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Mediating Abundance and Scarcity: Implementing an HIV/AIDS-Targeted Project Within a Government Hospital in Tanzania

Noelle Sullivan

While free antiretroviral therapy (ART) in Tanzania has undeniably increased accessibility of services, the effects of ART programs as they are brought into existing health facilities are more ambiguous. As transnational nongovernmental organizations (NGOs) establish clinics within government hospitals, we see a telling example of how NGOs are providing services *from within* the state. The conditions of NGO-operated clinics within government health facilities act as a daily reminder of the failures of the government to provide health workers with that to which they feel entitled: adequate pay, access to sophisticated technology, upgraded training, extra-duty allowances, and a professional working environment. At the same time, health personnel compete to position themselves in such a way to be able to make claims on the state *through* these NGO clinics, which is the only means available for them to access the very resources to which they feel entitled by their profession.

Key Words: government hospitals; health sector reform; HIV/AIDS; medical personnel; PEPFAR; Tanzania

Amid claims of inadequate infrastructures and problematic vertical funding mechanisms within African health sectors, there is little information about what is at stake when externally financed health programs are implemented within existing government medical facilities. This article aims to situate

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HIV/AIDS programs, such as those sponsored by the President's Emergency Plan for Aids Relief (PEPFAR), within the institutions in which they operate. While free antiretroviral therapy (ART) has undeniably increased access to much-needed services, the effects of ART programs on government-owned health facilities are more ambiguous. The ideals and values that underlie biomedicine call for technologies, medicines, and specialized forms of expertise. Yet many African biomedical facilities are chronically understaffed, under-resourced, and underfinanced. Thus, the abundant resources of HIV/AIDS programs are embedded into contexts of institutional scarcity.

As transnational nongovernmental organizations (NGOs) establish clinics and targeted interventions within existing government health facilities in aid-dependent countries, we see a telling example of how NGOs not only operate parallel to the state (cf. Ferguson and Gupta 2002) but also provide services *from within* the state. Those government health units housing externally funded programs allow for no easy distinction between "public" and "private" social services (Blundo and Le Meur 2008). NGO-sponsored health programs have access to significant financial and technological resources. They are, in essence, biomedical and bureaucratic "enclaves" (Ferguson 2006; Blundo and Le Meur) within government health facilities. These materially and technologically enriched enclaves are characteristic of what Lock and Nguyen called the "non-governmental phase of biomedicine," whereby NGOs, development agencies, and humanitarian interventions mobilize biomedical technologies and practices to improve health care provision to the world's poor (2010:148).

Within government health units, enclaves mark the ailments or target populations that are the top priorities of the state and, especially, of donors with interests in intervening in healthcare in heavily indebted poor countries. Not surprisingly, enclaves are most often established surrounding three targeted areas that are part of the Millennium Development Goals, to which Tanzania is a signatory: HIV/AIDS, malaria, and reproductive and child health (RCH). Thus, PEPFAR-funded and NGO-sponsored HIV/AIDS clinics are only one kind of enclave that commonly operates within Tanzanian government medical facilities. However, in important respects, HIV/AIDS clinics are unique among these enclaves. RCH and malaria enclaves largely emphasize preventive services. They are generally not technology-intensive and build on expertise that many health workers already possess. Conversely, HIV/AIDS clinics engage in both prevention and long-term treatment of an incurable disease—one for which therapy regimes and associated technologies are often changing. ARTs are very expensive. Patients receiving them require regular laboratory testing and clinic visits to monitor the progression of the virus, their adherence to strict

drug regimens, and their bodies' responses to treatment. Overall, clinics providing ARTs are more technology-intensive than those for RCH and malaria. This is reflected in the fact that between 2004 and 2008, the United States' foreign aid contributed $11.1 billion on HIV/AIDS alone, compared to $7.5 billion on other health programs such as infectious disease prevention, maternal and child health, and malaria control. Of the PEPFAR funds allocated from 2006 to 2009, 46 percent were spent on treatment, 29 percent on care, and 25 percent on prevention (US Government Accountability Office 2010). The biomedicine of HIV/AIDS clinics thus requires staff to have expertise in complex treatment regimes and standardized laboratory testing. As a result, clinic staff must receive regular training updates.

Since health sector reforms (HSR) were implemented in 1999–2000, the Tanzanian Ministry of Health and Social Welfare (MoH) aimed to improve working conditions, increase salaries, and update training for its workers. While the MoH has achieved some progress on these goals, the compensation and continued training of health workers has largely been subordinate to other initiatives, such as improving drug and equipment supplies and reforming management systems at the district level. In essence, these NGO-sponsored programs make available the very resources the state has promised but not delivered. Nowhere has Tanzania's MoH provided the technological and bureaucratic standards attained in the PEPFAR-sponsored HIV/AIDS clinics in the country.

Reflecting on the ambiguities of ART provision in central Mozambique, Ippolytos Kalofonos pointed to an "economy of scarcity," where food aid was made available to HIV-positive clients, but in insufficient supply to distribute to all people on ART (2010:371). The limited provision of food aid incited fierce competition among people living with HIV/AIDS, resentment among those who were seronegative, and dilemmas for clinic administrators forced to find ways to determine who were most needy within an overall context of hardship. As Whyte and others (2010) illustrated in Uganda, while externally-funded HIV/AIDS programs within government facilities increase work burdens without providing additional staff, they also provide opportunities for increased pay through allowances and new knowledge through workshops and training seminars—potentially leading to future promotion (see also Anders 2010). For health workers in Tanzania, enclaves enact an economy of scarcity surrounding the biomedical and professional possibilities that externally funded programs represent. The conditions of NGO-operated clinics within government health facilities act as a daily reminder of the failures of the government to provide health workers with that to which they feel entitled: adequate pay, access to sophisticated technology, upgraded training, extra-duty allowances, and a professional working environment. As government employees charged with managing

state *and* donor health programs, hospital administrators must determine how to distribute the vast resources of the enclaves among the staff. At the same time, health personnel compete to position themselves so as to make claims on the state *through* the enclave, as the only means available for them to access the resources to which they feel entitled (Wendland 2010).

Next, I explore how a PEPFAR-funded program impacted one Tanzanian government hospital. After outlining my methodology, I provide a brief history of HSR and HIV/AIDS in Tanzania. I then trace the kinds of infrastructural transformations that came about at the hospital after HSR, including the building of the HIV/AIDS clinic. In contrast to major changes in the hospital landscape, I highlight the ways that health workers continued to struggle with inadequate pay. Finally, I outline the paradoxes that came about when hospital administrators allocated the training and compensation benefits of the enclaves in an economy of scarcity, and to what effect for professional relationships within the hospital.

METHODOLOGY

This article is based on ethnographic research conducted during 11 months in 2008, primarily within a district hospital in Arusha region. I observed and sometimes participated in the daily routines of different departments in the hospital and conducted interviews in Kiswahili (the national language of Tanzania) with hospital staff at all levels. As it was common for hospital workers to use some English phrases in Kiswahili speech, italicized words in the quotations in this article denote those spoken in English. I also draw on interviews with an officer within the Tanzanian MoH, and a Tanzanian representative of the US NGO that operated the PEPFAR-funded HIV/AIDS program at the hospital. Certain aspects of the events outlined have been altered and all names have been omitted or converted to pseudonyms to protect the identity of the participants and the hospital. The hospital staff would not necessarily share the concerns that I outline. Most staff were proud of what the hospital accomplished in recent years and hoped that other donor projects would come to their workplace. Nonetheless, the presence of NGO enclaves within the hospital led to various contradictions and tensions, and it is important to highlight these ambiguities.

A BRIEF HISTORY OF HIV/AIDS PROGRAMS IN TANZANIA

Throughout its history as an independent country, Tanzania has been highly dependent on aid, and recently, a disproportionate amount of that funding

has been targeted toward HIV/AIDS prevention, treatment, and research. The first cases of HIV/AIDS occurred in 1983. In 1995, Tanzania had the highest number of reported HIV/AIDS cases of any African country. According to UNAIDS/World Health Organization (WHO; 2008), the estimated adult prevalence of HIV was highest between 1995 and 1997 and began to drop in subsequent years. The high prevalence of HIV/AIDS in the mid-1990s put pressure on a health sector already in a precarious state. In 2000, the Tanzania Commission for HIV/AIDS (TACAIDS) was established to lead the national response to the disease. Although by 2001 the government had strategic plans and policies in place to prevent and test for HIV, it was not until 2003 that the country adopted a Health Sector Strategy on HIV/AIDS, which included an integrated and gradual scaling up of ARTs (WHO 2005a).

The WHO and UNAIDS launched the "3 by 5 Initiative" in 2003, with a goal of providing ARTs to three million people in "developing" countries by the end of 2005. Drawing on discourses of universal human rights, this Initiative had an overall aim of achieving global universal access to treatment and prevention by 2010 (WHO 2003). Tanzania received support through the Initiative in October 2003, and the WHO target in Tanzania was for 220,000 patients to be receiving ARTs by the end of 2005. Yet by June 2005, Tanzania was estimated to be providing ARTs to only 2 to 3 percent of those needing it—making it one of the countries identified as having the highest unmet need (WHO 2005b).

Between 2004 and 2006, the government nearly doubled its expenditures on HIV/AIDS. In 2004, Tanzania began to receive massive injections of funds from PEPFAR and the Global Fund to scale up ART provision. PEPFAR funding to Tanzania increased from US$70.7 million in 2004 to US$313.4 million in 2008 (PEPFAR 2008b). When PEPFAR programs were implemented in Tanzania in 2004, they initially targeted 19 health facilities in the country (WHO 2005a) planning to supply ARTs to 1,500 people (PEPFAR 2008a, 2008b). PEPFAR's goal was to provide 209,111 Tanzanians with ARTs by 2008 (PEPFAR 2008a). However, as of September that year, it was still short of its goal, treating 144,100 HIV-positive Tanzanians (PEPFAR 2008b). Meanwhile, from the Global Fund's inception in 2001 until 2007, Tanzania secured nine grants equaling approximately US$400 million (TACAIDS 2007),[1] the vast majority of which was meant to target HIV/AIDS. In 2004, only 3000 people were receiving ARTs in Tanzania. By 2006, the number was more than 60,000, and by 2007, 96,699 Tanzanians had access (TACAIDS 2008). In 2008, the estimated population of Tanzania was just over 40 million people (Central Intelligence Agency 2010), with approximately 1.4 million Tanzanian adults and children living with HIV in 2007—an estimated prevalence rate of 10.9 percent in urban areas and 5.4 percent in rural areas (UNAIDS 2008).

BUILDING A GOVERNMENT HOSPITAL BEYOND THE STATE

This research was conducted at a government hospital in Arusha region, in northern Tanzania. The hospital, which I call Kiunga District Hospital, is peri-urban, located close to but outside of two urban areas. It is the largest of three hospitals servicing the immediate area. In 2007, Kiunga district had a projected population of nearly 300,000 people. While the recorded HIV rates for the district were 6 percent in 2007—lower than the estimated national average of 7 percent—the distribution was uneven.

HSR in Tanzania was in the planning stages in the mid-1990s, but was not largely implemented until 1999–2000. Prior to HSR, Kiunga District Hospital was operating under the difficult conditions prevalent throughout the country. While all services and drugs were free from the 1960s until the 1990s, they were frequently unavailable and the hospital was chronically understaffed. Workers knew that health sector reforms were being planned, but waiting for the resources needed to provide adequate health services was having adverse effects on morale. A nursing administrator commented that even into the late 1990s, the conditions in the hospital were very difficult. She said, "Medicines themselves, firstly there were none, so people on shift were waiting for the patients to come with their own notebook, and [doctors] would write down a drug [not available at the hospital] and told them to go find it elsewhere. So it was really difficult."

From 1999 to 2008, the changes that occurred at the hospital were extremely rapid. In 2000, HSR was implemented at Kiunga. The effects were remarkable, and two are of significance here. First, the MoH provided a series of training workshops and seminars to ease the transitions under HSR. Several of these related to management and data-gathering systems that Kiunga and its counterparts were to implement. Other training opportunities related to those health services that were of highest priority, with RCH seminars receiving a large proportion of funding. This was the first time that several staff members at Kiunga had received updated training since completing school, and they were grateful for the salary supplementation these workshops provided.

Second, the MoH instituted a variety of income-generating initiatives for health facilities. Cost sharing was introduced, requiring that patients pay fees for services and prescriptions that were previously free. This money remained within the individual health facilities, for use in supplementing equipment or drugs that the government did not provide, and for small infrastructural improvements. The MoH also encouraged individual health facilities to be entrepreneurial by seeking out "Public-Private Partnerships" (PPPs) with individuals, companies, and NGOs to supplement existing resources. From 2000 to 2004, Kiunga District Hospital procured funds

for some building projects: a small HIV testing and counseling clinic, a maternity ward, a minor surgical department, improvements to the administration block, and an extension to the file room. For the first time, the government allowed the hospital to foster its own connections with private companies and individual benefactors, and, as a result, from 2004 to 2008, the hospital nearly doubled in size, adding two new wards and major extensions to other areas financed through temporary grants. Little donor or benefactor attention was paid to the existing technologies and supplies at Kiunga, and much of the equipment was old and neglected: rickety wooden benches, worn mattresses, ripped sheets, windows without curtains or screens, torn bed nets, inoperative surgical lights, unreliable electricity and water supplies, paucity of stethoscopes and blood pressure cuffs, and only two ancient sterilizers to serve the entire facility. The hospital boasted new buildings and reliable supplies of essential drugs courtesy of the MoH, but these stood in stark contrast to the realities of medical practice, where—at least beyond drugs—the equipment needed was often absent or in disrepair. The staff was largely thankful for the improvements to the hospital, but it continued to be marked by scarcity. Staff had little expectation that the resources they needed would be provided, or that those resources they had available would function as required.

There were, however, two exceptions, and these were the two enclaves of Kiunga District Hospital: the RCH clinic and the HIV/AIDS clinic. These two units were high-priority areas of both the government and its donors and were well resourced and staffed. Supply chains to these enclaves were consistent and predictable, marked by regular visits from NGO representatives to evaluate their work and deliver supplies. The main difference between the two enclaves was that the RCH, which dealt mainly in preventive medicine and malaria services, did not boast a lot of sophisticated technology. Both the MoH and the NGO sponsoring programs in the RCH offered training seminars, but they were less frequent and paid less than those of the PEPFAR-funded HIV/AIDS program. Those workers affiliated with the HIV/AIDS clinic therefore received a disproportionate amount of the donor-sponsored resources available at the hospital. Meanwhile, the biomedical environment instituted there—marked by coveted and very expensive laboratory equipment and several computers—appealed to the professional ideals of the workers (Whyte, Whyte, and Kyaddondo 2010).

The small HIV/AIDS clinic opened in late 2002 for volunteer counseling and testing services (VCT). The structure comprised two small rooms and had limited capacity to provide services beyond testing. In 2004, the MoH appointed Kiunga as one of its roll-out sites for ART provision. The services were dubbed "CTC"—Counseling, Testing, and Care—to conceal that it was an HIV/AIDS clinic from the public. At that time, funds for the

CTC program were channeled through a web of donors. The United States Agency for International Development and the Global Fund financed an American transnational NGO, REFLECT (pseudonym), which was dedicated to HIV/AIDS-related issues. Sponsored by REFLECT, CTC services began at Kiunga in 2004. The clinic was open once a week, had one clinician and two nurses, and enrolled ten patients. By June 2006, the CTC clinic serviced more than 500 clients.

In 2006, PEPFAR awarded a grant to REFLECT to expand ART provision. Administrators at Kiunga District Hospital wrote a proposal to offer the facility as a site for ART scale-up. The proposal suggested that REFLECT finance an extension of the existing CTC building and provide funds for staff training in data collection and input, filing, and computer familiarization. It also requested additional personnel for the clinic: a minimum of three additional clinicians and four nurses, allowing the clinic to operate three times per week. The plan included extending training to other staff peripherally connected to the CTC clinic, and medical personnel within the smaller government health facilities in the district. Kiunga District Hospital's proposal was selected, very suddenly bringing a barrage of contacts, paperwork, and resources. The facility thus became one of the nearly 40 REFLECT-funded sites in Tanzania, distributed across four regions.

REFLECT agreed to pay for the suggested renovations to the existing CTC clinic, for laboratory equipment (including a machine to count CD4 levels), and other necessary resources. By October 2007, transformations to Kiunga's CTC clinic were complete. The changes were astonishing. A large covered waiting bay was attached to the existing CTC clinic, with two small rooms to the side: one for patient files and the other for a data-entry clerk, to enter information on each patient into an elaborate PEPFAR database. Another addition functioned as the main clinic. It had a long corridor, flanked by a series of rooms. The first room was reserved for ''adherence counseling,'' where patients who tested positive for HIV would be educated about the disease and the importance of following a strict regimen of drugs. The second room housed a small pharmacy, where ARTs and drugs for HIV-related afflictions would be provided. The third room was a small CTC-dedicated laboratory. At the end of the corridor were two patient consultation rooms. One of the existing clinic rooms had been converted into a filing and staff room, and the other was reserved for VCT. Once expanded, the building was filled with objects that made it into a very distinctive kind of place. While the rest of the hospital grappled with inadequate or absent equipment, the HIV/AIDS clinic was an enclave of abundance. The foyer housed a beautiful, hand-carved wooden bench with a padded seat and back, and a matching coffee table. The laboratory was filled with sophisticated technology, carefully labeled with the name of the donor(s) that paid for them (Figure 1).

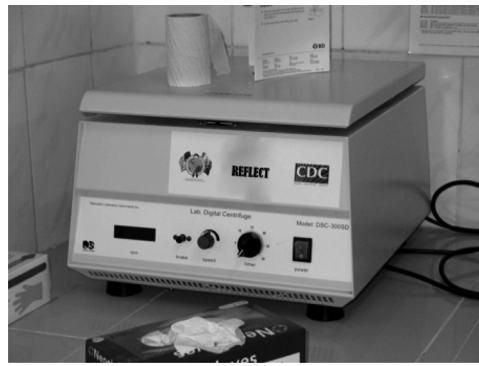

FIGURE 1 Centrifuge in the CTC Clinic at Kiunga District Hospital. "REFLECT" marks the place where the original logo was placed. Photo by N. Sullivan.

As of 2008, Kiunga District Hospital offered a variety of services, including outpatient clinic, dentistry, psychiatry, optical clinic, x-ray, ultrasound, physiotherapy, CTC clinic, RCH clinic, tuberculosis (TB) clinic, pharmacy, and surgery. Furthermore, there were four main wards for inpatients: a female ward, a male ward, a maternity ward, and a pediatric ward (Figure 2). Most of these services were offered prior to HSR, although the HIV/AIDS and RCH services had expanded considerably, and x-ray and surgical services began as of 2000–2001.

In light of transformations in infrastructure and availability of drugs and supplies, staff rarely complained about the working environment. Workers were accustomed to shortages and inadequate conditions, and with the many recent improvements, they were reticent to complain beyond stating that their work was "difficult" (*kazi yetu ni ngumu*). Instead, the main complaints related to money. Under HSR, there were minimal improvements to salaries. In 2008, the government announced salary increases for its employees. However, inflation and increases in the cost of living meant that despite the pay raises, the actual income of workers had been reduced drastically (Anders 2010). During an interview, an officer within the Health Sector Reform Secretariat of the MoH reflected:

> We are aware that with the inflation that we have had, the purchasing power differs, [and] the pay [increase] will not be much visible. So the pay has increased in nominal terms but the purchasing power is less than the previous. During that time for example when we started the reforms it was 1 US dollar to 370 T shillings. Today is 1 US dollar to 1700.

What progress the government made in terms of increasing the salaries of its workers had limited impacts, due to the economic hardships that the country

FIGURE 2 Signpost at Kiunga District Hospital directing patients to different departments. Photo by N. Sullivan.

had faced in recent years. Workers at Kiunga felt that the government was making an effort and had made important strides in terms of building up the capacity of the sector; however, they felt that additional efforts were needed. Reflecting on the transformations in the hospital infrastructure, a general nurse at the hospital stated, "*They have done something* in the Ministry of Health that is big . . . . We moved forward very well, but still it is not enough! . . . They have really tried, truly, on the side of *facilities* we see that they are trying," but staff felt that while there was significant improvement in the conditions of health care facilities, the state had largely neglected the workers themselves.

Despite of the small raise that took effect in mid-2008, many staff at Kiunga struggled with their inadequate salaries. The main complaints I heard about inadequate pay related to meeting family obligations (Anders 2010; Martin 2009):

> NS: I heard that you will receive increases in your salary.
> Nurse: There is nothing! They only gave us [an increase of] 20,000 there! If they give you twenty more, you have health insurance fees taken out [...] you have [union fees] taken out [...] that is, within that 200,000 [per month] that I get there is nothing left! I had to take out a loan, now I had to take out [another] loan to fulfill needs at home. Now I must pay on the loans, it is cut out of my pay and I am left with only 100,000, even except it isn't 100,000.... I have children that go to secondary school and one that is about to start, you are required to pay for the child around 500,000 [per year] so tell me, 500,000, can you sign for that? What if you don't have it? You don't even have the mind to understand how to save money![2]

WORKING BETWEEN ABUNDANCE AND SCARCITY

The two highest administrators at the district level of the health sector are the District Medical Officer (DMO), and the District Nursing Officer (DNO). The DMO is the officer in charge of all district health services and is the main representative of the MoH at the district level. He advocates for the health sector within the District Council—a political body that since decentralization is the main locus of planning and implementation of central and local government initiatives. The DNO works under the DMO and supervises nursing in the entire district. In Kiunga, she was responsible for assigning MoH- and donor-sponsored workshops to health workers. The offices of both the DMO and the DNO are located at the district hospital, and they are regularly present for staff meetings and various other hospital activities.

Ironically, while they were the main MoH representatives at the district level, the DMO and DNO were also the main decision-makers when it came to allocating the benefits of donor-sponsored programs. There were two ways that they could distribute these resources among the staff: by assigning them to work in the clinic where they would get access to allowances, and by allocating training opportunities.

The Benefits of HIV/AIDS Work and the Tensions of Targeted Training

As government employees, hospital workers were technically entitled to extra duty pay when they worked overtime, but they did not receive it.

Indeed, extra duty pay was a budgeted item every year in the Comprehensive Council Health Plan for Kiunga, but year after year, the DMO told the workers that the Council failed to acquire sufficient funds to pay the workers beyond their regular salaries. As the only unit of the hospital that provided extra duty pay, the CTC clinic was the sole department where the workers received that to which they felt they had a right. Indeed, the CTC provided more frequent and higher-paying salary supplements than other NGOs operating programs within the hospital. The CTC clinic included various allowances that would be paid to staff: overtime allowance, extra duty allowance, travel and per diem expenses, and monthly and quarterly CTC meeting allowances.

REFLECT representatives were aware of the effects of the salary supplementations they provided to health care workers. Peter, a Tanzanian REFLECT officer, stated that many of the facilities they funded were short staffed and already overburdened—unable to deal adequately with the inputs REFLECT required. He noted that when clinical workers were asked to meet for duties not related to the CTC clinic, they were not paid, causing additional friction within these facilities. While CTC staff received extra duty allowances, workers in other areas also undertook extra duty, without compensation. As noted by a CTC clinician, the extra duty allowances received from REFLECT created significant inequalities among workers:

> For example, *extra duty* we get it because of this donor [REFLECT]. But for example, the *extra duty* for the people who work in other departments, it is really hard. It is really hard. That is, they have not been paid in many years! Eeh. So there is a problem. They say that they have not been paid, not even a little bit.

In addition, for each attendance at CTC weekly meetings, the clinic staff would receive an allowance of 5,000 Tsh, and for monthly meetings, they were later reimbursed a 20,000 Tsh allowance.[3] According to Peter, in addition to their regular government salary, the staff was making from US $80 up to US $200 per month extra from working in the CTC clinic. For the various levels of doctors and nurses at the hospital, this was an additional 40 to 100 percent onto their monthly take-home salary.

Along with all of the resources it bestowed within the CTC clinic, REFLECT was one of the few providers of regular training workshops for the staff, and it offered workshops more frequently than those provided by the MoH or by any other NGO running programs at Kiunga. Training was highly desirable for all levels of the staff for a variety of reasons. Workshops upgraded professional skills, which might lead to promotions or additional training later on. Furthermore, workshops offered lucrative per

diems and travel allowances, which were extremely important given the reduced buying power of salaries. Staff members could use payment from workshops to build their family's future: school fees for children, additions to a house, and investments in small business opportunities (Anders 2010; Whyte et al. 2010). A nurse conveyed the impact that a REFLECT-sponsored training workshop had on her ability to fulfill her family obligations:

> Nurse: Even the other day I completed the PITC seminar.[4] There I received 200,000 shillings and with those 200,000 you can even send your child to school [...] If another person over there in a seminar got 225,000—200,000 you sent *pap!* [clapped hands together]. Twenty-five left to buy food for the home, aah you can see how the month flies by! *Yeah!*

Given the enormity of impact one seminar could have on a staff member's ability to support her family, it is no wonder that they were so popular.

Realizing the potential impact of workshops on staff morale, capacity, and income, the DMO advocated spreading workshops widely among the staff: "We cared about the employees so that when they saw patients they gave services. We gave them their allowances, cared about their going to training so the employees have really changed!" Given that the previous DMO had provided scant opportunities for lower grade staff, these efforts to distribute training widely did not go unnoticed:

> Nurse Aide: [Before the current administration], those in charge, they would leave you in the wards, we were left in the wards with the patients. [...] You are humiliated with the patients while they go to seminars [...] Now, when [the DMO] saw this, he saw that this wasn't rights. Why does this person not go and yet you go [to seminars]?

Although REFLECT had only started scaling up the CTC services in late 2007, by the end of 2008, well over half of the hospital staff had been to at least one REFLECT-funded workshop.

However, not all training opportunities were created alike. Some seminars only lasted a few days, whereas others were up to two weeks long. While nearly everyone had been to some kind of training session in 2008, not everybody felt that the administrator was allocating seminars fairly. A select few among the staff were particularly vocal about the fact that the District Council had not paid extra duty allowances to the general staff. They regularly claimed it was the staff's right to receive extra duty when working in the non-enclaved departments of the hospital. Staff who attempted to claim their rights to compensation through the DMO felt that

they were being denied more advantageous training opportunities. One senior doctor who was often vocal about compensation rights stated,

> A person who is really bothersome [*anasumbua sana*], he is only sent to seminars that last two or three days rather than the ones that last a week or two. So he will get something new in his head but even *income*, he will not get it.... The people who have cars here, people can get *compensated* salary [through seminars] until they are able to buy a car! Right? Or they can be *compensated* and ask for another seminar.... Those kinds of [long] seminars, you Noela will be given those seminars because you are not a nuisance [*usumbufu*]. But me, even as a nuisance I do my work.

This is a telling example of the limits to the ways that health personnel can make claims on the state within the enclaved hospital. This doctor continually challenged the state directly through the district health administrators, attempting to claim what he felt were worker's rights for the hospital as a whole. Yet because the same administrators were responsible for allocating donor-sponsored workshops and benefits, they could prevent him from accessing those rights through donor-sponsored programs like the CTC. Seeing his coworkers able to access extravagant resources (such as a car), this doctor felt a considerable amount of resentment for some of the staff, because he was trying to fight for their rights: "A person who does not ask questions, who does not *challenge*, nothing can change! I will continue to ask questions, and *challenges* must continue to come out. Right? Because others can see that one person asks questions and today they will ask a question." Thus, despite knowing that the only avenue available for accessing that to which he felt entitled was through the enclave, this doctor continued to hope that his persistence would inspire his coworkers to join him in making direct claims on the state.

Overall, the staff thought that donors such as REFLECT were highly desirable additions to their institution (cf. Kelsall and Mercer 2003). "Donors" (whether private, corporate, bilateral, or nongovernmental) were widely seen as the providers of the infrastructure and development within the hospital during the past decade. While there was appreciation for the steps that the MoH had taken in terms of formulating policies to reform the health sector, donors were seen as the source of what the hospital needed:

> Senior nurse: These changes are many, my goodness, these many changes I see. I see that many [changes] have been *pushed* by donors. The truth is that we are with the Ministry of Health, and they are giving us services. But if I look at the many changes in development, they have been done by donors! [...] This is why I say NGOs should continue to move forward because truly they are providing big contributions to social development.

This nurse's comment reflects a considerable reorientation due to HSR and the establishment of donor enclaves at the hospital. Prior to HSR, the hospital had to rely on a government that was unable to provide the resources and salaries that personnel needed to do their jobs. With the encouragement of facilities to forge their own PPPs, and with the establishment of non-state entities within the government hospital, the staff at Kiunga District Hospital began to look beyond the state for what at they needed, institutionally and professionally.

Negotiating Resources and Accusations: A Case Study

By the middle of 2008, accusations of favoritism began to surface. By then, REFLECT seminars had been going on for nearly a year, and the staff began to notice that particular individuals were going to multiple workshops while others had yet to be sent on their first. In June, at the monthly meeting for all hospital staff, a junior doctor publicly accused the administrators of favoritism because some people went to several seminars, and could thus increase their income. It was unfair for only a few select people to have access to extra training and extra pay. It was also her right, she argued, to be chosen to go to a seminar because she, like the rest of the staff, was also poor. This proclamation led a lot of murmuring among the staff. The vast majority of the staff mistrusted the DNO, Mary, who distributed training opportunities. Mary countered that some workshops were only meant for people who worked in a particular clinic. Her retort instigated even louder murmuring, and she started to get defensive. The DMO observed the escalated tensions, quickly walked across the floor and whispered something to Mary. Mary sat down. The DMO then explained that workshops belonged to everyone, that people would be given workshops gradually, and that some training was for particular individuals due to the department in which they worked.

As the agitated staff continued to mumble, Mary stood again: ''Let's discuss these problems so that we can finally be rid of them.'' She rationalized that many seminars were donor funded, and that as the providers of the money, donors were the ones with the power to decide what kinds of seminars to provide and who should attend. Mary's account was only partially true, however, and several workers were aware of this. Hospital files told a slightly more complex story: in many cases, REFLECT and other donors would send an e-mail or fax advertising a workshop, and asked administrators to provide the names of a specified number of staff to attend. While a few workshop announcements mentioned a specific name, many did not. In articulating the dilemma in this way, Mary was attempting to diffuse some of the hostility directed toward her.

The effects of Mary's explanation were short-lived. By October 2008, a particular event relating to REFLECT's training provisions escalated tensions. A nurse midwife, Catherine, received a letter stating that she was selected to participate in a two-week workshop at a nearby training facility. Due to its length the workshop would significantly increase her take-home salary. Catherine went to the facility on the designated date only to be told upon arrival that Sophia, the hospital's head nurse and Catherine's immediate boss, took her place in the workshop. Catherine returned to the hospital in tears.

News of Sophia's actions spread quickly among the staff. The monthly full staff meeting took place a week later. At the meeting, one of the senior doctors stood up and, in front of the entire crowd, spoke out against what Sophia had done. Sophia was absent, attending the workshop in place of Catherine. When the DMO heard about the incident, he was irate. He had been out of town and had not heard about it until then. He urged Catherine to speak to him privately to clarify what happened. He reminded the staff that a person's financial need for the seminar rarely weighed into the decision. The DMO also announced that he would take harsh steps against anyone who demonstrated favoritism in allocating seminars.

However, the issue did not end with the meeting. Complaints continued among staff about corruption within the administration. The DMO was scheduled for his one-month vacation, which took him out of the hospital. A week after the committee meeting, an article emerged in a national newspaper accusing the DMO of corruption. The article, written under a false name, stated that he had been using donor and government money for private purposes. Soon thereafter, Sophia returned to the hospital from the workshop. She attended the morning staff meeting, but remained silent throughout. When the meeting adjourned, she went to her office, prepared some administrative paperwork, and then left, also on her yearly vacation. With the DMO and Sophia out of the hospital, the facility had now been evacuated of two of its most powerful administrators, and work output slowed considerably. Several nurses with whom I spoke remarked about the tardiness of others (*wanachelewa*), and staff morale suffered. On several all-staff morning meetings in the following days, senior staff deplored the low attendance at work (*hawapo kazini*) and the tardiness of many employees. These repeated statements had little effect on staff attendance. When the DMO finally returned from vacation in December, he was uncharacteristically quiet. Previously, he was generally a boisterous, charismatic leader. Now, amid the gossip about corruption and favoritism that he worked so long to combat, he kept to his office.

Patient care suffered tremendously as staff felt that they had no incentive to work hard for a corrupt administration, as a senior nurse argued, "They

[the administrators] forget themselves to say such lies, they forget themselves and just leave in their cars in the morning.'' The comment pointed to the considerable hostility directed against the administrators, who at once represented the failures of the state, and the sole means by which hospital workers could access the very resources to which they felt entitled by their profession and their status as state workers. While the MoH acknowledged the rights of workers to updated training and adequate salaries, the government lacked the resources to make these promises into a reality. In an enclaved hospital where resources are abundant only in very specific departments, the DMO could do little to assuage their disillusionment.

CONCLUSION

NGO-sponsored enclaves offer one of the few means by which government health workers can access new knowledge, adequate pay, and opportunities for future promotions in Tanzania. This is particularly the case for those enclaves that provide HIV/AIDS services, which offer highly specialized training and make available sophisticated technologies uncharacteristic of the other enclaved and non-enclaved departments of the hospital. For the hospital personnel working at Kiunga, the enclaves had a number of paradoxical effects. First, the NGO-sponsored clinics within government health facilities erode any comfortable division between ''public'' and ''private'' health services (Blundo and Le Meur 2008). The district-level representatives of the Ministry of Health are the gatekeepers of NGO-funded training opportunities and salary supplementation. As distributors of externally-funded training and compensation, administrators must determine how to mediate the abundance of the enclaves amid the paucity of the other units of the hospital. Second, a decade ago, staff collectively endured the hardships of working in an environment plagued by chronic shortages of many of the things that would enable them to provide adequate care and sustain their families. While similar scarcities existed in the hospital in 2008, the deficiencies were made all the more present as the resources of the enclave served as an everyday reminder of the persistent inability of the government to live up to its promises. To the health workers struggling with inadequate pay and hoping for additional training, donor-sponsored programs presented opportunities to achieve personal and professional aspirations unavailable by any other means in the district hospital. However, it simultaneously eroded the staff's relationships with the administrators who stood between them and their hopes, and with each other as the economy of scarcity put them in competition with each other. Those staff members who did not agitate for worker rights were perceived to benefit disproportionately from donor-sponsored

workshops, fueling the resentment of other employees who hoped to inspire more collective action by advocating for that to which they felt entitled as state employees and medical professionals. Ironically, the abundant resources of NGO-sponsored HIV/AIDS clinics are eroding the very institutions and professional relationships on which they depend to provide ART services.

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NOTES

1. According to TACAIDS 2007 Annual Report, for HIV/AIDS alone Tanzania received US$5,400,000 in Round One; US$83.5 million in Round 3; and in June 2007 as part of Round 4, US$157.3 million had been approved.
2. All values stated are in Tanzanian shillings. The exchange rate at the time the interview was conducted was approximately 1178 Tsh to US $1.
3. In 2008, 5000 Tanzanian shillings (Tsh) was worth approximately US $4.20, and 20,000 Tsh was worth US $16.75, which was more than a day's wage for most nurses.
4. "Provider-Initiated Testing and Counseling." This is a program that helps medical practitioners to be able to identify patients who potentially are suffering from HIV-related afflictions and provides them with training on how to counsel these patients about the importance of getting testing and the availability of services.

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