered by an argument over her salary with her boss, said that seeing how little she was paid compared with her expatriate colleagues made her “feel black” – which she explained as making her feel undervalued and perceived to be “stupid and silly.” Cognizant and too-often reminded of the undercurrents of racism that pervade much of international health efforts, she and Lucia lamented how Tanzanian doctors were perceived by many in the global health community to be “underdeveloped”, and that “[living in a] low-resource country means [having] a low-resource mind.”

Persisting Sustainability Doctrine Practices in Tanzania’s Respectful Maternity Care Efforts

Numerous lessons learned from the MDG era emerged in anticipation of the UN’s new development initiative, the SDGs, which began in 2015 and included a focus on the importance of HSS (UN, 2017). But despite evidence that sustainability doctrine practices like trainings can weaken the health system in Tanzania, some more recent donor-funded RMC interventions often still adhere to its basic tenets: the prioritization of short-term, “feasible,” and locally owned programs donors believe may be sustained after donor support ends (URT, 2015).

The paramount importance of HSS for improved maternal health outcomes has been identified and promoted by researchers for decades. In a cross-country analysis, for example, Anand and Barnighausen (2004) found a direct relationship between the ratio of HCWs to population and women’s survival in childbirth and that of neonates – as the number of doctors, nurses, and midwives increase, survival increases proportionately. Nevertheless, maternal and reproductive healthcare sectors experience some of the most acute consequences of the human resources limitations in Tanzania (see also Gerein et al., 2006; Shoo et al., 2017), and the labor wards of the major public hospitals of Dar es Salaam are among the places where the lack of “staff, stuff, space and systems” can be most profoundly felt (Farmer, 2014, p. 7). As Esther explained, these hospitals operate at approximately 400% capacity, and on any given day, several women may be found laboring side-by-side in a bed. In efforts to increase institutional births believed to reduce the rate of maternal mortality, the hospitals recently experienced a nearly 34% increase in admissions without the budget line or support to provide quality care for such rapidly increasing numbers (URT, 2015). Further, those most responsible for caring for women – the city’s harried labor ward nurses – rush from woman to woman, where

Esther memorably told me “there’s a head popping out of a vagina every 20 minutes” (see also Naburi et al., 2017). As one Tanzanian ICU nurse at a private hospital explained to me, conditions in these labor wards are so notoriously bad that nurses are sometimes placed there as “punishment” for underperforming in other wards. Esther described them as akin to “prison islands” with people exchanging tips on how to “get out” and be relocated to other wards. Stories of bribery and corruption among labor ward staff also regularly appear in local newspapers, contributing to corrosive public distrust (Citizen, 2005).

Nevertheless, recent efforts to improve maternal health outcomes still often focus on symptoms of problems rather than the roots – in particular, the widespread and pernicious “disrespect and abuse” of pregnant and laboring women, rather than the critically insufficient “staff, stuff, and space” of Tanzanian labor wards (c.f. Kruk et al., 2018). Despite the uptick in urban institutional births Esther described at Dar hospitals, low rates of institutional births persist nationally, which many attribute to disrespect and abuse encountered in labor wards. This, in turn, is thought to be linked with stagnating maternal mortality rates, which in 2015–2016 was 556/100,000 (see Kujawski et al., 2015; MoHCDGEC, 2016a). A current focus in global maternal health to combat disrespect and abuse is respectful maternity care (RMC), which promotes women’s human right to respectful and dignified care (White Ribbon Alliance, 2011).

Similar to earlier HIV and BEmONC programs, RMC interventions primarily involve trainings targeted toward sensitizing HCWs (adapted from the WHO’s Health Workers for Change curriculum, Fonn & Xaba, 1996), and birth preparedness education for pregnant women (Ratcliffe et al., 2016a), two interventions that satisfy Swidler and Watkins’ (2009) sustainability doctrine mandates. Research suggests, however, that insufficient health system inputs underlie persistent issues of disrespect and abuse (WHO, 2018b). A recent study of RMC in Kigoma region evaluated patient and provider determinants of receipt of RMC based on three dimensions of respectful care: (1) friendliness/comfort/attention; (2) information/consent; and (3) non-abuse/kindness (Dynes et al., 2018). The majority of findings indicated structural and systemic constraints as exacerbating disrespect and abuse. From the provider side, nurses who attended the most births, and those who had the highest number of working hours, were more frequently reported as engaging in disrespectful or abusive actions. Alternatively, Dynes and colleagues note that healthcare providers who had access to multiple kinds of mentoring, and felt fairly compensated for their work, more frequently engaged in respectful maternity care. From the patient side, those who labored with a companion – something frequently not allowed in “bulging” labor wards because of a lack of space – reported more frequently receiving respectful care. The authors recommend strategies to provide more equitable pay, decrease workloads, provide more breaks, and increase mentoring opportunities – all dependent on HSS and long-term, stable funding – as being paramount for decreasing disrespect and abuse (Dynes et al., 2018; see also WHO, 2018b). Indeed, researchers affiliated with Dar’s RMC intervention described above note that for dignified care during childbirth to be sustainable, “institutional

commitment to providing necessary resources and staff will be needed” (Ratcliffe et al., 2016b, p. 1).

Large-scale efforts to implement RMC in Tanzania were first laid out in a stakeholder meeting in Dar in 2015, convened by the MoH and USAID’s Maternal and Child Survival Program, and attended by 47 participants from multiple East African Ministries of Health, Tanzanian regional health offices, bilateral organizations, and NGOs (URT, 2015). Esther was an attendee at the meeting, and voiced her frustration with the continued lack of public sector support, by arguing that supporting staff to manage high workloads and operate effectively within the overcrowded wards was essential. Further, she advised the group that investing in HSS with RMC as a focus area should be prioritized rather than another vertical program. She has since advocated for “caring for carers” as a principal way to improve maternal health outcomes in Dar es Salaam, which include issues like fair pay, more staff, and increasing the space and number of hospitals to accommodate the growing numbers of women. Reflecting on her experience one evening over dinner with me, she rhetorically asserted her objectives, using the same rights-based language that RMC advocates have used: “what about the rights of healthcare workers?”

Conclusion

A shared framework for HSS was first developed at the WHO’s 2005 “Montreux Challenge” when it became evident that strong health systems were essential for effective and sustainable health care (Hafner & Shiffman, 2013; Sheikh et al., 2011). Yet still today, donor policies promoting sustainability can hinder progress toward HSS, one of the “bitter ironies” encountered across PMTCT, BEmONC, and RMC programs described in this chapter (Swidler & Watkins, 2009, p. 1192). In donors’ quest to develop more “locally owned,” sustainable programs staffed by Tanzanian professionals, an NGO-driven brain drain emerged, shifting HCWs from public to NGO sectors, and from clinical practice to “desk jobs,” eroding the pool of practicing health workers. Further, short-term activities like trainings were frequently implemented, which at the same time could undermine the health workforce by enrolling clinicians in a revolving door of trainings. Finally, donors sidestepped opportunities to assist the Tanzanian government in strengthening the public sector (see also Maluka et al., 2018), including supporting policies that would have made their interventions more effective and alleviate some of the pressures on HCWs themselves. In the overburdened labor wards in Dar’s largest hospitals, as Dynes et al. (2018) explained, providing more equitable pay, decreasing workloads, increasing mentoring opportunities, and encouraging larger institutional commitments to providing resources and staff are needed, particularly as women are increasingly encouraged to deliver in facilities that are already severely under-resourced (Wendland, 2018).

As outlined in these ethnographic cases, a disconnect between donor rhetoric and action creates an irony of the sustainability doctrine: the cultivation of “aid dependency” is frequently cited as a reason to not pledge long-term, stable resources to

HSS objectives (UNAIDS, 2012), while paradoxically, programs characterized as “sustainable” can undermine them. The harmful consequences of these policies can be significant: as McKay (2017a, b) illustrates in her work in Mozambique, the tradeoff in avoiding “aid dependency” is often the establishment of more precarious systems of care, which can ultimately lead to stagnating or worsening maternal health over the long term.

External donors are not solely responsible for strengthening health systems, of course, and limitations of this work include a gap in information about the Tanzanian government’s own efforts and shortcomings in doing so. Despite this, a focus on donor-funded programs illuminates an important question: why do these policies and priorities persist despite widespread acknowledgement of the harm they can do? Through tracking the rhetorical slippage of “sustainability” over time, it can be seen as a buzzword: used to create an appearance of advancing sustainable health care, without significantly challenging the powerful market-based structures of the status quo. While intended to alleviate problems complicated by donor dependency and LMICs’ decreasing ability to fund public health services, the sustainability doctrine instead primarily advances neoliberal “global health” orientations, dependent on metrics and accountable to donors more often than to those accessing care (Adams, 2016; Maluka et al., 2018). Sustainability’s shifting reference to maintaining a system of short-term, NGO-run programs reinforces the “philanthrocapitalist” model that circumvents nation states in favor of NGOs (Birn, 2014). The lack of support for public care then further entrenches the notion of nation-states’ inability to build successful public health systems in resource-poor contexts (Adams, 2016).

The amount of donor funds still available for global health services, and particularly for maternal and child health (MCH) initiatives, provides a window of opportunity to do things more effectively and durably to build up public health sectors (Pfeiffer, 2013). In 2017, US\$11.6 billion in DAH was dedicated to MCH, nearly the peak of funding HIV received during the rapid scale up of HIV programming (IHME, 2018). The current SDG development agenda provides further opportunity, emphasizing HSS to achieve SDG #3: “ensure healthy lives and promote well-being for all at all ages” (UN, 2017). Tanzania has embraced the SDG model of harmonization in maternal health contexts, linking not only the multiple domains that can impact maternal health, such as gender-based violence and male engagement in family planning (USAID, 2019a, b), but also better establishing integration of services (MoHCDGEC, 2016b, p. 10).

Donors can support these efforts in part by directing funds to public sector initiatives rather than bypassing them in favor of NGOs (Pfeiffer et al., 2008; Pfeiffer, 2013). This is of particular importance for growing economies like Tanzania’s, which is expected to soon transition “beyond aid” (Whiteside et al., 2019), and is in line with the most recent Astana Declaration which affirms “the primary role and responsibility of Governments at all levels in promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health” (WHO, 2018a). Whether this will come to be in Tanzania or is just another policy on paper remains to be seen – as Henry noted, “We have the most beautiful policies, but they are never put into practice.”

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